Original Application

Starr Regional Medical Center

CN1701-002

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

JAN 13 '17 AM 9:56

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. ***Name of Facility, Agency, or Institution***

Starr Regional Medical Center--Etowah
Name

886 Highway 411 North — McMinn
Street or Route — County

Etowah — TN — 37331
City — State — Zip Code

Website address: _____

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

2. ***Contact Person Available for Responses to Questions***

Kim H. Looney — Attorney
Name — Title

Waller Lansden Dortch & Davis LLP — kim.looney@wallerlaw.com
Company Name — Email address

511 Union Street, Suite 2700 — Nashville — TN — 37219
Street or Route — City — State — Zip Code

Attorney — 615-850-8722 — 615-244-6804
Association with Owner — Phone Number — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable)*. ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

1. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

Response: Starr Regional Medical Center-Etowah ("SRMC-Etowah" or "Hospital"), is a 72-bed acute care hospital located in McMinn County, Tennessee. The applicant and Starr Regional Medical Center-Athens (118 beds), also located in McMinn County, operate under the 190-bed consolidated license held by its owner, Athens Regional Medical Center, LLC. The Hospital is seeking approval to expand its existing 14-bed inpatient geriatric psychiatric unit to 18 beds. The expansion of the unit will be accomplished without increasing Etowah's 72 bed complement by redistributing 4 of its medical/surgical beds. The project will not impact the 118 licensed beds at the main hospital campus in Athens or the 190 total licensed beds for both sites.

SRMC-Etowah is the only provider of geriatric psychiatric inpatient services in McMinn County. It serves primarily patients 65+ years of age, and occasionally patients 55-64 years of age, who because of dementia or early stages of Alzheimer's are appropriate for a geriatric unit.

2) Ownership structure;

Response: SRMC-Etowah is owned by Athens Regional Medical Center, LLC, which in turn is owned by LifePoint Health, Inc through other subsidiaries wholly (100%) owned by LifePoint Health, Inc. LifePoint is a national hospital company with headquarters in the Nashville area. SRMC-Etowah is a member of the LifePoint Central Group, an operational grouping of facilities consisting of 22 hospitals in multiple states, including 10 hospitals in Tennessee (see organization chart and listing of LifePoint hospitals in Attachment Section A-4A.

3) Service area;

Response: The primary service area for SRMC-Etowah includes Bradley, McMinn, Meigs, Monroe, and Polk Counties. This service area accounted for approximately 65.9% of the geriatric psychiatric unit's total patient days in CY 2015, with a low to high range of 3.6% from Meigs County and 27% from McMinn County. The service area will not change as a result of the proposed expansion. The total population of the PSA is estimated at 239,717 persons in CY 2017 increasing 3.3% to 247,717 persons in CY 2021. The overall statewide population is projected to grow 4.2% from CY 2017 to CY 2021. The age 65+ population of the PSA is projected to grow 14.7% from CY 2017 to CY 2021. Approximately 24% of the PSA's residents were enrolled in TennCare compared with a statewide average of 22.6% in CY 2016. The proportion of TennCare enrollment in the PSA's total population ranges from 27.4% in Meigs County to 22.3% in Polk County.

4) Existing similar service providers;

Response: There are no other providers in the primary service area focusing on geriatric psychiatric care. Skyridge Medical Center Westside, in Bradley County has a 30-bed unit that serves primarily adults below the age of 65, although it does admit a small number of patients over age 65 who are appropriate for their unit. The focus and treatment for a general adult patient population is very different than that for a geropsychiatric patient population.

5) Project cost;

Response: The total estimated project cost is $633,351.00. See the project cost chart for a further breakdown of estimated costs.

6) Funding;

Response: The project costs will be funded by LifePoint Health, Inc., the applicant's parent company, through a cash transfer.

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

Response: The unit is currently operating with a positive financial margin and is projected to continue to do so with an expanded patient census, so will have a positive financial margin in the first year of operation.

8) Staffing.

Response: The applicant staffs its treatment programs in accordance with the needs of its patients and their expected lengths of stay. It is expected that an additional 2.5 FTEs will be needed as the result of the implementation of this project.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B. of this application. Please summarize in one page or less each of the criteria:

1) Need;

Response:

- The applicant received a CON in 2014 to increase its geropsychiatric beds from 10 to 14. The addition of these beds allowed more of the frail, elderly population to receive geropsychiatric services closer to home. As the utilization of these

services has increased, it is now necessary to seek an increase in the number of beds again.

- Admissions to the 14-bed unit at the Hospital have increased by approximately 40% during the past 3 years. The unit reached almost 75% average annual occupancy in CY 2016.
- This reflects a high rate of utilization for a small unit with all semi-private beds. The "annual average" can mask a problem of a wide swing in census and a lack of available beds on many days. In CY 2016, occupancy rose to 85% or more during the second quarter of the year.
- The fact that all of the beds are semi-private is an exacerbating circumstance. It is necessary to separate patients by gender, and sometimes by diagnosis. In a busy week, having to use semi-private rooms as private rooms to achieve gender separation and appropriate diagnosis mix lowers available bed capacity. That constraint is not reflected in annual average occupancy calculations that assume all empty beds are always available. In addition, a smaller number of beds makes it more challenging as well.
- By CY 2021, demand for geriatric psychiatric beds is expected to increase in part due to a 14.9% growth rate in the target population in the service area.

2) Economic Feasibility;

Response: The costs of the project are reasonable. The applicant anticipates a positive cash flow in the first year of operation of the additional beds.

3) Appropriate Quality Standards; and

Response: The applicant is part of a much larger hospital company, which is used to implementing and measuring quality standards.

4) Orderly Development to adequate and effective health care.

Response: There are no other psychiatric beds focusing on the geriatric patient population in the applicant's primary service area. While there is another unit at Skyridge, that unit serves primarily an adult patient population and rarely serves patients who are over the age of 65. Treatment of the adult patient population is very different from that of the geriatric patient population.

C. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Response: N/A

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4. SECTION A: PROJECT DETAILS

A. Owner of the Facility, Agency or Institution

Athens Regional Medical Center, LLC
Name

Phone Number

114 West Madison Avenue
Street or Route

McMinn
County

Athens
City

TN
State

37303
Zip Code

B. Type of Ownership of Control (Check One)

A.	Sole Proprietorship	_____	F.	Government (State of TN or Political Subdivision)	_____
B.	Partnership	_____	G.	Joint Venture	_____
C.	Limited Partnership	_____	H.	Limited Liability Company	X
D.	Corporation (For Profit)	_____	I.	Other (Specify) _____	_____
E.	Corporation (Not-for-Profit)	_____			

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx. **Attachment Section A-4A.**

Response: See copy of corporate documents included as Attachment Section A-4A.

Describe *the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.*

5. *Name of Management/Operating Entity (If Applicable)(for management of the geropsychiatric service only)*

Horizon Mental Health Management, LLC
Name

(Out of State)
County

1965 Lakepoint Drive, Suite 100
Street or Route

Lewisville
City

TX
State

75057-6424
Zip Code

Website address: _____

For new facilities or existing facilities *without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.* **Attachment Section A-5**.

Response: See Management Services Agreement included as Attachment Section A-5.

6A. ***Legal Interest in the Site of the Institution*** ***(Check One)***

A.	Ownership	X	D.	Option to Lease	_____
B.	Option to Purchase	_____	E.	Other (Specify) _____	_____
C.	Lease of Years	_____			

Check appropriate line above: *For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

Response: See copy of Deed included as Attachment Section A-6A.

6B. Attach **a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site** on an 8 1/2" x 11" sheet of white paper, single or double-sided. ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

1) Plot Plan **must include**:

a. Size of site (***in acres***);

b. Location of structure on the site;

c. Location of the proposed construction/renovation; and

d. Names of streets, roads or highway that cross or border the site.

Response: See plot plan included as Attachment Section A-6B-1.

2) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 ½ by 11 sheet of paper or as many as necessary to illustrate the floor plan.

Response: See floor plan included as Attachment Section A-6B-2.

3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Attachment Section A-6A, 6B-1 a-d, 6B-2, 6B-3.

Response: The Hospital is located in Etowah, Tennessee on US Highway 411, which parallels I-75 running southwest to northeast between the Chattanooga and Knoxville areas. US 411 is 12-14 miles east of I-75 for most of the distance between Chattanooga and Knoxville. As shown in the table below, SRMC-Etowah's campus is approximately a half hour drive or less from all the largest communities in its 5-county geropsychiatric primary service area. It is more than an hour's drive time from Knoxville and Chattanooga.

Etowah itself is a small community. The Hospital campus is on the west side of US 411/Tennessee Avenue, a few hundred yards north of its intersection with State Highway 30 (David Lillard Memorial Highway), which connects Etowah and Athens. Etowah does not have public transportation. Non-emergency patients throughout the service area typically drive personal vehicles to healthcare providers.

Mileage and Drive Times Between Project and Major Communities In or Near the Primary Service Area

	County	Distance	Drive Time
1. Athens	McMinn	9.5 mi.	13 min.
2. Cleveland	Bradley	29.6 mi.	35 min.
3. Decatur	Meigs	22.8 mi.	29 min.
4. Sweetwater	Monroe	25.3 mi.	31 min.
5. Madisonville	Monroe	15.8 mi.	20 min.
6. Tellico Plain	Monroe	16.4 mi.	26 min.
7. Benton	Polk	14.7 mi.	18 min.

7. ***Type of Institution*** ***(Check as appropriate--more than one response may apply)***

A. Hospital (Specify) Geropsychiatric X
B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty _____
C. ASTC, Single Specialty _____
D. Home Health Agency _____
E. Hospice _____
F. Mental Health Hospital _____
G. Mental Health Residential Treatment Facility _____
H. Mental Retardation Institutional Habilitation Facility (ICF/MR) _____
I. Nursing Home _____
J. Outpatient Diagnostic Center _____
K. Recuperation Center _____
L. Rehabilitation Facility _____
M. Residential Hospice _____
N. Non-Residential Methadone Facility _____
O. Birthing Center _____
P. Other Outpatient Facility (Specify) _____ _____
Q. Other (Specify) _____ _____

Check appropriate lines(s).

8. ***Purpose of Review*** ***(Check) as appropriate--more than one response may apply)***

A. New Institution _____
B. Replacement/Existing Facility _____
C. Modification/Existing Facility X
D. Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify) _____ _____
E. Discontinuance of OB Services _____
F. Acquisition of Equipment _____
G. Change in Bed Complement *[Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]* X
H. Change of Location _____
I. Other (Specify) _____ _____

9. **Medicaid/TennCare, Medicare Participation**

MCO Contracts [Check all that apply]

X AmeriGroup X United Healthcare Community Plan X BlueCare X TennCare Select

Medicare Provider Number: Hospital: 440068; Geropsychiatric Unit 44S068

Medicaid Provider Number: Hospital: 440068; Geropsychiatric Unit 44S068

Certification Type: General Hospital; Psychiatric Unit

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare _____Yes _____No X N/A Medicaid/TennCare _____Yes_____No X N/A

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.

	Current Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempted	TOTAL Beds at Completion
1) Medical	50	0	-4			46
2) Surgical						
3) ICU/CCU	8	7				8
4) Obstetrical						
5) NICU						
6) Pediatric						
7) Adult Psychiatric						
8) Geriatric Psychiatric	14	14	+4			18
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)	24	24				24
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)	64	64				64
19) ICF/IID						
20) Residential Hospice						
TOTAL	72	17	NC			72

*Beds approved but not yet in service **Beds exempted under 10% per 3 year provision

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. **Attachment Section A-10.**

Response: The beds are not new beds to the facility but a reallocation of 4 beds from acute care to psychiatric. In 2014, when the hospital received the CON for an increase from 10 to 14 geropsychiatric beds, the Hospital asked licensure to put the license for the acute care beds in an inactive status.

C. **Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.**

Response: N/A

CON Number(s)	CON Expiration Date	Total Licensed Beds Approved

11. Home Health Care Organizations – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

Response: N/A

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	☐	McMinn	☐	☐	☐
Campbell	☐	☐	☐	McNairy	☐	☐	☐
Cannon	☐	☐	☐	Macon	☐	☐	☐
Carroll	☐	☐	☐	Madison	☐	☐	☐
Carter	☐	☐	☐	Marion	☐	☐	☐
Cheatham	☐	☐	☐	Marshall	☐	☐	☐
Chester	☐	☐	☐	Maury	☐	☐	☐
Claiborne	☐	☐	☐	Meigs	☐	☐	☐
Clay	☐	☐	☐	Monroe	☐	☐	☐
Cocke	☐	☐	☐	Montgomery	☐	☐	☐
Coffee	☐	☐	☐	Moore	☐	☐	☐
Crockett	☐	☐	☐	Morgan	☐	☐	☐
Cumberland	☐	☐	☐	Obion	☐	☐	☐
Davidson	☐	☐	☐	Overton	☐	☐	☐
Decatur	☐	☐	☐	Perry	☐	☐	☐
DeKalb	☐	☐	☐	Pickett	☐	☐	☐
Dickson	☐	☐	☐	Polk	☐	☐	☐
Dyer	☐	☐	☐	Putnam	☐	☐	☐
Fayette	☐	☐	☐	Rhea	☐	☐	☐
Fentress	☐	☐	☐	Roane	☐	☐	☐
Franklin	☐	☐	☐	Robertson	☐	☐	☐
Gibson	☐	☐	☐	Rutherford	☐	☐	☐
Giles	☐	☐	☐	Scott	☐	☐	☐
Grainger	☐	☐	☐	Sequatchie	☐	☐	☐
Greene	☐	☐	☐	Sevier	☐	☐	☐
Grundy	☐	☐	☐	Shelby	☐	☐	☐
Hamblen	☐	☐	☐	Smith	☐	☐	☐
Hamilton	☐	☐	☐	Stewart	☐	☐	☐
Hancock	☐	☐	☐	Sullivan	☐	☐	☐
Hardeman	☐	☐	☐	Sumner	☐	☐	☐
Hardin	☐	☐	☐	Tipton	☐	☐	☐
Hawkins	☐	☐	☐	Trousdale	☐	☐	☐
Haywood	☐	☐	☐	Unicoi	☐	☐	☐
Henderson	☐	☐	☐	Union	☐	☐	☐
Henry	☐	☐	☐	Van Buren	☐	☐	☐
Hickman	☐	☐	☐	Warren	☐	☐	☐
Houston	☐	☐	☐	Washington	☐	☐	☐
Humphreys	☐	☐	☐	Wayne	☐	☐	☐
Jackson	☐	☐	☐	Weakley	☐	☐	☐
Jefferson	☐	☐	☐	White	☐	☐	☐
Johnson	☐	☐	☐	Williamson	☐	☐	☐
Knox	☐	☐	☐	Wilson	☐	☐	☐
Lake	☐	☐	☐				

12. Square Footage and Cost Per Square Footage Chart

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
Geriatric Psych	West Wing	6,800	0	West Wing	2,800	0	9,600
Unit/Department GSF Sub-Total							
Other GSF Total							
Total GSF		6800			2,800	0	9,600
*Total Cost					$352,000		
**Cost Per Square Foot					$125.72		
Cost per Square Foot Is Within Which Range *(For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda)*					X Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile

* The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.

13. MRI, PET, and/or Linear Accelerator

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or
2. Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:

A. Complete the chart below for acquired equipment.

☐ Linear Accelerator	Mev _____	Types:	☐ SRS ☐ IMRT ☐ IGRT ☐ Other _____	
	Total Cost*: _____		☐ By Purchase ☐ By Lease	Expected Useful Life (yrs) _____
	☐ New	☐ Refurbished	☐ If not new, how old? (yrs) _____	
☐ MRI	Tesla: _____	Magnet:	☐ Breast ☐ Extremity ☐ Open ☐ Short Bore ☐ Other _____	
	Total Cost*: _____		☐ By Purchase ☐ By Lease	Expected Useful Life (yrs) _____
	☐ New	☐ Refurbished	☐ If not new, how old? (yrs) _____	
☐ PET	☐ PET only	☐ PET/CT	☐ PET/MRI	
	Total Cost*: _____		☐ By Purchase ☐ By Lease	Expected Useful Life (yrs) _____
	☐ New	☐ Refurbished	☐ If not new, how old? (yrs) _____	

* As defined by Agency Rule 0720-9-.01(13)

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

Response: Not Applicable

C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

Response: Not Applicable

D. Schedule of Operations:

Location	Days of Operation (*Sunday through Saturday*)	Hours of Operation (*example: 8 am – 3 pm*)
Fixed Site *(Applicant)*		
Mobile Locations *(Applicant)*		
(Name of Other Location)		
(Name of Other Location)		

E. Identify the clinical applications to be provided that apply to the project.

Response: Not Applicable

F. If the equipment has been approved by the FDA within the last five years provide documentation of the same.

Response: Not Applicable

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the State Health Plan developed pursuant toT.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper, single-sided or double sided.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. ***If a question does not apply to your project, indicate "Not Applicable (NA)."***

QUESTIONS

NEED

1. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the Tennessee Health Services and Development Agency or found on the Agency's website at http://www.tn.gov/hsda/article/hsda-criteria-and-standards.

PSYCHIATRIC INPATIENT SERVICES

1. **Determination of Need:** The population-based estimate of the total need for psychiatric inpatient services is a guideline of 30 beds per 100,000 general population, using population estimates prepared by the TDH and applying the applicable data in the Joint Annual Report (JAR). These estimates represent gross bed need and shall be adjusted by subtracting the existing applicable staffed beds including certified beds in outstanding CONs operating in the area as counted by the TDH in the JAR. For adult programs, the age group of 18-64 years shall be used in calculating the estimated total number of beds needed; additionally, if an applicant proposes a geriatric psychiatric unit, the age range 65+ shall be used. For child inpatients, the age group is 12 and under, and if the program is for adolescents, the age group of 13-17 shall be used. The HSDA may take into consideration data provided by the applicant justifying the need for additional beds that would exceed the guideline of 30 beds per 100,000 general population. Special consideration may be given to applicants seeking to serve child, adolescent, and geriatric inpatients. Applicants may demonstrate limited access to services for these specific age groups that supports exceeding the guideline of 30 beds per 100,000 general population. An applicant seeking to exceed this guideline shall utilize TDH and TDMHSAS data to justify this projected need and support the request by addressing the factors listed under the criteria "Additional Factors".

Response: Applying the formula to the total population in the service area shows a need for 75 beds in the service area. There are currently 44 beds in the service area, so there is net need for 29 beds for the total population. When you apply the formula to the population 65 and older in 2021, there is a need for 17 beds in the service area. The applicant currently has 14 beds, so there is net need for 3 beds. The applicant's own utilization supports the need for an additional 4 beds. Because the formula generally underestimates the need for the geriatric population, the applicant feels there is a need for at least 4 more geropsychiatric beds in the service area. The population aged 65 and older is expected to grow 14.9% between 2017 and 2021, which increases demand for additional beds.

2. **Additional Factors**: An applicant shall address the following factors:
    a. The willingness of the applicant to accept emergency involuntary and nonemergency indefinite admissions;

       Response: The applicant does not accept involuntary admissions or nonemergency indefinite admissions. This is partially because involuntary admissions are atypical for this patient population. The court system generally disfavors signing off on involuntary admissions for geriatric patients.

    b. The extent to which the applicant serves or proposes to serve the TennCare population and the indigent population;

       Response: The applicant is a certified TennCare provider.

    c. The number of beds designated as "specialty" beds (including units established to treat patients with specific diagnoses);

       Response: The beds are all geropsychiatric beds.

    d. The ability of the applicant to provide a continuum of care such as outpatient, intensive outpatient treatment (IOP), partial hospitalization, or refer to providers that do;

       Response: The applicant focuses its efforts on inpatient geropsychiatric services and refers to other providers who can provide outpatient, IOP, or partial hospitalization services.

    e. Psychiatric units for patients with intellectual disabilities;

       Response: The applicant does not serve this patient population.

    f. Free standing psychiatric facility transfer agreements with medical inpatient facilities;

       Response: The applicant is part of the larger Starr Regional Medical Center hospital system, which offers medical inpatient services.

g. The willingness of the provider to provide inpatient psychiatric services to all populations (including those requiring hospitalization on an involuntary basis, individuals with co-occurring substance use disorders, and patients with comorbid medical conditions); and

Response: The applicant is unable to provide geropsychiatric services for individuals with co-occurring substance use disorders. As to patients with comorbid medical conditions, the applicant employs a physician on site to treat medical conditions for patients that present with chronic conditions as well as medical treatment that becomes necessary after admission. There is also a 24/7 Emergency Room attached to the facility in case acute care becomes necessary.

h. The applicant shall detail how the treatment program and staffing patterns align with the treatment needs of the patients in accordance with the expected length of stay of the patient population.

Response: The applicant staffs its treatment programs in accordance with the needs of its patients and their expected lengths of stay.

i. Special consideration shall be given to an inpatient provider that has been specially contracted by the TDMHSAS to provide services to uninsured patients in a region that would have previously been served by a state operated mental health hospital that has closed.

j. **Response**: N/A

k. Special consideration shall be given to a service area that does not have a crisis stabilization unit available as an alternative to inpatient psychiatric care.

Response: There is not a crisis stabilization unit available as an alternative to inpatient psychiatric care in the primary service area. Rather, a crisis response team operated as part of Hiwassee Mental Health Center, a stated facility, is utilized in order to assess patients for CON for commitment.

3. **Incidence and Prevalence**: The applicant shall provide information on the rate of incidence and prevalence of mental illness and substance use within the proposed service area in comparison to the statewide rate. Data from the TDMHSAS or the Substance Abuse and Mental Health Services Administration (SAMHSA) shall be utilized to determine the rate. This comparison may be used by the HSDA staff in review of the application as verification of need in the proposed service area.

Response: The regions occupied by the PSA account for 17.02% and 17.12% of all CY 2015 admissions to regional mental health institutes and private psychiatric hospitals that contract with the Tennessee Department of Mental Health and Substance Abuse Services ("TDMHSAS") respectively, per the 2016 TDMHSAS Behavioral Health County and Region Services Data Book. Admissions in the regions have steadily been on the rise from 1.9 per 1,000 population and 2.7 per 1,000 population in CY 2013 to 2.3 per 1,000 population and 2.9 per 1,000

population in CY 2015. Bradley (2.8), McMinn (3.3), Meigs (3.2), Monroe (2.2), and Polk (3.8) all had particularly high incidences of admissions per 1,000 population.

4. **Planning Horizon**: The applicant shall predict the need for psychiatric inpatient beds for the proposed first two years of operation.

   Response: The applicant anticipates there is a need for at least 4 more geropsychiatric beds in the service area for the first two years of operation. It will continue to monitor utilization and monitor the needs of the service area.

5. **Establishment of Service Area**: The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The proposal's sensitivity and responsiveness to the special needs of the service area shall be considered, including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, other medically underserved populations, and those who need services involuntarily. The applicant may also include information on patient origination and geography and transportation lines that may inform the determination of need for additional services in the region.

   Response: The geographic service area is reasonable and based on the service area that the applicant currently serves for geropsychiatric services. The applicant treats all patients regardless of sex, race or ethnicity, and income.

6. **Composition of Services**: Inpatient hospital services that provide only substance use services shall be considered separately from psychiatric services in a CON application; inpatient hospital services that address co-occurring substance use/mental health needs shall be considered collectively with psychiatric services. Providers shall also take into account concerns of special populations (including, e.g., supervision of adolescents, specialized geriatric, and patients with comorbid medical conditions). The composition of population served, mix of populations, and charity care are often affected by status of insurance, TennCare, Medicare, or TriCare; additionally, some facilities are eligible for Disproportionate Share Hospital payments based on the amount of charity care provided, while others are not. Such considerations may also result in a prescribed length of stay.

   Response: The applicant provides services to geropsychiatric patients; it does not treat any other age population for psychiatric services other than the occasional patient who is less than age 65, but is appropriate for admission to a geropsychiatric unit. Because the age of the patients it treats is almost exclusively over the age of 65, the applicant's payor mix is 98% Medicare patients.

7. **Patient Age Categorization**: Patients should generally be categorized as children (0-12), adolescents (13-17), adults (18-64), or geriatrics (65+). While an adult inpatient psychiatric service can appropriately serve adults of any age, an applicant shall indicate if they plan to only serve a portion of the adult population so that the determination of need may be based on that age-limited population. Applicants shall be clear regarding the age range they intend to serve; given the small number of hospitals who serve younger children (12 and under), special consideration shall

be given to applicants serving this age group. Applicants shall specify how patient care will be specialized in order to appropriately care for the chosen patient category.

Response: Although the applicant will primarily serve the population age 65+, care will also be provided to a few patients ages 55-64, who are appropriate for a geropsychiatric unit, generally because of their medical condition.

8. **Services to High-Need Populations**: Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are involuntarily committed, uninsured, or low-income.

   Response: The applicant serves patients who are involuntarily committed. Because it is a geropsychiatric unit, 98% of the patients are Medicare patients.

9. **Relationship to Existing Applicable Plans; Underserved Area and Populations**: The proposal's relationships to underserved geographic areas and underserved population groups shall also be a significant consideration. The impact of the proposal on similar services in the community supported by state appropriations shall be assessed and considered; the applicant's proposal as to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, shall also be assessed and considered. The degree of projected financial participation in the Medicare and TennCare programs shall be considered.

   Response: The elderly patient population is a fragile patient population that is growing. This project should have no impact on any other provider in the applicant's service area because the applicant is the only provider that serves this elderly patient population The applicant does not accept involuntary admissions. Approximately 98% of its payer mix is Medicare.

   Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall also include how the applicant's services may differ from existing services (e.g., specialized treatment of an age-limited group, acceptance of involuntary admissions, and differentiation by payor mix). Accessibility to specific special need groups shall also be discussed in the application.

   Response: There are no similar services available in the service area. The applicant has a geropsychiatric unit with 14 beds and is seeking to add 4 more beds. Skyridge Medical Center - Westside in Bradley County has a 30 bed psychiatric unit that serves the general adult population. The treatment of these 2 patient populations is very different. The applicant's patient population is almost entirely Medicare while Skyridge has a limited number of Medicare patients.

10. **Expansion of Established Facility**: Applicants seeking to add beds to an existing facility shall provide documentation detailing the sustainability of the existing facility. This documentation shall include financials, and utilization rates. A facility

seeking approval for expansion should have maintained an occupancy rate for all licensed beds of at least 80 percent for the previous year. The HSDA may take into consideration evidence provided by the applicant supporting the need for the expansion or addition of services without the applicant meeting the 80 percent threshold. Additionally, the applicant shall provide evidence that the existing facility was built and operates, in terms of plans, service area, and populations served, in accordance with the original project proposal.

Response: The applicant received a CON in 2014 to increase its geropsychiatric beds from 10 to 14. The addition of these beds allowed more of the frail, elderly population to receive geropsychiatric services closer to home. As the utilization of these services has increased, it is now necessary to seek an increase in the number of beds again. Admissions to the 14-bed unit at the Hospital have increased by approximately 40% during the past 3 years. The unit reached almost 75% average annual occupancy in 2016, which reflects a high rate of utilization for a small unit with all semi-private beds. The "annual average" can mask a problem of a wide swing in census and a lack of available beds on many days. In 2016, occupancy was 85% or more during some periods of the second quarter of the year.

The fact that all of the beds are semi-private is an exacerbating circumstance. It is necessary to separate patients by gender, and sometimes by diagnosis. In a busy week, having to use semi-private rooms as private rooms to achieve gender separation and appropriate diagnosis mix lowers available bed capacity. That constraint is not reflected in annual average occupancy calculations that assume all empty beds are always available. In addition, a smaller number of beds makes it more challenging as well. By 2021, demand for geriatric psychiatric beds is expected to increase in part due to a 14.9% growth rate in the target population in the applicant's service area.

The existing facility operates its 14 geropsychiatric beds in accordance with the CON it received in 2014.

11. **Licensure and Quality Considerations**: Any existing applicant for this CON service category shall be in compliance with the appropriate rules of the TDH and/or the TDMHSAS. The applicant shall also demonstrate its accreditation status with the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or other applicable accrediting agency. Such compliance shall provide assurances that applicants are making appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems, and children who need quiet space). Applicants shall also make appropriate accommodations so that patients are separated by gender in regards to sleeping as well as bathing arrangements. Additionally, the applicant shall indicate how it would provide culturally competent services in the service area (e.g., for veterans, the Hispanic population, and LBGT population).

Response: The applicant is licensed by the Tennessee Department of Health and accredited by the Joint Commission. SMRC-Etowah makes appropriate accommodations for patients and provides separate sleeping and bathing

arrangements based on gender. The applicant would also provide services in accordance with any cultural variations in its patient population.

12. **Institution for Mental Disease Classification**: It shall also be taken into consideration whether the facility is or will be classified as an Institution for Mental Disease (IMD). The criteria and formula involve not just the total number of beds, but the average daily census (ADC) of the inpatient psychiatric beds in relation to the ADC of the facility. When a facility is classified as an IMD, the cost of patient care for Bureau of TennCare enrollees aged 21-64 will be reimbursed using 100 percent state funds, with no matching federal funds provided; consequently, this potential impact shall be addressed in any CON application for inpatient psychiatric beds.

    Response: The applicant primarily provides services to patients 65 and up, with only 1% of its payor mix covered by TennCare. As such, this criteria should not present a significant concern.

13. **Continuum of Care**: Free standing inpatient psychiatric facilities typically provide only basic acute medical care following admission. This practice has been reinforced by Tenn. Code Ann. § 33-4-104, which requires treatment at a hospital or by a physician for a physical disorder prior to admission if the disorder requires immediate medical care and the admitting facility cannot appropriately provide the medical care. It is essential, whether prior to admission or during admission, that a process be in place to provide for or to allow referral for appropriate and adequate medical care. However, it is not effective, appropriate, or efficient to provide the complete array of medical services in an inpatient psychiatric setting.

    Response: The applicant typically provides geropsychiatric services only after medical conditions have been treated.

14. **Data Usage**: The TDH and the TDMHSAS data on the current supply and utilization of licensed and CON-approved psychiatric inpatient beds shall be the data sources employed hereunder, unless otherwise noted. The TDMHSAS and the TDH Division of Health Licensure and Regulation have data on the current number of licensed beds. The applicable TDH JAR provides data on the number of beds in operation. Applicants should utilize data from both sources in order to provide an accurate bed inventory.

    Response: The bed inventory in the applicant's service area is limited to the 14 geropsychiatric beds provided by the applicant and the 30 adult psychiatric beds provided at Skyridge located in Bradley County. As previously stated, these beds are not interchangeable, as the adult patients and the geriatric patients require very different treatment to meet their psychiatric needs.

15. **Adequate Staffing**: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed Service Area. Each applicant shall outline planned staffing patterns including the number and type of physicians. Additionally, the applicant shall address what kinds of shifts are intended to be utilized (e.g., 8 hour, 12 hour, or Baylor plan). Each unit is required

to be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times. This staffing level is the minimum necessary to provide safe care. The applicant shall state how the proposed staffing plan will lead to quality care of the patient population served by the project. However, when considering applications for expansions of existing facilities, the HSDA may determine whether the existing facility's staff would continue without significant change and thus would be sufficient to meet this standard without a demonstration of efforts to recruit new staff.

Response: The applicant currently provides staffing sufficient to provide for a census of 14 patients, its current bed complement. Registered nurses, licensed practical nurses, and CNAs work in 12-hour shifts whereas social workers and activities therapists work 8-hour shifts. The applicant projects that an addition of 2.5 FTEs will be needed in order to provide sufficient staffing for a census of 15-18 patients. Some of the current staff are long-time employees whereas others are newer to applicant's operations. Applicant has begun to offer signing bonuses in order to recruit additional nurses where necessary.

16. **Community Linkage Plan**: The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health care system providers/services and working agreements with other related community services assuring continuity of care (e.g., agreements between freestanding psychiatric facilities and acute care hospitals, linkages with providers of outpatient, intensive outpatient, and/or partial hospitalization services). If they are provided, letters from providers (e.g., physicians, mobile crisis teams, and/or managed care organizations) in support of an application shall detail specific instances of unmet need for psychiatric inpatient services. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of Inpatient Psychiatric Bed usage.

    Response: Applicant is part of the larger Starr Regional Medical Center hospital system, which offers full acute care services. Further, applicant receives referrals from nursing homes, assisted living centers, physicians, and other hospitals. Other than applicant's sister facility, the primary source of hospital referrals to applicant is from Tennova Healthcare in Cleveland, Tennessee (Bradley County).

17. **Access**: The applicant must demonstrate an ability and willingness to serve equally all of the patients related to the application of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed service area.

    Response: The applicant treats all those patients who are appropriate for the geropsychiatric services that it provides. The applicant provides the only geropsychiatric services in its 5 county service area.

18. **Quality Control and Monitoring**: The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. An applicant that owns or administers other psychiatric

facilities shall provide information on their surveys and their quality improvement programs at those facilities, whether they are located in Tennessee or not.

Response: The applicant will report such data as required by the HSDA. The applicant does not own or operate any other facilities in Tennessee or otherwise.

19. **Data Requirements**: Applicants shall agree to provide the TDH, the TDMHSAS, and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services at the applicant's facility and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

    Response: The applicant shall provide the TDH, the TDMHSAS and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services at the applicant's facility and to provide that data in the time and format requested.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to related previously approved projects of the applicant.

   Response: The applicant's owner only recently acquired the Hospital and merged it with Starr Regional Medical Center-Athens. Long range planning for coordinated operation of both campuses is underway, but is not yet complete.

   However, it is already clear that there is a long-standing commitment to high quality behavioral healthcare at SRMC-Etowah. In recognition of this, the applicant's owner, LifePoint Health, Inc., is proposing substantial capital expenditures in this project to expand and enhance its program of adult psychiatric services at that campus. SRMC-Etowah's inpatient medical/surgical beds were designated inactive in 2014.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable. **Attachment – Section – Need-3.**

   Response: The geropsychiatric primary service area of SRMC-Etowah consists of Bradley, McMinn, Meigs, Monroe, and Polk counties. Those five contiguous counties contributed to over 66% of the unit's admissions in CY 2015. The service area and patient origin for the expanded unit are projected to be the same. The tables below show each county's historical and projected utilization of the geropsychiatric unit's services.

Please complete the following tables, if applicable:

Service Area Counties	2015 Historical Utilization-County Residents	2015 % of total patient days
Bradley	474 patient days	15.1%
McMinn	851 patient days	27.2%
Meigs	112 patient days	3.6%
Monroe	415 patient days	13.3%
Polk	224 patient days	7.2%
Service Area Total	**2,076 patient days**	**66.3%**
Other	1,056 patient days	33.7%
Grand Total	3,132 patient days	100%

Source: Tennessee Department of Health, Joint Annual Report of Hospitals, 2013-2015. Internal data from applicant.

Service Area Counties	2018 Projected Utilization-County Residents	% of total patients
Bradley	697 patient days	15.1%
McMinn	1,255 patient days	27.2%
Meigs	166 patient days	3.6%
Monroe	614 patient days	13.3%
Polk	332 patient days	7.2%
Service Area Total	**3,064 patient days**	**66.3%**
Other	1,551 patient days	33.7%
Grand Total	4,615 patient days	100%

County Level Map

Service Area

A. 1) Describe the demographics of the population to be served by the proposal.

Response: See the table below for a look at the demographics of the service area population. The projected increase in the target population (age 65+) is only slightly less than that for the state overall, but the targeted population projected as a percentage of the total is higher than that for the state of Tennessee, indicating that this area has a higher percentage of those aged 65 and older. The median age of the population is older in each county in the service area as opposed to the state overall. The median household income in each county is lower than in the state overall and the percent of the population below the poverty level is higher in each county in the service area than the state overall.

2) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data: http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data: http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Demographic Variable/Geographic Area	Department of Health/Health Statistics							Bureau of the Census 2015				TennCare	
	Total Population-Current Year 2017	Total Population-Projected Year 2021	Total Population-% Change	*Target Population-Current Year 2017	*Target Population-Project Year 2021	*Target Population-% Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees Dec. 2016	TennCare Enrollees as % of Total
Bradley	106,600	110,730	3.9%	18,458	21,022	13.9%	19%	39.4	$42,114	19,357	19.6%	23,794	22.3%
McMinn	54,783	56,019	2.3%	11,440	13,033	13.9%	23.3%	42.7	$38,535	10,220	19.9%	13,181	24.1%
Meigs	12,285	12,518	1.9%	2,796	3,286	17.5%	26.3%	44.3	$34,424	2,377	20.8%	3,360	27.4%
Monroe	48,511	50,551	4.2%	10,889	12,876	18.2%	25.5%	43.0	$35,291	8,627	19.3%	12,430	25.6%
Polk	17,538	17,899	2.1%	3,888	4,233	8.9%	23.6%	44.0	$38,925	3,094	18.9%	4,433	25.3%
Primary Service Area Total	239,717	247,717	3.3%	47,472	54,450	14.7%	22%	N/A	N/A	N/A	N/A	57,198	23.9%
State of TN Total	6,887,572	7,179,512	4.2%	1,133,025	1,312,118	15.8%	18.3%	38.4	$45,219	1,117,594	17.6%	1,559,209	22.6%

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 2020.*

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and

ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: Like other services of SRMC-Etowah, this proposed small geropsychiatric bed addition will be accessible to all of the above groups. It will accept Medicare, TennCare, and commercial-pay patients, although given the age group of the patient population served, the majority of the patients are covered by Medicare.

5. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

   Response: The only other provider of inpatient adult psychiatric care in the applicant's service area is Skyridge Medical Center Westside, a hospital in Bradley County, Tennessee, near Chattanooga. Skyridge is 31.9 miles, and a 38 minute drive, from SRMC-Etowah. Further, Bradley County is on the southern end of the service area. As such, it is further away than SRMC-Etowah than other service area communities in McMinn, Meigs, and Monroe counties. As has been stated previously, the two providers providing adult psychiatric care do not serve the same or similar patient populations in that Skyridge serves a general adult psychiatric patient population and SRMC-Etowah is limited to geriatric psychiatric patients, both of which require very different treatment.

The following tables provide utilization data for the two psychiatric units operating in the service area from 2013-2015, the most current data available from the Joint Annual Reports of Hospitals.

Licensed Psychiatric Acute Care Hospital Bed Utilization in Primary Service Area 2013-2015							
2013 Joint Annual Reports of Hospitals							
Facility Name	County	Licensed Psychiatric Beds	Admissions	Patient Days	Avg. Length of Stay (Days)	Avg. Daily Census (Patients)	Occupancy
Skyridge Medical Center Westside	Bradley	29	937	4,642	5	12.7	44%
SRMC-Etowah	McMinn	10	186	1,887	10.1	5.2	51.7%
2014 Joint Annual Reports of Hospitals							
Facility Name	County	Licensed Psychiatric Beds	Admissions	Patient Days	Avg. Length of Stay (Days)	Avg. Daily Census (Patients)	Occupancy
Skyridge Medical Center Westside	Bradley	29	841	4,107	4.9	11.3	38.8%
SRMC-Etowah	McMinn	10	262	2,909	11.1	8.0	79.7%
2015 Joint Annual Reports of Hospitals							
Facility Name	County	Licensed Psychiatric Beds	Admissions	Patient Days	Avg. Length of Stay (Days)	Avg. Daily Census (Patients)	Occupancy
Skyridge Medical Center Westside	Bradley	29	751	3,127	4.2	8.6	29.5%
SRMC-Etowah	McMinn	14	261	3,108	11.9	8.5	60.8%

Source: Tennessee Department of Health, Joint Annual Report of Hospitals, 2013-2015. Internal data from applicant.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: The table below page provides historic and projected utilization data for inpatient geropsychiatric care services from CY2016 and projected data for CY 2018 and 2019. Please see the table above for utilization data for CY2013-2015. The applicant applied conservative growth rates based on its existing utilization, which are validated by applying the guidelines for growth formula for additional psychiatric beds.

2016 Utilization Data							
Facility Name	County	Licensed Psychiatric Beds	Admissions	Patient Days	Avg. Length of Stay (Days)	Avg. Daily Census (Patients)	Occupancy
SRMC-Etowah	McMinn	14	299	3816	12.8	10.5	75%
2018 Projected Utilization Data							
Facility Name	County	Licensed Psychiatric Beds	Admissions	Patient Days	Avg. Length of Stay (Days)	Avg. Daily Census (Patients)	Occupancy
SRMC-Etowah	McMinn	18	362	4615	12.7	12.6	70.2%
2019 Projected Utilization Data							
Facility Name	County	Licensed Psychiatric Beds	Admissions	Patient Days	Avg. Length of Stay (Days)	Avg. Daily Census (Patients)	Occupancy
SRMC-Etowah	McMinn	18	377	4818	12.8	13.2	73.3%

Source: Tennessee Department of Health, Joint Annual Report of Hospitals, 2013-2015. Internal data from applicant. Projections based on historical data.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

   A. All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee). (See Application Instructions for Filing Fee)

      Response: Please see Project Cost Chart.

   B. The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

      Response: Not Applicable

   C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

      Response: Not Applicable

   D. Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

      Response: See Square Footage Chart and Project Cost Chart.

   E. For projects that include new construction, modification, and/or renovation—**documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

      1) A general description of the project;
      2) An estimate of the cost to construct the project;
      3) A description of the status of the site's suitability for the proposed project; and
      4) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

      Response: See architect letter included Attachment Section C-Economic Feasibility 1-E.

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PROJECT COST CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	$76,500.00
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$45,000.00
	3.	Acquisition of Site	$0.00
	4.	Preparation of Site	$0.00
	5.	Total Construction Costs	$352,000.00
	6.	Contingency Fund	$50,000.00
	7.	Fixed Equipment (Not included in Construction Contract)	$0.00
	8.	Moveable Equipment (List all equipment over $50,000 as separate attachments)	$46,800.00
	9.	Other (Specify) Telecommunications	$41,151.00
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	$0.00
	2.	Building only	$0.00
	3.	Land only	$0.00
	4.	Equipment (Specify) _____	$0.00
	5.	Other (Specify) _____	$0.00
C.	Financing Costs and Fees:		
	1.	Interim Financing	$6,900.00
	2.	Underwriting Costs	$0.00
	3.	Reserve for One Year's Debt Service	$0.00
	4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)		$618,351.00
E.	CON Filing Fee		$15,000.00
F.	Total Estimated Project Cost (D+E)	**TOTAL**	$633,351.00

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2. Identify the funding sources for this project.

   Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

   _____ A. Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

   _____ B. Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

   _____ C. General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;

   _____ D. Grants – Notification of intent form for grant application or notice of grant award;

   X E. Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

   _____ F. Other – Identify and document funding from all other sources.

   Response: This project will be funded/financed by LifePoint Health, Inc., the parent company of the applicant facility. Documentation of financing is included as Attachment C-Economic Feasibility 2-E.

3. Complete Historical Data Charts on the following two pages—***Do not modify the Charts provided or submit Chart substitutions!***

   Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. **Only complete one chart if it suffices.**

   Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

HISTORICAL DATA CHART-
STARR REGIONAL MEDICAL CENTER

X Total Facility
□ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

		Year 2013	Year 2014	Year 2015
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) ADMISSIONS	3,533	2,808	2,686
	PATIENT DAYS	14,703	12,131	11,398
B.	Revenue from Services to Patients			
	1. Inpatient Services	**$ 78,837,543**	**$ 74,172,151**	**$ 75,783,128**
	2. Outpatient Services	$180,271,920	$195,786,116	$222,745,419
	3. Emergency Services	$0.00	$0.00	$0.00
	4. Other Operating Revenue (Specify) Cafeteria Sales, Release of Information, Rebates, Professional Building Revenue, Grant Revenue, Vending Machine, CPR Classes	$327,086	$272,909	$289,958
	Gross Operating Revenue	**$ 259,436,549**	**$ 270,231,176**	**$ 298,818,505**
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	**$ 180,541,186**	**$ 191,327,718**	**$ 217,323,967**
	2. Provision for Charity Care	$1,385,332	$701,738	$823,163
	3. Provisions for Bad Debt	$14,838,336	$15,367,283	$14,887,942
	Total Deductions	**$ 196,764,854**	**$ 207,396,739**	**$ 233,035,072**
NET OPERATING REVENUE		**$ 62,671,695**	**$ 62,834,437**	**$ 65,783,433**
D.	Operating Expenses			
	1. Salaries and Wages			
	a. Direct Patient Care	$17,375,100	$14,467,833	$14,795,794
	b. Non-Patient Care	$5,019,173	$4,534,492	$3,918,939
	2. Physician's Salaries and Wages			
	3. Supplies	$8,509,847	$6,918,878	$7,269,008
	4. Rent			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates	$286,752	$324,238	$302,882
	5. Management Fees:			
	a. Paid to Affiliates	$2,851,344	$2,946,272	$3,546,426
	b. Paid to Non-Affiliates	$532,937	$0.00	$0.00
	6. Other Operating Expenses	$14,134,506	$18,554,040	$19,586,523
	Total Operating Expenses	**$ 48,709,659**	**$ 44,280,397**	**$ 46,197,180**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$ 13,962,036**	**$ 18,554,040**	**$ 19,586,523**
F.	Non-Operating Expenses			
	1. Taxes	**$ 4,393,462**	**$ 4,117,888**	**$ 4,063,923**
	2. Depreciation	$4,087,664	$3,510,918	$3,462,903
	3. Interest	$4,610,371	$4,997,892	$5,377,036
	4. Other Non-Operating Expenses	$360,000	$360,000	$360,000
	Total Non-Operating Expenses	**$13,451,497**	**$12,966,698**	**$13,263,862**
NET INCOME (LOSS)		**$510,539**	**$5,587,342**	**$6,322,390**

Chart Continues Onto Next Page

NET INCOME (LOSS)	$ 510,539	$ 5,587,342	$ 6,322,390
G. Other Deductions			
1. Annual Principal Debt Repayment	$ 270,891	$ 0.00	$ 0.00
2. Annual Capital Expenditure	$75,298	$3,495,210	$1,935,248
Total Other Deductions	$ 346,189	$ 3,495,210	$ 1,935,248
NET BALANCE	$ 164,350	$ 2,092,132	$ 4,387,142
DEPRECIATION	$ 4,087,664	$ 3,510,918	$ 3,462,903
FREE CASH FLOW (Net Balance + Depreciation)	$ 4,252,014	$ 5,603,050	$ 7,850,045

HISTORICAL DATA CHART
SRMC GEROPSYCHIATRIC UNIT @ 14 BEDS

☐ Total Facility
X Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

	Year 2013	Year 2014	Year 2015
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **PATIENT DAYS**	2,404	2,907	3,108
B. Revenue from Services to Patients			
1. Inpatient Services	**$ 3,453,763**	**$ 7,132,160**	**$ 7,565,295**
2. Outpatient Services	$0.00	$0.00	$0.00
3. Emergency Services	$0.00	$0.00	$0.00
4. Other Operating Revenue (Specify)_____	$0.00	$0.00	$0.00
Gross Operating Revenue	**$ 3,453,763**	**$ 7,132,160**	**$ 7,565,295**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	**$ 1,625,651**	**$ 5,208,562**	**$ 5,341,431**
2. Provision for Charity Care	$0.00	$0.00	$0.00
3. Provisions for Bad Debt	$0.00	$0.00	$0.00
Total Deductions	**$ 1,625,651**	**$ 5,208,562**	**$ 5,341,431**
NET OPERATING REVENUE	**$ 1,828,112**	**$ 1,993,598**	**$ 2,223,864**
D. Operating Expenses			
1. Salaries and Wages			
a. Direct Patient Care	$665,240	$745,967	$828,516
b. Non-Patient Care	$0.00	$0.00	$0.00
2. Physician's Salaries and Wages	$0.00	$0.00	$0.00
3. Supplies	$12,607	$19,263	$22,884
4. Rent			
a. Paid to Affiliates	$0.00	$0.00	$0.00
b. Paid to Non-Affiliates	$672	$6,705	$4,175
5. Management Fees:			
b. Paid to Affiliates	$0.00	$0.00	$0.00
b. Paid to Non-Affiliates	$532,937	$488,942	$478,806
6. Other Operating Expenses	$18,867	$61,005	$69,819
Total Operating Expenses	**$ 1,230,323**	**$ 1,321,882**	**$ 1,404,200**
E. **Earnings Before Interest, Taxes and Depreciation**	**$ 597,789**	**$ 601,716**	**$ 819,664**
F. Non-Operating Expenses			
1. Taxes	**$ 5,206**	**$ 8,152**	**$ 8,288**
2. Depreciation	$89,479	$131,616	$128,419
3. Interest	$3,817	$4,008	$4,325
4. Other Non-Operating Expenses	$0.00	$0.00	$0.00
Total Non-Operating Expenses	**$98,502**	**$143,776**	**$141,032**
NET INCOME (LOSS)	**$499,287**	**$457,940**	**$678,632**

Chart Continues Onto Next Page

NET INCOME (LOSS)	$ 499,287	$ 457,940	$ 678,632
G. Other Deductions			
1. Annual Principal Debt Repayment	$	$	$
2. Annual Capital Expenditure			
Total Other Deductions	$	$	$
NET BALANCE	$	$	$
DEPRECIATION	$	$	$
FREE CASH FLOW (Net Balance + Depreciation)	$	$	$

X Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES
Starr Regional Medical Center

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	Year 2015
1. Professional Services Contract	$ 4,184,855	$ 4,352,043	$ 5,199,019
2. Contract Labor	$0.00	$0.00	$0.00
3. Imaging Interpretation Fees	$0.00	$0.00	$0.00
4. See list of expenses included as Attachment, Economic Feasibility, Historical Data, Item 3	$9,949,651	$10,736,641	$11,165,112
5.			
6.			
7.			
Total Other Expenses	$ 14,134,506	$ 15,088,684	$ 16,364,131

□ Total Facility
X Project Only

HISTORICAL DATA CHART-OTHER EXPENSES
SRMC Geropsychiatric Unit @14 Beds

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	Year 2015
1. Professional Services Contract	$ 0.00	$ 0.00	$ 0.00
2. Contract Labor	$0.00	$0.00	$0.00
3. Imaging Interpretation Fees	$0.00	$0.00	$0.00
4. Repairs & Maintenance	$720	$4,314	$3,797
5. Benefits	$1,350	$54,537	$61,388
6. Contract Services	$0.00	$1,862	$3,939
7. Utilities	$16,797	$158	$0.00
8. Travel & Professional Dues	$0.00	$134	$695
Total Other Expenses	$ 18,867	$ 61,005	$ 69,819

4. Complete Projected Data Charts on the following two pages – ***Do not modify the Charts provided or submit Chart substitutions!***

   The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. **Only complete one chart if it suffices.**

   Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

X Total Facility
□ Project Only

PROJECTED DATA CHART
STARR REGIONAL MEDICAL CENTER

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 2017	Year 2018
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **ADMISSIONS**	2,496	2,411
	PATIENT DAYS	11,283	10,899
B.	Revenue from Services to Patients		
	1. Inpatient Services	$88,320,673	$92,056,621
	2. Outpatient Services	$278,144,091	$300,733,265
	3. Emergency Services	$0.00	$0.00
	4. Other Operating Revenue (Specify) Cafeteria Sales, Release of Information, Rebates, Professional Building Revenue, Grant Revenue, Vending Machine, CPR Classes	$238,610	$238,610
	Gross Operating Revenue	$366,703,374	$393,028,496
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$281,211,385	$306,254,790
	2. Provision for Charity Care	$1,379,341	$1,450,641
	3. Provisions for Bad Debt	$14,055,962	$14,924,134
	Total Deductions	$296,646,688	$322,629,565
NET OPERATING REVENUE		$70,056,686	$70,398,931
D.	Operating Expenses		
	1. Salaries and Wages		
	a. Direct Patient Care	$14,443,260	$14,377,682
	b. Non-Patient Care	$4,582,076	$4,600,784
	2. Physician's Salaries and Wages		
	3. Supplies	$8,422,391	8,496,552
	4. Rent		
	a. Paid to Affiliates	$0.00	$0.00
	b. Paid to Non-Affiliates	$384,080	$433,430
	5. Management Fees:		
	a. Paid to Affiliates	$0.00	$0.00
	b. Paid to Non-Affiliates	$3,041,395	$3,278,385
	6. Other Operating Expenses	$17,331,173	$18,097,840
	Total Operating Expenses	$ 48,204,295	$ 49,284,673
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 21,852,391	$ 21,114,258
F.	Non-Operating Expenses		
	1. Taxes	$ 3,417,494	$ 3,127,868
	2. Depreciation	$3,095,731	$3,095,731
	3. Interest	$4,988,433	$4,988,433
	4. Other Non-Operating Expenses	$360,000	$360,000
	Total Non-Operating Expenses	$ 11,861,658	$ 11,572,032
NET INCOME (LOSS)		$ 9,990,733	$ 9,542,226

Chart Continues Onto Next Page

NET INCOME (LOSS)	$ 9,990,733	$ 9,542,226
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$ 0.00	$ 0.00
2. Annual Capital Expenditure	$550,000	$550,000
Total Other Deductions	$ 550,000	$ 550,000
NET BALANCE	$ 9,440,734	$ 8,992,226
DEPRECIATION	$ 3,095,731	$ 3,095,731
FREE CASH FLOW (Net Balance + Depreciation)	$ 12,536,465	$ 12,087,957

PROJECTED DATA CHART-SRMC
GEROPSYCHIATRIC UNIT @ 18 BEDS

□ Total Facility
X Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 2018	Year 2019
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **PATIENT DAYS**	4,615	4,818
B.	Revenue from Services to Patients		
	1. Inpatient Services	$7,935,067	$8,439,067
	2. Outpatient Services	$0.00	$0.00
	3. Emergency Services	$0.00	$0.00
	4. Other Operating Revenue (Specify)	$0.00	$0.00
	Gross Operating Revenue	$7,935,067	$8,439,067
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$5,221,274	$5,569,784
	2. Provision for Charity Care	$0.00	$0.00
	3. Provisions for Bad Debt	$0.00	$0.00
	Total Deductions	$5,221,274	$5,569,784
NET OPERATING REVENUE		$2,713,793	$2,869,283
D.	Operating Expenses		
	1. Salaries and Wages	$1,153,016	$1,203,016
	a. Direct Patient Care		
	b. Non-Patient Care		
	2. Physician's Salaries and Wages		
	3. Supplies	$29,658	$33,658
	4. Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	$3,292	$3,292
	5. Management Fees:		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	$500,000	$500,000
	6. Other Operating Expenses	$96,981	$93,757
	Total Operating Expenses	$ 1,782,947	$ 1,833,723
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 930,846	$ 1,035,560
F.	Non-Operating Expenses		
	1. Taxes	$ 8,500	$ 8,500
	2. Depreciation	$96,981	$93,757
	3. Interest	$4,500	$4,500
	4. Other Non-Operating Expenses	$0.00	$0.00
	Total Non-Operating Expenses	$ 143,000	$ 143,000
NET INCOME (LOSS)		$ 787,846	$ 892,560

Chart Continues Onto Next Page

NET INCOME (LOSS)	$ 787,846	$ 892,560
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$	$
2. Annual Capital Expenditure		
Total Other Deductions	$	$
NET BALANCE	$	$
DEPRECIATION	$	$
FREE CASH FLOW (Net Balance + Depreciation)	$	$

X Total Facility
□ Project Only

PROJECTED DATA CHART-OTHER EXPENSES
Starr Regional Medical Center

OTHER EXPENSES CATEGORIES	Year 2017	Year 2018
1. Professional Services Contract	$ 5,425,150	$ 5,418,086
2. Contract Labor	$0.00	$0.00
3. Imaging Interpretation Fees	$0.00	$0.00
4. See list of expenses included as Attachment, Economic Feasibility, Projected Data, Item 4	$11,906,023	$12,679,754
5.		
6.		
7.		
Total Other Expenses	$ 17,331,173	$ 18,097,840

□ Total Facility
X Project Only

PROJECTED DATA CHART-OTHER EXPENSES
SRMC Geropsychiatric Unit @ 14 Beds

OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1. Professional Services Contract	$	$
2. Contract Labor		
3. Imaging Interpretation Fees		
4. Marketing	$25,000	$25,000
5. Benefits	$65,000	$65,000
6. Contract Services	$2,000	$2,000
7. Repairs & Maintenance	$4,981	$757
Total Other Expenses	$ 96,981	$ 93,757

5. A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year	Current Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	7,132,160	7,565,295	7,935,067	8,439,067	11.5%
Deduction from Revenue *(Total Deductions/Utilization Data)*	5,208,562	5,341,431	5,221,274	5,569,784	4.3%
Average Net Charge *(Net Operating Revenue/Utilization Data)*	661	715	588	595	-16.7%

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response: The project will not cause an increase in charges beyond the typical annual charge adjustment. The capital investment required to implement the project is relatively small. The average daily charge for the applicant for CY 2015 was $1,593.10. However, charges in this service are not particularly relevant because almost all of the unit's services will be reimbursed at rates set by Medicare.

C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: The projected average gross charges for this project are comparable to the average gross charges for the other closest geriatric psychiatric inpatient units. In CY2015, the most recent year for which JAR data is available, SRMC-Etowah's average gross charge per day was almost 9% lower than Erlanger North Hospital's (Knox County) and only 2.3% more than Parkwest Medical Center's (Hamilton County). SRMC-Etowah's average gross charge per admission was also lower than Erlanger-North's and higher than Parkwest's, primarily because SRMC-Etowah has a slightly longer average length of stay than Parkwest and a significantly lower average length of stay when compared to Erlanger-North.

2015 Comparative Gross Charges in the Service Area For Geriatric Psychiatric Inpatient Care						
Provider	Admissions	Patient Days	Gross IP Charges	Avg. Gross Charge Per Day	Avg. Gross Charge Per Admission	Avg. Length of Stay
Erlanger-North (Hamilton Cnty)	233	3,407	$5,908,115	$1,734.11	$25,356.72	27.5
Parkwest (Knox Cnty)	461	4,896	$7,621,358	$1,556.65	$16,532.23	10.6
SRMC-Etowah	251	3,006	$4,788,976	$1,593.14	$19,079.59	12

The following table illustrates the most frequent DRG's admitted to the SRMC geropsychiatric program, with their current average charges, their current levels of Medicare reimbursement, and their projected Years One and Two average gross charges.

Starr Regional Medical Center-Etowah Charge Data for Most Frequent Admission DRG's-Geropsychiatric Unit					
DRG	Descriptor	Current Medicare Allowable	Average Gross Charge		
			Current	Year 1	Year 2
884	Organic Disturbances & Mental Retardation	$7,389.26	$26,638.36	$21,858.12	$22,189.79
885	Psychoses	$6,914.47	$26,638.37	$21,784.02	$22,046.63
57	Degenerative Nervous System Disorders w/o MCC	$6,368.55	$26,638.38	$22,353.30	$21,610.91

6. A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility. **NOTE: Publicly held entities only need to reference their SEC filings.**

Response: The utilization increases reasonably projected for the unit will ensure that it continues to operate cost-effectively. Further, this is an existing program with a modest positive operating budget. It will continue to operate with a positive margin as census increases in response to availability of additional inpatient beds. Included as Attachment-Section C-Economic Feasibility-6A is the 10-K SEC filing for the applicant's ultimate parent company.

Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	32.69	31.28	36.85	34.30	36.09

B. Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt/Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Response: As a geropsychiatric until focusing almost entirely on Medicare-age patients, almost all of the payor mix will consist of Medicare and managed Medicare revenues. This mix is projected to remain approximately the same in the near future.

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	$7,463,205	98%
TennCare/Medicaid	$40,524	1%
Commercial/Other Managed Care	$61,566	1%
Self-Pay	$0.00	0%
Charity Care	$0.00	0%
Other (Specify)_____	$0.00	0%
Total	$7,565,295	100%

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical

staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Response: See chart below.

Position Classification	Existing FTEs (enter year)	Projected FTEs Year 1	Average Wage (Contractual Rate)	Area Wide/Statewide Average Wage
A. Direct Patient Care Positions				
Registered Nurse	9.0	10.0	$30.61	$27.35
Licensed Practical Nurse	2.0	1.0	$10.64	$17.65
Staff CNA/MHT	4.0	6.0	$12.91	$10.75
LSW	1.5	2.0	$32.51	$14.80
Activities Therapist	1.0	1.0	$12.91	$19.00
Total Direct Patient Care Positions	17.5	20.0		
B. Non-Patient Care Positions				
Total Non-Patient Care Positions				
Total Employees *(A+B)*				
C. Contractual Staff				
Program Director RN	1.0	1.0	Contracted	
Nurse Manager	1.0	1.0	Contracted	
Physician Director	1.0	1.0	Contracted	
Total Staff *(A+B+C)*	20.5	23.0		

9. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

   A. Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

   Response: Maintaining the status quo at 14 beds was rejected because SRMC-Etowah is the only provider of geropsychiatric care in this rural five county area and its admissions peaks over 75% occupancy are now so frequent that, in CY 2017, the unit will begin turning away admissions for lack of bed space.

   A four-bed expansion was proposed instead of two because the Hospital needs to be assured of having sufficient beds to meet demand for the next few years.

   B. Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

   Response: Not Applicable. This project will be completed through renovation of existing space.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

   Response: SRMC-Etowah coordinates closely with its main campus at Athens on all matters of acute care operations. Discharge decisions are not made by the Hospital but are facilitated by the Hospital, at the patient's discretion. Nursing homes in the area provide post-acute/long term care to many patients discharged from SRMC-Etowah. Service area nursing homes include the following:

   Bradley County: Bradley Healthcare & Rehabilitation Center; Life Care Center of Cleveland; Signature Healthcare of Cleveland

   McMinn County: Etowah Health Care Center; LifeCare Center of Athens; McMinn Memorial Nursing Home; NHC Healthcare

   Meigs County: Brookewood Nursing Center

   Monroe County: East Tennessee Health Care Center; Sweetwater Nursing Center; Wood Presbyterian Home

   Polk County: Life Care Center of Copper Basin

2. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

   A. Positive Effects

   Response: There are only positive effects as a result of the proposed expansion of geropsychiatric beds by the applicant. Its current occupancy is such that it frequently is full, given the gender separation and diagnosis separation that are necessary. The addition of 4 beds will allow the applicant to continue to meet the psychiatric needs of its geriatric patient population.

   B. Negative Effects

   Response: There are no similar services available in the applicant's service area so there is no duplication of services and therefore no facility to negatively affect.

3. A. Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies,

such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

Response: The applicant will engage in recruiting activities to recruit any additional professional staff needed as a result of the expansion, including offering a recruiting bonus to new nursing staff.

B. Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

Response: The applicant is an existing hospital that is licensed by the State of Tennessee and certified by the Joint Commission. As such, it is familiar with any and all regulations and requirements.

C. Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response: Starr Regional Medical Center is a clinical rotation site for numerous students in the health professions. The college/universities/training centers with which Starr Regional has student affiliation agreements include:

- Belmont University
- Bethel College
- Chattanooga State Community College
- Cleveland State Community College
- East Tennessee State University
- Knoxville Business College
- Lincoln Memorial University
- Miller-Motte Technical Institute
- Roane State Community College
- South College
- Southern Adventist College
- Tennessee Technology Center of Athens
- Tennessee Technical University
- Trevecca Nazarene University
- Tri-County Community College
- University of North Dakota
- University of Tennessee at Chattanooga
- University of Tennessee at Knoxville
- Virginia College of Business and Health

4. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: Board for Licensure of Healthcare Facilities, Tennessee Department of Health

Response: The applicant is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities.

Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.): Medicare Certification from TDH, TennCare Certification from TDH

Response: The applicant is certified by both Medicare and TennCare from the Tennessee Department of Health.

Accreditation (i.e., Joint Commission, CARF, etc.): The Joint Commission

Response: The applicant is accredited by The Joint Commission.

A. If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

Response: The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, certified for participation in Medicare and Medicaid/TennCare, and fully accredited by The Joint Commission. See Attachment Section-Contribution to the Orderly Development of Health Care-4A for copies of the current license and accreditation certificate.

B. For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

Response: See statement of deficiencies and plan of correction included Attachment Section-Contribution to the Orderly Development of Health Care-4B.

C. Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

Response: None

1) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Response: N/A

5. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

A. Has any of the following:

1) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

2) Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

3) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

B. Been subjected to any of the following:

1) Final Order or Judgment in a state licensure action;

Response: None

2) Criminal fines in cases involving a Federal or State health care offense;

Response: None

3) Civil monetary penalties in cases involving a Federal or State health care offense;

Response: None

4) Administrative monetary penalties in cases involving a Federal or State health care offense;

Response: None

5) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

Response: None

6) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

Response: None

7) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

Response: None

8) Is presently subject to a corporate integrity agreement.

Response: None

6. Outstanding Projects:

A. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

Outstanding Projects					
CON Number	Project Name	Date Approved	*Annual Progress Report(s)		Expiration Date
			Due Date	Date Filed	

*Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

Response: N/A

B. Provide a brief description of the current progress, and status of each applicable outstanding CON.

Response: N/A

7. Equipment Registry – For the applicant and all entities in common ownership with the applicant.

A. Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)? _____

Response: Yes, CT, MRI and Mobile PET/CT services are offered.

B. If yes, have you submitted their registration to HSDA? If you have, what was the date of submission?

Response: Yes, March 2016.

C. If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission?

Response: Yes, March 2016.

QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

Response: The applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency and pertaining to the certificate of need.

STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

1. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

   Response: As the service area population ages and its mental health needs increase, inpatient units such as this are needed to replace diminished State commitments to maintaining inpatient campuses in major cities. The location of these units closer to the residents they serve also makes them more accessible.

2. People in Tennessee should have access to health care and the conditions to achieve optimal health.

   Response: This unit focuses on the elderly patient aged 65 and older, for whom Medicare assistance is available. This ensures reasonable accessibility to needed care, but only if there are sufficient beds to meet local demands. SRMC-Etowah filed this application to avoid encountering increased numbers of days in which beds are not available when the medical staff requests an admission.

3. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

   Response: Adult psychiatric inpatient care is provided in the project service area by two hospitals. Although they compete, they have also apparently specialized in the patient populations they primarily serve—with the applicant's facility playing a much larger role in the care of elderly patients, and the other facility playing a larger role in the care of younger adults ages 18-64. This is a blend of the two competing objectives of efficiently utilizing existing investments, while also maintaining effective competition to ensure continuing availability of patient choices based on convenience and quality of care.

4. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

   Response: The applicant is licensed and fully accredited by the Joint Commission.

5. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

   Response: The SRMC two-hospital system participates in the training of health professionals in several disciplines. Please see Section 3(C) of the Contribution to the Orderly Development of Health Care portion of the application.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

Response: Please see proof of publication showing that publication occurred in The Daily Post Athenian, the paper of general circulation for McMinn County on January 10, 2017.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(9)(A) states that "...Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

Response: N/A

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

2. If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		
2. Architectural and engineering contract signed	2	4/17
3. Construction documents approved by the Tennessee Department of Health	150	9/17
4. Construction contract signed	30	10/17
5. Building permit secured	7	10/17
6. Site preparation completed	0	
7. Building construction commenced	1	10/17
8. Construction 40% complete	48	12/17
9. Construction 80% complete	48	2/18
10. Construction 100% complete (approved for occupancy	24	3/18
11. *Issuance of License	N/A	
12. *Issuance of Service	N/A	
13. Final Architectural Certification of Payment	45	4/18
14. Final Project Report Form submitted (Form HR0055)	300	2/19

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

Attachment Section A-4A

Organizational Documents
Organizational Chart
Facility Listing

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

WALLER LANSDEN DORTCH & DAVIS LLP
ATTN: ANN K. RICH
STE 2700
511 UNION ST
NASHVILLE, TN 37219-1791

Request Type: Certified Copies | Issuance Date: 01/10/2017
Request #: 225491 | Copies Requested: 1

Document Receipt

Receipt # : 003041511	Filing Fee:	$20.00
Payment-Check/MO - WALLER LANSDEN DORTCH & DAVIS LLP, NASHVILLE, TN		$20.00

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that **ATHENS REGIONAL MEDICAL CENTER, LLC**, Control # 414689 was formed or qualified to do business in the State of Tennessee on 09/26/2001. ATHENS REGIONAL MEDICAL CENTER, LLC has a home jurisdiction of DELAWARE and is currently in an Active status. The attached documents are true and correct copies and were filed in this office on the date(s) indicated below.

Tre Hargett
Secretary of State

Processed By: Sheila Keeling

The attached document(s) was/were filed in this office on the date(s) indicated below:

Reference #	Date Filed	Filing Description
4306-0209	09/26/2001	Initial Filing
4306-0213	09/26/2001	Common Amendment
4399-0252	01/22/2002	Registered Agent Change (by Entity)
4455-2312	04/01/2002	2001 Annual Report (Due 04/01/2002)
4775-0043	03/31/2003	2002 Annual Report (Due 04/01/2003)
5097-1189	04/01/2004	2003 Annual Report (Due 04/01/2004)
5243-0482	09/27/2004	Registered Agent Change (by Agent)
5400-2723	03/23/2005	2004 Annual Report (Due 04/01/2005)
5786-0989	06/05/2006	2005 Annual Report (Due 04/01/2006)
5991-0405	03/19/2007	2006 Annual Report (Due 04/01/2007)
6272-1846	04/01/2008	2007 Annual Report (Due 04/01/2008)
6489-0168	03/25/2009	2008 Annual Report (Due 04/01/2009)
A0015-2960	04/01/2010	2009 Annual Report (Due 04/01/2010)

The attached document(s) was/were filed in this office on the date(s) indicated below:

Reference #	Date Filed	Filing Description
A0056-0024	02/03/2011	2010 Annual Report (Due 04/01/2011)
A0102-1129	01/27/2012	2011 Annual Report (Due 04/01/2012)
A0153-1904	02/05/2013	2012 Annual Report (Due 04/01/2013)
7254-1284	11/04/2013	Assumed Name
7254-1285	11/04/2013	Assumed Name
7254-1286	11/04/2013	Assumed Name
7254-1287	11/04/2013	Assumed Name
A0234-3084	04/10/2014	2013 Annual Report (Due 04/01/2014)
B0065-5613	03/10/2015	2014 Annual Report (Due 04/01/2015)
B0199-2090	02/17/2016	2015 Annual Report (Due 04/01/2016)
B0278-5633	09/12/2016	Assumed Name Change

12

B0278-5633 09/12/2016 12:01 PM Received by Tennessee Secretary of State Tre Hargett

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR CHANGE OR CANCELLATION OF ASSUMED LIMITED LIABILITY COMPANY NAME

For Office Use Only

Pursuant to the provisions of §48-207-101(e) of the Tennessee Limited Liability Company Act or §48-249-106(e) of the Tennessee Revised Limited Liability Company Act, the undersigned Limited Liability Company hereby submits this application:

1. The true name of the Limited Liability Company is: Athens Regional Medical Center, LLC

2. The state or country of formation is: Delaware

3. The Limited Liability Company intends to cease transacting business under an assumed Limited Liability Company name by changing or cancelling it;

4. The assumed Limited Liability Company name to be changed from or cancelled is:

McMinn Memorial Nursing Home and Rehab Center

5. If the assumed name is to be changed, the assumed LLC name which the LLC proposes to use is:

Starr Regional Health & Rehabilitation

09/09/16
Signature Date

Assistant Secretary
Signer's Capacity

Athens Regional Medical Center, LLC
Name of Limited Liability Company

Kathy Teague
Signature

Kathy Teague
Name (typed or printed)

SS-4229 (Rev. 01/06)

RDA 2458

4297 0655

4306 0209

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

RECEIVED
STATE OF TENNESSEE
01 SEP 26 PM 1:51
RILEY DARNELL
SECRETARY OF STATE

APPLICATION FOR CERTIFICATE OF AUTHORITY

For Office Use Only
RECEIVED
STATE OF TENNESSEE
01 SEP 14 AM 11:48
RILEY DARNELL
SECRETARY OF STATE

To the Secretary of State of the State of Tennessee:

Pursuant to the provisions of § 48-246-301 of the Tennessee Limited Liability Company Act, the undersigned hereby applies for a certificate of authority to transact business in the State of Tennessee, and for that purpose sets forth:

1. The name of the Limited Liability Company is: Athens Regional Medical Center, LLC

If different, the name under which the certificate of authority is to be obtained is: _____

NOTE: The Secretary of State of the State of Tennessee may not issue a certificate of authority to a foreign Limited Liability Company if its name does not comply with the requirements of § 48-207-101 of the Tennessee Limited Liability Company Act. If obtaining a certificate of authority under an assumed Limited Liability Company name, an application must be filed pursuant to § 48-207-101(d).

2. The state or country under whose law it is formed is: Delaware

3. The date of its organization is: August 24, 2001 *(must be month, day and year)*

4. The complete street address (including zip code) of its principal office is:

Street	City/State	Zip Code
103 Powell Court Suite 200	Brentwood, Tennessee	37027

5. The complete street address (including the county and the zip code) of its registered office in Tennessee:

Street	City/State	County	Zip Code
2908 Poston Avenue	Nashville, Tennessee	Davidson	37203

The name of its registered agent at that office is: Corporation Service Company

6. The number of members at the date of filing 1

7. If the limited liability company commenced doing business in Tennessee prior to the approval of this application, the date of commencement (month, day and year) _____.

NOTE: This application must be accompanied by a certificate of existence (or a document of similar import) duly authenticated by the Secretary of State or other official having custody of the Limited Liability Company records in the state or country under whose law it is organized. The certificate shall not bear a date of more than two (2) months prior to the date the application is filed in this state.

September 5, 2001
Signature Date

Manager
Signer's Capacity

Athens Regional Medical Center, LLC
Name of Limited Liability Company

[signature]
Signature

William F. Carpenter III
Name (typed or printed)

SS-4333 (Rev. 7/00) RDA 2400

05166802

Tennessee Limited Liability Company Annual Report Form

AR Filing #: 05166802
FILED: Feb 17, 2016 8:48AM

File online at: http://TNBear.TN.gov/AR

Due on/Before:04/01/2016 Reporting Year: 2015

Annual Report Filing Fee Due:
$300 minimum plus $50 for each member over 6 to a maximum of $3000
$20 additional if changes are made in block 3 to the registered agent/office

This Annual Report has been successfully paid for and filed. Please keep this report for your records.

Payment-Credit Card - State Payment Center - CC #: 3663410818

SOS Control Number: 414689
Limited Liability Company - Foreign Date Formed: 08/24/2001 Formation Locale: DELAWARE

(1) Name and Mailing Address:
ATHENS REGIONAL MEDICAL CENTER, LLC
330 SEVEN SPRINGS WAY
BRENTWOOD, TN 37027-5098

(2) Principal Office Address:
330 SEVEN SPRINGS WAY
BRENTWOOD, TN 37027-5098

(3) Registered Agent (RA) and Registered Office (RO) Address:
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

Agent Changed: No
Agent County: KNOX COUNTY

(4) This LLC is (as currently registered in Tennessee): ____Director Managed, ____Manager Managed, X Member Managed, ____Board Managed, ____Other.

If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent). If governed by the pre-2006 LLC act and board managed, list board members and managers.

Name	Business Address	City, State, Zip

(5) Provide the names and business addresses, including zip codes, of any LLC Officers (if governed by the Revised LLC Act), or their equivalent.

Name	Business Address	City, State, Zip

(6) Number of members on the date the annual report is executed: 1
____This LLC is prohibited from doing business in Tennessee (check if applicable)

(7) Signature: Electronic
(8) Date: 02/17/2016
(9) Type/Print Name: Kelly Lettmann
(10) Title: POA

B0199-2090 02/17/2016 8:48 AM Received by Tennessee Secretary of State Tre Hargett

04822278

Tennessee Limited Liability Company Annual Report Form

AR Filing #: 04822278
FILED: Mar 10, 2015 5:42PM

File online at: http://TNBear.TN.gov/AR

Due on/Before:04/01/2015 Reporting Year: 2014

Annual Report Filing Fee Due:
$300 minimum plus $50 for each member over 6 to a maximum of $3000
$20 additional if changes are made in block 3 to the registered agent/office

This Annual Report has been successfully paid for and filed. Please keep this report for your records.

CC Payment Ref #: 161115784

SOS Control Number: 414689
Limited Liability Company - Foreign Date Formed: 08/24/2001 Formation Locale: DELAWARE

(1) Name and Mailing Address:
ATHENS REGIONAL MEDICAL CENTER, LLC
330 SEVEN SPRINGS WAY
BRENTWOOD, TN 37027-5098

(2) Principal Office Address:
330 SEVEN SPRINGS WAY
BRENTWOOD, TN 37027-5098

(3) Registered Agent (RA) and Registered Office (RO) Address:
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

Agent Changed: No
Agent County: KNOX COUNTY

(4) This LLC is (change if incorrect): ____Director Managed, ____Manager Managed, X Member Managed, ____Board Managed, ____Other.

If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent). If governed by the pre-2006 LLC act and board managed, list board members and managers.

Name	Business Address	City, State, Zip

(5) Provide the names and business addresses, including zip codes, of any LLC Officers (if governed by the Revised LLC Act), or their equivalent.

Name	Business Address	City, State, Zip

(6) Number of members on the date the annual report is executed: 1
____This LLC is prohibited from doing business in Tennessee (check if applicable)

(7) Signature: Electronic
(8) Date: 03/10/2015
(9) Type/Print Name: Michelle Donato
(10) Title: POA

30065-5613 03/10/2015 5:42 PM Received by Tennessee Secretary of State Tre Hargett

Tennessee Limited Liability Company Annual Report Form

AR Filing #: 04232188
FILED: Apr 10, 2014 12:45PM
DLN #: A0234 3084.001

File online at: http://TNBear.TN.gov/AR

Due on/Before: 04/01/2014 Reporting Year: 2013

Annual Report Filing Fee Due:
$300 minimum plus $50 for each member over 6 to a maximum of $3000
$20 additional if changes are made in block 3 to the registered agent/office

This Annual Report has been successfully paid for and filed. Please keep this report for your records.

CC Payment Ref #: 155547472

SOS Control Number: 414689
Limited Liability Company - Foreign Date Formed: 08/24/2001 Formation Locale: DELAWARE

(1) Name and Mailing Address:
ATHENS REGIONAL MEDICAL CENTER, LLC
330 SEVEN SPRINGS WAY
BRENTWOOD, TN 37027-4536

(2) Principal Office Address:
330 SEVEN SPRINGS WAY
BRENTWOOD, TN 37027-4536

(3) Registered Agent (RA) and Registered Office (RO) Address:
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

Agent Changed: No
Agent County: KNOX COUNTY

(4) This LLC is (change if incorrect): ____Director Managed, X Manager Managed, ____Member Managed, ____Board Managed, ____Other.

If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent). If governed by the pre-2006 LLC act and board managed, list board members and managers.

Name	Business Address	City, State, Zip
Jeff G Seraphine	330 SEVEN SPRINGS WAY	BRENTWOOD, TN 37027
Christy S. Green	330 SEVEN SPRINGS WAY	BRENTWOOD, TN 37027
Michael S. Coggin	330 SEVEN SPRINGS WAY	BRENTWOOD, TN 37027

(5) Provide the names and business addresses, including zip codes, of any LLC Officers (if governed by the Revised LLC Act), or their equivalent.

Name	Business Address	City, State, Zip

(6) Number of members on the date the annual report is executed: 3

____This LLC is prohibited from doing business in Tennessee (check if applicable)

(7) Signature: Electronic

(8) Date: 04/10/2014 12:45 PM

(9) Type/Print Name: Michelle Donato

(10) Title: POA

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REGISTRATION OF ASSUMED LIMITED LIABILITY COMPANY NAME

For Office Use Only

Pursuant to the provisions of §48-207-101 (d) of the Tennessee Limited Liability Company Act or §48-249-106(d) of the Tennessee Revised Limited Liability Company Act, the undersigned Limited Liability Company hereby submits this application:

1. The true name of the Limited Liability Company is:

Athens Regional Medical Center, LLC

2. The state or country of organization is:

Delaware

3. The Limited Liability Company intends to transact business under an assumed Limited Liability Company name.

4. The assumed Limited Liability Company name the Limited Liability Company proposes to use is:

Starr Regional Medical Center

NOTE: The assumed Limited Liability Company name must meet the requirements of §48-207-101 of the Tennessee Limited Liability Company Act or §48-249-106 of the Tennessee Revised Limited Liability Company Act, as applicable.

November 4, 2013
Signature Date

Vice President and Secretary
Signer's Capacity

Athens Regional Medical Center, LLC
Name of Limited Liability Company

Christy S. Green
Signature

Christy S. Green
Name (typed or printed)

SS-4230 (Rev. 01/06)

Filing Fee: $20.00

RDA 2458

7254.1287, 11/04/2013, 15:54:22, Received by Tennessee Secretary of State Tre Hargett

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REGISTRATION OF ASSUMED LIMITED LIABILITY COMPANY NAME

For Office Use Only

Pursuant to the provisions of §48-207-101 (d) of the Tennessee Limited Liability Company Act or §48-249-106(d) of the Tennessee Revised Limited Liability Company Act, the undersigned Limited Liability Company hereby submits this application:

1. The true name of the Limited Liability Company is:

Athens Regional Medical Center, LLC

2. The state or country of organization is:

Delaware

3. The Limited Liability Company intends to transact business under an assumed Limited Liability Company name.

4. The assumed Limited Liability Company name the Limited Liability Company proposes to use is:

Starr Regional Medical Center - Athens

NOTE: The assumed Limited Liability Company name must meet the requirements of §48-207-101 of the Tennessee Limited Liability Company Act or §48-249-106 of the Tennessee Revised Limited Liability Company Act, as applicable.

November 4, 2013
Signature Date

Vice President and Secretary
Signer's Capacity

Athens Regional Medical Center, LLC
Name of Limited Liability Company

Christy S. Green
Signature

Christy S. Green
Name (typed or printed)

SS-4230 (Rev. 01/06) Filing Fee: $20.00 RDA 2458

7254.1286, 11/04/2013, 15:54:21, Received by Tennessee Secretary of State Tre Hargett

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REGISTRATION OF ASSUMED LIMITED LIABILITY COMPANY NAME

For Office Use Only

Pursuant to the provisions of §48-207-101 (d) of the Tennessee Limited Liability Company Act or §48-249-106(d) of the Tennessee Revised Limited Liability Company Act, the undersigned Limited Liability Company hereby submits this application:

1. The true name of the Limited Liability Company is:

Athens Regional Medical Center, LLC

2. The state or country of organization is:

Delaware

3. The Limited Liability Company intends to transact business under an assumed Limited Liability Company name.

4. The assumed Limited Liability Company name the Limited Liability Company proposes to use is:

Starr Regional Medical Center - Etowah

NOTE: The assumed Limited Liability Company name must meet the requirements of §48-207-101 of the Tennessee Limited Liability Company Act or §48-249-106 of the Tennessee Revised Limited Liability Company Act, as applicable.

November 4, 2013
Signature Date

Vice President and Secretary
Signer's Capacity

Athens Regional Medical Center, LLC
Name of Limited Liability Company

Christy S. Green
Signature

Christy S. Green
Name (typed or printed)

SS-4230 (Rev. 01/06) Filing Fee: $20.00 RDA 2458

7254.-285, 11/04/2013, 15:54:21, Received by Tennessee Secretary of State Tre Hargett

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REGISTRATION OF ASSUMED LIMITED LIABILITY COMPANY NAME

For Office Use Only

Pursuant to the provisions of §48-207-101 (d) of the Tennessee Limited Liability Company Act or §48-249-106(d) of the Tennessee Revised Limited Liability Company Act, the undersigned Limited Liability Company hereby submits this application:

1. The true name of the Limited Liability Company is:

Athens Regional Medical Center, LLC

2. The state or country of organization is:

Delaware

3. The Limited Liability Company intends to transact business under an assumed Limited Liability Company name.

4. The assumed Limited Liability Company name the Limited Liability Company proposes to use is:

McMinn Memorial Nursing Home and Rehab Center

NOTE: The assumed Limited Liability Company name must meet the requirements of §48-207-101 of the Tennessee Limited Liability Company Act or §48-249-106 of the Tennessee Revised Limited Liability Company Act, as applicable.

November 4, 2013
Signature Date

Vice President and Secretary
Signer's Capacity

Athens Regional Medical Center, LLC
Name of Limited Liability Company

Christy S. Green
Signature

Christy S. Green
Name (typed or printed)

SS-4230 (Rev. 01/06) Filing Fee: $20.00 RDA 2458

7254.1284, 11/04/2013, 15:54:20, Received by Tennessee Secretary of State Tre Hargett

Tennessee Limited Liability Company Annual Report Form

AR Filing #: 03322505
FILED: Feb 5, 2013 9:40AM

File online at: http://TNBear.TN.gov/AR

Due on/Before:04/01/2013 Reporting Year: 2012

Annual Report Filing Fee Due:
$300 minimum plus $50 for each member over 6 to a maximum of $3000
$20 additional if changes are made in block 3 to the registered agent/office

This Annual Report has been successfully paid for and filed. Please keep this report for your records.

CC Payment Ref #: 148753652

SOS Control Number: 414689
Limited Liability Company - Foreign Date Formed: 08/24/2001 Formation Locale: DELAWARE

(1) Name and Mailing Address:
ATHENS REGIONAL MEDICAL CENTER, LLC
GRETCHEN CATRON
STE 200
103 POWELL CT
BRENTWOOD, TN 37027-5079

(2) Principal Office Address:
STE 200
103 POWELL CT
BRENTWOOD, TN 37027-5079

Image #: A0153-1904

(3) Registered Agent (RA) and Registered Office (RO) Address:
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

Agent Changed: No
Agent County: KNOX COUNTY

(4) This LLC is (change if incorrect): ____Director Managed, ____Manager Managed, _X_Member Managed, ____Board Managed, ____Other.

If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent), respectively.

Name	Business Address	City, State, Zip

(5) Provide the names and business addresses, including zip codes, of the LLC managers (if governed by the LLC Act), or any officers (if governed by the Revised LLC Act), (or their equivalent), respectively.

Name	Business Address	City, State, Zip
Christy S. Green	103 Powell Court	Brentwood, TN 37027
Christopher J. Monte	103 Powell Court Suite 200	Brentwood, TN 37027
Mark B. Poppell	103 Powell Court Suite 200	Brentwood, TN 37027
Michael S. Coggin	103 Powell Court Suite 200	Brentwood, TN 37027
R. Scott Raplee	103 Powell Court Suite 200	Brentwood, TN 37027
Michael B. Clark	103 Powell Court Suite 200	Brentwood, TN 37027
A. Gene Smith	103 Powell Court Suite 200	Brentwood, TN 37027

(6) Number of members on the date the annual report is executed: _1__
____This LLC is prohibited from doing business in Tennessee (check if applicable)

(7) Signature: Electronic (8) Date: 02/05/2013 9:40 AM

(9) Type/Print Name: Christy S. Green (10) Title: Officer

Tennessee Limited Liability Company Annual Report Form

AR Filing #: 02867178
Status: Complete

File online at: http://TNBear.TN.gov/AR

Due on/Before: 04/01/2012 Reporting Year: 2011

This Annual Report has been successfully paid for and submitted. Your Annual Report will be reviewed by Business Services and filed within 48 hours. Please keep this report for your records.

Annual Report Filing Fee Due:
$300 minimum plus $50 for each member over 6 to a maximum of $3000
$20 additional if changes are made in block 3 to the registered agent/office

SOS Control Number: 414689
Limited Liability Company - Foreign Date Formed: 08/24/2001 Formation Locale: DELAWARE

(1) Name and Mailing Address:
ATHENS REGIONAL MEDICAL CENTER, LLC
STE 200
103 POWELL CT
BRENTWOOD, TN 37027-5079

(2) Principal Office Address:
STE 200
103 POWELL CT
BRENTWOOD, TN 37027-5079

Image #: A0102-1129

(3) Registered Agent (RA) and Registered Office (RO) Address: Agent Changed: No
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

(4) This LLC is (change if incorrect): ____Director Managed, ____Manager Managed, X Member Managed, ____Board Managed, ____Other.

If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent), respectively.

Name	Business Address	City, State, Zip

(5) Provide the names and business addresses, including zip codes, of the LLC managers (if governed by the LLC Act), or any officers (if governed by the Revised LLC Act), (or their equivalent), respectively.

Name	Business Address	City, State, Zip
Christy S. Green	103 Powell Court	Brentwood, TN 37027
Christopher J. Monte	103 Powell Court Suite 200	Brentwood, TN 37027
Mark B. Poppell	103 Powell Court Suite 200	Brentwood, TN 37027
Michael S. Coggin	103 Powell Court Suite 200	Brentwood, TN 37027
R. Scott Raplee	103 Powell Court Suite 200	Brentwood, TN 37027
Michael B. Clark	103 Powell Court Suite 200	Brentwood, TN 37027
A. Gene Smith	103 Powell Court Suite 200	Brentwood, TN 37027

(6) Number of members on the date the annual report is executed if there are more than six (6) members: 1
____This LLC is prohibited from doing business in Tennessee (check if applicable)

(7) Signature: Electronic (8) Date: 01/26/2012 11:32 AM

(9) Type/Print Name: Christy S. Green (10) Title: Officer

Tennessee Limited Liability Company Annual Report Form

AR Filing #: 02479751
Status: Complete

File online at: http://TNBear.TN.gov/AR

Due on/Before:04/01/2011 Reporting Year: 2010

Annual Report Filing Fee Due:
$300 minimum plus $50 for each member over 6 to a maximum of $3000
$20 additional if changes are made in block 3 to the registered agent/office

This Annual Report has been successfully paid for and submitted. Your Annual Report will be reviewed by Business Services and filed within 48 hours. Please keep this report for your records.

SOS Control Number: 414689
Limited Liability Company - Foreign Date Formed: 08/24/2001 Formation Locale: Delaware

(1) Name and Mailing Address:
ATHENS REGIONAL MEDICAL CENTER, LLC
103 POWELL COURT
SUITE 200
BRENTWOOD, TN 37027

(2) Principal Office Address:
103 POWELL COURT
SUITE 200
BRENTWOOD, TN 37027

Image #: A0056-0024

(3) Registered Agent (RA) and Registered Office (RO) Address: Agent Changed: No
C T Corporation System
800 S Gay Street, Suite 2021
Knoxville, TN 37929

(4) This LLC is (change if incorrect): ____Director Managed, ____Manager Managed, X Member Managed, ____Board Managed, ____Other.

If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent), respectively.

Name	Business Address	City, State, Zip

(5) Provide the names and business addresses, including zip codes, of the LLC managers (if governed by the LLC Act), or any officers (if governed by the Revised LLC Act), (or their equivalent), respectively.

Name	Business Address	City, State, Zip
Christopher J. Monte	103 Powell Court Suite 200	Brentwood, TN 37027
Mark B. Poppell	103 Powell Court Suite 200	Brentwood, TN 37027
Michael S. Coggin	103 Powell Court Suite 200	Brentwood, TN 37027
R. Scott Raplee	103 Powell Court Suite 200	Brentwood, TN 37027
Michael B. Clark	103 Powell Court Suite 200	Brentwood, TN 37027
A. Gene Smith	103 Powell Court Suite 200	Brentwood, TN 37027

(6) Number of members on the date the annual report is executed if there are more than six (6) members: 1
____This LLC is prohibited from doing business in Tennessee (check if applicable)

(7) Signature: Electronic (8) Date: 02/02/2011 4:37 PM

(9) Type/Print Name: Christopher J Monte (10) Title: Vice President

Tennessee Limited Liability Company Annual Report Form

AR Filing #: 02262558
Status: Complete

File online at: http://TNBear.TN.gov/AR

Due on/Before:04/01/2010

Annual Report Filing Fee Due:
$300 minimum plus $50 for each member over 6 to a maximum of $3000
$20 additional if changes are made in block 3 to the registered agent/office

This Annual Report has been successfully paid for and submitted. Your Annual Report will be reviewed by Business Services and filed within 48 hours. Please keep this report for your records.

SOS Control Number: 414689
Limited Liability Company - Foreign Date Formed: 08/24/2001 Formation Locale: Delaware

(1) Name and Mailing Address:
ATHENS REGIONAL MEDICAL CENTER, LLC
103 POWELL COURT
SUITE 200
BRENTWOOD, TN 37027 USA

(2) Principal Office Address:
103 POWELL COURT
SUITE 200
BRENTWOOD, TN 37027 USA

Image #: A0015-2960

(3) Registered Agent (RA) and Registered Office (RO) Address: Agent Changed: No
CT CORPORATION SYSTEM
800 S GAY ST
STE 2021
KNOXVILLE, TN 37929 USA

(4) This LLC is (change if incorrect): ____Director Managed, ____Manager Managed, X Member Managed, ____Board Managed, ____Other.

If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent), respectively.

Name	Business Address	City, State, Zip

(5) Provide the names and business addresses, including zip codes, of the LLC managers (if governed by the LLC Act), or any officers (if governed by the Revised LLC Act), (or their equivalent), respectively.

Name	Business Address	City, State, Zip
Christopher J. Monte	103 Powell Court Suite 200	Brentwood, TN 37027
Mary Kim E. Shipp	103 Powell Court Suite 200	Brentwood, TN 37027
Mark B. Poppell	103 Powell Court Suite 200	Brentwood, TN 37027
Michael S. Coggin	103 Powell Court Suite 200	Brentwood, TN 37027
Randy McVay	103 Powell Court Suite 200	Brentwood, TN 37027
R. Scott Raplee	103 Powell Court Suite 200	Brentwood, TN 37027
Michael B. Clark	103 Powell Court Suite 200	Brentwood, TN 37027
A. Gene Smith	103 Powell Court Suite 200	Brentwood, TN 37027

(6) Number of members on the date the annual report is executed if there are more than six (6) members: 1
____This LLC is prohibited from doing business in Tennessee (check if applicable)

(7) Signature: Electronic (8) Date: 03/31/2010 9:17 AM

(9) Type/Print Name: Mary Kim E. Shipp (10) Title: Secretary

Athens Regional Medical Center, LLC
(sole member: LifePoint Holdings 2, LLC)
EIN: 62-1866028

Managers:
Michael B. Clark, President
A. Gene Smith, Chief Financial Officer
R. Scott Raplee, Group President
Bradley R. Owens, Group CFO
Michael S. Coggin, Senior Vice President
William E. Hoffman, Jr., Senior Vice President
Christopher J. Monte, Vice President
Mary Kim E. Shipp, Secretary

Address for Above Managers:
103 Powell Court, Suite 200
Brentwood, TN 37027

6489.0169

STATE OF TENNESSEE
2009 MAR 25 AM 10: 24
SECRETARY OF STATE

LIMITED LIABILITY COMPANY ANNUAL REPORT

Annual Report Filing Fee Due:
$50 per member, with a minimum fee of $300 and a maximum fee of $3000.
There is an additional fee of $20 if any changes are made in block #6 to the registered agent/office.

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Avenue N. 6th Floor
William R. Snodgrass Tower
Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 12

THIS REPORT IS DUE ON OR BEFORE: 04/01/09

(1) SECRETARY OF STATE CONTROL Number: 0414689

(2A.) NAME AND MAILING ADDRESS OF COMPANY

ATHENS REGIONAL MEDICAL CENTER, LLC

103 POWELL COURT
SUITE 200
BRENTWOOD, TN 37027

(2B.) STATE OR COUNTRY OF FORMATION

(2C.) ADD OR CHANGE MAILING ADDRESS:

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
103 POWELL COURT, SUITE 200, BRENTWOOD, TN 37027

B. CHANGE OF PRINCIPAL ADDRESS:

STREET CITY STATE ZIP CODE + 4

6489.0168

(4) This LLC is ☐ BOARD MANAGED ☐ DIRECTOR MANAGED ☐ MANAGER MANAGED ☒ MEMBER MANAGED (check one box)
If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent), respectively. Attach an additional sheet if necessary.

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4

(5) Provide the names and business addresses, including zip codes, of the LLC managers (if governed by the LLC Act), or any officers (if governed by the Revised LLC Act), (or their equivalent), respectively. Attach an additional sheet if necessary.

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
See Attachment		

STATE OF TENNESSEE
2009 MAR 25 AM 10:24
SECRETARY OF STATE

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM
B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
800 S. GAY STREET, SUITE 2021, KNOXVILLE, TN 37929-9710
C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(i.) CHANGE OF REGISTERED AGENT: _____

(ii.) CHANGE OF REGISTERED OFFICE (Street Address): _____

(City) _____ (State) TN (Zip Code + 4) _____ (County) _____

(7) Number of members on the date the annual report is executed if there are more than six (6) members: _____

☐ This LLC is prohibited from engaging in business in Tennessee (check box if applicable).

(8) SIGNATURE MKShipp

(9) DATE 3-23-09

(10) TYPE/PRINT NAME OF SIGNER Mary Kim E. Shipp

(11) TITLE OF SIGNER Secretary

* * THIS REPORT MUST BE DATED AND SIGNED * *

SS-4253 (Rev. 01-06) INSTRUCTIONS: www.state.tn.us/sos/ or 615-741-2286 RDA 1678

ATHENS REGIONAL MEDICAL CENTER, LLC
103 Powell Court, Suite 200
Brentwood, Tennessee 37027
(615) 372-8500
FEIN: 62-1866028

6272.1847

Sole member: LifePoint Holdings 2, LLC

Appointed Managers:

Michael B. Clark, President
David M. Dill, Chief Financial Officer
William M. Gracey, Chief Operating Officer
Paul D. Gilbert, Senior Vice President
William E. Hoffman, Jr., Senior Vice President
R. Scott Raplee, Senior Vice President
Gary D. Willis, Senior Vice President
Bradley R. Owens, Vice President
W. Vail Willis, Vice President
Christopher J. Monte, Vice President
Mary Kim E. Shipp, Secretary

Address for Members/Managers:

103 Powell Court
Suite 200
Brentwood, TN 37027

LIMITED LIABILITY COMPANY ANNUAL REPORT

Annual Report Filing Fee Due:
$50 per member, with a minimum fee of $300 and a maximum fee of $3000.
There is an additional fee of $20 if any changes are made in block #6 to the registered agent/office.

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Avenue N. 6th Floor
William R. Snodgrass Tower
Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 12

THIS REPORT IS DUE ON OR BEFORE: 04/01/08

(1) SECRETARY OF STATE CONTROL Number: 0414689

(2A.) NAME AND MAILING ADDRESS OF COMPANY

ATHENS REGIONAL MEDICAL CENTER, LLC

103 POWELL COURT
SUITE 200
BRENTWOOD, TN 37027

(2B.) STATE OR COUNTRY OF FORMATION

Delaware

(2C.) ADD OR CHANGE MAILING ADDRESS:

6272.1846

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
103 POWELL COURT, SUITE 200, BRENTWOOD, TN 37027

B. CHANGE OF PRINCIPAL ADDRESS:

STREET CITY STATE ZIP CODE + 4

(4) This LLC is ☐ BOARD MANAGED ☐ DIRECTOR MANAGED ☐ MANAGER MANAGED ☒ MEMBER MANAGED (check one box)
If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent), respectively. Attach an additional sheet if necessary.

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
See Attachment		

(5) Provide the names and business addresses, including zip codes, of the LLC managers (if governed by the LLC Act), or any officers (if governed by the Revised LLC Act), (or their equivalent), respectively. Attach an additional sheet if necessary.

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
See Attachment		

RECEIVED
2008 APR 1 PM 4:08
SECRETARY OF STATE

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM
B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
800 S. GAY STREET, SUITE 2021, KNOXVILLE, TN 37929-9710
C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(i.) CHANGE OF REGISTERED AGENT: _____

(ii.) CHANGE OF REGISTERED OFFICE (Street Address): _____

(City) _____ (State) TN (Zip Code +4) _____ (County) _____

(7) Number of members on the date the annual report is executed if there are more than six (6) members: _____

☐ This LLC is prohibited from engaging in business in Tennessee (check box if applicable).

(8) SIGNATURE MKShipp

(9) DATE 3.26.08

(10) TYPE/PRINT NAME OF SIGNER Mary Kim Shipp

(11) TITLE OF SIGNER Secretary

*** * THIS REPORT MUST BE DATED AND SIGNED * ***

SS-4253 (Rev. 01-06)

INSTRUCTIONS: www.state.tn.us/sos/ or 615-741-2286

RDA 1678

ATHENS REGIONAL MEDICAL CENTER, LLC
103 Powell Court, Suite 200
Brentwood, Tennessee 37027
(615) 372-8500
FEIN: 62-1866028

5991.0406

RECEIVED
STATE OF TENNESSEE
2007 MAR 19 PM 12: 12
RILEY DARNELL
SECRETARY OF STATE

Sole member: LifePoint Holdings 2, LLC

Appointed Managers:

Joné Law Koford	President
Michael J. Culotta	Chief Financial Officer
William M. Gracey	Chief Operating Officer
Paul D. Gilbert	Senior Vice President
William E. Hoffman, Jr.	Senior Vice President
R. Scott Raplee	Senior Vice President
Gary D. Willis	Senior Vice President
Bradley R. Owens	Vice President
Christopher J. Monte	Vice President
W. Vail Willis	Vice President
Mary Kim E. Shipp	Secretary

LIMITED LIABILITY COMPANY ANNUAL REPORT

Annual Report Filing Fee Due:
$50 per member, with a minimum fee of $300 and a maximum fee of $3000.
There is an additional fee of $20 if any changes are made in block #6 to the registered agent/office.

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Avenue N. 6th Floor
William R. Snodgrass Tower
Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 12

THIS REPORT IS DUE ON OR BEFORE: 04/01/07

(1) SECRETARY OF STATE CONTROL Number: 0414689

(2A.) NAME AND MAILING ADDRESS OF COMPANY

ATHENS REGIONAL MEDICAL CENTER, LLC

103 POWELL COURT
SUITE 200
BRENTWOOD, TN 37027

F 09/26/2001 FOR PROFIT

(2B.) STATE OR COUNTRY OF FORMATION

DELAWARE

(2C.) ADD OR CHANGE MAILING ADDRESS:

RECEIVED
STATE OF TENNESSEE
2007 MAR 19 PM 12:12
RILEY DARNELL
SECRETARY OF STATE

5991.0405

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
103 POWELL COURT, SUITE 200, BRENTWOOD, TN 37027

B. CHANGE OF PRINCIPAL ADDRESS:

STREET CITY STATE ZIP CODE + 4

(4) This LLC is ☐ BOARD MANAGED ☐ DIRECTOR MANAGED ☐ MANAGER MANAGED ☒ MEMBER MANAGED (check one box)
If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent), respectively. Attach an additional sheet if necessary.

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4

(5) Provide the names and business addresses, including zip codes, of the LLC managers (if governed by the LLC Act), or any officers (if governed by the Revised LLC Act), (or their equivalent), respectively. Attach an additional sheet if necessary.

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
See Attachment		

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM
B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
800 S. GAY STREET, SUITE 2021, KNOXVILLE, TN 37929-9710
C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(I.) **CHANGE OF REGISTERED AGENT:** _____

(II.) **CHANGE OF REGISTERED OFFICE (Street Address):** _____

(City) _____ (State) TN (Zip Code +4) _____ (County) _____

(7) Number of members on the date the annual report is executed if there are more than six (6) members: _____

☐ This LLC is prohibited from engaging in business in Tennessee (check box if applicable).

(8) SIGNATURE MKShipp

(9) DATE 03.12.07

(10) TYPE/PRINT NAME OF SIGNER Mary Kim E. Shipp

(11) TITLE OF SIGNER Secretary

*** * THIS REPORT MUST BE DATED AND SIGNED * ***

SS-4253 (Rev. 01-08) INSTRUCTIONS: www.state.tn.us/sos/ or 615-741-2286 RDA 1678

ATHENS REGIONAL MEDICAL CENTER, LLC
103 Powell Court, Suite 200
Brentwood, Tennessee 37027
(615) 372-8500
FEIN: 62-1866028

Sole member: LifePoint Holdings 2, LLC

Appointed Managers:

Joné Law Koford	President
William F. Carpenter III	Executive Vice President & Secretary
Michael J. Culotta	Chief Financial Officer
William M. Gracey	Chief Operating Officer
R. Scott Raplee	Senior Vice President
Bradley R. Owens	Vice President
Gary D. Willis	Vice President
William E. Hoffman, Jr.	Vice President
Christopher J. Monte	Vice President
W. Vail Willis	Vice President
Mary Kim E. Shipp	Assistant Secretary

5786.0990

LIMITED LIABILITY COMPANY ANNUAL REPORT

Annual Report Filing Fee Due:
$50 per member, with a minimum fee of $300 and a maximum fee of $3000.
There is an additional fee of $20 if any changes are made in block #6 to the registered agent/office.

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Avenue N. 6th Floor
William R. Snodgrass Tower
Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 12

THIS REPORT IS DUE ON OR BEFORE: 04/01/06

(1) SECRETARY OF STATE CONTROL Number: 0414689

(2A.) NAME AND MAILING ADDRESS OF COMPANY

ATHENS REGIONAL MEDICAL CENTER, LLC

103 POWELL COURT
SUITE 200
BRENTWOOD, TN 37027

332007

F 09/26/2001 FOR PROFIT

(2B.) STATE OR COUNTRY OF FORMATION
DELAWARE

(2C.) ADD OR CHANGE MAILING ADDRESS:

RECEIVED
SECRETARY OF STATE
2006 MAY -8 AM 11:00
RILEY DARNELL
SECRETARY OF STATE

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
103 POWELL COURT, SUITE 200, BRENTWOOD, TN 37027
B. CHANGE OF PRINCIPAL ADDRESS:

STREET CITY STATE ZIP CODE + 4

(4) This LLC is ☐ BOARD MANAGED ☐ DIRECTOR MANAGED ☐ MANAGER MANAGED ☒ MEMBER MANAGED (check one box)
If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent), respectively. Attach an additional sheet if necessary.

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4

(5) Provide the names and business addresses, including zip codes, of the LLC managers (if governed by the LLC Act), or any officers (if governed by the Revised LLC Act), (or their equivalent), respectively. Attach an additional sheet if necessary.

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
See Attachment		

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM
B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
800 S. GAY STREET, SUITE 2021, KNOXVILLE, TN 37929-9710
C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(i.) CHANGE OF REGISTERED AGENT: _____

(ii.) CHANGE OF REGISTERED OFFICE (Street Address): _____

(City) _____ (State) TN (Zip Code +4) _____ (County) _____

RECEIVED
STATE OF TENNESSEE
06 MAR 22 AM 11:40
RILEY DARNELL
SECRETARY OF STATE

(7) Number of members on the date the annual report is executed if there are more than six (6) members: _____

☐ This LLC is prohibited from engaging in business in Tennessee (check box if applicable).

(8) SIGNATURE M E Shipp

(9) DATE 03/06/06

(10) TYPE/PRINT NAME OF SIGNER Mary Kim E. Shipp

(11) TITLE OF SIGNER Manager

** THIS REPORT MUST BE DATED AND SIGNED **

SS-4253 (Rev. 01-06) INSTRUCTIONS ON BACK RDA 1878

5786.0989

ATHENS REGIONAL MEDICAL CENTER, LLC
103 Powell Court, Suite 200
Brentwood, Tennessee 37027
(615) 372-8500
FEIN: 62-1866028

Sole member: LifePoint Holdings 2, LLC

Appointed Managers:

Jone Law Koford	President
William F. Carpenter III	Executive Vice President & Secretary
Michael J. Culotta	Chief Financial Officer
William M. Gracey	Chief Operating Officer
R. Scott Raplee	Senior Vice President
Patrick Whitmore	Vice President
Gary D. Willis	Vice President
Kelvin M. Ault	Vice President
W. Vail Willis	Vice President
Mary Kim E. Shipp	Assistant Secretary

LIMITED LIABILITY COMPANY ANNUAL REPORT

ANNUAL REPORT FILING FEE DUE:
$50 per member, with a minimum fee of $300 and a maximum fee of $3000.
There is an additional fee of $20 if any changes are made in block #5 to the registered agent/office.

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 12 IF DIFFERENT, CORRECT MONTH IS _____

THIS REPORT IS DUE ON OR BEFORE: 04/01/05

(1) SECRETARY OF STATE CONTROL #: 0414689

(2A) NAME AND MAILING ADDRESS OF LIMITED LIABILITY COMPANY

ATHENS REGIONAL MEDICAL CENTER, LLC

103 POWELL COURT
SUITE 200
BRENTWOOD, TN 37027

F 09/26/2001 FOR PROFIT

(2B.) STATE OR COUNTRY OF FORMATION:
DELAWARE

(2C.) ADD OR CHANGE MAILING ADDRESS:

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
103 POWELL COURT, SUITE 200, BRENTWOOD, TN 37027
B. CHANGE OF PRINCIPAL ADDRESS:

STREET	CITY	STATE	ZIP CODE + 4

*** * BLOCK 4 MUST BE COMPLETED OR THE ANNUAL REPORT WILL BE RETURNED * ***

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF ITS GOVERNORS, IF BOARD MANAGED; THE MANAGERS, IF MEMBER MANAGED. (ATTACH ADDITIONAL SHEET IF NECESSARY.)

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
See Attachment		

[ ] BOARD MANAGED
[X] MEMBER MANAGED

[ ] THIS LLC IS PROHIBITED FROM ENGAGING IN BUSINESS IN TENNESSEE?

(5) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM

B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
800 S. GAY STREET, SUITE 2021, KNOXVILLE, TN 37929-9710

C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(I) CHANGE OF REGISTERED AGENT: _____

(II) CHANGE OF REGISTERED OFFICE: _____

STREET	CITY	STATE (MUST BE IN TN)	ZIP CODE + 4	COUNTY

RECEIVED
05 MAR 23 AM 11:12
SECRETARY OF STATE

(6) NUMBER OF MEMBERS AT THE DATE OF THIS FILING: 1

(7) SIGNATURE: MLSharp

(8) DATE: March 14, 2005

(9) TYPE/PRINT NAME OF SIGNER: Mary Kim F. Shipp

(10) TITLE OF SIGNER: Manager

*** * THIS REPORT MUST BE DATED AND SIGNED * ***

CONTINUED ON BACK

SECRETARY OF STATE
DIVISION OF BUSINESS SERVICES
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

RECEIVED
STATE OF TENNESSEE
2004 SEP 27 AM 8:00
FILED
SECRETARY OF STATE

MASS CHANGE OF REGISTERED OFFICE (BY AGENT)

Pursuant to the provisions of Sections 48-15-102 and 48-25-108 of the Tennessee Business Corporation Act, Sections 48-55-102 and 48-65-108 of the Tennessee Nonprofit Corporation Act, Section 48-208-102 of the Tennessee Limited Liability Company Act, Sections 61-2-104 and 61-2-904 of the Tennessee Revised Uniform Limited Partnership Act, and Section 61-1-144 of the Tennessee Uniform Limited Partnership Act, the undersigned registered agent hereby submits this application to change its business address and the registered office address of the businesses noted below:

1. **The names of the affected corporations, limited liability companies, limited partnerships and limited liability partnerships are identified in the attached list by their S.O.S. control numbers, which list is incorporated herein by reference.**

2. **The street address of its current registered office of record is 530 Gay Street, Knoxville, TN 37902.**

3. **The name of the current registered agent is C T CORPORATION SYSTEM.**

4. **The street address (including county) of the new registered office is:**

   800 S. Gay Street, Suite 2021, Knoxville, TN 37929-9710 (Knox)

5. **After the change, the street addresses of the registered office and the business office of the registered agent will be identical.**

6. **The corporations, limited liability companies, limited partnerships and limited liability partnerships identified in the attached list, and which are companies active on the records of C T Corporation System, have been notified of the change of address for the registered office.**

7. **The change submitted for the business entities for which C T Corporation System does not provide active statutory representation services is filed for State administrative purposes using information provided by the State. C T Corporation System disclaims knowledge of, and responsibility for, any companies for which C T Corporation System does not provide active services.**

9/21/04
Signature Date

Signature of Registered Agent

Kenneth J. Eva, Vice President
Printed or Typed Name

ATHENS REGIONAL MEDICAL CENTER, LLC
103 Powell Court, Suite 200
Brentwood, Tennessee 37027
(615) 372-8500
FEIN: 62-1866028

Sole member: LifePoint Holdings 2, LLC

Appointed Managers:

William M. Gracey	President
William F. Carpenter III	Senior Vice President and Secretary
Michael J. Culotta	Senior Vice President and Chief Financial Officer
R. Scott Raplee	Vice President
Gary D. Willis	Vice President
William E. Hoffman, Jr.	Vice President
Kelvin M. Ault	Vice President
W. Vail Willis	Vice President
Mary Kim E. Shipp	Assistant Secretary

LIMITED LIABILITY COMPANY ANNUAL REPORT

ANNUAL REPORT FILING FEE DUE:
$50 per member, with a minimum fee of $300 and a maximum fee of $3000.
There is an additional fee of $20 if any changes are made in block #5 to the registered agent/office.

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TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Avenue North
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Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 12 IF DIFFERENT, CORRECT MONTH IS _____

THIS REPORT IS DUE ON OR BEFORE 04/01/04

(1) SECRETARY OF STATE CONTROL #: 0414689

(2A.) NAME AND MAILING ADDRESS OF LIMITED LIABILITY COMPANY

ATHENS REGIONAL MEDICAL CENTER, LLC

103 POWELL COURT
SUITE 200
BRENTWOOD, TN 37027

F 09/26/2001 FOR PROFIT

(2B.) STATE OR COUNTRY OF FORMATION:
DELAWARE

(2C.) ADD OR CHANGE MAILING ADDRESS:

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
103 POWELL COURT, SUITE 200, BRENTWOOD, TN 37027
B. CHANGE OF PRINCIPAL ADDRESS:

STREET	CITY	STATE	ZIP CODE + 4

*** * BLOCK 4 MUST BE COMPLETED OR THE ANNUAL REPORT WILL BE RETURNED * ***

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF ITS GOVERNORS, IF BOARD MANAGED; THE MANAGERS, IF MEMBER MANAGED (ATTACH ADDITIONAL SHEET IF NECESSARY.)

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
See Attachment		

☐ BOARD MANAGED

☒ MEMBER MANAGED

☐ THIS LLC IS PROHIBITED FROM ENGAGING IN BUSINESS IN TENNESSEE?

(5) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM

B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
530 GAY ST, KNOXVILLE, TN 37902

C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE

(II) CHANGE OF REGISTERED AGENT: _____

(III) CHANGE OF REGISTERED OFFICE: _____

STREET	CITY	STATE (MUST BE IN TN)	ZIP CODE + 4	COUNTY

(6) NUMBER OF MEMBERS AT THE DATE OF THIS FILING 1

(7) SIGNATURE MKShipp

(8) DATE 02/29/04

(9) TYPE/PRINT NAME OF SIGNER Mary Kim E. Shipp

(10) TITLE OF SIGNER Manager

*** * THIS REPORT MUST BE DATED AND SIGNED * ***

CONTINUED ON BACK

ATHENS REGIONAL MEDICAL CENTER, LLC
103 Powell Court, Suite 200
Brentwood, Tennessee 37027
(615) 372-8500
FEIN: 62-1866028

Sole member: LifePoint Holdings 2, LLC

Managers:

William M. Gracey, President
William F. Carpenter III, SVP, Secretary and General Counsel
Michael J. Culotta, SVP and CFO
R. Scott Raplee, Vice President and Division CFO
Gary D. Willis, Vice President and Controller
William E. Hoffman, Jr., Vice President
Mary Kim E. Shipp, Assistant Secretary

LIMITED LIABILITY COMPANY ANNUAL REPORT

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Please return completed form to:
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Attn: Annual Report
312 Eighth Avenue North
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Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 12 IF DIFFERENT, CORRECT MONTH IS _____

THIS REPORT IS DUE ON OR BEFORE: 04/01/03

(1) SECRETARY OF STATE CONTROL #: 0414689

(2A.) NAME AND MAILING ADDRESS OF LIMITED LIABILITY COMPANY

ATHENS REGIONAL MEDICAL CENTER, LLC

103 POWELL COURT
SUITE 200
BRENTWOOD, TN 37027

F 09/26/2001 FOR PROFIT

(2B.) STATE OR COUNTRY OF FORMATION:
DELAWARE

(2C.) ADD OR CHANGE MAILING ADDRESS:

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
103 POWELL COURT, SUITE 200, BRENTWOOD, TN 37027
B. CHANGE OF PRINCIPAL ADDRESS:

STREET	CITY	STATE	ZIP CODE + 4

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(ATTACH ADDITIONAL SHEET IF NECESSARY.)

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
See attached		

☐ BOARD MANAGED
☒ MEMBER MANAGED

☐ THIS LLC IS PROHIBITED FROM ENGAGING IN BUSINESS IN TENNESSEE?

RECEIVED
TENNESSEE
2003 MAR 23 AM 3:33
RILEY CARNELL
SECRETARY OF STATE

(5) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM

B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
530 GAY ST, KNOXVILLE, TN 37902

C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE

(i) CHANGE OF REGISTERED AGENT: _____

(ii) CHANGE OF REGISTERED OFFICE: _____

STREET	CITY	STATE (MUST BE IN TN)	ZIP CODE + 4	COUNTY

(6) NUMBER OF MEMBERS AT THE DATE OF THIS FILING: 1

(7) SIGNATURE: [signature]

(8) DATE: March 23, 2003

(9) TYPE/PRINT NAME OF SIGNER: Mary Kim E. Shipp

(10) TITLE OF SIGNER: Manager

*** * THIS REPORT MUST BE DATED AND SIGNED * ***

ATHENS REGIONAL MEDICAL CENTER, LLC
103 Powell Court, Suite 200
Brentwood, Tennessee 37027
(615) 372-8500
FEIN: 62-1866028

Sole Managing Member: LifePoint Holdings 2, LLC

Appointed Managers:

Kenneth C. Donahey	Chairman, Chief Executive Officer and President
Michael J. Culotta	Senior Vice President and Chief Financial Officer
William F. Carpenter III	Senior Vice President, General Counsel and Secretary
Daniel S. Slipkovich	Division President
William M. Gracey	Division President
Joné Law Koford	Division President
Roberto G. Pantoja	Vice President and Controller
William E. Hoffman, Jr.	Vice President

LIMITED LIABILITY COMPANY ANNUAL REPORT

4455 2312

ANNUAL REPORT FILING FEE DUE:
$50 per member, with a minimum fee of $300 and a maximum fee of $3000.
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Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 12 IF DIFFERENT, CORRECT MONTH IS _____

THIS REPORT IS DUE ON OR BEFORE: 04/01/02

(1) SECRETARY OF STATE CONTROL #: 0414689

(2A.) NAME AND MAILING ADDRESS OF LIMITED LIABILITY COMPANY

ATHENS REGIONAL MEDICAL CENTER, LLC

103 POWELL COURT
SUITE 200
BRENTWOOD, TN 37027

F 09/26/2001 FOR PROFIT

(2B.) STATE OR COUNTRY OF FORMATION:
DELAWARE

(2C.) ADD OR CHANGE MAILING ADDRESS:

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
103 POWELL COURT, SUITE 200, BRENTWOOD, TN 37027
B. CHANGE OF PRINCIPAL ADDRESS:

STREET	CITY	STATE	ZIP CODE + 4

*** * BLOCK 4 MUST BE COMPLETED OR THE ANNUAL REPORT WILL BE RETURNED * ***

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF ITS GOVERNORS, IF BOARD MANAGED; THE MANAGERS, IF MEMBER MANAGED.
(ATTACH ADDITIONAL SHEET IF NECESSARY.)

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
See attached		

☐ BOARD MANAGED
☒ MEMBER MANAGED

☐ THIS LLC IS PROHIBITED FROM ENGAGING IN BUSINESS IN TENNESSEE?

(5) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
CORPORATIVE SERVICE COMPANY

B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
2908 POSTON AVENUE, NASHVILLE, TN 37203

C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(I) CHANGE OF REGISTERED AGENT: _____

(II) CHANGE OF REGISTERED OFFICE: _____

STREET	CITY	STATE (MUST BE IN TN)	ZIP CODE + 4	COUNTY

(6) NUMBER OF MEMBERS AT THE DATE OF THIS FILING: 1

(7) SIGNATURE: W F Carpenter III

(8) DATE: 3/27/2002

(9) TYPE/PRINT NAME OF SIGNER: William F. Carpenter III

(10) TITLE OF SIGNER: Manager

*** * THIS REPORT MUST BE DATED AND SIGNED * ***

CONTINUED ON BACK

4399 0252

6

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

CHANGE OF REGISTERED AGENT/OFFICE (BY A LIMITED LIABILITY COMPANY)

For Office Use Only

RECEIVED
OFFICE OF TENNESSEE
02 JAN 22 AM 10: 10
RILEY DACHELL
SECRETARY OF STATE

Pursuant to the provisions of § 48-208-102(a) of the Tennessee Limited Liability Company Act, the undersigned Limited Liability Company hereby submits this application:

1. The name of the Limited Liability Company is: Athens Regional Medical Center, LLC

2. The street address of its current registered office is: 2908 Poston Avenue, Nashville, TN 37203

3. If the current registered office is to be changed, the street address of the new registered office, the zip code of such office, and the county in which the office is located is: 530 Gay Street, Knoxville, Tennessee 37902, County of Knox

4. The name of the current registered agent is: Corporation Service Company

5. If the current registered agent is to be changed, the name of the new registered agent is: C T Corporation System

6. After the change(s), the street addresses of the registered office and the business office of the registered agent will be identical.

01/15/02
Signature Date

Manager
Signer's Capacity

Athens Regional Medical Center, LLC
Name of Limited Liability Company

[signature]
Signature

William F. Carpenter III
Name (typed or printed)

SS-4225 (Rev. 8/98)

RDA 3458

TN048 - 6/28/98 C T System Online

4306 0213

ATHENS COMMUNITY HOSPITAL, INC.

RECEIVED
STATE OF TENNESSEE
01 SEP 26 PM 1:51
RILEY DARNELL
SECRETARY OF STATE

CONSENT TO USE OF NAME

Athens Community Hospital, Inc., a corporation organized under the laws of the State of Tennessee, hereby consents to the following: (i) the qualification in the State of Tennessee of "Athens Regional Medical Center, LLC," a Delaware limited liability company, and (ii) the use of the name "Athens Regional Medical Center" by Athens Regional Medical Center, LLC in the State of Tennessee.

Within the next thirty (30) days, Athens Community Hospital, Inc. intends to transfer to Athens Regional Medical Center, LLC, pursuant to an asset purchase agreement, substantially all of the assets used in the operation of its business, including the name "Athens Regional Medical Center." Athens Community Hospital, Inc. will also withdraw the assumed name filing for "Athens Regional Medical Center" within the next sixty (60) days as required under the Business Name Availability Guidelines of the Tennessee Secretary of State, Division of Business Services.

IN WITNESS WHEREOF, the said Athens Community Hospital, Inc. has caused this consent to be executed by its Assistant Secretary this 20th day of September, 2001.

ATHENS COMMUNITY HOSPITAL, INC.

By: _____

Title: __Vice President_____

1013566A

4297 0656

State of Delaware

4306 0210

PAGE 1

Office of the Secretary of State

I, HARRIET SMITH WINDSOR, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "ATHENS REGIONAL MEDICAL CENTER, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-NINTH DAY OF AUGUST, A.D. 2001.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE NOT BEEN ASSESSED TO DATE.

Harriet Smith Windsor

Harriet Smith Windsor, Secretary of State

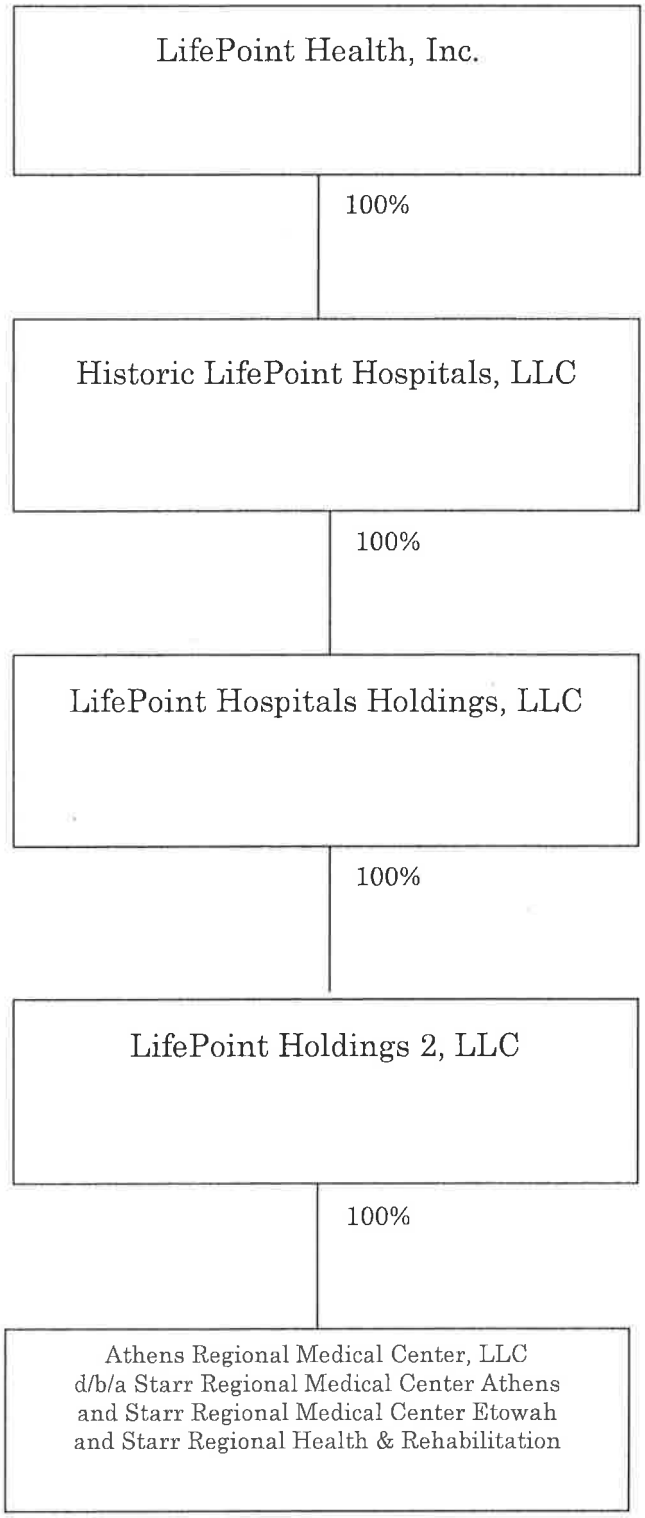
3429678 8300

010427555

AUTHENTICATION: 1319680

DATE: 08-29-01

Starr Regional Medical Center Athens
Starr Regional Medical Center Etowah
and
Starr Regional Health & Rehabilitation



LifePoint Health, Inc. has an ownership interest in the below-listed facilities.

Name of Facility and Address
HOSPITALS
Andalusia Regional Hospital Community Hospital of Andalusia, LLC. DBA Andalusia Regional Hospital 849 South Three Notch Street Andalusia, AL 36420 TIN: 62-1081822 Provider #: 010036
Ashley Regional Medical Center Ashley Valley Medical Center, LLC DBA Ashley Regional Medical Center 151 W. 200 N Vernal, UT 84078 TIN: 62-1762532 Provider #: 460030
Bluegrass Community Hospital Woodford Hospital, LLC DBA Bluegrass Community Hospital 360 Amsden Avenue Versailles KY 40383 TIN: 52-2260534 Provider #: 181308
Bolivar Medical Center PHC-Cleveland, Inc. DBA Bolivar Medical Center 901 East Sunflower Road Cleveland, MS 38732 TIN: 62-1812558 Provider #: 250093
Bourbon Community Hospital Bourbon Community Hospital, LLC DBA Bourbon Community Hospital 9 Linville Drive Paris, KY 40361 TIN: 62-1757924 Provider #: 180046
Castleview Hospital Castleview Hospital, LLC DBA Castleview Hospital 300 N. Hospital Drive Price, UT 84501 TIN: 62-1762357 Provider #: 460011
Central Carolina Hospital DLP Central Carolina Medical Center, LLC d/b/a Central Carolina Hospital 1135 Carthage Street Sanford, NC 27330 TIN: 81-0691912 Provider #: 340020
Clark Memorial Hospital RHN Clark Memorial Hospital, LLC DBA Clark Memorial Hospital 1220 Missouri Avenue Jeffersonville, IN 47130 TIN: 47-4000401 Provider #: 150009

Name of Facility and Address
Clark Regional Medical Center Kentucky Hospital, LLC DBA Clark Regional Medical Center 175 Hospital Drive Winchester, KY 40391 TIN: 62-1772321 Provider #: 180092
Clinch Valley Medical Center Clinch Valley Medical Center, Inc. DBA Clinch Valley Medical Center 6801 Gov. G. C. Peery Highway Richlands, VA 24641 TIN: 54-1058953 Provider #: 490060
Colorado Plains Medical Center PHC-Fort Morgan, Inc. DBA Colorado Plains Medical Center 1000 Lincoln Street, CS 4200 Ft. Morgan, CO 80701 TIN: 27-0113173 Provider #: 060044
Conemaugh Memorial Medical Center DLP Conemaugh Memorial Medical Center, LLC DBA Conemaugh Memorial Medical Center 1086 Franklin Street Johnstown, PA 15905 TIN: 61-1739000 Provider #: 390110
Conemaugh Meyersdale Medical Center DLP Conemaugh Meyersdale Medical Center, LLC DBA Conemaugh Meyersdale Medical Center 200 Hospital Drive Meyersdale, PA 15552-1249 TIN: 36-4787404 Provider #: 391302
Conemaugh Miners Medical Center DLP Conemaugh Miners Medical Center, LLC DBA Conemaugh Miners Medical Center 290 Haida Avenue Hastings, PA 16646-0689 TIN: 32-0442133 Provider #: 390130
Danville Regional Medical Center Danville Regional Medical Center, LLC DBA Danville Regional Medical Center 142 South Main Street Danville VA 24541 TIN: 20-2028539 Provider #: 490075
Ennis Regional Medical Center PRHC-Ennis, L.P. DBA Ennis Regional Medical Center 2201 West Lampasas Street Ennis, TX 75119 TIN: 62-1789402 Provider #: 450833
Fauquier Hospital Fauquier Medical Center, LLC DBA Fauquier Hospital 500 Hospital Drive Warrenton, VA 20186 TIN: 46-3107896 Provider #: 490023

Name of Facility and Address
Fleming County Hospital Fleming Medical Center LLC DBA Fleming County Hospital 55 Foundation Drive Flemingburg, KY 41041 TIN: 47-3937528 Provider #: 180053
Frye Regional Medical Center DLP Frye Regional Medical Center, LLC d/b/a Frye Regional Medical Center 420 North Center Street Hickory, NC 28601 TIN: 35-2547114 Provider #: 340116
Georgetown Community Hospital Georgetown Community Hospital, LLC DBA Georgetown Community Hospital 1140 Lexington Road Georgetown, KY 40324 TIN: 62-1757921 Provider #: 180101
Harris Regional Hospital DLP Harris Regional Hospital, LLC DBA Harris Regional Hospital 68 Hospital Drive Sylva, NC 28779-2772 TIN: 38-3932775 Provider#: 340016
Havasu Regional Medical Center Havasu Regional Medical Center, LLC DBA Havasu Regional Medical Center 101 Civic Center Lane Lake Havasu City, AZ 86403 TIN: 20-5220956 Provider #: 030069
Haywood Regional Medical Center DLP Haywood Regional Medical Center, Inc. DBA Haywood Regional Medical Center 262 Leroy George Drive Clyde, NC 28721-7430 TIN: 30-0830918 Provider#: 340184
Jackson Purchase Medical Center PineLake Regional Hospital, LLC DBA Jackson Purchase Medical Center 1099 Medical Center Circle Mayfield, KY 42066-1099 TIN: 62-1757927 Provider #: 180116
Lake Cumberland Regional Hospital Lake Cumberland Regional Hospital, LLC DBA Lake Cumberland Regional Hospital 305 Langdon Street Somerset, KY 42501 TIN: 62-1757920 Provider #: 180132
Livingston Regional Hospital Livingston Regional Hospital, LLC DBA Livingston Regional Hospital 315 Oak Street Livingston, TN 38570 TIN: 62-1762419 Provider #: 440187

Name of Facility and Address
Logan Memorial Hospital Logan Memorial Hospital, LLC DBA Logan Memorial Hospital 1625 Nashville Street Russellville, KY 42276 TIN: 62-1757917 Provider #: 180066
Logan Regional Medical Center Logan General Hospital, LLC DBA Logan Regional Medical Center 20 Hospital Drive Logan WV 25601 TIN: 05-0539357 Provider #: 510048
Los Alamos Medical Center PHC-Los Alamos, Inc. DBA Los Alamos Medical Center 3917 West Road Los Alamos, NM 87544 TIN: 03-0390794 Provider #: 320033
Maria Parham Medical Center DLP Maria Parham Medical Center, LLC DBA Maria Parham Medical Center 566 Ruin Creek Road Henderson, NC 27536 TIN: 45-2743520 Provider #: 340132
Meadowview Regional Medical Center Meadowview Regional Medical Center, LLC DBA Meadowview Regional Medical Center 989 Medical Park Drive Maysville, KY 41056 TIN: 62-1757929 Provider #: 180019
Memorial Hospital of Martinsville and Henry County PHC-Martinsville, Inc. DBA Memorial Hospital of Martinsville and Henry County 320 Hospital Drive Martinsville, VA 24112 TIN: 04-3597974 Provider #: 490079
Memorial Medical Center of Las Cruces PHC-Las Cruces, Inc. DBA Memorial Medical Center of Las Cruces 2450 Telshor Blvd. Las Cruces, NM 88011 TIN: 27-0085482 Provider #: 320018
Mercy Regional Medical Center and **Acadian Medical Center, A Campus of Mercy Regional Medical Center** Ville Platte Medical Center, LLC DBA Mercy Regional Medical Center (Main Campus) 800 East Main Street Ville Platte, LA 70586 (Acadian Campus) 3501 Hwy 190 East Eunice, LA 70535 TIN: 62-1868757 Provider #: 190167

Name of Facility and Address
Minden Medical Center PHC-Minden, L.P. DBA Minden Medical Center 1 Medical Plaza Minden, LA 71055 TIN: 62-1789340 Provider #: 190144
Nason Hospital Nason Medical Center, LLC DBA Nason Hospital 105 Nason Drive Roaring Spring, PA 16673-1202 TIN: 47-2546387 Provider #: 390062
Northeastern Nevada Regional Hospital PHC-Elko, Inc. DBA Northeastern Nevada Regional Hospital 2001 Errecart Blvd. Elko, NV 89801 TIN: 62-1740235 Provider #: 290008
Palestine Regional Medical Center Palestine Principal Healthcare Limited Partnership DBA Palestine Regional Medical Center 2900 South Loop 256 Palestine, TX 75801 TIN: 74-2791525 Provider #: 450747
Parkview Regional Hospital Mexia Principal Healthcare Limited Partnership DBA Parkview Regional Hospital 600 South Bonham Street Mexia, TX 76667 TIN: 62-1692446 Provider #: 450400
Person Memorial Hospital DLP Person Memorial Hospital, LLC DBA Person Memorial Hospital 615 Ridge Road Rexboro, NC 27573 TIN: 45-2909143 Provider #: 340159
Providence Hospital (Downtown Campus) Providence Hospital, LLC d/b/a Providence Hospital 2435 Forest Drive Columbia, SC 29204 (Northeast Campus) 120 Gateway Corporate Boulevard Columbia, SC 29203 TIN: 35-2546435 Provider #: 420026
St. Francis Hospital St. Francis Health, LLC d/b/a St. Francis Hospital 2122 Manchester Expressway Columbus, GA 31904 TIN: 47-5259919 Provider #: 110129
UP Health System Bell Acquisition Bell Hospital, LLC DBA UP Health System Bell 901 Lakeshore Drive Ishpeming, MI 49849-1367 TIN: 80-0935981 Provider #: 231321

Name of Facility and Address
UP Health System Marquette DLP Marquette General Hospital, LLC DBA UP Health System Marquette 420 West Magnetic Street Marquette, MI 49855 TIN: 80-0818718 Provider # 230054
UP Health System Portage Portage Hospital, LLC DBA UP Health System Portage 500 Campus Drive Hancock, MI 49930-1569 TIN: 90-0998484 Provider #: 230108
Raleigh General Hospital Raleigh General Hospital, LLC DBA Raleigh General Hospital 1710 Harper Rd. Beckley, WV 25801-3397 TIN: 55-0261260 Provider #: 510070
Riverview Regional Medical Center Riverview Medical Center, LLC DBA Riverview Regional Medical Center 158 Hospital Drive Carthage, TN 37030 TIN: 62-1762469 Provider #: 441307
Rockdale Hospital Rockdale Hospital, LLC DBA Rockdale Medical Center 1412 Milstead Avenue Conyers, GA 30012 TIN: 26-3202930 Provider #: 110091
Rutherford Regional Medical Center DLP Rutherford Regional Health System, LLC DBA Rutherford Regional Medical Center 288 S. Ridgecrest Avenue Rutherfordton, NC 28139 TIN: 30-0811171 Provider #: 340013
SageWest Health Care - Riverton and **SageWest Health Care - Lander** Riverton Memorial Hospital, LLC DBA SageWest Health Care - Riverton and DBA SageWest Health Care - Lander (Main Campus) 2100 W. Sunset Dr. Riverton, WY 82501 (Lander Campus) 1320 Bishop Randall Drive Lander, WY 82520 TIN: 62-1762468 Provider #: 530008
Scott Memorial Hospital RHN Scott Memorial Hospital, LLC DBA Scott Memorial Hospital 1451 N. Gardner Street Scottsburg, IN 47170-7751 TIN: 46-1113518 Provider # 151334

Name of Facility and Address
Southern Tennessee Regional Health System Lawrenceburg Crockett Hospital, LLC DBA Southern Tennessee Regional Health System Lawrenceburg US Highway 43 South Lawrenceburg, TN 38464 TIN: 62-1762364 Provider #: 440175
Southern Tennessee Regional Health System Pulaski Hillside Hospital, LLC DBA Southern Tennessee Regional Health System Pulaski 1265 East College St. Pulaski, TN 38478 TIN: 62-1762382 Provider #: 440020
Southern Tennessee Regional Health System Winchester and **Southern Tennessee Regional Health System Sewanee, A Campus of Southern Tennessee Regional Health System Winchester** Southern Tennessee Medical Center, LLC DBA Southern Tennessee Regional Health System Winchester and DBA Southern Tennessee Regional Health System Sewanee, A Campus of Southern Tennessee Regional Health System Winchester (Main Campus) 185 Hospital Road Winchester, TN 37398 (EHH Campus) 1260 University Avenue Sewanee, TN 37375 TIN: 62-1762535 Provider #: 440058
Spring View Hospital Spring View Hospital, LLC DBA Spring View Hospital 320 Loretto Road Lebanon, KY 40033 TIN: 20-0155414 Provider #: 180024
Starr Regional Medical Center Athens and **Starr Regional Medical Center Etowah** Athens Regional Medical Center, LLC DBA Starr Regional Medical Center Athens and Starr Regional Medical Center Etowah (Main Campus) 1114 West Madison Ave Athens, TN 37303 (Etowah Campus) 886 Highway 411 North Etowah, TN 37331 TIN: 62-1866028 Provider #: 440068
Sumner Regional Medical Center Sumner Regional Medical Center, LLC DBA Sumner Regional Medical Center 555 Hartsville Pike Gallatin, TN 37066 TIN: 27-2618766 Provider #: 440003
Swain County Hospital DLP Swain County Hospital, LLC d/b/a Swain County Hospital 45 Plateau Street Bryson City, NC 28713-4200 TIN: 32-0441929 Provider#: 341305

Name of Facility and Address
Teche Regional Medical Center PHC-Morgan City, L.P. DBA Teche Regional Medical Center 1125 Marguerite Street Morgan City, LA 70380 TIN: 62-1865278 Provider #: 190014
Trousdale Medical Center Trousdale Medical Center, LLC DBA Trousdale Medical Center 500 Church Street Hartsville, TN 37074 TIN: 27-2618876 Provider #: 441301
Twin County Regional Hospital DLP Twin County Regional Healthcare, LLC DBA Twin County Regional Hospital 200 Hospital Drive Galax, VA 24333-2227 TIN: 45-4601843 Provider # 490115
Valley View Medical Center PHC- Fort Mohave, Inc. DBA Valley View Medical Center 5330 South Hwy. 95 Ft. Mohave, AZ 86426 TIN; 32-0063628 Provider #: 030117
Vaughan Regional Medical Center Vaughan Regional Medical Center, LLC DBA Vaughan Regional Medical Center 1015 Medical Center Prkwy. Selma, AL 36701 TIN: 62-1864231 Provider #: 010118
Watertown Regional Medical Center Watertown Medical Center, LLC DBA Watertown Regional Medical Center 125 Hospital Drive Watertown, WI 53098 TIN: 47-3937421 Provider #:520116
Western Plains Medical Complex Dodge City Healthcare Group, LLC DBA Western Plains Medical Complex 3001 Avenue A Dodge City, KS 67801 TIN: 61-1275266 Provider #: 170175
Wilson Medical Center DLP Wilson Medical Center, LLC DBA Wilson Medical Center 1705 Tarboro St SW Wilson NC 27893-3428 TIN: 46-4317222 Provider #: 340126
Wythe County Community Hospital Wythe County Community Hospital, LLC DBA Wythe County Community Hospital 600 West Ridge Road Wytheville, VA 24382 TIN: 20-2468795 Provider #: 490111
HOSPICES

Name of Facility and Address
Hospice of Wilson Medical Center DLP Wilson Medical Center, LLC d/b/a Hospice of Wilson Medical Center 1705 Tarboro St SW Wilson NC 27893-3428 TIN: 46-4317222 Provider #: 341532
Twin County Hospice DLP Twin County Regional Healthcare, LLC DBA Twin County Hospice 200 Hospital Drive Galax, VA 24333-2227 TIN: 45-4601843 Provider # 491531
UP Health System Home Care and Hospice DLP Marquette General Hospital, LLC DBA UP Health System Home Care and Hospice 2420 1st Ave. S., Suite 102 Escanaba, MI 49829- 1309 TIN: 80-0818718 Provider # 231571 1110 10th Ave., Suite 102 Menominee, MI 49858-3058
UP Health System Home Care and Hospice Portage Portage Hospital, LLC DBA UP Health System Home Care and Hospice Portage 821 W. Water Street Hancock, MI 49930-1953 TIN: 90-0998484 Provider #: 231602
HOME HEALTH AGENCIES
Carolina Home Care DLP Rutherford Regional Health System, LLC DBA Carolina Home Care 2270 US Highway 74A BYP Suite 345 Forest City, NC 28043 TIN: 30-0811171 Provider #: 347169
Conemaugh Home Health DLP Conemaugh Memorial Medical Center, LLC DBA Conemaugh Home Health 315 Locust Street First Floor Suite Johnstown, PA 15901-1651 TIN: 61-1739000 Provider #: 397406
Harris Home Health DLP Harris Regional Hospital, LLC DBA Harris Home Health 20 WestCare Drive Suite 303 Sylva, NC 28779-5278 TIN: 38-3932775 Provider#: 347029
Home Care Services of Haywood Regional Medical Center DLP Haywood Regional Medical Center, LLC DBA Home Care Services of Haywood Regional Medical Center 560 Leroy George Drive Clyde, NC 28721-7408 TIN: 30-0830918 Provider#: 347035

Name of Facility and Address
Maria Parham Medical Center DLP Maria Parham Medical Center, LLC DBA Maria Parham Medical Center 566 Ruin Creek Road Henderson, NC 27536 TIN: 45-2743520 Provider #: 347222
Nason Hospital Home Health Agency Nason Medical Center, LLC DBA Nason Hospital Home Health Agency 108 Nason Drive Roaring Spring, PA 16673-1202 TIN: 47-2546387 Provider #: 397292
Twin County Regional Home Health DLP Twin County Regional Healthcare, LLC DBA Twin County Regional Home Health 200 Hospital Drive Galax, VA 24333-2227 TIN: 45-4601843 Provider # 497040
UP Health System Home Care and Hospice DLP Marquette General Hospital, LLC DBA UP Health System Home Care and Hospice 580 West College Avenue Marquette, MI 49855 TIN: 80-0818718 Provider #: 237093 2420 1st Ave. S., Suite 102 Escanaba, MI 49829-1309 1110 10th Ave., Suite 102 Menominee, MI 49858-3058
UP Health System Home Care and Hospice Portage Portage Hospital, LLC DBA UP Health System Home Care and Hospice Portage 821 W. Water Street Hancock, MI 49930-1953 TIN: 90-0998484 Provider #: 237262
RURAL HEALTH CLINICS
Auburn Community Health Clinic Logan Physician Practices LLC DBA Auburn Community Health Clinic 128 Sugar Maple Dr. Auburn, KY 42206 TIN: 62-1824635 Provider #: 188929
Conemaugh Physician Group - Davidsville DLP Conemaugh Physician Practices, LLC DBA Conemaugh Physician Group - Davidsville 207 Woodstown Hwy. Hollsopple, PA 15935-7119 TIN: 32-0442710 Provider #: 393923

Name of Facility and Address
Conemaugh Physician Group - Highlands DLP Conemaugh Physician Practices, LLC DBA Conemaugh Physician Group - Highlands 4324 Glades Pike Somerset, PA 15501-1143 TIN: 32-0442710 Provider #: 393902
Conemaugh Physician Group - Jennerstown DLP Conemaugh Physician Practices, LLC DBA Conemaugh Physician Group - Jennerstown 1609 W. Pitt Street Jennerstown, PA 15467 TIN: 32-0442710 Provider #: 393922
Conemaugh Physician Group - New Paris DLP Conemaugh Physician Practices, LLC DBA Conemaugh Physician Group - New Paris 4186 Cortland Drive New Paris, PA 15554-7706 TIN: 32-0442710 Provider #: 393901
Conemaugh Physician Group - Portage DLP Conemaugh Physician Practices, LLC DBA Conemaugh Physician Group - Portage 3670 Portage Street Suite 105 Portage, PA 15946-6546 TIN: 32-0442710 Provider #: 393909
Conemaugh Physician Group - St. Benedict DLP Conemaugh Physician Practices, LLC DBA Conemaugh Physician Group - St. Benedict 564 Theatre Road Carrolltown, PA 15722-7702 TIN: 32-0442710 Provider #: 393907
Cresson Family Practice DLP Conemaugh Physician Practices, LLC DBA Cresson Family Practice 225 Keystone Avenue Cresson, PA 16630-1214 TIN: 32-0442710 Provider #: 393910
Emory Medical Center Castleview Hospital, LLC DBA Emory Medical Center 90 West Main Street Castle Dale, UT 84513 TIN: 62-1762357 Provider #: 463985
Family Health Care Center of Gretna Danville Physician Practices LLC DBA Family Health Care Center of Gretna 305 N. Main St. Gretna, VA 24557 TIN: 20-2999870 Provider #: 493836

Name of Facility and Address
Family Health Care Meyersdale RHC DLP Conemaugh Meyersdale Medical Center, LLC DBA Family Health Care Meyersdale RHC 7160 Mason Dixon Highway Meyersdale, PA 15552 TIN: 36-4787404 Provider #: 393410
Marion Clinic Vaughan Regional Medical Center, LLC DBA Marion Clinic Route 2, Box 4D Highway 45 South Marion, AL 36756 TIN: 62-1864231 Provider #: 013982
Martinsville Pediatrics Martinsville Physician Practices LLC DBA Martinsville Pediatrics 1109 Brookdale St., Ste. C Martinsville, VA 24112 TIN: 20-4277914 Provider #: 498917
Mountain Medical Clinic AMG-Southern Tennessee LLC DBA Mountain Medical Clinic 21 1st St Monteagle, TN 37356 TIN: 62-1763648 Provider #: 448912
Parkview Regional Medical Clinic Mexia Principal Healthcare Limited Partnership DBA Parkview Regional Medical Clinic 600 South Bonham Street Mexia, TX 76667 TIN: 62-1692446 Provider #: 673999
Pediatric Family Care Center DLP Twin County Physician Practices LLC DBA Pediatric Family Care Center 106 Doctors Park Galax, VA 24333 TIN: 45-4601912 Provider #: 498910
Powell County Clinic Kentucky Hospital, LLC DBA Powell County Clinic 68 E Elkins Street Stanton, KY 40380 TIN: 62-1772321 Provider #:183469
Spring View Clinic Spring View Hospital LLC DBA Spring View Clinic 137 W. Main St. Springfield, KY 40069 TIN: 20-0155414 Provider # 183474
Stell Family Practice Minden Physician Practices LLC DBA Stell Family Practice 102 Office park Dr. Minden, LA 71055 TIN: 27-0151827 Provider #: 193879

Name of Facility and Address
The Women's Clinic Minden Physician Practices, LLC DBA The Women's Clinic 427 Homer Road Minden, LA 71055 TIN: 27-0151827 Provider #: 193879
UP Health System Kingsford DLP Marquette Physician Practices Inc. DBA UP Health System Kingsford 800 East Blvd. Kingsford, MI 49802 TIN: 80-0835058 Provider #: 233885
UP Health System Trenary DLP Marquette Physician Practices Inc. DBA UP Health System Trenary E 2995 State Hwy M67 Trenary, MI 49891 TIN: 80-0835058 Provider #: 233837
AMBULATORY SURGICAL CENTERS
Lake Cumberland Surgery Center Lake Cumberland Surgery Center, LP DBA Lake Cumberland Surgery Center 301 Langdon Street Somerset, KY 42503 TIN: 62-1864099 Provider #: ASC1034
Lohman Endoscopy Center Lohman Endoscopy Center, LLC DBA Lohman Endoscopy Center 4381 E. Lohman Ave. Las Cruces, NM 88011-8255 TIN: 27-1432797 Provider #: NMB2511
The Surgery Center of Athens Athens Surgery Center, LLC DBA The Surgery Center of Athens 105 N. Meadows Dr. Athens, TN 37303-4172 TIN: 80-0812776 Provider #: 103G496076
SKILLED NURSING FACILITIES
Clark Regional Medical Center Kentucky Hospital, LLC DBA Clark Regional Medical Center 175 Hospital Drive Winchester, KY 40391-9591 TIN: 62-1772321 Provider #: 185428
Clinch Valley Medical Center Clinch Valley Medical Center, Inc. DBA Clinch Valley Medical Center - SNF Unit 6801 Governor GC Peery Hwy. Richlands, VA 24641-2194 TIN: 54-1058953 Provider #: 491581

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Name of Facility and Address
Conemaugh Memorial Medical Center Transitional Care Unit DLP Conemaugh Medical Center, LLC DBA Conemaugh Memorial Medical Center Transitional Care Unit 320 Main Street Johnstown, PA 15901-1601 TIN: 61-1739000 Provider #: 396102
Fauquier Health Rehabilitation And Nursing Center Fauquier Medical Center, LLC DBA Fauquier Health Rehabilitation and Nursing Center 360 Hospital Drive Warrenton, VA 20186 TIN: 46-3168620 Provider #: 495233
Havasu Regional Medical Center Havasu Regional Medical Center, LLC DBA Havasu Regional Medical Center 1811 Mesquite Avenue Lake Havasu City, AZ 86403 TIN: 20-5220956 Provider # 035287
Lake Cumberland Regional Hospital - Skilled Nursing Unit Lake Cumberland Regional Hospital, LLC DBA Lake Cumberland Regional Hospital - Skilled Nursing Unit 305 Langdon Street Somerset, KY 42503-2750 TIN: 62-1757920 Provider #: 185407
Starr Regional Health & Rehabilitation Athens Regional Medical Center, LLC DBA Starr Regional Health & Rehabilitation 886 Highway 411 N. Etowah, TN 37331-1912 TIN: 62-1866028 Provider #: 445277
Person Memorial Hospital DLP Person Memorial Hospital, LLC DBA Person Memorial Hospital 615 Ridge Road Roxboro, NC 27573-4629 TIN: 45-2909143 Provider #: 345004
PortagePointe Portage Hospital, LLC DBA PortagePointe 520 Campus Drive Hancock, MI 49930-1569 TIN: 90-0998484 Provider #: 235624
Southern Tennessee Regional Health System Winchester - Skilled Facility Southern Tennessee Medical Center, LLC DBA Southern Tennessee Regional Health System Winchester - Skilled Facility 185 Hospital Road Winchester, TN 37398-2404 TIN: 62-1762535 Provider #: 445222

Name of Facility and Address
Wilson Rehabilitation and Nursing Center DLP WilMed Nursing Care and Rehabilitation Center, LLC d/b/a Wilson Rehabilitation and Nursing Center 1705 Tarboro St SW Wilson NC 27893-3428 TIN: 35-2491141 Provider #: 345423
Wythe County Community Hospital - Skilled Nursing Facility Wythe County Community Hospital, LLC DBA Wythe County Community Hospital - Skilled Nursing Facility 600 W. Ridge Road Wytheville, VA 24382-1044 TIN: 20-2468795 Provider #: 495167
END STAGE RENAL DISEASE
UP Health System Portage Dialysis Center Portage Hospital, LLC DBA UP Health System Portage Dialysis Center 500 Campus Drive Hancock, MI 49930 TIN: 90-0998484 Provider #: 232347

Attachment Section A-5A

Management Services Agreement

SERVICES AGREEMENT

THIS SERVICES AGREEMENT (the "Agreement") is made this 1st day of September, 2016, (the "Effective Date") by and between Horizon Health Behavioral Health Services ("Contractor"), and Athens Regional Medical Center, LLC d/b/a Starr Regional Medical Center Etowah formerly known as Woods Memorial Hospital, LLC, an acute care hospital (the "Hospital").

RECITALS

WHEREAS, Hospital is a general hospital located in Etowah, Tennessee and desires to operate a 10 bed geropsychiatric inpatient service (the "Program") in order to fully utilize Hospital's facilities and provide additional services to the community it serves;

WHEREAS, Contractor is in the business of developing systems, procedures and programs necessary for the operation of psychiatric programs by general hospitals, and Contractor has the expertise necessary for the management and operation of the Program;

WHEREAS, the parties desire to enter into an agreement whereby Contractor will manage the Program for the Hospital.

NOW, THEREFORE, in consideration of the mutual covenants herein contained, and for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto, for themselves, their heirs, successors and assigns, agree as follows:

1. OBLIGATIONS OF CONTRACTOR.

1.1. Management Services. Beginning on the Effective Date, Hospital hereby engages Contractor, and Contractor hereby accepts such engagement, to provide day-to-day management services to and for the Program, pursuant to the following terms and conditions (the "Services"):

(a) During the Term of this Agreement, the Contractor shall be responsible for the day-to-day operations of the Program through its on-site Director, Behavioral Health, provided however, that the Program shall remain all times subject to the ultimate control of the Hospital;

(b) Provide the Hospital's senior management staff with consultation relative to strategic matters associated with the operation of the Program;

(c) Provide personnel as needed for the Program and as further described in Exhibit A (the "Program Staff"), attached hereto and incorporated herein by reference. The Director, Behavioral Health shall function as a departmental head and shall report to Hospital management as such. Contractor shall consult with Hospital in the selection of its Director, Behavioral Health or shall not continue to employ the Director, Behavioral Health or any other Program Staff to whom Hospital reasonably objects. Hospital shall provide Contractor written notice of any Program Staff to which it reasonably objects and Contractor shall have thirty (30) days from the date of such notice to correct the Program Staff job performance deficiencies. In the event that the Hospital still desires that the Program Staff be removed from the Program after such thirty (30) day period, Contractor agrees to remove such employee(s) within fifteen (15) days of such notice. The Program Staff shall be compensated by Contractor and shall be responsible to the Director, Behavioral Health, provided, however, that the Program Staff shall at all times be subject to the Hospital's policies and procedures for its own employees. Contractor shall have the right to terminate the employment of Program Staff and to hire such additional Program Staff

as Contractor determines is reasonably necessary from time to time. In the performance of this Agreement, it is mutually understood and agreed that the Program Staff are at all times acting and performing as employees of Contractor and not the Hospital. Nothing herein is intended to affect Contractor's status as employer of each Program Staff or Contractor's control over such individuals during the Term of this Agreement;

(d) Provide Contractor's expertise in assisting the Hospital with the development, introduction, implementation, and continuing oversight of policies and procedures for the most efficient and clinically effective operation of the Program, including, without limitation, treatment planning, therapeutic services, nursing services, and employee training;

(e) Assure that all Program personnel participate in the Hospital's hospital-wide quality assurance, safety, risk management, compliance, infection control and other similar programs;

(f) Assist and advise the Hospital with respect to maintaining compliance with all applicable federal, state, and local statutes, regulations, ordinances, and licensing, certification, and applicable third-party accrediting body standards and requirements, including, without limitation, as applicable, the Special Medicare Conditions of Participation for Psychiatric Services for exempt units.

(g) Provide on-site training to Hospital nursing, therapy, activity/occupational therapy, secretarial and clerical staff in the Program procedures and operation of the Program;

(h) Provide, at Contractor's expense, one hundred percent (100%) of all training materials for Contractor-sponsored programs; clinical program manuals, and, following the Effective Date, travel expenses for Contractor on-site, regional and national personnel;

(i) Assist and advise Hospital in the preparation of any and all information, data and materials required for an application for accreditation, certification, licensure and survey by voluntary, local, state and national organizations;

(j) Assure all physician orders for the Program are entered into the Hospital's Computerized Physician Order Entry ("CPOE") program; and

(k) Conduct, at Contractor's own expense, ongoing independent audits of the Program's financial and clinical performance through its regional and corporate clinical staff. Contractor will share results of these audits with Hospital in the form of a report as requested by Hospital, but no less frequently than on a biannual basis. In the event areas of non-compliance are identified in the audit process, Contractor will develop and submit corrective plan of action to the Hospital for Hospital's review and approval.

2. OBLIGATIONS OF THE HOSPITAL.

2.1. Hospital covenants and agrees that, at its expense, it shall:

(a) Ensure that the Program remains at all times licensed under applicable state law, certified to participate in Medicare, Medicaid, and any other applicable Federal Healthcare Program, and accredited by the Joint Commission or such other third-party accrediting agency as may be appropriate;

(b) Maintain that portion of the Hospital facility where the Program is located in compliance with all applicable federal, state, and local licensing requirements and applicable thirty-party accrediting body requirements;

(c) Furnish all Hospital facilities, and patient services required to satisfy the needs of the Program patients not provided by Contractor;

(d) Provide nursing, secretarial, clerical, therapy, and other required support staff necessary to operate the Program, including but not limited to, nurses, nursing assistants, psychiatric technicians, activity/occupational therapists, master level therapist(s), unit clerks, and Program secretary;

(e) Provide the physician resources necessary to operate the Program in accordance with all local, state and federal governing regulatory and licensure requirements as well as any Hospital-specific departmental rules and bylaws. Such physician resources shall include, but may not be limited to:

(i) Psychiatrists necessary to ensure admitting, discharge, daily patient rounds and after hours and weekend coverage are available to ensure full utilization of the Program.
(ii) Other physician resources necessary to operate the Program and ensure that required medical processes, such as initial medical history and physical and ongoing medical consulting services to the Program's patients, are available as required.

(f) Require that all Hospital staff who interact with the Program receive on-site training by Contractor in the procedures to be followed in the Program; and

(g) Promptly notify Contractor in writing within five (5) business days of the following:

(i) Any action against any of its licenses, its accreditation by the Joint Commission or any successor of the Joint Commission;
(ii) Any governmental action initiated against Hospital which could materially affect this Agreement; or
(iii) Any legal action claiming medical malpractice related to services provided to Program patients filed against Hospital or Hospital's physicians during the Term of this Agreement.

3. BILLING AND COMPENSATION.

3.1. Billing. Hospital or its duly authorized agent shall have the exclusive and sole right to invoice and collect all charges for Hospital services rendered to Program patients. All amounts collected by Hospital or Hospital's duly authorized agent pursuant to such invoices shall belong exclusively to Hospital and Contractor shall have no right or interest in the same. However, charges for professional services rendered to Program patients by health professionals such as physicians, clinical nurse specialist, advanced registered nurse practitioners, etc., shall be invoiced and collected by the health professional or their employer, if so assigned by the health professional. Contractor will assist Hospital in the appeal process for any denials that occur related to the Program with the understanding that Hospital shall have the sole responsibility for such appeals

3.2. Fees. The Hospital shall pay to Contractor the fees set forth in Exhibit B, attached hereto and incorporated herein by reference.

3.3. Effect of Admissions Hold. If the Program is at any time placed on an admissions hold by any governmental authority, or private or governmental payor, as a result of Program deficiencies identified by any governmental authority, Contractor's monthly management fee shall be subject to a Reduction (as hereinafter defined) for the duration in which the Program remains on an admissions hold as a result of Program deficiencies identified by any governmental authority, provided, however, that Contractor's monthly management fee shall not be reduced if Contractor made a written recommendation to Hospital to change an area identified by Contractor or the relevant government authority as deficient and Hospital elected not to make the change recommended in writing by Contractor. The Reduction in the Management Fee shall be calculated as follows: Hospital shall identify the average daily census (ADC) for the Program during the ninety (90) days immediately preceding the effective date of the admissions hold (the "Measurement Period"). The ADC during the admissions hold period will be calculated on the last day of each month that the hold is in effect. If the ADC for the Program during the admissions hold period falls below the Measurement Period ADC, then that percentage reduction as compared to the Measurement Period ADC will be applied to the fixed monthly management fee as a discount during any month where the ADC falls below the Measurement Period ADC. The total Reduction shall not exceed 50% of the monthly management fee. If the actual ADC during the admissions hold period remains at or above the Measurement Period ADC, then no penalty shall apply. Additionally, if the monthly fee paid to Contractor is other than a fixed Management fee, this section shall not apply. For example, if the ADC for March 2017 is 9, and the Program is placed on admissions hold for such month, and the ADC for the ninety (90) day period immediately preceding March 2017 is 11, then the Reduction shall apply to the monthly management fee for March 2017. If the monthly management fee is then the Reduction for March 2017 would be and the monthly management fee due to Contractor for March 2017 would be

9 ADC/11 ADC = 82%
100% minus 82% = 18% Reduction
18% =
monthly management fee due to Contractor for March 2017

Example 2: If the ADC during a month in which the Program is placed on admissions hold is 4, and the ADC during the preceding Measurement Period was 11, then the Reduction applicable to a monthly management fee of hall be

4 ADC/11 ADC = 36%
100% minus 36% = 64% (Reduce to 50%) on
monthly management fee due to Contractor for month during which Program is on admissions hold.

3.4. Compensation Terms. The parties agree that the compensation terms set forth in this Section 3 have been negotiated on an arm's length basis and constitute the fair market value of Contractor's Services. The parties further agree that no payment made by the Hospital to Contractor

pursuant to this Agreement shall be made in exchange for any referral, directly or indirectly, of any patients to the Hospital.

4. REPRESENTATIONS AND WARRANTIES.

4.1. No Federal Healthcare Exclusion. Each party represents and warrants to the other party that any personnel employed by or otherwise under contract or agreement to provide services to or on behalf of such party are not currently excluded, debarred or otherwise ineligible to participate in any federal healthcare program, as defined in 42 U.S.C. Section 1320a-7b(f), that such party has no knowledge of any basis for such exclusion exists, and that such party has not been subject to any final adverse action as defined under the Health Care Fraud and Abuse Data Collection Program. Each party agrees to notify the other party immediately if the notifying party receives notice or otherwise becomes aware that it is subject to any sanction described in this Section 4.1.

5. TERM AND TERMINATION.

5.1. Term. This Agreement shall commence on the Effective Date and continue for an initial term of three (3) years from the Effective Date unless terminated earlier pursuant to this Agreement (the "Initial Term"). Hospital shall be responsible for the Pass-Through Expenses as contained in Exhibit B. This Agreement will automatically renew for successive twelve (12) month periods after the expiration of the Initial Term (an "Extended Term"), provided, however, that any Extended Term may be terminated upon (a) the full execution of a new agreement between the parties covering the same services; or (b) not less than ninety (90) days prior written notice of termination by either party to the other party during the Extended Term. As used herein, "Term" shall mean the Initial Term and any Extended Term.

5.2. Termination Without Cause. Either party may, following the end of the thirtieth (30th) month following the Effective Date, terminate this Agreement without cause by providing ninety (90) days' prior written notice stating the intended date of termination.

5.3. Termination for Breach. Either party may terminate this Agreement immediately, after providing sixty (60) days' prior written notice to the other party of a material breach of any term or condition of this Agreement specifying with particularity the material term, condition or covenant which has not been performed or has been breached by the other party, provided that the breach is not cured within the sixty (60) day notice period. If the breaching party is unable to cure such breach within the sixty (60) day notice period and has undertaken good faith efforts to cure the breach within a reasonable period of time, the non-breaching party may consent in its sole discretion to a reasonable extension of the cure period.

5.4. Immediate Termination. Notwithstanding any other provision of this Agreement, either party may terminate this Agreement immediately in the event that the other party fails to maintain the insurance coverages required by this Agreement or the other party's representation in Section 4.1 becomes untrue. This Agreement may be terminated immediately, upon the filing, by either party, of a voluntary petition of bankruptcy, or if either party makes an assignment for the benefit of creditors or otherwise seeks relief from creditors under any federal or state bankruptcy, insolvency, reorganization or moratorium statute.

5.5. Immediate Termination by Hospital. Notwithstanding any other provision of this Agreement, Hospital may terminate this Agreement immediately (i) in the event the Hospital closes for any reason, (ii) for units paid by Medicare as an exempt psychiatric unit, upon the loss of distinct part unit designation of the Program from CMS for any reason, provided, however, that should this Agreement

terminate as a result of the loss of distinct part unit status through no fault of Contractor, then Contractor shall be entitled to payment of the monthly management fee through the end of the then current Term of the Agreement, not to exceed twelve (12) months; (iii) in the event Hospital loses its designation as a Medicare provider for any reason; or (iv) in the event of any investigation by any federal, state or other governmental agency into the conduct of Contractor of the operation of the Program or any other business of Contractor or any of its principals, with respect to its businesses in which Contractor is involved, provided that such investigation: (x) involves alleged violations of criminal laws; or (y) would be likely to have a material adverse effect on Contractor and its ability to fulfill its obligations under this Agreement in the event that such investigation were to be resolved in a manner materially adverse to Contractor.

5.6. Either party may, upon written notice effective immediately, terminate this Agreement in the event that Hospital is unable to obtain the necessary Certificate of Need ("CON") for the Program. Hospital reserves the right, at its sole discretion, to withdraw or amend the CON at any time; however, Hospital shall be responsible for paying to Contractor any Contractor Start-up Fees incurred prior to termination under this provision.

5.7. Health and Safety. This Agreement may be terminated by either party immediately upon written notice to the other party upon the reasonable determination by the party giving notice that the health and safety of patients is being endangered by the other party hereto. Such notice shall be accompanied by sworn statements or documented evidence of facts giving rise to such termination.

5.8. Non-Payment. This Agreement may be terminated upon written notice by Contractor in the event Hospital defaults in the payment of or otherwise fails to pay any undisputed amount due Contractor hereunder on or before the due date, and such default remains uncorrected for a period of ten (10) days after written notice of such breach from Contractor.

5.9. Actions on Termination. Upon termination of this Agreement, in addition to the other obligations set forth herein, Contractor and the Hospital will cooperate to assure a smooth wind down of the Agreement, and the Hospital and Contractor will return the other party's Confidential Information (in whatever form or format) to the other, or at the other party's option, destroy all of such other party's Confidential Information, with the exception of any computer hardware or software, which shall be returned to the party that owns such hardware or software.

6. EXCLUSIVITY; NONCOMPETITION; NONSOLICITATION; CONFIDENTIALITY; CONFIDENTIAL INFORMATION

6.1. Exclusivity. During the Term of this Agreement, so long as it is not in default hereunder, Contractor shall be the sole and exclusive provider of Services for the Program.

6.2. Nonsolicitation of Employees. During the Term of this Agreement neither party shall, without the written consent of the other party, directly solicit for employment any employees of the other party hired for the provision of services under this Agreement. In the event a party solicits for employment any employees of the other party, the hiring party shall pay the other party a fee equal to fifty percent (50%) of the first year annual base salary of such employee. Such fee shall be paid within thirty (30) days of the effective date of the employee's employment with the hiring party. With respect to any individual who was employed by the Hospital immediately prior to being employed by Contractor hereunder, such individual may be rehired by the Hospital notwithstanding this Section 6.2, and no fee shall be payable hereunder with respect to such rehiring. The terms of this Section 6.2 shall not apply to either party's hiring of any employee who is not directly solicited by the hiring party and is hired after responding to a publicly advertised available position with the hiring party.

6.3. Confidentiality. Except for disclosure to their legal counsel, accountants or financial advisors, neither Contractor nor the Hospital shall disclose the terms of this Agreement to any person who is not a party or signatory to this Agreement, unless disclosure thereof is required by law or otherwise authorized by the provisions of this Agreement or expressly by the other party.

7. INDEMNIFICATION.

7.1 Each party shall defend, indemnify and hold the other party, its officers, directors, parents, subsidiaries, affiliates, employees and agents harmless from and against any and all liability, loss, expense, reasonable attorneys' fees, or claims for injury or damages arising out of the performance of this Agreement in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the acts or omissions of the indemnifying party, its officers, agents or employees.

8. INSURANCE.

8.1. Contractor shall maintain at all times during the Term of this Agreement cyber liability insurance coverage (including, but not limited to, coverage for investigations and mitigation of any data breaches or breaches of patient information) relating to errors and omissions liability, network and information security liability, and communications and media liability, with a limit of Ten Million Dollars and 00/100 ($10,000,000.00) per occurrence, and commercial and professional liability insurance covering all risks and exposures arising out of the performance of Services pursuant to this Agreement in the amounts of One Million Dollars and 00/100 ($1,000,000.00) per occurrence and Three Million Dollars and 00/100 ($3,000,000.00) in the annual aggregate. Contractor will maintain this professional liability coverage during the Term of this Agreement and for a period of three (3) years after termination of the Agreement. In addition, Hospital and its parent companies and affiliates shall be named as additional insureds under the cyber liability insurance coverage required to be provided by Contractor hereunder. Upon request by Hospital, Contractor shall provide Hospital with an insurance certificate or other suitable document evidencing the coverage required to be provided by Contractor hereunder. The insurance policies shall provide that Hospital be given at least thirty (30) days' prior notice of cancellation, non-renewal, termination, or material modification. The terms of this Section 8.1 shall survive the termination of this Agreement.

8.2. Hospital shall maintain at all times during the Term of this Agreement cyber liability insurance coverage (including, but not limited to, coverage for investigations and mitigation of any data breaches or breaches of patient information) relating to errors and omissions liability, network and information security liability, and communications and media liability, with a limit of Ten Million Dollars and 00/100 ($10,000,000.00) per occurrence. Hospital shall maintain at all times during the Term of this Agreement, commercial and professional liability insurance or a comparable program of self-insurance covering all risks and exposures arising out of operation of the Program in the amount of at least One Million Dollars and 00/100 ($1,000,000.00) per occurrence and Three Million Dollars and 00/100 ($3,000,000.00) in the annual aggregate. In the event Hospital procures professional liability insurance coverage which is not on an occurrence basis, Hospital shall obtain subsequent policies which have a retroactive date of coverage that is inclusive of the Effective Date of this Agreement. Hospital will maintain this professional liability coverage during the Term of this Agreement and for a period of three (3) years after termination of the Agreement. In addition, Contractor and its parent companies and affiliates shall be named as additional insureds under the cyber liability insurance coverage required to be provided by Hospital hereunder. Upon request by Contractor, Hospital shall provide Contractor with an insurance certificate or other suitable document evidencing coverage. The Hospital shall give Contractor at least thirty (30) days prior notice of cancellation, non-renewal, termination, or material modification of

such insurance policy or program. The terms of this Section 8.2 shall survive the termination of this Agreement.

9. MISCELLANEOUS.

9.1. Independent Contractor. Neither the Hospital nor any of the physicians providing services at the Hospital are or shall be an employee, agent or servant of Contractor; instead, the Hospital and such physicians are independent contractors who are providing services on a fee for service basis to the Program's patients. Furthermore, Contractor is not and shall not be an employee, agent or servant of the Hospital or such physicians; instead, Contractor is an independent contractor providing management services to the Hospital on a fee for service basis. It is agreed and acknowledged by Contractor and the Hospital that, as an independent contractor, Contractor retains the right to contract with and provide services to facilities and persons other than the Hospital and its patients subject to the restrictions otherwise set forth in Section 6.2, above.

9.2. Patient Admissions. All decisions regarding the admission of Patients to the Program shall be made by an appropriately credentialed member of the Hospital Medical Staff in accordance with the admissions criteria established by the Hospital and without regard to any patient's ability to pay.

9.3. Patient Care. Nothing in this Agreement shall dictate how the Hospital or any physician, clinical nurse specialist, advanced registered nurse practitioner, etc. shall practice medicine, deliver patient care or exercise medical judgment. The Hospital and the patients' provider shall have complete control over the diagnosis and treatment of all patients and neither Contractor nor any employee of Contractor shall exercise any direct supervision or control over the individual treatment of patients by the Hospital or Hospital's physicians.

9.4. Non-Discrimination. Neither party will discriminate in the performance of services or the quality of goods or care provided to patients on the basis of race, sex, age, religion or national origin.

9.5. Privacy Laws. Both parties shall comply with any and all state and federal privacy laws and regulations that apply to the protection of individually identifiable health information as are in effect during the term of this Agreement including, without limiting the generality of the foregoing, HIPAA and the Health Information Technology for Economic and Clinical Health ("HITECH") Act, included in Division A, Title XIII, Subtitle D of the American Recovery and Reinvestment Act of 2009 and the regulations promulgated thereunder. Contractor agrees to maintain privacy standards for any such information consistent with all implemented and applicable laws, rules and regulations. The terms of this Section 9.5 shall survive the termination of this Agreement. Contractor agrees that it shall be a so-called business associate of the Hospital under HIPAA and shall enter into the HIPAA Business Associate Agreement with the Hospital set forth in Exhibit D, attached hereto and incorporated herein by reference.

9.6. Program Name. The name of the Program will be Starr Regional Medical Center Etowah to optimize community identification, create a strong name relationship and achieve cost savings through regional awareness. The Program name may be used in publications and periodicals about professional and patient awareness of the Program. The Hospital's use of the Program name will comply with protocols for font, logo, design and layout specified by Contractor and Hospital. The Program's name shall be the sole and exclusive property of the Hospital.

9.7. Government Access to Records. Contractor agrees, to the extent required by law, to make available upon reasonable request to the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, or any of their duly authorized representatives, this Agreement and all books, documents and records necessary to verify the nature and extent of the costs of providing

services under this Agreement. Such inspection shall be available up to four (4) years after the rendering of such services. If Contractor, subject to the Hospital's consent, carries out its responsibilities through a subcontract of Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period with a related organization, the subcontract will also contain a government access to records clause similar to this clause. No attorney-client, accountant-client, or other legal privilege will be deemed to have been waived by the Hospital or Contractor by virtue of this Agreement. The obligations set forth in this Section 9.7 shall survive the termination of this Agreement.

9.8. Force Majeure. If either party fails to perform any of its obligations under this Agreement due to any cause beyond the reasonable control of such party, including, but not limited to, an act of God, act or omission of civil or military authorities of the state in which Hospital is located or the United States of America, fire, strike, flood, riot, delay of transportation or the inability due to the aforementioned causes to obtain necessary labor, material or facilities, such party will not be deemed liable under this Agreement for failing to fulfill such obligations.

9.9. Assignment. This Agreement is binding upon and inures to the benefit of the parties hereto and their respective successor and assigns; provided, however, that this Agreement is not assignable without the prior written consent of the other party, with the exception of an assignment by either party to an entity directly owned or controlled by, or which owns or controls, or which is under common ownership or control of such party or an assignment to a new owner of substantially all of the assets of such party.

9.10. Waiver. Neither the waiver of any breach or default, nor the failure of either of the parties to enforce any of the provisions of this Agreement or to exercise any right hereunder, will be construed as a waiver of any subsequent breach or default, or as a waiver of any rights or provisions hereunder.

9.11. Severability. If any provision of this Agreement is, under applicable law, deemed invalid or unenforceable, such provision shall, to the extent permitted under applicable law, be construed by modifying or limiting it so as to be valid and enforceable to the maximum extent possible under applicable law.

9.12. Governing Law. This Agreement is governed by and construed in accordance with the laws of the State of Kentucky (the "State").

9.13. Jurisdiction and Venue. The proper venue for any suit, action or legal proceeding arising out of or relating to this Agreement shall be brought in the state and county in which the Hospital is located.

9.14. Master Contract Database. To the extent required by 42 C.F.R. section 411.357 (d) (1) (ii), all service agreements between Hospital and Contractor are maintained electronically in a master contract database that is maintained and updated centrally and is available for review upon request by an authorized governmental official.

9.15. Headings. The headings contained in this Agreement are for reference purposes only and do not affect its meaning or interpretation.

9.16. Notices. All notices that are required pursuant to this Agreement are to be in writing, mailed by first class certified mail, return receipt requested, postage prepaid, or transmitted by hand delivery, or any nationally recognized overnight courier service. Notices will be deemed given upon

receipt or refusal, and are to be delivered to the following addresses or such other addresses as Contractor or the Hospital may designate from time to time:

If to Contractor:	Horizon Health Behavioral Health Services 1965 Lakepointe Drive, Suite 100 Lewisville, TX 75057 Attn: John F. DeVaney, President
If to the Hospital:	Athens Regional Medical Center, LLC, d/b/a Starr Regional Medical Center Etowah P.O. Box 250 Athens, Tennessee 37371 Attn: Hospital CEO
With a copy to:	LifePoint Health 330 Seven Springs Way Brentwood, TN 37027 Attn: Legal Department

9.17. Authorized Signatory. Each party represents and warrants to the other that the execution, delivery and performance of this Agreement and provisions contained herein are within its corporate powers. Each signatory to this Agreement is properly empowered and has all requisite authority necessary to enter into this Agreement and has duly and validly executed and delivered this Agreement accordingly.

9.18. Counterparts. This Agreement may be executed in one or more counterparts, all of which together shall constitute only one Agreement.

9.19. Headings. The headings contained in this Agreement are used solely for convenience and shall not be deemed to define or limit the provisions of this Agreement.

9.20. Entire Agreement; Modification. This Agreement and its attachments are the entire agreement between the parties and all prior written or oral promises or representations regarding the subject matter hereof are superseded. No amendments or modifications of this Agreement will be binding upon either party unless in writing and signed by both parties.

9.21. No Referrals. The parties agree that no benefits or consideration paid hereunder is conditioned on or in exchange for any referrals or recommendation of referrals by one party to the other, or the generation of any business by one party for the other.

9.22. Changes in Law or Regulation. The parties intend that this Agreement comply with all relevant state and federal laws and regulations relating to the provision of the Services, and to the reimbursement of such services under the Medicare, Medicaid and other reimbursement programs. If any provision of this Agreement is held by a court or administrative body of competent jurisdiction to be invalid, illegal or unenforceable for any reason and in any respect, such invalidity, illegality or unenforceability shall in no event affect prejudice or disturb the validity of the remainder of this Agreement, which shall be and remain in full force and effect, enforceable in accordance with its terms. Notwithstanding the foregoing, in the event that there shall be a change in law, regulation or interpretation thereof by a court or government agency that adversely affects the continuing legality of this Agreement, both parties agree to negotiate in good faith to revise this Agreement to conform with such laws or regulations while preserving the economic terms of this Agreement. If the parties do not reach agreement

with respect to such an addendum within sixty (60) days within a written request to negotiate following a change in such law, regulation, or interpretation thereof, then either party may terminate this Agreement by providing ninety (90) days' written notice to the other, or at such earlier time as may be required by law or regulation.

9.23. No Third Party Beneficiaries. The parties agree that this Agreement is entered into for the sole benefit of the parties and that there shall be no third party beneficiaries of this Agreement. The parties agree that this Agreement is not intended to, and shall not be construed to, create or confer any rights in or upon any person or entity not a party to it.

9.24. No Physician Ownership. Each party represents and warrants, at the time of execution of this Agreement, that none of its owners are physicians or immediately family members (as such terms are defined for the purposes of the Stark Law, 42 U.S.C. § 1395nn (publicly-traded stock excepted), which create, or might create, a referral relationship to the Hospital in violation of the federal and state fraud and abuse laws and regulations; and further, that for the duration of this Agreement, each party shall promptly notify the other party of any change in its ownership structure that would result in the creation of such a referral relationship.

9.25. Contractor's Confidential Information. Hospital agrees and acknowledges that the Program, its operation, layout, business systems, software, management information systems, trade secrets, service marks, designs, strategy, treatment related materials, manuals, policies and procedures, protocols, documents and information, including without limitation the IP (collectively, the "Contractor Confidential Information"), were developed by Contractor at great expense, time and effort, are confidential and are the property of and belong solely to Contractor. Hospital and its subsidiaries and affiliates and their respective officers, directors, employees, agents and representatives shall not use Contractor Confidential Information for any purpose other than the operation of the Program and the provision of the Services under this Agreement, and shall not disclose, publish or disseminate any Contractor Confidential Information to any third party, other than its attorneys, accountants, and financial advisors, without the prior written consent of Contractor, except as may be required by applicable law. If required by law to disclose any Contractor Confidential Information, the Hospital will immediately notify Contractor of the requested disclosure and permit Contractor to respond to such request if possible. The provisions of this Section shall survive the termination for any reason or expiration of this Agreement.

9.26. Hospital's Confidential Information. Contractor agrees that information provided by the Hospital, consisting of patient information, software management systems, trade secrets, service marks, financial information and related business information, policies and procedures, protocols, Hospital operations, documentation and records (collectively, the "Hospital Confidential Information") are confidential and are the property of and belong solely to the Hospital. Contractor and its subsidiaries and affiliates and their respective officers, directors, employees, agents and representatives shall not use Hospital Confidential Information for any purpose other than the operation of the Program and the provision of the Services under this Agreement, and shall not disclose, publish or disseminate any Hospital Confidential Information to any third party, other than its attorneys, accountants, and financial advisors, without the prior written consent of the Hospital, except as may be required by applicable law. If required by law to disclose any Hospital Confidential Information, Contractor will immediately notify the Hospital of the requested disclosure and permit the Hospital to respond to such request if possible. The provisions of this Section shall survive the termination for any reason or expiration of this Agreement.

9.27. Exceptions to Confidentiality Requirements. Notwithstanding the provisions of Section 9.25 or Section 9.26 to the contrary, information which at the time of disclosure, is already freely available to the public, or, through no fault of the recipient, becomes freely available to the public, then

such information shall not be considered Contractor Confidential Information or Hospital Confidential Information, as applicable.

9.28. Compliance with Confidentiality Provisions. All Hospital Personnel are obligated to comply with the confidentiality provisions of Section 9.25, and the Hospital shall use its commercially reasonable efforts to require the Hospital Personnel to comply with the provisions thereof. All Contractor Personnel are obligated to comply with the confidentiality provisions of Section 9.26, and Contractor shall use its commercially reasonable efforts to require the Contractor Personnel to comply with the provisions thereof.

9.29. Alternate Dispute Resolution. The parties firmly desire to resolve all disputes arising hereunder without resort to litigation in order to protect their respective business reputations and the confidential nature of certain aspects of their relationship. Accordingly, any controversy or claim arising out of or relating to this Agreement shall be settled by arbitration administered by the American Health Lawyers Association in accordance with its rules. The award or decision rendered by the arbitrator will be final, binding, and conclusive, and judgment may be entered upon such award by any court of competent jurisdiction. The arbitration process itself, and any other information or disclosures revealed by either party to the arbitrator or to the other party during the arbitration process will be confidential. No disclosure of the award shall be made by the parties except as required by the law or as necessary or appropriate to effectuate the terms thereof. The location of such arbitration shall be in the city where the Hospital is located unless the parties mutually agree to another location. The dispute shall be governed by the laws of the State in which the Hospital is located. Further, the prevailing party shall be entitled to recover all costs and expenses associated with arbitration, including reasonable attorneys' fees. If the arbitrator determines that neither party has substantively prevailed, the parties shall bear equally the fees and costs of the arbitrator and the related expense of arbitration. This section specifically survives the termination of this Agreement.

[Signature Page to Follow]

IN WITNESS WHEREOF, the parties have duly executed this Agreement as of the date first above written.

HORIZON HEALTH BEHAVIORAL HEALTH SERVICES

By: John F. DeVaney

Printed Name: John F. DeVaney

Title: President

Date: 9/16/16

HOSPITAL:
ATHENS REGIONAL MEDICAL CENTER, LLCD//B/A STARR REGIONAL MEDICAL CENTER

By: [signature]

Printed Name: David Ally

Title: Chief Financial Officer

Date: 9/19/16

4849-8272-1062.5

EXHIBIT A
PROGRAM STAFF

Program Staff	Full-Time Equivalent ("FTE")
Program Director/_Nurse Manager	1.0
Community Education Manager	1.0
Medical Director	Part-time – Independent Contractor
Weekend Coverage Physician(s)	Part-time – Independent Contractor(s)

EXHIBIT C
QUALITY SCORECARD

At the beginning of each Term, Contractor's monthly fee shall be prorated in the amount of five percent (5%) per month (the "Quality Withhold"). Hospital and Contractor shall meet within sixty (60) days after the end of each contract year to review the Quality Scorecard results to determine which portion, if any, of the Quality Withholds are due and owing to Contractor based upon achievement of the Scorecard results. The annual Quality Scorecard target metrics shall be reviewed and agreed upon by the parties at the beginning of each year by the parties. The Quality Scorecard metrics may include:

Medical Necessity Documentation		
	Pre-Admission Screening justifies IP Level of	
	Psychiatric Evaluation	
	History and Physical / Neuro Exam	
	Physician Certification/ Recertification	
	Treatment Plan	
	Physician Progress Notes	
	Physician Discharge Summary	
	Suicide Risk Assessment	
Operational, Financial and Exemption Criteria		
	Annual Attestation Re-verification (DPU only)	
	Staffing Issues (Medical Director/DON/SW/PhD)	
	Volume (Based on budgeted ADC)	
	Policy and Procedure	
	UM/LOS Management	
	Billing/UB04	
Clinical Program		
	Multidisciplinary Progress Notes (Nursing &	
	Assessments (Nursing/Psychosocial/Activity)	
	Group Therapy Notes	
	Group Therapies 28hrs/wk & weekends	
	Suicide Safety Plan/Observation Monitoring	
	Discharge Continuing Care Plan	
	Restraint/Seclusion &/ or ECT	
	Performance Improvement/HBIPS	
Outreach/Referral Development		
	Referral Development Process	
Environment of Care Safety		
	Potential High Risk Safety Issues	
High Risk Survey Results		
	Joint Commission /CMS/State Surveys	

Scorecard Range	Annual Quality Withhold	Explanation
>90%	100%	If the overall score achieved at the end of the immediately preceding contract year is greater than or equal to 90, 100% of Management Fees previously withheld as the Quality Withhold will be paid to Contractor.
80-89%	75%	If the overall score achieved at the end of the immediately preceding contract year is between 80% and 89%, 75% of Management Fees previously withheld as the Quality Withhold will be paid to Contractor.
70-79%	50%	If the overall score achieved at the end of the immediately preceding contract year is between 70% and 79%, 50% of Management Fees previously withheld as the Quality Withhold will be paid to Contractor.
<69%	0%	If the overall score achieved at the end of the immediately preceding contract year is less than 69%, 0% of Management Fees previously withheld as the Quality Withhold will be paid to Contractor.

EXHIBIT D

HIPAA BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the "Agreement") is made by and among Hospital (herein referred to as "Covered Entity") and Contractor (hereinafter individually and collectively referred to as "Business Associate"). Covered Entity and Business Associate shall be collectively referred to herein as the "Parties".

WHEREAS, Covered Entity is entering into a business relationship with Business Associate that is memorialized in that certain Services Agreement, as may be amended from time to time (the "Underlying Agreement") pursuant to which Business Associate may be considered a "business associate" of Covered Entity as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including all pertinent regulations (45 CFR Parts 160 and 164) issued by the U.S. Department of Health and Human Services as either have been amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) (collectively "HIPAA Law");

WHEREAS, the nature of the prospective contractual relationship between Covered Entity and Business Associate may involve the exchange of Protected Health Information ("PHI") as that term is defined under HIPAA Law; and

For good and lawful consideration as set forth in the Underlying Agreement, Covered Entity and Business Associate enter into this agreement for the purpose of ensuring compliance with the requirements of the HIPAA Law and relevant state law.

NOW THEREFORE, the premises having been considered and with acknowledgment of the mutual promises and of other good and valuable consideration herein contained, the Parties, intending to be legally bound, hereby agree as follows:

I. DEFINITIONS. Terms not defined below shall have the meaning set forth in the HIPAA Law.

A. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

B. Breach. "Breach" shall have the same meaning as the term "breach" in 45 CFR §164.402.

C. Designated Record Set. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR §164.501.

D. Electronic Protected Health Information, EPHI or Electronic PHI. "Electronic Protected Health Information", "EPHI" or "Electronic PHI" shall have the same meaning as the term "electronic protected health information" in 45 CFR §160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

E. Encrypted or Encryption. Any encryption requirements set forth in this Agreement must meet the U.S. Department of Health and Human Services Guidance

Specifying the Technologies and Methodologies that Render Protected Health

Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of HITECH Act.

F. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E, as amended by the HITECH Act and as may otherwise be amended from time to time.

G. Protected Health Information or PHI. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR §160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. As used in this Agreement, Protected Health Information shall also include Electronic PHI.

H. Required by Law. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.

I. Secretary. "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or his or her designee.

J. Security Incident. "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR § 164.304.

K. Security Rule. The "Security Rule" shall mean the regulations found at 45 CFR Part 160 and Part 164, Subparts A and C, as amended by the HITECH Act and as may otherwise be amended from time to time.

L. State Privacy and Security Laws. "State Privacy and Security Laws" shall mean all applicable state laws relating to privacy, security, data breach and confidentiality of the information provided to Business Associate under this Agreement.

M. Subcontractor. "Subcontractor" shall have the same meaning as the term "subcontractor" in 45 CFR § 160.103.

N. Unsecured Protected Health Information. "Unsecured Protected Health Information" or "Unsecured PHI" shall have the same meaning as the term "unsecured protected health information" in 45 CFR §164.402.

II. APPLICABILITY

A. This Agreement applies to all agreements and relationships between Covered Entity and Business Associate, whether written or verbal, pursuant to which Covered Entity provides or will provide any Protected Health Information to Business Associate in any form whatsoever (the "Underlying Agreement"). As of the Effective Date, this Agreement shall automatically amend and be incorporated as part of the Underlying Agreement, whether or not specifically referenced therein. Should there be any conflict between the language of this Agreement and the Underlying Agreement (either previous or subsequent to the date of this Agreement), the language and provisions of this Agreement shall control and prevail unless the Parties specifically refer in a subsequent written agreement to this Agreement by its title and date and specifically state that the provisions of the later written agreement shall control over this Agreement.

III. USE OR DISCLOSURE OF PHI BY BUSINESS ASSOCIATE

A. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Underlying Agreement, provided that such use or disclosure would not violate the Privacy Rule, if done by Covered Entity.

B. Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of Business Associate or to carry its legal responsibilities. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

C. Business Associate shall only use and disclose PHI if such use or disclosure complies with each applicable requirement of 45 CFR §164.504(e).

D. Business Associate shall use reasonable efforts to limit uses, disclosures, and requests for PHI to the minimum necessary to accomplish the intended purposes of such use, disclosure or request, in accordance with the minimum necessary standards at 45 CFR § 164.502(b) and in any guidance issued by the Secretary.

IV. DUTIES OF BUSINESS ASSOCIATE RELATIVE TO PHI

A. Business Associate shall not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.

B. Business Associate shall be directly responsible for full compliance with the relevant requirements of the Privacy Rule to the same extent as Covered Entity.

C. Business Associate shall comply with the applicable provisions of the Security Rule directing the implementation of Administrative, Physical and Technical Safeguards for Electronic Protected Health Information and the development and enforcement of related policies, procedures, and documentation standards (including but not limited to designation of a security official), and shall enter into written agreements with any Subcontractors that create, receive, maintain, or transmit Electronic Protected Health Information on behalf of Business Associate pursuant to which the Subcontractors shall agree to comply with the applicable requirements of the Security Rule. Business Associate shall implement safeguards and policies, procedures, and documentation consistent with the requirements of 45 C.F.R. §§ 164.306, 164.308, 164.310, 164.312, 164.314 and 164.316. Any hard drives on any computers or laptops that are used to access, receive, send, or maintain Covered Entities' Electronic Protected Health Information must be Encrypted and all communications must be Encrypted if sending Electronic Protected Health Information over an open network. Mobile devices or external or removable media, including, without limitation backup tapes, used for sending, receiving, or storing Electronic Protected Health Information must be Encrypted and password protected.

D. In the event of an unauthorized use or disclosure of PHI or a Breach of Unsecured PHI, Business Associate shall mitigate, to the extent practicable, any harmful effects of said disclosure that are known to it.

E. Business Associate agrees to enter into a written agreement with any Subcontractor that creates, receives, maintains, or transmits PHI on behalf of Business Associate, which complies with the requirements of 45 C.F.R. § 164.504(e)(2) through (e)(4), and pursuant to which the Subcontractor agrees to the same restrictions and conditions that apply to Business Associate with respect to such PHI.

F. To the extent applicable, Business Associate shall provide access to Protected Health Information in a Designated Record Set at reasonable times, at the request of Covered Entity or, as directed by Covered Entity, to an Individual (or Individual's designee) in order to meet the requirements under 45 CFR §164.524. Business Associate shall notify Covered Entity within five (5) days of receipt of any request for access by an Individual. Covered Entity shall determine whether to grant or deny any access requested by the Individual. The information shall be provided in the form or format requested, if it is readily producible in such form or format, or in summary, if the Individual has agreed in advance to accept the information in summary form. If the Individual requests an electronic copy of his or her PHI maintained in a Designated Record Set electronically, Business Associate shall provide the Individual (or Individual's designee) with access to the information in the electronic form and format requested by the Individual, if it is readily producible in such form or format, or, if not, in a machine readable electronic form and format agreed to by the Individual. No fee for copying or providing access to the PHI may be charged.

G. If Business Associate maintains a Designated Record Set on behalf of Covered Entity, Business Associate shall amend the PHI maintained by Business

Associate as directed by Covered Entity within five (5) days of such request. Business Associate shall notify Covered Entity within five (5) days of receipt of any request for amendment by an Individual. Covered Entity shall determine whether to grant or deny any access or amendment requested by the Individual. Business Associate shall have a process in place for requests for amendments and for appending such requests to the Designated Record Set, as requested by Covered Entity. No fee for copying or amending the PHI may be charged.

H. Business Associate shall, upon request with reasonable notice and at no charge, provide Covered Entity access to its premises for a review and demonstration of its internal practices and procedures for safeguarding PHI. The fact that Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's premises, systems, policies and procedures does not relieve Business Associate of its responsibility to comply with this Agreement, nor does Covered Entity's: (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of Covered Entity's enforcement rights under this Agreement.

I. Business Associate agrees to document and make available such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528 and Section 13405(c) of the HITECH Act, and any implementing regulations. Should an Individual make a request to Covered Entity for an accounting of disclosures of his or her PHI pursuant to 45 C.F.R. §164.528, Business Associate agrees to promptly provide Covered Entity with information in a format and manner sufficient to respond to the Individual's request. No fee for providing the accounting of disclosures of PHI may be charged. This Section shall survive termination of the Agreement.

J. If an Individual requests Business Associate to restrict the use or disclosure of PHI, Business Associate will forward the request to Covered Entity within five (5) days of Business Associate's receipt of the request. Covered Entity will be responsible for making all determinations regarding the grant or denial of a Individual's request for restrictions, and Business Associate will make no such determinations. Business Associate will restrict the use or disclosure of PHI consistent with Covered Entity's instructions, and shall further comply with any Individual's request for restrictions on PHI disclosures that Covered Entity or Business Associate is required by law to honor, including without limitation, requested restrictions on payment or health care operations-related disclosures to health plans when the Individual (or other person on behalf of the Individual) has paid the Individual's health care provider in full, unless otherwise required by law. No fee for providing the restriction of PHI may be charged.

K. Business Associate shall make its internal practices, books, records, and any other material requested by the Secretary relating to the use, disclosure, and safeguarding of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for the purpose of determining compliance with the Privacy Rule. The aforementioned information shall be made available to the Secretary in the manner and place as designated by the Secretary or the Secretary's duly appointed delegate. Under this Agreement, Business Associate shall comply and cooperate with any request for documents or other information from the Secretary directed to Covered Entity that seeks documents or other information held by

Business Associate. Notwithstanding this provision, no attorney-client, accountant-client or other legal privilege will be deemed waived by Business Associate or Covered Entity as a result of this Section. Except to the extent prohibited by law, Business Associate agrees to notify Covered Entity immediately upon receipt by Business Associate of any and all requests by or on behalf of any and all government authorities served upon Business Associate relating to this Section or Protected Health Information.

L. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 42 C.F.R. §164.502(j)(1).

M. Business Associate may not de-identify any Protected Health Information without the express prior written consent of the Covered Entity, and if such consent is given, Business Associate must comply with the requirements set forth at 45 C.F.R. § 164.514 for de-identifying PHI. Business Associate shall not sell any Protected Health Information without the express prior written consent of Covered Entity. Business Associate shall not transmit, to any Individual for whom Business Associate has Protected Health Information, any communication about a product or service that encourages the recipient of the communication to purchase or use that product or service in violation of any of the marketing prohibitions set forth in the HIPAA Law. Business Associate shall not use or disclose Protected Health Information for fundraising purposes as prohibited under the HIPAA Law.

N. Covered Entity shall have the right, at its expense, during Business Associate's normal business hours, to evaluate, test, and review Business Associate's HIPAA-HITECH policies and procedures, facilities, books, records and systems which contain Covered Entity's PHI and EPHI in order to ensure compliance with the terms and conditions of this Agreement and the HIPAA Law. Covered Entity shall have the right to conduct such audit by use of its own employees or by use of outside consultants and auditors. Business Associate agrees to cooperate with Covered Entity, and to otherwise provide any reasonable assistance to Covered Entity necessary for Covered Entity to carry out any audit as permitted herein, at no additional cost to Covered Entity. Upon Covered Entities' written request, Business Associate agrees to provide an annual written attestation of its compliance to the HIPAA Law in the form and format requested by Covered Entity in order to obtain satisfactory assurances in accordance with the HIPAA Law that Business Associate will appropriately safeguard the information with which it is entrusted. Covered Entity shall protect the confidentiality of all confidential and proprietary information of Business Associate to which Covered Entity or its agents have access during the course of such audit. The fact that Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Business Associate of its responsibility to comply with this Agreement, nor does Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of Covered Entity's enforcement rights under this Agreement. Notwithstanding the foregoing, Covered Entity assumes no obligation to perform any inspection or audit of Business Associate's practices or policies, and assumes no liability for any violation or breach caused by Business Associate, whether an audit is performed or not.

O. To the extent Business Associate is to carry out any covered entity obligation of Covered Entity under the Privacy Rule, Business Associate shall agree to comply with the same Privacy Rule requirements that apply to Covered Entity in the performance of such obligation.

V. REPORTING

A. Privacy Breach. Business Associate will report to Covered Entity any use or disclosure of Covered Entity's PHI that is not permitted by this Agreement or the Underlying Agreement within two (2) business days of discovery of the unauthorized use or disclosure. In addition, Business Associate will report to Covered Entity following discovery and without unreasonable delay, but in no event later than two (2) days following discovery of any suspected or actual Breach of Unsecured Protected Health Information or any actual or suspected disclosure or inappropriate access of Covered Entity's information which is subject to State Privacy and Security Laws. Business Associate shall cooperate with Covered Entity in investigating the potential or actual breach, disclosure or inappropriate access and in meeting Covered Entity's obligations under the HITECH Act and any other state or federal privacy or security breach notification laws, including, without limitation, assisting the Covered Entity with performing a risk assessment as set forth in 45 C.F.R. §164.402(2) and providing any information and documentation related to such risk assessment to the Covered Entity promptly upon request. Any such report shall contain at a minimum the information set forth on Exhibit A attached hereto and incorporated by reference. Since time is of the essence under the HITECH Act and State Privacy and Security Laws, in addition to providing the report in accordance with the notice provisions contained in Section X.B below, a copy of the report shall be faxed to the Privacy Officer at (615) 695-8426 or to such other person as Covered Entity shall request in writing of Business Associate. To the extent any Breach of Unsecured Protected Health Information or unauthorized acquisition or access to information subject to State Privacy and Security Laws is attributable to either: (i) a breach of the obligations under this Agreement by Business Associate or (ii) a violation of the HIPAA Law or State Privacy and Security Laws by Business Associate, Business Associate shall bear (a) the costs incurred by Covered Entity in complying with its legal obligations relating to such breach or violation, and (b) in addition to other damages for which Business Associate may be liable for under this Agreement, the following expenses incurred by Covered Entity in responding to such breach: (1) the cost of preparing and distributing notifications to affected Individuals, (2) the cost of providing notice to government agencies, credit bureaus, and/or other required entities, (3) the cost of providing affected Individuals with credit monitoring services for a specific period not to exceed twenty-four (24) months, or longer if required by law, to the extent the incident could lead to a compromise of the data subject's credit or credit standing, (4) call center support for such affected Individuals for a specific period not to exceed thirty (30) days from the date the breach notification is sent to such affected Individuals and (5) the cost of any other measures required under applicable law.

B. Security Incident. Business Associate agrees to report to Covered Entity any Security Incident affecting Electronic Protected Health Information of Covered Entity within two (2) business days of becoming aware of the Security Incident. Business Associate shall mitigate, to the extent practicable, any harmful effect known to Business Associate of a Security Incident.

VI. TERM AND TERMINATION

JAN 13 '17 AM9:56

A. Term. The Term of this Agreement shall be effective as of the date the Underlying Agreement is effective (the "Effective Date"), and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy the Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section VI. Notwithstanding anything to the contrary contained in this Agreement, Business Associate shall not destroy any Protected Health Information without the prior written consent of Covered Entity.

B. Termination for Cause. Upon Covered Entity's knowledge of a breach by Business Associate, Business Associate's violation of the HIPAA Laws or a Breach of Unsecured Protected Health Information by Business Associate or any Subcontractor of Business Associate, Covered Entity shall, within its sole discretion, either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, terminate this Agreement; or

2. Immediately terminate this Agreement.

C. Effect of Termination.

1. Except as provided in paragraph C(2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy (at Covered Entity's sole discretion) all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity within five (5) days of the effective date of the termination. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall not retain any copies of the Protected Health Information. Business Associate will be responsible for recovering any PHI from such agents or subcontractors at no cost to Covered Entity. Any information that is in electronic format shall be provided to Covered Entity at no additional charge. The format to be provided should be one that is commonly used for export (i.e. comma delimited, text file, Word, Excel or Access database) that is agreeable to Covered Entity.

2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible. If such written notification that return or destruction of Protected Health Information is infeasible and agreed to by Covered Entity, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

3. Should Business Associate make a disclosure of PHI in violation of this Agreement, Covered Entity shall have the right to immediately terminate any contract, other than this Agreement, then in force between the Parties, including the Underlying Agreement.

VII. REMEDIES IN EVENT OF BREACH, DISCLAIMER AND INDEMNIFICATION

A. Business Associate hereby recognizes that irreparable harm may result to Covered Entity, and to the business of Covered Entity, in the event of breach by Business Associate of any of the covenants and assurances contained in this Agreement. As such, in the event of breach of any of the covenants and assurances contained in Sections III, IV or V above, Covered Entity shall be entitled to enjoin and restrain Business Associate from any continued violation of Sections III, IV or V.

B. PHI IS PROVIDED TO BUSINESS ASSOCIATE SOLELY ON AN "AS IS" BASIS. COVERED ENTITY DISCLAIMS ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY, NON-INFRINGEMENT AND FITNESS FOR A PARTICULAR PURPOSE. As between Covered Entity and Business Associate, any PHI disclosed, delivered or provided to Business Associate in connection with the Agreement, shall be deemed to be the exclusive property of Covered Entity. In no event shall Business Associate or its subcontractors claim any rights with respect to such PHI. Without prior written consent from an authorized officer of Covered Entity, neither Business Associate nor its agents or subcontractors shall transfer or export any PHI provided by Covered Entity outside the United States or store any PHI provided by Covered Entity in a hosted/cloud computing environment. Additionally, Business Associate shall not use, authorize to use or disclose the PHI for the purpose of developing information or statistical compilations for use by third parties or other division or subsidiary of Business Associate or for any commercial exploitation.

C. Business Associate will indemnify, defend and hold Covered Entity and its officers, directors, employees, agents, affiliates, successors and assigns harmless, from and against any and all losses, liabilities, damages, costs, penalties, fines and expenses (including reasonably attorneys' fees and costs) arising out of or related to either: (i) the Business Associate's breach of its obligations under this Agreement and/or (ii) any third-party claim based upon any breach of this Agreement, violation of HIPAA Laws or State Privacy and Security Laws by Business Associate or by its employees, agents or subcontractors ("Claim"). If Business Associate assumes the defense of a Claim, Covered Entity shall have the right, at its expense, to participate in the defense of such Claim, and Business Associate shall not take any final action with respect to such Claim without the prior written consent of Covered Entity. This Section shall survive termination of this Agreement and any Claim is without regard to any limitation or exclusion of damages or liability provisions otherwise set forth in the Agreement or the Underlying Agreement.

VIII. MODIFICATION. This Agreement may only be modified through a writing signed by the Parties. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the HIPAA Law.

IX. INTERPRETATION OF THIS CONTRACT IN RELATION TO OTHER CONTRACTS BETWEEN THE PARTIES. Should there be any conflict between the language of this contract

and any other contract entered into between the Parties (either previous or subsequent to the date of this Agreement), the language and provisions of this Agreement shall control and prevail unless the Parties specifically refer in a subsequent written agreement to this Agreement by its title and date and specifically state that the provisions of the later written agreement shall control over this Agreement.

X. **COMPLIANCE WITH STATE LAW**. Business Associate shall comply with State Privacy and Security Laws. If the HIPAA Law and the law of the State in which Covered Entity is located conflict regarding the degree of protection provided for Protected Health Information, Business Associate shall comply with the more restrictive protection requirement.

XI. **MISCELLANEOUS.**

A. Ambiguity. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the HIPAA Law.

B. Notice to Covered Entity. Any notice required under this Agreement to be given Covered Entity shall be made in writing to Hospital, with a copy to LifePoint Hospitals, 103 Powell Court, Brentwood, TN 37027, Attention: Compliance, Privacy Officer.

C. Notice to Business Associate. Any notice required under this Agreement to be given Business Associate shall be made in writing to Contractor.

IN WITNESS WHEREOF and acknowledging acceptance and agreement of the foregoing, the Parties affix their signatures hereto.

COVERED ENTITY:	BUSINESS ASSOCIATE:
By:	By:
Name: David S Alley	Name: Jack DeVaney
Title: CFO	Title: President

4849-8272-1062.5

EXHIBIT A1

FORM OF NOTIFICATION TO COVERED ENTITY OF

BREACH OF UNSECURED PHI AND STATE LAW

Date completed: _____

This notification is made pursuant to the Business Associate Agreement between _____ _____(Covered Entity), and_____(Business Associate).

Business Associate hereby notifies Covered Entity that there has been an actual or potential breach of unsecured (unencrypted) protected health information (PHI) or information subject to State Privacy and Security Laws that Business Associate (or its agents or subcontractors) has used or has had access to under the terms of the Business Associate Agreement.

I.Characteristics of the Breach

Date of the breach:_____ Date the breach was discovered:_____

Description of the breach: _____

_____

_____

_____

_____

_____

_____

How was the breach discovered? _____

Number of individuals affected by the breach: _____

Are over 500 individuals affected by the breach?

Yes___No ____

Have you been able to identify all individuals affected by the breach?

Yes___No ____

If yes, for how many of the affected individuals do you have current addresses? _____

Does the information disclosed in the breach identify, or can reasonably be used to identify, specific patients?

Yes___No ____

If no, please explain why the information does not identify, or cannot reasonably be used to identify, specific patients: _____

_____

Does the information disclosed in the breach contain any sensitive information or other information that can be used in a manner that would be adverse or cause financial or reputational harm to the individual?

Yes___No ____

If no, explain why the information cannot be used in an adverse or harmful manner to the individual: _____

_____

_____

Was all of the patient(s') information compromised or only portions?

Yes___No ____

If only portions of the information, explain which portions of the information were compromised: _____

_____

_____

Indicate type of breach:

___	Theft	___	Unauthorized Access	___	Unknown
___	Loss	___	Hacking/IT Incident	___	Other: _____
___	Improper Disposal	___	Phishing		_____
					_____
					_____

Location of breached information:

____Laptop	____Portable Media/Device	____ Other: _____
____Desktop Computer	____EMR	_____
____Email	____Paper	_____
		_____

Description of types of unsecured PHI or other data involved in the breach:

____	Demographic (full or partial name)	____	Account number	____	ICD-9-CM or CPT-codes
____	Social security number	____	Disability Code	____	Driver's license, insurance card, or other form of identification
____	Date of birth	____	Financial (billing info, credit card # or check/bank account number)	____	Other: _____ _____ _____ _____
____	Home address	____	Clinical (any mention of diagnosis, procedure, or treatment provided)		

Are the patient(s) or the patient(s') family members aware of the incident?

Yes____No _____

If yes, describe _____

_____

_____

II. Description of Safeguards

Safeguards that were in place prior to the breach:

____	Firewalls	____	Encrypted wireless	____	Secure browser
____	Packet Filtering	____	Logic access control	____	Biometrics
____	Intrusion detection	____	Anti-virus software (list product name):	____	Strong authentication
____	Other:	____	Physical security:		

_____

_____

_____

_____

Was the data encrypted in compliance with the encryption standards set forth in the U.S. Department of Health and Human Services Guidance Specifying the Technologies and Methodologies that Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of HITECH Act?

Yes No ____

If yes, please identify the method of encryption: _____

_____

_____

If no, please identify any other methods of securing the information (for example, password protected file): _____

_____

III. The Recipient

Can you determine whether the PHI was actually acquired or viewed by the unintended recipient?

Yes___No ____

If yes, please explain how and provide any information regarding the information viewed, length of time viewed, whether it was e-mailed or saved to another device and who viewed the information:

_____

_____

Did the breach involve a good faith, unintentional acquisition, access or use of PHI by the entity's employee/workforce member? (For example, a billing employee receives and opens an e-mail containing PHI about a patient which a nurse mistakenly sent to the billing employee. The billing employee notices that he is not the intended recipient, alerts the nurse of the misdirected e-mail, and then deletes it.)

Yes No ____

If yes, please explain: _____

_____

_____

Did the breach involve an inadvertent disclosure to another authorized person within the entity or Organized Health Care Arrangement in which the entity participates? (For example – A physician who has authority to use or disclose PHI at a hospital by virtue of participating in an organized health care arrangement with the hospital is similarly situated to a nurse or billing employee at the hospital.)

Yes No ____

If yes, please explain: _____

_____

_____

Did the breach involve a recipient who could not reasonably have retained or remembered the data? (For example – A covered entity, due to a lack of reasonable safeguards, sends a number of explanations of benefits (EOBs) to the wrong individuals. A few of the EOBs are returned by the post office, unopened, as undeliverable.)

Yes No ____

If yes, please explain: _____

_____

Was the unauthorized person who received the PHI or to whom the disclosure was made covered by HIPAA and/or a licensed healthcare provider?

Yes___No _____

If yes, please identify the licensed healthcare provider, the type of license and any state confidentiality regulations which require the licensed provider to maintain the confidentiality of the information:

_____

Can any of the information be used by an unauthorized recipient to further the recipient's own interests?

Yes___No _____

If no, explain why none of the information cannot be used by an unauthorized recipient to further the recipient's own interests? _____

_____

_____

IV. Addressing the Breach

Description of what Business Associate is doing to investigate the breach: _____

_____

_____

_____

_____

_____

Has law enforcement been notified?:

Yes___No ____

If so, describe _____

_____

Did law enforcement ask for patient notification delay (based on hindering an investigation or causing harm to national security)

Yes___No ____

If yes, please provide documentation of the police request and deadline for notifications: _____

_____

_____

Was satisfactory assurance obtained from the recipient of PHI indicating that PHI will not be further used or disclosed?

Yes___No ____

If yes, please attach and explain: _____

_____

Has the information been returned or properly destroyed? (If destroyed – need to obtain satisfactory assurance that the information was destroyed.)

Yes___No ____

If yes, please attach the assurances and explain the circumstances: _____

_____

Description of what Business Associate is doing to mitigate harm to the individual(s): _____

_____

_____

Description of what Business Associate is doing to protect against any further breaches: _____

_____

_____

Contact information to ask questions and obtain additional information:

Name: _____

Title: _____

Address: _____

_____

Email Address: _____

Phone Number: _____

Attachment - Section A-6A

Deed

Cheryl Ingram, Register
McMinn County

Rec #:	162843	Instrument #:	162843
Rec'd:	15.00	Recorded	
State:	0.00	12/2/2013 at 12:57 PM	
Clerk:	0.00	in Warranty Deed Book	
Other:	2.00	19Y	
Total:	17.00	Pgs 312-314	

FROM: LifePoint Holdings 2, LLC

TO: Athens Regional Medical Center, LLC

Address New Owner as Follows:	Send Tax Bills To:	Map-Parcel No.
Athens Regional Medical Center, LLC c/o Lifepoint Hospitals, Inc. 103 Powell Court, Suite 200 Brentwood, TN 37027	SAME	Map 107B Group C Parcel 001.00

THIS INSTRUMENT PREPARED BY: Matthew T. Harris, Esq., Waller Lansden Dortch & Davis, LLP, 511 Union Street, Suite 2700, Nashville, Tennessee 37219-1760

STATE OF TENNESSEE)
COUNTY OF Maury Williamson

The actual consideration for this transfer is $-0-.

DEBRA L. TERRY
STATE OF TENNESSEE NOTARY PUBLIC

Affiant

Subscribed and sworn to before me, this the 26 day of November, 2013.

Notary Public

My Comm. Expires May 18 2015

QUITCLAIM DEED

FOR AND IN CONSIDERATION of Ten Dollars ($10.00), and other good and valuable consideration, LifePoint Holdings 2, LLC, a Delaware limited liability company ("Grantor"), by these presents, does hereby quitclaim and convey unto Athens Regional Medical Center, LLC, a Delaware limited liability company ("Grantee"), its successors and assigns, all its right, title and interest, in and to the parcel or tract of land in McMinn County, Tennessee, more particularly described on Exhibit "A" attached hereto and incorporated herein by reference.

This is improved property known as 886 Highway 411 North, Etowah, Tennessee.

Property Transfer Noted
Date 12-2-13 No. 13-1673
Tax I.D. 04 107B C 107B 001.00
McMinn County Property Assessor

11061204.1

1

IN WITNESS WHEREOF, this instrument has been executed this 26 day of November, 2013.

LIFEPOINT HOLDINGS 2, LLC, a Delaware limited liability company

By: Christopher J. Monte
Name: CHRISTOPHER J. MONTE
Title: VICE PRESIDENT

STATE OF TENNESSEE)
COUNTY OF Maury Williamson

Before me, a Notary Public in and for said State and County, duly commissioned and qualified, personally appeared Christopher J Monte, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself to be the Vice President of LifePoint Holdings 2, LLC, the within named bargainor, a Delaware limited liability company, and that he executed the foregoing instrument for the purposes therein contained, by signing the name of the limited liability company by himself as Vice President.

Witness my hand, at office, this 26 day of November, 2013.

Deborah Perry
Notary Public

My Commission Expires: May 18, 2015

11061204.1

2

EXHIBIT A

Legal Description

Situated in District No. 1 of McMinn County, Tennessee and North of the City of Etowah and being more particularly described as follows:

BEGINNING at an iron pin on the Northern Right of Way line of Grady Road and running with said right of way for three courses to wit: (1) North 88 degrees 31 minutes 37 seconds West for a distance of 519.55 feet; (2) along the arc of a curve to the right having a radius of 221.16 feet, and arc length of 278.62 feet (chord bearing and distance North 48 degrees 03 minutes 09 seconds West, 260.55 feet) to a point; (3) North 11 degrees 18 minutes 48 seconds West for a distance of 397.41 feet to an iron pin; thence leaving said right of way and running with the common boundary line of now or formerly DHMC Real Estate South 89 degrees 59 minutes 58 seconds East for a distance of 470.29 feet to an iron pin; thence with the common boundary lines of Lot 43 as recorded in Plat Book 2, page 6 for two courses to wit: (1) South 00 degrees 00 minutes 14 seconds West for a distance of 50.00 feet to an iron pin; (2) South 87 degrees 15 minutes 29 seconds East for a distance of 422.28 feet to an iron pin on the Western Right of Way line of U.S. Highway 411; Thence running with said right of way South 00 degrees 00 minutes 00 seconds East for a distance of 339.00 feet to an iron pin; thence leaving said right of way and running with Tract two for two courses to wit: (1) South 90 degrees 00 minutes 00 seconds West for a distance of 92.13 feet to an iron pin; (2) South 03 degrees 00 minutes 32 seconds West for a distance of 168.24 feet to the Point and place of beginning.

Property contains 9.82 acres more or less.

Being the same property conveyed to LifePoint Holdings 2, LLC, by deed from Woods Memorial Hospital, LLC recorded in Deed Book 19Y, page 296, Register's Office for McMinn County, Tennessee.

This Instrument Prepared by Valley Title Services, LLC
202 North White Street, Athens, Tennessee 37303

The following description is:
_____ taken from the prior deed:
_XX_ based upon a new survey:
_____ provided by the parties:
_____(Other) _____
(TCA 66-24-121)

SEND TAX STATEMENTS TO:

Athens Regional Medical Center, LLC
c/o LifePoint Hospitals, Inc.
330 Seven Springs Way

Brentwood, TN 37027

I, or We, hereby swear or affirm that the actual consideration for this transfer or value of the property transferred whichever is greater is $7,500.00, which amount is equal to or greater that the amount which the property transferred would command at a fair voluntary sale.

Mary Lynn Hayes
AFFIANT

Subscribed and sworn to before me this 30th day of April, 2014.

Sharon Kennedy
NOTARY PUBLIC
My Commission Expires: 9-23-18

SHARON KENNEDY STATE OF TENNESSEE NOTARY PUBLIC COUNTY OF McMINN

For Register's Office Stamp – Recording Information

Cheryl Ingram, Register
McMinn County

Rec #:	165665	Instrument #:	165665
Rec'd:	10.00	Recorded	
State:	27.75	4/30/2014 at 11:31 AM	
Clerk:	1.00	in Warranty Deed Book	
Other:	2.00	20B	
Total:	40.75	Pgs 337-338	

THIS DEED HAS BEEN PREPARED FROM INFORMATION SUPPLIED BY OR ON BEHALF OF THE PARTIES. THE PREPARER DOES NOT WARRANT OR CERTIFY TITLE, ACCURACY OF DESCRIPTION, NOR COMPLIANCE WITH PLANNING AND ZONING LAWS. BEFORE SIGNING THIS DEED, CONSULT WITH YOUR TAX ADVISOR REGARDING POSSIBLE STATE AND FEDERAL TAX CONSEQUENCES.

TAX ID: Part of 04 – 107B – C – 2
(District – Map – Parcel)

WARRANTY DEED

THIS INDENTURE, made this 30th day of April, 2014, A.D., between

JAMES W. STEPHENS and wife, ANNETTE F. STEPHENS, AND DOMINIC R. STEPHENS, Grantors, and

ATHENS REGIONAL MEDICAL CENTER, LLC a Delaware Limited Liability Company, Grantee.

WITNESSETH: that said Grantors, for and in consideration of the sum of One Dollar ($1.00) and other good and valuable considerations, to them in hand paid by the Grantee, the receipt of which is hereby acknowledged, have bargained, sold and conveyed unto the Grantee the following described premises, to-wit:

SITUATED in the Fourth Civil District of McMinn County, within the Corporate limits of the City of Etowah, lying on the East side of Grady Road, being property containing a helipad as depicted on the Boundary Survey/Subdivision of record in **Plat Cabinet I, Page 917** in the Register's Office of McMinn County, Tennessee. Said parcel being more particularly described as follows:

To reach the point of beginning, begin at a an 5/8 inch rebar set in the East line of Grady Road; same marking the Northwest corner of the Athens Regional Medical Center, LLC Property (Deed Book 19-Y Page 312) and the Southwest corner of the Stephens Property (Deed Book 20A Pages 41-43), thence North 88 degrees 48 minutes 04 seconds East 66.41 feet to an iron pin; **FROM SAID POINT OF BEGINNING** as follows:

North 06 degrees 53 minutes 55 seconds West 89.24 feet to an iron pin corner;
North 85 degrees 29 minutes 30 seconds East 109.07 feet to an iron pin corner;
South 01 degrees 26 minutes 39 seconds West 95.41 feet to an iron pin corner; and
South 88 degrees 55 minutes 41 seconds West 95.62 feet to the **POINT OF BEGINNING.**

Property Transfer Noted
Date 4-30-14 No. 14-512
Tax I.D. 04-107B-C-107B.00260
McMinn County Property Assessor

BEING PART of the property conveyed to James W. Stephens and wife, Annette F. Stephens and Dominic R. Stephens, Tenants in Common with Express Right of Survivorship by Warranty Deed from DHMC Real Estate, LLC, a Tennessee Limited Liability Company, recorded on March 10, 2014 in Deed Book 20A Pages 41-43 in the Register's Office of McMinn County, Tennessee.

WITH THE HEREDITAMENTS and appurtenances thereto appertaining, hereby releasing all claims to homestead and dower therein. **TO HAVE AND TO HOLD THE** said premises to the said Grantee, their heirs and assigns forever.

And said Grantors, for themselves and for their heirs, executors and administrators do hereby covenant with said Grantee, their heirs, and assigns, that they are lawfully seized in fee simple of the premises above conveyed and have full power, authority and right to convey the same, and that said premises are free from all encumbrances and that they will forever warrant and defend the said premises and the title thereto against the lawful claims of all persons whomsoever.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, as the case may demand.

IN WITNESS WHEREOF, the said Grantors hereunder set their hands and seals the day and year first above written.

JAMES W. STEPHENS

ANNETTE F. STEPHENS

DOMINIC R. STEPHENS

STATE OF TENNESSEE
COUNTY OF MCMINN

Personally appeared before me, the undersigned authority, a Notary Public in and for said County and State, the within named bargainers, **James W. Stephens, Annette F. Stephens, and Dominic R. Stephens**, with whom I am personally acquainted, (or proved to me on the basis of satisfactory evidence), and who acknowledged that they executed the within instrument for the purposes therein contained.

Witness my hand and official seal at office, this 30th day of April, 2014.

MARY LYNNE THOMPSON
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF McMINN

NOTARY PUBLIC
My Commission Expires: My Commission Expires 05-23-16

This Instrument Prepared by Valley Title Services, LLC
202 North White Street, Athens, Tennessee 37303

The following description is:
_____ taken from the prior deed:
_____ based upon a new survey:
_____ provided by the parties:
XX (Other) Recorded Plat
(TCA 66-24-121)

SEND TAX STATEMENTS TO:

Athens Regional Medical Center, LLC
c/o LifePoint Hospitals, Inc.
330 Seven Springs Way

Brentwood, TN 37027

I, or We, hereby swear or affirm that the actual consideration for this transfer or value of the property transferred whichever is greater is $7,500.00, which amount is equal to or greater that the amount which the property transferred would command at a fair voluntary sale.

AFFIANT

Subscribed and sworn to before me this 17th day of December, 2014.

NOTARY PUBLIC My Commission Expires
My Commission Expires: 05-23-16

MARY LYNNE THOMPSON STATE OF TENNESSEE NOTARY PUBLIC COUNTY OF McMINN

For Register's Office Stamp – Recording Information

Cheryl Ingram, Register
McMinn County
Rec #: 170396 Instrument #: 170396
Rec'd: 10.00 Recorded
State: 27.75 12/18/2014 at 3:20 PM
Clerk: 1.00 in Warranty Deed Book
Other: 2.00 20G
Total: 40.75 Pgs 538-539

THIS DEED HAS BEEN PREPARED FROM INFORMATION SUPPLIED BY OR ON BEHALF OF THE PARTIES. THE PREPARER DOES NOT WARRANT OR CERTIFY TITLE, ACCURACY OF DESCRIPTION, NOR COMPLIANCE WITH PLANNING AND ZONING LAWS. BEFORE SIGNING THIS DEED, CONSULT WITH YOUR TAX ADVISOR REGARDING POSSIBLE STATE AND FEDERAL TAX CONSEQUENCES.

TAX ID: Part of 04 – 107B – C – 2
(District – Map – Parcel)

WARRANTY DEED

THIS INDENTURE, made this 17th day of December, 2014, A.D., between

JAMES W. STEPHENS and wife, ANNETTE F. STEPHENS, AND DOMINIC R. STEPHENS, Grantors, and

ATHENS REGIONAL MEDICAL CENTER, LLC a Delaware Limited Liability Company

Grantee.

WITNESSETH: that said Grantors, for and in consideration of the sum of One Dollar ($1.00) and other good and valuable considerations, to them in hand paid by the Grantees, the receipt of which is hereby acknowledged, have bargained, sold and conveyed unto the Grantees the following described premises, to-wit:

SITUATED in the Fourth Civil District of McMinn County, Tennessee and being a lot, triangular in shape, and designated as the property to be transferred to Athens Reg Med CTR LLC, on plat of record in **Plat Cabinet I Page 996** in the Register's Office of McMinn County, Tennessee. Said being more particularly described as follows:

Commencing at the Southeastern corner of Lot 36 and South 88 degrees 59 minutes 20 seconds West for 58.00 feet to an iron pin found with Cap #1640 which is the **POINT OF BEGINNING**, thence running with property of Athens Regional Medical Center LLC (Deed Book 19-Y, Page 312) South 88 degrees 48 minutes 09 seconds West for 79.59 feet to a new iron pin with Cap #1640; thence a new line with property of DHMC Real Estate LLC (Deed Book 18-B, Page 591) North 05 degrees 01 minute 58 seconds East for 75.18 feet to a new iron pin with Cap #1640 in the line of property of Tim Cathey; thence with Cathey property (Deed Book 18-B, Page 270) South 44 degrees 54 minutes 10 seconds East for 103.38 feet to the **POINT OF BEGINNING, containing 0.07 acres, more or less.**

Property Transfer Noted
Date 12-18-14 No. 14-1754
Tax I.D. 04-107B-C-107B-002.00
McMinn County Property Assessor

BEING A PORTION of the property conveyed to James W. Stephens and wife, Annette F. Stephens and Dominic R. Stephens by Warranty Deed from DHMC Real Estate, LLC, recorded on March 10, 2014 in Deed Book 20-A, Pages 41-43 in the Register's office of McMinn County, Tennessee.

WITH THE HEREDITAMENTS and appurtenances thereto appertaining, hereby releasing all claims to homestead and dower therein. **TO HAVE AND TO HOLD THE** said premises to the said Grantees, their heirs and assigns forever.

And said Grantors, for themselves and for their heirs, executors and administrators do hereby covenant with said Grantees, their heirs, and assigns, that they are lawfully seized in fee simple of the premises above conveyed and have full power, authority and right to convey the same, and that said premises are free from all encumbrances and that they will forever warrant and defend the said premises and the title thereto against the lawful claims of all persons whomsoever.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, as the case may demand.

IN WITNESS WHEREOF, the said Grantors hereunder set their hands and seals the day and year first above written.

JAMES W. STEPHENS

ANNETTE F. STEPHENS

DOMINIC R. STEPHENS

STATE OF TENNESSEE
COUNTY OF MCMINN

Personally appeared before me, the undersigned authority, a Notary Public in and for said County and State, the within named bargainers, **James W. Stephens, Annette F. Stephens,** and **Dominic R. Stephens,** with whom I am personally acquainted, (or proved to me on the basis of satisfactory evidence), and who acknowledged that they executed the within instrument for the purposes therein contained.

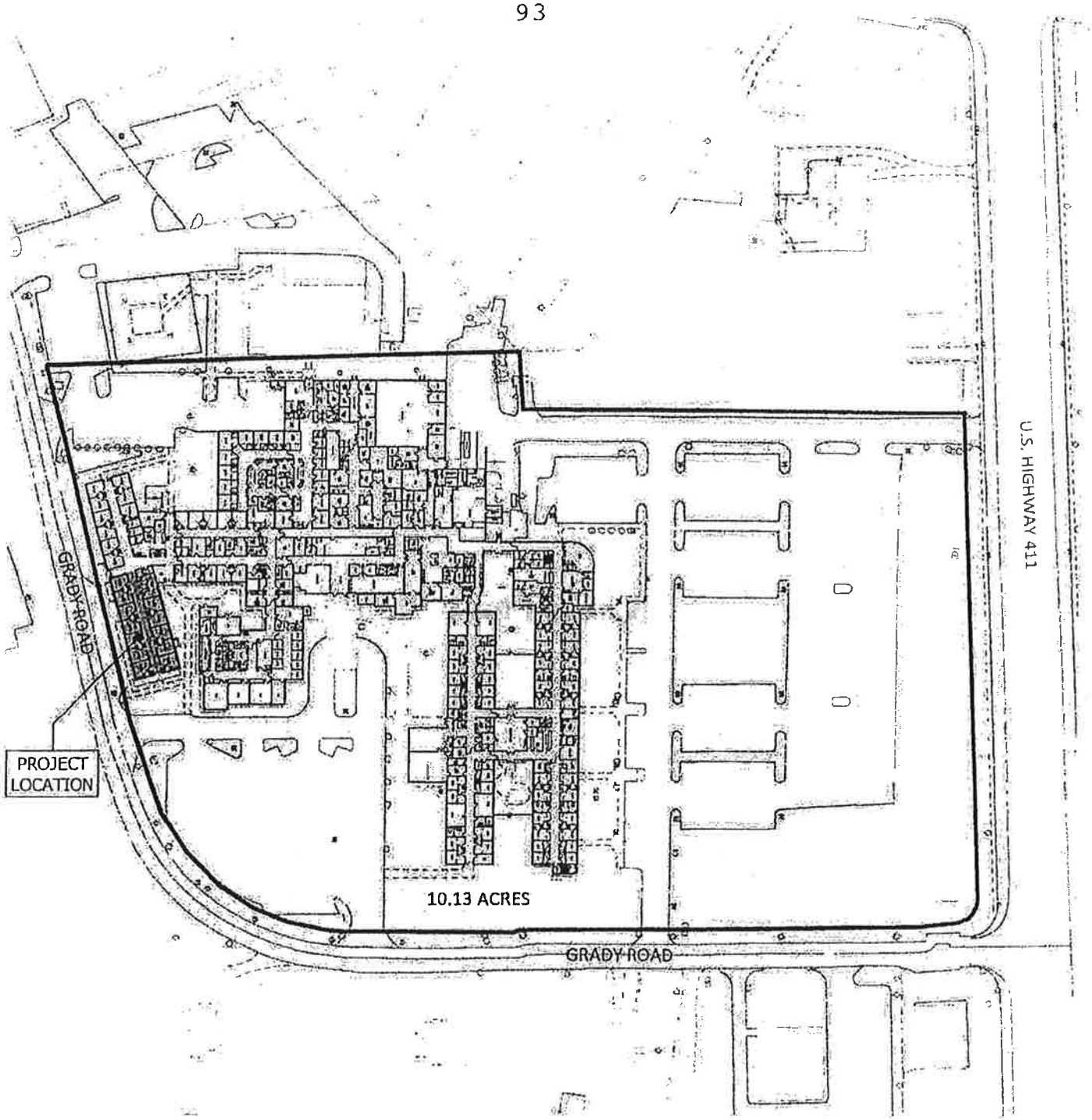
Witness my hand and official seal at office, this 17th day of December, 2014.

MARY LYNNE THOMPSON
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF MCMINN

NOTARY PUBLIC My Commission Expires
My Commission Expires: 05-23-16

Attachment - Section A-6B.1

Plot Plan



GERO-PSYCH EXPANSION for
STARR REGIONAL MEDICAL CENTER - ETOWAH

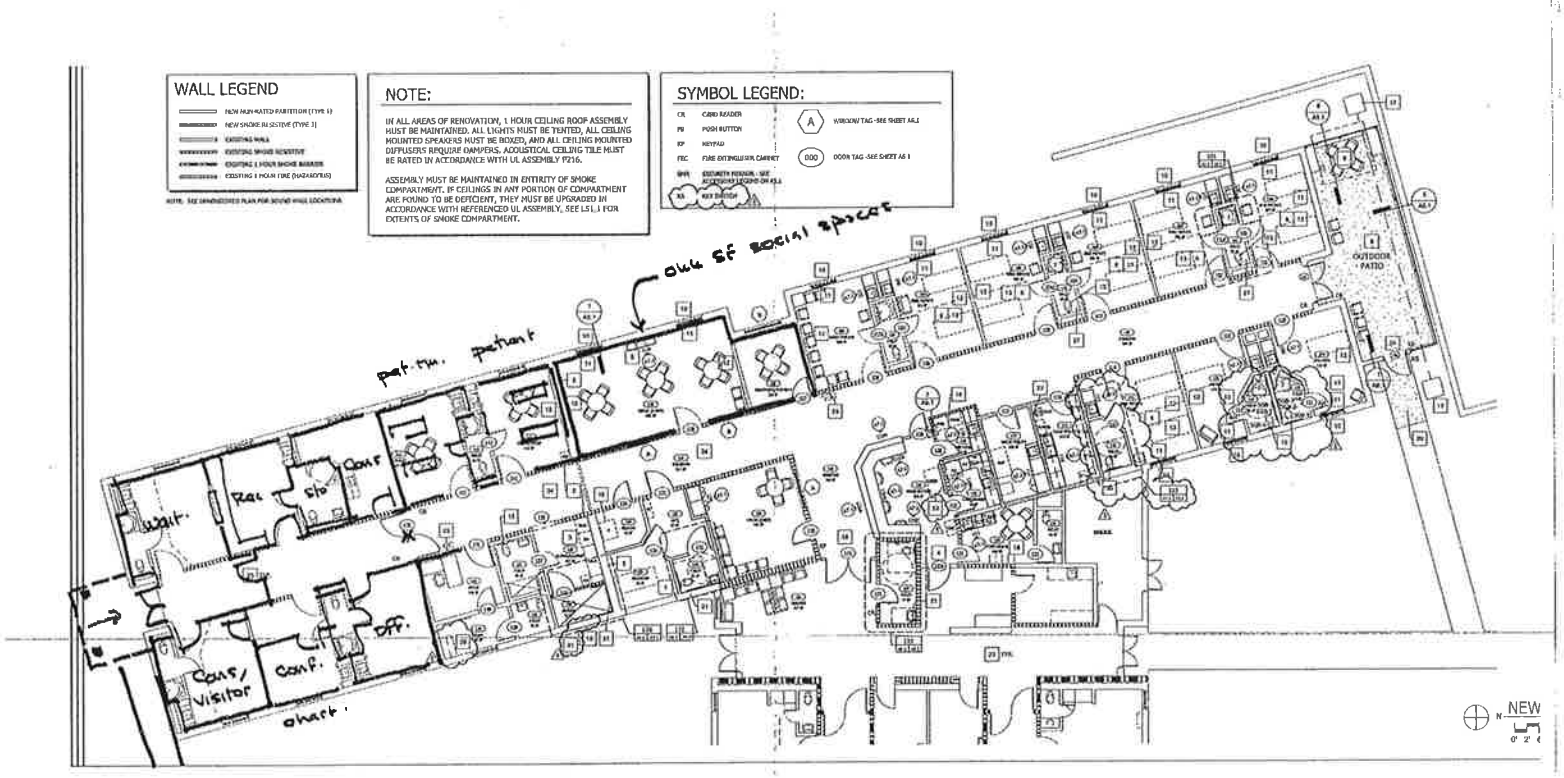
SITE PLAN
10.13 ACRES

ETOWAH, TENNESSEE
MARCH 10, 2014 - NOT FOR CONSTRUCTION
HINSON MILLER KICKIRILLO ARCHITECTS, PLLC

NOT TO SCALE

Attachment - Section A-6B.2

Floor Plan



Expanded to 18 bed.

Attachment - Section C - Economic Feasibility-1E

Architect Letter

HMK
ARCHITECTS PLLC

January 10, 2017

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services and Development Agency
500 Deadrick Street, Suite 850
Nashville, TN 37243

RE: Starr Regional Medical Center - Etowah
Geriatric-Psychiatric Unit Expansion – Verification of Construction Cost

Dear Ms. Hill:

We have reviewed the construction cost developed for the Geriatric-Psychiatric Unit bed expansion at Starr Regional Medical Center located in Etowah, Tennessee. The construction cost of $352,000.00 is based on 2,800 square feet of renovation to the existing facility, which will increase the unit's bed total from 14 to 18.

It is our professional opinion that the construction cost proposed which equates to $125.70 per square foot is consistent with historical data based on our experience with similar type projects. It is important to note, that our opinion is based on normal market conditions, price escalation, etc.

The project will be developed under the current codes and standards enforced by the State of Tennessee as follows:

2012 International Building Code/2012 International Mechanical Code/2012 International Plumbing Code
2012 International Gas Code
2011 National Electrical Code
2012 NFPA 1, excluding NFPA 5000
2012 NFPA 101, Life Safety Code
2010 FGI Guidelines for the Design and Construction of Health Care Facilities
2002 North Carolina Accessibility Code with 2004 Amendments/2010 Americans with Disabilities Act (ADA)

Sincerely,

HMK ARCHITECTS PLLC

Donald C. Miller, NCARB, AIA – [TN License No. 100019]

5300 MARYLAND WAY, SUITE 109 BRENTWOOD, TN 37027 T (615) 369 6020 F (615) 369 6021 WWW.HMKA.COM

Attachment - Section C - Economic Feasibility-2E

CFO Letter

LIFEPOINT
HEALTH

January 6, 2017

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, TN 37243

Re: Starr Regional Medical Center CON Application for Four Geropsychiatric Beds

Dear Mrs. Hill:

Starr Regional Medical Center – Etowah is applying for a Certificate of Need to add four geropsychiatric beds in one phase over the next 12 months.

As Chief Financial Officer of LifePoint's Central Group, the group to which this facility belongs, I am writing to confirm LifePoint Health, Inc. will provide the approximately $660,000 required to implement this project. LifePoint's financial statements are provided in the application.

Sincerely,

Jonathan C. Wall
Chief Financial Officer, Central Group

JCW/ph

330 Seven Springs Way, Brentwood, Tennessee 37027
Phone 615.920.7000

LIFEPOINTHEALTH.NET

Attachment - Section C - Economic Feasibility-3 and 4

Historical Data Chart and Projected Data Chart
Detail of Other Expenses

HISTORIC DATA CHART
DETAIL OF D.9, OTHER EXPENSES

				Projected		
	2013	2014	2015	2016	2017	2018
Expense Category						
Other Expenses						
Contract Services	$ 4,184,855.00	$ 4,352,043.00	$ 5,199,019	$ 5,432,223	$ 5,425,150	$ 5,418,086.21
Total Contract Services	$ 4,184,855.00	$ 4,352,043.00	$ 5,199,019.00	$ 5,432,223.00	$ 5,425,150.00	$ 5,418,086.21
Contract Labor		$ 58,050.00	$ -	$ 8,098		$ -
Legal and Accounting Services	$ 195,426.06	$ 128,102.30	$ 90,295	$ 87,144	$ 87,144	$ 87,144.00
Marketing Expenses	$ 118,557.32	$ 155,031.96	$ 203,615	$ 232,425	$ 232,425	$ 232,425.00
Postage and Transportation	$ 104,370.00	$ 95,768.99	$ 95,932	$ 94,306	$ 94,306	$ 94,306.00
Travel and Entertainment	$ 126,826.12	$ 112,761.87	$ 131,108	$ 137,229	$ 137,229	$ 137,229.00
Dues and Subscriptions	$ 219,642.29	$ 163,577.78	$ 174,232	$ 159,302	$ 161,293	$ 163,308.88
Education and Development	$ 48,885.60	$ 85,432.11	$ 36,222	$ 44,643	$ 68,228	$ 104,273.01
Physician Recruitment	$ 86,537.17	$ (78,319.20)	$ 140,032	$ 118,937	$ 120,448	$ 121,978.20
Oper Exp-other	$ 140,335.98	$ 98,659.05	$ 153,763	$ 76,517	$ 103,420	$ 139,781.96
(Gain) Loss on sale of assets	$ 891.26	$ (33,179.36)	$ 28,804	$ 2,292	$ 2,292	$ 2,292.00
Benefits	$ 5,043,219.00	$ 4,347,623.00	$ 4,303,353	$ 4,315,052	$ 4,398,487	$ 4,483,535.28
Professional Fees	$ 2,892,543.00	$ 2,698,284.00	$ 2,588,286	$ 2,507,220	$ 2,760,273	$ 3,038,866.57
Repairs and maintenance	$ 1,698,115.00	$ 1,692,395.00	$ 1,721,222	$ 1,709,383	$ 1,800,771	$ 1,897,044.84
Utilities	$ 1,393,461.00	$ 1,451,195.00	$ 1,388,671	$ 1,361,606	$ 1,408,759	$ 1,457,544.93
Insurance	$ 468,706.00	$ 523,424.00	$ 447,363	$ 392,800	$ 532,320	$ 721,396.59
Interest Income	$ (1,778.90)	$ (898.58)	$ (2,823)	$ (1,372)	$ (1,372)	$ (1,372.00)
Dividend Income	$ (2,578,453.00)	$ (762,176.00)	$ (334,961)			
Other Income and Expense	$ (7,632.68)	$ 909.02		$ (4,934)		$ -
Total Other Expenses Excluding Contract Services	$ 9,949,651.22	$ 10,736,640.94	$ 11,165,112.44	$ 11,240,648.00	$ 11,906,023.00	$ 12,679,754.26
Total Other Expenses	$ 14,134,506.22	$ 15,088,683.94	$ 16,364,131.44	$ 16,672,871.00	$ 17,331,173.00	$ 18,097,840.47

Attachment - Section C - Economic Feasibility-6A

SEC Documents

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

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

For the fiscal year ended December 31, 2015

or

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

For the transition period from to

Commission file number: 000-51251

LifePoint Health, Inc.

(Exact Name of Registrant as Specified in its Charter)

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

(615) 920-7000
(Registrant's Telephone Number, Including Area Code)

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

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

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).
Yes ☑ No ☐

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

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

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

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

The aggregate market value of the shares of registrant's Common Stock held by non-affiliates as of June 30, 2015, was approximately $2.8 billion.

As of February 5, 2016, the number of outstanding shares of the registrant's Common Stock was 43,133,285.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement for its 2016 annual meeting of stockholders are incorporated by reference into Part III of this report.

LifePoint Health, Inc.

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PART I

Item 1. *Business.*

Overview of Our Company

LifePoint Health, Inc., formerly known as LifePoint Hospitals, Inc., a Delaware corporation, acting through its subsidiaries, owns and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. Unless the context otherwise requires, LifePoint Health, Inc. and its subsidiaries are referred to herein as "LifePoint," the "Company," "we," "our" or "us." At December 31, 2015, on a consolidated basis, we operated 67 hospital campuses in 21 states throughout the United States ("U.S."), having a total of 8,243 licensed beds. We generate revenues primarily through hospital services offered at our facilities. We generated $5,214.3 million, $4,483.1 million and $3,678.3 million in revenues during the years ended December 31, 2015, 2014 and 2013, respectively.

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

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

Business Strategy

Opportunities in Existing Markets

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

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

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

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

Opportunities in New Markets

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

In 2011, we formed Duke LifePoint Healthcare, a joint venture between LifePoint and a wholly-controlled affiliate of Duke University Health System, Inc. ("Duke"), with a mission to own and operate community hospitals as well as improve the delivery of healthcare services. We own a controlling interest in Duke LifePoint Healthcare. We believe this partnership, which combines our operational resources and experience with Duke's expertise in the development of clinical services and quality systems, further strengthens our ability to acquire well-positioned hospitals. Since its formation in 2011 and through December 31, 2015, we have completed the acquisition of twelve acute care hospitals and ancillary facilities through Duke LifePoint Healthcare.

In 2012, we entered into a joint venture agreement with Norton Healthcare, Inc. to form the Regional Health Network of Kentucky and Southern Indiana ("RHN"), the purpose of which is to own and operate hospitals in non-urban communities in Kentucky and Southern Indiana. Through RHN, we acquired Clark Memorial Hospital ("Clark Memorial"), a 236 bed acute care hospital located in Jeffersonville, Indiana, effective August 1, 2015, and Scott Memorial Hospital ("Scott Memorial"), a 25 bed critical access hospital located in Scottsburg, Indiana, effective January 1, 2013.

We continue to make other strategic acquisitions on an opportunistic basis, including the following additional facilities during the year ended December 31, 2015:

- an 80% interest in an entity that owns and operates Watertown Regional Medical Center ("Watertown"), a 95 bed acute care hospital located in Watertown, Wisconsin, effective September 1, 2015;
- Fleming County Hospital ("Fleming"), a 52 bed acute care hospital located in Flemingsburg, Kentucky, effective August 1, 2015; and
- Nason Hospital ("Nason"), a 45 bed acute care hospital located in Roaring Spring, Pennsylvania, effective February 1, 2015.

Cost Management

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

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

Additionally, in connection with our efforts to responsibly manage purchasing costs, we participate along with other healthcare companies in a group purchasing organization, HealthTrust Purchasing Group, which makes certain national supply and equipment contracts available to our facilities. We owned an approximate 5.7% equity interest in this group purchasing organization at December 31, 2015.

Operations

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

As of December 31, 2015, with the exception of certain of our critical access hospitals, including Bluegrass Community Hospital ("Bluegrass"), Bell Hospital ("Bell") and Meyersdale Medical Center ("Meyersdale"), all of our hospitals are accredited by the Joint Commission. With such accreditation, our hospitals are deemed to meet the Medicare Conditions of Participation and are, therefore, eligible to participate in government-sponsored provider programs, such as the Medicare and Medicaid programs. Bluegrass, Bell and Meyersdale participate in the Medicare program by otherwise meeting the Medicare Conditions of Participation.

Services Provided and Peer Review

The range of services that can be offered at any of our hospitals depends significantly on the efforts, abilities and experience of the physicians on the medical staffs of our hospitals, most of whom have no long-term contractual relationship with us. Under state laws and other licensing standards, hospital medical staffs are generally self-governing organizations subject to ultimate oversight by a hospital's local governing board. Our hospitals are staffed by licensed physicians who have been admitted to the medical staffs of individual hospitals, and in many cases, credentialed (or authorized) to provide specialized services by the medical executive (or other comparable) committees of the hospitals and the local governing boards. The medical executive or other applicable committees are generally comprised of physicians on a hospital's medical staff, and the boards generally include members of a hospital's medical staff as well as community leaders. In addition to medical staff credentialing decisions, these boards establish policies concerning medical, professional and ethical practices, monitor these practices, and are responsible for reviewing these practices in order to determine that they conform to established standards of proper and appropriate medical care. Although we maintain quality assurance programs to support and monitor quality of care standards and to meet accreditation and regulatory requirements, decisions about whether physicians can practice at our hospitals, the scope of each such physician's practice, the oversight of the quality of the care being provided by such physicians, and physician disciplinary or corrective actions are made or are the responsibility of the medical executive, peer review, quality assurance, utilization review, and other related medical staff committees and the local governing boards at each hospital. As a result, our ability to address quality of care and performance concerns relating to non-employed physicians may be limited. We also monitor patient care evaluations and other quality of care assessment activities on a regular basis.

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

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

Availability of Information

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

Sources of Revenue

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

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

	2015		2014		2013	
	Amount	Ratio	Amount	Ratio	Amount	Ratio
Medicare	$ 1,515.0	29.1 %	$ 1,361.4	30.4 %	$ 1,199.5	32.6 %
Medicaid	841.6	16.1	619.8	13.8	517.0	14.1
HMOs, PPOs and other private insurers	2,791.9	53.5	2,476.7	55.2	1,876.1	51.0
Self-pay	744.1	14.3	744.9	16.6	766.5	20.8
Other	121.8	2.3	98.1	2.2	69.6	1.9
Revenues before provision for doubtful accounts	6,014.4	115.3	5,300.9	118.2	4,428.7	120.4
Provision for doubtful accounts	(800.1)	(15.3)	(817.8)	(18.2)	(750.4)	(20.4)
Revenues	$ 5,214.3	100.0 %	$ 4,483.1	100.0 %	$ 3,678.3	100.0 %

Patients generally are not responsible for any difference between customary hospital charges and amounts reimbursed for the services under Medicare, Medicaid, private insurance plans, HMOs or PPOs, but are responsible for services not covered by these plans and for patient responsibility amounts due in connection with the exclusion, deductible or co-payment features of their coverage. The amounts of exclusions, deductibles and co-payments for which our patients are responsible generally have been increasing each year as employers have been shifting a higher percentage of healthcare costs to employees. Beginning in 2014, our self-pay revenues began to decrease due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. This shift partially offset trends our hospitals have experienced in recent years, including increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments.

Medicare

Our revenues from Medicare were approximately $1,515.0 million, or 29.1% of total revenues for the year ended December 31, 2015. Medicare provides hospital and medical insurance benefits, regardless of income, to persons age 65 and over, some disabled persons and persons with end-stage renal disease. All of our hospitals are currently certified as providers of Medicare services. Amounts received under the Medicare program are often significantly less than the hospital's customary charges for the services provided. Since 2003, Congress and CMS have made several sweeping changes to the Medicare program and its reimbursement methodologies, such as the implementation of the prescription drug benefit that was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA") and the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act"). Additionally, the Middle Class Tax Relief and Job Creation Act of 2012 and the American Taxpayer Relief Act of 2012 ("ATRA") required further reductions in Medicare payments, and the Budget Control Act of 2011 ("BCA") imposed a 2% reduction in Medicare spending which began on April 1, 2013. The Bipartisan Budget Act of 2015 ("BBA"), which provides $80 billion in discretionary spending sequestration relief over the next two years, extends the 2% reduction in Medicare spending, which was imposed by the BCA, through federal fiscal year ("FFY") 2025 and, effective January 1, 2017, reduces Medicare payments to off-campus hospital outpatient departments that were not in operation prior to November 2, 2015.

Medicare Inpatient Prospective Payment System

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

The base MS-DRG operating expense payment rate that is used by the Medicare program in the IPPS is adjusted by an update factor on an annual basis. The index used to adjust the base MS-DRG payment rate, which is known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. For FFYs 2016 (which began on October 1, 2015 and will end on September 30, 2016), 2015 (which began on October 1, 2014 and ended on September 30, 2015), and 2014 (which began on October 1, 2013 and ended on September 30, 2014), the hospital market basket index increased 2.4%, 2.9%, and 2.5%, respectively. Generally, however, the percentage increase in the MS-DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the hospital market basket increases for FFY 2016, FFY 2015 and FFY 2014 were reduced by CMS by 0.20%, 0.20% and 0.30%, respectively. As also mandated by the Affordable Care Act for FFY 2012 and each subsequent fiscal year, the market basket increase is reduced by a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity. For FFY 2016, FFY 2015 and FFY 2014, the productivity adjustment equated to a 0.5% reduction in the market basket increase for each year. In addition, in FFY 2013, FFY 2012 and FFY 2011, IPPS payment rates to hospitals were increased by 1.0%, decreased by 2.0% and decreased by 2.9%, respectively, for documentation and coding adjustments that were required by the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007 (the "TMA Act"), and decreased by 0.8% in FFYs 2016, 2015 and 2014 for additional documentation and coding adjustments required by ATRA. The market basket increase for FFY 2014 was also reduced by 0.2% to offset the cost of the changes that were implemented to the Medicare program's admission and medical review criteria for hospital inpatient admissions services in connection with the "two midnight rule," which is discussed in more detail below.

From FFY 2005 through 2007, the MMA required all acute care hospitals to participate in CMS's Hospital Inpatient Quality Reporting Program (the "IQR Program") in order to receive the full hospital market basket update. Beginning in FFY 2007, the Deficit Reduction Act of 2005 (the "DRA") expanded the number of quality measures that were required to be reported and increased the reduction in reimbursement to hospitals that do not participate in the IQR Program from 0.4% to 2.0%. Beginning in FFY 2015, hospitals that do not participate in the IQR Program will lose one-quarter of the percentage in their payment updates. Our hospitals reported all quality measures required by CMS related to the IQR Program and will receive the full market basket update through FFY 2016. In addition, hospitals that are not meaningful electronic health record ("EHR") users are also subject to an additional 50% reduction of the hospital market basket increase.

On October 1, 2007, CMS replaced the previously existing 538 diagnosis related groups with 745 MS-DRGs. The MS-DRGs are intended to more accurately reflect the cost of providing inpatient services and eliminate any incentives that hospitals may have to only treat the healthiest and most profitable patients. The MS-DRGs were phased-in over a two year period, with FFY 2009, which began on October 1, 2008, being the first year that IPPS payments to hospitals were based entirely on the new MS-DRGs.

To offset the effect of the coding and discharge classification changes that CMS believed would occur as hospitals implemented the MS-DRG system, CMS established prospective documentation and coding adjustments to the national standardized amounts of (1.2%) in FFY 2008 and (1.8%) in both FFYs 2009 and 2010. However, the TMA Act, which was enacted on September 29, 2007, effectively decreased the reductions for FFYs 2008 and 2009 to (0.6%) and (0.9%), respectively. In addition, the TMA Act required CMS to conduct a "look-back" beginning in FFY 2010 and make appropriate changes to the reduction percentages based on actual FFY 2008 and 2009 claims data. Based on its evaluation, CMS determined that IPPS payments increased by 2.5% in FFY 2008 and 5.4% in FFY 2009 due solely to the implementation of the MS-DRG System. The increases exceeded the cumulative prospective adjustments by 5.8% for FFYs 2008 and 2009. The TMA Act required CMS to recoup the increase in spending in FFYs 2008 and 2009 by FFY 2012. In the IPPS final rule for FFY 2011, CMS reduced the standardized amount by (2.9%), which represented half of the required retrospective adjustment. The remaining (2.9%) retrospective reduction was implemented in FFY 2012. However, because the (2.9%) retrospective reduction that was made in FFY 2011 was restored in FFY 2012, the retrospective adjustment that was made in FFY 2012 was essentially negated. The (2.9%) retrospective reduction that was made in FFY 2012 was restored in FFY 2013.

The TMA Act also required CMS to make an additional prospective cumulative adjustment of (3.9%) to eliminate the full effect of the documentation and coding changes on future payments. The TMA Act gave CMS discretion as to the timing of the implementation of the prospective documentation and coding adjustment, and CMS did not implement any portion of the adjustment in FFYs 2010 and 2011. CMS did, however, implement a (2.0%) prospective documentation and coding adjustment in FFY 2012 and completed the remaining (1.9%) prospective adjustment in FFY 2013.

In addition to the adjustments that were required by the TMA Act, ATRA, which was enacted on January 1, 2013, required CMS to recoup $11 billion from IPPS payments in FFYs 2014 through 2017 to offset an additional increase in aggregate payments to hospitals that Congress believes occurred from FFY 2008 through 2013 solely as the result of the transition to the MS-DRG system and was not recaptured by the adjustments that were mandated by the TMA Act. In FFY 2014, FFY 2015 and FFY 2016, CMS applied (0.8%) adjustments as part of the recovery process required by ATRA. CMS has indicated that it expects a similar adjustment in FFY 2017 to recover the remaining outstanding amount.

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

	Medicare MS-DRG Payments	Medicare Capital Payments
2015	$ 631.0	$ 47.1
2014	$ 585.5	$ 45.9
2013	$ 535.5	$ 41.7

In addition to MS-DRG and capital payments, hospitals may qualify for outlier payments for cases involving patients whose treatment costs are extraordinarily high when compared to the costs of treating an average patient in the same MS-DRG.

Hospitals may also qualify for Medicare disproportionate share hospital ("DSH") payments, if they treat a high percentage of low-income patients. The adjustment is generally based on the hospital's disproportionate patient percentage ("DPP"), which is equal to the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of total inpatient days attributable to patients eligible for Medicaid but not Medicare Part A. Hospitals whose DPP meets or exceeds a specified threshold amount are eligible for a DSH payment adjustment. The Affordable Care Act requires Medicare DSH payments to providers to be reduced by 75% beginning in FFY 2014, subject to adjustment if the Affordable Care Act does not decrease uncompensated care to the extent anticipated. The amount that is withheld will be reduced by the percentage change in uninsured individuals under the age of 65 from 2013 to the current year (as normalized to reflect the October 1 commencement date for each FFY) minus 0.1% in FFY 2014 and minus 0.2% in FFYs 2015 and 2016, and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period. The IPPS final rule for FFY 2016 established the uncompensated care amount which will be distributed to qualifying hospitals in FFY 2016 at $6.4 billion, down from $7.65 billion in FFY 2015. Medicare DSH payments received in the aggregate by our hospitals for 2015, 2014 and 2013 were approximately $66.4 million, $73.5 million and $67.8 million, respectively.

"Two-Midnight Rule"

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

While the IPPS final rule for FFY 2014 became effective on October 1, 2013, CMS initially indicated that, for a period of 90 days after the effective date of the rule, it would not permit recovery auditor contractors ("RACs") and other Medicare review contractors to review inpatient admissions of one midnight or less that began between October 1, 2013 and December 31, 2013. CMS subsequently extended that delay to inpatient admissions that occur on or prior to September 30, 2014. CMS did, however, instruct Medicare Administrative Contractors ("MACs") to review, on a pre-payment basis, a small sample (approximately 10 – 25) of inpatient hospital claims relating to admissions that occurred between June 30, 2014 and September 30, 2014, and that spanned less than two midnights after admission in order to determine each hospital's compliance with the new inpatient admission and medical review criteria. Hospitals were permitted to rebill denied inpatient hospital admissions in accordance with the rule.

On April 1, 2014, President Obama signed the Protecting Access to Medicare Act of 2014 ("PAMA") into law. Among other things, PAMA prohibited CMS from allowing RACs to conduct inpatient hospital patient status reviews on claims with dates of admission October 1, 2013 through March 31, 2015, and permitted CMS to continue to allow MACs to review, on a pre-payment basis, a small sample of inpatient hospital claims relating to admissions that spanned less than two midnights and that occured on or after October 1, 2013 but before March 31, 2015, in order to determine hospital compliance with the new inpatient admission and medical review criteria. The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), which was signed into law by President Obama on April 16, 2015, extended the prohibition on RAC inpatient hospital patient status reviews on claims with dates of admission through September 30, 2015, but it did allow CMS and its MACs to continue to conduct their pre-payment, "probe and educate" reviews for claims with dates of admission through that same date.

On May 15, 2014, CMS solicited comments in the IPPS proposed rule for FFY 2015 regarding the development of an alternative payment methodology under the Medicare program for short inpatient hospital stays. Among other things, CMS is seeking input on how to define a short inpatient hospital stay for Medicare payment purposes and how to determine the appropriate payment amounts for short inpatient hospital stays. In the IPPS final rule for FFY 2015, CMS indicated it would consider the comments received in future rulemaking.

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

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

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In addition, legislation has previously been introduced in Congress that, among other things, would generally prohibit Medicare review contractors from denying claims due to the length of a patient's stay or a determination that services could have been provided in an outpatient setting and require CMS to develop a new payment methodology for services that are provided during short inpatient hospital stays. We cannot predict whether the legislation that has been introduced in Congress, or any other similar legislation, will be adopted or, if adopted, the amount of reimbursement that would be paid under any alternative payment methodology that is developed by CMS.

Furthermore, federal lawsuits have been filed challenging the Two-Midnight Rule primarily on the grounds that the implementation of the rule itself, and the payment reduction associated with the rule (i.e., 0.2% IPPS payment reduction to hospitals) violate the Administrative Procedure Act. In connection with one of those lawsuits, the U.S. District Court in Washington, D.C. held that the Secretary of the Department of Health and Human Services ("HHS") failed to give hospitals and other members of the public a meaningful opportunity to comment on the 0.2% IPPS payment reduction that was contained in the IPPS final rule for FFY 2014 and ordered CMS to give hospitals another opportunity to comment on the reduction. In response to the ruling, CMS published a new notice regarding the 0.2% IPPS payment reduction on December 1, 2015 and stated that it plans to publish a final rule on or before March 18, 2016. We cannot predict the outcome of the upcoming CMS final rule on the 0.2% IPPS payment reduction or whether the pending federal court challenges to the Two-Midnight Rule will be successful.

Medicare Hospital Outpatient Prospective Payment System

The Balanced Budget Refinement Act of 1999 ("BBRA") established a prospective payment system for outpatient hospital services that commenced on August 1, 2000. Under OPPS, hospital outpatient services are classified into groups called ambulatory payment classifications ("APCs"). Services in each APC are clinically similar and are similar in terms of the resources they require. Depending on the services provided, a hospital may be paid for more than one APC for an encounter. CMS establishes a payment rate for each APC by multiplying the scaled relative weight for the APC by a conversion factor. The payment rate is further adjusted to reflect geographic wage differences. The APC conversion factors for CYs 2016, 2015 and 2014 were $73.725, $74.144 and $72.672, respectively, after the inclusion of the 0.7% reduction for CY 2015 and CY 2016, and the 0.8% reduction for CY 2014, that were required by the Affordable Care Act and a 2.0% reduction for CY 2016 to account for approximately $1 billion in inflation in OPPS payments that CMS believes resulted from excess packaged payments for clinical laboratory services. APC classifications and payment rates are reviewed and adjusted on an annual basis, and, historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services. To receive the full increase, hospitals must satisfy the reporting requirements of the Hospital Outpatient Quality Data Reporting Program (the "HOPQDRP"). Hospitals that do not satisfy the reporting requirements of the HOPQDRP are subject to a reduction of 2.0% from the fee schedule increase factor. Our hospitals reported all quality measures required by CMS for HOPQDRP and will receive the full market basket update through CY 2016.

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

	Medicare APC Payments
2015	$ 427.7
2014	$ 387.4
2013	$ 328.4

Medicare Dependent and Low Volume Hospital Programs

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

Medicare Bad Debt Reimbursement

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

The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases, an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period. In these cases, the recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made. In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs is reduced by 35%. Under this program, our hospitals received an aggregate of approximately $25.9 million, $18.1 million and $21.7 million for 2015, 2014 and 2013, respectively.

Physician Services

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

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

Medicaid

Our revenues under the various state Medicaid programs, including state-funded managed care programs, were approximately $841.6 million, or 16.1% of total revenues for the year ended December 31, 2015. These payments are typically based on fixed rates determined by the individual states. Included in these payments are DSH and other supplemental payments received under various state Medicaid programs. For 2015, 2014 and 2013, our revenues attributable to DSH and other supplemental payments were approximately $205.4 million, $155.7 million and $128.7 million, respectively. The increase in revenues from DSH and other supplemental payments is primarily attributable to additional funding provided by certain states, which was made available in part by additional annual state provider taxes on certain of our hospitals and changes in classification of state programs.

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

Many states in which we operate are facing budgetary challenges and have adopted, or may be considering, legislation that is intended to control or reduce Medicaid expenditures, enroll Medicaid recipients in managed care programs, and/or impose additional taxes on hospitals to help finance or expand their Medicaid programs. Budget cuts, federal or state legislation, or other changes in the administration or interpretation of government health programs by government agencies or contracted managed care organizations could have a material adverse effect on our financial position and results of operations.

Annual Cost Reports

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

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

Recovery Audit Contractors

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

The original recovery audit contracts expired in February 2014, and CMS is still in the process of procuring new agreements for the RAC program. In connection with the procurement of the new recovery audit contracts, CMS has made a number of enhancements to the RAC program, including the establishment of a RAC program Provider Relations Coordinator, requiring RACs to maintain an overturn rate of less than 10% at the first level of appeal, requiring RACs to maintain an accuracy rate of at least 95%, and establishing additional documentation request limits based on a provider's compliance with Medicare rules, that are intended to address provider and other stakeholder concerns, CMS has indicated that it will likely incorporate additional enhancements into the new recovery audit contracts.

Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs are accurate, many of our hospitals have had Medicare claims audited by the RAC program. While our hospitals have successfully appealed many of the adverse determinations raised by Medicare RAC audits, we cannot predict if this trend will continue or the results of any future audits. We cannot predict the volume or outcome of any future audits conducted by the various state Medicaid RAC programs to which our hospitals will be subject. During the year ended December 31, 2015, RAC audits resulted in a reduction to revenue of approximately $4.9 million. During the year ended December 31, 2014, as a result of both our participation in a CMS administrative agreement settlement process and our success in appealing adverse RAC determinations, we recognized additional revenue of approximately $9.1 million. During the year ended December 31, 2013, RAC audits resulted in a reduction to revenue of approximately $6.8 million.

HMOs, PPOs and Other Private Insurers

In addition to government programs, our hospitals are reimbursed by differing types of private payors including HMOs, PPOs, other private insurance companies and employers. Also included in this category are the patient responsibility portions for co-payment and deductible obligations under these programs. Our revenues from HMOs, PPOs and other private insurers were approximately $2,791.9 million, or 53.5% of total revenues for the year ended December 31, 2015. Revenues from HMOs, PPOs and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services. These discounted arrangements often limit our ability to increase charges in response to increasing costs. We actively negotiate with these payors in an effort to maintain or increase the pricing of our healthcare services; however, we have no control over patients switching their healthcare coverage to a payor with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. We expect this trend to continue in the coming years.

Self-pay and Charity Care

Self-pay revenues are derived from patients who do not have any form of healthcare coverage. Our revenues from self-pay patients were approximately $744.1 million, or 14.3% of total revenues for the year ended December 31, 2015. The revenues associated with self-pay patients are generally reported at our gross charges. We evaluate these patients, after the patient's medical condition is determined to be stable, for qualifications of Medicaid or other governmental assistance programs, as well as our local hospital's policy for charity care. We do not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is our policy not to pursue collection of amounts related to these patients.

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

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

	Self-Pay Revenues	Charity Care Write-Offs	Combined Total
2015	$ 744.1	$ 89.3	$ 833.4
2014	$ 744.9	$ 80.9	$ 825.8
2013	$ 766.5	$ 132.1	$ 898.6

Provision for Doubtful Accounts

To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. The primary uncertainty lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients. Our provision for doubtful accounts had the effect of reducing total revenues by approximately $800.1 million, or 15.3% of total revenues for the year ended December 31, 2015. Prior to 2014, our provision for doubtful accounts as a percentage of revenue increased steadily year over year as a result of increases in our self-pay revenues. Beginning in 2014, our self-pay revenues began to decrease as discussed above. As a result, for the year ended December 31, 2015, our provision for doubtful accounts as a percentage of revenue also decreased.

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

Health Care Reform

The Affordable Care Act dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, providing additional funding for Medicaid in states that choose to expand their programs, reducing Medicare and Medicaid DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, and instituting certain private health insurance reforms. Although some of the measures contained in the Affordable Care Act did not take effect immediately or do not take effect until a later date, certain of the reductions in Medicare spending, such as negative adjustments to the Medicare hospital inpatient and outpatient prospective payment system market basket updates and the incorporation of productivity adjustments to the Medicare program's annual inflation updates, became effective prior to 2015. In addition, a number of the provisions of the Affordable Care Act that were originally scheduled to have already become effective in 2015 or earlier, such as the employer mandate (for employers with 50 to 99 employees), the Small Business Health Option Program (for employers with 100 or fewer full-time employees), and the taxes on medical device manufacturers and expensive employee-sponsored health plans, were delayed until 2016 or later, and additional delays in the implementation of these or other provisions of the Affordable Care Act could be imposed in the future.

There have been and likely will continue to be a number of legal challenges to various provisions of the Affordable Care Act. For example, in 2012, the U.S. Supreme Court upheld the constitutionality of the Affordable Care Act, including the "individual mandate" provisions of the Affordable Care Act that generally require all individuals to obtain healthcare insurance or pay a penalty. However, the U.S. Supreme Court also held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. As a result, at December 31, 2015, only nine of the states in which we operate are currently implementing expansions to their Medicaid programs. Accordingly, some low-income persons in other states that are not expanding Medicaid may not have insurance coverage as intended by the Affordable Care Act. In addition, CMS has recently indicated that in light of the availability of federal funding for Medicaid expansion, it may not be willing to continue to provide certain uncompensated care funding, which would likely have a more significant impact in the states that have not expanded their Medicaid programs. Furthermore, the U.S. House of Representatives has filed a lawsuit challenging the use of federal funds to pay insurance companies for cost sharing reductions that are provided to certain individuals who purchase insurance through the Affordable Care Act health insurance marketplace exchange (an "Exchange"). If successful, the lawsuit could result in insurance premium increases for individuals purchasing their insurance coverage through the Exchanges or lead to a decrease in the number of insurers offering insurance coverage on the Exchanges.

The net effect of the Affordable Care Act on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, gradual implementation and possible amendment, as well as the uncertainty as to the extent to which states will choose to expand their Medicaid programs and the extent to which individuals will elect coverage. We are also unable to predict with a high level of precision how providers, payors, employers and other market participants will continue to respond to the various reform provisions. As a result, we are unable to predict with any certainty the net effect on our business, financial condition or results of operations of the expected increases in insured individuals using our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions of the Affordable Care Act that may affect us. Furthermore, several bills have been and may continue to be introduced in Congress to delay, defund or repeal implementation of or amend significant provisions of the Affordable Care Act, and the results of such legislative efforts may impact our business in the future. During 2015, and primarily as a result of the expansion of health insurance coverage, we experienced an increase in revenues from providing care to certain previously uninsured individuals. Although we expect this trend to continue, the future impact and timing of such expansion remains difficult to predict for the reasons discussed above, will be gradual and may not offset scheduled decreases in reimbursement.

Expanded Coverage

Based on original Congressional Budget Office ("CBO") and CMS estimates, by 2019, the Affordable Care Act was expected to expand coverage to 32 to 34 million additional individuals (resulting in coverage of an estimated 94% of the legal U.S. population). This increased coverage was expected to occur through a combination of public program expansion and private sector health insurance and other reforms. However, in July 2012, the CBO revised its estimate to reflect the impact of the U.S. Supreme Court's determination that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program was unconstitutional. On March 9, 2015, the CBO projected, as a result of the U.S. Supreme Court's decision and other factors, that there will be three million more uninsured individuals in 2016 and one million fewer uninsured individuals in 2022 than originally projected.

Medicaid Expansion

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

The Affordable Care Act materially changed the requirements for Medicaid eligibility. As originally enacted, commencing January 1, 2014, the Affordable Care Act essentially required all state Medicaid programs to provide Medicaid coverage to virtually all adults under 65 years old with incomes at or under 133% of the federal poverty level ("FPL"). In addition, the Affordable Care Act also required states to apply a "5% income disregard" to the Medicaid eligibility standard, so that Medicaid eligibility would effectively be extended to those with incomes up to 138% of the FPL. To offset the cost of the Medicaid program's expansion, the Affordable Care Act authorized the federal government to provide states with "matching funds" (referred to as "Enhanced FMAP") to cover the costs of covering the newly eligible individuals. Beginning in 2014, states began receiving an Enhanced FMAP for the individuals enrolled in Medicaid pursuant to the Affordable Care Act. The Enhanced FMAP percentage is as follows: 100% for CYs 2014 through 2016; 95% in 2017; 94% in 2018; 93% in 2019; and 90% in 2020 and thereafter. It is anticipated that the new eligibility requirements will expand Medicaid and CHIP coverage by an estimated 12 million individuals in 2016 and 14 million individuals in 2022, with a disproportionately large percentage of the new Medicaid coverage likely to be in states that currently have relatively low income eligibility requirements.

In 2012, the U.S. Supreme Court held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. As a result, the expansion of the Medicaid program to all individuals under 65 years old with incomes at or under 133% of FPL is now optional. CMS has stated that there is no deadline for states to determine whether they will expand their Medicaid programs and has indicated that if a state does decide to expand its Medicaid program, it may also decide to drop the expanded coverage at a later date. While the U.S. Supreme Court's decision will result in fewer individuals being covered by the Medicaid and CHIP programs, it is unclear how many states will elect to implement the Medicaid expansion and when that expansion will occur. Therefore, we are unable to predict the future impact of the Medicaid expansion on our business model, financial condition or result of operations.

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

In addition, beginning in 2014, the Affordable Care Act allows Medicaid participating hospitals to make presumptive determinations of Medicaid eligibility for certain categories of individuals, such as pregnant women, infants, children, and parents and other caretaker relatives and their spouses. If an individual is found to be presumptively eligible for Medicaid benefits, the hospital will get paid for the services it provides during the temporary presumptive eligibility period, just as though the patient were already enrolled in the Medicaid program. However, states have significant flexibility in developing their state-specific presumptive eligibility rules and can establish standards that hospitals must meet in order to make presumptive eligibility determinations. For example, a state may impose standards related to the accuracy of a hospital's presumptive eligibility determinations, require hospitals to tell individuals how to apply for and obtain a full Medicaid application, establish policies that require hospitals to assist individuals in completing a Medicaid application, and develop proficiency standards, trainings, and audits with which hospitals must comply. If a presumptive eligibility determination is made in accordance with the applicable federal and state presumptive eligibility requirements, a state will not be permitted to recoup money from the hospital for the services that were rendered during the presumptive eligibility period. A state may, however, disqualify a hospital from making future presumptive eligibility determinations if the hospital does not meet the state's established performance standards.

Historically, states often have attempted to reduce Medicaid spending by limiting benefits and tightening Medicaid eligibility requirements. Effective March 23, 2010, the Affordable Care Act required states to at least maintain Medicaid eligibility standards established prior to the enactment of the law for adults until January 1, 2014 and for children until October 1, 2019. States with budget deficits may, however, seek exemptions from this requirement, but only to address eligibility standards that apply to adults making more than 133% of the FPL.

Private Sector Expansion

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

Larger employers will continue to be subject to new requirements and incentives to provide health insurance benefits to their full time employees. Effective January 1, 2015, employers with 100 or more employees that do not offer health insurance to 70% of their full-time employees and their dependents are subject to a penalty if an employee obtains coverage through one of the Exchanges and the coverage is subsidized by the government. Effective January 1, 2016, that requirement was extended to employers with 50 to 99 employees, and all employers subject to the requirement are required to offer health insurance coverage to 95% of their full-time employees and their dependents in order to avoid penalties. The employer penalties range from $2,000 to $3,000 per employee, subject to certain thresholds and conditions. In addition, the Affordable Care Act also originally required employers with more than 200 employees to amend their group health plans to automatically enroll new full-time employees and to continue automatic enrollment for current employees. However, the BBA repealed this automatic enrollment requirement, and the Consolidated Appropriations Act, which was signed by President Obama on December 18, 2015, delayed the implementation of the Affordable Care Act's tax on certain expensive employer sponsored plans (the "Cadillac Tax") until 2020.

As enacted, the Affordable Care Act uses various means to induce individuals who do not have health insurance to obtain coverage. As of January 1, 2014, individuals were required to maintain health insurance for a minimum defined set of benefits or pay a tax penalty; however, individuals technically had until March 31, 2014 to obtain insurance. The penalty in most cases is $325 for 2015 and $695 for 2016, and indexed to a cost of living adjustment in subsequent years. The Internal Revenue Service ("IRS"), in consultation with HHS, is responsible for enforcing the tax penalty, although the Affordable Care Act limits the availability of certain IRS enforcement mechanisms. In addition, for individuals and families below 400% of the FPL, the cost of obtaining health insurance will be subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. It is anticipated that those at the lowest income levels will have the majority of their premiums subsidized by the federal government, in some cases in excess of 95% of the premium amount. To facilitate the purchase of health insurance by individuals and small employers, each state was required to establish an Exchange by January 1, 2014. Based on CBO estimates, approximately 9.5 million individuals obtained their health insurance coverage through an Exchange in 2015, and that number is expected to increase to 11 million in 2016. Health insurers participating in the Exchange must offer a set of minimum benefits to be defined by HHS and may offer more benefits, and must offer at least two, and up to five, levels of plans that vary by the percentage of medical expenses that must be paid by the enrollee. Each level of plan must require the enrollee to share certain specified percentages of medical expenses up to the deductible/co-payment limit. Health insurers may establish varying deductible/co-payment levels, up to the statutory maximum (estimated to be between $6,000 and $7,000 for an individual). The health insurers must cover 100% of the amount of medical expenses in excess of the deductible/co-payment limit. For example, an individual making 100% to 200% of the FPL will have co-payments and deductibles reduced to about one-third of the amount payable by those with the same plan with incomes at or above 400% of the FPL.

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

Public Program Spending

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

Payments for Hospitals

Under the Medicare program, hospitals receive reimbursement for general, acute care hospital inpatient services under the IPPS. CMS establishes fixed IPPS payment amounts per inpatient discharge based on the patient's assigned MS-DRG. These MS-DRG rates are updated each FFY, which begins October 1, using the hospital market basket index, which takes into account inflation experienced by hospitals and other entities outside the healthcare industry in purchasing goods and services.

The Affordable Care Act provides for a number of types of annual reductions in the market basket. One is a general reduction of a specified percentage each FFY starting in 2010 and extending through 2019. These reductions are as follows: FFY 2010, 0.25% for discharges occurring on or after April 1, 2010; 2011 (0.25%); 2012 (0.1%); 2013 (0.1%); 2014 (0.3%); 2015 (0.2%); 2016 (0.2%); 2017 (0.75%); 2018 (0.75%); and 2019 (0.75%).

Another type of reduction to the market basket is a "productivity adjustment" that was implemented by HHS beginning in FFY 2012. The amount of that reduction is the projected nationwide productivity gains over the preceding 10 years. To determine the projection, HHS uses the Bureau of Labor Statistics ("BLS") 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Affordable Care Act does not contain guidelines for HHS to use in projecting the productivity figure. The market basket update for FFY 2016, FFY 2015 and FFY 2014 was reduced by 0.5% each year as a result of this productivity adjustment.

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

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

Quality-Based Payment Adjustments and Reductions for Inpatient Services

The Affordable Care Act established or expanded provisions to promote value-based purchasing and to link payments to quality and efficiency. Among other things, it requires HHS to implement a value-based purchasing program for inpatient hospital services. This program applied beginning in FFY 2013 to payments for discharges occurring on or after October 1, 2012, and rewards hospitals based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period. As part of the program, the Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1.0% in FFY 2013 and increasing by 0.25% for each fiscal year up to 2.0% in FFY 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet and exceed certain quality performance standards established by HHS. Under the program, each hospital's performance is evaluated during a specified performance period, and hospitals receive points on each of a number of pre-determined measures based on the higher of (i) their level of achievement relative to an established standard or (ii) their improvement in performance from their performance during a prior baseline period. Each hospital's combined scores on all the measures are translated into value-based incentive payments beginning with inpatient discharges occurring on or after October 1, 2012. Hospitals that receive higher total performance scores receive higher incentive payments than those that receive lower total performance scores. Because the Affordable Care Act provides that the funds pooled and otherwise set aside for the value-based purchasing program will be fully distributed, hospitals with high scores may receive greater reimbursement under the value-based purchasing program than they would have otherwise, and hospitals with low scores may receive reduced Medicare inpatient hospital payments.

In addition, the Affordable Care Act prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. With respect to Medicare, beginning in FFY 2015, hospitals that fall into the top 25.0% of national risk-adjusted HAC rates for all hospitals in the previous year receive a 1.0% reduction in their total Medicare payments. Hospitals with excessive readmissions for conditions designated by HHS will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard.

Beginning in FFY 2013, inpatient payments were reduced if a hospital experiences "excessive readmissions" within a 30-day period of discharge for heart attack, heart failure, pneumonia or other conditions designated by HHS. Hospitals with what HHS defines as "excessive readmissions" for these conditions will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Each hospital's performance will be publicly reported by HHS. HHS has the discretion to determine what "excessive readmissions" means, the amount of the payment reduction and other terms and conditions of this program. The basic maximum payment reduction amount is 3.0% for FFY 2015 and beyond.

Outpatient Market Basket and Productivity Adjustment

Hospital outpatient services paid under OPPS are classified into APCs. The APC payment rates are updated each calendar year based on the market basket. The first two market basket changes outlined above — the general reduction and the productivity adjustment — apply to outpatient services as well as inpatient services, although these are applied on a calendar year basis. The percentage changes specified in the Affordable Care Act summarized above as the general reduction for the IPPS — e.g., 0.2% in CY 2016 — are the same for the OPPS.

Medicare and Medicaid Disproportionate Share Hospital Payments

The Medicare DSH program provides for additional payments to hospitals that treat a disproportionate share of low-income patients. Under the Affordable Care Act, beginning in FFY 2014, Medicare DSH payments were reduced to 25% of the amount they otherwise would have been absent the new law. The remaining 75% of the amount that would otherwise be paid under Medicare DSH will be effectively pooled, and this pool will be reduced further each year by a formula that reflects reductions in the national level of uninsured who are under 65 years of age. In other words, the greater the level of coverage for the uninsured nationally, the more the Medicare DSH payment pool will be reduced. Each hospital will then be paid, out of the reduced DSH payment pool, an amount allocated based upon its level of uncompensated care. CMS estimates that Medicare DSH payments and additional payments for uncompensated care made to hospitals in FFY 2016 will be reduced overall by 1% as compared to the Medicare DSH payments and uncompensated care payments distributed to hospitals in FFY 2015.

The Affordable Care Act does not mandate what data source HHS must use to determine the reduction, if any, in the uninsured population nationally. In addition, with respect to defining "uncompensated care" for the purposes of the Medicare DSH reductions, the IPPS final rules for FFYs 2014, 2015 and 2016 provide that instead of actually measuring the amount of uncompensated care that is provided by DSH hospitals, CMS will use Medicaid days and Medicare Supplemental Security Income ("SSI") days as proxies for determining levels of uncompensated care. In the IPPS final rule for FFY 2016, CMS did, however, indicate from worksheet S-10 of the Medicare cost report that it intends to use the data for the purposes of measuring the amount of uncompensated care that is provided by DSH hospitals within a reasonable amount of time and that it intends to further discuss this issue in the IPPS proposed rule for FFY 2017, which likely will be released in April 2016.

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

Accountable Care Organizations

The Affordable Care Act requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("ACOs"). The Medicare Shared Savings Program allows providers (including hospitals), physicians and other designated professionals and suppliers to voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program. To date, approximately 434 ACOs have been established to participate in the Medicare Shared Savings Program, and additional ACOs are being established by private payors.

Bundled Payment Pilot Programs

The Affordable Care Act created the Center for Medicare & Medicaid Innovation (the "Innovation Center") with responsibility for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for healthcare that create savings under the Medicare and Medicaid programs while improving quality of care. One initiative announced by the Innovation Center is a voluntary bundled payment initiative involving over 400 participants that links payments to participating providers for services provided during an episode of care. As required by the Affordable Care Act, HHS established a separate five-year, voluntary, national pilot program on payment bundling for Medicare services. Under the program, organizations enter into payment arrangements that include financial and performance accountability for episodes of care, and these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. Participating providers agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care. The Affordable Care Act also provides for a bundled payment demonstration project for Medicaid services, but CMS has not yet implemented this project.

In addition, on November 16, 2015, CMS published a final rule that creates a new payment model, called the Comprehensive Care for Joint Replacement Model ("CJR Model"), that will test, for a five year period, whether bundled payments to acute care hospitals for episodes of care for lower-extremity joint (hip or knee) replacement will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. Under the CJR Model, the hospital in which the lower extremity replacement or other procedure takes place will be accountable for the costs and quality of related care from the time of the surgery through 90 days after hospital discharge, which will be considered to be the "episode" of care. Depending on the hospital's quality and cost performance during the episode, the hospital will either receive an additional payment from Medicare or will be required to repay Medicare for a portion of the episode spending. CMS believes that the CJR Model will give hospitals an incentive to work with physicians, home health agencies, skilled nursing facilities, and other providers to make sure that Medicare beneficiaries receive the coordinated care they need with the goal of reducing avoidable hospitalizations and complications. The CJR Model will be implemented in 67 metropolitan statistical areas (MSAs), including some MSAs in which our facilities are located, and most hospitals in those MSAs will be required to participate.

Specialty Hospital Limitations

Over the last decade, we have faced competition from hospitals that have physician ownership. The Affordable Care Act prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. While the Affordable Care Act grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand. As of December 31, 2015, we operate one hospital through a joint venture with physicians in which we own a controlling interest.

Impact of Affordable Care Act on the Company

The expansion of health insurance coverage under the Affordable Care Act has resulted in an increase in the number of patients using our facilities who have either private or public program coverage. Further, the Affordable Care Act provides for a value-based purchasing program, which could create possible sources of additional revenue.

While the Affordable Care Act has had a positive impact on revenue, it is difficult to predict with great precision the timing or size of any potential revenue gains to us as a result of these elements of the Affordable Care Act, because of uncertainty surrounding a number of material factors, including the following:

- how many previously uninsured individuals will ultimately obtain coverage as a result of the Affordable Care Act (the CBO made a number of assumptions to derive its estimate, including how many individuals will ignore substantial subsidies and decide to pay the penalty rather than obtain health insurance, the number of individuals who will obtain insurance through an Exchange and the number of states that will expand their Medicaid programs);
- what percentage of the future newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the number of states that ultimately elect to expand their Medicaid programs and when that expansion occurs;
- the extent to which states will enroll any new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the future rates paid to hospitals by private payers for newly covered individuals under different plans, including those covered through the newly created Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- the future rates paid by state governments under the Medicaid program for newly covered individuals;
- how the value-based purchasing and other quality programs will be implemented;

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

On the other hand, the Affordable Care Act provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. Since 45.2% of our revenues in 2015 were from Medicare and Medicaid, collectively, reductions to these programs will significantly impact us and could offset any positive effects of the Affordable Care Act. It is difficult to predict with great precision the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from Medicare and Medicaid business when the reductions are fully implemented;
- whether reductions required by the Affordable Care Act will be changed by statute;
- the size of the Affordable Care Act's annual productivity adjustment to the market basket in future years;
- the amount of the Medicare DSH reductions that will be made, commencing in FFY 2014;
- the allocation to our hospitals of the Medicaid DSH reductions, commencing in FFY 2018;
- what the losses in revenues will be, if any, from the Affordable Care Act's quality initiatives;
- how successful ACOs in which we participate, if any, will be at coordinating care and reducing costs;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and
- reductions to Medicare payments CMS may impose for "excessive readmissions."

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

Competition for Patients

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

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

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

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

Competition for Professionals

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

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

Many physicians today prefer to be employed, rather than operating their own practices or joining existing medical groups. Our hospitals and affiliated entities had more employed physicians at the end of 2015 than at the end of 2014. When employing office-based physicians, we also often employ office employees and other personnel necessary to support these physicians and incur additional expenses as a result. We expect this trend to continue.

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

Employees

At December 31, 2015, we had approximately 40,000 employees. The majority are hospital-based employees, including nursing staff, physical and occupational therapists, laboratory and radiology technicians, pharmacy staff, facility maintenance workers and the administrative staffs of our hospitals. Additionally, we employ a number of physicians. We are subject to federal minimum wage and hour laws and various state labor laws, and we maintain a number of different employee benefit plans. Approximately 1,200 of our employees are subject to collective bargaining agreements. We consider our employee relations to be generally good. Some of our hospitals experience union organizing activity from time to time; however, we do not currently expect any of these efforts to materially affect our future operations.

Government Regulation

Overview

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

Acute care hospitals are subject to periodic inspection by federal, state and local authorities to determine their compliance with applicable regulations and requirements necessary for licensing, certification and accreditation. All of our hospitals are currently licensed under appropriate state laws and are qualified to participate in the Medicare and Medicaid programs. In addition, as of December 31, 2015, with the exception of Bluegrass, Bell and Meyersdale, all of our hospitals were accredited by the Joint Commission.

Utilization Review

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

Value-Based Purchasing

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

In 2011, we were selected by HHS to participate in the Hospital Engagement Network as part of the nationwide Partnership for Patients Initiative designed to reduce injuries to patients in a hospital setting as well as minimize exposure to preventable illnesses. As part of our participation in the project, including two one-year extensions, we will continue to receive funding from HHS through 2016 to sponsor various types of training and education focused on patient safety and quality of care.

Fraud and Abuse Laws

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

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

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

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

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

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

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

The Stark law prohibits physicians from referring Medicare and Medicaid patients to selected types of healthcare entities in which they or any of their immediate family members have ownership or a compensation relationship unless an exception applies. These types of referrals are commonly known as "self referrals". A violation of the Stark law may result in a denial of payment and require refunds to patients and the Medicare program for all claims that were unlawfully submitted during the entire period that the violation existed, civil monetary penalties of up to $15,000 for each violation, civil monetary penalties of up to $100,000 for circumvention schemes, civil monetary penalties of up to $10,000 for each day that an entity fails to report required information to HHS, and exclusion from participation in the Medicare and Medicaid programs and other federal programs. In addition, violations of the Stark law could also result in penalties under the federal False Claims Act. There are ownership and compensation arrangement exceptions to the self-referral prohibition. There are also exceptions for many of the customary financial arrangements between physicians and facilities, including employment contracts, leases and recruitment agreements, and there is a "whole hospital exception," which allows a physician to make a referral to a hospital if the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. The Affordable Care Act significantly modified the requirements of the whole hospital exception and placed a number of restrictions on the ownership structure, operations, and expansion of physician owned hospitals. One of our facilities is subject to those requirements. We intend for our financial arrangements with physicians to comply with the exceptions included in the Stark law and regulations. In recent years, CMS has issued a number of proposed and final rules modifying the Stark law exceptions. While some changes have been implemented, others remain in proposed form or have been delayed. Further, the Stark law and related regulations have been subject to little judicial interpretation to date. We anticipate that there will be further changes in the future that will require us to continue to modify our activities.

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

Federal False Claims Act

The federal False Claims Act prohibits providers from, among other things, knowingly submitting false or fraudulent claims for payment to the federal government. The federal False Claims Act defines the term "knowingly" broadly, and while simple negligence generally will not give rise to liability, submitting a claim with reckless disregard to its truth or falsity can constitute the "knowing" submission of a false or fraudulent claim for the purposes of the False Claims Act. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. When a private party brings a qui tam action under the federal False Claims Act, the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation. If a provider is found to be liable under the federal False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus mandatory civil monetary penalties of between $5,500 to $11,000 for each separate false claim. The government has used the federal False Claims Act to prosecute Medicare and other government healthcare program fraud such as coding errors, billing for services not provided, submitting false cost reports, and providing care that is not medically necessary or that is substandard in quality.

Changes in the Regulatory Environment

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

In addition to the changes mentioned above, the Affordable Care Act created federal False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later. On February 11, 2016, CMS published a final rule that provides clarification around the meaning of overpayment identification and generally establishes a six year lookback period for Medicare Part A and Part B providers and suppliers. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments, and accurately prepare cost reports. In light of the provisions of FERA and the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law, including technical violations of certain fraud and abuse laws, and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law. Finally, the BBA requires each agency, including HHS and the Department of Justice ("DOJ"), to adjust civil monetary penalty amounts, including those that may be assessed under the Stark law and False Claims Act, by August 1, 2016, subject to a maximum increase of 150%, and annually thereafter based on updates to the Consumer Price Index or a lesser amount if the agency involved determines that increasing the civil monetary penalty amount by the Consumer Price Index would have a negative economic impact or the costs of the increase outweigh the benefits.

State Laws

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

Emergency Medical Treatment and Active Labor Act

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

Administrative Simplification Provisions and Privacy and Security Requirements

We are subject to the administrative simplification provisions of HIPAA which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. In January 2009, CMS published its 10th revision of International Statistical Classification of Diseases and Related Health Problems ("ICD-10") and related changes to the formats used for certain electronic transactions. Health plans and providers, including our hospitals, were required to implement the new ICD-10 coding system, which greatly expands the number and detail of billing codes used for inpatient claims, by October 1, 2015. As a result of our implementation of ICD-10, we made significant investments in technology and training. Although we believe that we have made all of the modifications necessary to ensure compliance with the changes prescribed by ICD-10, we may still be affected by third party implementation difficulties and experience delays in reimbursement, underpayment for services, or possible denials of payments from payors.

Additionally, we are subject to the privacy and security regulations promulgated under HIPAA and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), which are designed to protect the confidentiality, availability and integrity of protected health information and establish an array of patient rights with respect to such information. The HIPAA privacy and security regulations apply to covered entities, which include health plans, health care clearinghouses, and health care providers that conduct certain standard transactions (such as billing insurance) electronically. In addition, certain provisions of the privacy and security regulations apply to business associates, which are entities that perform certain functions or activities on behalf of covered entities that require access to or the use or disclosure of protected health information. In certain circumstances, a covered entity may be held liable for the actions of its business associate if HHS determines an agency relationship exists between the covered entity and the business associate under federal agency law.

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

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

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

Corporate Practice of Medicine and Fee-Splitting

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

Certificates of Need

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

Not-for-Profit Hospital Conversion Legislation

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

State Hospital Rate-Setting Activity

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

Medical Malpractice Tort Law Reform

Medical malpractice tort law has historically been maintained at the state level. All states have laws governing medical liability lawsuits. Over half of the states have limits on damages awards. Almost all states have eliminated joint and several liability in malpractice lawsuits, and many states have established limits on attorney fees. Recently, many states had bills introduced in their legislative sessions to address medical malpractice tort reform. Proposed solutions include enacting limits on non-economic damages, malpractice insurance reform, and gathering lawsuit claims data from malpractice insurance companies and the courts for the purpose of assessing the connection between malpractice settlements and premium rates. Reform legislation has also been proposed, but not adopted, at the federal level that could preempt additional state legislation in this area.

Environmental Regulation

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

Regulatory Compliance Program

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

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

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

Risk Management and Insurance

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding a self-insured retention ("SIR") level. Our SIR for professional liability claims is $5.0 million per claim at December 31, 2015 with a $5.0 million inner aggregate. Additionally, our SIR for workers' compensation claims is $1.0 million per claim in all states in which we operate except for Wyoming. We participate in a state specific program in Wyoming for our workers' compensation claims arising in this state. Our SIR levels are evaluated annually as a part of our insurance program's renewal process.

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

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

Item 1A. *Risk Factors.*

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

Our revenues will decline if federal or state programs reduce our Medicare or Medicaid payments or if managed care companies reduce reimbursement amounts. In addition, the financial condition of payors and healthcare cost containment initiatives may limit our revenues and profitability.

In 2015, we derived 45.2% of our revenues from the Medicare and Medicaid programs, collectively. Numerous factors could materially decrease, or delay timing of, Medicare and Medicaid payments to our facilities. These factors include statutory and regulatory payment reduction or other changes, administrative rulings and determinations concerning patient and provider eligibility, the method of calculating reimbursements and requirements for utilization review. Furthermore, the Affordable Care Act, as amended by the Pathway Act and PAMA, the Tax Relief Act and the ATRA provide for material scheduled reductions in the growth of Medicare and Medicaid program spending, including reductions in market basket updates and DSH funding.

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

In addition, revenues from HMOs, PPOs, insurance companies, employers and other private payors are the result of negotiated rates. These rates may decline based on renegotiations and the respective bargaining power of the parties. In addition, the general trend towards further consolidation among private payors should increase their bargaining power over fee structures. As a result, payors increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk related to paying for care provided. This includes moving away from a percent of charge payment structure to a fixed payment, which typically reduces our reimbursement rate and limits our ability to raise prices going forward. The impact of these changes is magnified by the fact that many individuals and employers have moved to private payor plans. Low cost plans purchased through the healthcare exchanges are also increasingly using narrow and tiered networks that limit beneficiary provider choices, restrict or exclude our facilities or impose significantly higher cost sharing obligations when care is obtained from providers in a disfavored tier.

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

We cannot predict with a great level of precision the effect that the Affordable Care Act and its ongoing implementation may have on our business, financial condition or results of operations.

The Affordable Care Act continues to alter the U.S. healthcare system by decreasing the number of uninsured Americans and through its attempts to reduce the overall cost of healthcare. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, providing additional funding for Medicaid in states that choose to expand their programs, reducing Medicare and Medicaid DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, and instituting certain private health insurance reforms. The Affordable Care Act includes certain reductions in Medicare spending, such as negative adjustments to the hospital inpatient and outpatient prospective payment system market basket updates, the revision of annual inflation updates and other cost-containment measures, including planned payment reductions.

Beginning in 2014, and primarily as a result of the expansion of state Medicaid programs, we experienced an increase in revenues from providing care to certain previously uninsured individuals. While we expect this trend to continue, the future impact and timing of such coverage expansion, and utilization of care by newly-insured individuals, remains difficult to predict and may not offset scheduled decreases in reimbursement. Only ten of the states in which we operate have decided to implement expansions to their Medicaid programs. Accordingly, some low-income persons in other states that are not expanding Medicaid will not have insurance coverage as intended by the Affordable Care Act.

A number of the provisions of the Affordable Care Act that were originally scheduled to have already become effective, such as the employer mandate (for employers with 50 to 99 employees), the Small Business Health Option Program (for employers with 100 or fewer full-time employees), and the Cadillac Tax, were delayed until 2016 or later. Additional delays in the implementation of these or other provisions of the Affordable Care Act could be imposed in the future. We are unable to predict with a high level of precision how providers, payors, employers and other market participants will continue to respond to the various reform provisions because certain provisions are scheduled for implementation over the coming years. Furthermore, several bills have been and may continue to be introduced in Congress to delay, defund or repeal implementation of or amend all significant provisions of the Affordable Care Act, and there is ongoing litigation over the interpretation and implementation of certain provisions of the law. As a result of these factors and numerous other variables, including the law's complexity and the lack of complete implementing regulations and interpretive guidance, we are unable to predict with any certainty the future net effect of the Affordable Care Act on our business, financial condition or results of operations.

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

For financial or strategic reasons, we conduct much of our business through joint ventures. By far the largest of our joint ventures is Duke LifePoint Healthcare, which is owned by the Company and a wholly-controlled affiliate of Duke, and which currently operates fourteen hospital campuses in four states, including recent acquisitions effective January 1, 2016. In recent years, most of our large acquisitions have been conducted through Duke LifePoint Healthcare.

While we own a substantial majority of the equity in Duke LifePoint Healthcare, the long term success of Duke LifePoint Healthcare is dependent on ongoing collaboration and the alignment of our interests with those of Duke. In the event of a material disagreement with Duke or the breach of our joint venture agreement, Duke LifePoint Healthcare may be subject to dissolution, unwinding or purchase of either party's interest, which could have a material adverse effect on our revenues and results of operations. Even if Duke LifePoint Healthcare is not dissolved or unwound, our inability to involve Duke LifePoint Healthcare in our acquisitions and future operations could make it more difficult to source new targets or win competitive bidding processes, and our revenue or earnings growth may be hindered.

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

We may be unable to timely and effectively integrate facilities that we acquire with our ongoing operations and to achieve the anticipated financial results and synergies from such acquisitions, individually or in the aggregate. Many of the facilities we have acquired had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced delays in improving the operating margins or effectively integrating the operations of our acquired facilities and we may experience such delays in implementing operating procedures and systems in newly or future acquired facilities. Integrating an acquired facility could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel.

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

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

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

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

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

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

All participants in the healthcare industry are required to comply with numerous overlapping laws and regulations at the federal, state and local government levels. These laws and regulations require that hospitals meet various requirements, including those relating to relationships with physicians and other referral sources, the adequacy and quality of medical care, inpatient admission criteria, privacy and security of health information, standards for equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, compliance with building codes and environmental protection, among other matters. Many of the laws and regulations applicable to the healthcare industry are complex and may be violated inadvertently, and there are numerous enforcement authorities, including CMS, OIG, the Department of Justice, state attorneys general, and contracted auditors, as well as private plaintiffs. Moreover, the Affordable Care Act created potential False Claims Act liabilities for failing to report and repay identified overpayments within sixty (60) days of identifying the overpayment or the date by which a corresponding cost report is due, whichever is later.

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

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

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

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

The federal False Claims Act prohibits providers from, among other things, knowingly submitting false claims for payment to the federal government. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. We are required to provide information to our employees and certain contractors about state and federal false claims laws and whistleblower provisions and protections. Defendants found to be liable under the federal False Claims Act may be required to pay up to three times the actual damages sustained by the government, plus mandatory civil penalties ranging between $5,500 and $11,000 for each separate false claim, subject to annual increases as set forth in the BBA.

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

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

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

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

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

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

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

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

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

We have significantly increased the number of physicians we employ. We believe that physician employment by acute care hospitals is consistent with industry trends and has become more common as a result of actual and potential reductions in payment amounts for physician services and increasing costs to physicians, such as EHR implementation and professional liability insurance expenses. Employed physicians generally present more direct risks to us than those presented by independent members of our hospitals' medical staffs, as well as require us to incur additional expenses. The potential liabilities and increased expenses could have an adverse effect on our results of operations if current trends continue.

Controls designed to reduce inpatient services may reduce our revenues.

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

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

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

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

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

The primary collection risks associated with our accounts receivable relate to the uninsured patient accounts and patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and co-payments) remain outstanding. The provision for doubtful accounts relates primarily to amounts due directly from patients. While we have experienced a reduction in uninsured patients, the risk of collection from insured patients, and the amounts due, have increased, and will likely continue to increase, as more individuals are enrolled in insurance plans with high deductibles or high co-payments, including those purchased on insurance exchanges. Additionally, plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices. If we provide services when not a participating provider in the network, it can result in higher patient responsibility amounts that a patient may not have the ability to pay or may choose not to pay.

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The amount of our provision for doubtful accounts is based on our assessments of historical collection trends, business and economic conditions, trends in federal and state governmental and private employer health coverage and other collection indicators. If the recent decrease in the uninsured population as a result of the Affordable Care Act does not continue, the proportion of accounts receivable being comprised of uninsured accounts and deterioration in the collectability of these accounts could adversely affect our collections of accounts receivable, results of operations and revenues. In addition, even after full implementation of the Affordable Care Act, we may continue to experience bad debts and be required to provide uninsured discounts and charity care for patients that choose not to purchase coverage, undocumented immigrants who are not permitted to enroll in a health insurance exchange or government healthcare programs and in states that do not expand their Medicaid programs.

The industry emphasis on value-based purchasing may negatively affect our revenues.

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

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

We may have difficulty acquiring hospitals on favorable terms.

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

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

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

In recent years, the legislatures and attorneys general of several states have become more interested in approving the sales of hospitals by tax-exempt entities. This heightened scrutiny may increase the cost and difficulty, or prevent the completion, of transactions with tax-exempt organizations in the future. Our failure to acquire hospitals consistent with our growth plans could prevent us from increasing our revenues.

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

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

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

In addition to these legal requirements, there is competition from other communities and facilities for these physicians, and this competition continues after the physician is practicing in one of our communities. For example, integrated accountable care organizations and other kinds of "narrow" provider networks or organizations may exclude our physicians from their plans' networks of healthcare providers. These contracting networks often organize hospitals, physicians and ancillary healthcare providers into exclusive networks involving a fewer number of healthcare providers. If our affiliated providers are excluded from such networks, we may have difficulty recruiting new providers or retaining existing providers.

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

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

In addition to our physicians, the operations of our hospitals are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians. We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including nurses and other non-physician healthcare professionals. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue and the competition for experienced and talented hospital management personnel is intense. This may result in employee turnover, require us to enhance wages and benefits to recruit and retain management, nurses and other medical support personnel, recruit personnel from foreign countries, and hire more expensive temporary or contract personnel. In addition, the states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. If our labor costs increase, we may not be able to raise rates to offset these increased costs. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs could have a material adverse effect on our revenues or results of operations.

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

Our business depends heavily on effective information systems to process clinical, operational and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and to develop new systems in order to keep pace with continuing changes in information processing technology. We rely on multiple third party providers of financial, clinical, patient accounting and network information services and, as a result, we face operational challenges in maintaining multiple provider platforms and facilitating the interface of such systems with one another. The third party providers may not have appropriate controls to protect confidential information. We do not control the information systems of third party providers, and in some cases we may have difficulty accessing information archived on third party systems, which could subject us to liability for failure to respond to legal or payor information requests. If these systems fail or are interrupted, if our access to these systems is limited in the future or if providers develop systems more appropriate for the urban healthcare market and not suited for our hospitals, our operations could suffer.

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

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

As required by the American Recovery and Reinvestment Act of 2009 ("ARRA"), the HHS has developed and implemented an incentive payment program for eligible hospitals and healthcare professionals that adopt and meaningfully use EHR technology. HHS uses the Provider Enrollment, Chain and Ownership System ("PECOS") to verify Medicare enrollment prior to making EHR incentive program payments. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, including having an enrollment record in PECOS, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. Further, beginning in FFY 2015, eligible hospitals and professionals that fail to demonstrate meaningful use of certified EHR technology will be subject to reduced payments from Medicare. Even if we do meet such requirements, the incentive payments we have received in prior years for EHR implementation are scheduled to be materially reduced over the coming years and to end entirely in 2017. EHR incentive payments that we have previously recognized are subject to audit and potential recoupment if it is determined that we did not meet the applicable meaningful use standards required in connection with such incentive payments.

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

Health plans and providers, including our hospitals, were required to transition to the new ICD-10 coding system by October 1, 2015, which greatly expands the number and detail of billing codes used for inpatient claims. As a result of our implementation of ICD-10, we have made additional investments in technology and training. Although we believe we have made all of the modifications necessary to ensure full compliance with the changes prescribed by ICD-10, we may still be affected by third party implementation difficulties, and experience delays in reimbursement, underpayment for services or possible denials of payments from payors. Further, the transition to the more detailed ICD-10 coding system could cause decreased reimbursement if conditions are reclassified to MS-DRGs or commercial payment groupings with lower levels of reimbursement than the assignments under the previous system. At this early stage of transition, we are not able to predict the overall financial impact that ICD-10 will have on our financial position, results of operations and cash flows.

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

There are numerous federal and state laws and regulations addressing employee, patient and consumer privacy concerns, including unauthorized access to or theft of personal information. In the ordinary course of our business, we, and vendors acting on our behalf, collect and store sensitive data, including individual health data and other personally identifiable information of our patients and employees and such information is often targeted by criminal organizations. The secure processing, maintenance and transmission of this information is critical to our operations and business strategy. We have developed a comprehensive set of policies and procedures in our efforts to comply with HIPAA and other privacy and information security laws. The HHS Office for Civil Rights has imposed civil monetary penalties and corrective action plans on covered entities for violating HIPAA's privacy and security rules. In addition, state attorneys general and private plaintiffs have brought civil actions seeking injunctions and damages in response to violations of HIPAA's privacy and security rules. As cybersecurity threats continue to evolve, we may not be able to anticipate certain attack methods in order to implement effective protective measures, and we may be required to expand significant additional resources to continue to modify and strengthen our security measures, investigate and remediate any vulnerabilities in our information systems and infrastructure, or invest in new technology designed to mitigate security risks. Our networks and technology systems are also subject to disruption due to events such as a major earthquake, fire, telecommunications failure, terrorist attack or other catastrophic event. If, in spite of our security and compliance efforts we or any of our business associates were to experience a breach, loss, or other compromise of such personal health information or other personally identifiable information, such event could disrupt our operations, result in increased data protection costs, damage our reputation, or result in regulatory penalties, legal claims and liability under HIPAA and other state and federal laws, which could have a material adverse effect on our results of operations.

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

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

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

We also face significant and increasing competition from services offered by physicians (including physicians on our medical staffs) in their offices and from other specialized care providers, including outpatient surgery, oncology, physical therapy and diagnostic centers (including many in which physicians may have an ownership interest). Some of our hospitals have and will seek to develop outpatient facilities where necessary to compete effectively. However, to the extent that other providers are successful in developing outpatient facilities or physicians are able to offer additional, advanced services in their offices, our market share for these services will likely decrease in the future.

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

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

- defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals; or
- purchase a high-deductible insurance plan or no insurance at all, which increases a hospital's dependence on self-pay revenue. Moreover, a greater number of uninsured patients may seek care in our emergency rooms.

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

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

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

	Hospital Campuses in State as of December 31, 2015	Revenue Concentration by State					
		2015		2014		2013	
		Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Virginia	6	$ 641.9	12.3 %	$ 624.4	13.9 %	$ 469.2	12.8 %
Kentucky	10	638.5	12.2	587.9	13.1	520.9	14.2
North Carolina	7	580.3	11.1	372.6	8.3	129.6	3.5
Pennsylvania	4	566.5	10.9	172.5	3.8	-	-
Michigan	3	476.2	9.1	460.8	10.3	345.4	9.4
Tennessee	10	420.7	8.1	404.5	9.0	394.9	10.7
New Mexico	2	287.3	5.5	266.5	5.9	256.5	7.0

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

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

As of December 31, 2015, our total debt, excluding unamortized debt issuance costs, discount and premium, was $2,691.0 million. We also have the ability to incur significant amounts of additional indebtedness, subject to the conditions imposed by the terms of the agreements and indentures governing our existing indebtedness or any additional indebtedness that we may incur in the future.

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

- Under our debt agreements, we are required to satisfy and maintain specified financial ratios and tests. Failure to comply with these obligations may cause an event of default which, if not cured or waived, could require us to repay substantial indebtedness immediately. Moreover, if debt repayment is accelerated, we will be subject to higher interest rates on our debt obligations as a result of these covenants, and our credit ratings may be adversely impacted.
- We may be vulnerable in the event of downturns and adverse changes in the general economy or our industry.
- We may have difficulty obtaining additional financing at favorable interest rates to meet our requirements for working capital, capital expenditures, acquisitions, general corporate or other purposes.
- We will be required to dedicate a substantial portion of our cash flow to the payment of principal and interest on indebtedness, which will reduce the amount of funds available for operations, capital expenditures and future acquisitions.
- Any borrowings we incur at variable interest rates generally expose us to increases in interest rates.
- A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. We may be required to pay our indebtedness immediately if we default on any of the numerous financial or other restrictive covenants contained in the debt agreements. It is not certain whether we will have, or will be able to obtain, sufficient funds to make these accelerated payments. If any senior debt is accelerated, our assets may not be sufficient to repay such indebtedness and our other indebtedness.
- In the event of a default, we may be forced to pursue one or more alternative strategies, such as restructuring or refinancing our indebtedness, selling assets, reducing or delaying capital expenditures or seeking additional equity capital. There can be no assurances that any of these strategies could be effected on satisfactory terms, if at all, or that sufficient funds could be obtained to make these accelerated payments.

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

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

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

We may not be able to generate sufficient cash flow through operations or successfully access other capital resources to fund all of our capital expenditure commitments in connection with acquired facilities.

As part of our on-going acquisition strategy, we often commit to making significant capital improvements at acquired facilities over a number of years. At December 31, 2015, we estimated our total remaining unfulfilled capital expenditure commitments to be approximately $1,702.6 million. Please see "Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations - Contractual Obligations, Commitments and Off-Balance Sheet Arrangements*" for more information about the general timing and impact of these contractual obligations.

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

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

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

Some states require prior approval for the purchase, construction and expansion of healthcare facilities, based on the state's determination of need for additional or expanded healthcare facilities or services. In addition, certain states in which we operate hospitals require a certificate of need for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and for certain other planned activities. We may not be able to obtain certificates of need required for expansion activities in the future. In addition, all of the states in which we operate facilities require hospitals and most healthcare providers to maintain one or more licenses. If we fail to obtain any required certificate of need or license, our ability to operate or expand operations in those states could be impaired.

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

Item 1B. ***Unresolved Staff Comments.***

We have no unresolved SEC staff comments.

Item 2. *Properties.*

The following table presents certain information with respect to our hospital campuses as of December 31, 2015:

Hospital	City	Acquisition/Opening/ Lease Date	Licensed Beds	Real Property Status
Alabama				
Andalusia Regional Hospital	Andalusia	May 11, 1999	88	Own
Vaughan Regional Medical Center (a)	Selma	April 15, 2005	175	Own (a)
Arizona				
Havasu Regional Medical Center (b)	Lake Havasu City	April 15, 2005	171	Own (b)
Valley View Medical Center	Fort Mohave	November 8, 2005	90	Own
Colorado				
Colorado Plains Medical Center	Fort Morgan	April 15, 2005	50	Lease
Georgia				
Rockdale Medical Center	Conyers	February 1, 2009	158	Own
Indiana				
Scott Memorial Hospital (c)	Scottsburg	January 1, 2013	25	Own (c)
Clark Memorial Hospital (c)	Jeffersonville	August 1, 2015	236	Own (c)
Kansas				
Western Plains Medical Complex	Dodge City	May 11, 1999	99	Own
Kentucky				
Bluegrass Community Hospital	Versailles	January 2, 2001	25	Own
Bourbon Community Hospital	Paris	May 11, 1999	58	Own
Clark Regional Medical Center	Winchester	May 1, 2010	79	Own
Georgetown Community Hospital	Georgetown	May 11, 1999	75	Own
Jackson Purchase Medical Center	Mayfield	May 11, 1999	107	Own
Lake Cumberland Regional Hospital	Somerset	May 11, 1999	295	Own
Logan Memorial Hospital	Russellville	May 11, 1999	75	Own
Meadowview Regional Medical Center	Maysville	May 11, 1999	100	Own
Spring View Hospital	Lebanon	October 1, 2003	75	Own
Fleming County Hospital	Flemingsburg	August 1, 2015	52	Own
Louisiana				
Mercy Regional Medical Center - Acadian (d)	Eunice	April 15, 2005	42	Own
Mercy Regional Medical Center - Ville Platte (d)	Ville Platte	December 1, 2001	67	Own
Minden Medical Center	Minden	April 15, 2005	161	Own
Teche Regional Medical Center	Morgan City	April 15, 2005	165	Lease
Michigan				
Bell Hospital	Ishpeming	December 1, 2013	25	Own
Marquette General Hospital (e)	Marquette	September 1, 2012	307	Own (e)
Portage Health (a)	Hancock	December 1, 2013	96	Own (a)
Mississippi				
Bolivar Medical Center	Cleveland	April 15, 2005	199	Lease
Nevada				
Northeastern Nevada Regional Hospital	Elko	April 15, 2005	75	Own
New Mexico				
Los Alamos Medical Center	Los Alamos	April 15, 2005	47	Own
Memorial Medical Center of Las Cruces	Las Cruces	April 15, 2005	199	Lease
North Carolina				
Harris Regional Hospital (e)	Sylva	August 1, 2014	86	Own (e)
Haywood Regional Medical Center (e)	Clyde	August 1, 2014	169	Own (e)
Maria Parham Medical Center (f)	Henderson	November 1, 2011	102	Own (f)
Person Memorial Hospital (e)	Roxboro	October 1, 2011	110	Own (e)
Rutherford Regional Medical Center (f)	Rutherfordton	June 1, 2014	143	Own (f)
Swain County Hospital (e)	Bryson City	August 1, 2014	48	Own (e)
Wilson Medical Center (f)	Wilson	March 1, 2014	384	Own (f)
Pennsylvania				
Conemaugh Memorial Medical Center (e)	Johnstown	September 1, 2014	539	Own (e)
Meyersdale Medical Center (e)	Meyersdale	September 1, 2014	20	Own (e)
Miners Medical Center (e)	Hastings	September 1, 2014	30	Own (e)
Nason Medical Center	Roaring Spring	February 1, 2015	45	Own

Hospital	City	Acquisition/Opening/ Lease Date	Licensed Beds	Real Property Status
Tennessee				
Crockett Hospital	Lawrenceburg	May 11, 1999	99	Own
Emerald-Hodgson Hospital	Sewanee	May 11, 1999	41	Own
Hillside Hospital	Pulaski	May 11, 1999	95	Own
Livingston Regional Hospital	Livingston	May 11, 1999	114	Own
Riverview Regional Medical Center	Carthage	September 1, 2010	35	Own
Southern Tennessee Medical Center	Winchester	May 11, 1999	157	Own
Starr Regional Medical Center - Athens (g)	Athens	October 1, 2001	118	Own
Starr Regional Medical Center - Etowah (g)	Etowah	July 1, 2012	160	Own
Sumner Regional Medical Center	Gallatin	September 1, 2010	155	Own
Trousdale Medical Center	Hartsville	September 1, 2010	25	Own
Texas				
Ennis Regional Medical Center	Ennis	April 15, 2005	60	Lease
Palestine Regional Medical Center	Palestine	April 15, 2005	156	Own
Parkview Regional Hospital	Mexia	April 15, 2005	58	Lease
Utah				
Ashley Regional Medical Center	Vernal	May 11, 1999	39	Own
Castleview Hospital	Price	May 11, 1999	49	Own
Virginia				
Clinch Valley Medical Center	Richlands	July 1, 2006	175	Own
Danville Regional Medical Center	Danville	July 1, 2005	250	Own
Fauquier Health (a)	Warrenton	November 1, 2013	210	Own (a)
Memorial Hospital of Martinsville and Henry County	Martinsville	April 15, 2005	220	Own
Twin County Regional Hospital (f)	Galax	April 1, 2012	141	Own (f)
Wythe County Community Hospital	Wytheville	June 1, 2005	100	Lease
West Virginia				
Logan Regional Medical Center	Logan	December 1, 2002	140	Own
Raleigh General Hospital	Beckley	July 1, 2006	300	Own
Wisconsin				
Watertown Regional Medical Center (a)	Watertown	September 1, 2015	95	Own (a)
Wyoming				
SageWest Healthcare - Lander (h)	Lander	July 1, 2000	89	Own
SageWest Healthcare - Riverton (h)	Riverton	May 11, 1999	70	Own
			8,243	

(a) The hospital is owned and operated by a joint venture between us and a local not-for-profit entity. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(b) The hospital is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest. The real property on which the hospital is located is owned by the LifePoint member and leased to the joint venture.
(c) The hospital is owned and operated by RHN, a joint venture between us and Norton Healthcare, Inc. A wholly-owned LifePoint affiliate owns a controlling interest in RHN.
(d) Mercy Regional Medical Center maintains a campus in both Acadian and Ville Platte.
(e) The hospital is owned and operated by Duke LifePoint Healthcare. A wholly-owned LifePoint affiliate owns a controlling interest in Duke LifePoint Healthcare.
(f) The hospital is owned and operated by a joint venture between a local not-for-profit entity and Duke LifePoint Healthcare.
(g) Starr Regional Medical Center maintains a campus in both Athens and Etowah.
(h) SageWest Healthcare maintains a campus in both Lander and Riverton.

We own and operate medical office buildings in conjunction with many of our hospitals. These medical office buildings are primarily occupied by physicians who practice at our hospitals. Additionally, we lease approximately 203,000 square feet of office space in Brentwood, Tennessee for our health support center. All of our facilities are suitable for their respective uses and are generally adequate for our present needs.

Item 3. ***Legal Proceedings.***

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

In addition, hospitals are subject to the regulation and oversight of various state and federal governmental agencies. Further, under the federal False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against hospitals that submit false claims for payments to, or improperly retain overpayments from, governmental payors. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without our knowledge. Although the healthcare industry has seen numerous ongoing investigations related to compliance and billing practices, hospitals, in particular, continue to be a primary enforcement target for the OIG, the DOJ and other governmental fraud and abuse programs. Certain of our individual facilities have received, and from time to time, other facilities may receive, inquiries or subpoenas from fiscal intermediaries, and federal and state agencies. Any proceedings against us may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on our financial position, results of operations and liquidity.

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

In connection with our acquisitions of Marquette General Hospital ("Marquette General") and Conemaugh Health System ("Conemaugh"), the two sellers self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. These self-disclosures are pending with CMS. With respect to Marquette General, to the extent that the seller's satisfaction of its retained liabilities, including those under its CMS voluntary self-disclosure, causes its net proceeds from the acquisition to be less than $15.0 million, we have agreed to pay additional purchase consideration to the seller. With respect to Conemaugh, to the extent that the potential settlement exceeds the seller's indemnification threshold in accordance with the asset purchase agreement, we will likely be responsible for funding any deficit. We believe we have made reasonable estimates of our potential exposure for these two matters, and at December 31, 2015, we have recorded a reserve for Marquette General of $18.0 million.

On September 16, 2013, we and two of our hospitals, Vaughan Regional Medical Center, located in Selma, Alabama, and Raleigh General Hospital, located in Raleigh, West Virginia, made a voluntary self-disclosure to the Civil Division of the DOJ. The voluntary self-disclosure related to concerns regarding the clinical appropriateness of certain interventional cardiology procedures conducted by one physician in each of these hospitals' cardiac catheterization laboratories. On September 24, 2013, the U.S. Attorney's Office in the Southern District of West Virginia served a subpoena on Raleigh General Hospital. Raleigh General Hospital produced responsive documents to the subpoena, including patient files. The government investigations are ongoing and we continue to cooperate with the government in addressing these matters. Following reviews by independent interventional cardiologists, we notified patients of these two physicians who may have received an unnecessary procedure of such fact.

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

Additionally, we, and two of our subsidiaries, including Raleigh General Hospital, as well as Dr. Kenneth Glaser, have been named in 86 individual lawsuits filed in the circuit court of Raleigh County, West Virginia. These lawsuits allege that patients at Raleigh General Hospital received unnecessary interventional cardiology procedures. Through December 31, 2015, one additional patient has notified Raleigh General Hospital that he intends to file a lawsuit against the hospital.

The lawsuits identified above variously seek compensatory and punitive damages, costs, attorneys' fees and other available damages. Additional claims, including claims involving patients to whom we did not send notice, have been threatened and may be asserted against us or the hospital. Any present or future claims that are ultimately successful could result in us and/or the hospitals being found liable and the government investigations may also result in damages, fines and penalties. Such liability, damages and penalties could be material. We cannot, however, reasonably estimate the potential liability, if any, in connection with any of these matters, and no liability has been recorded as of December 31, 2015.

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

Item 4. ***Mine Safety Disclosures.***

Not applicable.

PART II

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

Market Information for Common Stock

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

	High	Low
2016		
First Quarter (through February 11, 2016)	$ 74.70	$ 64.94
2015		
First Quarter	$ 77.84	$ 64.52
Second Quarter	$ 86.99	$ 69.21
Third Quarter	$ 88.18	$ 68.41
Fourth Quarter	$ 76.39	$ 58.61
2014		
First Quarter	$ 56.77	$ 50.18
Second Quarter	$ 66.02	$ 50.51
Third Quarter	$ 76.50	$ 60.04
Fourth Quarter	$ 74.76	$ 62.95

On February 11, 2016, the last reported sales price for our common stock on the NASDAQ Global Select Market was $65.92 per share.

Stockholders

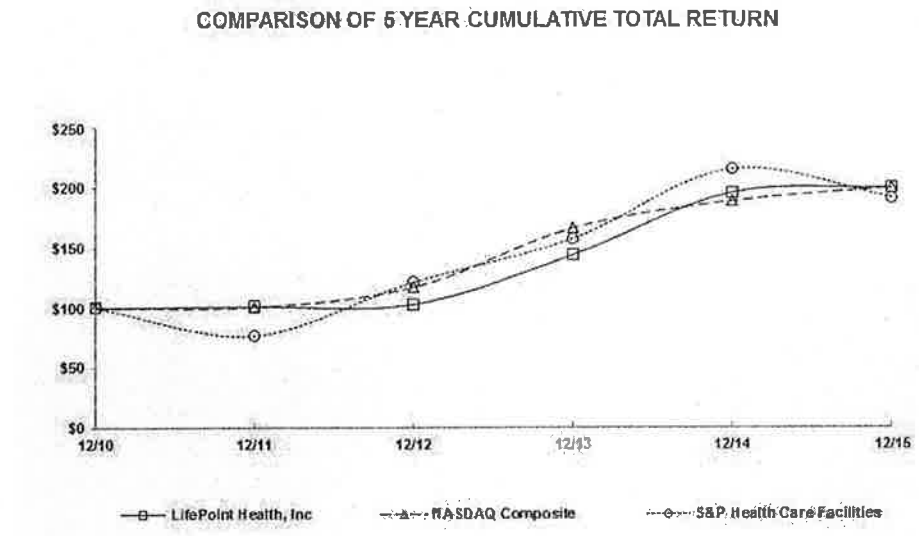
As of February 5, 2016, there were 9,264 holders of record of shares of our common stock.

Dividends

We have never declared or paid cash dividends on our common stock. We intend to retain future earnings to finance the growth and development of our business and, accordingly, do not currently intend to declare or pay any cash dividends on our common stock. Our Board of Directors will evaluate our future earnings, results of operations, financial condition and capital requirements in determining whether to declare or pay cash dividends. Delaware law prohibits us from paying any dividends unless we have capital surplus or net profits available for this purpose. In addition, the senior secured credit agreement with, among others, Citibank, N.A., as administrative agent, and the lenders party thereto (the "Senior Credit Agreement") and certain other indebtedness of the Company impose restrictions on our ability to pay dividends.

Stock Performance

The graph below compares the yearly percentage change of cumulative total stockholder return on our common stock with (a) the cumulative total return of a broad equity market index, the NASDAQ Composite Index (the "Broad Index") and (b) the cumulative total return of a published industry index, the S&P Health Care Facilities (Hospital Management) Index (the "Industry Index"). The graph begins on December 31, 2010, and the comparison assumes the investment of $100 on such date in each of our common stock, the Broad Index and the Industry Index and assumes the reinvestment of all dividends, if any. The table following the graph presents the corresponding data for December 31, 2010, and each subsequent fiscal year end.



	12/10	12/11	12/12	12/13	12/14	12/15
LifePoint Health, Inc.	$ 100.00	$ 101.09	$ 102.72	$ 143.78	$ 195.67	$ 199.73
NASDAQ Composite	$ 100.00	$ 100.53	$ 116.92	$ 166.19	$ 188.78	$ 199.95
S&P Health Care Facilities	$ 100.00	$ 76.68	$ 121.34	$ 157.40	$ 215.51	$ 191.52

Recent Purchases of Equity Securities by the Issuer and Affiliated Purchasers

Our Board of Directors has authorized the repurchase of outstanding shares of our common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other customary factors in accordance with a repurchase plan adopted in 2011, as subsequently amended and extended in February 2013 (the "2011 Repurchase Plan"), a repurchase plan adopted in 2014, as subsequently amended and extended in October 2015 (the "2014 Repurchase Plan") and a repurchase plan adopted on June 3, 2015 (the "2015 Repurchase Plan"). The 2011 Repurchase Plan and 2014 Repurchase Plan provided for the repurchase of up to $350.0 million and $150.0 million in shares of our common stock, respectively, and we have repurchased all shares authorized for repurchase under these plans. The 2015 Repurchase Plan provides for the repurchase of up to $150.0 million in shares of our common stock through December 3, 2016. As of December 31, 2015, we had remaining authority to repurchase approximately $125.0 million in shares in accordance with the 2015 Repurchase Plan. We are not obligated to repurchase any specific number of shares under any of our repurchase plans. We have designated the shares repurchased in accordance with our repurchase plans as treasury stock.

We repurchased approximately 0.5 million shares for an aggregate purchase price, including commissions, of $32.5 million at an average purchase price of $71.43 per share during the three months ended December 31, 2015 in connection with our repurchase plans. Additionally, we redeem shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to our various stockholder-approved stock-based compensation plans. We redeemed a nominal number of shares vested under these plans during the three months ended December 31, 2015. We have designated these shares as treasury stock.

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

The following table summarizes our share repurchase activity by month for the three months ended December 31, 2015:

	Total Number of Shares Purchased	Weighted Average Price Paid per Share	Total Number of Shares Purchased as Part of a Publicly Announced Program	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Program (In millions)
October 1, 2015 to October 31, 2015	36,000	$ 70.03	36,000	$ 155.0
November 1, 2015 to November 30, 2015	165,828	$ 71.18	165,828	$ 143.2
December 1, 2015 to December 31, 2015 (a)	253,882	$ 71.79	253,590	$ 125.0
Total	455,710	$ 71.43	455,418	$ 125.0

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

Item 6. ***Selected Financial Data.***

The table below contains our selected financial data for, or as of the end of, the last five years ended December 31, 2015. The selected financial data is derived from our consolidated financial statements. The timing of acquisitions and divestitures completed during the years presented affects the comparability of the selected financial data. Additionally, we have recognized certain transaction costs in connection with acquisitions as well as certain other non-operating (gains) losses and impairment charges during certain of the periods presented that affected the comparability of the selected financial data. Furthermore, certain balance sheet information has been adjusted to reflect our adoptions of Accounting Standards Update ("ASU") 2015-17, "Income Taxes: Balance Sheet Classification of Deferred Taxes" and ASU 2015-3, "Simplifying the Presentation of Debt Issuance Costs". You should read this table in conjunction with the consolidated financial statements and related notes included elsewhere in this report and in Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations.*

	Years Ended December 31,				
	2015	2014	2013	2012	2011
	(In millions, except per share amounts)				
Statements of Operations Data:					
Revenues	$ 5,214.3	$ 4,483.1	$ 3,678.3	$ 3,391.8	$ 3,026.1
Income from continuing operations attributable to LifePoint Health, Inc. stockholders	181.9	126.1	127.8	151.9	162.7
Income from continuing operations per share:					
Basic	$ 4.14	$ 2.81	$ 2.76	$ 3.22	$ 3.30
Diluted	$ 3.95	$ 2.69	$ 2.68	$ 3.14	$ 3.22
Weighted average shares outstanding:					
Basic	43.9	44.9	46.3	47.2	49.3
Diluted	46.1	46.9	47.6	48.4	50.5
Balance Sheet Data (as of end of year):					
Cash and cash equivalents	$ 284.0	$ 191.5	$ 637.9	$ 85.0	$ 126.2
Working capital	647.3	640.1	390.8	337.9	341.5
Property and equipment, net	2,482.3	2,377.5	2,197.2	2,030.9	1,830.4
Total assets	5,996.8	5,355.3	5,411.8	4,557.8	4,223.9
Total debt, excluding unamortized debt issuance costs, discounts and premium	2,691.0	2,208.6	2,386.3	1,739.3	1,652.8
Total LifePoint Health, Inc. stockholders' equity	2,263.9	2,154.6	2,210.1	2,050.5	1,945.2

	Years Ended December 31,				
	2015	2014	2013	2012	2011
	(In millions, except per share amounts)				
Other Financial Data:					
Adjusted EBITDA (a)	$ 705.7	$ 634.2	$ 537.0	$ 545.6	$ 536.2
Capital expenditures	(274.7)	(207.1)	(185.2)	(221.4)	(219.9)
Cash provided by operating activities - continuing operations	627.1	412.3	354.1	382.9	401.2
Cash used in investing activities	(876.3)	(473.2)	(372.3)	(422.1)	(342.1)
Cash provided by (used in) financing activities	341.7	(385.5)	571.2	(1.3)	(140.6)

(a) We define Adjusted EBITDA as earnings before depreciation and amortization; interest expense, net; impairment charges; other non-operating (gains) losses; provision for income taxes; income from discontinued operations, net of income taxes and net income attributable to noncontrolling interests and redeemable noncontrolling interests. We use Adjusted EBITDA to evaluate our operating performance and as a measure of performance for incentive compensation purposes. Additionally, our credit facility uses Adjusted EBITDA, subject to further permitted adjustments, for certain financial covenants. We believe Adjusted EBITDA is a measure of performance used by some investors, equity analysts and others to make informed investment decisions. In addition, multiples of current or projected Adjusted EBITDA are used to estimate current or prospective enterprise value. Adjusted EBITDA should not be considered as a measure of financial performance in accordance with U.S. generally accepted accounting principles ("GAAP"), and the items excluded from Adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA should not be considered in isolation or as an alternative to net income, cash flows generated by operating, investing or financing activities or other financial statement data presented in the consolidated financial statements as an indicator of financial performance or liquidity. Because Adjusted EBITDA is not a measurement determined in accordance with GAAP and is susceptible to varying calculations, Adjusted EBITDA as presented may not be comparable to other similarly titled measures of other companies.

The following table reconciles Adjusted EBITDA as presented above to net income attributable to LifePoint Health, Inc. for the periods presented (in millions):

	Years Ended December 31,				
	2015	2014	2013	2012	2011
	(In millions, except per share amounts)				
Adjusted EBITDA	$ 705.7	$ 634.2	$ 537.0	$ 545.6	$ 536.2
Less:					
Depreciation and amortization	279.0	250.5	228.2	193.1	165.8
Interest expense, net	114.4	123.0	97.0	100.0	107.1
Impairment charges	13.8	57.7	-	4.0	-
Other non-operating (gains) losses	(4.0)	-	0.3	4.4	-
Provision for income taxes	109.5	68.1	79.3	88.5	97.8
Income from discontinued operations, net of income taxes	-	-	(0.4)	-	(0.2)
Net income attributable to noncontrolling interests and redeemable noncontrolling interests	11.1	8.8	4.4	3.7	2.8
Net income attributable to LifePoint Health, Inc.	$ 181.9	$ 126.1	$ 128.2	$ 151.9	$ 162.9

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

We recommend that you read this discussion together with our consolidated financial statements and related notes included elsewhere in this report. Unless otherwise indicated, all relevant financial and statistical information included herein relates to our continuing operations.

Forward-Looking Statements

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

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

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

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

Overview

We own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. At December 31, 2015, on a consolidated basis, we operated 67 hospital campuses in 21 states throughout the U.S, having a total of 8,243 licensed beds. We generate revenues primarily through patient services offered at our facilities. We generated $5,214.3 million, $4,483.1 million and $3,678.3 million, respectively, in revenues during the years ended December 31, 2015, 2014 and 2013. In 2015, we derived 45.2% of our revenues from the Medicare and Medicaid programs, collectively. Payments made to our facilities pursuant to the Medicare and Medicaid programs for services rendered rarely exceed our costs for such services. As a result, we rely largely on payments made by private or commercial payors, together with certain limited services provided to Medicare recipients, to generate an operating profit. The healthcare industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial payors. This places a premium on efficient operation, the ability to reduce or control costs and the need to leverage the benefits of our organization across all of our facilities.

Competitive and Structural Environment

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

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

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

In addition to competitive concerns, many of our communities are experiencing slow growth, and in some cases, population losses. We believe this trend has occurred mainly as a result of recent challenging economic conditions because the economies in the non-urban communities in which our facilities primarily operate are often dependent on a small number of larger employers, especially manufacturing or other facilities. This causes the economies of our communities to be more sensitive to economic downturns and slower to rebound when the overall U.S. economy improves. In addition, other economic factors, including, potentially, self-rationing of healthcare services, have made it more difficult to increase the number of patients who seek care at many of our facilities.

Business Strategy

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

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

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

Regulatory Environment

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

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

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act") dramatically altered the U.S. Healthcare system and was intended to decrease the number of uninsured individuals and reduce the overall cost of healthcare. It attempts to achieve those goals by expanding coverage of uninsured individuals, reducing Medicare and Medicaid disproportionate share hospital payments, reducing the growth in Medicare program spending, and expanding the use of quality and other performance-based payment methodologies. The net effect of the Affordable Care Act on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, gradual implementation and possible amendment, as well as the uncertainty as to the extent to which states will choose to expand their Medicaid programs and the extent to which individuals will elect coverage. In addition, a number of the provisions of the Affordable Care Act that were originally scheduled to have already become effective, such as the employer mandate (for employers with 50 to 99 employees), the Small Business Health Option Program (for employers with 100 or fewer full-time employees), and the taxes on expensive employee-sponsored health plans, were delayed until 2016 or later, and additional delays in the implementation of these or other provisions of the Affordable Care Act could be imposed in the future. We are also unable to predict with a high level of precision how providers, payors, employers and other market participants will continue to respond to the various reform provisions, and, as a result, we are unable to predict with any certainty the net effect on our business, financial condition or results of operations of the expected increases in insured individuals using our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions of the Affordable Care Act that may affect us. For example, some private insurers may choose not to participate in the healthcare exchanges or may limit their participation through narrow networks and tiered networks that limit beneficiary provider choices or impose significantly higher cost sharing obligations when care is obtained from providers in a disfavored tier. Furthermore, several bills have been and may continue to be introduced in Congress to delay, defund or repeal implementation of or amend significant provisions of the Affordable Care Act, and there is ongoing litigation over the interpretation and implementation of certain provisions of the law. The results of such legal and legislative efforts may impact our business in the future. During 2015, and primarily as a result of the expansion of health insurance coverage, we experienced an increase in revenues from providing care to certain previously uninsured individuals. Although we expect this trend to continue, the future impact and timing of such expansion remains difficult to predict for the reasons discussed above, will be gradual and may not offset scheduled decreases in reimbursement.

Revenue Sources

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

Medicare and Medicaid Reimbursement

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

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

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Medicaid programs are funded by both the federal government and state governments to provide healthcare benefits to certain low income individuals and groups. Many states in which we operate are facing budgetary challenges and have adopted, or may be considering, legislation that is intended to control or reduce Medicaid expenditures, enroll Medicaid recipients in managed care programs, and/or impose additional taxes on hospitals to help finance or expand their Medicaid programs. In addition, as of December 31, 2015, only nine of the states in which we operate are currently implementing expansions to their Medicaid programs. Given the reduced federal financing of expanded Medicaid programs that takes effect in 2017, we are unable to predict how many, if any, additional states in which we operate will expand their Medicaid programs or how many, if any, of the states in which we operate that have expanded their Medicaid programs will keep their expansions in place in the future.

Physician Services

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

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

HMOs, PPOs, and Other Private Insurers

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

Self-pay Patients

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

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

Adoption of Electronic Health Records

The HITECH Act was enacted into law on February 17, 2009 as part of ARRA. The HITECH Act includes provisions designed to increase the use of EHR by both physicians and hospitals. EHR meaningful use objectives and measures that hospitals and physicians must meet in order to qualify for incentive payments will be implemented in three stages. Stage 1 has been in effect since 2011; however, on September 4, 2012, HHS released final requirements for Stage 2, which took effect on October 1, 2013. In 2015, HHS finalized the requirements for Stage 3 and made modifications to EHR incentive programs for the years 2015 through 2017. Additional changes to the EHR incentive programs will likely be required as the provisions of MACRA are implemented. We strive to comply with the EHR meaningful use requirements of the HITECH Act in time to qualify for the maximum available incentive payments. Our compliance has and will continue to result in significant costs including business process changes, professional services focused on successfully designing and implementing our EHR solutions along with costs associated with the hardware and software components of the project. As we complete our full implementation of certified EHR technology in accordance with all three phases of the program, our EHR incentive payments will decline and ultimately end. We currently estimate that at a minimum total costs incurred to comply will be recovered through the total EHR incentive payments over the projected lifecycle of this initiative.

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

Results of Operations

The following definitions apply throughout the remaining portion of *Management's Discussion and Analysis of Financial Condition and Results of Operations*. Additionally, unless noted otherwise, discussions throughout the remaining portion of *Management's Discussion and Analysis of Financial Condition and Results of Operations* relate to the Company's continuing operations.

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

bps. Basis points.

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

Continuing operations. Continuing operations information includes the results of our health support center, our same-hospital operations and the results of our recent acquisitions. Additionally, continuing operations information includes the results of our hospitals that were disposed during the years ended December 31, 2015 and 2014, but excludes the results of our hospitals that were disposed prior to the adoption of ASU 2014-8, "Presentation of Financial Statements and Property, Plant, and Equipment - Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity".

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

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

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

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

N/A. Not applicable.

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

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

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

Same-hospital. Same-hospital information includes the results of our health support center and the same 63 hospitals operated during the three months ended December 31, 2015 and 2014, and the same 55 hospitals operated during the years ended December 31, 2015 and 2014. Same-hospital information excludes our hospitals that have previously been disposed.

For the Three Months Ended December 31, 2015 and 2014

Operating Results Summary

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

	Three Months Ended December 31,			
	2015		2014	
	Amount	% of Revenues	Amount	% of Revenues
Revenues before provision for doubtful accounts	$ 1,570.7	114.6 %	$ 1,483.7	117.5 %
Provision for doubtful accounts	200.0	14.6	220.8	17.5
Revenues	1,370.7	100.0	1,262.9	100.0
Salaries and benefits	652.7	47.6	612.4	48.5
Supplies	218.4	15.9	199.0	15.8
Other operating expenses	330.9	24.2	299.9	23.7
Other income	(15.5)	(1.1)	(22.4)	(1.8)
Depreciation and amortization	71.9	5.2	59.7	4.8
Interest expense, net	29.7	2.2	29.2	2.3
Impairment charges	-	-	45.5	3.6
Other non-operating gain	(4.0)	(0.3)	-	-
	1,284.1	93.7	1,223.3	96.9
Income before income taxes	86.6	6.3	39.6	3.1
Provision for income taxes	31.2	2.3	12.9	1.0
Net income	55.4	4.0	26.7	2.1
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(2.4)	(0.1)	(4.3)	(0.3)
Net income attributable to LifePoint Health, Inc.	$ 53.0	3.9 %	$ 22.4	1.8 %

Revenues

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

	Three Months Ended December 31,		Increase (Decrease)	% Increase (Decrease)
	2015	2014		
Consolidated:				
Revenues before provision for doubtful accounts	$ 1,570.7	$ 1,483.7	$ 87.0	5.9 %
Provision for doubtful accounts	200.0	220.8	(20.8)	(9.4)
Revenues	$ 1,370.7	$ 1,262.9	$ 107.8	8.5
Same-hospital:				
Revenues before provision for doubtful accounts	$ 1,483.3	$ 1,436.0	$ 47.3	3.3 %
Provision for doubtful accounts	193.7	203.5	(9.8)	(4.8)
Revenues	$ 1,289.6	$ 1,232.5	$ 57.1	4.6

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

	Three Months Ended December 31,			
	2015		2014	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 380.0	27.7 %	$ 357.9	28.3 %
Medicaid	216.6	15.8	168.1	13.3
HMOs, PPOs and other private insurers	746.6	54.5	731.5	58.0
Self-pay	196.8	14.4	197.5	15.6
Other	30.7	2.2	28.7	2.3
Revenues before provision for doubtful accounts	1,570.7	114.6	1,483.7	117.5
Provision for doubtful accounts	(200.0)	(14.6)	(220.8)	(17.5)
Revenues	$ 1,370.7	100.0 %	$ 1,262.9	100.0 %

Our revenues per equivalent admission on a consolidated and same-hospital basis were as follows for the three months ended December 31, 2015 and 2014:

	Three Months Ended December 31,			
	2015	2014	Increase	% Increase
Revenues per equivalent admission - consolidated	$ 8,715	$ 8,226	$ 489	5.9
Revenues per equivalent admission - same-hospital	$ 8,803	$ 8,323	$ 480	5.8

Revenues Before Provision for Doubtful Accounts

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

	Three Months Ended December 31,		Increase (Decrease)	% Increase (Decrease)
	2015	2014		
Consolidated:				
Admissions	59,219	60,252	(1,033)	(1.7)
Equivalent admissions	157,280	153,538	3,742	2.4
Medicare case mix index	1.47	1.38	0.09	6.5
Average length of stay (days)	4.9	4.9	-	-
Inpatient surgeries	16,635	16,012	623	3.9
Outpatient surgeries	63,013	59,775	3,238	5.4
Total surgeries	79,648	75,787	3,861	5.1
Emergency room visits	371,508	378,643	(7,135)	(1.9)
Outpatient factor	2.65	2.55	0.10	4.0
Same-hospital:				
Admissions	55,363	57,802	(2,439)	(4.2)
Equivalent admissions	146,490	148,089	(1,599)	(1.1)
Medicare case mix index	1.47	1.39	0.08	5.8
Average length of stay (days)	5.0	5.0	-	-
Inpatient surgeries	15,379	15,529	(150)	(1.0)
Outpatient surgeries	58,199	58,169	30	0.1
Total surgeries	73,578	73,698	(120)	(0.2)
Emergency room visits	353,084	359,436	(6,352)	(1.8)
Outpatient factor	2.65	2.56	0.09	3.3

For the three months ended December 31, 2015, our same-hospital revenues before provision for doubtful accounts increased $47.3 million, or 3.3%, to $1,483.3 million as compared to $1,436.0 million for the same period last year. This increase was primarily driven by a 5.8% increase in our same-hospital revenues per equivalent admission as a result of higher contracted rates from HMOs, PPOs and other private insurers as well as case mix improvements. This increase was partially offset by a 1.1% decrease in same-hospital equivalent admissions for the three months ended December 31, 2015 as compared to the same period last year, primarily as a result of a 1.8% decrease in emergency room visits and a 0.2% decrease in total surgeries. The decrease in our same-hospital total surgeries was primarily attributable to declines in certain low acuity inpatient surgeries.

Provision for Doubtful Accounts

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

	Three Months Ended December 31,							
	2015	% of Revenues	2014	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Consolidated:						
Related key indicators:						
Charity care write-offs	$ 22.1	1.6 %	$ 14.6	1.2 %	$ 7.5	51.2 %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 196.8	14.4 %	$ 197.5	15.6 %	$ (0.7)	(0.4) %
Net revenue days outstanding (at end of period)	51.3	N/A	56.4	N/A	(5.1)	(9.0) %
Same-hospital:						
Related key indicators:						
Charity care write-offs	$ 20.7	1.6 %	$ 13.8	1.1 %	$ 6.9	49.8 %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 189.0	14.7 %	$ 184.1	14.9 %	$ 4.9	2.7 %
Net revenue days outstanding (at end of period)	51.2	N/A	56.7	N/A	(5.5)	(9.7) %

Our provision for doubtful accounts relates principally to amounts due from patients included in our self-pay population and other amounts such as co-payments and deductibles due from patients included in other payor categories. For the three months ended December 31, 2015, our provision for doubtful accounts decreased by $20.8 million, or 9.4%, to $200.0 million on a consolidated basis and by $9.8 million, or 4.8%, to $193.7 million on a same-hospital basis as compared to the same period last year. These decreases in our provision for doubtful accounts, on both a consolidated and same-hospital basis, are generally reflective of an improvement in the amount and timing of cash collections, including recoveries of amounts that were previously fully reserved. Additionally, on a consolidated basis, for the three months ended December 31, 2015, our results were further benefited from the successful obtainment of provider numbers for the Medicare and Medicaid programs at certain of our recently acquired facilities when compared to the same period last year. Improvements in our accounts receivable are reflected in the reduction to our net revenue days outstanding. Specifically, our net revenue days outstanding at December 31, 2015 improved to 51.3 days compared to 56.4 days at December 31, 2014 on a consolidated basis. On a same-hospital basis, our net revenue days outstanding at December 31, 2015 improved to 51.2 days compared to 56.7 days at December 31, 2014.

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

Expenses and Other Income

Salaries and Benefits

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

	Three Months Ended December 31,					
	2015	% of Revenues	2014	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 652.7	47.6 %	$ 612.4	48.5 %	$ 40.3	6.6 %
Man-hours per equivalent admission	114	N/A	109	N/A	5	4.6 %
Salaries and benefits per equivalent admission	$ 4,150	N/A	$ 4,036	N/A	$ 114	2.8 %

For the three months ended December 31, 2015, our salaries and benefits expense increased to $652.7 million, or 6.6%, as compared to $612.4 million for the same period last year primarily as a result of our recent acquisitions and the impact of an increasing number of employed physicians and their related support staff.

Supplies

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

	Three Months Ended December 31,					
	2015	% of Revenues	2014	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 218.4	15.9 %	$ 199.0	15.8 %	$ 19.4	9.7 %
Supplies per equivalent admission	$ 1,389	N/A	$ 1,295	N/A	$ 94	7.3 %

For the three months ended December 31, 2015, our supplies expense increased to $218.4 million, or 9.7%, as compared to $199.0 million for the same period last year primarily as a result of our recent acquisitions as well as an increase in our same-hospital supplies per equivalent admission as a result of a higher utilization of more expensive supplies in areas such as orthopedics and cancer-related drugs.

Other Operating Expenses

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

	Three Months Ended December 31,					
	2015	% of Revenues	2014	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Professional fees	$ 55.0	4.0 %	$ 45.0	3.6 %	$ 10.0	22.2 %
Utilities	23.3	1.7	22.9	1.8	0.4	1.8
Repairs and maintenance	37.7	2.8	35.1	2.8	2.6	7.3
Rents and leases	13.5	1.0	14.0	1.1	(0.5)	(3.1)
Insurance	13.8	1.0	13.6	1.1	0.2	1.8
Physician recruiting	4.0	0.3	4.9	0.4	(0.9)	(18.2)
Contract services	103.0	7.5	88.1	7.0	14.9	16.8
Non-income taxes	35.2	2.6	34.3	2.7	0.9	2.7
Other	45.4	3.3	42.0	3.2	3.4	7.9
	$ 330.9	24.2	$ 299.9	23.7	$ 31.0	10.3 %

For the three months ended December 31, 2015, our other operating expenses increased to $330.9 million, or 10.3%, as compared to $299.9 million for the same period last year primarily as a result of our recent acquisitions as well as an increase in our same-hospital professional fees and contract services. As a result of a continued shortage of physicians in many of our communities, we have experienced increasing professional fees in areas such as anesthesiology and hospitalists. Additionally, our same-hospital contract services expenses have increased primarily as a result of higher business office collection efforts as a result of an increase in our same-hospital revenues as well as additional contract services associated with an increasing number of employed physicians.

Other Income

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income in accordance with Accounting Standards Codification ("ASC") 450-30, "Gain Contingencies" ("ASC 450-30") when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the three months ended December 31, 2015, we recognized $15.5 million in Medicare and Medicaid EHR incentive payments, collectively, as compared to $22.4 million recognized in the same period last year.

Depreciation and Amortization

For the three months ended December 31, 2015, our depreciation and amortization expense increased by $12.2 million, or 20.4%, to $71.9 million, or 5.2% of revenues, as compared to $59.7 million, or 4.8% of revenues for the same period last year. Our depreciation and amortization expense increased primarily as a result of our recent acquisitions as well as a result of significant increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. Accordingly, we anticipate that our depreciation and amortization expense will continue to increase in future periods as a result of these factors in addition to the impact of capital expenditure commitments associated with our recent acquisitions.

Interest Expense

For the three months ended December 31, 2015, our interest expense increased by $0.5 million, or 2.1%, to $29.7 million as compared to $29.2 million for the same period last year. The increase in our interest expense is primarily attributable to an increase in our weighted average total debt outstanding during the three months ended December 31, 2015 as compared to the same period last year. On December 4, 2015, we issued in a public offering $500.0 million of 5.875% unsecured senior notes due December 1, 2023 (the "5.875% Senior Notes") with The Bank of New York Mellon Trust Company, N.A., as trustee. For a further discussion of our debt and corresponding interest rates, see "Liquidity and Capital Resources — Debt."

Impairment Charges

In connection with the sale of substantially all of the assets of Lakeland Community Hospital ("Lakeland"), Northwest Medical Center ("Northwest") and Russellville Hospital ("Russellville") located throughout northwest Alabama, effective January 1, 2015, we recognized impairment charges in the aggregate of $45.5 million, $28.1 million net of income taxes, or $0.60 loss per diluted share, during the three months ended December 31, 2014. The impairment charges include the write-down of property, equipment, allocated goodwill and certain other assets to their estimated fair values.

Other Non-Operating Gain

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

Provision for Income Taxes

Our provision for income taxes was $31.2 million, or 2.3% of revenues, for the three months ended December 31, 2015, as compared to $12.9 million, or 1.0% of revenues, for the same period last year. The effective tax rate increased to 37.1% for the three months ended December 31, 2015, compared to 36.6% for the same period last year. Our effective tax rate was lower for the three months ended December 31, 2014 primarily due to the reversal of accrued interest as a result of the favorable resolution of a previously open tax matter following the conclusion of an IRS examination.

For the Years Ended December 31, 2015 and 2014

Operating Results Summary

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

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

Revenues

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

	Years Ended December 31,		Increase	% Increase
	2015	2014	(Decrease)	(Decrease)
Consolidated:				
Revenues before provision for doubtful accounts	$ 6,014.4	$ 5,300.9	$ 713.5	13.5 %
Provision for doubtful accounts	800.1	817.8	(17.7)	(2.2)
Revenues	$ 5,214.3	$ 4,483.1	$ 731.2	16.3
Same-hospital:				
Revenues before provision for doubtful accounts	$ 4,747.4	$ 4,614.1	$ 133.3	2.9 %
Provision for doubtful accounts	666.7	692.2	(25.5)	(3.7)
Revenues	$ 4,080.7	$ 3,921.9	$ 158.8	4.0

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

	Years Ended December 31,			
	2015		2014	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 1,515.0	29.1 %	$ 1,361.4	30.4 %
Medicaid	841.6	16.1	619.8	13.8
HMOs, PPOs and other private insurers	2,791.9	53.5	2,476.7	55.2
Self-pay	744.1	14.3	744.9	16.6
Other	121.8	2.3	98.1	2.2
Revenues before provision for doubtful accounts	6,014.4	115.3	5,300.9	118.2
Provision for doubtful accounts	(800.1)	(15.3)	(817.8)	(18.2)
Revenues	$ 5,214.3	100.0 %	$ 4,483.1	100.0 %

Our revenues per equivalent admission on a consolidated and same-hospital basis were as follows for the years ended December 31, 2015 and 2014:

	Years Ended December 31,			
	2015	2014	Increase	% Increase
Revenues per equivalent admission - consolidated	$ 8,445	$ 8,145	$ 300	3.7
Revenues per equivalent admission - same-hospital	$ 8,515	$ 8,286	$ 229	2.8

Revenues Before Provision for Doubtful Accounts

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

	Years Ended December 31,		Increase (Decrease)	% Increase (Decrease)
	2015	2014		
Consolidated:				
Admissions	236,474	221,587	14,887	6.7
Equivalent admissions	617,434	550,422	67,012	12.2
Medicare case mix index	1.43	1.38	0.05	3.6
Average length of stay (days)	4.9	4.9	-	-
Inpatient surgeries	65,432	59,231	6,201	10.5
Outpatient surgeries	243,820	214,130	29,690	13.9
Total surgeries	309,252	273,361	35,891	13.1
Emergency room visits	1,477,113	1,363,459	113,654	8.3
Outpatient factor	2.61	2.48	0.13	5.2
Same-hospital:				
Admissions	184,191	190,859	(6,668)	(3.5)
Equivalent admissions	479,265	473,330	5,935	1.3
Medicare case mix index	1.43	1.39	0.04	2.9
Average length of stay (days)	4.9	4.8	0.1	2.1
Inpatient surgeries	49,351	51,348	(1,997)	(3.9)
Outpatient surgeries	192,480	189,310	3,170	1.7
Total surgeries	241,831	240,658	1,173	0.5
Emergency room visits	1,208,488	1,171,697	36,791	3.1
Outpatient factor	2.60	2.48	0.12	4.9

For the year ended December 31, 2015, our same-hospital revenues before provision for doubtful accounts increased $133.3 million, or 2.9%, to $4,747.4 million as compared to $4,614.1 million last year. This increase was primarily driven by increases in our same-hospital equivalent admissions as well as higher contracted rates from HMOs, PPOs and other private insurers. For the year ended December 31, 2015, our same-hospital equivalent admissions increased 1.3% as compared to the prior year, primarily as a result of a 3.1% increase in emergency room visits and a 0.5% increase in total surgeries. Additionally, our same-hospital revenues per equivalent admission increased 2.8% as compared to the prior year.

Provision for Doubtful Accounts

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

	Years Ended December 31,					
	2015	% of Revenues	2014	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Consolidated:						
Related key indicators:						
Charity care write-offs	$ 89.3	1.7 %	$ 80.9	1.8 %	$ 8.4	10.4 %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 744.1	14.3 %	$ 744.9	16.6 %	$ (0.8)	(0.1) %
Net revenue days outstanding (at end of period)	51.3	N/A	56.4	N/A	(5.1)	(9.0) %
Same-hospital:						
Related key indicators:						
Charity care write-offs	$ 55.5	1.4 %	$ 68.2	1.7 %	$ (12.7)	(18.6) %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 637.6	15.6 %	$ 620.9	15.8 %	$ 16.7	2.7 %
Net revenue days outstanding (at end of period)	51.2	N/A	56.7	N/A	(5.5)	(9.7) %

Our provision for doubtful accounts relates principally to amounts due from patients included in our self-pay population and other amounts such as co-payments and deductibles due from patients included in other payor categories. For the year ended December 31, 2015, our provision for doubtful accounts decreased by $17.7 million, or 2.2%, to $800.1 million on a consolidated basis and by $25.5 million, or 3.7%, to $666.7 million on a same-hospital basis as compared to the prior year. These decreases in our provision for doubtful accounts, on both a consolidated and same-hospital basis, are generally reflective of an improvement in the amount and timing of cash collections, including recoveries of amounts that were previously fully reserved. Additionally, on a consolidated basis, for the year ended December 31, 2015, our results were further benefited from the successful obtainment of provider numbers for the Medicare and Medicaid programs at certain of our recently acquired facilities when compared to the prior year. Improvements in our accounts receivable are reflected in the reduction to our net revenue days outstanding. Specifically, our net revenue days outstanding at December 31, 2015 improved to 51.3 days compared to 56.4 days at December 31, 2014 on a consolidated basis. On a same-hospital basis, our net revenue days outstanding at December 31, 2015 improved to 51.2 days compared to 56.7 days at December 31, 2014.

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

Expenses and Other Income

Salaries and Benefits

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

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

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

Supplies

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

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

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

Other Operating Expenses

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

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

For the year ended December 31, 2015, our other operating expenses increased to $1,246.4 million, or 14.6%, as compared to $1,087.3 million for the prior year primarily as a result of our recent acquisitions, and to a lesser extent, as a result of moderate increases in our same-hospital professional fees and contract services. As a result of a continued shortage of physicians in many of our communities, we have experienced increasing professional fees in areas such as anesthesiology, emergency room physician coverage and hospitalists. Additionally, our same-hospital contract services expenses have increased primarily as a result of higher business office collection efforts as a result of an increase in our same-hospital revenues as well as additional contract services associated with an increasing number of employed physicians.

Other Income

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

Depreciation and Amortization

For the year ended December 31, 2015, our depreciation and amortization expense increased by $28.5 million, or 11.4% to $279.0 million, or 5.3% of revenues, as compared to $250.5 million, or 5.6% of revenues for the prior year. Our depreciation and amortization expense increased primarily as a result of our recent acquisitions as well as a result of increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. Accordingly, we anticipate that our depreciation and amortization expense will continue to increase in future periods as a result of these factors in addition to the impact of capital expenditure commitments associated with our recent acquisitions.

Interest Expense

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

Impairment Charges

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

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

Other Non-Operating Gain

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

Provision for Income Taxes

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

For the Years Ended December 31, 2014 and 2013

Operating Results Summary

The following table summarizes the results of operations for the years ended December 31, 2014 and 2013 (dollars in millions):

	Years Ended December 31,			
	2014		2013	
	Amount	% of Revenues	Amount	% of Revenues
Revenues before provision for doubtful accounts	$ 5,300.9	118.2 %	$ 4,428.7	120.4 %
Provision for doubtful accounts	817.8	18.2	750.4	20.4
Revenues	4,483.1	100.0	3,678.3	100.0
Salaries and benefits	2,134.5	47.6	1,727.4	47.0
Supplies	699.0	15.6	577.1	15.7
Other operating expenses	1,087.3	24.3	900.9	24.4
Other income	(71.9)	(1.6)	(64.1)	(1.7)
Depreciation and amortization	250.5	5.6	228.2	6.2
Interest expense, net	123.0	2.7	97.0	2.6
Impairment charges	57.7	1.3	-	-
Other non-operating loss, net	-	-	0.3	-
	4,280.1	95.5	3,466.8	94.2
Income from continuing operations before income taxes	203.0	4.5	211.5	5.8
Provision for income taxes	68.1	1.5	79.3	2.2
Income from continuing operations	134.9	3.0	132.2	3.6
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(8.8)	(0.2)	(4.4)	(0.1)
Income from continuing operations attributable to LifePoint Health, Inc.	$ 126.1	2.8 %	$ 127.8	3.5 %

Revenues

The following table presents the components of revenues for the years ended December 31, 2014 and 2013 (dollars in millions):

	Years Ended December 31,			
	2014	2013	Increase	% Increase
Revenues before provision for doubtful accounts	$ 5,300.9	$ 4,428.7	$ 872.2	19.7 %
Provision for doubtful accounts	817.8	750.4	67.4	9.0
Revenues	$ 4,483.1	$ 3,678.3	$ 804.8	21.9

The following table shows the sources of our revenues by payor, including adjustments to estimated reimbursement amounts and provision for doubtful accounts, for the years ended December 31, 2014 and 2013 (dollars in millions):

	Years Ended December 31,			
	2014		2013	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 1,361.4	30.4 %	$ 1,199.5	32.6 %
Medicaid	619.8	13.8	517.0	14.1
HMOs, PPOs and other private insurers	2,476.7	55.2	1,876.1	51.0
Self-pay	744.9	16.6	766.5	20.8
Other	98.1	2.2	69.6	1.9
Revenues before provision for doubtful accounts	5,300.9	118.2	4,428.7	120.4
Provision for doubtful accounts	(817.8)	(18.2)	(750.4)	(20.4)
Revenues	$ 4,483.1	100.0 %	$ 3,678.3	100.0 %

Our revenues per equivalent admission were as follows for the years ended December 31, 2014 and 2013:

	Years Ended December 31,			
	2014	2013	Increase	% Increase
Revenues per equivalent admission	$ 8,145	$ 7,852	$ 293	3.7

Revenues Before Provision for Doubtful Accounts

The following table shows the key drivers of our revenues before provision for doubtful accounts for the years ended December 31, 2014 and 2013:

	Years Ended December 31,			
	2014	2013	Increase	% Increase
Admissions	221,587	199,252	22,335	11.2
Equivalent admissions	550,422	468,441	81,981	17.5
Medicare case mix index	1.38	1.37	0.01	0.7
Average length of stay (days)	4.9	4.6	0.3	6.5
Inpatient surgeries	59,231	53,306	5,925	11.1
Outpatient surgeries	214,130	183,311	30,819	16.8
Total surgeries	273,361	236,617	36,744	15.5
Emergency room visits	1,363,459	1,171,537	191,922	16.4
Outpatient factor	2.48	2.35	0.13	5.7

For the year ended December 31, 2014, our revenues before provision for doubtful accounts increased by $872.2 million, or 19.7%, to $5,300.9 million on a continuing operations basis, as compared to $4,428.7 million for the prior year. This increase was primarily attributable to our acquisitions completed in 2014 and 2013 in addition to growth in our same-hospital equivalent admissions, higher contracted rates from HMOs, PPOs and other private insurers as well as the favorable impact of healthcare reform. Additionally, we experienced a payor mix shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate.

Provision for Doubtful Accounts

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts for the years ended December 31, 2014 and 2013 (dollars in millions):

	Years Ended December 31,					
	2014	% of Revenues	2013	% of Revenues	Decrease	% Decrease
Related key indicators:						
Charity care write-offs	$ 80.9	1.8 %	$ 132.1	3.6 %	$ (51.2)	(38.8) %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 744.9	16.6 %	$ 766.5	20.8 %	$ (21.6)	(2.8) %
Net revenue days outstanding (at end of period)	56.4	N/A	59.1	N/A	(2.7)	(4.6) %

Our provision for doubtful accounts relates principally to amounts due from patients included in our self-pay population and other amounts such as co-payments and deductibles due from patients included in other payor categories. For the year ended December 31, 2014, our provision for doubtful accounts increased by $67.4 million, or 9.0%, to $817.8 million on a continuing operations basis, as compared to $750.4 million for the prior year. This increase was primarily a result of our acquisitions completed in 2014 and 2013, partially offset by a decrease in same-hospital self-pay revenues as compared to the prior year. The decrease in same-hospital self-pay revenues was primarily due to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. However, as patient financial responsibility continued to increase with higher co-payment and deductible obligations, our provision for doubtful accounts increased to reflect the difficulty in collecting these amounts.

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

Expenses and Other Income

Salaries and Benefits

The following table summarizes our salaries and benefits, man-hours per equivalent admission and salaries and benefits per equivalent admission for the years ended December 31, 2014 and 2013:

	Years Ended December 31,					
	2014	% of Revenues	2013	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 2,134.5	47.6 %	$ 1,727.4	47.0 %	$ 407.1	23.6 %
Man-hours per equivalent admission	108	N/A	107	N/A	1	0.9 %
Salaries and benefits per equivalent admission	$ 3,870	N/A	$ 3,683	N/A	$ 187	5.1 %

For the year ended December 31, 2014, our salaries and benefits expense increased to $2,134.5 million, or 23.6%, as compared to $1,727.4 million for the prior year primarily as a result of our acquisitions completed in 2014 and 2013 and the impact of an increasing number of employed physicians and their related support staff.

Supplies

The following table summarizes our supplies and supplies per equivalent admission for the years ended December 31, 2014 and 2013:

	Years Ended December 31,					
	2014	% of Revenues	2013	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 699.0	15.6 %	$ 577.1	15.7 %	$ 121.9	21.1 %
Supplies per equivalent admission	$ 1,270	N/A	$ 1,232	N/A	$ 38	3.1 %

For the year ended December 31, 2014, our supplies expense increased to $699.0 million, or 21.1%, as compared to $577.1 million for the prior year primarily a result of our acquisitions completed in 2014 and 2013.

Other Operating Expenses

The following table summarizes our other operating expenses for the years ended December 31, 2014 and 2013 (dollars in millions):

	Years Ended December 31,					
	2014	% of Revenues	2013	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Professional fees	$ 161.1	3.6 %	$ 142.5	3.9 %	$ 18.6	13.0 %
Utilities	87.7	2.0	70.4	1.9	17.3	24.6
Repairs and maintenance	122.4	2.7	97.6	2.7	24.8	25.4
Rents and leases	45.4	1.0	36.5	1.0	8.9	24.3
Insurance	50.6	1.1	40.4	1.1	10.2	25.0
Physician recruiting	22.9	0.5	26.4	0.7	(3.5)	(13.3)
Contract services	319.7	7.1	256.4	7.0	63.3	24.7
Non-income taxes	124.2	2.8	102.0	2.8	22.2	21.8
Other	153.3	3.5	128.7	3.3	24.6	19.2
	$ 1,087.3	24.3	$ 900.9	24.4	$ 186.4	20.7 %

For the year ended December 31, 2014, our other operating expenses increased to $1,087.3 million, or 20.7%, as compared to $900.9 million for the prior year primarily as a result of our acquisitions completed in 2014 and 2013. Additionally, our same-hospital other operating expenses increased primarily as a result of increases in same-hospital contract services and other expenses. Our same-hospital contract services expense increased primarily as a result of increased fees and expenses related to the completion of our shared centralized resource initiatives at the majority of our hospitals. Our same-hospital other expenses increased as a result of additional transactional expenses related to our acquisitions completed in 2014 and 2013, including legal and consulting fees.

Other Income

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income in accordance with ASC 450-30 when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the year ended December 31, 2014, we recognized $71.9 million in Medicare and Medicaid EHR incentive payments, collectively, as compared to $64.1 million recognized in the prior year.

Depreciation and Amortization

For the year ended December 31, 2014, our depreciation and amortization expense increased by $22.3 million, or 9.8% to $250.5 million, or 5.6% of revenues, as compared to $228.2 million, or 6.2% of revenues for the prior year. Our depreciation and amortization expense increased primarily as a result of our acquisitions completed in 2014 and 2013 as well as a result of significant increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act.

Interest Expense

Our interest expense increased by $26.0 million, or 26.7%, to $123.0 million, for the year ended December 31, 2014, as compared to $97.0 million for the prior year. The increase in our interest expense is primarily attributable to an increase in our total debt outstanding during the year ended December 31, 2014 as compared to the prior year. On December 6, 2013, we issued in a private placement $700.0 million of 5.5% unsecured senior notes due December 1, 2021 (the "5.5% Senior Notes") with The Bank of New York Mellon Trust Company, N.A., as trustee. The net proceeds from this issuance were partially used to repay $100.0 million of our senior secured incremental term loans (the "Incremental Term Loans"). Subsequently, on May 12, 2014, we issued $400.0 million of additional 5.5% Senior Notes with terms substantially identical to those of the initial offering. The additional notes were issued at a premium of $12.0 million for total net proceeds from the issuance of $412.0 million which were used to fund, in part, the cash-settled portion of the maturity or conversion of our outstanding 3½% convertible senior subordinated notes due May 15, 2014 (the "3½% Notes"). For a further discussion of our debt and corresponding interest rates, see "Liquidity and Capital Resources — Debt."

Impairment Charges

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

Other Non-Operating Loss, net of Gain

In connection with certain debt transactions and modifications completed during the year ended December 31, 2013, we recognized debt transaction costs of $5.9 million.

Additionally, in connection with an acquisition completed in 2012, we made reasonable estimates and recorded an estimated obligation representing the fair values of our potential contingent obligations to the seller pursuant to the asset purchase agreement. Subsequently, the seller finalized its settlement of certain of these obligations at an amount that was less than we originally estimated. As a result, during the year ended December 31, 2013, we reduced our originally recorded contingent obligations and recognized a gain of approximately $5.6 million.

Provision for Income Taxes

Our provision for income taxes was $68.1 million, or 1.5% of revenues, for the year ended December 31, 2014, as compared to $79.3 million, or 2.2% of revenues, for the prior year. The effective tax rate decreased to 35.1% for the year ended December 31, 2014, as compared to 38.3% for the prior year. Our effective tax rate was lower for the year ended December 31, 2014 as a result of the reversal of a $6.0 million valuation allowance that was established during 2013 against our deferred tax assets for federal net operating losses generated by our Michigan physician practice operations which were previously thought to be unrecoverable.

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash flows provided by our operations and our debt borrowings. We believe that our internally generated cash flows and the amounts available under our Senior Credit Agreement will be adequate to service existing debt, finance internal growth and fund capital expenditures and certain small to mid-size hospital acquisitions. Certain larger hospital acquisitions may, however, require additional financing. On December 4, 2015, we issued in a public offering $500.0 million of 5.875% Senior Notes. The proceeds from this issuance were primarily used to fund hospital acquisitions.

The following table presents summarized cash flow information for the years ended December 31, 2015, 2014 and 2013 (in millions):

	2015	2014	2013
Net cash flows provided by continuing operations	$ 627.1	$ 412.3	$ 354.1
Less: Purchases of property and equipment	(274.7)	(207.1)	(185.2)
Free operating cash flow	352.4	205.2	168.9
Acquisitions, net of cash acquired	(619.4)	(265.6)	(188.1)
Proceeds from sale of hospital	18.8	-	-
Proceeds from borrowings	500.0	412.0	1,053.0
Payments of borrowings	(16.9)	(585.4)	(453.7)
Repurchases of common stock	(134.5)	(222.3)	(39.1)
Payments of debt issuance costs	(7.2)	(7.2)	(20.0)
Proceeds from exercise of stock options	11.5	23.9	39.2
Other	(12.2)	(7.0)	(7.3)
Net change in cash and cash equivalents	$ 92.5	$ (446.4)	$ 552.9

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

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

Our cash flows provided by continuing operations for the year ended December 31, 2014 as compared to 2013 were positively impacted by higher net income, excluding the impact of certain non-cash charges, partially offset by an increase in our outstanding accounts receivable subsequent to our purchase at certain of our recently acquired facilities as a result of the time lag involved in obtaining provider numbers for the Medicare and Medicaid programs.

Capital Expenditures

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

The following table reflects our capital expenditures for the years ended December 31, 2015, 2014 and 2013 (dollars in millions):

	2015	2014	2013
Capital and routine projects	$ 206.2	$ 161.4	$ 128.3
Information systems	68.5	45.7	56.9
	$ 274.7	$ 207.1	$ 185.2
Depreciation expense	$ 276.7	$ 247.6	$ 222.9
Ratio of capital expenditures to depreciation expense	99.3 %	83.6 %	83.1 %

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

Our total capital expenditures in 2015 were higher than in 2014 as a result of investments to modernize and expand the service-lines provided by our facilities and also as a result of capital expenditure commitments in connection with certain of our recent acquisitions.

Debt

An analysis and roll-forward of our long-term debt, including current maturities, during 2015 is as follows (in millions):

	December 31, 2014	Proceeds from Borrowings	Payments of Borrowings	Payments of Debt Issuance Costs	Amortization of Debt Issuance Costs, Discount and Premium	Other	December 31, 2015
Senior Credit Agreement:							
Term Facility	$ 421.9	$ -	(16.9)	-	-	-	$ 405.0
Incremental Term Loans	222.6	-	-	-	-	-	222.6
6.625% Senior Notes	400.0	-	-	-	-	-	400.0
5.5% Senior Notes	1,100.0	-	-	-	-	-	1,100.0
5.875% Senior Notes	-	500.0	-	-	-	-	500.0
Unamortized debt issuance costs, discount and premium	(19.0)	-	-	(7.2)	4.0	-	(22.2)
Capital leases and financing obligations	64.1	-	(2.3)	-	-	1.6	63.4
	$ 2,189.6	$ 500.0	$ (19.2)	$ (7.2)	$ 4.0	$ 1.6	$ 2,668.8

We use leverage, or our total debt to total capitalization ratio, to make financing decisions. The following table illustrates our financial statement leverage and the classification of our debt, all of which was senior, as either fixed rate or variable rate at December 31, 2015 and 2014 (dollars in millions):

	December 31, 2015	December 31, 2014	Increase
Current portion of long-term debt	$ 25.0	$ 19.2	$ 5.8
Long-term debt, net	2,643.8	2,170.4	473.4
Unamortized debt issuance costs, discount and premium	22.2	19.0	3.2
Total debt, excluding unamortized debt issuance costs, discount and premium	2,691.0	2,208.6	482.4
Total LifePoint Health, Inc. stockholders' equity	2,263.9	2,154.6	109.3
Total capitalization	$ 4,954.9	$ 4,363.2	$ 591.7
Total debt to total capitalization	54.3 %	50.6 %	370 bps
Percentage of total debt:			
Fixed rate debt	76.7 %	70.8 %	
Variable rate debt	23.3	29.2	
	100.0 %	100.0 %	

Liquidity and Capital Resources Outlook

We expect the total level of spending for capital expenditures to be greater in 2016 as compared to 2015 as a result of our various capital commitments in connection with several of our facilities.

At December 31, 2015, we had uncompleted projects with an estimated additional cost to complete and equip of approximately $158.5 million. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the Senior Credit Agreement.

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

We believe that cash generated from our operations and borrowings available under the Senior Credit Agreement will be sufficient to meet our working capital needs, the purchase prices for certain small to mid-size hospital acquisitions, planned capital expenditures and other expected operating needs over the next twelve months and into the foreseeable future prior to the maturity dates of our outstanding debt.

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Contractual Obligations, Commitments and Off-Balance Sheet Arrangements

Contractual Obligations

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

The following table summarizes our significant contractual obligations as of December 31, 2015 and the future periods in which such obligations are expected to be settled in cash (in millions):

	Payment Due by Period				
Contractual Obligations	**Total**	**2016**	**2017 - 2018**	**2019 - 2020**	**After 2020**
Long-term debt obligations [a]	$ 3,384.1	$ 155.6	$ 847.1	$ 632.8	$ 1,748.6
Capital expenditure obligations [b]	1,702.6	203.5	329.4	296.3	873.4
Capital and financing lease obligations [c]	95.1	8.3	14.9	15.3	56.6
Operating lease obligations [d]	146.2	32.9	40.5	23.9	48.9
Other liabilities [e]	210.5	46.3	67.2	39.3	57.7
Purchase obligations [f]	918.5	291.1	302.6	211.0	113.8
Total	$ 6,457.0	$ 737.7	$ 1,601.7	$ 1,218.6	$ 2,899.0

(a) Included in long-term debt obligations are principal and interest owed on our outstanding debt obligations. These amounts exclude our unamortized debt issuance costs, discount and premium and related non-cash amortization. These obligations are explained further in Note 5 to our consolidated financial statements included elsewhere in this report. We used the 2.18% and 2.93% effective interest rates at December 31, 2015 for our $405.0 million outstanding senior secured term loan facility (the "Term Facility") and $222.6 million outstanding Incremental Term Loans, respectively, to estimate interest payments on these variable rate debt instruments.

(b) We are subject to annual capital expenditure commitments in connection with several of our facilities including our recent acquisitions. Additionally, we had projects under construction with an estimated additional cost to complete and equip of approximately $158.5 million as of December 31, 2015. However, because we can terminate substantially all of the related construction contracts at any time without paying a termination fee, these costs are excluded from the above table except for amounts contractually committed by us.

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

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

(e) Included in other liabilities are the current and long-term portions of our reserves for self-insurance claims of $41.5 million and $154.7 million, respectively, but excluding the portion of the reserve related to our estimate of recoveries for certain claims in excess of our self-insured retention levels that do not require us to make cash payments. Please refer to "Critical Accounting Estimates — Reserves for Self-Insurance Claims" in this report for more information on our reserves for self-insurance claims. Additionally, included in other long-term liabilities are the estimated cash contributions we expect to make to our defined benefit pension plans sufficient to meet our minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended, and our other long-term obligations which require the delivery of cash and for which we can reasonably estimate the timing of such payments.

(J) The following table summarizes our significant purchase obligations as of December 31, 2015 and the future periods in which such obligations are expected to be settled in cash (in millions):

	Payment Due by Period				
Purchase Obligations	Total	2016	2017 - 2018	2019 - 2020	After 2020
Shared centralized resource model agreements [1]	$ 412.0	$ 61.0	$ 120.0	$ 119.0	$ 112.0
IT Services [2]	106.1	57.1	44.4	4.6	-
GEMS obligations [3]	180.1	36.0	72.0	72.1	-
Other purchase obligations [4]	220.3	137.0	66.2	15.3	1.8
Total	$ 918.5	$ 291.1	$ 302.6	$ 211.0	$ 113.8

(1) We have various arrangements with a third party to provide certain nonclinical business functions to us, including payroll, supply chain management and revenue cycle functions under a shared centralized resource model for periods ranging from two to seven years.
(2) We have various arrangements with third parties to provide information technology services, including, but not limited to, financial, clinical, patient accounting and other information services to us under contracts ranging from one to five years.
(3) General Electric Medical Services ("GEMS") provides diagnostic imaging equipment maintenance and bio-medical services to us pursuant to a contract that expires on December 31, 2020.
(4) Reflects our minimum commitments to purchase goods or services under non-cancelable contracts as of December 31, 2015.

Off-Balance Sheet Arrangements

We had standby letters of credit outstanding of approximately $19.9 million as of December 31, 2015, all of which relates to the self-insured retention levels of our professional and general liability insurance and workers' compensation programs as security for the payment of claims.

Recently Issued Accounting Pronouncements

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

Critical Accounting Estimates

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

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

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

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

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

The discussion that follows presents information about our critical accounting estimates, as well as the effects of hypothetical changes in the material assumptions used to develop each estimate.

Revenue Recognition and Accounts Receivable

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

Approximately 98.7%, 99.4% and 97.7% of our revenues during the years ended December 31, 2015, 2014 and 2013, respectively, relate to discounted charges, which were comprised of the following sources (as a percentage of revenues):

	2015	2014	2013
Medicare	29.1 %	30.4 %	32.6 %
Medicaid	16.1	13.8	14.1
HMO's, PPO's and other private insurers	53.5	55.2	51.0

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

We monitor our processes for calculating contractual allowances through:

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

Medicare and Medicaid

The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e., gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under the Medicaid program's prospective reimbursement systems, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates.

Discounts for retrospectively cost-based revenues are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under these programs are subject to adjustment based on administrative review and audit by third party intermediaries, which can take several years to resolve completely. Adjustments related to final settlements decreased our revenues by $0.5 million for the year ended December 31, 2015 and increased our revenues by $2.5 million and $5.6 million for the years ended December 31, 2014 and 2013, respectively.

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

HMOs, PPOs and Other Private Insurers

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

If our overall estimated contractual discount percentage on our managed care program revenues for the year ended December 31, 2015 were changed by 1%, our net income would change by approximately $35.5 million, or diluted earnings per share of $0.77. This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate the amount expected to be received based on payor contract provisions, historical collection data as well as other factors and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts for managed care plans would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Provision and Allowance for Doubtful Accounts

To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts. Our allowance for doubtful accounts, included in our consolidated balance sheets as of December 31, 2015 and 2014 was $796.8 million and $709.5 million, respectively. Our provision for doubtful accounts, included in our consolidated results of operations for the years ended December 31, 2015, 2014 and 2013, was $800.1 million, $817.8 million and $750.4 million, respectively.

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

The approximate amounts and percentages of billed insured and uninsured (including self-pay, co-payments, deductibles and Medicaid pending) gross accounts receivable (prior to allowance for contractual discounts and allowance for doubtful accounts) in summarized aging categories as of December 31, 2015 and 2014 are presented below (in millions). Prior year uninsured gross accounts receivable amounts have been adjusted to conform to current year presentation.

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

	December 31, 2014					
	Insured Receivables		Uninsured Receivables		Combined	
	Amount	Percent of Receivables	Amount	Percent of Receivables	Amount	Percent of Receivables
0 to 90 days	$ 966.2	82.5 %	$ 240.9	28.1 %	$ 1,207.1	59.5 %
91 to 150 days	111.9	9.6	159.9	18.7	271.8	13.4
151 to 360 days	74.0	6.3	413.9	48.3	487.9	24.1
Over 361	18.7	1.6	42.4	4.9	61.1	3.0
	$ 1,170.8	100.0 %	$ 857.1	100.0 %	$ 2,027.9	100.0 %

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

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

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

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

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

The process of determining our allowance for doubtful accounts requires us to estimate uncollectible self-pay accounts. Our estimate of uncollectible self-pay accounts is primarily based on our collection history, adjusted for anticipated changes in collection trends, if significant. Our estimate may be impacted by changes in regional economic conditions, business office operations, payor mix and trends in federal or state governmental healthcare coverage or other third party payors. If the actual self-pay collection percentage would change by 1.5% from our estimated self-pay collection percentage for the year ended December 31, 2015, our net income would change by approximately $7.0 million, or diluted earnings per share of $0.15. The resulting change in this analytical tool is considered to be a reasonably likely change that would affect our overall assessment of this critical accounting estimate.

Goodwill Impairment Analysis

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired businesses. Our goodwill included in our consolidated balance sheets as of December 31, 2015 and 2014 was $1,667.5 million and $1,636.1 million, respectively. Please refer to Note 4 to our consolidated financial statements included elsewhere in this report for a detailed rollforward of our goodwill.

In accordance with ASC 350-10, "Intangibles — Goodwill and Other" ("ASC 350-10") goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. Our business comprises a single operating reporting unit for impairment test purposes. For the purposes of these analyses, our estimate of fair value are based on a combination of the income approach, which estimates the fair value of us based on our future discounted cash flows, and the market approach, which estimates the fair value of us based on comparable market prices. Our estimate of future discounted cash flows is based on assumptions and projections we believe to be currently reasonable and supportable. Our assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix, and changes in legislation and other payor payment patterns.

If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. During the years ended December 31, 2015, 2014 and 2013, we performed our annual impairment tests as of October 1, and did not incur an impairment charge.

Reserves for Self-Insurance Claims

We are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding a self-insured retention level. Our self-insured retention level for professional liability claims is $5.0 million per claim at December 31, 2015 with a $5.0 million inner aggregate per claim. Additionally, as of December 31, 2015, our self-insured retention level for workers' compensation claims is $1.0 million per claim in all states in which we operate except for Wyoming. We participate in a state specific program in Wyoming for our workers' compensation claims arising in this state. Our self-insured retention level is evaluated annually as a part of our insurance program's renewal process.

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

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

Our reserves for professional liability claims are based upon quarterly actuarial calculations. Our reserves for employee workers' compensation claims are based upon semi-annual actuarial calculations. Our reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. We have discounted our reserves for self-insured claims to their present value using a discount rate of 1.35%, 1.50% and 1.55% at December 31, 2015, 2014 and 2013, respectively. We select a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

The following table provides information regarding our reserves for self-insured claims at December 31, 2015 and 2014 (in millions):

	December 31, 2015	December 31, 2014
Undiscounted	$ 205.0	$ 186.2
Discounted (as reported)	$ 196.2	$ 177.5

The following table presents the changes in our reserves for self-insured claims for the years ended December 31, 2015 and 2014 (in millions):

	2015	2014
Reserve at the beginning of the period	$ 177.5	$ 168.0
Increase for the provision of current year claims	52.1	55.1
Decrease for the provision of prior year claims	(1.0)	(5.2)
Payments related to current year claims	(6.1)	(3.5)
Payments related to prior year claims	(28.0)	(35.3)
Provision for the change in discount rate	0.9	0.3
Noncash change in reserve for claims in excess of self-insured retention levels	0.8	(1.9)
Reserve at the end of the period	$ 196.2	$ 177.5

As of December 31, 2015 and 2014, less than 1% of our reserves for self-insured claims represents reserves for settled and unpaid claims. Our average lag time between the settlement and payment of a self-insured claim ranges from 1 to 2 weeks.

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

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

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

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

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

December 31, 2015 reserve:		
As reported	$	196.2
With 70% Confidence Level	$	210.6
With 80% Confidence Level	$	222.5
With 90% Confidence Level	$	255.6
December 31, 2014 reserve:		
As reported	$	177.5
With 70% Confidence Level	$	187.4
With 80% Confidence Level	$	198.0
With 90% Confidence Level	$	227.0

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of our quarterly and semi-annual actuarial calculations resulted in changes to our reserves for self-insured claims for prior years. As a result, for the years ended December 31, 2015, 2014 and 2013, our related self-insured claims expense decreased by $1.0 million, $5.1 million and $12.9 million, which increased net income by approximately $0.6 million, $3.3 million and $7.9 million, or $0.01, $0.07 and $0.17 per diluted share, respectively.

Accounting for Stock-Based Compensation

We issue stock-based awards, including stock options, appreciation rights and other stock-based awards (nonvested stock, restricted stock, restricted stock units and performance shares) to certain officers, employees and non-employee directors in accordance with our various stockholder-approved stock-based compensation plans. We account for our stock-based awards in accordance with the provisions of ASC 718-10, "Compensation — Stock Compensation" ("ASC 718-10") and accordingly recognize compensation expense over each of the stock-based award's requisite service period based on the estimated grant date fair value. Our stock-based compensation expense was $35.0 million, $29.7 million and $25.4 million for the years ended December 31, 2015, 2014 and 2013, respectively.

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

The following table shows the weighted average assumptions we used to develop the fair value estimates under our HW-II option valuation model and the resulting estimates of weighted-average fair value per share of stock options granted during the years ended December 31, 2015, 2014 and 2013:

	2015	2014	2013
Expected volatility	29.0 %	29.0 %	30.8 %
Risk-free interest rate, minimum	0.01	0.05	0.02
Risk-free interest rate, maximum	2.20	2.71	2.90
Expected dividends	-	-	-
Average expected term (years)	5.3	5.4	5.3
Fair value per share of stock options granted	$ 18.66	$ 13.95	$ 11.98

Population Stratification

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

Expected Volatility

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

Risk-Free Interest Rate

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

Expected Dividends

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

Pre-Vesting Forfeitures

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

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

Post-Vesting Cancellations

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

Expected Term

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

The fair value calculations of our stock option grants are affected by assumptions that are believed to be reasonable based upon the facts and circumstances at the time of grant. Changes in our volatility estimates can materially affect the fair values of our stock option grants. If our estimated weighted-average volatility for the year ended December 31, 2015 were 10% higher, our net income would decrease by approximately $0.7 million, or $0.02 per diluted share.

Generally, the fair value of our restricted stock unit awards is determined based on the closing price of our common stock on the trading date immediately prior to the grant date. However, of the restricted stock units granted during the years ended December 31, 2015 and 2014, 145,000 and 236,000 were performance-based awards, respectively. In addition to requiring continuing service of the employee, the percentage of these restricted stock units that are earned at the end of the performance period is determined based on our three-year annualized total shareholder return relative to a peer group, Standard and Poor's Global Industry Classification Standard's Sub-industry: Health Care Facilities with over $500.0 million in revenues or its equivalent. For the performance-based restricted stock units granted during the year ended December 31, 2015, the number of shares payable at the end of the three-year performance period ranges from 0% to 200% of the targeted units. For the performance-based restricted stock units granted during the year ended December 31, 2014, the number of shares payable at the end of the three-year performance period ranges from 0% to 100% of the targeted units, with any portion of the award that exceeds 100% up to 200% of the targeted units settled in cash equal to the fair market value on the date certification of the level of performance is achieved. For valuation purposes, these awards were bifurcated into their two independent sub-award components for the portion that would be settled in our common stock and for the portion that would be settled in cash. We recognize compensation expense for the portion of the performance-based restricted stock units that will ultimately be settled in our common stock for the targeted units if the requisite service period is rendered, even if the market condition is never satisfied. Additionally, we classify as a liability and recognize compensation expense for the portion of the award that will ultimately be settled in cash for the targeted units at its Monte-Carlo simulation value which has been marked-to-market.

Accounting for Income Taxes

Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our income statement. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or increase this allowance, we must include an expense as part of the income tax provision in our results of operations. Our deferred tax asset balances in our consolidated balance sheets were $303.7 million and $280.7 million as of December 31, 2015 and 2014, respectively. Our valuation allowances for deferred tax assets in our consolidated balance sheets were $64.5 million and $66.4 million as of December 31, 2015 and 2014, respectively.

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

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

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

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

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

Our deferred tax liabilities exceeded our deferred tax assets by $29.9 million as of December 31, 2015, excluding the impact of valuation allowances. Historically, we have produced federal taxable income, and as such, we believe that the likelihood of not realizing the federal tax benefit of our deferred tax assets is remote. However, we do have subsidiaries with a history of tax losses in

certain state jurisdictions and, based upon those historical tax losses, we assumed that the subsidiaries would not be profitable in the future for those states' tax purposes. If our assertion regarding the future profitability of those subsidiaries was incorrect, then our deferred tax assets would be understated by the amount of the state valuation allowance of $64.5 million at December 31, 2015.

The IRS may propose adjustments for items we have failed to identify as tax contingencies. If the IRS were to propose and sustain assessments equal to 10% of our taxable income for 2015, we would incur approximately $14.0 million of additional tax payments for 2015 plus interest and penalties, if applicable.

Segment Reporting

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

Inflation

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

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

Interest Rates

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

Outstanding Debt

As of December 31, 2015, we had outstanding debt, excluding unamortized debt issuance costs, discount and premium, of $2,691.0 million, 23.3%, or $627.6 million, of which was subject to variable rates of interest. If the variable interest rates on our long-term debt were 100 basis points higher during the year ended December 31, 2015, our net income would have decreased by approximately $4.0 million, or $0.09 per diluted share.

Cash Balances

Certain of our outstanding cash balances are invested overnight with high credit quality financial institutions. We do not hold direct investments in auction rate securities, collateralized debt obligations, structured investment vehicles or mortgage-backed securities. We do not have significant exposure to changing interest rates on invested cash at December 31, 2015. As a result, the interest rate market risk implicit in these investments at December 31, 2015, if any, is low.

Item 8. ***Financial Statements and Supplementary Data.***

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

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

We did not experience a change in or disagreement with our accountants during the year ended December 31, 2015.

Item 9A. ***Controls and Procedures.***

Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

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

Management's Annual Report on Internal Control Over Financial Reporting

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

Changes in Internal Control Over Financial Reporting

There has been no change in our internal control over financial reporting during the fourth quarter ended December 31, 2015 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. ***Other Information.***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance.***

Executive Officers

This information is incorporated by reference to the information contained under the caption "Executive Compensation — Executive Officers of the Company" included in our proxy statement relating to our 2016 annual meeting of stockholders.

Code of Ethics

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

Directors

This information is incorporated by reference to the information contained under the caption "Proposal 1: Election of Directors" included in our proxy statement relating to our 2016 annual meeting of stockholders.

Section 16(a) Beneficial Ownership Reporting Compliance

This information is incorporated by reference to the information contained under the caption "Ownership of Equity Securities of the Company — Section 16(a) Beneficial Ownership Reporting Compliance" included in our proxy statement relating to our 2016 annual meeting of stockholders.

Stockholder Nominees

This information is incorporated by reference to the information contained under the caption "Proposal 1: Election of Directors — Director Nomination Process" included in our proxy statement relating to our 2016 annual meeting of stockholders.

Audit and Compliance Committee

This information is incorporated by reference to the information contained under the caption "Audit and Compliance Committee Report" included in our proxy statement relating to our 2016 annual meeting of stockholders.

Item 11. ***Executive Compensation.***

This information is incorporated by reference to the information contained under the captions "Compensation Committee Report," "Compensation Discussion and Analysis," "Executive Compensation," "Corporate Governance — Compensation Committee Interlocks and Insider Participation," and "Director Compensation," included in our proxy statement relating to our 2016 annual meeting of stockholders.

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

This information is incorporated by reference to the information contained under the captions "Ownership of Equity Securities of the Company" and "Executive Compensation — Potential Payments upon Termination or Change in Control" included in our proxy statement relating to our 2016 annual meeting of stockholders.

Equity Compensation Plan Information

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

The following table provides aggregate information as of December 31, 2015, with respect to shares of common stock that may be issued in accordance with our equity compensation plans:

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity Compensation Plans Approved by Security Holders	3,679,736 (1)	$ 46.46 (2)	3,674,533 (3)
Equity Compensation Plans not Approved by Security Holders	None	None	None
Total	3,679,736	$ 46.46	3,674,533

(1) Includes the following:
- 3,674,772 shares of common stock to be issued upon exercise of outstanding stock options granted in accordance with the 1998 LTIP and the 2013 LTIP; and
- 4,964 shares of common stock to be issued upon the vesting of deferred stock units outstanding in accordance with the ODSICP.

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

(3) Includes the following:
- 3,647,320 shares of common stock available for issuance in accordance with the 2013 LTIP; and
- 27,213 shares of common stock available for issuance in accordance with the Amended and Restated Management Stock Purchase Plan (the "MSPP").

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

This information is incorporated by reference to the information contained under the captions "Corporate Governance —Independence and Related Person Transactions" and "Corporate Governance — Board Meetings and Committees" included in our proxy statement relating to our 2016 annual meeting of stockholders.

Item 14. ***Principal Accountant Fees and Services.***

This information is incorporated by reference to the information contained under the caption "Proposal 2: Ratification of Selection of Independent Registered Public Accounting Firm" and "Fees and Services of the Independent Registered Public Accounting Firm" included in our proxy statement relating to our 2016 annual meeting of stockholders.

PART IV

Item 15. ***Exhibits, Financial Statement Schedules.***

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

(1) ***Consolidated Financial Statements:***

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

(2) ***Consolidated Financial Statement Schedules:***

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

(3) ***Exhibits:***

Exhibit Number		Description of Exhibits
3.1	—	Amended and Restated Certificate of Incorporation of LifePoint Health, Inc., as amended (incorporated by reference from exhibits to the LifePoint Health, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2015, File No. 000-51251).
3.2	—	Sixth Amended and Restated By-Laws of LifePoint Health, Inc. (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed May 11, 2015, File No. 000-51251).
4.1	—	Form of Specimen Stock Certificate (incorporated by reference from exhibits to the Registration Statement on Form S-4, as amended, filed by Historic LifePoint Hospitals, Inc. on October 25, 2004, File No. 333-119929).
4.2	—	Amended and Restated Rights Agreement, dated February 25, 2009, by and between LifePoint Hospitals, Inc. and American Stock Transfer & Trust Company, LLC (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed February 25, 2009, File No. 000-51251).
4.3	—	Amendment No. 1 to Amended and Restated Rights Agreement by and between LifePoint Health, Inc. and American Stock Transfer & Trust Company, LLC, dated as of September 21, 2015 (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed September 21, 2015, File No. 000-51251).
4.4	—	Indenture, dated September 23, 2010, by and among LifePoint Hospitals, Inc., the guarantors named therein and Bank of New York Mellon Trust Company, N.A. as trustee (including the Form of 6.625% Senior Notes due 2020) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed September 27, 2010, File No. 000-51251).
4.5	—	Supplemental Indenture, dated as of August 23, 2013, by and among LifePoint Hospitals, Inc. the guarantors named herein and The Bank of New York Mellon Trust Company, N.A., as Trustee, to the Indenture, dated as of September 23, 2010, as supplemented (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed August 26, 2013, File No. 000-51251).
4.6	—	Indenture, dated as of December 6, 2013, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Bank of New York Mellon Trust Company, N.A. as trustee (including the Form of 5.5% Senior Note due 2021) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 9, 2013, File No. 000-51251).
4.7	—	Senior Debt Securities Indenture, dated as of December 4, 2015, by and between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed December 4, 2015, File No. 000-51251).
4.8	—	Supplemental Indenture, dated as of December 4, 2015, by and among the Company, the Guarantors party thereto, and The Bank of New York Mellon Trust Company, N.A., as trustee (including the form of 5.875% Senior Notes due 2023) (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed December 4, 2015, File No. 000-51251).

10.1	—	Computer and Data Processing Services Agreement dated May 19, 2008, by and between HCA Information Technology Services, Inc. and LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed May 21, 2008, File No. 000-51251).
10.2	—	Amendment to the Computer and Data Processing Services Agreement, dated June 13, 2012, by and between HCA – Information Technology & Services, Inc. and LifePoint Corporate Services, General Partnership (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2012, File No. 000-51251).
10.3	—	LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan, dated June 30, 2005, as amended by the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010, the Amendment dated April 23, 2012 and the Amendment dated June 5, 2012 (incorporated by reference from Appendix A and B to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).*
10.4	—	Form of LifePoint Hospitals, Inc. Restricted Stock Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*
10.5	—	LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from Appendix C to the Historic LifePoint Hospitals, Inc. Proxy Statement dated April 28, 2004, File No. 000-29818).*
10.6	—	First Amendment, dated December 10, 2008, to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).*
10.7	—	Amendment No. 2 to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed June 6, 2014, File No. 000-51251).*
10.8	—	Form of LifePoint Hospitals, Inc. Performance Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*
10.9	—	LifePoint Hospitals, Inc. Change in Control Severance Plan, as amended and restated (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 16, 2008, File No. 000-51251).*
10.10	—	LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan, dated January 1, 2003, as amended by the Amendment dated May 22, 2003, the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated March 24, 2009, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 29, 2010, File No. 000-51251).*
10.11	—	Amendment, dated April 18, 2012 to the LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan (incorporated by reference from exhibits to LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2012, File No. 000-51251).*
10.12	—	Form of Outside Directors Restricted Stock Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2006, File No. 000-51251).*
10.13	—	LifePoint Hospitals, Inc. Amended and Restated Outside Directors Stock and Incentive Compensation Plan, dated May 12, 2009, as amended by the Amendment dated April 27, 2010, the Amendment dated June 8, 2010 and the Amendment dated June 5, 2012 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).*
10.14	—	Form of LifePoint Hospitals, Inc. Deferred Restricted Stock Award (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*
10.15	—	LifePoint Hospitals Deferred Compensation Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 15, 2009, File No. 000-51251).*

10.16 — Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated December 22, 2010 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, File No. 000-51251).*

10.17 — Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated March 14, 2011 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, File No. 000-51251).*

10.18 — Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated November 24, 2014 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2014, File No. 000-51251).*

10.19 — Credit Agreement, dated as of July 24, 2012, among LifePoint Hospitals, Inc., as borrower, the lenders referred to therein, Citibank, N.A. as administrative agent, Bank of America, N.A. and Barclays Bank PLC, as co-syndication agents, and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and Barclays Bank PLC, as joint lead arrangers and joint bookrunners (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2012, File No. 000-51251).

10.20 — Incremental Facility Amendment No. 1, dated as of February 6, 2013, by and among LifePoint Hospitals, Inc., as borrower, the lenders referred to therein, Citibank, N.A., as administrative agent, and consented to by Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as leads arrangers, to the Credit Agreement, dated as of July 24, 2012, among Borrower, the lenders referred to therein, Citibank, N.A. as administrative agent, Bank of America, N.A. and Barclays Bank PLC as co-syndication agents and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as joint lead arrangers and joint bookrunners (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed February 7, 2013, File No. 000-51251).

10.21 — Credit Agreement Amendment No. 2, dated as of August 23, 2013, by and among LifePoint Hospitals, Inc., the lenders party thereto, Citibank, N.A., as administrative agent and consented to by Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC, as lead arrangers, to that certain Credit Agreement, dated as of July 24, 2012, among LifePoint Hospitals, Inc., the lenders party thereto, the Administrative Agent, Bank of America, N.A. and Barclays Bank PLC, as co-syndication agents and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as joint lead arrangers and joint bookrunners, as amended by Incremental Facility Amendment No. 1 dated as of February 6, 2013 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed August 26, 2013, File No. 000-51251).

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

10.23 — First Amendment to the Amended and Restated Executive Severance and Restrictive Covenant Agreement, dated December 11, 2012, by and between HSCGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 17, 2012, File No. 000-51251).*

10.24 — Recoupment Policy Relating to Unearned Incentive Compensation of Executive Officers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed May 20, 2008, File No. 000-51251).*

10.25 — LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan (incorporated by reference from Appendix A to the LifePoint Hospitals, Inc. Proxy Statement filed April 24, 2013, File No. 000-51251).*

10.26 — Amendment to the LifePoint Health, Inc. 2013 Long-Term Incentive Plan (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed June 4, 2015, File No. 000-51251).

10.27 — Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement (Performance-Based Vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*

10.28	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.29	—	Form of LifePoint Hospitals, Inc. Nonqualified Stock Option Agreement for the LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.30	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement for non-employee directors (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2013, File No. 000-51251).*
10.31	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Outside Director Restricted Stock Unit Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.32	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (time-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.33	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (performance-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.34	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2014, File No. 000-51251).*
10.35	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting; deferral provision) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2014, File No. 000-51251).*
10.36	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting; deferral provision) (filed herewith).*
10.37	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Non-Qualified Stock Option Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2014, File No. 000-51251).*
10.38	—	Form of Indemnification Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, File No. 000-51251).*
10.39	—	Voluntary Resignation Agreement and General Release by and between Jeffrey S. Sherman and HSGCP, LLC, dated September 4, 2013 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed September 6, 2013, File No. 000-51251).*
12.1	—	Ratio of Earnings to Fixed Charges
21.1	—	List of Subsidiaries
23.1	—	Consent of Independent Registered Public Accounting Firm
31.1	—	Certification of the Chief Executive Officer of LifePoint Health, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	—	Certification of the Chief Financial Officer of LifePoint Health, Inc. pursuant to Section 302 of the Sarbanes Oxley Act of 2002

32.1	—	Certification of the Chief Executive Officer of LifePoint Health, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	—	Certification of the Chief Financial Officer of LifePoint Health, Inc. pursuant to Section 906 of the Sarbanes Oxley Act of 2002
101.INS	—	XBRL Instance Document**
101.SCH	—	XBRL Taxonomy Extension Schema Document**
101.CAL	—	XBRL Taxonomy Calculation Linkbase Document**
101.DEF	—	XBRL Taxonomy Definition Linkbase Document**
101.LAB	—	XBRL Taxonomy Label Linkbase Document**
101.PRE	—	XBRL Taxonomy Presentation Linkbase Document**

* - Management Compensation Plan or Arrangement
** - Furnished electronically herewith

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Management's Report on Internal Control Over Financial Reporting

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

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

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

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

The Company assessed its internal control system as of December 31, 2015 in relation to criteria for effective internal control over financial reporting described in "Internal Control — Integrated Framework" issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework). Based on its assessment, the Company has determined that, as of December 31, 2015, its system of internal control over financial reporting was effective.

The Company acquired Nason Hospital, Fleming County Hospital, Clark Memorial Hospital, and Watertown Regional Medical Center during the year ended December 31, 2015. The Company excluded all four of these hospitals from its assessment of and conclusion on the effectiveness of its internal control over financial reporting. As of December 31, 2015, these hospitals constituted $164.1 million and $91.1 million of total and net assets, respectively, and $143.3 million and ($10.3) million of revenues and net loss attributable to LifePoint Health, Inc., respectively, for the year then ended.

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

/s/ William F. Carpenter III	/s/ Leif M. Murphy
Chief Executive Officer and	Executive Vice President and
Chairman of the Board of Directors	Chief Financial Officer

Brentwood, Tennessee
February 12, 2016

Report of Independent Registered Public Accounting Firm

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

We have audited LifePoint Health, Inc.'s (the "Company") internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework) (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

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

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

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

As indicated in the accompanying Management's Report on Internal Control over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Nason Hospital, Fleming County Hospital, Clark Memorial Hospital, and Watertown Regional Medical Center, which are included in the 2015 consolidated financial statements of LifePoint Health, Inc. and constituted $164.1 million and $91.1 million of total and net assets, respectively, as of December 31, 2015 and $143.3 million and ($10.3) million of revenues and net loss attributable to LifePoint Health, Inc., respectively, for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of Nason Hospital, Fleming County Hospital, Clark Memorial Hospital, and Watertown Regional Medical Center.

In our opinion, LifePoint Health, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of LifePoint Health, Inc. as of December 31, 2015 and 2014 and the related consolidated statements of operations, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2015 of LifePoint Health, Inc. and our report dated February 12, 2016 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 12, 2016

Report of Independent Registered Public Accounting Firm

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

We have audited the accompanying consolidated balance sheets of LifePoint Health, Inc. (the "Company") as of December 31, 2015 and 2014, and the related consolidated statements of operations, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2015. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of LifePoint Health, Inc. at December 31, 2015 and 2014, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2015, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 1 to the consolidated financial statements, the Company changed its presentation of debt issuance costs as a result of the adoption of the amendments to the FASB Accounting Standards Codification resulting from Accounting Standards Update No. 2015-03, *Simplifying the Presentation of Debt Issuance Costs*, effective December 31, 2015 and the classification of deferred tax assets and liabilities as a result of the adoption of the amendments to the FASB Accounting Standards Codification resulting from Accounting Standards Update 2015-17, *Income Taxes: Balance Sheet Classification of Deferred Taxes*, effective December 31, 2015.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), LifePoint Health, Inc.'s internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework) and our report dated February 12, 2016 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 12, 2016

LIFEPOINT HEALTH, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS
For the Years Ended December 31, 2015, 2014 and 2013
(In millions, except per share amounts)

	2015	2014	2013
Revenues before provision for doubtful accounts	$ 6,014.4	$ 5,300.9	$ 4,428.7
Provision for doubtful accounts	800.1	817.8	750.4
Revenues	5,214.3	4,483.1	3,678.3
Salaries and benefits	2,496.9	2,134.5	1,727.4
Supplies	815.0	699.0	577.1
Other operating expenses	1,246.4	1,087.3	900.9
Other income	(49.7)	(71.9)	(64.1)
Depreciation and amortization	279.0	250.5	228.2
Interest expense, net	114.4	123.0	97.0
Impairment charges	13.8	57.7	-
Other non-operating (gains) losses	(4.0)	-	0.3
	4,911.8	4,280.1	3,466.8
Income from continuing operations before income taxes	302.5	203.0	211.5
Provision for income taxes	109.5	68.1	79.3
Income from continuing operations	193.0	134.9	132.2
Income from discontinued operations, net of income taxes	-	-	0.4
Net income	193.0	134.9	132.6
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(11.1)	(8.8)	(4.4)
Net income attributable to LifePoint Health, Inc.	$ 181.9	$ 126.1	$ 128.2
Basic earnings per share attributable to LifePoint Health, Inc. stockholders:			
Continuing operations	$ 4.14	$ 2.81	$ 2.76
Discontinued operations	-	-	0.01
Net income	$ 4.14	$ 2.81	$ 2.77
Diluted earnings per share attributable to LifePoint Health, Inc. stockholders:			
Continuing operations	$ 3.95	$ 2.69	$ 2.68
Discontinued operations	-	-	0.01
Net income	$ 3.95	$ 2.69	$ 2.69
Weighted average shares and dilutive securities outstanding:			
Basic	43.9	44.9	46.3
Diluted	46.1	46.9	47.6
Amounts attributable to LifePoint Health, Inc. stockholders:			
Income from continuing operations, net of income taxes	$ 181.9	$ 126.1	$ 127.8
Income from discontinued operations, net of income taxes	-	-	0.4
Net income	$ 181.9	$ 126.1	$ 128.2

LIFEPOINT HEALTH, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
For the Years Ended December 31, 2015, 2014 and 2013
(In millions)

	2015	2014	2013
Net income	$ 193.0	$ 134.9	$ 132.6
Other comprehensive income (loss), net of income taxes:			
Unrealized gain (loss) on changes in funded status of pension benefit obligations, net of (provision) benefit for income taxes of ($0.9), $4.2 and ($1.9) for the years ended December 31, 2015, 2014 and 2013, respectively	1.7	(7.8)	3.2
Other comprehensive income (loss)	1.7	(7.8)	3.2
Comprehensive income	194.7	127.1	135.8
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(11.1)	(8.8)	(4.4)
Comprehensive income attributable to LifePoint Health, Inc.	$ 183.6	$ 118.3	$ 131.4

LIFEPOINT HEALTH, INC.

CONSOLIDATED BALANCE SHEETS
For the Years Ended December 31, 2015 and 2014
(In millions)

	2015	2014
ASSETS		
Current assets:		
Cash and cash equivalents	$ 284.0	$ 191.5
Accounts receivable, less allowances for doubtful accounts of $796.8 and $709.5 at December 31, 2015 and 2014, respectively	743.7	752.6
Inventories	127.7	115.2
Prepaid expenses	50.8	45.4
Income taxes receivable	-	33.0
Other current assets	59.8	85.7
	1,266.0	1,223.4
Property and equipment:		
Land	162.8	134.8
Buildings and improvements	2,272.3	2,155.9
Equipment	1,767.8	1,633.8
Construction in progress (estimated costs to complete and equip after December 31, 2015 is $158.5)	119.4	72.9
	4,322.3	3,997.4
Accumulated depreciation	(1,840.0)	(1,619.9)
	2,482.3	2,377.5
Intangible assets, net	70.6	69.1
Other long-term assets	510.4	49.2
Goodwill	1,667.5	1,636.1
Total assets	$ 5,996.8	$ 5,355.3
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 164.3	$ 158.5
Accrued salaries	206.0	202.4
Income taxes payable	28.9	-
Other current liabilities	194.5	203.2
Current maturities of long-term debt	25.0	19.2
	618.7	583.3
Long-term debt, net	2,643.8	2,170.4
Deferred income taxes	94.4	114.7
Long-term portion of reserves for self-insurance claims	154.7	133.2
Other long-term liabilities	72.8	84.7
Total liabilities	3,584.4	3,086.3
Redeemable noncontrolling interests	103.6	87.1
Equity:		
LifePoint Health, Inc. stockholders' equity:		
Preferred stock, $0.01 par value; 10,000,000 shares authorized; no shares issued	-	-
Common stock, $0.01 par value; 90,000,000 shares authorized; 66,613,238 and 66,245,310 shares issued at December 31, 2015 and 2014, respectively	0.7	0.7
Capital in excess of par value	1,556.4	1,496.2
Accumulated other comprehensive loss	(2.7)	(4.4)
Retained earnings	1,655.0	1,473.1
Common stock in treasury, at cost, 23,480,203 and 21,672,250 shares at December 31, 2015 and 2014, respectively	(945.5)	(811.0)
Total LifePoint Health, Inc. stockholders' equity	2,263.9	2,154.6
Noncontrolling interests	44.9	27.3
Total equity	2,308.8	2,181.9
Total liabilities and equity	$ 5,996.8	$ 5,355.3

LIFEPOINT HEALTH, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 2015, 2014 and 2013
(In millions)

	2015	2014	2013
Cash flows from operating activities:			
Net income	$ 193.0	$ 134.9	$ 132.6
Adjustments to reconcile net income to net cash provided by operating activities:			
Income from discontinued operations	-	-	(0.4)
Stock-based compensation	30.0	27.3	25.4
Depreciation and amortization	279.0	250.5	228.2
Amortization of physician minimum revenue guarantees	12.0	14.7	17.2
Amortization of debt issuance costs, discounts and premium	5.1	14.0	26.9
Impairment charges	13.8	57.7	-
Other non-operating (gains) losses	(4.0)	-	0.3
Deferred income taxes (benefit)	(14.4)	22.8	(20.4)
Reserve for self-insurance claims, net of payments	17.9	11.7	3.3
Increase (decrease) in cash from operating assets and liabilities, net of effects from acquisitions and divestitures:			
Accounts receivable	38.7	(54.3)	(27.0)
Inventories, prepaid expenses and other current assets	19.9	(18.6)	(17.1)
Accounts payable, accrued salaries and other current liabilities	(24.7)	(14.4)	(16.3)
Income taxes payable/receivable	61.9	(35.5)	1.8
Other	(1.1)	1.5	(0.4)
Net cash provided by operating activities - continuing operations	627.1	412.3	354.1
Net cash used in operating activities - discontinued operations	-	-	(0.1)
Net cash provided by operating activities	627.1	412.3	354.0
Cash flows from investing activities:			
Purchases of property and equipment	(274.7)	(207.1)	(185.2)
Acquisitions, net of cash acquired	(619.4)	(265.6)	(188.1)
Proceeds from sale of hospital	18.8	-	-
Other	(1.0)	(0.5)	1.0
Net cash used in investing activities	(876.3)	(473.2)	(372.3)
Cash flows from financing activities:			
Proceeds from borrowings	500.0	412.0	1,053.0
Payments of borrowings	(16.9)	(585.4)	(453.7)
Repurchases of common stock	(134.5)	(222.3)	(39.1)
Payments of debt issuance costs	(7.2)	(7.2)	(20.0)
Proceeds from exercise of stock options	11.5	23.9	39.2
Other	(11.2)	(6.5)	(8.2)
Net cash provided by (used in) financing activities	341.7	(385.5)	571.2
Change in cash and cash equivalents	92.5	(446.4)	552.9
Cash and cash equivalents at beginning of period	191.5	637.9	85.0
Cash and cash equivalents at end of period	$ 284.0	$ 191.5	$ 637.9
Supplemental disclosure of cash flow information:			
Interest payments	$ 103.2	$ 112.8	$ 68.6
Capitalized interest	$ 2.2	$ 1.0	$ 1.4
Income tax payments, net	$ 62.0	$ 80.9	$ 98.2

LIFEPOINT HEALTH, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
For the Years Ended December 31, 2015, 2014 and 2013
(In millions)

	LifePoint Health, Inc. Stockholders							
	Common Stock		Capital in Excess of Par Value	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Treasury Stock	Noncontrolling Interests	Total
	Shares	Amount						
Balance at January 1, 2013	46.9	$ 0.6	$ 1,403.5	$ 0.2	$ 1,218.8	$ (572.6)	$ 22.6	$ 2,073.1
Net income	-	-	-	-	128.2	-	4.4	132.6
Other comprehensive income	-	-	-	3.2	-	-	-	3.2
Exercise of stock options, tax benefits of stock-based awards and other	1.1	0.1	41.8	-	-	-	-	41.9
Stock-based compensation	-	-	25.4	-	-	-	-	25.4
Repurchases of common stock, at cost	(0.9)	-	-	-	-	(39.1)	-	(39.1)
Noncash change in noncontrolling interests as a result of acquisition and other	-	-	-	-	-	-	1.0	1.0
Cash distributions to noncontrolling interests	-	-	-	-	-	-	(5.5)	(5.5)
Balance at December 31, 2013	47.1	0.7	1,470.7	3.4	1,347.0	(611.7)	22.5	2,232.6
Net income	-	-	-	-	126.1	-	2.3	128.4
Other comprehensive loss	-	-	-	(7.8)	-	-	-	(7.8)
Exercise of stock options, tax benefits of stock-based awards and other	0.8	-	28.0	-	-	-	-	28.0
Stock-based compensation	-	-	27.3	-	-	-	-	27.3
Repurchases of common stock, at cost	(3.9)	-	-	-	-	(222.3)	-	(222.3)
Conversion of 3 ½ % Notes	0.6	-	(22.1)	-	-	23.0	-	0.9
Noncash change in noncontrolling interests as a result of acquisition and other	-	-	(7.7)	-	-	-	4.4	(3.3)
Cash distributions to noncontrolling interests	-	-	-	-	-	-	(1.9)	(1.9)
Balance at December 31, 2014	44.6	0.7	1,496.2	(4.4)	1,473.1	(811.0)	27.3	2,181.9
Net income	-	-	-	-	181.9	-	1.7	183.6
Other comprehensive income	-	-	-	1.7	-	-	-	1.7
Exercise of stock options, tax benefits of stock-based awards and other	0.3	-	19.4	-	-	-	-	19.4
Stock-based compensation	-	-	30.0	-	-	-	-	30.0
Repurchases of common stock, at cost	(1.8)	-	-	-	-	(134.5)	-	(134.5)
Issuance of warrant and reclassification of warrant liability	-	-	13.7	-	-	-	-	13.7
Noncash change in noncontrolling interests as a result of acquisition and other	-	-	(2.9)	-	-	-	18.3	15.4
Cash distributions to noncontrolling interests	-	-	-	-	-	-	(2.4)	(2.4)
Balance at December 31, 2015	43.1	$ 0.7	$ 1,556.4	$ (2.7)	$ 1,655.0	$ (945.5)	$ 44.9	$ 2,308.8

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

Note 1. Organization and Summary of Significant Accounting Policies

Organization

LifePoint Health, Inc., formerly known as LifePoint Hospitals, Inc., a Delaware corporation, acting through its subsidiaries, owns and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities in 21 states throughout the United States ("U.S."). Unless the context otherwise indicates, LifePoint Health, Inc. and its subsidiaries are referred to herein as "LifePoint" or the "Company." Unless noted otherwise, discussions in these notes pertain to the Company's continuing operations, which exclude the results of those facilities that were disposed prior to the adoption of Accounting Standards Update ("ASU") 2014-8, "Presentation of Financial Statements and Property, Plant, and Equipment - Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity" ("ASU 2014-8").

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through the Company's direct or indirect ownership of a majority interest and exclusive rights granted to the Company as the sole general partner or controlling member of such entities. Additionally, the Company consolidates any entities for which it receives the majority of the entity's expected returns or is at risk for the majority of the entity's expected losses based upon its investment or financial interest in the entity. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation.

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

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

Use of Estimates

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

Discontinued Operations

For the year ended December 31, 2013, prior to the adoption of ASU 2014-8, the Company has presented the operating results and cash flows of its previously disposed facilities as discontinued operations, net of income taxes, in the accompanying consolidated financial statements in accordance with the provisions of ASC 360-10, "Property, Plant and Equipment", ("ASC 360-10").

In April 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-8. Among other provisions and in addition to expanded disclosures, ASU 2014-8 changes the definition of what components of an entity qualify for discontinued operations treatment and reporting from a reportable segment, operating segment, reporting unit, subsidiary or asset group to only those components of an entity that represent a strategic shift that has, or will have, a major effect on an entity's operations and financial results. Additionally, ASU 2014-8 requires disclosure about a disposal of an individually significant component of an entity that does not qualify for discontinued operations presentation in the financial statements, including the pretax profit or loss, attributable to the component of an entity for the period in which it is disposed of or is classified as held for sale. The disclosure of this information is required for all of the same periods that are presented in the entity's results of operations for the period. The Company adopted the provisions of ASU 2014-8 beginning with the year ended December 31, 2014.

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LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

As more fully discussed in Note 3, during the years ended December 31, 2015 and 2014, the Company sold Putnam Community Medical Center ("Putnam") located in Palatka, Florida, substantially all of the assets of Lakeland Community Hospital ("Lakeland"), Northwest Medical Center ("Northwest") and Russellville Hospital ("Russellville") located throughout northwest Alabama, and certain assets of River Parishes Hospital ("River Parishes") located in LaPlace, Louisiana. The Company has determined that none of the aforementioned disposals qualify for discontinued operations treatment in accordance with the provisions of ASU 2014-8. However, the Company has provided the additional required disclosures.

General and Administrative Costs

The majority of the Company's expenses are "cost of revenue" items. Costs that could be classified as "general and administrative" by the Company would include its health support center overhead costs, which were $235.5 million, $223.4 million and $182.1 million for the years ended December 31, 2015, 2014 and 2013, respectively. Included in the Company's health support center overhead costs are depreciation and amortization expenses related primarily to the Company's information systems platforms of $32.8 million, $29.5 million and $27.0 million for the years ended December 31, 2015, 2014 and 2013, respectively. Additionally, included in the Company's health support center overhead costs are transactional expenses related to the Company's recent acquisitions, including legal and consulting fees, which were $10.8 million, $12.4 million and $6.0 million for the years ended December 31, 2015, 2014 and 2013, respectively. See Note 2 for a further discussion of the Company's recent acquisition activity.

Fair Value of Financial Instruments

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

Cash and Cash Equivalents, Accounts Receivable and Accounts Payable

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

Long-Term Debt

The carrying amounts and fair values of the Company's senior secured term loan facility (the "Term Facility") and senior secured incremental term loans (the "Incremental Term Loans") under its senior secured credit agreement with, among others, Citibank, N.A. ("Citibank"), as administrative agent, and the lenders party thereto (the "Senior Credit Agreement"), 6.625% unsecured senior notes due October 1, 2020 (the "6.625% Senior Notes"), 5.5% unsecured senior notes due December 1, 2021 (the "5.5% Senior Notes") and 5.875% unsecured senior notes due December 1, 2023 (the "5.875% Senior Notes"), excluding unamortized debt issuance costs, discount and premium, as of December 31, 2015 and December 31, 2014 were as follows (in millions):

	Carrying Amount		Fair Value	
	December 31, 2015	December 31, 2014	December 31, 2015	December 31, 2014
Senior Credit Agreement:				
Term Facility	$ 405.0	$ 421.9	$ 404.5	$ 420.3
Incremental Term Loans	$ 222.6	$ 222.6	$ 222.3	$ 222.0
6.625% Senior Notes	$ 400.0	$ 400.0	$ 414.0	$ 422.0
5.5% Senior Notes	$ 1,100.0	$ 1,100.0	$ 1,105.5	$ 1,130.3
5.875% Senior Notes	$ 500.0	$ -	$ 506.3	$ -

The fair values of the Company's long-term debt instruments were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10, "Fair Value Measurements and Disclosures" ("ASC 820-10"). As more fully discussed in Note 5, effective December 4, 2015, the Company issued $500.0 million of 5.875% Senior Notes.

Common Stock Warrant

As partial consideration in connection with the Company's acquisition of Conemaugh Health System ("Conemaugh"), the Company issued a warrant to the seller. The warrant, initially classified as a liability, was marked-to-market using an option pricing model which considered the warrant's contractual term, a combination of both historical volatility and implied volatility from traded options of the Company's common stock, risk-free interest rates and dividend assumptions. Since all significant inputs were market-based and observable, the warrant was categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10.

Subsequently, effective July 23, 2015, the Company amended certain of the terms of its original asset purchase agreement with the seller and eliminated the provisions that resulted in the classification of the warrant as a liability. Accordingly, the Company completed a final mark-to-market valuation of the warrant and reclassified it to stockholders' equity upon the effective date of the modification. As of July 23, 2015 and December 31, 2014, the fair value of the warrant was approximately $11.7 million and $9.2 million, respectively. These amounts are included in the accompanying consolidated balance sheets under the captions "Capital in excess of par value" and "Other long-term liabilities" as of December 31, 2015 and 2014, respectively.

Revenue Recognition and Accounts Receivable

Overview

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

The Company's revenues by payor and approximate percentages of revenues were as follows for the years ended December 31, 2015, 2014 and 2013 (in millions):

	2015		2014		2013	
	Amount	Ratio	Amount	Ratio	Amount	Ratio
Medicare	$ 1,515.0	29.1 %	$ 1,361.4	30.4 %	$ 1,199.5	32.6 %
Medicaid	841.6	16.1	619.8	13.8	517.0	14.1
HMOs, PPOs and other private insurers	2,791.9	53.5	2,476.7	55.2	1,876.1	51.0
Self-pay	744.1	14.3	744.9	16.6	766.5	20.8
Other	121.8	2.3	98.1	2.2	69.6	1.9
Revenues before provision for doubtful accounts	6,014.4	115.3	5,300.9	118.2	4,428.7	120.4
Provision for doubtful accounts	(800.1)	(15.3)	(817.8)	(18.2)	(750.4)	(20.4)
Revenues	$ 5,214.3	100.0 %	$ 4,483.1	100.0 %	$ 3,678.3	100.0 %

Contractual Discounts and Cost Report Settlements

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

Cost report settlements under reimbursement agreements with Medicare, Medicaid and certain other payors are estimated and recorded in the period the related services are rendered and are adjusted in future periods as final settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. The net adjustments to estimated cost report settlements resulted in a decrease to revenues of approximately $0.5 million, a decrease to net income of approximately $0.3 million and a decrease to diluted earnings per share of approximately $0.01 for the year ended December 31, 2015. The net adjustments to estimated cost report settlements resulted in increases to revenues of approximately $2.5 million and $5.6 million, increases to net income of approximately $1.6 million and $3.5 million, and increases to diluted earnings per share of approximately $0.03 and $0.07 for the years ended December 31, 2014 and 2013, respectively. The net cost report settlements due from the Company included as a current liability under the caption "Other current liabilities" in the accompanying consolidated balance sheets, were approximately $12.9 million and $11.2 million at December 31, 2015 and 2014, respectively. The Company's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs.

Laws and regulations governing Medicare and Medicaid programs are complex and subject to interpretation. The Company believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Company's financial statements. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

Charity Care

Self-pay revenues are derived primarily from patients who do not have any form of healthcare coverage. The revenues associated with self-pay patients are generally reported at the Company's gross charges. The Company evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the local hospital's policy for charity care. The Company provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the years ended December 31, 2015, 2014 and 2013, the Company estimates that its costs of care provided under its charity care programs approximated $23.3 million, $21.2 million and $35.2 million, respectively. The decrease in the Company's estimated costs of charity care during the years ended December 31, 2015 and 2014 as compared to the year ended December 31, 2013 was primarily due to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of the Company's patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which the Company operates. The Company does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Company's policy not to pursue collection of amounts related to these patients.

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

Provision and Allowance for Doubtful Accounts

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

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

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

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

	Balances at Beginning of Year	Additions Recognized as a Reduction to Revenues	Accounts Written Off, Net of Recoveries	Balances at End of Year
Year ended December 31, 2015	$ 709.5	$ 800.1	$ (712.8)	$ 796.8
Year ended December 31, 2014	$ 741.2	$ 817.8	$ (849.5)	$ 709.5
Year ended December 31, 2013	$ 558.4	$ 750.4	$ (567.6)	$ 741.2

The allowances for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts were 51.7% and 48.5% as of December 31, 2015 and 2014, respectively. Additionally, as of December 31, 2015 and 2014, the allowances for doubtful accounts plus certain contractual allowances and discounts related to self-pay patients as a percentage of self-pay receivables were 88.9% and 88.4%, respectively.

Concentration of Revenues

During the years ended December 31, 2015, 2014 and 2013, approximately 45.2%, 44.2% and 46.7%, respectively, of the Company's revenues related to patients participating in the Medicare and Medicaid programs, collectively. The Company's management recognizes that revenues and receivables from government agencies are significant to the Company's operations, but it does not believe that there are significant credit risks associated with these government agencies. The Company's management does not believe that there are any other significant concentrations of revenues from any particular payor that would subject the Company to any significant credit risks in the collection of its accounts receivable.

The Company's revenues are particularly sensitive to regulatory and economic changes in certain states where the Company generates significant revenues. The following is an analysis by state of revenues as a percentage of the Company's total revenues for those states in which the Company generates significant revenues for the years ended December 31, 2015, 2014 and 2013:

		Revenue Concentration by State					
	Hospital Campuses in State as of December 31, 2015	2015		2014		2013	
		Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Virginia	6	$ 641.9	12.3 %	$ 624.4	13.9 %	$ 469.2	12.8 %
Kentucky	10	638.5	12.2	587.9	13.1	520.9	14.2
North Carolina	7	580.3	11.1	372.6	8.3	129.6	3.5
Pennsylvania	4	566.5	10.9	172.5	3.8	-	-
Michigan	3	476.2	9.1	460.8	10.3	345.4	9.4
Tennessee	10	420.7	8.1	404.5	9.0	394.9	10.7
New Mexico	2	287.3	5.5	266.5	5.9	256.5	7.0

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

Other Income

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

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

For the years ended December 31, 2015, 2014 and 2013, the Company recognized $49.7 million, $71.9 million and $64.1 million in EHR incentive payments, respectively, under the Medicare and Medicaid HITECH Act programs, collectively. These payments are reflected separately in the accompanying consolidated statement of operations under the caption "Other income". Amounts recognized as other income that the Company anticipates collecting in future periods, but that were uncollected as of the balance sheet date totaled approximately $22.9 million and $36.8 million as of December 31, 2015 and 2014, respectively, and are included in the accompanying consolidated balance sheets under the caption "Other current assets".

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

Cash and Cash Equivalents

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

Inventories

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

Long-Lived Assets

Property and Equipment

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

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

	Years		
Buildings and improvements (including those under capital leases and financing obligations)	10	-	40
Equipment	3	-	10
Equipment under capital leases	3	-	5

Depreciation expense was $276.7 million, $247.6 million and $222.9 million for the years ended December 31, 2015, 2014 and 2013, respectively. Amortization expense related to assets under capital leases and financing obligations and capitalized internal-use software costs are included in depreciation expense.

As of December 31, 2015, the majority of the Company's assets under capital leases and financing obligations are primarily comprised of prepaid capital leases. The Company's assets under capital leases and financing obligations are set forth in the following table at December 31, 2015 and 2014 (in millions):

	2015	2014
Buildings and improvements	$ 303.0	$ 287.2
Equipment	40.2	45.8
	343.2	333.0
Accumulated amortization	(126.5)	(111.3)
	$ 216.7	$ 221.7

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

As more fully discussed in Note 3, during the years ended December 31, 2015 and 2014, the Company recognized pre-tax impairment charges of $13.8 million and $57.7 million, respectively, in connection with the divestiture of certain of its hospitals. A portion of these charges related to the write-down of property and equipment to their estimated fair values.

Goodwill and Intangible Assets

The Company accounts for its acquisitions in accordance with ASC 805-10 using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350-10, "Intangibles — Goodwill and Other" ("ASC 350-10"), goodwill and intangible assets with indefinite lives are reviewed by the Company at least annually for impairment. The Company's business comprises a single reporting unit for impairment test purposes. For the purposes of these analyses, the Company's estimates of fair value are based on a combination of the income approach, which estimates the fair value of the Company based on its future discounted cash flows, and the market approach, which estimates the fair value of the Company based on comparable market prices. During the years ended December 31, 2015, 2014 and 2013, the Company performed its annual impairment tests as of October 1 and did not incur an impairment charge.

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

Income Taxes

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

Point of Life Indemnity, Ltd.

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

Reserves for Self-Insurance Claims

Given the nature of the Company's operating environment, it is subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding a self-insured retention level. The Company's self-insured retention level for professional liability claims is $5.0 million per claim at December 31, 2015 with a $5.0 million inner aggregate. Additionally, the Company's self-insured retention level for workers' compensation claims is $1.0 million per claim in all states in which it operates except for Wyoming. The Company participates in a state specific program in Wyoming for its workers' compensation claims arising in this state. The Company's self-insured retention levels are evaluated annually as a part of its insurance program's renewal process.

The Company's reserves for self-insurance claims reflects the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The Company's expense for self-insurance claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of the Company's self-insured retention levels; the administrative costs of the insurance program; and interest expense related to the discounted portion of the liability. The Company's expense for self-insurance claims was approximately $56.4 million, $50.6 million and $40.4 million for the years ended December 31, 2015, 2014 and 2013, respectively.

The Company's reserves for professional liability claims are based upon quarterly actuarial calculations. The Company's reserves for employee workers' compensation claims are based upon semi-annual actuarial calculations. These reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. The Company's reserves for self-insured claims have been discounted to their present value using a discount rate of 1.35%, 1.50% and 1.55% at December 31, 2015, 2014 and 2013, respectively. The Company's management selects a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

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

The following table provides information regarding the classification of the Company's reserves for self-insured claims at December 31, 2015 and 2014 (in millions):

	2015	2014
Current portion	$ 41.5	$ 44.3
Long-term portion	154.7	133.2
	$ 196.2	$ 177.5

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of the Company's quarterly and semi-annual actuarial calculations resulted in changes to its reserves for self-insured claims for prior years. As a result, for the years ended December 31, 2015, 2014 and 2013, the Company's related self-insured claims expense decreased by $1.0 million, $5.1 million and $12.9 million, which increased net income by approximately $0.6 million, $3.3 million and $7.9 million, or $0.01, $0.07 and $0.17 per diluted share, respectively.

Self-Insured Medical Benefits

The Company is self-insured for substantially all of the medical expenses and benefits of its employees. The reserve for medical benefits primarily reflects the current estimate of incurred but not reported losses based upon an annual actuarial calculation as of the balance sheet date. The undiscounted reserve for self-insured medical benefits was $28.5 million at both December 31, 2015 and 2014, and is included in the Company's accompanying consolidated balance sheets under the caption "Other current liabilities".

Noncontrolling Interests and Redeemable Noncontrolling Interests

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

The following table presents the changes in the Company's noncontrolling interests during the years ended December 31, 2015 and 2014 (in millions):

Balance at January 1, 2014	$ 22.5
Net income attributable to noncontrolling interests	2.3
Acquisitions	8.3
Distributions and other	(5.8)
Balance at December 31, 2014	27.3
Net income attributable to noncontrolling interests	1.7
Acquisitions	17.0
Distributions and other	(1.1)
Balance at December 31, 2015	$ 44.9

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

The following table presents the changes in the Company's redeemable noncontrolling interests during the years ended December 31, 2015 and 2014 (in millions):

Balance at January 1, 2014	$ 59.8
Net income attributable to redeemable noncontrolling interests	6.5
Acquisitions	19.6
Distributions and other	1.2
Balance at December 31, 2014	87.1
Net income attributable to redeemable noncontrolling interests	9.4
Acquisitions	7.7
Fair value adjustments	3.6
Distributions and other	(4.2)
Balance at December 31, 2015	$ 103.6

Segment Reporting

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

Stock-Based Compensation

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

Deferred Cash Awards

The Company grants deferred cash awards to certain employees that are subject to continuing service requirements and a ratable vesting term of three years. The Company recognizes compensation expense for these awards over their requisite service period. For the years ended December 31, 2015, 2014 and 2013, expense related to the Company's deferred cash awards was approximately $8.6 million, $7.6 million and $7.0 million, respectively. As of December 31, 2015, there was $11.2 million of total estimated unrecognized compensation costs related to deferred cash awards arrangements. The Company expects to recognize this cost over a weighted average period of 1.3 years.

Defined Contribution Plans

The Company maintains multiple defined contribution retirement plans that cover a majority of the Company's employees with a discretionary matching policy based on the Company's financial performance and definite contribution formulas for employees at certain facilities. The Company's expense related to its defined contribution plans was $23.6 million, $24.5 million and $11.1 million for the years ended December 31, 2015, 2014 and 2013, respectively.

Defined Benefit Pension Plans

In connection with its acquisition of Marquette General Health System ("Marquette General"), effective September 1, 2012, the Company acquired certain assets and assumed certain liabilities associated with the benefits in the seller's defined benefit pension plan of certain employees covered by a collective bargaining agreement. The Company has established a separate defined benefit pension plan (the "Marquette Pension Plan"), to facilitate its administration of the assumed portion of the seller's defined benefit pension plan. Additionally, in connection with its acquisition of Bell Hospital ("Bell"), effective December 1, 2013, the Company assumed sponsorship of Bell's defined benefit pension plan, which provides benefits to certain non-union employees (the "Bell Pension Plan" and, collectively with the Marquette Pension Plan, the "Pension Plans").

The Company accounts for its Pension Plans in accordance with ASC 715-30 "Compensation – Defined Benefit Plans", ("ASC 715-30"). In accordance with ASC 715-30, the Company recognizes the unfunded liability of its Pension Plans in the Company's consolidated balance sheets and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the Pension Plans' assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligation is measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality.

Earnings Per Share ("EPS")

EPS is based on the weighted average number of common shares outstanding and the effect of stock options, other stock-based awards, common stock warrants and convertible debt instruments, when dilutive. In addition, the numerator of EPS, net income attributable to LifePoint Health, Inc., is adjusted for interest expense related to the Company's convertible debt instruments, when dilutive, as more fully discussed in Note 5 and Note 12. The computation of the Company's basic and diluted EPS is set forth in Note 12.

Adoption of Recently Issued Accounting Standards

ASU 2015-17, "Income Taxes: Balance Sheet Classification of Deferred Taxes"

In November 2015, the FASB issued ASU 2015-17, "Income Taxes: Balance Sheet Classification of Deferred Taxes" ("ASU 2015-17"). ASU 2015-17 requires deferred tax assets and liabilities to be netted and presented as a single non-current amount in the balance sheet, rather than separating them into current and non-current amounts. The Company adopted the provisions of ASU 2015-17 during the fourth quarter of 2015 and retrospectively for all periods presented. The adoption of ASU 2015-17 had no impact on the Company's results of operations or cash flows.

ASU 2015-3, "Simplifying the Presentation of Debt Issuance Costs"

In April 2015, the FASB issued ASU 2015-3, "Simplifying the Presentation of Debt Issuance Costs" ("ASU 2015-3"). ASU 2015-3 requires debt issuance costs related to a recognized debt liability to be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts, rather than separately as an asset. The Company adopted the provisions of ASU 2015-3 during the fourth quarter of 2015 and retrospectively for all periods presented. The adoption of ASU 2015-3 had no impact on the Company's results of operations or cash flows.

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The following is a summary of the line items impacted by the adoption of ASU 2015-17 and ASU 2015-3 in the Company's December 31, 2014 accompanying consolidated balance sheet (in millions):

	As Originally Reported	Adjustments for the Adoption of ASU 2015-17	Adjustments for the Adoption of ASU 2015-3	As Currently Reported
Deferred tax assets	$ 72.8	$ (72.8)	$ -	$ -
Total current assets	$ 1,296.2	$ (72.8)	$ -	$ 1,223.4
Deferred loan costs, net	$ 31.7	$ -	$ (31.7)	$ -
Other long-term assets	$ 46.4	$ -	$ 2.8	$ 49.2
Total assets	$ 5,457.0	$ (72.8)	$ (28.9)	$ 5,355.3
Long-term debt, net	$ 2,199.3	$ -	$ (28.9)	$ 2,170.4
Deferred income taxes	$ 187.5	$ (72.8)	$ -	$ 114.7
Total liabilities	$ 3,188.0	$ (72.8)	$ (28.9)	$ 3,086.3
Total liabilities and equity	$ 5,457.0	$ (72.8)	$ (28.9)	$ 5,355.3

Accounting Standards Not Yet Adopted

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

In September 2015, the FASB issued ASU 2015-16, "Business Combinations: Simplifying the Accounting for Measurement-Period Adjustments" ("ASU 2015-16"). ASU 2015-16 eliminates the requirement for an acquirer to retrospectively adjust its financial statements for changes to provisional amounts that are identified during the measurement-period following the consummation of a business combination. Instead, ASU 2015-16 requires these types of adjustments to be made during the reporting period in which they are identified and would require additional disclosure or separate presentation of the portion of the adjustment that would have been recorded in the previously reported periods as if the adjustment to the provisional amounts had been recognized as of the acquisition date. ASU 2015-16 is effective prospectively for fiscal years beginning after December 15, 2015, including interim periods within those years. The adoption of ASU 2015-16 is not expected to have a material impact on the Company's results of operations.

ASU 2015-2, "Consolidation"

In February 2015, the FASB issued ASU 2015-2 "Consolidation" ("ASU 2015-2"). ASU 2015-2 includes amendments that are intended to improve targeted areas of consolidation for legal entities including reducing the number of consolidation models from four to two and simplifying the FASB ASC. The provisions of ASU 2015-2 are effective for annual reporting periods beginning after December 15, 2015. The amendments may be applied retrospectively in previously issued financial statements for one or more years with a cumulative effect adjustment to retained earnings as of the beginning of the first year restated. Early adoption is permitted. The adoption of ASU 2015-2 is not expected to have a material impact on the Company's financial position, results of operation, cash flows or financial disclosures.

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

In May 2014, the FASB issued ASU 2014-9, "Revenue from Contracts with Customers" ("ASU 2014-9"). ASU 2014-9 provides for a single comprehensive principles-based standard for the recognition of revenue across all industries through the application of the following five-step process:

Step 1: Identify the contract(s) with a customer.
Step 2: Identify the performance obligations in the contract.
Step 3: Determine the transaction price.
Step 4: Allocate the transaction price to the performance obligations in the contract.
Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

Among other provisions and in addition to expanded disclosure about the nature, amount, timing and uncertainty of revenue as well as certain additional quantitative and qualitative disclosures, ASU 2014-9 changes the healthcare industry specific presentation guidance under ASU 2011-7, "Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities." The provisions of ASU 2014-9 are effective for annual periods beginning after December 15, 2017, including interim periods within those years. Early adoption is not permitted. The Company is currently evaluating the impact that the adoption of ASU 2014-9 will have on its revenue recognition policies and procedures, financial position, result of operations, cash flows, financial disclosures and control framework.

Note 2. Acquisitions

2015 Acquisitions

Watertown Regional Medical Center ("Watertown")

Effective September 1, 2015, the Company acquired an 80% interest in an entity that owns and operates Watertown, a 95 bed acute care hospital located in Watertown, Wisconsin for total consideration, including 80% of the net working capital, of approximately $32.9 million, comprised of $30.9 million in cash and the issuance of a warrant with an estimated fair value of $2.0 million. See Note 8 for further discussion of the Company's common stock warrants. The Company has committed to invest in Watertown an additional $73.7 million in capital expenditures and improvements over the next ten years. The results of operations of Watertown are included in the Company's results of operations beginning on September 1, 2015. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company's acquisition of Watertown have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the final appraisals. The Company expects to finalize its analysis during 2016.

Clark Memorial Hospital ("Clark Memorial")

Effective August 1, 2015, through its joint venture with Norton Healthcare, Inc., the Regional Health Network of Kentucky and Southern Indiana ("RHN"), the Company acquired Clark Memorial, a 236 bed acute care hospital located in Jeffersonville, Indiana for approximately $56.5 million, including net working capital. The Company has committed to invest in Clark Memorial an additional $80.0 million in capital expenditures and improvements over the next ten years. The results of operations of Clark Memorial are included in the Company's results of operations beginning on August 1, 2015. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company's acquisition of Clark Memorial have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the final appraisals. The Company expects to finalize its analysis during 2016.

Fleming County Hospital ("Fleming")

Effective August 1, 2015, the Company acquired Fleming, a 52 bed acute care hospital located in Flemingsburg, Kentucky for approximately $21.8 million, including net working capital. The Company has committed to invest in Fleming an additional $7.0 million in capital expenditures and improvements over the next ten years. The results of operations of Fleming are included in the Company's results of operations beginning on August 1, 2015. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company's acquisition of Fleming have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the final appraisals. The Company expects to finalize its analysis during 2016.

Nason Hospital ("Nason")

Effective February 1, 2015, the Company acquired Nason, a 45 bed acute care hospital located in Roaring Spring, Pennsylvania for approximately $3.5 million, including net working capital. The Company has committed to invest in Nason an additional $8.5 million in capital expenditures and improvements over the next ten years. The results of operations of Nason are included in the Company's results of operations beginning on February 1, 2015.

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2014 Acquisitions

Conemaugh Health System ("Conemaugh")

Effective September 1, 2014, through Duke LifePoint Healthcare, the Company acquired Conemaugh for total consideration, including net working capital, of approximately $125.0 million, comprised of $115.0 million in cash and the issuance of a warrant with an estimated fair value of $10.0 million. See Note 8 for further discussion of the Company's common stock warrants. Conemaugh is comprised of Conemaugh Memorial Medical Center, a 470 bed acute care hospital, 39 bed rehabilitation facility and 30 bed long-term care facility located in Johnstown, Pennsylvania, Meyersdale Medical Center, a 20 bed critical access hospital located in Meyersdale, Pennsylvania, and Miners Medical Center, a 30 bed acute care hospital located in Hastings, Pennsylvania. The results of operations of Conemaugh are included in the Company's results of operations beginning on September 1, 2014.

Haywood Regional Medical Center ("Haywood")

Effective August 1, 2014, through Duke LifePoint Healthcare, the Company acquired Haywood, a 169 bed acute care hospital located in Clyde, North Carolina for approximately $28.5 million, including net working capital. The results of operations of Haywood are included in the Company's results of operations beginning on August 1, 2014.

WestCare Health System ("WestCare")

Effective August 1, 2014, through Duke LifePoint Healthcare, the Company acquired WestCare for approximately $19.0 million, including net working capital and the assumption of certain capital leases. WestCare is comprised of Harris Regional Hospital, an 86 bed acute care hospital located in Sylva, North Carolina, and Swain County Hospital, a 48 bed critical access hospital located in Bryson City, North Carolina. The results of operations of WestCare are included in the Company's results of operations beginning on August 1, 2014.

Rutherford Regional Medical Center ("Rutherford")

Effective June 1, 2014, through Duke LifePoint Healthcare, the Company acquired an 80% interest in an entity that owns Rutherford, a 143 bed acute care hospital located in Rutherfordton, North Carolina for approximately $27.2 million, including net working capital. The results of operations of Rutherford are included in the Company's results of operations beginning on June 1, 2014.

Wilson Medical Center ("Wilson")

Effective March 1, 2014, through Duke LifePoint Healthcare, the Company acquired an 80% interest in an entity that owns Wilson, a 294 bed hospital and 90 bed long-term care facility located in Wilson, North Carolina for approximately $59.8 million, including net working capital. The results of operations of Wilson are included in the Company's results of operations beginning on March 1, 2014.

2013 Acquisitions

Bell Hospital ("Bell")

Effective December 1, 2013, the Company acquired Bell, a 25 bed critical access hospital located in Ishpeming, Michigan for approximately $28.3 million, including net working capital. The results of operations of Bell are included in the Company's results of operations beginning on December 1, 2013.

Portage Health ("Portage")

Effective December 1, 2013, the Company acquired an 80% interest in an entity that owns and operates Portage, a 36 bed hospital and 60 bed long-term care facility located in Hancock, Michigan for approximately $37.3 million, including 80% of the net working capital. The results of operations of Portage are included in the Company's results of operations beginning on December 1, 2013.

Fauquier Health ("Fauquier")

Effective November 1, 2013, the Company acquired an 80% interest in an entity that owns and operates Fauquier, a 97 bed hospital and 113 bed long-term care facility located in Warrenton, Virginia for approximately $103.7 million, including 80% of the net working capital. The results of operations of Fauquier are included in the Company's results of operations beginning on November 1, 2013.

Scott Memorial Hospital ("Scott Memorial")

Effective January 1, 2013, through RHN, the Company acquired Scott Memorial, a 25 bed critical access hospital located in Scottsburg, Indiana for approximately $9.5 million, including net working capital. The results of operations of Scott Memorial are included in the Company's results of operations beginning on January 1, 2013.

Other

The Company completed certain ancillary service-line acquisitions and finalized net working capital settlements totaling $58.7 million, $16.1 million and $18.8 million during the years ended December 31, 2015, 2014 and 2013, respectively.

Additionally, during the year ended December 31, 2015, the Company recorded a bargain purchase gain of approximately $4.0 million, $2.5 million net of income taxes, or $0.05 per diluted share, as a result of the final fair values assigned to the tangible and intangible assets acquired less obligations assumed, in connection with our acquisition of a hospital, exceeding the total cash consideration paid. This amount is reflected in the accompanying consolidated statement of operations under the caption "Other non-operating (gains) losses" for the year ended December 31, 2015.

Note 3. Divestitures and Impairment Charges

Putnam Community Medical Center

Effective May 1, 2015, the Company sold Putnam for $18.8 million, including net working capital. Included in the Company's consolidated statements of operations is a net loss before income taxes attributable to Putnam of $2.6 million for the year ended December 31, 2015, net income before income taxes attributable to Putnam of $3.2 million for the year ended December 31, 2014 and a net loss before income taxes attributable to Putnam of $1.7 million for the year ended December 31, 2013.

In connection with the Company's sale of Putnam, the Company recognized impairment charges of $10.8 million, $7.0 million net of income taxes, or $0.15 loss per diluted share, during the year ended December 31, 2015. The impairment charges include the write-down of property, equipment, allocated goodwill and certain other assets to their estimated fair values as well as the finalization of the net working capital settlement.

Northwest Alabama Market

Effective January 1, 2015, the Company sold substantially all of the assets of Lakeland, Northwest and Russellville. Included in the Company's consolidated statements of operations is net income before income taxes attributable to these three facilities in the aggregate of $1.7 million for the year ended December 31, 2015 and net losses before income taxes attributable to these three facilities in the aggregate of $0.3 million and $6.8 million for the years ended December 31, 2014 and 2013, respectively.

In connection with the Company's sale of Lakeland, Northwest and Russellville, the Company recognized impairment charges in the aggregate of $3.0 million and $45.5 million, $1.9 million and $28.1 million net of income taxes, or $0.04 and $0.60 loss per diluted share, during the years ended December 31, 2015 and 2014, respectively. The impairment charges include the write-down of property, equipment, allocated goodwill and certain other assets to their estimated fair values.

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River Parishes

Effective November 1, 2014, the Company sold certain assets of River Parishes and discontinued its operation. Included in the Company's consolidated statements of operations are net losses before income taxes attributable to River Parishes of $0.4 million, $4.0 million and $4.5 million for the years ended December 31, 2015, 2014 and 2013, respectively.

In connection with the Company's sale of River Parishes, the Company recognized an impairment charge of $12.2 million, $7.8 million net of income taxes, or $0.16 loss per diluted share, during the year ended December 31, 2014. The impairment charge includes the write-down of property, equipment and allocated goodwill to their estimated fair values.

Note 4. Goodwill and Intangible Assets

The following table presents the changes in the carrying amount of goodwill during the years ended December 31, 2015 and 2014 (in millions):

Balance at January 1, 2014	$ 1,651.0
Acquisitions	10.2
Divestitures	(2.9)
Adjustments related to prior year acquisitions	(22.2)
Balance at December 31, 2014	1,636.1
Acquisitions	31.5
Divestitures	(5.3)
Adjustments related to prior year acquisitions	5.2
Balance at December 31, 2015	$ 1,667.5

The following table provides information regarding the Company's intangible assets, which are included in the accompanying consolidated balance sheets at December 31, 2015 and 2014 (in millions):

	2015	2014
Amortized intangible assets:		
Contract-based physician minimum revenue guarantees		
Gross carrying amount	$ 48.9	$ 62.3
Accumulated amortization	(28.9)	(35.5)
Net total	20.0	26.8
Non-competition agreements and other		
Gross carrying amount	20.2	23.6
Accumulated amortization	(11.2)	(15.9)
Net total	9.0	7.7
Total amortized intangible assets		
Gross carrying amount	69.1	85.9
Accumulated amortization	(40.1)	(51.4)
Net total	29.0	34.5
Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	30.6	29.5
Licenses, provider numbers, accreditations and other	11.0	5.1
Net total	41.6	34.6
Total intangible assets:		
Gross carrying amount	110.7	120.5
Accumulated amortization	(40.1)	(51.4)
Net total	$ 70.6	$ 69.1

Contract-Based Physician Minimum Revenue Guarantees

The Company has committed to provide certain financial assistance pursuant to recruiting agreements, or "physician minimum revenue guarantees," with various physicians practicing in the communities it serves. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician to assist in establishing his or her practice.

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460-10, "Guarantees" ("ASC 460-10"). In accordance with ASC 460-10, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized as a component of other operating expenses, in the accompanying consolidated statements of operations, over the period of the physician contract, which typically ranges from four to five years. As of December 31, 2015 and 2014, the Company's liability for contract-based physician minimum revenue guarantees was $8.1 million and $9.3 million, respectively. These amounts are included as a current liability under the caption "Other current liabilities" in the Company's accompanying consolidated balance sheets.

Non-Competition Agreements

The Company has entered into non-competition agreements with certain physicians and other individuals which are amortized on a straight-line basis over the term of the agreements.

Certificates of Need and Certificates of Need Exemptions

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and certain equipment at the Company's facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. The Company has acquired facilities in certain states that have adopted certificate of need laws. The Company has determined that these intangible assets have an indefinite useful life.

Licenses, Provider Numbers, Accreditations and Other

To operate hospitals, the Company must obtain certain licenses, provider numbers and accreditations from federal, state and other accrediting agencies. The Company has acquired facilities in certain jurisdictions that require licenses, provider numbers and accreditations. The Company has determined that these intangible assets have an indefinite useful life.

Amortization Expense

Amortization expense for the Company's intangible assets, including physician minimum revenue guarantee expense in accordance with ASC 460-10, during the years ended December 31, 2015, 2014 and 2013 was $14.5 million, $17.6 million and $22.5 million, respectively.

Total estimated amortization expense for the Company's intangible assets during the next five years and thereafter are as follows (in millions):

2016	$	11.9
2017		7.5
2018		4.9
2019		3.1
2020		1.1
Thereafter		0.5
	$	29.0

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Note 5. Long-Term Debt

The Company's long-term debt, all of which was senior, consists of the following at December 31, 2015 and 2014 (in millions):

	2015	2014
Senior Credit Agreement:		
Term Facility	$ 405.0	$ 421.9
Incremental Term Loans	222.6	222.6
6.625% Senior Notes	400.0	400.0
5.5% Senior Notes	1,100.0	1,100.0
5.875% Senior Notes	500.0	-
Unamortized debt issuance costs, discount and premium	(22.2)	(19.0)
	2,605.4	2,125.5
Capital leases and financing obligations	63.4	64.1
Total debt	$ 2,668.8	$ 2,189.6

Maturities of the Company's long-term debt at December 31, 2015, excluding unamortized debt issuance costs, discount and premium and other obligations that do not require eventual settlement in cash, are as follows for the years indicated (in millions):

2016	$ 25.0
2017	607.0
2018	2.1
2019	2.2
2020	402.5
Thereafter	1,625.3
	$ 2,664.1

Senior Credit Agreement

Terms

The Senior Credit Agreement, which was issued effective July 24, 2012 and matures on July 24, 2017, provides for the Term Facility, the Incremental Term Loans and a $350.0 million Revolving Facility. The Term Facility requires scheduled quarterly repayments in an amount equal to 2.5% per annum for each of the first, second and third years and 5.0% per annum for the fourth year and first three quarters of the fifth year, with the balance due at maturity. Additionally, the Term Facility and Incremental Term Loans are subject to mandatory prepayments based on excess cash flow, as well as upon the occurrence of certain other events, as specifically described in the Senior Credit Agreement. The Senior Credit Agreement is guaranteed on a senior basis by the Company's subsidiaries with certain limited exceptions.

Letters of Credit and Availability

The Revolving Facility may be utilized for letters of credit and swingline loans up to a maximum of $75.0 million and $25.0 million, respectively. Issued letters of credit and outstanding swingline loans reduce the amounts available for borrowing under the Revolving Facility. As of December 31, 2015, the Company had $19.9 million in letters of credit outstanding that were related to the self-insured retention level of its general and professional liability insurance and workers' compensation programs as security for payment of claims. Under the terms of the Senior Credit Agreement, amounts available for borrowing under the Revolving Facility were $330.1 million as of December 31, 2015.

The Senior Credit Agreement may, subject to certain conditions and to receipt of commitments from new or existing lenders, be increased up to a total of (i) $800.0 million and (ii) an amount such that, after giving pro forma effect to such increase and to the use of proceeds therefrom, the Company's secured leverage ratio does not exceed 3.50:1.00; provided that no lender is obligated to participate in any such increase.

Interest Rates

Interest on the outstanding borrowings under the Senior Credit Agreement is payable at the Company's option at either an adjusted London Interbank Offer Rate ("LIBOR") or an adjusted base rate plus an applicable margin. The applicable margin under the Senior Credit Agreement ranges from 1.50% to 2.50% for LIBOR loans and from 0.50% to 1.50% for adjusted base rate loans based on the Company's total leverage ratio, calculated in accordance with the Senior Credit Agreement.

As of December 31, 2015, the applicable annual interest rates under the Term Facility and the Incremental Term Loans were 2.18% and 2.93%, respectively, which were based on the 30-day adjusted LIBOR plus the applicable margins. The 30-day adjusted LIBOR was 0.43% for both the Term Facility and the Incremental Term Loans as of December 31, 2015.

Covenants

The Senior Credit Agreement requires the Company to satisfy a maximum total leverage ratio calculated on a trailing four quarter basis not to exceed the following thresholds for the indicated date ranges:

Date Range	Maximum Total Leverage Ratio
July 1, 2015 to June 30, 2016	4.50:1.00
July 1, 2016 to June 30, 2017	4.25:1.00

The Company was in compliance with this covenant as of December 31, 2015.

In addition, the Senior Credit Agreement contains certain customary affirmative and negative covenants, which among other things, limit the Company's ability to incur additional debt, create liens, merge, consolidate, enter into acquisitions, sell assets, effect sale leaseback transactions, pay dividends, pay subordinated debt and effect transactions with its affiliates. It does not contain provisions that would accelerate the maturity dates upon a downgrade in the Company's credit rating. However, a downgrade in the Company's credit rating could adversely affect its ability to obtain other capital sources in the future and could increase the Company's cost of borrowings.

6.625% Senior Notes

Effective September 23, 2010, the Company issued in a private placement $400.0 million of 6.625% unsecured senior notes due October 1, 2020 with The Bank of New York Mellon Trust Company, N.A., as trustee. The 6.625% Senior Notes bear interest at the rate of 6.625% per year, payable semi-annually on April 1 and October 1. The 6.625% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by certain of the Company's existing and future domestic subsidiaries.

The Company may redeem its 6.625% Senior Notes, in whole or in part, for a redemption price equal to a percentage of the principal amount of the notes redeemed (plus accrued and unpaid interest, if any, to the date of redemption) based on the following redemption schedule:

October 1, 2015 to September 30, 2016	103.313 %
October 1, 2016 to September 30, 2017	102.208 %
October 1, 2017 to September 30, 2018	101.104 %
October 1, 2018 and thereafter	100.000 %

If the Company experiences a change of control under certain circumstances, it must offer to repurchase all of the notes at a price equal to 101.000% of their principal amount, plus accrued and unpaid interest, if any, to the repurchase date.

The 6.625% Senior Notes contain customary affirmative and negative covenants, which among other things, limit the Company's ability to incur additional debt, create liens, pay dividends, effect transactions with its affiliates, sell assets, pay subordinated debt, merge, consolidate, enter into acquisitions and effect sale leaseback transactions.

5.5% Senior Notes

Effective December 6, 2013 and again on May 12, 2014, the Company issued in two separate private placements $700.0 million and $400.0 million, respectively, of the 5.5% Senior Notes with The Bank of New York Mellon Trust Company, N.A., as trustee. Collectively, the 5.5% Senior Notes mature on December 1, 2021 and bear interest at the rate of 5.5% per year, payable semi-annually on June 1 and December 1. The 5.5% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by certain of the Company's existing and future domestic subsidiaries.

The Company may redeem up to 35% of the aggregate principal amount of the 5.5% Senior Notes, at any time before December 1, 2016, with the net cash proceeds of certain equity offerings at a redemption price equal to 105.500% of the principal amount to be redeemed, plus accrued and unpaid interest, provided that at least 65% of the aggregate principal amount of the 5.5% Senior Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of any such qualified equity offering.

The Company may redeem the 5.5% Senior Notes, in whole or in part, at any time prior to December 1, 2016 at a price equal to 100% of the principal amount of the notes redeemed plus an applicable make-whole premium, plus accrued and unpaid interest, if any, to the date of redemption. The Company may redeem the 5.5% Senior Notes, in whole or in part, at any time on or after December 1, 2016, plus accrued and unpaid interest, if any, to the date of redemption plus a redemption price equal to a percentage of the principal amount of the notes redeemed based on the following redemption schedule:

December 1, 2016 to November 30, 2017	104.125 %
December 1, 2017 to November 30, 2018	102.750 %
December 1, 2018 to November 30, 2019	101.375 %
December 1, 2019 and thereafter	100.000 %

If the Company experiences a change in control under certain circumstances, it must offer to purchase the notes at a purchase price equal to 101.000% of the principal amount, plus accrued and unpaid interest to the date of purchase.

The 5.5% Senior Notes contain customary affirmative and negative covenants, which among other things, limit the Company's ability to incur additional debt, create liens, pay dividends, effect transactions with its affiliates, sell assets, pay subordinated debt, merge, consolidate, enter into acquisitions and effect sale leaseback transactions.

5.875% Senior Notes

Effective December 4, 2015, the Company issued in a public offering $500.0 million of 5.875% unsecured senior notes due December 1, 2023 with The Bank of New York Mellon Trust Company, N.A., as trustee. The 5.875% Senior Notes bear interest at the rate of 5.875% per year, payable semi-annually on June 1 and December 1. The 5.875% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by certain of the Company's existing and future domestic subsidiaries.

The Company may redeem up to 35% of the aggregate principal amount of the 5.875% Senior Notes, at any time before December 1, 2018, with the net cash proceeds of certain equity offerings at a redemption price equal to 105.875% of the principal amount to be redeemed, plus accrued and unpaid interest, provided that at least 65% of the aggregate principal amount of the 5.875% Senior Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of any such qualified equity offering.

The Company may redeem the 5.875% Senior Notes, in whole or in part, at any time prior to December 1, 2018 at a price equal to 100% of the principal amount of the notes redeemed plus an applicable make-whole premium, plus accrued and unpaid interest, if any, to the date of redemption. The Company may redeem the 5.875% Senior Notes, in whole or in part, at any time on or after December 1, 2018, plus accrued and unpaid interest, if any, to the date of redemption plus a redemption price equal to a percentage of the principal amount of the notes redeemed based on the following redemption schedule:

December 1, 2018 to November 30, 2019	104.406 %
December 1, 2019 to November 30, 2020	102.938 %
December 1, 2020 to November 30, 2021	101.469 %
December 1, 2021 and thereafter	100.000 %

If the Company experiences a change in control under certain circumstances, it must offer to purchase the notes at a purchase price equal to 101.000% of the principal amount, plus accrued and unpaid interest to the date of purchase.

The 5.875% Senior Notes contain customary affirmative and negative covenants, which among other things, limit the Company's ability to incur additional debt, create liens, pay dividends, effect transactions with its affiliates, sell assets, pay subordinated debt, merge, consolidate, enter into acquisitions and effect sale leaseback transactions.

3½% Notes

Effective May 15, 2014, the 3½% convertible senior subordinated notes due May 15, 2014 (the "3½% Notes") matured. Prior to maturity, certain holders of the 3½% Notes exercised their right to convert per $1,000 in principal held for (i) an amount in cash, equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, the lesser of the daily conversion value for such volume-weighted average price trading day and $50; and (ii) a number of shares of the Company's common stock in an amount equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, any excess of the daily conversion value above $50. Upon maturity or conversion of the 3½% Notes, the Company delivered to the holders cash of approximately $574.2 million and approximately 0.6 million shares of its common stock previously held in treasury at an average historical cost basis of $35.86 per share, or $23.0 million.

Debt Issuance Costs

The Company capitalized costs incurred in connection with various issuances of debt of $7.2 million during each of the years ended December 31, 2015 and 2014.

Amortization of Discounts on Convertible Debt

In accordance with ASC 470-20, "Debt with Conversion and Other Options" ("ASC 470-20"), the Company separately accounted for the liability and equity components of its convertible debt instruments in a manner that reflected the Company's nonconvertible debt borrowing rates for its 3½% Notes and its 3¼% convertible senior subordinated debentures (the "3¼% Debentures") at their fair values at their date of issuance. The resulting discounts were amortized as a component of interest expense over the expected lives of similar liabilities that do not have associated equity components, which for the Company's 3½% Notes and its 3¼% Debentures were its maturity dates. The Company amortized the discount for its 3½% Notes through May 2014 at which point they matured. Additionally, the Company amortized the discount for its 3¼% Debentures through February 2013 at which point they were all repurchased.

For the years ended December 31, 2014 and 2013, the contractual cash interest expense and non-cash interest expense (discount amortization) for the Company's convertible debt instruments were as follows (in millions).

	2014	2013
3½% Notes:		
Contractual cash interest expense	$ 7.5	$ 20.1
Non-cash interest expense (discount amortization)	8.1	20.5
Total interest expense	$ 15.6	$ 40.6
3¼% Debentures:		
Contractual cash interest expense		$ 0.9
Non-cash interest expense (discount amortization)		0.9
Total interest expense		$ 1.8

Considering both the contractual cash interest expense and the non-cash amortization of the discounts for the 3½% Notes and 3¼% Debentures, the effective annual interest rates for the period the 3½% Notes were outstanding during the years ended December 31, 2014 and 2013 were 7.28% and 7.06%, respectively, and the effective annual interest rate for the period the 3¼% Debentures were outstanding during the year ended December 31, 2013 was 6.50%.

Note 6. Income Taxes

The provision for income taxes for the years ended December 31, 2015, 2014 and 2013 consists of the following (in millions):

	2015	2014	2013
Current:			
Federal	$ 122.8	$ 47.2	$ 94.0
State	7.9	1.4	9.2
	130.7	48.6	103.2
Deferred:			
Federal	(17.1)	26.7	(24.5)
State	(2.9)	(4.8)	(5.0)
	(20.0)	21.9	(29.5)
Change in valuation allowance	(1.2)	(2.4)	5.6
Total	$ 109.5	$ 68.1	$ 79.3

The decrease in the valuation allowance during the year ended December 31, 2014 was primarily a result of the reversal of a valuation allowance established during the year ended December 31, 2013 against the Company's deferred tax assets for federal net operating losses generated by the Company's physician practice operations in the state of Michigan, which were previously thought to be unrecoverable. The impact of the reversal during the year ended December 31, 2014 resulted in an increase to net income of $6.0 million, or $0.13 per diluted share. Various subsidiaries have state net operating loss carry forwards in the aggregate of approximately $995.3 million (primarily in Alabama, Florida, Indiana, Louisiana, Pennsylvania, Tennessee, Virginia and West Virginia) with expiration dates through the year 2035.

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The following is a reconciliation of the statutory federal income tax rate to the Company's effective income tax rate for income from continuing operations before income taxes and excluding net income from non-controlling interests for the years ended December 31, 2015, 2014 and 2013:

	2015	2014	2013
Federal statutory rate	35.0 %	35.0 %	35.0 %
State income taxes, net of federal income tax benefits	2.2	1.0	2.1
Valuation allowances	(1.1)	(1.3)	2.9
Income tax liability reversals	-	(0.3)	(0.3)
Other items, net	1.5	0.7	(1.4)
Effective income tax rate	37.6 %	35.1 %	38.3 %

Deferred income taxes result from temporary differences in the recognition of assets, liabilities, revenues and expenses for financial accounting and tax purposes. Sources of these differences and the related tax effects are as follows as of December 31, 2015 and 2014 (in millions):

	2015	2014
Deferred income tax liabilities:		
Depreciation and amortization	$ (329.2)	$ (325.8)
Prepaid expenses	(2.8)	(2.7)
Other	(1.6)	(0.5)
Total deferred income tax liabilities	(333.6)	(329.0)
Deferred income tax assets:		
Provision for doubtful accounts	50.8	52.9
Employee compensation	103.7	89.9
Professional liability claims	53.4	53.9
Net operating losses and other	95.8	84.0
Total deferred income tax assets	303.7	280.7
Valuation allowance	(64.5)	(66.4)
Net deferred income tax assets	239.2	214.3
Deferred income taxes	$ (94.4)	$ (114.7)

A reconciliation of the beginning and ending liability for gross unrecognized tax benefits at December 31, 2015 and 2014 is as follows (in millions):

	2015	2014
Balance at beginning of year	$ 1.1	$ 15.0
Additions for tax positions of prior years	-	2.4
Reductions for tax positions of prior years	(0.3)	(15.2)
Reductions for settlements with taxing authorities	(0.5)	(0.8)
Reductions for lapse of statutes of limitations	-	(0.3)
Balance at end of year	$ 0.3	$ 1.1

The components of the long-term income tax liability at December 31, 2015 and 2014 are as follows (in millions):

	2015	2014
Unrecognized tax benefits	$ 0.3	$ 1.1
Accrued interest and penalties	0.3	0.6
	$ 0.6	$ 1.7

The Company's U.S. Federal income tax returns for tax years 2012 and beyond remain subject to examination by the Internal Revenue Service. The expiration of the statutes of limitation related to the various state income tax returns that the Company and its subsidiaries file, varies by state. Generally, the Company's various state income tax returns for tax years 2009 and beyond remain subject to examination by various state taxing authorities. As a result of the expiration of the statutes of limitation for specific taxing jurisdictions, the Company's unrecognized tax positions could change within the next twelve months by a range of zero to $0.4 million.

Note 7. Other Current Liabilities

The following table provides information regarding the Company's other current liabilities, which are included in the accompanying consolidated balance sheets at December 31, 2015 and 2014 (in millions):

	2015	2014
Current portion of reserves for self-insurance claims	$ 41.5	$ 44.3
Self-insured medical benefits liability	28.5	28.0
Accrued interest	14.4	12.1
Estimated third-party cost report settlements	12.9	11.2
Accrued property taxes	8.2	10.3
Physician minimum revenue guarantee liability	8.1	9.3
Other	80.9	88.0
	$ 194.5	$ 203.2

Note 8. Stockholders' Equity

Preferred Stock

The Company's Amended and Restated Certificate of Incorporation provides that up to 10,000,000 shares of preferred stock may be issued, of which 90,000 shares have been designated as Series A Junior Participating Preferred Stock, par value $0.01 per share ("Series A Preferred Stock"). The Board of Directors has the authority to issue preferred stock in one or more series and to fix for each series the voting powers (full, limited or none), and the designations, preferences and relative participating, optional or other special rights and qualifications, limitations or restrictions on the stock and the number of shares constituting any series and the designations of this series, without any further vote or action by the stockholders. Because the terms of the preferred stock may be fixed by the Board of Directors without stockholder action, the preferred stock could be issued quickly with terms calculated to defeat a proposed takeover or to make the removal of the Company's management more difficult.

Preferred Stock Purchase Rights

On September 21, 2015, the Company entered into Amendment No. 1 (the "Amendment") to the Amended and Restated Rights Agreement (the "Rights Agreement"), dated as of February 25, 2009, between the Company and American Stock Transfer & Trust Company, LLC, as rights agent. The Amendment accelerated the expiration date of the preferred stock purchase rights (the "Rights") from February 25, 2019 to September 21, 2015. As a result, on September 21, 2015, the Rights Agreement was terminated and all of the Rights distributed to holders of the Company's common stock pursuant to the Rights Agreement expired.

Common Stock

Holders of the Company's common stock are entitled to one vote for each share held of record on all matters on which stockholders may vote. There are no preemptive, conversion, redemption or sinking fund provisions applicable to shares of the Company's common stock. In the event of liquidation, dissolution or winding up, holders of the Company's common stock are entitled to share ratably in the assets available for distribution, subject to any prior rights of any holders of preferred stock then outstanding. Delaware law prohibits the Company from paying any dividends unless it has capital surplus or net profits available for this purpose. In addition, certain restrictions imposed by the Company's various debt instruments may limit the Company's ability to pay dividends.

Common Stock in Treasury and Repurchases of Common Stock

The Company's Board of Directors has authorized the repurchase of outstanding shares of its common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other customary factors in accordance with a repurchase plan adopted in 2011, as subsequently amended and extended in February 2013 (the "2011 Repurchase Plan"), a repurchase plan adopted in 2014, as subsequently amended and extended in October 2015 (the "2014 Repurchase Plan") and a repurchase plan adopted on June 3, 2015 (the "2015 Repurchase Plan"). The 2011 Repurchase Plan and 2014 Repurchase Plan provided for the repurchase of up to $350.0 million and $150.0 million in shares of the Company's common stock, respectively, and the Company has repurchased all shares authorized for repurchase under these plans. The 2015 Repurchase Plan provides for the repurchase of up to $150.0 million in shares of the Company's common stock through December 3, 2016. As of December 31, 2015, the Company had remaining authority to repurchase approximately $125.0 million in shares in accordance with the 2015 Repurchase Plan. The Company is not obligated to repurchase any specific number of shares under any of its repurchase plans. The Company has designated the shares repurchased in accordance with its repurchase plans as treasury stock.

The following tables summarize the Company's share repurchases in accordance with its stock repurchase plans for the years ended December 31, 2015, 2014 and 2013 (in millions, except per share amounts):

	Amount	Total Number of Shares Repurchased	Weighted Average Price Paid per Share
Year ended December 31, 2015	$ 125.0	1.7	$ 74.64
Year ended December 31, 2014	$ 214.7	3.8	$ 57.00
Year ended December 31, 2013	$ 30.7	0.7	$ 45.75

Additionally, the Company redeems shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to the Company's various stockholder-approved stock-based compensation plans. The Company redeemed approximately 0.1 million, 0.1 million and 0.2 million shares vested under these plans during the years ended December 31, 2015, 2014 and 2013 for an aggregate price of approximately $9.5 million, $7.6 million and $8.4 million, respectively. The Company has designated these shares as treasury stock.

Common Stock Warrants

As partial consideration in connection with the Company's acquisition of Watertown, the Company issued a warrant to the seller with rights to purchase 55,024 shares of the Company's common stock at an exercise price of $80.37 per share. The Watertown warrant is exercisable ratably over three years beginning on September 1, 2016 and expires August 31, 2025. The Watertown warrant is classified as stockholders' equity and was issued to the seller with an estimated fair value of $2.0 million on the date of acquisition. This amount is included in the accompanying consolidated balance sheet under the caption "Capital in excess of par value" as of December 31, 2015.

As partial consideration in connection with the Company's acquisition of Conemaugh, the Company issued a warrant to the seller with rights to purchase 290,514 shares of the Company's common stock at an exercise price of $74.15 per share. The Conemaugh warrant is exercisable ratably over three years beginning on September 1, 2015 and expires August 31, 2024. The Conemaugh warrant, initially classified as a liability, was marked-to-market using an option pricing model which considered the warrant's contractual term, a combination of both historical volatility and implied volatility from traded options of the Company's common stock, risk-free interest rates and dividend assumptions. Subsequently, effective July 23, 2015, the Company amended certain of the terms of its original asset purchase agreement with the Conemaugh seller and eliminated the provisions that resulted in the classification of the Conemaugh warrant as a liability. Accordingly, the Company completed a final mark-to-market valuation of the Conemaugh warrant and reclassified it to stockholders' equity upon the effective date of the modification. As of July 23, 2015 and December 31, 2014, the fair value of the Conemaugh warrant was approximately $11.7 million and $9.2 million, respectively. These amounts are included in the accompanying consolidated balance sheets under the captions "Capital in excess of par value" and "Other long-term liabilities" as of December 31, 2015 and 2014, respectively.

Comprehensive Income

Comprehensive income consists of two components: net income and other comprehensive income (loss). Other comprehensive income (loss) refers to revenues, expenses, gains and losses that in accordance with ASC 220-10 "Comprehensive Income," are recorded as an element of stockholders' equity but are excluded from net income.

Changes in the funded status of the Company's pension benefit obligations resulted in a pretax comprehensive gain of $2.6 million, or $1.7 million net of taxes, for the year ended December 31, 2015, a pretax comprehensive loss of $12.0 million, or $7.8 million net of taxes, for the year ended December 31, 2014, and a pretax comprehensive gain of $5.1 million, or $3.2 million net of taxes, for the year ended December 31, 2013. The Company's defined benefit pension plans are further discussed in Note 10.

Note 9. Stock-Based Compensation

Overview

The Company issues stock-based awards, including stock options, appreciation rights and other stock-based awards (nonvested stock, restricted stock, restricted stock units and performance shares) to certain officers, employees and non-employee directors in accordance with the Company's various stockholder-approved stock-based compensation plans. The Company accounts for its stock-based awards in accordance with the provisions of ASC 718-10 and accordingly recognizes compensation expense over each of the stock-based award's requisite service period based on the estimated grant date fair value.

Stockholder-Approved Stock-Based Compensation Plans

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

Notwithstanding the specific grant vesting requirements, award agreements under the 2013 LTIP and the 1998 LTIP may provide for accelerated vesting in certain circumstances. Generally, award agreements provide for full vesting upon the death or disability of the participant. Some award agreements also provide for partial or full vesting upon involuntary termination of employment, provided that if the award is performance-based then the accelerated vesting would occur only if the performance goals are attained.

Stock Options

The Company granted options to purchase 828,910, 716,150 and 802,200 shares of the Company's common stock to certain officers and employees in accordance with its various stockholder-approved stock-based compensation plans during the years ended December 31, 2015, 2014 and 2013, respectively. Options to purchase shares granted to the Company's officers and employees were granted with an exercise price equal to the fair market value of the Company's common stock on the day of grant, based on the closing price of the Company's common stock on the trading date immediately prior to the grant date. Options to purchase shares granted to the Company's officers and employees become ratably exercisable beginning one year from the date of grant to three years after the date of grant and expire ten years from the date of grant.

Valuation

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

The following table shows the weighted average assumptions the Company used to develop the fair value estimates under its HW-II option valuation model and the resulting estimates of weighted-average fair value per share of stock options granted during the years ended December 31, 2015, 2014 and 2013:

	2015	2014	2013
Expected volatility	29.0 %	29.0 %	30.8 %
Risk-free interest rate, minimum	0.01	0.05	0.02
Risk-free interest rate, maximum	2.20	2.71	2.90
Expected dividends	-	-	-
Average expected term (years)	5.3	5.4	5.3
Fair value per share of stock options granted	$ 18.66	$ 13.95	$ 11.98

Population Stratification

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

Expected Volatility

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

Risk-Free Interest Rate

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

Expected Dividends

The Company has never paid any cash dividends on its common stock and does not anticipate paying any cash dividends in the foreseeable future. Accordingly, the Company uses an expected dividend yield of zero.

Pre-Vesting Forfeitures

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

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

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Post-Vesting Cancellations

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

Expected Term

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

Stock Option Activity

A summary of stock option activity during the year ended December 31, 2015 is as follows:

Stock Options	Number Shares	Weighted Average Exercise Price	Weighted Average Fair Value	Total Fair Value (In millions)	Aggregate Intrinsic Value (a) (In millions)	Weighted Average Remaining Contractual Term (In years)
Outstanding at December 31, 2014	3,172,810	$ 39.90	$ 11.74	$ 37.3	$ 101.6	6.80
Exercisable at December 31, 2014	1,768,659	$ 33.40	$ 10.74	$ 19.0	$ 68.1	5.44
Unvested at December 31, 2014	1,404,151	$ 48.09	$ 13.01	$ 18.3	$ 33.4	8.52
Granted	828,910	$ 71.03	$ 18.66	$ 15.4	N/A	N/A
Exercised	(273,147)	$ 42.26	$ 12.38	$ (3.4)	$ 8.7	N/A
Forfeited (pre-vest cancellation)	(51,667)	$ 60.33	$ 15.92	$ (0.8)	N/A	N/A
Vested	687,489	$ 46.03	$ 12.72	$ 8.7	N/A	N/A
Expired (post-vest cancellation)	(2,134)	$ 39.97	$ 12.18	$ -	N/A	N/A
Outstanding at December 31, 2015	3,674,772	$ 46.46	$ 13.20	$ 48.5	$ 99.0	6.59
Exercisable at December 31, 2015	2,180,867	$ 36.26	$ 11.16	$ 24.3	$ 81.0	5.24
Unvested at December 31, 2015	1,493,905	$ 61.34	$ 16.18	$ 24.2	$ 18.0	8.55

(a) The aggregate intrinsic value represents the difference between the underlying stock's market price and the stock's exercise price.

The total intrinsic value of stock options exercised during the years ended December 31, 2015, 2014 and 2013 was $8.7 million, $14.8 million and $13.6 million, respectively. The Company received $11.5 million, $23.9 million and $39.2 million in cash from stock option exercises during the years ended December 31, 2015, 2014 and 2013, respectively. The actual tax benefit realized for the tax deductions from stock option exercises totaled $2.1 million, $1.2 million and $0.1 million for the years ended December 31, 2015, 2014 and 2013, respectively.

As of December 31, 2015, there was $13.7 million of total estimated unrecognized compensation cost related to stock options. Total estimated unrecognized compensation cost will be adjusted for future changes in estimated forfeitures. The Company expects to recognize this cost over a weighted average period of 1.3 years.

Other Stock-Based Awards

The Company granted a total of 291,155, 369,871 and 466,162 restricted stock units and performance-based restricted stock units to certain officers, employees and non-employee directors in accordance with its various stockholder-approved stock-based compensation plans during the years ended December 31, 2015, 2014 and 2013, respectively. The fair value of the restricted stock units granted during the years ended December 31, 2015, 2014 and 2013 and the performance-based restricted stock units granted during the year ended December 31, 2013 was determined based on the closing price of the Company's common stock on the trading date immediately prior to the grant date. The fair value of the performance-based restricted stock units granted during the years ended December 31, 2015 and 2014 was estimated using the Monte-Carlo simulation valuation model as more fully described below. The restricted stock units and performance-based restricted stock units granted during the years ended December 31, 2015, 2014 and 2013 generally have either cliff-vesting periods from the grant date of three years, cliff-vesting periods from the grant date of six months and one day or ratable vesting periods beginning one year from the date of grant to three years after the date of grant.

Of the restricted stock units granted during the years ended December 31, 2015 and 2014, 145,000 and 236,000, respectively, were performance-based awards. In addition to requiring continuing service of the employee, the percentage of these restricted stock units that are earned at the end of the performance period is determined based on the Company's three-year annualized total shareholder return relative to a peer group, Standard and Poor's Global Industry Classification Standard's Sub-industry: Health Care Facilities with over $500.0 million in revenues or its equivalent. For the performance-based restricted stock units granted during the year ended December 31, 2015, the number of shares payable at the end of the three-year performance period ranges from 0% to 200% of the targeted units. For the performance-based restricted stock units granted during the year ended December 31, 2014, the number of shares payable at the end of the three-year performance period ranges from 0% to 100% of the targeted units, with any portion of the award that exceeds 100% up to 200% of the targeted units settled in cash equal to the fair market value on the date certification of the level of performance is achieved. For valuation purposes, these awards were bifurcated into their two independent sub-award components for the portion that would be settled in the Company's common stock and for the portion that would be settled in cash. The Company recognizes compensation expense for the portion of the performance-based restricted stock units that will ultimately be settled in the Company's common stock for the targeted units if the requisite service period is rendered, even if the market condition is never satisfied. Additionally, the Company classifies as a liability and recognizes compensation expense for the portion of the award that will ultimately be settled in cash for the targeted units at its Monte-Carlo simulation value which has been marked-to-market.

Additionally, of the restricted stock units granted during the year ended December 31, 2013, 322,000 were performance-based awards. In addition to requiring continuing service of an employee, the vesting of these performance-based awards was contingent upon the satisfaction of certain financial goals, specifically related to the achievement of targeted annual revenues or earnings goals within a three-year period. The performance criteria for the performance-based awards granted during the year ended December 31, 2013 have been certified as met by the Compensation Committee of the Company's Board of Directors, however, these awards are still subject to continuing service requirements and the three year cliff-vesting provisions.

A summary of other stock-based awards activity during the year ended December 31, 2015 is as follows:

Other Stock-Based Awards	Number Shares	Weighted Average Fair Value	Total Fair Value	Aggregate Intrinsic Value
			(In millions)	(In millions)
Outstanding at December 31, 2014	1,108,020	$ 49.55	$ 54.9	$ 79.7
Granted	291,155	$ 82.07	$ 23.9	N/A
Vested	(434,014)	$ 39.03	$ (16.9)	$ 31.0
Forfeited (pre-vest cancellation)	(27,870)	$ 61.49	$ (1.7)	N/A
Outstanding at December 31, 2015	937,291	$ 64.17	$ 60.2	$ 68.8
Unvested at December 31, 2015	863,745	$ 57.37	$ 49.6	$ 63.4

As of December 31, 2015, there was $23.8 million of total estimated unrecognized compensation cost related to other stock-based awards. Total estimated unrecognized compensation cost will be adjusted for future changes in estimated forfeitures. The Company expects to recognize this cost over a weighted average period of 1.5 years.

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Summary of Stock-Based Compensation

The following table summarizes the activity in accordance with all of the Company's stock-based compensation plans for the years ended December 31, 2015, 2014 and 2013:

		Stock Options Outstanding		Other Stock-Based Awards Outstanding		Deferred Stock Units Outstanding
	Shares Available For Grant	Number of Shares	Weighted Average Exercise Price	Number of Shares	Weighted Average Grant Date Price	Number of Shares
January 1, 2013	2,204,262	3,667,045	$ 34.12	1,466,161	$ 32.72	11,079
Stock-based awards granted	(1,145,200)	735,200	44.34	410,000	44.34	-
Stock-based awards cancelled	134,055	(78,370)	38.27	(55,685)	38.25	-
Cancellation of shares previously available for grant under the 1998 LTIP and ODSICP [a]	(1,188,734)	-	-	-	-	-
Shares made available for grant under the 2013 LTIP [b]	3,600,000	-	-	-	-	-
Stock-based awards granted [c]	(184,379)	67,000	45.96	56,162	47.59	-
Stock-based awards cancelled under the 1998 LTIP [d]	-	(146,565)	41.50	(66,839)	42.30	-
Stock-based awards cancelled under the MSPP [e]	16,186	-	-	(16,186)	10.60	-
Stock-based awards exercised or vested	-	(1,145,038)	34.25	(603,849)	31.31	-
December 31, 2013	3,436,190	3,099,272	36.30	1,189,764	37.79	11,079
Stock-based awards granted [b,c,f]	(1,489,180)	716,150	52.87	369,871	66.91	-
Stock-based awards cancelled under the 1998 LTIP [d]	-	(959)	15.23	(1,335)	38.95	-
Stock-based awards cancelled under the MSPP [e]	6,257	-	-	(6,257)	10.87	-
Stock-based awards exercised or vested	-	(641,653)	37.04	(444,023)	33.44	(798)
December 31, 2014	1,953,267	3,172,810	39.90	1,108,020	49.55	10,281
Stock-based awards granted [b,c,f]	(1,740,474)	828,910	71.03	291,155	82.07	-
Stock-based awards cancelled under the 2013 LTIP	92,742	(43,667)	63.26	(23,481)	65.23	-
Stock-based awards cancelled under the 1998 LTIP [d]	-	(10,134)	43.42	(4,002)	44.34	-
Stock-based awards cancelled under the MSPP [e]	387	-	-	(387)	12.15	-
Increase in shares available for grant upon stockholder approval	3,368,611	-	-	-	-	-
Stock-based awards exercised or vested	-	(273,147)	42.26	(434,014)	39.03	(5,317)
December 31, 2015	3,674,533 [g]	3,674,772	$ 46.46	937,291	$ 64.17	4,964

(a) All shares previously available for grant under the 1998 LTIP and ODSICP were cancelled effective June 4, 2013 in connection with the approval of the 2013 LTIP and no shares remain available for grant under either of these plans.

(b) Effective June 4, 2013, upon approval of the Company's stockholders, the Company replaced the 1998 LTIP and ODSICP with the 2013 LTIP. The 2013 LTIP made 3.6 million shares available for the grant of stock-based awards.

(c) Under the 2013 LTIP, stock-based awards are granted at a rate of 1.00 share for each stock option or appreciation rights award and 2.09 shares for each full-value award per 1.00 shared granted.

(d) Shares subject to awards granted under the 1998 LTIP and ODSICP that are cancelled subsequent to the effective date of the 2013 LTIP are not added to the shares available for grant under the 2013 LTIP.

(e) The Company is authorized to issue shares of the Company's common stock in the form of restricted stock at a discount of 25% in accordance with the Amended and Restated Management Stock Purchase Plan ("MSPP"). Effective July 1, 2012, the Company's Board of Directors suspended the right to acquire shares under the MSPP until further notice. Shares that were originally granted under the MSPP that were cancelled have been added back to shares available for future grant under the MSPP at a rate of 1.00 share per 1.00 share originally granted.

(f) Of the other stock-based awards granted during the years ended December 31, 2015 and 2014, 145,000 and 236,000, respectively, were performance-based awards. The number of shares payable at the end of the three-year performance period ranges from 0% to 200% of the targeted units for awards granted in 2015 and from 0% to 100% of the targeted units for awards granted in 2014. The Company has assumed that that maximum number of shares will be granted for purposes of reflecting shares available for grant. Shares available for grant will be adjusted in the future to reflect the actual number of shares issued upon settlement of these awards at the end of the performance measurement period.

(g) Of the 3,674,533 shares available for grant as of December 31, 2015, 3,647,320 shares are available for grant under the 2013 LTIP and 27,213 shares are available for grant under the MSPP.

The following table summarizes the Company's total stock-based compensation expense as well as the total recognized tax benefits related thereto for the years ended December 31, 2015, 2014 and 2013 (in millions):

	2015	2014	2013
Equity awards:			
Other stock-based awards	$ 19.3	$ 18.0	$ 16.8
Stock options	10.7	9.3	8.6
	30.0	27.3	25.4
Liability awards:			
Other stock-based awards	5.0	2.4	-
Total stock-based compensation expense	$ 35.0	$ 29.7	$ 25.4
Tax benefit on stock-based compensation expense	$ 14.0	$ 11.8	$ 10.1

The Company did not capitalize any stock-based compensation cost during the years ended December 31, 2015, 2014 or 2013. As of December 31, 2015, there was $37.5 million of total estimated unrecognized compensation cost related to all of the Company's stock compensation arrangements. Total estimated unrecognized compensation cost may be adjusted for future changes in estimated forfeitures. The Company expects to recognize this cost over a weighted-average period of 1.4 years.

Note 10. Defined Benefit and Multiemployer Pension Plans

Defined Benefit Pension Plans

The Company provides for benefits under the Pension Plans to certain employees covered by a collective bargaining agreement at one facility and to certain non-union employees at another facility. Both Pension Plans are closed to new participants. Participants in the Marquette Pension Plan are required to make annual contributions totaling 6% of annual compensation to the Marquette Pension Plan to continue accruing benefits. Participants in the Bell Pension Plan stopped accruing benefits when the Bell Pension Plan was frozen by Bell, effective October 31, 2005, prior to its assumption by the Company. The Company makes contributions to the Pension Plans sufficient to meet its minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended.

Status and Expense

The following table presents the changes in the benefit obligations and plan assets of the Pension Plans during the years ended December 31, 2015 and 2014 and the unfunded liability of the Pension Plans at December 31, 2015 and 2014 (in millions):

	2015	2014
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 57.8	$ 43.8
Service costs	0.8	0.5
Interest costs	2.2	2.1
Participant contributions	0.5	0.4
Actuarial (gain) loss	(5.0)	11.8
Benefits paid	(1.1)	(0.8)
Benefit obligation at end of year	55.2	57.8
Change in plan assets:		
Fair value of plan assets at beginning of year	29.0	26.1
Actual (loss) return on plan assets	(0.4)	1.9
Employer contributions	1.5	1.4
Participant contributions	0.5	0.4
Benefits and expenses paid	(1.1)	(0.8)
Fair value of plan assets at end of year	29.5	29.0
Unfunded liability included in other long-term liabilities in the Company's accompanying consolidated balance sheets	$ 25.7	$ 28.8

The Company recognizes changes in the funded status of the Pension Plans as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income (loss). For the year ended December 31, 2015, the Company recognized a pretax comprehensive gain of $2.6 million, or $1.7 million net of taxes, as an increase in stockholders' equity through accumulated other comprehensive income (loss). For the year ended December 31, 2014, the Company recognized pretax comprehensive loss of $12.0 million, or $7.8 million net of taxes, as a decrease in stockholders' equity through accumulated other comprehensive income (loss). For the year ended December 31, 2013, the Company recognized a pretax comprehensive gain of $5.1 million, or $3.2 million net of taxes, as an increase in stockholder's equity through accumulated other comprehensive income (loss). These adjustments were primarily related to changes in the Company's unfunded pension liability due to changes in the discount rates and mortality assumptions used to measure the projected benefit obligation.

The following table summarizes the projected benefit obligation, accumulated benefit obligation and fair value of plan assets related to the Pension Plans as of December 31, 2015 and 2014 (in millions):

	2015	2014
Projected benefit obligation	$ 55.2	$ 57.8
Accumulated benefit obligation	$ 50.4	$ 52.1
Fair value of plan assets	$ 29.5	$ 29.0

The following table summarizes the weighted-average assumptions used by the Company to determine its benefit obligation as of December 31, 2015 and 2014 (in millions):

	2015	2014
Discount rate	4.2 %	3.9 %
Rate of compensation increases, when applicable	3.0 %	3.0 %

The following table summarizes the components of net periodic costs for the years ended December 31, 2015, 2014 and 2013 (in millions):

	2015	2014	2013
Service cost	$ 0.8	$ 0.5	$ 0.8
Interest cost	2.2	2.1	1.5
Expected return on plan assets	(2.0)	(1.9)	(1.2)
Amortization of net actuarial loss (gain)	0.1	(0.2)	-
Total net periodic benefit cost	$ 1.1	$ 0.5	$ 1.1

The following table summarizes the weighted-average assumptions used by the Company to determine its net periodic benefit costs during the years ended December 31, 2015, 2014 and 2013 (in millions):

	2015	2014	2013
Discount rate	3.9 %	4.9 %	4.0 %
Rate of compensation increases, when applicable	3.0 %	3.0 %	3.0 %
Expected long-term return on plan assets	7.0 %	7.0 %	7.0 %

Plan Assets

The investment policy for the Pension Plans has been formulated to achieve a risk adjusted return that balances the need for asset growth against the risk of significant fluctuations in asset prices and the need for significant contributions from the Company. Fixed income investments include corporate and U.S. government and municipal bonds and notes as well as asset and mortgage-backed securities that employ liability-directed approaches to investments to minimize changes in the funded status of the Pension Plans. Equity securities investments include mutual funds that are balanced to achieve an overall rate of return that minimizes the need for additional employer contributions.

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On a quarterly basis, or more frequently as necessary, the current risk levels, asset performance and expected return on assets are reviewed and evaluated against goals and targets by a committee appointed to oversee investment of the Pension Plans' assets (the "Investment Committee"). The Investment Committee strives to maintain a balance between risk and return through the use of modern portfolio theory methods, in conjunction with Monte Carlo modeling to evaluate the behavior of the portfolio under different scenarios.

The Company measures the fair value of its Pension Plans' assets in accordance with ASC 820-10. ASC 820-10 establishes a framework for measuring fair value and establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. The tiers are as follows:

Level 1 - defined as observable inputs such as quoted prices in active markets;
Level 2 - defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and
Level 3 - defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

The Pension Plans' investments in mutual funds are valued at the net asset value ("NAV") of shares reported in the active market in which the funds are traded. Investments in corporate and U.S. government and municipal bonds and notes are generally valued at the closing price reported in the market in which the related instrument is traded. In certain limited circumstances, other corporate debt instruments are valued based on yields currently available on comparable securities of issuers with similar credit ratings. Investments in asset and mortgage-backed securities are valued based on external prices or on the basis of their future principal and interest payments that have been discounted to prevailing interest rates for similar investments, using market spread data and other current market assumptions on prepayments and defaults.

Because quoted prices are available for mutual funds and the markets in which they are traded are generally considered active, the Company has classified each of them as a Level 1 investment. Because all of the inputs used to value corporate and U.S. government and municipal bonds and notes, as well as asset and mortgage-backed securities are either directly or indirectly observable but other than quoted prices in active markets, the Company has classified these assets as Level 2 investments. Although quoted prices are generally available for the Pension Plans' investments in corporate and U.S. government and municipal bonds and notes, in certain limited circumstances, the markets in which the securities are distributed or traded may be limited to one or only a few brokers and vendors. Additionally, in certain other circumstances information regarding the trading volume of these investments is not always available or verifiable. The Company does not consider markets in which there are a limited number of brokers or vendors to be active.

The following table summarizes the assets of the Pension Plans, measured at fair value as of December 31, 2015 and 2014, by major asset category and aggregated by level within the fair value hierarchy (in millions):

	December 31, 2015			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and cash equivalents	$ 1.3	$ 1.3	$ -	$ -
Mutual funds	17.2	17.2	-	-
Corporate bonds and notes	8.8	-	8.8	-
U.S. government and municipal bonds and notes	0.8	-	0.8	-
Asset and mortgage-backed securities	1.4	-	1.4	-
Total	$ 29.5	$ 18.5	$ 11.0	$ -

	December 31, 2014			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and cash equivalents	$ 0.6	$ 0.6	$ -	$ -
Mutual funds	17.4	17.4	-	-
Corporate bonds and notes	8.8	-	8.8	-
U.S. government and municipal bonds and notes	0.9	-	0.9	-
Asset and mortgage-backed securities	1.3	-	1.3	-
Total	$ 29.0	$ 18.0	$ 11.0	$ -

The Company expects to contribute approximately $1.7 million to the Pension Plans during the year ended December 31, 2016. Additionally, the Company expects to make future benefit payments from the Pension Plans as follows for the years indicated (in millions):

2016	$ 1.3
2017	1.6
2018	1.8
2019	2.1
2020	2.3
Five years thereafter	14.5
	$ 23.6

Multiemployer Pension Plan

As a result of the acquisition of Bell effective December 1, 2013, the Company became obligated to contribute to a multiemployer pension plan on behalf of certain employees covered by collective bargaining agreements, in accordance with the terms of such collective bargaining agreements. The Company's contributions to the multiemployer pension plan are determined based on the terms of the applicable collective bargaining agreements. Multiemployer plans are different from single-employer plans because assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers. Also, if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers. If the Company stops participating in the multiemployer plan, the Company may be required to pay a withdrawal liability based on its portion of the unfunded status of the plan. Currently, the Company does not anticipate ending its participation in this plan.

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Note 11. Commitments and Contingencies

Legal Proceedings and General Liability Claims

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

In addition, hospitals are subject to the regulation and oversight of various state and federal governmental agencies. Further, under the federal False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against hospitals that submit false claims for payments to, or improperly retain overpayments from, governmental payors. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without the Company's knowledge. Although the healthcare industry has seen numerous ongoing investigations related to compliance and billing practices, hospitals, in particular, continue to be a primary enforcement target for the Office of Inspector General ("OIG"), the Department of Justice ("DOJ") and other governmental fraud and abuse programs. Certain of the Company's individual facilities have received, and from time to time, other facilities may receive, inquiries or subpoenas from fiscal intermediaries, and federal and state agencies. Any proceedings against the Company may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on the Company's financial position, results of operations and liquidity.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 imposed an affirmative obligation on healthcare providers to report and refund any overpayments received. "Overpayments" in this context include any amount received from a government program by a provider to which it is not entitled, regardless of the cause. Such overpayments are deemed to be fraudulent and become violations of the False Claims Act if not reported and refunded within the later of 60 days of identification or the date any corresponding cost report is due (if applicable). Hospitals can meet the obligation to report and refund in three ways: (1) refunding overpayments directly to the program; (2) self-disclosing the overpayment to the OIG via its voluntary self-disclosure protocol (with respect to False Claims Act and other violations not related to the Stark law); and (3) self-disclosing to the CMS via the self-referral disclosure protocol (with respect to overpayments caused by potential violations of the Stark law only) for which CMS has the authority to reduce the amounts otherwise owed.

In connection with the Company's acquisitions of Marquette General and Conemaugh, the two sellers self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. These self-disclosures are pending with CMS. With respect to Marquette General, to the extent that the seller's satisfaction of its retained liabilities, including those under its CMS voluntary self-disclosure, causes its net proceeds from the acquisition to be less than $15.0 million, the Company has agreed to pay additional purchase consideration to the seller. With respect to Conemaugh, to the extent that the potential settlement exceeds the seller's indemnification threshold in accordance with the asset purchase agreement, the Company will likely be responsible for funding any deficit. The Company's management believes it has made reasonable estimates of its potential exposure for these two matters and at December 31, 2015 has recorded a reserve for Marquette General of $18.0 million.

On September 16, 2013, the Company and two of its hospitals, Vaughan Regional Medical Center, located in Selma, Alabama, and Raleigh General Hospital, located in Raleigh, West Virginia, made a voluntary self-disclosure to the Civil Division of the DOJ. The voluntary self-disclosure related to concerns regarding the clinical appropriateness of certain interventional cardiology procedures conducted by one physician in each of these hospitals' cardiac catheterization laboratories. On September 24, 2013, the U.S. Attorney's Office in the Southern District of West Virginia served a subpoena on Raleigh General Hospital. Raleigh General Hospital produced responsive documents to the subpoena, including patient files. The government investigations are ongoing and the Company continues to cooperate with the government in addressing these matters. Following reviews by independent interventional cardiologists, the Company notified patients of these two physicians who may have received an unnecessary procedure of such fact.

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

Additionally, the Company, and two of its subsidiaries, including Raleigh General Hospital, as well as Dr. Kenneth Glaser, have been named in 86 individual lawsuits filed in the circuit court of Raleigh County, West Virginia. These lawsuits allege that patients at Raleigh General Hospital received unnecessary interventional cardiology procedures. Through December 31, 2015, one additional patient has notified Raleigh General Hospital that he intends to file a lawsuit against the hospital.

The lawsuits identified above variously seek compensatory and punitive damages, costs, attorneys' fees and other available damages. Additional claims, including claims involving patients to whom the Company did not send notice, have been threatened and may be asserted against the Company or the hospital. Any present or future claims that are ultimately successful could result in the Company and/or the hospitals being found liable and the government investigations may also result in damages, fines and penalties. Such liability, damages and penalties could be material. The Company cannot, however, reasonably estimate the potential liability, if any, in connection with any of these matters, and no liability has been recorded as of December 31, 2015.

The Company does not control and cannot predict with certainty the progress or final outcome of discussions with government agencies, investigations and legal proceedings against the Company. Therefore, the final amounts paid to resolve the foregoing matters could be material and could materially differ from amounts currently recorded, if any. Any such changes in the Company's estimates or any adverse judgments will impact the Company's future results of operations and cash flows.

Physician Commitments

The Company has committed to provide certain financial assistance pursuant to recruiting agreements with various physicians practicing in the communities it serves. In consideration for a physician's relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician, normally over a period of one year, to assist in establishing the physician's practice. The Company has committed to advance a maximum amount of approximately $16.8 million at December 31, 2015. The actual amount of such commitments to be subsequently advanced to physicians is estimated at $8.1 million and often depends upon the financial results of a physician's private practice during the guarantee period. Generally, amounts advanced under the recruiting agreements may be forgiven pro rata over a period of 36 to 48 months contingent upon the physician continuing to practice in the respective community. Pursuant to the Company's standard physician recruiting agreement, any breach or non-fulfillment by a physician under the physician recruiting agreement gives the Company the right to recover any payments made to the physician under the agreement. Additionally, the Company is subject to annual commitments for certain physician recruiting activities, including the continuation of existing or initiation of new activities with several of its facilities.

Capital Expenditure Commitments

The Company is reconfiguring some of its hospitals to more effectively accommodate patient services and to provide for a greater variety of services, as well as implementing various information system initiatives in its efforts to comply with the HITECH Act. The Company has incurred approximately $119.4 million in costs related to uncompleted projects as of December 31, 2015, which is included under the caption "Construction in progress" in the Company's accompanying consolidated balance sheet. At December 31, 2015, these uncompleted projects had an estimated cost to complete and equip of approximately $158.5 million. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities, including its recent acquisitions. At December 31, 2015, the Company estimated its total remaining unfulfilled capital expenditure commitments to be approximately $1,702.6 million.

Acquisitions

The Company has historically acquired businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, medical and general professional liabilities, workers compensation liabilities, previous tax liabilities and unacceptable business practices. Although the Company institutes policies designed to conform practices to its standards following completion of acquisitions, there can be no assurance that the Company will not become liable for past activities that may later be asserted to be improper by private plaintiffs or government agencies. Although the Company generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

Marquette Replacement Facility

On December 21, 2015, the Company acquired a parcel of land in Marquette, Michigan for approximately $4.0 million with the intention of constructing a replacement hospital for the existing Marquette General hospital. The Company anticipates that it will continue to operate the existing hospital campus until such point that the replacement hospital is ready for its intended use. Management currently expects that the construction of the replacement hospital will take approximately three years from its commencement date.

In accordance with ASC 360-10, the Company performed an evaluation of the recoverability of the carrying values of certain of the assets of Marquette General which management anticipates disposing. Because the estimated future undiscounted cash flows of Marquette General exceed the carrying values of the assets being considered for disposal, the Company has determined that these long-lived assets are not impaired. However, as a result of possible changes to the Company's plans for the existing hospital, including, but not limited to, the finalization of the plans for the replacement hospital, on-going discussions and negotiations with interested parties for the existing hospital, regulatory approvals and changing market conditions at the microeconomic and macroeconomic levels, the Company could be subject to an acceleration of depreciation for the portion of the existing hospital it anticipates disposing of in the future. The accelerated depreciation would reduce the carrying values of the portion of the hospital the Company does not anticipate retaining to their estimated fair values at the end of the estimated construction period of the replacement hospital.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

Leases

Overview

The Company leases real estate properties, buildings, vehicles and equipment under cancelable and non-cancelable leases. The leases expire at various times and have various renewal options. Certain leases that meet the lease capitalization criteria in accordance with ASC 840-10, "Leases", have been recorded as an asset and liability at the lower of the net present value of the minimum lease payments at the inception of the lease or the fair value of the asset at the inception date. Interest rates used in computing the net present value of the lease payments are based on the Company's incremental borrowing rate at the inception of the lease. Rental expense of operating leases for the years ended December 31, 2015, 2014 and 2013 was $52.9 million, $45.4 million and $36.5 million, respectively.

Health Support Center Financing Lease

Under a financing lease arrangement which commenced on December 1, 2013, the Company is leasing from an unrelated third party a health support center for a period of just over 15 years (the "HSC Lease"). In accordance with ASC 840-40, "Leases – Sale-Leaseback Transactions", upon commencement of the HSC Lease, the Company recorded an asset under the caption "Buildings and improvements" and a related financing obligation under the caption "Long-term debt" representing the cumulative costs incurred and funded by the unrelated third party to construct the new health support center. The Company is depreciating the associated asset and amortizing the related financing obligation over the expected lease agreement term of just over 15 years. At the end of the lease term, the Company expects there to be a residual net book value of the building which will equal the remaining unamortized obligation under the HSC Lease. The remaining unamortized obligation under the HSC Lease will not require the eventual settlement in cash but will rather be offset by the residual net book value of the building at the expiration of the original lease term.

Future minimum lease payments at December 31, 2015, for those leases having an initial or remaining non-cancelable lease term in excess of one year are as follows for the years indicated (in millions):

	Operating Leases	Capital Leases and Financing Obligations	Total
2016	$ 32.9	$ 8.3	$ 41.2
2017	24.0	7.4	31.4
2018	16.5	7.5	24.0
2019	12.3	7.6	19.9
2020	11.6	7.7	19.3
Thereafter	48.9	56.6	105.5
	$ 146.2	$ 95.1	$ 241.3
Less: interest portion		(58.6)	
		$ 36.5	

Tax Matters

See Note 6 for a discussion of the Company's contingent tax matters.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

Note 12. Earnings Per Share

The following table sets forth the computation of basic and diluted earnings per share for the years ended December 31, 2015, 2014 and 2013 (dollars and shares in millions, except per share amounts):

	2015	2014	2013
Numerator for basic and diluted earnings per share attributable to LifePoint Health, Inc.:			
Income from continuing operations	$ 193.0	$ 134.9	$ 132.2
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(11.1)	(8.8)	(4.4)
Income from continuing operations attributable to LifePoint Health, Inc. stockholders	181.9	126.1	127.8
Income from discontinued operations, net of income taxes	-	-	0.4
Net income attributable to LifePoint Health, Inc.	$ 181.9	$ 126.1	$ 128.2
Denominator:			
Weighted average shares outstanding - basic	43.9	44.9	46.3
Effect of dilutive securities:			
Stock options and other stock-based awards	2.2	1.8	1.3
Convertible debt instruments	-	0.2	-
Weighted average shares outstanding - diluted	46.1	46.9	47.6
Basic earnings per share attributable to LifePoint Health, Inc. stockholders:			
Continuing operations	$ 4.14	$ 2.81	$ 2.76
Discontinued operations	-	-	0.01
Net income	$ 4.14	$ 2.81	$ 2.77
Diluted earnings per share attributable to LifePoint Health, Inc. stockholders:			
Continuing operations	$ 3.95	$ 2.69	$ 2.68
Discontinued operations	-	-	0.01
Net income	$ 3.95	$ 2.69	$ 2.69

The Company's previously outstanding convertible debt instruments have been included in the calculation of diluted earnings per share for the years ended December 31, 2014 and 2013 whether or not the contingent requirements were met for conversion when their conversion price was less than the average market price of the Company's common stock for the period the convertible debt instruments were outstanding. Additionally, certain outstanding stock-based awards have been included in the calculation of diluted earnings per share to the extent they were dilutive for the years ended December 31, 2015, 2014 and 2013.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

Note 13. Unaudited Quarterly Financial Information

The quarterly interim financial information shown below has been prepared by the Company's management and is unaudited. It should be read in conjunction with the audited consolidated financial statements appearing herein (in millions, except per share amounts):

	2015			
	First	Second	Third	Fourth
Revenues	$ 1,263.7	$ 1,270.4	$ 1,309.5	$ 1,370.7
Net income	42.0	49.8	45.8	55.4
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(3.1)	(3.4)	(2.2)	(2.4)
Net income attributable to LifePoint Health, Inc.	$ 38.9	$ 46.4	$ 43.6	$ 53.0
Earnings per share attributable to LifePoint Health, Inc. stockholders:				
Basic	$ 0.88	$ 1.05	$ 0.99	$ 1.22
Diluted	$ 0.84	$ 1.00	$ 0.94	$ 1.16

	2014			
	First	Second	Third	Fourth
Revenues	$ 1,007.2	$ 1,047.0	$ 1,166.0	$ 1,262.9
Net income	37.7	41.8	28.7	26.7
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(0.6)	(2.7)	(1.2)	(4.3)
Net income attributable to LifePoint Health, Inc.	$ 37.1	$ 39.1	$ 27.5	$ 22.4
Earnings per share attributable to LifePoint Health, Inc. stockholders:				
Basic	$ 0.81	$ 0.88	$ 0.61	$ 0.50
Diluted	$ 0.78	$ 0.84	$ 0.59	$ 0.48

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

Note 14. Guarantor and Non-Guarantor Supplementary Information

The 6.625% Senior Notes, 5.5% Senior Notes and 5.875% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by substantially all of the Company's existing subsidiaries that guarantee the Senior Credit Agreement. The guarantors are 100% owned by the Company. Additionally, the guarantees are full and unconditional and are subject to customary release provisions as set forth in the agreements for the 6.625% Senior Notes, the 5.5% Senior Notes and the 5.875% Senior Notes.

The condensed consolidating financial information for the parent issuer, 100% owned guarantor subsidiaries, non-guarantor subsidiaries, certain eliminations and the Company is presented below for the years ended December 31, 2015, 2014 and 2013 and as of December 31, 2015 and 2014.

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Operations
For the Year Ended December 31, 2015
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 3,419.8	$ 2,594.6	$ -	$ 6,014.4
Provision for doubtful accounts	-	496.9	303.2	-	800.1
Revenues	-	2,922.9	2,291.4	-	5,214.3
Salaries and benefits	35.0	1,342.2	1,119.7	-	2,496.9
Supplies	-	422.2	392.8	-	815.0
Other operating expenses	(0.7)	729.6	517.5	-	1,246.4
Other income	-	(35.8)	(13.9)	-	(49.7)
Equity in earnings of affiliates	(260.7)	-	-	260.7	-
Depreciation and amortization	-	180.0	99.0	-	279.0
Interest expense, net	35.5	66.3	12.6	-	114.4
Impairment charges	-	13.8	-	-	13.8
Other non-operating gain	-	(4.0)	-	-	(4.0)
Management (income) fees	-	(59.7)	59.7	-	-
	(190.9)	2,654.6	2,187.4	260.7	4,911.8
Income before income taxes	190.9	268.3	104.0	(260.7)	302.5
Provision for income taxes	9.0	100.5	-	-	109.5
Net income	181.9	167.8	104.0	(260.7)	193.0
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(0.8)	(10.3)	-	(11.1)
Net income attributable to LifePoint Health, Inc.	$ 181.9	$ 167.0	$ 93.7	$ (260.7)	$ 181.9

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Operations
For the Year Ended December 31, 2014
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 3,482.6	$ 1,818.3	$ -	$ 5,300.9
Provision for doubtful accounts	-	576.5	241.3	-	817.8
Revenues	-	2,906.1	1,577.0	-	4,483.1
Salaries and benefits	29.7	1,331.5	773.3	-	2,134.5
Supplies	-	419.4	279.6	-	699.0
Other operating expenses	(0.6)	750.4	337.5	-	1,087.3
Other income	-	(56.8)	(15.1)	-	(71.9)
Equity in earnings of affiliates	(196.9)	-	-	196.9	-
Depreciation and amortization	-	180.0	70.5	-	250.5
Interest expense, net	43.4	68.9	10.7	-	123.0
Impairment charges	-	57.7	-	-	57.7
Management (income) fees	-	(45.1)	45.1	-	-
	(124.4)	2,706.0	1,501.6	196.9	4,280.1
Income before income taxes	124.4	200.1	75.4	(196.9)	203.0
(Benefit) provision for income taxes	(1.7)	69.8	-	-	68.1
Net income	126.1	130.3	75.4	(196.9)	134.9
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(1.0)	(7.8)	-	(8.8)
Net income attributable to LifePoint Health, Inc.	$ 126.1	$ 129.3	$ 67.6	$ (196.9)	$ 126.1

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Operations
For the Year Ended December 31, 2013
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 3,333.8	$ 1,094.9	$ -	$ 4,428.7
Provision for doubtful accounts	-	593.4	157.0	-	750.4
Revenues	-	2,740.4	937.9	-	3,678.3
Salaries and benefits	25.4	1,265.2	436.8	-	1,727.4
Supplies	-	398.9	178.2	-	577.1
Other operating expenses	0.8	697.2	202.9	-	900.9
Other income	-	(55.4)	(8.7)	-	(64.1)
Equity in earnings of affiliates	(182.2)	-	-	182.2	-
Depreciation and amortization	-	175.3	52.9	-	228.2
Interest expense, net	21.5	66.7	8.8	-	97.0
Other non-operating loss (gain)	5.9	-	(5.6)	-	0.3
Management (income) fees	-	(14.1)	14.1	-	-
	(128.6)	2,533.8	879.4	182.2	3,466.8
Income from continuing operations before income taxes	128.6	206.6	58.5	(182.2)	211.5
Provision for income taxes	0.4	78.9	-	-	79.3
Income from continuing operations	128.2	127.7	58.5	(182.2)	132.2
Income from discontinued operations, net of taxes	-	0.4	-	-	0.4
Net income	128.2	128.1	58.5	(182.2)	132.6
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(0.8)	(3.6)	-	(4.4)
Net income attributable to LifePoint Health, Inc.	$ 128.2	$ 127.3	$ 54.9	$ (182.2)	$ 128.2

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Comprehensive Income
For the Year Ended December 31, 2015
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Net income	$ 181.9	$ 167.8	$ 104.0	$ (260.7)	$ 193.0
Other comprehensive income, net of income taxes:					
Unrealized gain on changes in funded status of pension benefit obligations	1.7	0.2	2.4	(2.6)	1.7
Other comprehensive income	1.7	0.2	2.4	(2.6)	1.7
Comprehensive income	183.6	168.0	106.4	(263.3)	194.7
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(0.8)	(10.3)	-	(11.1)
Comprehensive income attributable to LifePoint Health, Inc.	$ 183.6	$ 167.2	$ 96.1	$ (263.3)	$ 183.6

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Comprehensive Income
For the Year Ended December 31, 2014
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Net income	$ 126.1	$ 130.3	$ 75.4	$ (196.9)	$ 134.9
Other comprehensive loss, net of income taxes:					
Unrealized loss on changes in funded status of pension benefit obligations	(7.8)	(2.6)	(9.4)	12.0	(7.8)
Other comprehensive loss	(7.8)	(2.6)	(9.4)	12.0	(7.8)
Comprehensive income	118.3	127.7	66.0	(184.9)	127.1
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(1.0)	(7.8)	-	(8.8)
Comprehensive income attributable to LifePoint Health, Inc.	$ 118.3	$ 126.7	$ 58.2	$ (184.9)	$ 118.3

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Comprehensive Income
For the Year Ended December 31, 2013
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Net income	$ 128.2	$ 128.1	$ 58.5	$ (182.2)	$ 132.6
Other comprehensive income, net of income taxes:					
Unrealized gain on changes in funded status of pension benefit obligations	3.2	0.2	4.9	(5.1)	3.2
Other comprehensive income	3.2	0.2	4.9	(5.1)	3.2
Comprehensive income	131.4	128.3	63.4	(187.3)	135.8
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(0.8)	(3.6)	-	(4.4)
Comprehensive income attributable to LifePoint Health, Inc.	$ 131.4	$ 127.5	$ 59.8	$ (187.3)	$ 131.4

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

LIFEPOINT HEALTH, INC.
Condensed Consolidating Balance Sheets
December 31, 2015
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$ -	$ 200.9	$ 83.1	$ -	$ 284.0
Accounts receivable, net	-	442.7	301.0	-	743.7
Inventories	-	75.1	52.6	-	127.7
Prepaid expenses	0.1	27.8	22.9	-	50.8
Other current assets	-	28.3	31.5	-	59.8
	0.1	774.8	491.1	-	1,266.0
Property and equipment:					
Land	-	74.0	88.8	-	162.8
Buildings and improvements	-	1,546.1	726.2	-	2,272.3
Equipment	-	1,344.0	423.8	-	1,767.8
Construction in progress	-	72.2	47.2	-	119.4
	-	3,036.3	1,286.0	-	4,322.3
Accumulated depreciation	-	(1,523.7)	(316.3)	-	(1,840.0)
	-	1,512.6	969.7	-	2,482.3
Intangible assets, net	-	30.2	40.4	-	70.6
Investments in subsidiaries	2,286.0	-	-	(2,286.0)	-
Due from subsidiaries	2,716.2	-	-	(2,716.2)	-
Other long-term assets	12.7	469.8	27.9	-	510.4
Goodwill	-	1,466.3	201.2	-	1,667.5
Total assets	$ 5,015.0	$ 4,253.7	$ 1,730.3	$ (5,002.2)	$ 5,996.8
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	$ -	$ 91.2	$ 73.1	$ -	$ 164.3
Accrued salaries	7.4	115.6	83.0	-	206.0
Income taxes payable	28.9	-	-	-	28.9
Other current liabilities	14.4	106.8	73.3	-	194.5
Current maturities of long-term debt	22.5	1.0	1.5	-	25.0
	73.2	314.6	230.9	-	618.7
Long-term debt, net	2,582.9	48.1	12.8	-	2,643.8
Due to Parent	-	2,044.4	671.8	(2,716.2)	-
Deferred income taxes	94.4	-	-	-	94.4
Long-term portion of reserves for self-insurance claims	-	104.5	50.2	-	154.7
Other long-term liabilities	0.6	25.4	46.8	-	72.8
Total liabilities	2,751.1	2,537.0	1,012.5	(2,716.2)	3,584.4
Redeemable noncontrolling interests	-	-	103.6	-	103.6
Total LifePoint Health, Inc. stockholders' equity	2,263.9	1,715.2	570.8	(2,286.0)	2,263.9
Noncontrolling interests	-	1.5	43.4	-	44.9
Total equity	2,263.9	1,716.7	614.2	(2,286.0)	2,308.8
Total liabilities and equity	$ 5,015.0	$ 4,253.7	$ 1,730.3	$ (5,002.2)	$ 5,996.8

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

LIFEPOINT HEALTH, INC.
Condensed Consolidating Balance Sheets
December 31, 2014
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$ -	$ 62.0	$ 129.5	$ -	$ 191.5
Accounts receivable, net	-	451.4	301.2	-	752.6
Inventories	-	71.3	43.9	-	115.2
Prepaid expenses	0.1	29.1	16.2	-	45.4
Income taxes receivable	33.0	-	-		33.0
Other current assets	-	53.5	32.2	-	85.7
	33.1	667.3	523.0	-	1,223.4
Property and equipment:					
Land	-	70.0	64.8	-	134.8
Buildings and improvements	-	1,542.2	613.7	-	2,155.9
Equipment	-	1,289.9	343.9	-	1,633.8
Construction in progress	-	49.6	23.3	-	72.9
	-	2,951.7	1,045.7	-	3,997.4
Accumulated depreciation	-	(1,398.3)	(221.6)	-	(1,619.9)
	-	1,553.4	824.1	-	2,377.5
Intangible assets, net	-	34.6	34.5	-	69.1
Investments in subsidiaries	2,025.6	-	-	(2,025.6)	-
Due from subsidiaries	2,352.1	-	-	(2,352.1)	-
Other long-term assets	9.4	19.4	20.4	-	49.2
Goodwill	-	1,440.5	195.6	-	1,636.1
Total assets	$ 4,420.2	$ 3,715.2	$ 1,597.6	$ (4,377.7)	$ 5,355.3
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	$ -	$ 90.4	$ 68.1	$ -	$ 158.5
Accrued salaries	-	130.9	71.5	-	202.4
Other current liabilities	14.5	112.7	76.0	-	203.2
Current maturities of long-term debt	16.9	0.9	1.4	-	19.2
	31.4	334.9	217.0	-	583.3
Long-term debt, net	2,108.6	49.1	12.7	-	2,170.4
Due to Parent	-	1,634.6	717.5	(2,352.1)	-
Deferred income taxes	114.7	-	-	-	114.7
Long-term portion of reserves for self-insurance claims	-	103.1	30.1	-	133.2
Other long-term liabilities	10.9	24.7	49.1	-	84.7
Total liabilities	2,265.6	2,146.4	1,026.4	(2,352.1)	3,086.3
Redeemable noncontrolling interests	-	-	87.1	-	87.1
Total LifePoint Health, Inc. stockholders' equity	2,154.6	1,567.0	458.6	(2,025.6)	2,154.6
Noncontrolling interests	-	1.8	25.5	-	27.3
Total equity	2,154.6	1,568.8	484.1	(2,025.6)	2,181.9
Total liabilities and equity	$ 4,420.2	$ 3,715.2	$ 1,597.6	$ (4,377.7)	$ 5,355.3

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Cash Flows
For the Year Ended December 31, 2015
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 181.9	$ 167.8	$ 104.0	$ (260.7)	$ 193.0
Adjustments to reconcile net income to net cash provided by operating activities:					
Equity in earnings of affiliates	(260.7)	-	-	260.7	-
Stock-based compensation	30.0	-	-	-	30.0
Depreciation and amortization	-	180.0	99.0	-	279.0
Amortization of physician minimum revenue guarantees	-	10.1	1.9	-	12.0
Amortization of debt issuance costs, discount and premium	5.1	-	-	-	5.1
Impairment charges	-	13.8	-	-	13.8
Other non-operating gain	-	(4.0)	-	-	(4.0)
Deferred income tax benefit	(14.4)	-	-	-	(14.4)
Reserve for self-insurance claims, net of payments	-	(7.3)	25.2	-	17.9
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	7.0	31.7	-	38.7
Inventories, prepaid expenses and other current assets	-	25.0	(5.1)	-	19.9
Accounts payable, accrued salaries and other current liabilities	7.3	(15.7)	(16.3)	-	(24.7)
Income taxes payable/receivable	61.9	-	-	-	61.9
Other	(0.9)	(0.5)	0.3	-	(1.1)
Net cash provided by operating activities	10.2	376.2	240.7	-	627.1
Cash flows from investing activities:					
Purchases of property and equipment	-	(156.8)	(117.9)	-	(274.7)
Acquisitions, net of cash acquired	-	(488.2)	(131.2)	-	(619.4)
Proceeds from sale of hospital	-	18.8	-	-	18.8
Other	(1.0)	-	-	-	(1.0)
Net cash used in investing activities	(1.0)	(626.2)	(249.1)	-	(876.3)
Cash flows from financing activities:					
Proceeds from borrowings	500.0	-	-	-	500.0
Payments of borrowings	(16.9)	-	-	-	(16.9)
Repurchases of common stock	(134.5)	-	-	-	(134.5)
Payments of debt issuance costs	(7.2)	-	-	-	(7.2)
Proceeds from exercise of stock options	11.5	-	-	-	11.5
Change in intercompany balances with affiliates, net	(362.1)	388.0	(25.9)	-	-
Other	-	0.9	(12.1)	-	(11.2)
Net cash (used in) provided by financing activities	(9.2)	388.9	(38.0)	-	341.7
Change in cash and cash equivalents	-	138.9	(46.4)	-	92.5
Cash and cash equivalents at beginning of period	-	62.0	129.5	-	191.5
Cash and cash equivalents at end of period	$ -	$ 200.9	$ 83.1	$ -	$ 284.0

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Cash Flows
For the Year Ended December 31, 2014
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 126.1	$ 130.3	$ 75.4	$ (196.9)	$ 134.9
Adjustments to reconcile net income to net cash (used in) provided by operating activities:					
Equity in earnings of affiliates	(196.9)	-	-	196.9	-
Stock-based compensation	27.3	-	-	-	27.3
Depreciation and amortization	-	180.0	70.5	-	250.5
Amortization of physician minimum revenue guarantees	-	13.1	1.6	-	14.7
Amortization of debt issuance costs, discounts and premium	14.0	-	-	-	14.0
Impairment charges	-	57.7	-	-	57.7
Deferred income taxes	22.8	-	-	-	22.8
Reserve for self-insurance claims, net of payments	-	7.9	3.8	-	11.7
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	(5.9)	(48.4)	-	(54.3)
Inventories, prepaid expenses and other current assets	-	(6.1)	(12.5)	-	(18.6)
Accounts payable, accrued salaries and other current liabilities	2.4	(38.6)	21.8	-	(14.4)
Income taxes payable/receivable	(35.5)	-	-	-	(35.5)
Other	(0.8)	1.8	0.5	-	1.5
Net cash (used in) provided by operating activities	(40.6)	340.2	112.7	-	412.3
Cash flows from investing activities:					
Purchases of property and equipment	-	(139.0)	(68.1)	-	(207.1)
Acquisitions, net of cash acquired	-	(11.4)	(254.2)	-	(265.6)
Other	(3.2)	3.3	(0.6)	-	(0.5)
Net cash used in investing activities	(3.2)	(147.1)	(322.9)	-	(473.2)
Cash flows from financing activities:					
Proceeds from borrowings	412.0	-	-	-	412.0
Payments of borrowings	(585.4)	-	-	-	(585.4)
Repurchases of common stock	(222.3)	-	-	-	(222.3)
Payments of debt issuance costs	(7.2)	-	-	-	(7.2)
Proceeds from exercise of stock options	23.9	-	-	-	23.9
Change in intercompany balances with affiliates, net	423.0	(689.9)	266.9	-	-
Other	(0.2)	0.5	(6.8)	-	(6.5)
Net cash provided by (used in) financing activities	43.8	(689.4)	260.1	-	(385.5)
Change in cash and cash equivalents	-	(496.3)	49.9	-	(446.4)
Cash and cash equivalents at beginning of period	-	558.3	79.6	-	637.9
Cash and cash equivalents at end of period	$ -	$ 62.0	$ 129.5	$ -	$ 191.5

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Cash Flows
For the Year Ended December 31, 2013
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 128.2	$ 128.1	$ 58.5	$ (182.2)	$ 132.6
Adjustments to reconcile net income to net cash (used in) provided by operating activities:					
Income from discontinued operations	-	(0.4)	-	-	(0.4)
Equity in earnings of affiliates	(182.2)	-	-	182.2	-
Stock-based compensation	25.4	-	-	-	25.4
Depreciation and amortization	-	175.3	52.9	-	228.2
Amortization of physician minimum revenue guarantees	-	15.5	1.7	-	17.2
Amortization of debt issuance costs and discounts	26.9	-	-	-	26.9
Other non-operating loss (gain)	5.9	-	(5.6)	-	0.3
Deferred income tax benefit	(20.4)	-	-	-	(20.4)
Reserve for self-insurance claims, net of payments	-	(0.7)	4.0	-	3.3
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	(22.9)	(4.1)	-	(27.0)
Inventories, prepaid expenses and other current assets	-	(15.0)	(2.1)	-	(17.1)
Accounts payable, accrued salaries and other current liabilities	(0.1)	(10.9)	(5.3)	-	(16.3)
Income taxes payable/receivable	1.8	-	-	-	1.8
Other	-	(0.7)	0.3	-	(0.4)
Net cash (used in) provided by operating activities - continuing operations	(14.5)	268.3	100.3	-	354.1
Net cash used in operating activities - discontinued operations	-	(0.1)	-	-	(0.1)
Net cash (used in) provided by operating activities	(14.5)	268.2	100.3	-	354.0
Cash flows from investing activities:					
Purchases of property and equipment	-	(149.4)	(35.8)	-	(185.2)
Acquisitions, net of cash acquired	-	(46.4)	(141.7)	-	(188.1)
Other	(1.9)	1.3	1.6	-	1.0
Net cash used in investing activities	(1.9)	(194.5)	(175.9)	-	(372.3)
Cash flows from financing activities:					
Proceeds from borrowings	1,053.0	-	-	-	1,053.0
Payments of borrowings	(453.7)	-	-	-	(453.7)
Repurchases of common stock	(39.1)	-	-	-	(39.1)
Payments of debt issuance costs	(20.0)	-	-	-	(20.0)
Proceeds from exercise of stock options	39.2	-	-	-	39.2
Change in intercompany balances with affiliates, net	(562.6)	459.7	102.9	-	-
Other	(0.4)	(0.1)	(7.7)	-	(8.2)
Net cash provided by financing activities	16.4	459.6	95.2	-	571.2
Change in cash and cash equivalents	-	533.3	19.6	-	552.9
Cash and cash equivalents at beginning of period	-	25.0	60.0	-	85.0
Cash and cash equivalents at end of period	$ -	$ 558.3	$ 79.6	$ -	$ 637.9

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

Note 15. Subsequent Events

Effective January 1, 2016, through Duke LifePoint Healthcare, the Company acquired Frye Regional Medical Center ("Frye"), a 355 bed acute care hospital located in Hickory, North Carolina and Central Carolina Hospital ("Central Carolina"), a 137 bed acute care hospital located in Sanford, North Carolina for approximately $190.9 million, including net working capital as well as the assumption of certain capital lease obligations. The purchase price of Frye and Central Carolina, which was paid on December 31, 2015, is reflected as a deposit and is included under the caption "Other long-term assets" in the accompanying consolidated balance sheet as of December 31, 2015.

Additionally, effective January 1, 2016, the Company acquired St. Francis Hospital ("St. Francis"), a 376 bed acute care hospital located in Columbus, Georgia for approximately $257.1 million. The purchase price of St. Francis, which was paid on December 31, 2015, is reflected as a deposit and is included under the caption "Other long-term assets" in the accompanying consolidated balance sheet as of December 31, 2015.

Lastly, effective February 1, 2016, the Company acquired Providence Hospitals ("Providence") for approximately $132.2 million, including net working capital. Providence is comprised of Providence Hospital (Downtown), a 258 bed acute care hospital, and Providence Hospital Northeast, a 74 bed acute care hospital, each located in Columbia, South Carolina.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, in the City of Brentwood, State of Tennessee, on February 12, 2016.

LIFEPOINT HEALTH, INC.

By: /s/ WILLIAM F. CARPENTER III
William F. Carpenter III
Chief Executive Officer and
Chairman of the Board of Directors

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant in the capacities and on the date indicated.

Name	Title	Date
/s/ WILLIAM F. CARPENTER III William F. Carpenter III	Chief Executive Officer and Chairman of the Board of Directors (Principal Executive Officer)	February 12, 2016
/s/ LEIF M. MURPHY Leif M. Murphy	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 12, 2016
/s/ MICHAEL S. COGGIN Michael S. Coggin	Chief Accounting Officer (Principal Accounting Officer)	February 12, 2016
/s/ GREGORY T. BIER Gregory T. Bier	Director	February 12, 2016
/s/ RICHARD H. EVANS Richard H. Evans	Lead Director	February 12, 2016
/s/ DEWITT EZELL, JR. DeWitt Ezell, Jr.	Director	February 12, 2016
/s/ MICHAEL P. HALEY Michael P. Haley	Director	February 12, 2016
/s/ MARGUERITE W. KONDRACKE Marguerite W. Kondracke	Director	February 12, 2016
/s/ JOHN E. MAUPIN, JR. John E. Maupin, Jr.	Director	February 12, 2016
/s/ REED V. TUCKSON Reed V. Tuckson	Director	February 12, 2016

Exhibit Number		Description of Exhibits
3.1	—	Amended and Restated Certificate of Incorporation of LifePoint Health, Inc., as amended (incorporated by reference from exhibits to the LifePoint Health, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2015, File No. 000-51251).
3.2	—	Sixth Amended and Restated By-Laws of LifePoint Health, Inc. (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed May 11, 2015, File No. 000-51251).
4.1	—	Form of Specimen Stock Certificate (incorporated by reference from exhibits to the Registration Statement on Form S-4, as amended, filed by Historic LifePoint Hospitals, Inc. on October 25, 2004, File No. 333-119929).
4.2	—	Amended and Restated Rights Agreement, dated February 25, 2009, by and between LifePoint Hospitals, Inc. and American Stock Transfer & Trust Company, LLC (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed February 25, 2009, File No. 000-51251).
4.3	—	Amendment No. 1 to Amended and Restated Rights Agreement by and between LifePoint Health, Inc. and American Stock Transfer & Trust Company, LLC, dated as of September 21, 2015 (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed September 21, 2015, File No. 000-51251).
4.4	—	Indenture, dated September 23, 2010, by and among LifePoint Hospitals, Inc., the guarantors named therein and Bank of New York Mellon Trust Company, N.A. as trustee (including the Form of 6.625% Senior Notes due 2020) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed September 27, 2010, File No. 000-51251).
4.5	—	Supplemental Indenture, dated as of August 23, 2013, by and among LifePoint Hospitals, Inc. the guarantors named herein and The Bank of New York Mellon Trust Company, N.A., as Trustee, to the Indenture, dated as of September 23, 2010, as supplemented (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed August 26, 2013, File No. 000-51251).
4.6	—	Indenture, dated as of December 6, 2013, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Bank of New York Mellon Trust Company, N.A. as trustee (including the Form of 5.5% Senior Note due 2021) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 9, 2013, File No. 000-51251).
4.7	—	Senior Debt Securities Indenture, dated as of December 4, 2015, by and between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed December 4, 2015, File No. 000-51251).
4.8	—	Supplemental Indenture, dated as of December 4, 2015, by and among the Company, the Guarantors party thereto, and The Bank of New York Mellon Trust Company, N.A., as trustee (including the form of 5.875% Senior Notes due 2023) (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed December 4, 2015, File No. 000-51251).
10.1	—	Computer and Data Processing Services Agreement dated May 19, 2008, by and between HCA Information Technology Services, Inc. and LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed May 21, 2008, File No. 000-51251).
10.2	—	Amendment to the Computer and Data Processing Services Agreement, dated June 13, 2012, by and between HCA – Information Technology & Services, Inc. and LifePoint Corporate Services, General Partnership (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2012, File No. 000-51251).
10.3	—	LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan, dated June 30, 2005, as amended by the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010, the Amendment dated April 23, 2012 and the Amendment dated June 5, 2012 (incorporated by reference from Appendix A and B to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).*

10.4	—	Form of LifePoint Hospitals, Inc. Restricted Stock Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*
10.5	—	LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from Appendix C to the Historic LifePoint Hospitals, Inc. Proxy Statement dated April 28, 2004, File No. 000-29818).*
10.6	—	First Amendment, dated December 10, 2008, to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).*
10.7	—	Amendment No. 2 to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed June 6, 2014, File No. 000-51251).*
10.8	—	Form of LifePoint Hospitals, Inc. Performance Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*
10.9	—	LifePoint Hospitals, Inc. Change in Control Severance Plan, as amended and restated (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 16, 2008, File No. 000-51251).*
10.10	—	LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan, dated January 1, 2003, as amended by the Amendment dated May 22, 2003, the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated March 24, 2009, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 29, 2010, File No. 000-51251).*
10.11	—	Amendment, dated April 18, 2012 to the LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan (incorporated by reference from exhibits to LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2012, File No. 000-51251).*
10.12	—	Form of Outside Directors Restricted Stock Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2006, File No. 000-51251).*
10.13	—	LifePoint Hospitals, Inc. Amended and Restated Outside Directors Stock and Incentive Compensation Plan, dated May 12, 2009, as amended by the Amendment dated April 27, 2010, the Amendment dated June 8, 2010 and the Amendment dated June 5, 2012 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).*
10.14	—	Form of LifePoint Hospitals, Inc. Deferred Restricted Stock Award (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*
10.15	—	LifePoint Hospitals Deferred Compensation Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 15, 2009, File No. 000-51251).*
10.16	—	Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated December 22, 2010 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, File No. 000-51251).*
10.17	—	Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated March 14, 2011 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, File No. 000-51251).*
10.18	—	Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated November 24, 2014 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2014, File No. 000-51251).*

10.19	—	Credit Agreement, dated as of July 24, 2012, among LifePoint Hospitals, Inc., as borrower, the lenders referred to therein, Citibank, N.A. as administrative agent, Bank of America, N.A. and Barclays Bank PLC, as co-syndication agents, and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and Barclays Bank PLC, as joint lead arrangers and joint bookrunners (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2012, File No. 000-51251).
10.20	—	Incremental Facility Amendment No. 1, dated as of February 6, 2013, by and among LifePoint Hospitals, Inc., as borrower, the lenders referred to therein, Citibank, N.A., as administrative agent, and consented to by Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as leads arrangers, to the Credit Agreement, dated as of July 24, 2012, among Borrower, the lenders referred to therein, Citibank, N.A. as administrative agent, Bank of America, N.A. and Barclays Bank PLC as co-syndication agents and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as joint lead arrangers and joint bookrunners (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed February 7, 2013, File No. 000-51251).
10.21	—	Credit Agreement Amendment No. 2, dated as of August 23, 2013, by and among LifePoint Hospitals, Inc., the lenders party thereto, Citibank, N.A., as administrative agent and consented to by Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC, as lead arrangers, to that certain Credit Agreement, dated as of July 24, 2012, among LifePoint Hospitals, Inc., the lenders party thereto, the Administrative Agent, Bank of America, N.A. and Barclays Bank PLC, as co-syndication agents and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as joint lead arrangers and joint bookrunners, as amended by Incremental Facility Amendment No. 1 dated as of February 6, 2013 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed August 26, 2013, File No. 000-51251).
10.22	—	Executive Severance and Restrictive Covenant Agreement, dated December 11, 2008, by and between LifePoint CSGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).*
10.23	—	First Amendment to the Amended and Restated Executive Severance and Restrictive Covenant Agreement, dated December 11, 2012, by and between HSCGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 17, 2012, File No. 000-51251).*
10.24	—	Recoupment Policy Relating to Unearned Incentive Compensation of Executive Officers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed May 20, 2008, File No. 000-51251).*
10.25	—	LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan (incorporated by reference from Appendix A to the LifePoint Hospitals, Inc. Proxy Statement filed April 24, 2013, File No. 000-51251).*
10.26	—	Amendment to the LifePoint Health, Inc. 2013 Long-Term Incentive Plan (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed June 4, 2015, File No. 000-51251).
10.27	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement (Performance-Based Vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.28	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.29	—	Form of LifePoint Hospitals, Inc. Nonqualified Stock Option Agreement for the LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.30	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement for non-employee directors (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2013, File No. 000-51251).*

10.31	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Outside Director Restricted Stock Unit Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.32	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (time-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.33	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (performance-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.34	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2014, File No. 000-51251).*
10.35	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting; deferral provision) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2014, File No. 000-51251).*
10.36	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting; deferral provision) (filed herewith).*
10.37	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Non-Qualified Stock Option Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2014, File No. 000-51251).*
10.38	—	Form of Indemnification Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, File No. 000-51251).*
10.39	—	Voluntary Resignation Agreement and General Release by and between Jeffrey S. Sherman and HSGCP, LLC, dated September 4, 2013 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed September 6, 2013, File No. 000-51251).*
12.1	—	Ratio of Earnings to Fixed Charges
21.1	—	List of Subsidiaries
23.1	—	Consent of Independent Registered Public Accounting Firm
31.1	—	Certification of the Chief Executive Officer of LifePoint Health, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	—	Certification of the Chief Financial Officer of LifePoint Health, Inc. pursuant to Section 302 of the Sarbanes Oxley Act of 2002
32.1	—	Certification of the Chief Executive Officer of LifePoint Health, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	—	Certification of the Chief Financial Officer of LifePoint Health, Inc. pursuant to Section 906 of the Sarbanes Oxley Act of 2002
101.INS	—	XBRL Instance Document**
101.SCH	—	XBRL Taxonomy Extension Schema Document**
101.CAL	—	XBRL Taxonomy Calculation Linkbase Document**

101.DEF	—	XBRL Taxonomy Definition Linkbase Document**
101.LAB	—	XBRL Taxonomy Label Linkbase Document**
101.PRE	—	XBRL Taxonomy Presentation Linkbase Document**

* = Management Compensation Plan or Arrangement
** = Furnished electronically herewith

LIFEPOINT HOSPITALS, INC.
2013 LONG-TERM INCENTIVE PLAN
Restricted stock unit AGREEMENT

FOR

[Name]
Grant Number [Grant Number]

1. ***Award of Restricted Stock Units***. LifePoint Health, Inc. (the "**Company**") grants, as of **[Date]** (the "**Date of Grant**"), to **[Name]** (the "**Recipient**"), **[Shares]** Restricted Stock Units (the "**RSUs**"). Each RSU represents the Company's unsecured obligation to pay the Recipient up to 200% of the Fair Market Value of a Share. The RSUs shall be settled in accordance with Section 4 in **_[all Shares] [all cash] [Shares, to the extent the Percentage Payable (as defined below) is equal to or less than the Threshold Percentage (as defined below) of _____% and cash, to the extent the Percentage Payable is greater than the Threshold Percentage]_**. The RSUs shall be subject to the terms, provisions and restrictions set forth in this Agreement and the LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan (the "**Plan**"), which is incorporated herein for all purposes. The grant of this Award, the issuance of any Shares (or any other securities of the Company pursuant thereto) and, if applicable, payment of cash, is subject to all of the terms and conditions herein and in the Plan. Unless otherwise provided herein, terms used herein that are defined in the Plan and not defined herein shall have the meanings attributable thereto in the Plan.

2. **Vesting of RSUs.**

(a) ***Performance Requirement.***

(i) The percentage of the Fair Market Value of a Share which is payable per RSU (the "**Percentage Payable**") shall be determined, except as otherwise provided in this Agreement, according to the table below (the "**Performance Goals**"), based on the Company's three-year annualized total shareholder return (the "**3-Year TSR**") relative to a peer group, Standard and Poor's Global Industry Classification Standard's Sub-industry: Health Care Facilities with over $500.0 million in revenues or its equivalent (the "**Relative 3-Year TSR**"), during the Performance Period:

Relative 3-Year TSR Achieved	Percentage Payable
Below 25th Percentile	0%
25th Percentile	50%
37.5 Percentile	75%
50th Percentile	100%
62.5 Percentile	150%
75th Percentile or higher	200%

The Percentage Payable will be determined using straight line interpolation if the level of Relative 3-Year TSR achieved is between two of the levels specified in the chart above.

(ii) The "Performance Period" for the Award is January 1, 20__, through December 31, 20__.

(iii) The Company's 3-Year TSR shall be determined using the Company's stock price average for the last thirty (30) trading days in 20__ and the last thirty (30) trading days in 20__.

(iv) Payment of the RSUs is conditioned upon the Committee certifying in writing upon the completion of the Performance Period that the Performance Goals specified herein were achieved and, if so, the level at which the Performance Goals are achieved, except as otherwise provided in this Agreement. If the objectives are not achieved, the RSUs will be forfeited and shall not vest and no payment shall be made hereunder.

(v) Performance shall be determined in accordance with generally accepted accounting principles; provided, however, that such performance shall be determined without regard to any change in accounting standards that may be required by the Financial Accounting Standards Board during the Performance Period, and by making appropriate adjustments to account for any spin-off or sale of a subsidiary or the disposition of assets by the Company during the Performance Period. Any such adjustments shall be made in a manner that (A) does not result in a discretionary increase in the amount payable under the Award and (B) is otherwise consistent with the qualification of Awards as "performance-based compensation" under Code Section 162(m) and the regulations thereunder.

(vi) Except as otherwise provided in this Agreement, there shall be no proportionate or partial vesting of the RSUs in or during the months, days or periods prior to the Vesting Date and all vesting of the RSUs shall occur only on the Vesting Date.

(b) ***General Vesting*** Except as otherwise provided in this Agreement, the RSUs subject to this Agreement will vest on _____ (the "Vesting Date"), provided that the Continuous Service of the Recipient continues through and on the Vesting Date and the Performance Goals are met.

(c) ***Acceleration of Vesting Upon Death***. Notwithstanding any other provision in this Agreement, in the event that the Recipient's Continuous Service terminates before the Vesting Date by reason of the Recipient's death, the RSUs subject to this Agreement shall be immediately vested as of the date of such death, and the Percentage Payable per RSU shall be one hundred percent (100%) or, if greater, the percentage determined pursuant to Section 2(a) above, except that such determination shall be based on the period beginning January 1, 20__ and ending on the date of the Recipient's death and the last thirty (30) trading days immediately prior to the Recipient's death shall be used to measure performance.

(d) ***Acceleration of Vesting Upon Disability***. Notwithstanding any other provision in this Agreement, in the event that the Recipient suffers a Disability prior to the Vesting Date, the RSUs subject to this Agreement shall be immediately vested as of the date of such Disability, and the Percentage Payable per RSU shall be one hundred percent (100%) or, if greater, the percentage determined pursuant to Section 2(a) above, except that such determination shall be based on the period beginning January 1, 20__ and ending on the date of the Recipient's

Disability and the last thirty (30) trading days immediately prior to the Recipient's Disability shall be used to measure performance.

(e) ***Acceleration of Vesting Upon a 409A Change in Control.*** Notwithstanding any other provision in this Agreement or the Plan, upon a 409A Change in Control during the Recipient's Continuous Service, the RSUs subject to this Agreement shall be immediately vested as of the date of such event and the Percentage Payable per RSU shall be two hundred percent (200%), unless either (i) the Company is the surviving entity in the 409A Change in Control and the RSU Award continues to be outstanding after the 409A Change in Control on substantially the same terms and conditions as were applicable immediately prior to the 409A Change in Control, or (ii) the successor company or its parent company assumes or substitutes for the RSU Award, as determined in accordance with Section 10(c)(ii) of the Plan. Notwithstanding the foregoing, in the event the Recipient's Continuous Service is terminated without Cause by the Company or any Related Entity or by such successor company or by the Recipient for Good Reason within 24 months following a 409A Change in Control and the RSUs subject to this Agreement did not vest pursuant to subsection (i) or (ii) of this Section 2(e), the RSUs subject to this Agreement shall be immediately vested as of the date of such termination of Continuous Service and the Percentage Payable per RSU shall be two hundred percent (200%).

(f) ***Acceleration of Vesting Upon Termination.*** Notwithstanding any other provision in this Agreement and except as otherwise provided in Section 2(g), in the event that the Recipient's Continuous Service is terminated prior to the Vesting Date either by the Company or any Related Entity without Cause or by the Recipient for Good Reason, a portion of the RSUs equal to (i) the number of full months of Continuous Service following the Date of Grant through the date of termination, divided by (ii) the total number of months between the Date of Grant and the Vesting Date, shall become vested as of the Vesting Date, provided that the Performance Goals described herein are attained during the Performance Period. The Percentage Payable per RSU shall be the percentage, if any, determined and certified by the Committee pursuant to Section 2(a) above.

(g) ***Acceleration of Vesting Upon Retirement.*** Notwithstanding any other provision in this Agreement, if the Recipient terminates his or her Continuous Service prior to the Vesting Date and after attaining age 62 (for reasons other than the reasons described in Sections 2(c), 2(d), 2(e) and 2(f) hereof) and completing at least five (5) years of Continuous Service (a "**Retirement Termination**"), the RSUs shall vest on the Vesting Date, provided that the Performance Goals described herein are attained during the Performance Period and provided further that, during the period (the "**Restricted Period**") beginning on the date the Recipient has a Retirement Termination (the "**Retirement Date**") and continuing until the Vesting Date, the Recipient agrees that he or she will not, in any capacity (including, but not limited to, as an owner, member, partner, shareholder, consultant, advisor, financier, agent, employee, officer, director, manager or otherwise), whether directly or indirectly, engage in a Competitive Activity (as such term is hereinafter defined). If the Recipient fails to comply with this provision, a portion of the RSUs equal to (i) the number of full months following the Date of Grant through the date the Recipient violates this provision, divided by (ii) the total number of months between the Date of Grant and the Vesting Date, shall become vested as of the Vesting Date, provided that the Performance Goals described herein are attained during the Performance Period, and the

unvested portion of the RSUs shall be forfeited. The Percentage Payable per RSU under this Subsection shall be the percentage, if any, determined and certified by the Committee pursuant to Section 2(a) above. As used in this Agreement, the term "**Competitive Activity**" shall mean and refer to: any person or entity (including their successors (including any successor(s) that results from any business combination, sale or merger), assigns and transferees, whether by operation of law or otherwise) that, whether on the Retirement Date or at any time within the Restricted Period, derives more than fifty percent of its revenues from one or more non-urban acute care hospitals (and associated outpatient healthcare facilities). Nothing in this subsection (g) shall prohibit the Recipient's ownership of stock in any publicly held company (other than the Company) listed on a national securities exchange or whose shares of stock are regularly traded in the over the counter market as long as such holding at no time exceeds two percent (2%) of the total outstanding stock of such company.

(h) ***Definitions***. For purposes of this Agreement, the following terms shall have the meanings indicated:

(i) ***"409A Change in Control"*** means an event which constitutes a "change in the ownership" of the Company, a "change in effective control" of the Company, or a "change in the ownership of a substantial portion of the assets" of the Company, each as defined under Treasury Regulations Section 1.409A-3(i)(5).

(ii) ***"Delivery Date"*** means the date on which any portion of the RSUs subject to this Agreement vest pursuant to this Section 2. Notwithstanding the foregoing, in the event the RSUs subject to this Agreement become vested upon an event which constitutes a "change in the ownership" of the Company, a "change in effective control" of the Company, or a "change in the ownership of a substantial portion of the assets" of the Company under Treasury Regulations Section 1.409A-3(i)(5), Delivery Date shall mean the date on or after such 409A Change in Control on which the Recipient has a Separation from Service, provided that such Separation from Service occurs within 24 months following such 409A Change in Control, or the date on which the RSUs subject to this Agreement would have vested pursuant to Sections 2(b), 2(c) or 2(d) in the absence of a 409A Change in Control occurring, whichever occurs earliest.

(iii) ***"Disability"*** means, solely for purposes of this Agreement and notwithstanding any provision in the Plan to the contrary, a medically determinable physical or mental impairment resulting in the Recipient's inability to perform the duties of his or her position or any substantially similar position, where such impairment can be expected to result in death or can be expected to last for a continuous period of not less than six months.

(iv) "***Non-Vested RSUs***" means any portion of the RSUs subject to this Agreement that have not become vested pursuant to this Section 2.

(v) ***"Separation from Service"*** means the voluntary or involuntary separation from service with the Service Recipient, determined in a manner consistent with Section 409A of the Code and the Treasury Regulations thereunder.

(vi) "***Service Recipient***" means the person or entity for whom the services resulting in the grant of the RSUs were performed, and with respect to whom the legally binding

right to the Award arises, and all persons with whom such person would be considered a single employer under Section 414(b) of the Code (employees of a controlled group of corporations), and all persons with whom such person would be considered a single employer under Section 414(c) of the Code (employees of partnerships, proprietorships, or other entities under common control).

(vii) "***Specified Employee***" means any Recipient who, at the time of his or her Separation from Service, is a "key employee", within the meaning of Section 416(i) of the Code, of any Service Recipient the shares of which are publicly traded on an established securities market or otherwise, determined in accordance with Section 409A of the Code.

(viii) "***Vested RSUs***" means any portion of the RSUs subject to this Agreement that are and have become vested pursuant to this Section 2.

3. ***Forfeiture of RSUs.*** Except as otherwise provided in Section 2, if the Recipient's Continuous Service is terminated prior to the Vesting Date, the RSUs shall be forfeited immediately upon such termination of Continuous Service without any payment to the Recipient.

4. ***Settlement of the RSUs.***

(a) ***Medium of Payment.*** The RSUs may be settled in Shares, cash, or a combination thereof, as determined by the Committee at the time of grant and set forth in Section 1 hereof.

(i) If Section 1 provides that the RSUs shall be settled in all Shares, the Vested RSUs shall be settled in a number of Shares equal to the number of Vested RSUs, multiplied by the Percentage Payable per RSU.

(ii) If Section 1 provides that the RSUs shall be settled in all cash, the Vested RSUs shall be settled in cash equal to the Fair Market Value of a Share on the date the Committee certifies the level of Performance Goals achieved, multiplied by the Percentage Payable per RSU, multiplied by the number of Vested RSUs.

(iii) If Section 1 provides that the RSUs shall be settled in a combination of Shares and cash, the Vested RSUs shall be settled in (A) a number of Shares equal to the number of Vested RSUs, multiplied by the percentage designated in Section 1 (the "Threshold Percentage") that is to be paid in Shares, plus (B) cash equal to the Fair Market Value of a Share on the date the Committee certifies the level of Performance Goals achieved, multiplied by the portion of the Percentage Payable per RSU that exceeds the Threshold Percentage, multiplied by the number of Vested RSUs; provided, however, that if the Percentage Payable is less than the Threshold Percentage established by the Committee at the time of grant, the Vested RSUs shall be settled in a number of Shares equal to the number of Vested Units, multiplied by the Percentage Payable per RSU.

Notwithstanding the foregoing, if the RSUs become vested due to the Recipient's death or Disability, the Fair Market Value of a Share on the date of the Recipient's death or Disability, as applicable, shall be used to calculate any cash payment. Furthermore, if the RSUs become vested on a 409A Change in Control pursuant to Section 2(e), the price paid per share in

connection with such 409A Change in Control shall be used to calculate any cash payment. If the RSUs become vested on the Recipient's termination of Continuous Service following a 409A Change in Control pursuant to Section 2(e), the Fair Market Value of a Share on the date of the Recipient's termination of Continuous Service shall be used to calculate any cash payment.

(b) ***Payment.*** Except as provided in Subsection (d) below, the Company shall deliver to the Recipient or in the event of the Recipient's death, to the beneficiary or beneficiaries designated by the Recipient, or if the Recipient has not so designated any beneficiary(ies), or no designated beneficiary survives the Recipient, to the personal representative of the Recipient's estate, Shares and, if applicable, cash as provided in Section 4(a), on, or as soon as administratively practicable after, the Delivery Date, but in no event more than sixty (60) days thereafter. Notwithstanding the foregoing, in the event there is a 409A Change in Control on or before the date on which the Company would otherwise deliver Shares pursuant to this Section 4(b), the Company may, in lieu of delivering Shares, deliver the consideration (whether stock, cash or other securities or property) received in the 409A Change in Control transaction by holders of Shares, or such other consideration as determined by the Committee in its sole discretion, equal to the Fair Market Value of the per Share consideration received by holders of Shares in the applicable transaction, multiplied by the number of Vested RSUs that were deliverable pursuant to this Section 4. The determination of such substantial equality of Fair Market Value of consideration shall be made by the Committee in its sole discretion and its determination shall be conclusive and binding.

(c) ***Distribution to Specified Employees.*** Notwithstanding the foregoing, if the Recipient is a Specified Employee, then no payments otherwise required to be made under this Agreement on account of the Recipient's Separation from Service shall be made before the date that is six (6) months after the date of the Recipient's Separation from Service or, if earlier, the date of the Recipient's death if such deferral is required to comply with Section 409A of the Code.

(d) ***Deferred Distribution.*** Notwithstanding any other provision, the Recipient may elect pursuant to the LifePoint Hospitals Deferred Compensation Plan (the "NQDC Plan") to defer settlement of the portion of Non-Vested RSUs to be settled in Shares until a date or event other than the Delivery Date, but only to the extent allowed by the Company and subject to the terms and conditions of the NQDC Plan, including but not limited to those provisions governing deferral elections and the timing of such deferral elections. The portion of Non-Vested RSUs subject to a valid deferral election by the Recipient under the NQDC Plan shall be distributed according to the terms of the NQDC Plan, but otherwise shall continue to be subject to the terms of this Agreement, the Plan, and the deferral election form. The portion of Non-Vested RSUs to be settled in cash if the Percentage Payable is greater than 100% shall be distributed according to the terms of this Agreement and the Plan and settlement of such portion may not be deferred pursuant to this Subsection and the NQDC Plan.

5. ***Rights with Respect to RSUs.***

(a) ***No Rights as Shareholder Until Delivery.*** Except as otherwise provided in this Section 5, the Recipient shall not have any rights, benefits or entitlements with respect to Shares

corresponding to the RSUs unless and until those Shares are delivered to the Recipient (and thus shall have no voting rights, or rights to receive any dividend declared, before those Shares are so delivered). On or after delivery, the Recipient shall have, with respect to the Shares delivered, all of the rights of a holder of Shares granted pursuant to the articles of incorporation and other governing instruments of the Company, or as otherwise available at law.

(b) ***Adjustments to RSUs.*** If at any time while this Agreement is in effect and before the RSUs have been settled, there shall be any increase or decrease in the number of issued and outstanding Shares of the Company through the declaration of a stock dividend or through any recapitalization resulting in a stock split-up, combination or exchange of such Shares, then the RSUs subject to this Agreement shall be adjusted in the same manner as the outstanding Shares of the Company. If any such adjustment shall result in a fractional RSU, such fraction shall be disregarded.

(c) ***No Restriction on Certain Transactions.*** Notwithstanding any term or provision of this Agreement to the contrary, the existence of this Agreement, or of any outstanding RSUs awarded hereunder, shall not affect in any manner the right, power or authority of the Company or any Related Entity to make, authorize or consummate: (i) any or all adjustments, recapitalizations, reorganizations or other changes in the Company's or any Related Entity's capital structure or its business; (ii) any merger, consolidation or similar transaction by or of the Company or any Related Entity; (iii) any offer, issue or sale by the Company or any Related Entity of any capital stock of the Company or any Related Entity, including any equity or debt securities, or preferred or preference stock that would rank prior to or on parity with the Shares represented by the RSUs and/or that would include, have or possess other rights, benefits and/or preferences superior to those that such Shares include, have or possess, or any warrants, options or rights with respect to any of the foregoing; (iv) the dissolution or liquidation of the Company or any Related Entity; (v) any sale, transfer or assignment of all or any part of the stock, assets or business of the Company or any Related Entity; or (vi) any other corporate transaction, act or proceeding (whether of a similar character or otherwise).

(d) ***Dividend Equivalents.*** During the term of this Agreement, the Recipient shall have the right to receive distributions (the "**Dividend Equivalents**") from the Company equal to any dividends or other distributions that would have been distributed to the Recipient if each RSU was instead an issued and outstanding Share owned by the Recipient. Dividend Equivalents payable with respect to the RSUs subject to this Agreement shall be subject to the following terms and conditions: (i) Dividend Equivalents payable with respect to the RSUs subject to this Agreement shall be paid on the date the RSUs to which such Dividend Equivalents relate are settled under Section 4 hereof, with such Dividend Equivalents to be accumulated, without interest, by the Company (the "**Accumulated Dividend Equivalents**"), (ii) all Accumulated Dividend Equivalents payable with respect to the RSUs subject to this Agreement shall be paid in cash, reduced by any applicable withholding taxes, and (ii) any Accumulated Dividend Equivalents with respect to the RSUs subject to this Agreement shall be forfeited and all rights of the Recipient to such Accumulated Dividend Equivalents shall terminate, without further obligation on the part of the Company, unless the portion of the RSUs subject to this Agreement to which such Accumulated Dividend Equivalents relate become Vested RSUs

pursuant to Section 2 hereof. Each Dividend Equivalent shall be treated as a separate payment for purposes of Section 409A of the Code.

6. ***Transferability***. The RSUs are not transferable unless and until the Shares have been delivered to the Recipient in settlement of the RSUs in accordance with this Agreement, otherwise than by will or under the applicable laws of descent and distribution. The terms of this Agreement shall be binding upon the executors, administrators, heirs, successors and assigns of the Recipient. Except as otherwise permitted pursuant to the first sentence of this Section, any attempt to effect a Transfer of any RSUs prior to the date on which the Shares have been delivered to the Recipient in settlement of the RSUs shall be void *ab initio*. For purposes of this Agreement, "Transfer" shall mean any sale, transfer, encumbrance, gift, donation, assignment, pledge, hypothecation, or other disposition, whether similar or dissimilar to those previously enumerated, whether voluntary or involuntary, and including, but not limited to, any disposition by operation of law, by court order, by judicial process, or by foreclosure, levy or attachment.

7. ***Tax Matters***.

(a) ***Withholding***. Any minimum tax withholding obligation of the Company arising in connection with this Award, and/or the lapse of restrictions with respect hereto, shall, to the extent permitted by law, be satisfied by the retention of cash and/or Shares issuable pursuant to this Award that have a then-current Fair Market Value equal to the amount of any minimum federal, state or local taxes of any kind required by law to be withheld with respect to this Award. If the retention of Shares described in the foregoing sentence is not permitted by law, as a condition to the Company's obligations with respect to the RSUs (including, without limitation, any obligation to deliver any Shares) hereunder, the Recipient shall make arrangements satisfactory to the Company to pay to the Company any federal, state or local taxes of any kind required to be withheld with respect to the vesting or delivery of Shares corresponding to such RSUs.

(b) ***Recipient's Responsibilities for Tax Consequences.*** The tax consequences to the Recipient (including without limitation federal, state, local and foreign income tax consequences) with respect to the RSUs (including without limitation the grant, vesting and/or delivery thereof) are the sole responsibility of the Recipient. The Recipient shall consult with his or her own personal accountant(s) and/or tax advisor(s) regarding these matters and the Recipient's filing, withholding and payment (or tax liability) obligations.

8. ***Amendment, Modification & Assignment.*** This Agreement may only be modified or amended in a writing signed by the parties hereto. No promises, assurances, commitments, agreements, undertakings or representations, whether oral, written, electronic or otherwise, and whether express or implied, with respect to the subject matter hereof, have been made by either party which are not set forth expressly in this Agreement. This Agreement (and Recipient's rights hereunder) may not be assigned, and the obligations of Recipient hereunder may not be delegated, in whole or in part. The rights and obligations created hereunder shall be binding on the Recipient and his heirs and legal representatives and on the successors and assigns of the Company.

9. ***Complete Agreement.*** This Agreement (together with those agreements and documents expressly referred to herein, for the purposes referred to herein) embody the complete and entire agreement and understanding between the parties with respect to the subject matter hereof, and supersede any and all prior promises, assurances, commitments, agreements, undertakings or representations, whether oral, written, electronic or otherwise, and whether express or implied, which may relate to the subject matter hereof in any way.

10. ***Miscellaneous.***

(a) ***No Right to (Continued) Employment or Service.*** This Agreement and the grant of RSUs hereunder shall not confer, or be construed to confer, upon the Recipient any right to employment or service, or continued employment or service, with the Company or any Related Entity.

(b) ***No Limit on Other Compensation Arrangements.*** Nothing contained in this Agreement shall preclude the Company or any Related Entity from adopting or continuing in effect other or additional compensation plans, agreements or arrangements, and any such plans, agreements and arrangements may be either generally applicable or applicable only in specific cases or to specific persons.

(c) ***Severability.*** If any term or provision of this Agreement is or becomes or is deemed to be invalid, illegal or unenforceable in any jurisdiction or under any applicable law, rule or regulation, then such provision shall be construed or deemed amended to conform to applicable law (or if such provision cannot be so construed or deemed amended without materially altering the purpose or intent of this Agreement and the grant of RSUs hereunder, such provision shall be stricken as to such jurisdiction and the remainder of this Agreement and the award hereunder shall remain in full force and effect).

(d) ***No Trust or Fund Created.*** Neither this Agreement nor the grant of RSUs hereunder shall create or be construed to create a trust or separate fund of any kind or a fiduciary relationship between the Company or any Related Entity and the Recipient or any other person. To the extent that the Recipient or any other person acquires a right to receive payments from the Company or any Related Entity pursuant to this Agreement, such right shall be no greater than the right of any unsecured general creditor of the Company.

(e) ***Law Governing.*** This Agreement shall be governed by and construed and enforced in accordance with the internal laws of the State of Delaware (without reference to the conflict of laws rules or principles thereof).

(f) ***Interpretation.*** This award of RSUs is subject to all of the terms, provisions and restrictions of this Agreement and the Plan. All decisions or interpretations of the Board or the Committee upon any questions arising under this Agreement or the Plan are binding, conclusive and final.

(g) ***Headings.*** Section, paragraph and other headings and captions are provided solely as a convenience to facilitate reference. Such headings and captions shall not be deemed

in any way material or relevant to the construction, meaning or interpretation of this Agreement or any term or provision hereof.

(h) ***Notices***. Any notice under this Agreement shall be in writing and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, registered, postage prepaid, and addressed, in the case of the Company, to the Company's General Counsel at 330 Seven Springs Way, Brentwood, Tennessee 37207, or if the Company should move its principal office, to such principal office, and, in the case of the Recipient, to the Recipient's last permanent address as shown on the Company's records, subject to the right of either party to designate some other address at any time hereafter in a notice satisfying the requirements of this Section.

(i) ***Compliance with Section 409A***

(i) ***General.*** It is the intention of both the Company and the Recipient that the benefits and rights to which the Recipient could be entitled pursuant to this Agreement comply with Section 409A of the Code and the Treasury Regulations and other guidance promulgated or issued thereunder ("**Section 409A**"), to the extent that the requirements of Section 409A are applicable thereto, and the provisions of this Agreement shall be construed in a manner consistent with that intention. If the Recipient or the Company believes, at any time, that any such benefit or right that is subject to Section 409A does not so comply, it shall promptly advise the other and shall negotiate reasonably and in good faith to amend the terms of such benefits and rights such that they comply with Section 409A (with the most limited possible economic effect on the Recipient and on the Company).

(ii) ***No Representations as to Section 409A Compliance.*** Notwithstanding the foregoing, the Company does not make any representation to the Recipient that the shares of RSUs and the Dividend Equivalents, if any, awarded pursuant to this Agreement are exempt from, or satisfy, the requirements of Section 409A, and the Company shall have no liability or other obligation to indemnify or hold harmless the Recipient or any Beneficiary for any tax, additional tax, interest or penalties that the Recipient or any Beneficiary may incur in the event that any provision of this Agreement, or any amendment or modification thereof or any other action taken with respect thereto is deemed to violate any of the requirements of Section 409A.

(iii) ***No Acceleration of Payments***. Neither the Company nor the Recipient, individually or in combination, may accelerate any payment or benefit that is subject to Section 409A, except in compliance with Section 409A and the provisions of this Agreement, and no amount that is subject to Section 409A shall be paid prior to the earliest date on which it may be paid without violating Section 409A.

(iv) ***Treatment of Each Installment as a Separate Payment.*** For purposes of applying the provisions of Section 409A to this Agreement, each separately identified amount to which the Recipient is entitled under this Agreement shall be treated as a separate payment. In addition, to the extent permissible under Section 409A, any series of installment payments under this Agreement shall be treated as a right to a series of separate payments.

(j) ***Non-Waiver of Breach***. The waiver by any party hereto of the other party's prompt and complete performance, or breach or violation, of any term or provision of this Agreement shall be effected solely in a writing signed by such party, and shall not operate nor be construed as a waiver of any subsequent breach or violation, and the waiver by any party hereto to exercise any right or remedy which he or it may possess shall not operate nor be construed as the waiver of such right or remedy by such party, or as a bar to the exercise of such right or remedy by such party, upon the occurrence of any subsequent breach or violation.

(k) ***Clawback of Benefits***. The Committee shall have full authority to implement any policies and procedures that it determines to be necessary or appropriate to comply with applicable securities laws or other laws, including, without limitation, Section 10D of the Exchange Act and any rules promulgated thereunder, including without limitation, including in this Agreement, or amending any this Agreement, without the consent of the Recipient, to include language for the clawback (recapture) by the Company of any benefits under this Agreement that the Committee deems necessary or appropriate to comply with that statutory provision and those rules.

EXHIBIT 12.1

LIFEPOINT HEALTH, INC.
COMPUTATIONS OF RATIOS OF EARNINGS TO FIXED CHARGES
(Unaudited)

(Dollars in Millions)

	Years Ended December 31,				
	2015	2014	2013	2012	2011
EARNINGS					
Income from continuing operations before income taxes	$ 302.5	$ 203.0	$ 211.5	$ 244.1	$ 263.3
Fixed charges, exclusive of capitalized interest	132.5	138.7	110.6	114.0	119.3
TOTAL EARNINGS	$ 435.0	$ 341.7	$ 322.1	$ 358.1	$ 382.6
FIXED CHARGES					
Interest charged to expense (a)	114.8	123.5	98.4	102.5	109.2
Interest portion of rental expense	17.7	15.2	12.2	11.5	10.1
Fixed charges, exclusive of capitalized interest	132.5	138.7	110.6	114.0	119.3
Capitalized interest	2.2	1.0	1.4	2.3	2.0
TOTAL FIXED CHARGES	$ 134.7	$ 139.7	$ 112.0	$ 116.3	$ 121.3
RATIO OF EARNINGS TO FIXED CHARGES	3.23	2.45	2.88	3.08	3.15

(a) excluding interest income

Exhibit 21.1

Subsidiaries of LifePoint Health, Inc.

Name of Entity	Location of Incorporation or Organization
Acquisition Bell Hospital, LLC	Michigan
America Management Companies, LLC	Delaware
AMG — Crockett, LLC	Delaware
AMG — Hillside, LLC	Delaware
AMG — Livingston, LLC	Delaware
AMG — Logan, LLC	Delaware
AMG — Southern Tennessee, LLC	Delaware
AMG — Trinity, LLC	Delaware
Andalusia Physician Practices, LLC	Delaware
Ashland Physician Services, LLC	Delaware
Ashley Valley Medical Center, LLC	Delaware
Ashley Valley Physician Practice, LLC	Delaware
Athens Physicians Practice, LLC	Delaware
Athens Regional Medical Center, LLC	Delaware
Athens Surgery Center, LLC	Delaware
Athens Surgery Center Partner, LLC	Delaware
Bartow Healthcare System, Ltd.	Florida
Bell JV, LLC	Delaware
Bell Physician Practices, Inc.	Michigan
Bolivar Physician Practices, LLC	Delaware
Bourbon Community Hospital, LLC	Delaware
Bourbon Physician Practice, LLC	Delaware
Brim Hospitals, Inc.	Oregon
Buffalo Trace Radiation Oncology Associates, LLC	Kentucky
Care Health Company, Inc.	Washington
Castleview Hospital, LLC	Delaware
Castleview Medical, LLC	Delaware
Castleview Physician Practice, LLC	Delaware
Clark Regional Physician Practices, LLC	Delaware
Clinch Professional Physician Services, LLC	Delaware
Clinch Valley Medical Center, Inc.	Virginia
Clinch Valley Physicians Associates, LLC	Virginia
Clinch Valley Pulmonology, LLC	Virginia
Clinch Valley Urology, LLC	Virginia
Colorado Plains Physician Practices, LLC	Delaware
Community-Based Services, LLC	Delaware
Community Hospital of Andalusia, Inc.	Alabama
Community Medical, LLC	Delaware
Crockett Hospital, LLC	Delaware
Crockett PHO, LLC	Delaware
Danville Diagnostic Imaging Center, LLC	Delaware
Danville Physician Practices, LLC	Delaware
Danville Regional Medical Center, LLC	Delaware
Danville Regional Medical Center School of Health Professions, LLC	Delaware
DLP Cardiac Partners, LLC	Delaware
DLP Cardiology Associates, LLC	Delaware
DLP Cardiology Physicians, LLC	Delaware
DLP Central Carolina Family Medicine, LLC	Delaware
DLP Central Carolina Medical Center, LLC	Delaware
DLP Central Carolina Physician Practices, LLC	Delaware

DLP Central NC Holding Company, LLC	Delaware
DLP Central NC JV, LLC	Delaware
DLP Conemaugh Holding Company, LLC	Delaware
DLP Conemaugh JV, LLC	Delaware
DLP Conemaugh Memorial Medical Center, LLC	Delaware
DLP Conemaugh Meyersdale Medical Center, LLC	Delaware
DLP Conemaugh Miners Medical Center, LLC	Delaware
DLP Conemaugh Physician Practices, LLC	Delaware
DLP Frye Regional Medical Center, LLC	Delaware
DLP Frye Regional Physician Practices, LLC	Delaware
DLP Graystone Family Practice Associates, LLC	Delaware
DLP Haywood Regional Medical Center, LLC	Delaware
DLP Harris JV, LLC	Delaware
DLP Harris Regional Hospital, LLC	Delaware
DLP Healthcare, LLC	Delaware
DLP Hickory Family Practice Associates, LLC	Delaware
DLP Maria Parham Medical Center, LLC	Delaware
DLP Maria Parham Physician Practices, LLC	Delaware
DLP Marquette General Hospital, LLC	Michigan
DLP Marquette Health Plan, LLC	Delaware
DLP Marquette Holding Company, LLC	Delaware
DLP Marquette JV, LLC	Delaware
DLP Marquette Physician Practices, Inc.	Michigan
DLP Partner, LLC	Delaware
DLP Partner Central Carolina, LLC	Delaware
DLP Partner Conemaugh, LLC	Delaware
DLP Partner Frye, LLC	Delaware
DLP Partner Marquette, LLC	Delaware
DLP Partner MedWest, LLC	Delaware
DLP Partner Twin County, LLC	Delaware
DLP Partner Wilson Rutherford, LLC	Delaware
DLP Person Memorial Hospital, LLC	Delaware
DLP Person Physician Practices, LLC	Delaware
DLP Rutherford Regional Health System, LLC	Delaware
DLP Rutherford Physician Practices, LLC	Delaware
DLP Swain County Hospital, LLC	Delaware
DLP Twin County Holding Company, LLC	Delaware
DLP Twin County Physician Practices, LLC	Delaware
DLP Twin County Regional Healthcare, LLC	Delaware
DLP Western Carolina Physician Practices, LLC	Delaware
DLP WilMed Nursing Care and Rehabilitation Center, LLC	Delaware
DLP Wilson Holding Company, LLC	Delaware
DLP Wilson Medical Center, LLC	Delaware
DLP Wilson Physician Practices, LLC	Delaware
Dodge City Healthcare Group, LLC	Kansas
Dodge City Healthcare Partner, Inc.	Kansas
Fauquier Holding Company, LLC	Delaware
Fauquier Long-Term Care, LLC	Delaware
Fauquier Medical Center, LLC	Delaware
Fauquier Partner, LLC	Delaware
Fauquier Physician Practices, LLC	Delaware
Fleming Medical Center, LLC	Delaware
Georgetown Community Hospital, LLC	Delaware
Georgetown Rehabilitation, LLC	Delaware

Havasu Regional Medical Center, LLC	Delaware
HCK Logan Memorial, LLC	Delaware
HDP Andalusia, LLC	Delaware
HDP Georgetown, LLC	Delaware
Hillside Hospital, LLC	Delaware
Historic LifePoint Hospitals, Inc.	Delaware
HRMC, LLC	Delaware
HSC Manager, LLC	Delaware
HSCGP, LLC	Delaware
HST Physician Practice, LLC	Delaware
Kansas Healthcare Management Company, Inc.	Kansas
Kansas Healthcare Management Services, LLC	Kansas
Kentucky Hospital, LLC	Delaware
Kentucky Medserv, LLC	Delaware
Kentucky MSO, LLC	Delaware
Kentucky Physician Services, Inc.	Kentucky
Lake Cumberland Cardiology Associates, LLC	Delaware
Lake Cumberland Physician Practices, LLC	Delaware
Lake Cumberland Regional Hospital, LLC	Delaware
Lake Cumberland Regional Physician Hospital Organization, LLC	Delaware
Lake Cumberland Surgery Center, LP	Delaware
Lakeland Community Hospital, LLC	Delaware
Lakeland Physician Practices, LLC	Delaware
Lander Valley Physician Practices, LLC	Delaware
Las Cruces Cardiology Group, LLC	Delaware
Las Cruces Endoscopy, LLC	Delaware
Las Cruces Endoscopy Partner, LLC	Delaware
Las Cruces Physician Practices, LLC	Delaware
LCMC MRI, LLC	Delaware
LCMC PET, LLC	Delaware
LHSC, LLC	Delaware
LifePoint Acquisition Corp.	Delaware
LifePoint Billing Services, LLC	Delaware
LifePoint Corporate Services, General Partnership	Delaware
LifePoint CSLP, LLC	Delaware
LifePoint Holdings 2, LLC	Delaware
LifePoint Hospitals Holdings, Inc.	Delaware
LifePoint Medical Group — Hillside, Inc.	Tennessee
LifePoint of Kentucky, LLC	Delaware
LifePoint of Lake Cumberland, LLC	Delaware
LifePoint PSO, LLC	Delaware
LifePoint RC, Inc.	Delaware
LifePoint VA Holdings, Inc.	Delaware
LifePoint WV Holdings, Inc.	Delaware
Livingston Regional Hospital, LLC	Delaware
Logan General Hospital, LLC	Delaware
Logan Healthcare Partner, LLC	Delaware
Logan Medical, LLC	Delaware
Logan Memorial Hospital, LLC	Delaware
Logan Oncology Care Associates, LLC	West Virginia
Logan Physician Practice, LLC	Delaware
Lohman Endoscopy Center, LLC	New Mexico
Los Alamos Physician Practices, LLC	Delaware
Martinsville Physician Practices, LLC	Delaware

Meadowview Physician Practice, LLC	Delaware
Meadowview Regional Medical Center, LLC	Delaware
Meadowview Rights, LLC	Delaware
Memorial Hospital of Martinsville & Henry County Ambulatory Surgery Center, LLC	Virginia
Memorial Prompt Care, LLC	Delaware
Mercy Physician Practices, LLC	Delaware
Mexia Principal Healthcare Limited Partnership	Texas
Mexia-Principal, Inc.	Texas
Minden Physician Practices, LLC	Delaware
Nason Medical Center, LLC	Delaware
Nason Physician Practices, LLC	Delaware
Northeastern Nevada Physician Practices, LLC	Delaware
Northwest Medical Center-Winfield, LLC	Delaware
Norton Partner, LLC	Delaware
NWMC – Winfield Anesthesia Physicians, LLC	Delaware
NWMC – Winfield Hospitalist Physicians, LLC	Delaware
NWMC – Winfield Physician Practices, LLC	Delaware
OmniPoint Surgical Associates, LLC	Delaware
Ontonagon Community Health Center, Inc.	Michigan
Opelousas Imaging Center Partner, LLC	Delaware
Opelousas PET/CT Imaging Center, LLC	Delaware
Orthopedics of Southwest Virginia, LLC	Virginia
Palestine-Principal G.P., Inc.	Texas
Palestine Principal Healthcare Limited Partnership	Texas
PH Copper Country Apothecaries, LLC	Delaware
PHC-Ashland, L.P.	Pennsylvania
PHC-Aviation, Inc.	Tennessee
PHC-Cleveland, Inc.	Mississippi
PHC-Doctors' Hospital, Inc.	Louisiana
PHC-Elko, Inc.	Nevada
PHC-Fort Mohave, Inc.	Arizona
PHC-Fort Morgan, Inc.	Colorado
PHC Hospitals, LLC	Delaware
PHC-Lake Havasu, Inc.	Arizona
PHC-Lakewood, Inc.	Louisiana
PHC-Las Cruces, Inc.	New Mexico
PHC-Los Alamos, Inc.	New Mexico
PHC-Louisiana, Inc.	Louisiana
PHC-Martinsville, Inc.	Virginia
PHC-Minden G.P., Inc.	Louisiana
PHC-Minden, L.P.	Louisiana
PHC-Morgan City, L.P.	Louisiana
PHC-Morgan Lake, Inc.	Louisiana
PHC-Opelousas, L.P.	Louisiana
PHC-Palestine, Inc.	Nevada
PHC-Selma, LLC	Delaware
PHC-Tennessee, Inc.	Tennessee
Piedmont Partner, LLC	Delaware
PineLake Physician Practice, LLC	Delaware
PineLake Regional Hospital, LLC	Delaware
Point of Life Indemnity, Ltd.	Cayman Islands
Poitras Practice, LLC	Delaware
Portage Holding Company, LLC	Delaware

Portage Hospital, LLC	Michigan
Portage JV, LLC	Delaware
Portage Partner, LLC	Delaware
Portage Physician Practices, Inc.	Michigan
PRHC-Alabama, LLC	Delaware
PRHC-Ennis G.P., Inc.	Texas
PRHC-Ennis, L.P.	Texas
Principal Hospital Company of Nevada, Inc.	Nevada
Principal Knox, L.L.C.	Delaware
Principal-Needles, Inc.	Tennessee
Providence Group Practices, LLC	Delaware
Providence Holding Company, LLC	Delaware
Providence Hospital, LLC	Delaware
Providence Physician Practices, LLC	Delaware
Province Healthcare Company	Delaware
R. Kendall Brown Practice, LLC	Delaware
Raleigh General Hospital, LLC	West Virginia
RHN Clark Memorial Hospital, LLC	Delaware
RHN Clark Memorial Physician Practices, LLC	Delaware
RHN Scott Memorial Hospital, LLC	Delaware
RHN Scott Physician Practices, LLC	Delaware
River Parishes Holdings, LLC	Delaware
River Parishes Hospital, LLC	Delaware
River Parishes Partner, LLC	Delaware
River Parishes Physician Practices, LLC	Delaware
Riverton Memorial Hospital, LLC	Delaware
Riverton Oncology Practice, LLC	Delaware
Riverton Physician Practices, LLC	Delaware
Riverview Medical Center, LLC	Delaware
Riverview Physician Practices, LLC	Delaware
Rockdale Clinically Integrated Medical Care Organization, LLC	Delaware
Rockdale Hospital, LLC	Delaware
Rockdale Physician Practices, LLC	Delaware
Russellville Hospital, LLC	Delaware
Russellville Physician Practices, LLC	Delaware
Select Healthcare, LLC	Delaware
Selma Diagnostic Imaging, LLC	Delaware
Siletchnik Practice, LLC	Delaware
Shared Business Services, LLC	Delaware
Smith County Memorial Hospital, LLC	Delaware
Somerset Surgery Partner, LLC	Delaware
Southern Tennessee EMS, LLC	Delaware
Southern Tennessee Medical Center, LLC	Delaware
Southern Tennessee PHO, LLC	Delaware
Spring View Hospital, LLC	Delaware
Spring View Physician Practices, LLC	Delaware
Springhill Medical Center, LLC	Delaware
SST Community Health, L.L.C.	Tennessee
St. Francis Affiliated Services, LLC	Delaware
St. Francis Health, LLC	Delaware
St. Francis Physician Practices, LLC	Delaware
Sumner Physician Practices, LLC	Delaware
Sumner Real Estate Holdings, LLC	Delaware
Sumner Regional Medical Center, LLC	Delaware

Teche Regional Physician Practices, LLC	Delaware
Texas Specialty Physicians	Texas
The LifePoint Community Foundation	Delaware
The MRI Center of Northwest Alabama, LLC	Delaware
The Regional Health Network of Kentucky and Southern Indiana, LLC	Delaware
THM Physician Practice, LLC	Delaware
Trousdale Medical Center, LLC	Delaware
Trousdale Physician Practices, LLC	Delaware
Two Rivers Physician Practices, LLC	Delaware
UP Imaging Management Services, LLC	Delaware
Valley View Physician Practices, LLC	Delaware
Vaughan Physician Practices, LLC	Delaware
Vaughan Regional Medical Center, LLC	Delaware
Ville Platte Medical Center, LLC	Delaware
Watertown Holding Company, LLC	Delaware
Watertown JV, LLC	Delaware
Watertown Medical Center, LLC	Wisconsin
Watertown Partner, LLC	Delaware
Watertown Physician Practices, LLC	Delaware
West Virginia Management Service Organization, Inc.	West Virginia
Western Plains Physician Practices, LLC	Delaware
Western Plains Regional Hospital, LLC	Delaware
Woodford Hospital, LLC	Delaware
Woods Memorial Hospital, LLC	Delaware
Wythe County Community Hospital, LLC	Delaware
Wythe County Physician Practices, LLC	Delaware
Zone, Incorporated	West Virginia

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Form S-3 (No. 333-202368) of LifePoint Hospitals, Inc.;

(2) Form S-8 (No. 333-207701) pertaining to the LifePoint Health, Inc. 2013 Long-Term Incentive Plan;

(3) Form S-8 (No. 333-190219) pertaining to the LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan;

(4) Form S-8 (No. 333-168476) pertaining to the LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan, LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan, and LifePoint Hospitals, Inc. Amended and Restated Outside Directors Stock Incentive Compensation Plan;

(5) Form S-8 (No. 333-159233) pertaining to the LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan, LifePoint Hospitals, Inc. Employee Stock Purchase Plan, LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan, LifePoint Hospitals, Inc. Retirement Plan, and LifePoint Hospitals, Inc. Amended and Restated Outside Director's Stock and Incentive Compensation Plan;

(6) Form S-8 (No 333-182932) pertaining to the LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan and to the LifePoint Hospitals, Inc. Amended and Restated Outside Directors Stock and Incentive Compensation Plan;

of our reports dated February 12, 2016, with respect to the consolidated financial statements of LifePoint Health, Inc. and the effectiveness of internal control over financial reporting of LifePoint Health, Inc., included in this Annual Report (Form 10-K) of LifePoint Health, Inc. for the year ended December 31, 2015.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 12, 2016

EXHIBIT 31.1

LIFEPOINT HEALTH, INC.
CERTIFICATION

I, William F. Carpenter III, certify that:

1. I have reviewed this annual report on Form 10-K of LifePoint Health, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report, based on such evaluation; and

d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ William F. Carpenter III
William F. Carpenter III
Chief Executive Officer and
Chairman of the Board of Directors

Date: February 12, 2016

EXHIBIT 31.2

LIFEPOINT HEALTH, INC.
CERTIFICATION

I, Leif M. Murphy, certify that:

1. I have reviewed this annual report on Form 10-K of LifePoint Health, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report, based on such evaluation; and

d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Leif M. Murphy
Leif M. Murphy
Executive Vice President and Chief Financial Officer

Date: February 12, 2016

EXHIBIT 32.1

LIFEPOINT HEALTH, INC.

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Report of LifePoint Health, Inc. (the "Company") on Form 10-K for the year ended December 31, 2015, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, William F. Carpenter III, Chief Executive Officer and Chairman of the Board of Directors of the Company, certify, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) To the best of my knowledge information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ William F. Carpenter III
William F. Carpenter III
Chief Executive Officer and
Chairman of the Board of Directors

Date: February 12, 2016

EXHIBIT 32.2

LIFEPOINT HEALTH, INC.

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Report of LifePoint Health, Inc. (the "Company") on Form 10-K for the year ended December 31, 2015, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Leif M. Murphy, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) To the best of my knowledge information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Leif M. Murphy
Leif M. Murphy
Executive Vice President and Chief Financial Officer

Date: February 12, 2016

JAN 13'17 AM 9:57

Attachment - Contribution to the Orderly Development Of Health Care - 4A

Current License
The Joint Commission Accreditation

Board for Licensing Health Care Facilities

State of Tennessee

0000000083

No. of Beds 0190

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

ATHENS REGIONAL MEDICAL CENTERLLC *to conduct and maintain a*

Hospital STARR REGIONAL MEDICAL CENTER

Located at 1114 WEST MADISON STREET, ATHENS

County of MCMINN *, Tennessee.*

This license shall expire JUNE 12 *,* 2017 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 31ST *day of* MAY *,* 2016 *.*

In the Distinct Category(ies) of:
GENERAL HOSPITAL
TRAUMA CENTER LEVEL 3
PEDIATRIC PRIMARY HOSPITAL

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By John J. Dreyzehner, MD
COMMISSIONER

Athens Regional Medical Center, LLC
Starr Regional Medical Center

Athens, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Laboratory Accreditation Program

May 21, 2016

Accreditation is customarily valid for up to 24 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #7803
Print/Reprint Date: 07/27/2016

Mark R. Chassin, MD, FACP, MPP, MPH
President

ıe Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health ca
her services provided in accredited organizations. Information about accredited organizations may be provided dire
ıe Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performar
dividual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

The Joint Commission

March 3, 2015

Re: # 7803
CCN: #440068
Program: Hospital
Accreditation Expiration Date: January 10, 2018

Mark Nichols
CEO
Athens Regional Medical Center, LLC
PO Box 250
Athens, Tennessee 37371-0250

Dear Mr. Nichols:

This letter confirms that your January 06, 2015 - January 09, 2015 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on February 23, 2015, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of January 10, 2015.

The Joint Commission is also recommending your organization for continued Medicare certification effective January 10, 2015. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location(s):

Athens Regional Breast Center
d/b/a Starr Regional Breast Center
711 Cook Drive Suite 240, Athens, TN, 37303

Athens Regional Cardiac Rehabilitation
d/b/a Starr Regional Cardiopulmonary Rehabilitation
1031 W. Madison, Athens, TN, 37303

Athens Regional Medical Center LLC
d/b/a Starr Regional Outpatient Rehabilitation Services - Etowah
874 & 876 Highway 411 North, Suites H & I, Etowah, TN, 37331

Athens Regional Medical Center, LLC
d/b/a Starr Regional Medical Center - Athens
1114 West Madison Avenue, Athens, TN, 37371-0250

The Joint Commission

Athens Regional Medical Center, LLC
d/b/a Starr Regional Medical Center - Etowah
886 Highway 411 North, Etowah, TN, 37331

Athens Regional Rehabilitation Center
d/b/a Starr Regional Rehabilitation Center - Athens
425 Old Riceville Road Suite 1, Athens, TN, 37303

Athens Regional Sleep Diagnostic Center
d/b/a Starr Regional Sleep Diagnostic Center - Athens
719 Cook Drive , Suite 113, Athens, TN, 37303

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

Attachment - Section - Contribution to the Orderly Development of Health Care-4B

Statement of Deficiencies and Plan of Correction

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING	(X3) DATE SURVEY COMPLETED
	440068		03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARR REGIONAL MEDICAL CENTER ATHENS	1114 W MADISON AVE ATHENS, TN 37371

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS A Validation Survey was conducted March 2-4 2015, at Starr Regional Medical Center Athens located at 1114 W Madison Ave, Athens Tennessee (TN), and the facility's one satellite hospital, Starr Regional Medical Center, Etowah, located at 886 Highway 411 North, Etowah, TN. For Identification purposes, Building A will refer to Starr Regional Medical Center, Athens at 1114 W Madison Ave, Athens TN; Building B will refer to Starr Regional Medical Center Etowah, 'located at 886 Highway 411 North, Etowah, TN.	A 000		
A 491	482.25(a) PHARMACY ADMINISTRATION The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure expired medications were not available for patient use for one of three anesthesia carts observed. The findings included: Observation on March 3, 2015, at 9:50 a.m., in the Operating Room (OR) of Building A, revealed, in the locked anesthesia cart, one 250 ml [milliliter] bottle of Forane [inhalant anesthesia] with an expiration date of September, 2014. Interview with the OR Nurse Manager on March 3, 2015, at 9:50 a.m., in the OR, confirmed the Forane was expired and was available for patient use.	A 491	The expired bottle of Forane was found on 3/3/15 and immediately removed and properly disposed of by the Director of Surgery. Forane is an inhalant used by an Anesthesiologist who is no longer practicing at our facility. That medication will no longer be stocked in the carts. Anesthesia providers will be responsible for daily monitoring of supplies in their carts and carts will also be checked at monthly room checks for any expired medications / items. If medications are expired, anesthesia providers will call Pharmacy to have medications replaced at that time. Any non-compliance will be addressed with the individual involved by the Director or designee.	3/3/15
A 700	482.41 PHYSICAL ENVIRONMENT	A 7001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margie Brusseau, CNO
TITLE: March 27, 2015
(X6) DATE: 03/16/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	440068		03/04/2015

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A 700	Continued From page 1 The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, interview, and record review during a validation survey for Life safety, the facility failed to maintain the physical plant and environment to ensure the safety of patients. The findings included: During observation, interview, and record review, with the Maintenance Director, on March 2-3, 2015, it was confirmed the facility failed to ensure corridor fire doors closed to a positive latch and, were undercut no more than 1-inch; failed to ensure self-closing fire doors were held open by approved devices; failed to maintain hazardous area's fire-rated construction; failed to ensure smoke detectors were not in air flow; failed to ensure sprinklers were not corroded or loaded and mis-matched with Quick response and standard response heads and medical gas storage rooms were appropriate; failed to maintain portable fire extinguishers and kitchen hood systems; failed to maintain fire dampers; and failed to ensure GFCI protected outlets were in wet areas. Refer to Life Safety Tags: K018, K021, K029, K052, K062, K064, K067, K069, K077, and K147.)	A 700		
A 724	482.41 (c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE	A 724		

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A724	Continued From page 2 Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure expired sutures were not available for patient use in one of one Operating Room (OR) hallways; failed to ensure expired lab collection tubes in one of one Magnetic Resonance Imaging (MRI) rooms were not available for patient use; and failed to ensure expired medical supplies were not available for patient use in one of two ultrasound rooms. The findings included: Observation on March 3, 2015, at 9:35 a.m., in the Building A Operating Room (OR) hallway, revealed a suture cart with the following expired sutures: nineteen individually wrapped 3.0 Chromic Gut sutures with an expiration date of January, 2015; eighteen individually wrapped 4.0 Ethilon sutures with an expiration date of January, 2015; thirty-four individually wrapped 5.0 Ethilon sutures with an expiration date of January, 2015; four individually wrapped Vicryl sutures with an expiration date of January, 2015; and forty-seven individually wrapped 2.0 PDS (polydioxanone) sutures with an expiration date of January, 2015. Interview with the OR Nurse Manager on March 3, 2015, at 9:35 a.m., in the OR Hallway, confirmed the sutures were expired and available for patient use. Observation on March 3, 2015, at 2:15 p.m., in the MRI room of Building A, revealed fifty green top blood collection tubes with an expiration date	A724	To ensure compliance of the Standard throughout the organization as a whole, the Quality Department will institute, effective of 3/26/15, a monthly check by all departments for expired items that would directly impact patient care. The Director / Manager of the unit will be held accountable for ensuring staff is completing the checks. This will be reported to the Quality / Safety Council (QSC) monthly. This is in addition to what has been set forth by the OR and Imaging. Any non-compliance will be addressed with the individual involved by the Director or designee. The expired suture was found on 3/3/15 and was immediately removed and properly disposed of by the Director of Surgery. The suture will be monitored three ways for expirations dates: 1. All expiration dates will be checked immediately before use in a surgical case. 2. Expiration dates will be checked when surgical staff members are reordering suture and outdates suture will be discarded. 3. Monthly spot checks will be completed by the Director or designee to ensure compliance.	3/26/15 3/3/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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A 724	Continued From page 3 of September. 2012. Interview with the OR Nurse Manager on March 3, 2015, at 2:15 p.m.. confirmed the blood collection tubes were expired and were available for patient use. Observation with the Director of Quality Management (DQM) on March 3, 2015, at 2:20 p.m., in Building B radiology department ultrasound room #1, revealed two hypodermic needle kits with an expiration date of May 2012, and four hypodermic needle kits with an expiration date of May 2013, stored in a cabinet drawer. Interview with the DOM on March 3, 2015, at 2:20 p.m., in ultrasound room #1, confirmed the hypodermic needle kits were expired and available for patient use.	A 724	The expired blood collection tubes were found on 3/3/15 and immediately removed by the MRI Technician. Monthly monitoring of expired supplies will be conducted by the staff and a double check will occur before patient care use occurs. The Director has implemented a monthly checklist for staff to sign when they have completed supply monitoring for expiration dates. The checklist will be maintained in the department and will be reviewed at the monthly Quality Safety Council meeting. Any non-compliance will be addressed by the Director or designee. The expired hypodermic needles were immediately removed and properly disposed of by the tech on 3/3/15. Monthly monitoring of expired supplies will be conducted by the staff and a double check will occur before patient care use occurs. The Director has implemented a monthly checklist for staff to sign when they have completed supply monitoring for expiration dates. The checklist will be maintained in the department and will be reviewed at the monthly Quality Safety Council meeting. Any non-compliance will be addressed by the Director or designee.	3/3/15 3/3/15
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to follow infection control policy for IV (intravenous) access for one patient (#5) of five patients observed with intravenous lines; failed to follow facility policy related to droplet isolation precautions for one of one patient (#32) observed in droplet precautions; and failed to	A 749		

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A 749	Continued From page 4 Ensure a sanitary environment for one of three x-ray rooms. The findings included: Medical record review revealed Patient #5 was admitted to Building A on February 20, 2015, for diagnosis including Colon Resection. Observation on March 2, 2015, at 12:30 p.m., in the patient's room, revealed the patient sitting in a chair with IV antibiotics infusing through an IV site inserted in the patient's right forearm. Continued observation revealed the IV insertion site dressing was not labeled with a date, time, or initials of the person who inserted the IV. Continued observation revealed the IV administration tubing was not labeled with a date or time. Medical record review of a nurse's note dated February 23, 2015, revealed "...IV insertion...site...rt[right] forearm [forearm]..." Continued review revealed no further documentation regarding removal of the peripheral IV from the right forearm. Review of facility policy, IV Catheter Maintenance, last revised May 2012, revealed "...routine Restarts and dressing changes will be made in accordance with the following procedure...to reduce the risk for phlebitis; peripheral IV catheters will be rotated every 96 hours (4 days)...dsg [dressing]...care...q [every] 4 days or with restart..." Review of facility policy, IV Dressing Change, last revised April 4, 2014, revealed "...place a transparent...dressing over the insertion	A 749	We reviewed our IV Catheter Maintenance policy for clarity and find no revisions are needed. An educational email was sent by the Director of Quality on 3/27/15 to all clinical areas where IVs are started reminding them to label all IV sites and tubing with date, time, and initials The ICP and Nursing Supervisors will monitor monthly for compliance to SRMC policy via a data collection tool and report to the Quality director, who will review the data and then report to the QSC. Any non-compliance will be addressed with the individual involved by the department manager or designee. Per SRMC policy on IV Catheter Maintenance, "To reduce the risk for phlebitis, peripheral IV catheters will be rotated every 96 hours (4 days) and immediately upon suspected contamination and/or complication. **If sites for venous access are limited and no evidence of phlebitis or infection is present, the catheter can be left in place for longer periods; however, the patient and the insertion site will be closely monitored"**	3/3/15 3/3/15

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A 749	Continued From page 5 site...label the dressing with the date and time of the procedure and your initials..." Review of facility policy, IV Tubing Change, last revised April 4, 2014, revealed "...label the administration set...with the date and time..." Interview with the Nurse Manager on March 2, 2015, at 12:40 p.m., in the patient's room, confirmed the IV had been inserted for seven days and the IV site and the IV tubing was not labeled with a date, time, or initials of the person who started the IV. Continued interview confirmed no physician order was written indicating the IV could remain in the patient's arm for longer than four days without being changed. Interview with the Director of Quality Management (DQM) on March 3, 2015, at 7:45 a.m., in the conference room, confirmed the facility failed to follow facility policy. Medical record review revealed patient #32 was admitted to Building A on February 27, 2015, with diagnoses including Influenza. Further review revealed the patient was placed on Droplet Precautions (recommended practices to prevent the transmission of infectious agents). Observation on March 2, 2015, at 3:25 p.m., on the B Wing in Building A, revealed Patient Care Technician (PCT) #1 in the patient's room with no gown, mask or gloves (PPE-personal protective equipment) in use. Further observation revealed the PCT exited the patient's room and failed to sanitize or wash the hands. Review of facility policy Precautions-Standard and Transmission Based last reviewed on March,	A 749	The policy has been approved by our Infection Control Committee and Medical Staff, and thus a physician order is not required to continue IV greater than 96 hours, if no signs of infection or phlebitis. We have added duration of IV sites to the monitoring tool to ensure that the policy is being followed. This will be reported to the Quality Director and the QSC. Any non-compliance will be addressed by the individual involved by the department manager or designee.	3/27/15
			The Director of Acute Care spoke with the Patient Care Technician on 3/2/15. The PCT is knowledgeable of SRMC's PPE protocol and hand washing protocol. The PCT was able to verbalize the correct procedure for PPE in droplet isolation and the importance of hand washing between patient rooms.	3/2/15

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	410068	B.WING	03/04/2015
NAME OF PROVIDER OR SUPPLIER STARR REGIONAL MEDICAL CENTER ATHENS		STREET ADDRESS, CITY, STATE, ZIP CODE 1114 W MADISON AVE ATHENS, TN 37371	

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A 749	Continued From page 6 2014, revealed "...droplet precautions...hand hygiene...wash/sanitize hands upon entry and upon exiting the room...PPE: wear gloves and mask when entering the room...dispose of PPE prior to exiting the room..." Further review revealed "...PPE refers to items which may reduce the risk of exposure of the health care workers to non-intact skin and mucus membranes and to blood/body fluids..these PPE may include but are not limited to..gloves, mask, protective eyewear...gowns and gloves..." Interview with the PCT on March 2, 2015, at 3:30 p.m., in the B Wing Hallway, confirmed the PCT did not wear the required PPE while in the patient's room and did not wash or sanitize the hands prior to exiting the patient's room. Interview with the B wing Unit Nurse Manager on March 2, 2015, at 3:35 p.m., in the B Wing nurse's station, confirmed the PCT failed to follow the facility's policy related to the droplet precautions, the use of PPE and standard infection control standards. Observation and interview with the DOM on March 3, 2015, at 1:15 p.m.. in Building B radiology department x-ray room #3, revealed a buildup of dust on the x-ray machine, the x-ray machine cables, and the floor behind the x-ray machine. Continued observation revealed a suction machine was stored on the floor behind the x-ray machine. Interview with the DOM confirmed the equipment was dirty, the floor was dirty, and the suction machine should not be stored on the floor.	A 749	All SRMC staff members are educated annually on infection prevention, proper PPE, and hand washing through our online learning system and records are electronically maintained. Employees are observed by the Director and charge nurse for use of proper PPE, and on-the-spot education is provided, as needed. The majority of the hand washing is performed inside the patient room. Alcohol hand sanitizer is installed in each room and caregivers are instructed by the IP and unit Directors to sanitize in view of the patient. Employees are educated by the IP and unit Directors to WASH IN and WASH OUT upon entry and exit of patient care areas The Infection Preventionist monitors monthly for hand washing compliance and reports the data to the Quality Safety Council. The IP and QSC will monitor for trends in any unit and look at those units individually for re-education. Any noncompliance will be addressed by the individual involved by the department manager or designee. The suction machine was removed from the room on 3/3/15 by the radiology tech. Although the room is not routinely used for patient care, the room immediately underwent a deep cleaning process. The Director of Imaging/EVS talked with the environmental staff members and had the xray rooms placed on the daily environmental services cleaning rounds list. The Director of Imaging/EVS will monitor for compliance. Any noncompliance will be addressed with the individual involved by the department manager or designee.	3/2/15 3/3/15

)EPARTMENT OF HEALTH AND HUMAN SERVICES
:ENTERS FOR MEDICARE & MEDICAID SERVICES

ITEMENT OF DEFICIENCIES) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING	(X3) DATE SURVEY COMPLETED
	440068		03/03/2015

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TARR REGIONAL MEDICAL CENTER ATHENS	1114 W MADISON AVE ATHENS, TN 37371

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 2-story (Partial) Type II(222), unprotected, non-combustible construction with a complete automatic sprinkler system. K6 PLAN APPROVAL: 1973 with additions in 1986, 1989, 1993, 1998 K7 SURVEY UNDER: 2000 EXISTING K8 118-bed Hospital During a validation survey on March 2-3, 2015, at Starr Regional Medical Center Athens Hospital, the facility failed to meet the condition of participation, for the physical environment (CFR 482.41). (Reference Tags C-0220, K018, K021, K029, K052, K062, K064, K067, K069, K077, and K147.)	K 000		
K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margie Brusseau | TITLE: CNO | (X6) DATE: 4/2/15

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K 021	Continued From page 2 c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors requiring to be self-closing were held open by approved devices. (NFPA 101, 7.2.1.8.1) The findings include: Observation and interview with the Maintenance Director, on March 2, 2015 at 11:56 a.m. confirmed the 1-1/2 hour rated CT room fire door had a door closer and was held open by a kickstand device. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 3, 2015.	K 021	The door with kickstand was removed under the impression that it was not on a fire or smoke wall on 3/24/15. However, the door was put back up without a kickstand on 4/2/15. The work order is 45562. The Director of Plant Operations along with the Director of Quality/Risk spoke with the Director of Imaging to ensure daily monitoring that a kickstand or other devices is not used to prop doors open in the department. Any noncompliance will be addressed with the individual involved by the department manager or designee.	3/24/15 4/2/15
K 029	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		

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ARR REGIONAL MEDICAL CENTER ATHENS	1114 W MADISON AVE ATHENS, TN 37371

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous area ' s fire rated construction was maintained. The findings include: 1. Observation and interview with the Maintenance Director, on March 2, 2015 between 11:30 a.m. and 2:50 p.m. confirmed the following rooms were used to store combustible materials and greater than 50 square feet ft and not provided with self-closing doors (NFPA 101, 7.2.1.8.1): - Patient rooms used for storage; 113, 115, 142 - Storage room marked "Private" between materials Management and Surgery. - Dietary dry storage room. 2. Observation and interview with the Maintenance Director, on March 2, 2015 at 8:05 a.m. confirmed unsealed penetration in the mechanical room wall at both the B and C side stairwell walls above the fire door. 3. Observation and interview with the Maintenance Director, on March 2, 2015 at 2:15 p.m. confirmed the kitchen dry storage room doors was not provided with a door closers (NFPA 101, 19.3.2.1 (7). These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 3, 2015.	K 029	1. Correction- rooms involved were 115 and 117, not 113. These are patient rooms and not designated storage areas. The extra beds that were placed in there were removed on 3/4/15 by the Director of Acute Care. The Director of Acute Care and the Charge Nurse will monitor for compliance to keep the rooms clear of storage items. Door closures for room 142, the storage room marked "Private" between Material Mgmt and Surgery, were ordered 3/24/17 and will be installed no later than 4/6/15. A door closure was installed on the dietary dry storage room on 3/24/15, work order 35573, by Plant Operations. 2. The Penetrations were sealed with fire caulk on 3/3/15, work order 45385, by Plant Operations. The PM for fire walls is semi-annual. The policies, Above Ceiling Access for Outside Contractor and Fire and Smoke Walls, were reviewed on 4/2/15 by the Director of Plant Operations and The Director of QRM and it was found that no revision to either policy was needed. 3. Door closure for Dietary Dry Storage Room was installed on 3/24/15, work order 355736, by Plant Operations.	1. 3/4/15 for rooms 115/117 Door closure in Dietary 3/24/15 4/6/15 Install for the other rooms 2. 3/3/15 4/2/15 3. 3/24/15
K 052	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 • MAIN B. WING	(X3) DATE SURVEY COMPLETED
	440068		03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARR REGIONAL MEDICAL CENTER ATHENS	1114W MADISON AVE ATHENS, TN 37371

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 4 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		
	This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to ensure smoke detectors were at least 3-feet from air flow. (NFPA 72, 2-3.5.1). The findings include: Observation and interview with the Maintenance Director, on March 3, 2015 at 8:45 a.m., confirmed the smoke detector at the "C" wing exit to the outside stairwell was 1-foot from the air diffuser. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 3, 2015.		The smoke detector at "C" wing exit to the outside stairwell was relocated to meet the required distance on 3/26/15 by Plant Operations. Work order # 45600.	3/26/15
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		
	This STANDARD is not met as evidenced by:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING	(X3) DATE SURVEY COMPLETED
	440068		03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARR REGIONAL MEDICAL CENTER ATHENS	1114 W MADISON AVE ATHENS, TN 37371

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 5 Based on observation and record review, it was determined the facility failed to ensure the sprinkler system was maintained (NFPA 25, Table 9-1 & 9-2.7). The findings include: 1. Observation and interview on March 2, 2015 between 10:00 a.m. and 2:30 p.m. revealed the following sprinkler heads are covered with lint or corroded; - 1 of 3 sprinkler heads in the maintenance office is covered with lint - 1 of 2 sprinkler heads in the dietary dish room is covered with lint. - 1 of 20 sprinkler heads above the 3 bay sink in dietary is corroded. 2. Observation with the Maintenance Director on March 2, 2015 at 2:50 p.m. confirmed standard response and quick response sprinkler heads mixed in the same compartment at the following locations: - Corridor outside the diagnostic care center - Operating room suite corridor - Same day surgery corridor These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 3, 2015.	K 062	1. The Sprinkler heads in the maintenance office were cleaned 3/17/15, work order 45507, by plant operations. The sprinkler heads in the dietary dish room were cleaned 3/18/15, work order 45507, by plant operations. The sprinkler heads above the 3 bay sink in dietary that are corroded will be replaced. The Sprinkler heads will arrive 4/6 - 4/10/15, installation will be no later than 4/20/15 2. A quote from Vendor (Simplex) was requested. Vendor came 3/18/15. Sprinkler heads will arrive 4/6 - 4/10/15, installation will be no later than 4/20/15.	
K 064	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN W. ING	(X3) DATE SURVEY COMPLETED
	440068		03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARR REGIONAL MEDICAL CENTER ATHENS	1114 W MADISON AVE ATHENS, TN 37371

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 064	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation, interview and record review, it was determined fire extinguishers failed to comply with the maintenance requirements of NFPA 10. The findings include: 1. Observation and interview with the Maintenance Director, on March 2, 2015 at 11:45 a.m. confirmed the C02 portable extinguishers which were last tested in January 201O have not had their 5-year Hydrostatic testing or annual conductivity test performed. 2. Record review with the Maintenance Director, on March 2, 2015 at 11:45 a.m. revealed the report dated 1/9/2015 had 40 portable fire extinguishers needing service that has not been corrected. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 3, 2015.	K064	1. Forty extinguishers were ordered and received 3/16/15, including CO2 extinguishers. The annual Conductivity test was performed on all CO2 extinguishers that same day, and tags are present on all extinguishers. 2. Forty extinguishers were ordered and received 3/16/1, including CO2 extinguishers. The annual Conductivity test was performed on all CO2 extinguishers that same day, and tags are present on all extinguishers	3/16/15
K 067	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on record review and interview, it was	K067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING	(X3) DATE SURVEY COMPLETED
	440068		03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 067	Continued From page 7 determined that the facility failed to maintain fire and smoke dampers in the building. (NFPA 96) The findings include: Record review and interview with the maintenance director on March 2nd, 2015 at 12:00 p.m. revealed the following fire dampers and smoke dampers are not maintained; 1) Fire Dampers 1-FD-012, 1-FD-024 and P-FD-060 are not accessible. 2) Fire Damper P-FD-005 has a broken spring. 3) Smoke Dampers 1-SD-017 and 1-SD-018 are not accessible. 4) Smoke Damper 1-SD-014 has no air to the actuator. This finding was verified by the maintenance director and acknowledged by the assistant administrator during the exit conference on March 3rd, 2015.	K 067	A Quote from the vendor was received on 3/27/15, with completion of repair to be no later than 4/20/15. The responsible individual is the Director of Plant Operations.	
K 069	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review, it was determined that the facility failed to maintain the kitchen hood suppression system. The findings include: Record review with the maintenance clerk on March 2nd, 2015 at 12:00 p.m. revealed a	K 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING	(X3) DATE SURVEY COMPLETED
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K069	Continued From page 8 hydrostatic test has not been performed on the suppression system in dietary since 2002. Documentation indicates it was due in 2014. (NFPA 96) This finding was verified by the maintenance director and acknowledged by the assistant administrator during the exit conference on March 3rd, 2015.	K069	The vendor, Simplex, was contacted on 3/18/2015 by the Director of Plant Operations to complete the hydrostatic test. The test was completed on 3/25/2015. Subsequent to the survey, documentation was found where Hydrostatic test on the suppression system of the range hood system had been performed in 2009 and is on file.	3/25/15
K077	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4. This STANDARD is not met as evidenced by: (NFPA 99, 4-3.1.1.2 (a)(4) The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage. Based on observation and interview, it was determined electrical components in medical gas storage locations were located greater than five (5) feet above the floor. The findings include: Observation and interview with the Maintenance Director, on March 2, 2015 at 10:52 a.m. confirmed the N202 manifold room light switch was located approximately 42" above the finished floor. This finding was verified by the Maintenance Supervisor and acknowledged by the	K077	The N2O2 manifold room light switch was raised to required height requirement on 3/23/15. Work order is 45508. No further action is needed.	3/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01-MAIN B. WING	(X3) DATE SURVEY COMPLETED
	440068		015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARR REGIONAL MEDICAL CENTER ATHENS	1114 W MADISON AVE ATHENS, TN 37371

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 077	Continued From page 9 Administrator during the exit conference on March 3, 2015.	K077		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined GFCI outlets were located in all wet areas. The findings include: Observation and interview with the Maintenance Director, on March 2, 2015 at 2:14 p.m. confirmed GFCI outlets were not provided in the B and C wing ice machine rooms at the counter. (NFPA 70, 517-20). This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 3, 2015.	K 147	The outlet on B Wing was changed on 3/18/15 to a GFCI outlet and the outlet on C Wing was changed on 3/20/15 to a GFCI outlet. The work orders for both were 45537. No further action is required.	B W 3/18/15 C W 3/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 02 - ETOWAH B. WING	(X3) DATE SURVEY COMPLETED
	440068		03/03/2015

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STARR REGIONAL MEDICAL CENTER ATHENS	1114 W MADISON AVE ATHENS, TN 37371

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K 029	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with % hour fire-rated doors) or an approved automatic fire extinguishing system in accordance. with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to have self-closing doors for hazardous areas. The findings include: Observation on March 3, 2015 at 8:50 a.m. revealed the clean utility room in the senior care unit is storing clean linens and room 9 in central wing is being used for storage, these rooms are not provided with a door that is self-closing. This finding was verified by the director of the engineering department and acknowledged by administration during the exit conference on March 3, 2015.	K 029	The clean linen was removed from both rooms on 3/3/15 and staff was told not to use rooms as storage. The nurse manager or designee will be responsible on a daily basis to ensure the rooms are not being used as storage. Any items found will be removed immediately. This will also be monitored monthly in hospital environmental rounds conducted by the ICP and Safety Officer. Results of the monthly environmental rounds are then reported to the QSC. Any noncompliance will be addressed with the individual involved by the department manager or designee.	3/3/15
K 056	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING 02 - ETOWAH B WING	(X3) DATE SURVEY COMPLETED
	440068		03/03/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDE' 'TIFYING INFOPMATIO:Vl	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

K 056 Continued From page 1 K 056

building. The system is properly maintained in accordance with NFPA 25, Standarc' f:::>r the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

This STANDARD is not met as evidenced by: Based on observation, it was detarmined that the facility failed to sprinkler all areas.

The findings include

Observation on March 3, 20 15 at 10 1'₌a m. revealed the central hall janitors closet by the gift shop is not sprinkled.

This finding was verified by the director of the engineering department and acknowledged by administration during the ex.t conference on March 3, 2015.
NFPA 5-1.1*

The vendor, Simplex, came 3/18/15 and a quote was received. Sprinkler heads have been ordered and will arrive 4/6 - 4/10/15. Installation will be no later than 4/20/15.

K 064 NFPA 101 LIFE SAFETY CODE STANDARD K 064

Portable fire extinguishers are provided in all health care occupancies in accordanG•:: vv;tn 9.7.4.1. 19.3.5.6, NFfJA 10

'ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SIIPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING 02 - ETOWAH B WING	(X3) DATE SURVEY COMPLETED
	440068		03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F'JLL REGULATORY OR LSC IDE'NTIFYING INI=ORMAION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
K 064	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview it was determined that the facility failed to have fire extinguishers within 30 feet of the helicopter pad. The findings include: Observation and interview with the director of the engineering department on March 3. 2015 at 12:15 p.m. revealed the 2 of 2 fire extinguishers for the helicopter pad are not within 30 feet. The fire extinguishers *are* located approximately 70 feet away from the helicopter pad s.nd behind shrubbery that is next to the buildir1£i. This finding was verifiad by the director of the engineering department and acknowledged by administration during the exit conference on March 3, 2015. NFPA 10 Table 3-3 1	K 064	A fire cabinet was ordered and received; it was installed within the required distance on 3/25/15 by Plant Operations. Work order 6580.	3/25/15
K 144	NFPA 101 LIFE SAFETY COIJE STANDARO Generators are inspected weekly and exercised under load for 30 minutes per month 1n accordance with NFPA 98. 3.4.4.-1. This STANDARD is not mE/:as evider.cec. by: Based on observation and interview, a was determined that the facility failed to l1ave an annunciator for the generator in a continuously	K 144		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERV..I.GES,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA OENTIFICATIOI MUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440068	A BUILDING 02 • ETOWAH B WING	03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARR REGIONAL MEDICAL CENTER ATHENS	1114 W MADISON AVE ATHENS, TN 37371

(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 5Y FULL REGULATORY OR LSC IDE'NTIFYIUG INFORrI.A.TION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
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K 144	Continued From page 3 monitored bcation. The findings include: Observation and interview w:th the director of the engineering department on March 3, 2015 at 9:00 a m. revealed the annur.ciator for the generator that serves the West Wing is at a nur$ing station that is not being used anymore. This finding was verified by the director of the engineering department and acknowledged by administration during the exit conference on March 3, 2015. NFPA99 3-4.1.1.15	K 144	A quote from vendor to relocate the annunciator to the Emergency Department was received on 3/27/15. Work will begin 4/9/15 and will be completed no later than 4/20/15 by the Director of Plant Operations or designee.	

Attachment - Section - Contribution to the Orderly Development of Health Care

Proof of Publication

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Insertion Date: January 10, 2017

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that:

Starr Regional Medical Center-Etowah, a hospital owned by: Athens Regional Medical Center, LLC, with an ownership type of corporation, and to be managed by Horizon Mental Health Management, LLC, intends to file an application for a Certificate of Need for the expansion of its existing geropsychiatric unit from fourteen (14) beds to eighteen (18) beds, located at 886 Highway 411 North, Etowah (McMinn County), Tennessee 37331. Upon opening the 4 geropsychiatric beds, Starr Regional Medical Center - Etowah will close 4 of its general acute care hospital beds. The project will not change the total number of licensed hospital beds. The project does not contain major medical equipment or initiate or discontinue any health service, and it will not affect licensed bed complements other than as described above. The cost of this project is approximately $660,000.

The anticipated date of filing the application is on or before January 13, 2017.

The contact person for this project is Kim Harvey Looney, Esq., Attorney, who may be reached at: Waller Lansden Dortch & Davis LLP, 511 Union Street, Suite 2700, Nashville, TN 37219, (615) 850-8722.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

2017

2017

dent's date of death.

This 20th day of December, 2016

Estate of Verlin B. Gravely
Deceased

Simmons Bank, Successor by merger to Citizens national Bank, Wealth Management Group

Michael L. Blevins, Vice President
Personal Representative

Biddle & Trew, LLP Attorneys
P.O. Box 10
Athens, TN 37371-0010

Patty S. Gaines, Clerk & Master
Kimberly Ervin, Deputy Clerk

Insertion Dates: January 10 and 17, 2017

the children, which are m
the school district or by a
for the school district. T
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For more information, ple
Rhonda Sarshuri, Superv
cial Education, at 423-745
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7	6	8	4	3	5	1	9	2
9	3	4	1	2	8	6	7	5
3	4	9	5	8	1	2	6	7
5	2	6	3	7	4	9	1	8
8	1	7	9	6	2	5	4	3

BRIDGE

Joey Adams, a comedian, said, "It's very easy to be witty tomorrow, after you get a chance to do some research and rehearse your ad libs."

It's very easy to make your contract tomorrow, after you get a chance to do some research and find out where the opponents' cards lie.

This deal is an example. Six spades is easy to make after a quick glance at the

North
♠ A Q 6
♥ A J 5 3
♦ A Q J 10 7
♣ 7

West
♠ 10 7
♥ 8 6
♦ K 8
♣ K Q 10 8 5 4 2

East
♠ J 8
♥ K 9
♦ 9 2
♣ J 9

South
♠ K 9 5 4 2
♥ Q 10
♦ 6 5 4 3
♣ A 3

Dealer: West
Vulnerable: Both

South	West	North
	3♣	Dbl.
Dbl.	Pass	Pass

D-715-1 9/97

INVOICE NO.	INV. DATE	GROSS AMOUNT	DISCOUNT AMOUNT	NET AMOUNT
* DIRECT ALL INQUIRIES TO:				
* STARR REGIONAL MEDICAL CENTER				
* 1114 WEST MADISON AVE				
* P.O. BOX 250				
* ATHENS, TN		37303		
* (423) 745-1414				
*				
* FOR PAYEE:				
* TN HEALTH SERVICES AND				
* DEVELOPMENT AGENCY				
* 4219 HILLSBORO ROAD, SUITE 210				
* NASHVILLE TN 37215				
*				
*				
The Deficit Reduction Act of 2005 requires certain				
entities to implement policies related to fraud				
and abuse in healthcare. These policies are				
available in hospital administrative offices for				
your review.				
*				
* ID 05460-803067		SR *SPECIAL HANDLING*		
JAN2017	01/05/17	15000.00	0.00	15000.00
** SMART VOUCHER 17006807 2. USERID LAWSON				
Check Remittance Comments				

INVOICE NO.	INV. DATE	GROSS AMOUNT	DISCOUNT AMOUNT	NET AMOUNT

1/07/2017 PAGE 01 OF 01 1666 BANK NO. Z2 SP

CHECK AMT. $*****15,000.00 CHECK NO. 04413049

THIS MULTI-TONE AREA OF THE DOCUMENT CHANGES COLOR GRADUALLY AND EVENLY FROM DARK TO LIGHT WITH DARKER AREAS BOTH TOP AND BOTTOM.
THE BACK OF THIS DOCUMENT CONTAINS AN ARTIFICIAL WATERMARK. HOLD AT ANGLE TO VIEW, AND THERMOCHROMIC PRINTING. IF NOT PRESENT, DO NOT NEGOTIATE THIS DOCUMENT.

THIS CHECK CLEARS POSITIVE PAY

STARR REGIONAL MEDICAL CENTER
1114 WEST MADISON AVE
P.O. BOX 250
ATHENS, TN 37303
09 100-000090 1701 1 27-1

Z2 05460-803067
SUNTRUST BANK
ATLANTA, GA

04413049

64-79
611

DATE 1/07/2017

$*****15,000.00

PAY FIFTEEN THOUSAND DOLLARS AND 00/100

TO THE ORDER OF:

TN HEALTH SERVICES AND
DEVELOPMENT AGENCY
4219 HILLSBORO ROAD, SUITE 210
ATTN. % DEVELOPMENT SUPP
NASHVILLE, TN 37215

Michael S. Coggin
Christopher J. Monte

THIS CHECK CLEARS POSITIVE PAY

⑈04413049⑈ ⑆061100790⑆ 8800614888⑈

JAN 13'17 AM9:57

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

Kim H. Looney, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE

Sworn to and subscribed before me this 13th day of January, 2017 a Notary
(Month) (Year)
Public in and for the County/State of Tennessee.

NOTARY PUBLIC

My commission expires, January 8, 2019.
(Month/Day) (Year)

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON

MY COMMISSION EXPIRES:
JANUARY 8, 2019

4811-7128-7871.6

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

February 1, 2017

Kim Looney, Esq.
Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219

RE: Certificate of Need Application -- Starr Regional Medical Center-Etowah - CN1701-002
The expansion of the hospital's existing fourteen (14) bed geri-psychiatric unit to eighteen (18) beds. Upon opening the four (4) additional proposed beds, the applicant will close four (4) general hospital beds at Etowah with the result that the licensed beds at Etowah (72) and the total consolidated licensed beds (190) for both the Etowah and Athens hospitals will not change. The estimated project cost is $621,351.

Dear Ms. Looney:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1607, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on February 1, 2017. The first 60 days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review. You will receive a copy of their findings. The Health Services and Development Agency will review your application on April 26, 2017.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: February 1, 2017

RE: Certificate of Need Application
Starr Regional Medical Center-Etowah - CN1701-002

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on February 1, 2017 and end on April 1, 2017.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Kim Looney, Esq.

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

JAN 10 '17 PM 1:41

LETTER OF INTENT

The Publication of Intent is to be published in the The Daily Post Athenian (Name of Newspaper) which is a newspaper of general circulation in McMinn (County), Tennessee, on or before January 10 (Month/Day), 20 17 (Year) for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Starr Regional Medical Center - Etowah (Name of Applicant) hospital (Facility Type-Existing)

owned by: Athens Regional Medical Center, LLC with an ownership type of corporation

and to be managed by: Horizon Mental Health Management, LLC intends to file an application for a Certificate of Need

for [PROJECT DESCRIPTION BEGINS HERE]: the expansion of its existing geropsychiatric unit from fourteen (14) beds to eighteen (18) beds, located at 886 Highway 411 North, Etowah (McMinn County), Tennessee 37331. Upon opening the 4 geropsychiatric beds, Starr Regional Medical Center - Etowah will close 4 of its general acute care hospital beds. The project will not change the total number of licensed hospital beds. The project does not contain major medical equipment or initiate or discontinue any health service, and it will not affect licensed bed complements other than as described above. The cost of this project is approximately $660,000.

The anticipated date of filing the application is: On or before January 13, 20 17

The contact person for this project is Kim Harvey Looney, Esq. (Contact Name) Attorney (Title)

who may be reached at: Waller Lansden Dortch & Davis LLP (Company Name) 511 Union Street, Suite 2700 (Address)

Nashville (City) TN (State) 37219 (Zip Code) 615 (Area Code) / 850-8722 (Phone Number)

Kim H. Looney (Signature) January 10, 2017 (Date) Kim.Looney@wallerlaw.com (Email-Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Supplemental #1
Original

Starr Regional Medical Center (Etowah)

CN1701-002

waller

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
P.O. Box 198966
Nashville, TN 37219-8966

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

SUPPLEMENTAL #1
January 25, 2017
4:19 pm

615.244.6380 main
615.244.6804 fax
wallerlaw.com

January 25, 2017

Phillip M. Earhart
HSDA Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Starr Regional Medical Center (Etowah Campus)
Certificate of Need Application CN1701-002

Dear Phillip:

This letter is submitted as the supplemental response to your letter dated January 18, 2017, wherein additional information or clarification was requested regarding the above-referenced CON application.

---

1. **Section A., Project Details, Name of Management/Operating Entity**

   The management agreement in Attachment Section A-5 is noted. Please provide Exhibit 5 of the agreement.

   Response: There is no Exhibit 5 to the management agreement, but there is an Exhibit B that was omitted due to the proprietary nature of the financial terms contained therein.

   If applicable, please provide a website address of the management/operating entity.

   Response: The website address is www.horizonhealth.com.

2. **Section A., Project Details, Floor Plan**

   The floor plan in Attachment A-6B.2 is noted. However, please provide larger, more detailed images of your project which includes legible labeling of patient care rooms (noting private and semi-private), ancillary rooms, equipment rooms, etc.

   Response: Please see revised floor plan included as Attachment A-6B.2.

3. **Section A., Project Details, Item 10, Bed Complement Data**

The Bed Complement Data for the Etowah location is noted. However, it appears the nursing home beds are separately licensed. Please remove the licensed nursing home beds from the bed complement chart and include the number of licensed nursing home beds under the bed complement data chart and submit a replacement page 9.

Response: See replacement page 9 included as Attachment Section A, Item 10-3.

It appears the beds staffed by the applicant totals 21 not 17. Please clarify.

Response: Only the 14 geriatric inpatient psychiatric beds are currently staffed. Please see replacement page 9 included as Attachment Section A, Item 10-3.

Please clarify why the applicant is not staffing the current 50 licensed medical beds at the Etowah campus.

Response: The 50 licensed medical beds have been held in an inactive status since 2014 while the applicant determines the proper course of action with respect to them. Because its parent facility is only 8 miles away and has sufficient licensed beds to take care of the medical needs of the service area population, Starr Regional Medical Center has not needed to staff the beds thus far and is still evaluating its options as to how to make the best use of that space. However, Starr Regional Medical Center as a whole continues to offer a full array of medical and psychiatric services, with the exception of inpatient acute care beds.

4. **Section B, Need, Item l.a. (Psychiatric Inpatient Services-Service Specific Criteria-) Item 1 Determination of Need**

Please complete the following table to determine psychiatric bed need.

	Population 2017		Gross Need Pop. X (30 beds/100,000)		Current licensed beds		Net Need	
	Adults 18-65*	Adults 65+	Adults 18-65*	Adults 65+	Adults 18-65*	Adults 65+	Adults 18-65*	Adults 65+
Proposed Service Area	135,280	47,472	41	15	30	14	11	1

Note: The population of ages 20-64 was utilized as this was the most consistent age category based on the Tennessee Department of Health's projected population data.

The need for particular services and beds is generally projected 4 years in the future. When you apply the psychiatric bed need formula to the estimated 65 and older population for 2021, there is a need for 17 beds in the service area. The applicant currently has 14 beds, so there is a net need

for 3 beds in 2021. Because the bed need formula for psychiatric patients generally underestimates the need for the geriatric population because of their higher utilization rate for these services, the applicant feels there is a need for at least 4 more geropsychiatric beds in the service area. In addition, the semi-private rooms being proposed by the applicant would necessitate the construction of an even number of beds. Because a determination of need should take into account the future need in the years following the construction and implementation of the project, the applicant feels it is appropriate to consider the need for the project 4 years in the future. Thus the need for the 4 additional beds proposed by the applicant has been established.

5. Section B, Need, Item I.a. (Psychiatric Inpatient Services-Service Specific Criteria-) Item 2 Additional Factors

a. It is noted the applicant will not accept involuntary admissions. Where would an involuntary geriatric patient from the proposed service area be admitted for inpatient psychiatric care?

Response: It is the applicant's understanding that Moccasin Bend Mental Health Institute, a state-run facility in nearby Hamilton County, accepts involuntary admissions.

b. It is noted the applicant refers patients to other providers who can provide outpatient, intensive outpatient treatment (IOP), and partial hospitalization services. Please indicate the providers within and outside of the applicant's service area that provides outpatient, intensive outpatient treatment (IOP), and partial hospitalization services.

Response: Providers in the service area providing such psychiatric services include:

- Bradford County: Camelot Care Centers-Cleveland (MH-Outpatient); Centerstone Bradley County (MH-Outpatient); Life Bridges, Inc. (MH-Outpatient); Mental Health Cooperative, Inc.-Cleveland (MH-Outpatient); Omni Community Health-Cleveland (MH-Outpatient); Hiwassee Mental Health Center-Cleveland (MH-Outpatient); Glynn Newman, MD, Psychiatrist-Cleveland;

- McMinn County: Cherokee Health Systems-Englewood (MH-Outpatient); Health Connect America, Inc.-Athens (MH-Outpatient); McMinn County Center (MH-Outpatient); Omni Community Health-Athens (MH-Outpatient); Omni Community Health-Athens 2 (MH-Outpatient); Hiwassee Mental Health Center-Athens (MH-Outpatient);

- Meigs County: None;

- Monroe County: Generations Mental Health Center-Vonore (MH-Outpatient); Hiwassee Mental Health Center-Madisonville(MH-Outpatient); and

- Polk County: None.

The applicant generally refers patients requiring outpatient psychiatric services to:

- Hiwassee Mental Health Center located nearest to the patient's respective county; and
- Dr. Glynn Newman, M.D., a psychiatrist in Cleveland, Tennessee.

c. Please clarify if a crisis team member from Hiwassee Mental Health Center is required to conduct an inpatient psychiatric assessment for a Medicare patient.

Response: A crisis team member from Hiwassee Mental Health Center is not ordinarily required to conduct an inpatient psychiatric assessment for a Medicare patient unless the physician or hospital requires their assistance. However, where a Medicare patient has been arrested, a crisis team member from Hiwassee Mental Health Center is required to conduct an inpatient psychiatric assessment because they serve as the gatekeeper for Moccasin Bend Mental Health Institute in Chattanooga.

6. Section B, Need, Item l.a. (Psychiatric Inpatient Services-Service Specific Criteria-) Item 3 Incidence and Prevalence

Please indicate the Tennessee statewide 2016 rate and prevalence of mental illness and substance abuse.

Response: The most recent County and Region Behavioral Health Prevalence Estimates published by the TDMHSAS places the Tennessee statewide percentage of adults with any mental illness in the past year at 20.6%.

7. Section B, Need, Item l.a. (Psychiatric Inpatient Services-Service Specific Criteria-) Item 12 Institution for Mental Disease Classification

Please clarify if the applicant is classified as an IMD.

Response: The applicant is not currently classified as an IMD, but it could receive such a designation as the result of the addition of 4 more beds. However, the applicant primarily provides services to patients 65 and up, with only 1% of its payor mix covered by TennCare. As such, if the applicant chooses to apply for and receives this designation, it will not have a significant impact on cost to the State.

8. Section B, Need, Item l.a. (Psychiatric Inpatient Services-Service Specific Criteria-) Item 13 Continuum of Care

Please indicate where patients are referred for treatment for unexpected medical issues after inpatient psychiatric admissions.

Response: The majority of the patients needing treatment for unexpected medical issues can be treated onsite through SRMC-Etowah's existing medical capabilities, and, if not, then they are transferred to the closest hospital, SRMC-Athens, SRMC-Etowah's parent facility, which is approximately 8 miles away.

9. **Section B, Need, Item l.a. (Psychiatric Inpatient Services-Service Specific Criteria-) Item 15 Adequate Staffing**

   Please clarify if the applicant's geriatric psychiatric inpatient unit is staffed with at least two direct patient care staff, one of which is nurse, at all times.

   Response: Yes, please see revised page 44 included as Attachment Section C, Economic Feasibility, Item 8.

   It is noted the applicant projects to hire 2.5 FTEs to provide sufficient staffing for a census of 15-18 patients. What type of positions will be included in the 2.5 FTEs?

   Response: The projected staffing includes 1 LPN who will be replaced with an RN. The 2.5 new FTEs include 2 new Certified Nursing Assistant FTEs as well as .5 Licensed Social Worker FTEs.

10. **Section B, Need, Item l.a. (Psychiatric Inpatient Services-Service Specific Criteria-) Item 18 Quality Control and Monitoring**

    Please discuss the applicant's existing quality improvement, and outcome and process monitoring system.

    Response: SRMC-Etowah maintains quality improvement and outcome and process monitoring as required pursuant to its licensure by the state and accreditation by The Joint Commission. The Performance Improvement Plan for the Geropsych Program functions as a part of Starr Regional Medical Center's overall Performance Improvement Plan. The program "Team Improvement Plan" is composed of indicators that define how the unit contributes to the overall organizational goals for improvement in service, outcome and/or cost. The purpose of the plan is to ensure the delivery of quality care to all patients. This is accomplished through consistent monitoring of the clinical services of the unit including Outcome Measurements using the CQI+ Outcomes Measurement Reports. The CQI+ Outcomes Measurement System provides a comprehensive, structured and methodologically sound procedure for measuring clinical effectiveness of the treatments provided and patient/family satisfaction with treatment on discharge. When opportunities are identified as a result of review and data collection, a plan of correction is identified and monitored towards resolution. In addition, review and research of evidenced based and best practice measures will be implemented to improve patient care and outcomes. Specific measures include: minutes of physical restraint use, minutes of seclusion use, number of falls, number of falls that result in injury, patient symptomatology/function from admission to discharge, patient/family overall satisfaction, medical transfers, and unplanned readmissions within 30 days.

11. Section C. Economic Feasibility Item 3 and 4 (Historical and Projected Data Chart)

Historical Data Charts

The Historical Data Chart for the total facility is noted. However, total operating expenses for the Years 2014 and 2015 is calculated incorrectly. In addition, the "other expenses category" break-out totals for 2014 and 2015 were transferred incorrectly to the Historical Data Chart for the total facility. Please correct and submit a revised Historical Data Chart.

The Historical Data Chart for the Project only is noted. However, the Net Operating Revenue for Year 2014 is calculated incorrectly. In addition, the Earnings Before Interest, Taxes, and Depreciation total for 2014 is incorrect. Please correct and submit a revised historical data chart.

Response: Please see revised pages 32 through 35 (Historical Data Charts for total facility and project only) included as Attachment Section C, Economic Feasibility-Item 3.

Projected Data Charts

The Projected Data Chart for the total facility is noted. However, the total operating expenses column for 2017 appears to be incorrect. Please correct and submit a replacement page 37.

The Projected Data Chart for the project only is noted. However, the total non-operating expenses column totals for 2018 and 2019 are incorrect. In addition, the "other expenses" breakout total for 2019 on page 40 is incorrect. Please correct and transfer and correct amount to the Projected Data Chart. Also, please correct the Projected Data Chart-Other Expenses heading on the bottom of page 40 to reflect 18 beds rather than 14. Please submit a corrected page 40.

Response: Please see revised pages 37 through 40 (Projected Data Charts for total facility and project only) included as Attachment Section C, Economic Feasibility-Item 3.

12. Section C, Economic Feasibility, Item 5.A. and 5.B.

The table identifying the project's average gross charge, average deduction from operating revenue, and average net charge is noted. However, the calculations are incorrect. Please correct.

Response: Please see revised page 41 which corrects the calculations included as Attachment Section C, Economic Feasibility, Item 5A.

Please compare proposed charges in Year One of the proposed project to the average daily charge of $1,593 in Year 2015.

Response: The original response was the result of a miscalculation. The average net charge for the facility in 2015 was $715.53 per day compared to an average net charge of $588.04 per day in Year one, a reduction of almost 17%.

13. Section C. Economic Feasibility, Item 6.A. Net Operating Margin Ratio

Please recalculate and verify the Net Operating Margin Ratio of 31.28 for the 1st year previous to current Year. It appears to calculate at 30.18.

Response: The Net Operating Margin Ratio for the 1st Year previous to Current Year was correctly calculated as 31.28 (EBITDA $601,716/Net Operating Revenue $1,923,598). Please see revised page 43 included as Attachment Section C, Economic Feasibility, Item 6A.

14. Section C, Economic Feasibility, Item 7

The applicant's Projected Payor mix in Year One is noted. However, the table total of $7,565,295 does not match the total in the Projected Data Chart of $7,935,067. Please correct and submit a replacement page 43.

Response: Please see revised page 43 included as Attachment Section C, Economic Feasibility, Item 7.

15. Section C, Economic Feasibility, Item 8

Please complete Section B. of the table on page 44 and submit a replacement page.

Response: Please see revised page 44 included as Attachment Section C, Economic Feasibility, Item 8.

16. Section C, Contribution to Orderly Development, Item 1

It is noted the applicant works closely with the main campus in Athens regarding acute care. Please indicate the distance from the Etowah campus to the Athens campus.

Response: SRMC-Etowah and SRMC-Athens are located 8.16 miles from each other.

17. Section C, Contribution to Orderly Development, Item 4.B

The latest licensure survey is noted. Please provide a letter from the appropriate agency that all deficiencies/findings have been corrected as a result of the survey.

Response: Please see letter from The Joint Commission stating no deficiencies included as Attachment Section C, Contribution to the Orderly Development of Health Care, Item 4.B. As a

waller

facility granted deemed status, Medicare and other relevant agencies accept the results of The Joint Commission's survey as evidence of compliance with regulatory standards.

18. Project Completion Forecast Chart

Please indicate the initial HSDA decision date.

Response: Please see revised page 54 included as Attachment, Project Completion Forecast Chart noting the initial HSDA decision date.

Please contact me if you have any questions or need additional information.

Sincerely,

Kim Harvey Looney

KHL:lag
Enclosures

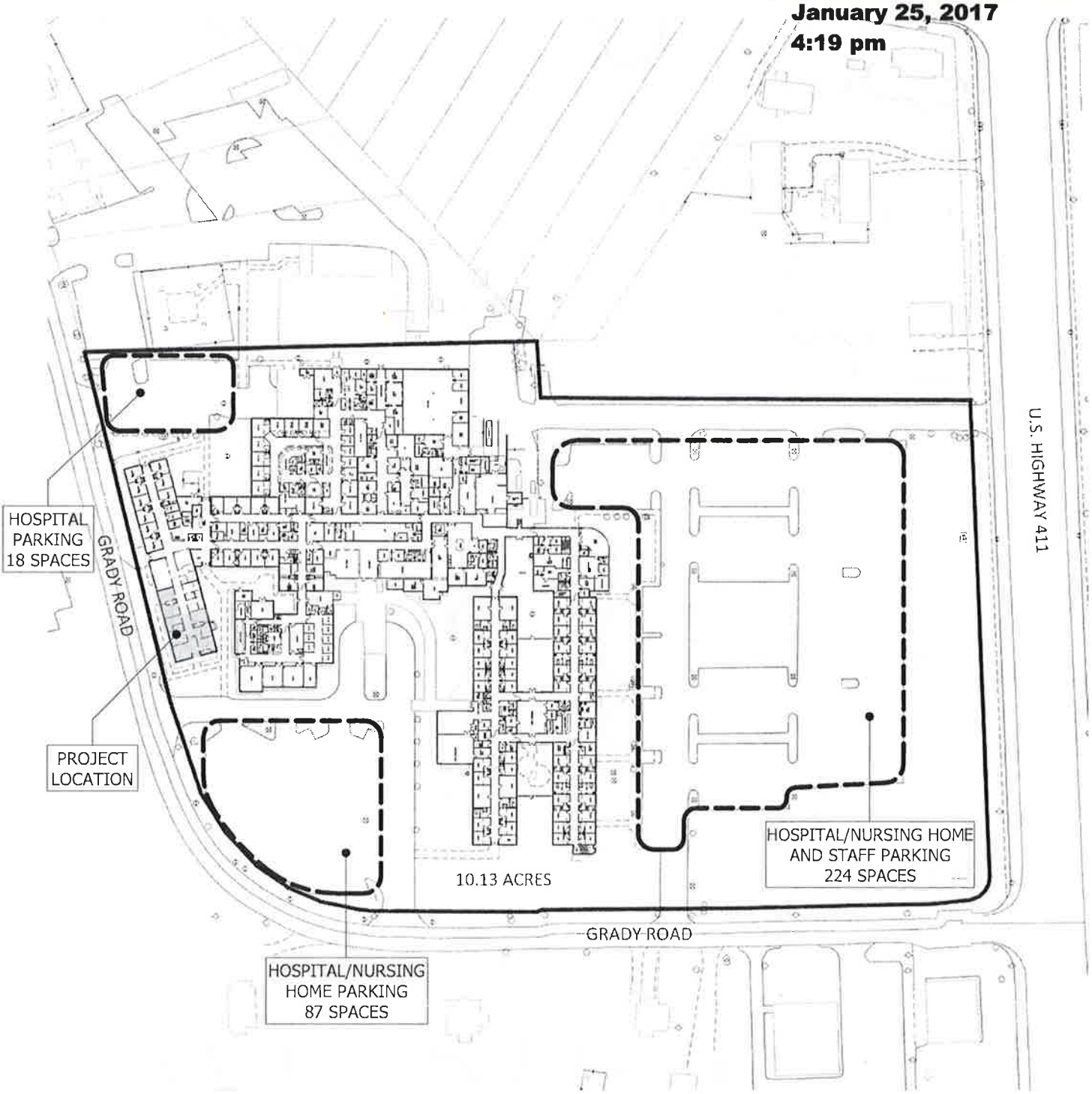
JAN 25 '17 PM4:
SUPPLEMENTAL #1
January 25, 2017
4:19 pm

Attachment Section A, Project Details-Item 6B.2

Revised Floor Plan

SUPPLEMENTAL #1

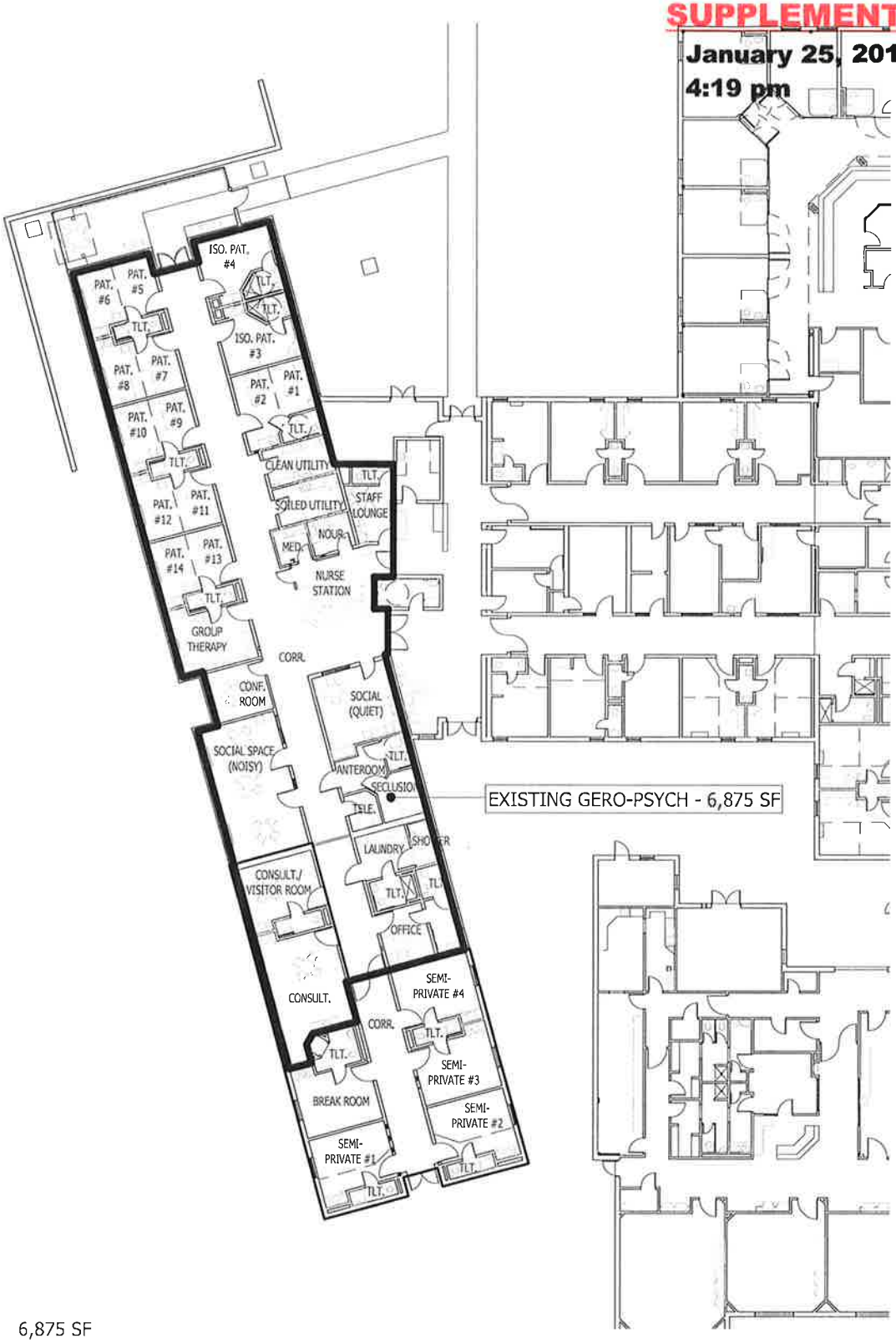
January 25, 2017
4:19 pm



GERIATRIC-PSYCH EXPANSION for STARR REGIONAL MEDICAL CENTER - ETOWAH	SITE PLAN 10.13 ACRES
ETOWAH, TENNESSEE JANUARY 24, 2017 - NOT FOR CONSTRUCTION HMK ARCHITECTS PLLC	NOT TO SCALE

SUPPLEMENTAL #1

January 25, 2017
4:19 pm

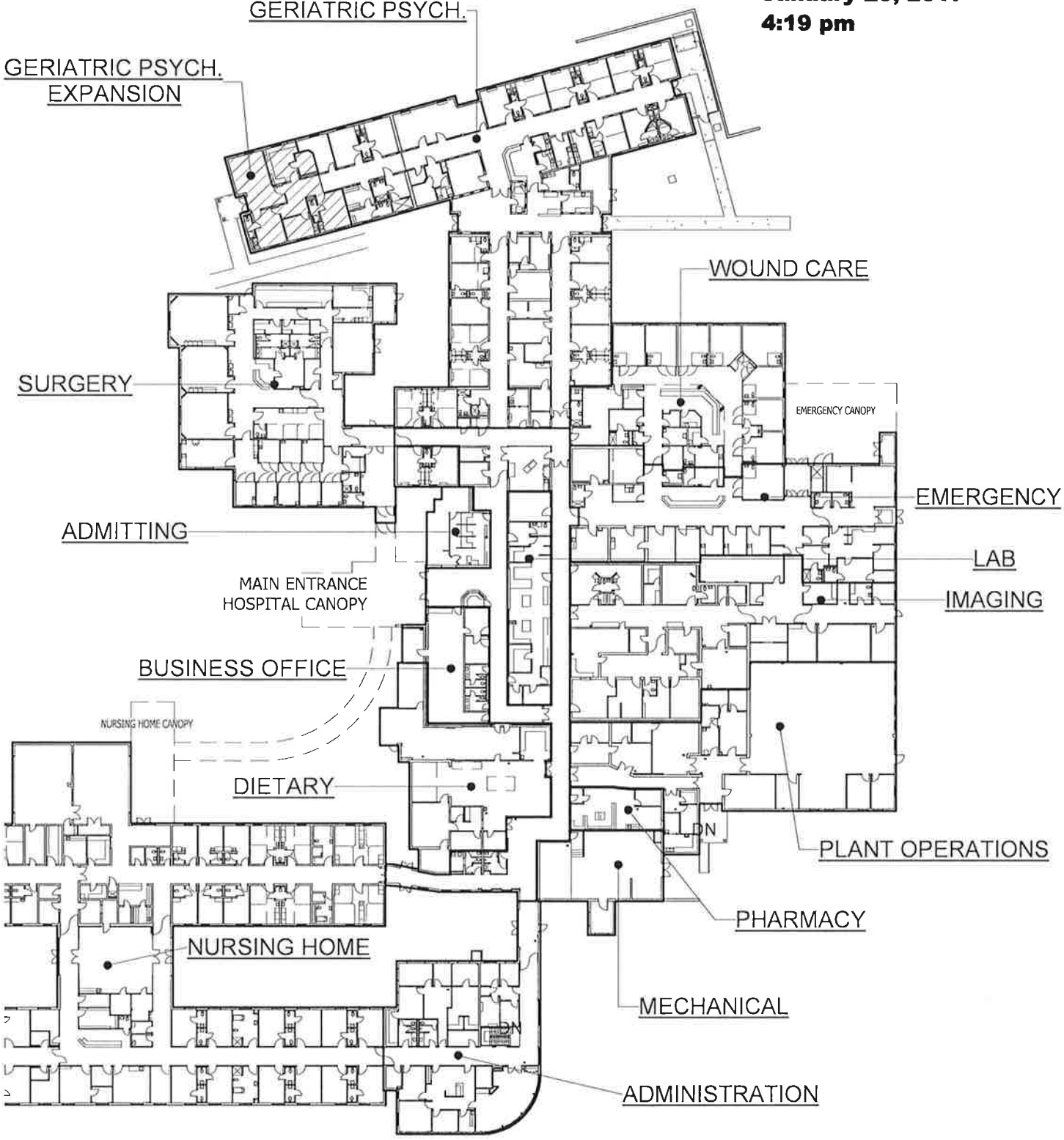


EXISTING SF - 6,875 SF

GERIATRIC-PSYCH EXPANSION for STARR REGIONAL MEDICAL CENTER - ETOWAH	EXISTING FLOOR PLAN 14 BEDS
ETOWAH, TENNESSEE JANUARY 24, 2017 - NOT FOR CONSTRUCTION HMK ARCHITECTS PLLC	

SUPPLEMENTAL #1

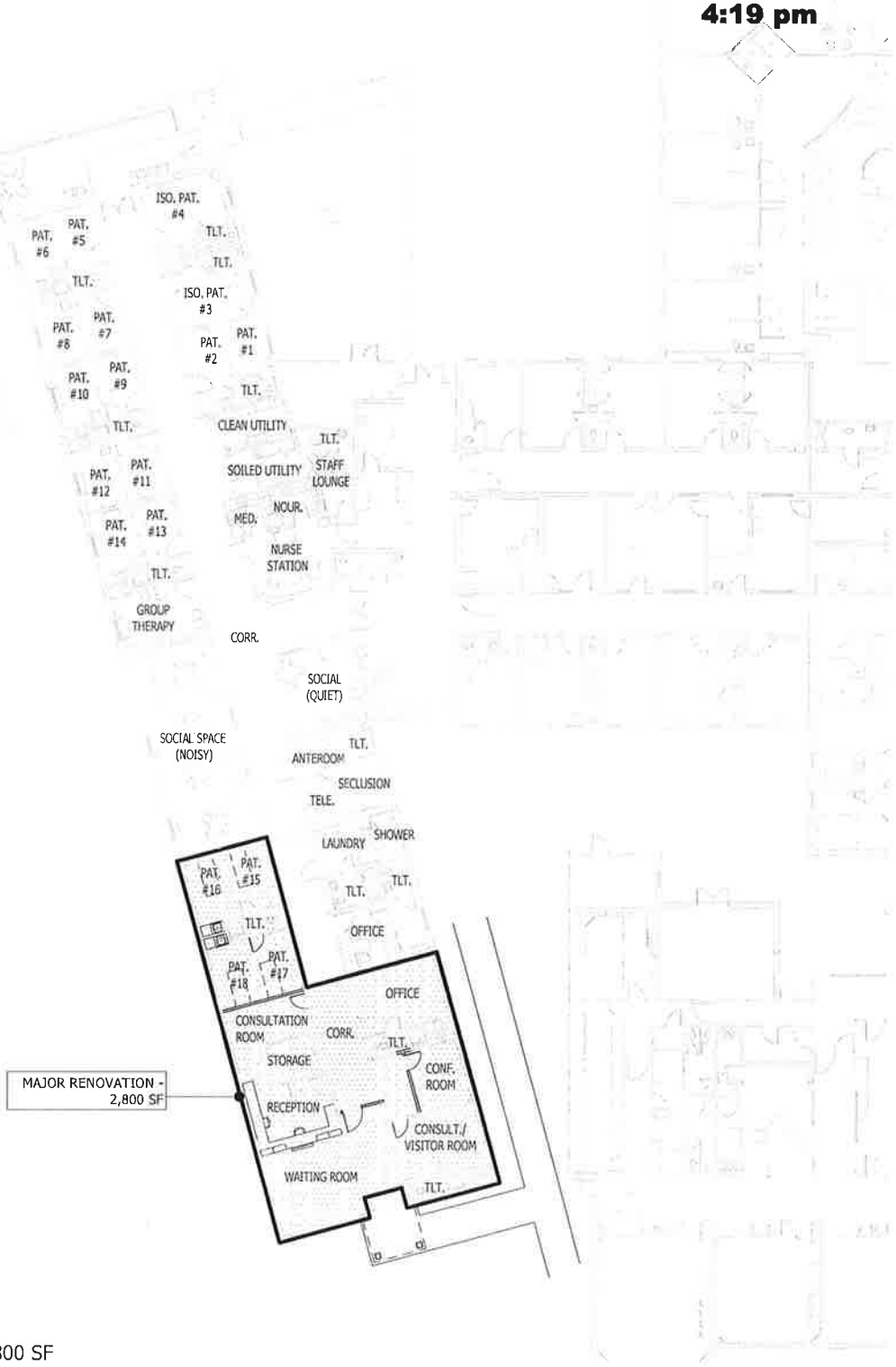
January 25, 2017
4:19 pm



GERIATRIC-PSYCH EXPANSION for STARR REGIONAL MEDICAL CENTER - ETOWAH	DEPARTMENT PLAN
ETOWAH, TENNESSEE JANUARY 24, 2017 - NOT FOR CONSTRUCTION HMK ARCHITECTS PLLC	NOT TO SCALE

SUPPLEMENTAL #1

January 25, 2017
4:19 pm



RENOVATED SF - 2,800 SF

GERIATRIC-PSYCH EXPANSION for STARR REGIONAL MEDICAL CENTER - ETOWAH

PROPOSED - NEW WORK PLAN
18 BEDS

ETOWAH, TENNESSEE
JANUARY 24, 2017 - NOT FOR CONSTRUCTION
HMK ARCHITECTS PLLC

SUPPLEMENTAL #1

January 25, 2017
4:19 pm

Attachment Section A, Project Details-Item 10-3

Revised Page 9

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.

	Current Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempted	TOTAL Beds at Completion
1) Medical	50	0	-4			46
2) Surgical						
3) ICU/CCU	8	0				8
4) Obstetrical						
5) NICU						
6) Pediatric						
7) Adult Psychiatric						
8) Geriatric Psychiatric	14	14	+4			18
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL	72	14	NC			72

*Beds approved but not yet in service **Beds exempted under 10% per 3 year provision

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. **Attachment Section A-10.**

Response: The beds are not new beds to the facility but a reallocation of 4 beds from acute care to psychiatric. In 2014, when the hospital received the CON for an increase from 10 to 14 geropsychiatric beds, the Hospital asked licensure to put the license for the acute care beds in an inactive status.

C. **Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.**

Response: N/A

CON Number(s)	CON Expiration Date	Total Licensed Beds Approved

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staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Response: See chart below.

	Position Classification	Existing FTEs (enter year)	Projected FTEs Year 1	Average Wage (Contractual Rate)	Area Wide/Statewide Average Wage
A.	**Direct Patient Care Positions**				
	Registered Nurse	9.0	10.0	$30.61	$27.35
	Licensed Practical Nurse	2.0	1.0	$10.64	$17.65
	Staff CNA/MHT	4.0	6.0	$12.91	$10.75
	LSW	1.5	2.0	$32.51	$14.80
	Activities Therapist	1.0	1.0	$12.91	$19.00
	Total Direct Patient Care Positions	17.5	20.0		
B.	**Non-Patient Care Positions**				
	Total Non-Patient Care Positions	0.0	0.0		
	Total Employees *(A+B)*	17.5	20.0		
C.	**Contractual Staff**				
	Program Director RN	1.0	1.0	Contracted	
	Nurse Manager	1.0	1.0	Contracted	
	Physician Director	1.0	1.0	Contracted	
	Total Staff *(A+B+C)*	20.5	23.0		

9. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

   A. Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

   Response: Maintaining the status quo at 14 beds was rejected because SRMC-Etowah is the only provider of geropsychiatric care in this rural five county area and its admissions peaks over 75% occupancy are now so frequent that, in CY 2017, the unit will begin turning away admissions for lack of bed space.

   A four-bed expansion was proposed instead of two because the Hospital needs to be assured of having sufficient beds to meet demand for the next few years.

   B. Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

   Response: Not Applicable. This project will be completed through renovation of existing space.

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Attachment Section C, Economic Feasibility-Items 3 and 4

Revised Pages 33-35
Historical Data Charts

SUPPLEMENTAL #1

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HISTORICAL DATA CHART-
STARR REGIONAL MEDICAL CENTER

X Total Facility
□ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

		Year 2013	Year 2014	Year 2015
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) ADMISSIONS	3,533	2,808	2,686
	PATIENT DAYS	14,703	12,131	11,398
B.	Revenue from Services to Patients			
	1. Inpatient Services	**$ 78,837,543**	**$ 74,172,151**	**$ 75,783,128**
	2. Outpatient Services	$180,271,920	$195,786,116	$222,745,419
	3. Emergency Services	$0.00	$0.00	$0.00
	4. Other Operating Revenue (Specify) Cafeteria Sales, Release of Information, Rebates, Professional Building Revenue, Grant Revenue, Vending Machine, CPR Classes	$327,086	$272,909	$289,958
	Gross Operating Revenue	**$ 259,436,549**	**$ 270,231,176**	**$ 298,818,505**
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	**$ 180,541,186**	**$ 191,327,718**	**$ 217,323,967**
	2. Provision for Charity Care	$1,385,332	$701,738	$823,163
	3. Provisions for Bad Debt	$14,838,336	$15,367,283	$14,887,942
	Total Deductions	**$ 196,764,854**	**$ 207,396,739**	**$ 233,035,072**
NET OPERATING REVENUE		**$ 62,671,695**	**$ 62,834,437**	**$ 65,783,433**
D.	Operating Expenses			
	1. Salaries and Wages			
	a. Direct Patient Care	$17,375,100	$14,467,833	$14,795,794
	b. Non-Patient Care	$5,019,173	$4,534,492	$3,918,939
	2. Physician's Salaries and Wages			
	3. Supplies	$8,509,847	$6,918,878	$7,269,008
	4. Rent			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates	$286,752	$324,238	$302,882
	5. Management Fees:			
	a. Paid to Affiliates	$2,851,344	$2,946,272	$3,546,426
	b. Paid to Non-Affiliates	$532,937	$0.00	$0.00
	6. Other Operating Expenses	$14,134,506	$ 15,088,684	$16,364,131
	Total Operating Expenses	**$ 48,709,659**	**$ 44,280,397**	**$ 46,197,180**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$ 13,962,036**	**$ 18,554,040**	**$ 19,586,523**
F.	Non-Operating Expenses			
	1. Taxes	**$ 4,393,462**	**$ 4,117,888**	**$ 4,063,923**
	2. Depreciation	$4,087,664	$3,510,918	$3,462,903
	3. Interest	$4,610,371	$4,997,892	$5,377,036
	4. Other Non-Operating Expenses	$360,000	$360,000	$360,000
	Total Non-Operating Expenses	**$13,451,497**	**$12,966,698**	**$13,263,862**
NET INCOME (LOSS)		**$510,539**	**$5,587,342**	**$6,322,390**

Chart Continues Onto Next Page

SUPPLEMENTAL #1

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NET INCOME (LOSS)	**$ 510,539**	**$ 5,587,342**	**$ 6,322,390**
G. Other Deductions			
1. Annual Principal Debt Repayment	**$ 270,891**	**$ 0.00**	**$ 0.00**
2. Annual Capital Expenditure	$75,298	$3,495,210	$1,935,248
Total Other Deductions	**$ 346,189**	**$ 3,495,210**	**$ 1,935,248**
NET BALANCE	**$ 164,350**	**$ 2,092,132**	**$ 4,387,142**
DEPRECIATION	**$ 4,087,664**	**$ 3,510,918**	**$ 3,462,903**
FREE CASH FLOW (Net Balance + Depreciation)	**$ 4,252,014**	**$ 5,603,050**	**$ 7,850,045**

SUPPLEMENTAL #1

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HISTORICAL DATA CHART
SRMC GEROPSYCHIATRIC UNIT @ 14 BED

□ Total Facility
X Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

	Year 2013	Year 2014	Year 2015
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **PATIENT DAYS**	2,404	2,907	3,108
B. Revenue from Services to Patients			
1. Inpatient Services	**$ 3,453,763**	**$ 7,132,160**	**$ 7,565,295**
2. Outpatient Services	$0.00	$0.00	$0.00
3. Emergency Services	$0.00	$0.00	$0.00
4. Other Operating Revenue (Specify)_____	$0.00	$0.00	$0.00
Gross Operating Revenue	**$ 3,453,763**	**$ 7,132,160**	**$ 7,565,295**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	**$ 1,625,651**	**$ 5,208,562**	**$ 5,341,431**
2. Provision for Charity Care	$0.00	$0.00	$0.00
3. Provisions for Bad Debt	$0.00	$0.00	$0.00
Total Deductions	**$ 1,625,651**	**$ 5,208,562**	**$ 5,341,431**
NET OPERATING REVENUE	**$ 1,828,112**	**$ 1,923,598**	**$ 2,223,864**
D. Operating Expenses			
1. Salaries and Wages			
a. Direct Patient Care	$665,240	$745,967	$828,516
b. Non-Patient Care	$0.00	$0.00	$0.00
2. Physician's Salaries and Wages	$0.00	$0.00	$0.00
3. Supplies	$12,607	$19,263	$22,884
4. Rent			
a. Paid to Affiliates	$0.00	$0.00	$0.00
b. Paid to Non-Affiliates	$672	$6,705	$4,175
5. Management Fees:			
b. Paid to Affiliates	$0.00	$0.00	$0.00
b. Paid to Non-Affiliates	$532,937	$488,942	$478,806
6. Other Operating Expenses	$18,867	$61,005	$69,819
Total Operating Expenses	**$ 1,230,323**	**$ 1,321,882**	**$ 1,404,200**
E. **Earnings Before Interest, Taxes and Depreciation**	**$ 597,789**	**$ 601,716**	**$ 819,664**
F. Non-Operating Expenses			
1. Taxes	**$ 5,206**	**$ 8,152**	**$ 8,288**
2. Depreciation	$89,479	$131,616	$128,419
3. Interest	$3,817	$4,008	$4,325
4. Other Non-Operating Expenses	$0.00	$0.00	$0.00
Total Non-Operating Expenses	**$98,502**	**$143,776**	**$141,032**
NET INCOME (LOSS)	**$499,287**	**$457,940**	**$678,632**

Chart Continues Onto Next Page

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NET INCOME (LOSS)	$ 499,[illegible]	$ 457,940	$ 678,632
G. Other Deductions			
1. Annual Principal Debt Repayment	$	$	$
2. Annual Capital Expenditure			
Total Other Deductions	$	$	$
NET BALANCE	$	$	$
DEPRECIATION	$	$	$
FREE CASH FLOW (Net Balance + Depreciation)	$	$	$

X Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES
Starr Regional Medical Center

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	Year 2015
1. Professional Services Contract	$ 4,184,855	$ 4,352,043	$ 5,199,019
2. Contract Labor	$0.00	$0.00	$0.00
3. Imaging Interpretation Fees	$0.00	$0.00	$0.00
4. See list of expenses included as Attachment, Economic Feasibility, Historical Data, Item 3	$9,949,651	$10,736,641	$11,165,112
5.			
6.			
7.			
Total Other Expenses	$ 14,134,506	$ 15,088,684	$ 15,088,684

□ Total Facility
X Project Only

HISTORICAL DATA CHART-OTHER EXPENSES
SRMC Geropsychiatric Unit @14 Beds

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	Year 2015
1. Professional Services Contract	$ 0.00	$ 0.00	$ 0.00
2. Contract Labor	$0.00	$0.00	$0.00
3. Imaging Interpretation Fees	$0.00	$0.00	$0.00
4. Repairs & Maintenance	$720	$4,314	$3,797
5. Benefits	$1,350	$54,537	$61,388
6. Contract Services	$0.00	$1,862	$3,939
7. Utilities	$16,797	$158	$0.00
8. Travel & Professional Dues	$0.00	$134	$695
Total Other Expenses	$ 18,867	$ 61,005	$ 69,819

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Attachment Section C, Economic Feasibility-Items 3 and 4

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Projected Data Charts

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PROJECTED DATA CHART
STARR REGIONAL MEDICAL CENTER

X Total Facility
□ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 2017	Year 2018
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **ADMISSIONS**	2,496	2,411
	PATIENT DAYS	11,283	10,899
B.	Revenue from Services to Patients		
	1. Inpatient Services	$88,320,673	$92,056,621
	2. Outpatient Services	$278,144,091	$300,733,265
	3. Emergency Services	$0.00	$0.00
	4. Other Operating Revenue (Specify) Cafeteria Sales, Release of Information, Rebates, Professional Building Revenue, Grant Revenue, Vending Machine, CPR Classes	$238,610	$238,610
	Gross Operating Revenue	$366,703,374	$393,028,496
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$281,211,385	$306,254,790
	2. Provision for Charity Care	$1,379,341	$1,450,641
	3. Provisions for Bad Debt	$14,055,962	$14,924,134
	Total Deductions	$296,646,688	$322,629,565
NET OPERATING REVENUE		$70,056,686	$70,398,931
D.	Operating Expenses		
	1. Salaries and Wages		
	a. Direct Patient Care	$14,443,260	$14,377,682
	b. Non-Patient Care	$4,582,076	$4,600,784
	2. Physician's Salaries and Wages		
	3. Supplies	$8,422,391	8,496,552
	4. Rent		
	a. Paid to Affiliates	$0.00	$0.00
	b. Paid to Non-Affiliates	$384,080	$433,430
	5. Management Fees:		
	a. Paid to Affiliates	$0.00	$0.00
	b. Paid to Non-Affiliates	$3,041,395	$3,278,385
	6. Other Operating Expenses	$17,331,173	$18,097,840
	Total Operating Expenses	$ 48,204,375	$ 49,284,673
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 21,852,311	$ 21,114,258
F.	Non-Operating Expenses		
	1. Taxes	$ 3,417,494	$ 3,127,868
	2. Depreciation	$3,095,731	$3,095,731
	3. Interest	$4,988,433	$4,988,433
	4. Other Non-Operating Expenses	$360,000	$360,000
	Total Non-Operating Expenses	$ 11,861,658	$ 11,572,032
NET INCOME (LOSS)		$ 9,990,733	$ 9,542,226

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NET INCOME (LOSS)	$ 9,990,733	$ 9,542,226
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$ 0.00	$ 0.00
2. Annual Capital Expenditure	$550,000	$550,000
Total Other Deductions	$ 550,000	$ 550,000
NET BALANCE	$ 9,440,734	$ 8,992,226
DEPRECIATION	$ 3,095,731	$ 3,095,731
FREE CASH FLOW (Net Balance + Depreciation)	$ 12,536,465	$ 12,087,957

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PROJECTED DATA CHART-SRMC
GEROPSYCHIATRIC UNIT @ 18 BEDS

□ Total Facility
X Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

	Year 2018	Year 2019
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **PATIENT DAYS**	4,615	4,818
B. Revenue from Services to Patients		
1. Inpatient Services	$7,935,067	$8,439,067
2. Outpatient Services	$0.00	$0.00
3. Emergency Services	$0.00	$0.00
4. Other Operating Revenue (Specify)	$0.00	$0.00
Gross Operating Revenue	$7,935,067	$8,439,067
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$5,221,274	$5,569,784
2. Provision for Charity Care	$0.00	$0.00
3. Provisions for Bad Debt	$0.00	$0.00
Total Deductions	$5,221,274	$5,569,784
NET OPERATING REVENUE	$2,713,793	$2,869,283
D. Operating Expenses		
1. Salaries and Wages	$1,153,016	$1,203,016
a. Direct Patient Care		
b. Non-Patient Care		
2. Physician's Salaries and Wages		
3. Supplies	$29,658	$33,658
4. Rent		
a. Paid to Affiliates		
b. Paid to Non-Affiliates	$3,292	$3,292
5. Management Fees:		
a. Paid to Affiliates		
b. Paid to Non-Affiliates	$500,000	$500,000
6. Other Operating Expenses	$96,981	$92,757
Total Operating Expenses	$ 1,782,947	$ 1,832,723
E. **Earnings Before Interest, Taxes and Depreciation**	$ 930,846	$ 1,035,560
F. Non-Operating Expenses		
1. Taxes	$ 8,500	$ 8,500
2. Depreciation	$130,000	$130,000
3. Interest	$4,500	$4,500
4. Other Non-Operating Expenses	$0.00	$0.00
Total Non-Operating Expenses	$ 143,000	$ 143,000
NET INCOME (LOSS)	$ 787,846	$ 892,560

Chart Continues Onto Next Page

SUPPLEMENTAL #1
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NET INCOME (LOSS)	$ 787,846	$ 892,560
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$	$
2. Annual Capital Expenditure		
Total Other Deductions	$	$
NET BALANCE	$	$
DEPRECIATION	$	$
FREE CASH FLOW (Net Balance + Depreciation)	$	$

X Total Facility
□ Project Only

PROJECTED DATA CHART-OTHER EXPENSES
Starr Regional Medical Center

OTHER EXPENSES CATEGORIES	Year 2017	Year 2018
1. Professional Services Contract	$ 5,425,150	$ 5,418,086
2. Contract Labor	$0.00	$0.00
3. Imaging Interpretation Fees	$0.00	$0.00
4. See list of expenses included as Attachment, Economic Feasibility, Projected Data, Item 4	$11,906,023	$12,679,754
5.		
6.		
7.		
Total Other Expenses	$ 17,331,173	$ 18,097,840

□ Total Facility
X Project Only

PROJECTED DATA CHART-OTHER EXPENSES
SRMC Geropsychiatric Unit @ 18 Beds

OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1. Professional Services Contract	$	$
2. Contract Labor		
3. Imaging Interpretation Fees		
4. Marketing	$25,000	$25,000
5. Benefits	$65,000	$65,000
6. Contract Services	$2,000	$2,000
7. Repairs & Maintenance	$4,981	$757
Total Other Expenses	$ 96,981	$ 92,757

Attachment Section C, Economic Feasibility-Item 5.A

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5. A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year	Current Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	$2,453.44 /day	$2,434.14 /day	$1,719.41 /day	$1,751.57 /day	-28%
Deduction from Revenue *(Total Deductions/Utilization Data)*	$1,791.73 /day	$1,718.61 /day	$1131.37 /day	$1,156.04 /day	-3.3%
Average Net Charge *(Net Operating Revenue/Utilization Data)*	$661.71 /day	$715.53 /day	$588.04 /day	$595.53 /day	-16.8%

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response: The project will not cause an increase in charges beyond the typical annual charge adjustment. The capital investment required to implement the project is relatively small. The average net daily charge for the applicant for CY 2015 was $715.53. However, charges in this service are not particularly relevant because almost all of the unit's services will be reimbursed at rates set by Medicare.

C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: The projected average gross charges for this project are comparable to the average gross charges for the other closest geriatric psychiatric inpatient units. In CY2015, the most recent year for which JAR data is available, SRMC-Etowah's average gross charge per day was almost 9% lower than Erlanger North Hospital's (Knox County) and only 2.3% more than Parkwest Medical Center's (Hamilton County). SRMC-Etowah's average gross charge per admission was also lower than Erlanger-North's and higher than Parkwest's, primarily because SRMC-Etowah has a slightly longer average length of stay than Parkwest and a significantly lower average length of stay when compared to Erlanger-North.

2015 Comparative Gross Charges in the Service Area For Geriatric Psychiatric Inpatient Care

Provider	Admissions	Patient Days	Gross IP Charges	Avg. Gross Charge Per Day	Avg. Gross Charge Per Admission	Avg. Length of Stay
Erlanger-North (Hamilton Cnty)	233	3,407	$5,908,115	$1,734.11	$25,356.72	27.5
Parkwest (Knox Cnty)	461	4,896	$7,621,358	$1,556.65	$16,532.23	10.6
SRMC-Etowah	251	3,006	$4,788,976	$1,593.14	$19,079.59	12

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Attachment Section C, Economic Feasibility-Item 7

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Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	32.69	31.28	36.85	34.30	36.09

B. Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt/Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Response: As a geropsychiatric until focusing almost entirely on Medicare-age patients, almost all of the payor mix will consist of Medicare and managed Medicare revenues. This mix is projected to remain approximately the same in the near future.

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	$7,776,365.66	98%
TennCare/Medicaid	$79,350.67	1%
Commercial/Other Managed Care	$79,350.67	1%
Self-Pay	$0.00	0%
Charity Care	$0.00	0%
Other (Specify)_____	$0.00	0%
Total	$7,935,067	100%

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical

SUPPLEMENTAL #1

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Attachment Section C, Contribution to Orderly Development-Item 4.B

The Joint Commission Letter

The Joint Commission

March 3, 2015

Re: # 7803
CCN: #440068
Program: Hospital
Accreditation Expiration Date: January 10, 2018

Mark Nichols
CEO
Athens Regional Medical Center, LLC
PO Box 250
Athens, Tennessee 37371-0250

Dear Mr. Nichols:

This letter confirms that your January 06, 2015 - January 09, 2015 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on February 23, 2015, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of January 10, 2015.

The Joint Commission is also recommending your organization for continued Medicare certification effective January 10, 2015. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location(s):

Athens Regional Breast Center
d/b/a Starr Regional Breast Center
711 Cook Drive Suite 240, Athens, TN, 37303

Athens Regional Cardiac Rehabilitation
d/b/a Starr Regional Cardiopulmonary Rehabilitation
1031 W. Madison, Athens, TN, 37303

Athens Regional Medical Center LLC
d/b/a Starr Regional Outpatient Rehabilitation Services - Etowah
874 & 876 Highway 411 North, Suites H & I, Etowah, TN, 37331

Athens Regional Medical Center, LLC
d/b/a Starr Regional Medical Center - Athens
1114 West Madison Avenue, Athens, TN, 37371-0250

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

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January 25, 2017
4:19 pm

The Joint Commission

Athens Regional Medical Center, LLC
d/b/a Starr Regional Medical Center - Etowah
886 Highway 411 North, Etowah, TN, 37331

Athens Regional Rehabilitation Center
d/b/a Starr Regional Rehabilitation Center - Athens
425 Old Riceville Road Suite 1, Athens, TN, 37303

Athens Regional Sleep Diagnostic Center
d/b/a Starr Regional Sleep Diagnostic Center - Athens
719 Cook Drive , Suite 113, Athens, TN, 37303

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

SUPPLEMENTAL #1

January 25, 2017
4:19 pm

Attachment, Project Completion Forecast Chart

Revised Page 54

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		4/17
2. Architectural and engineering contract signed	2	4/17
3. Construction documents approved by the Tennessee Department of Health	150	9/17
4. Construction contract signed	30	10/17
5. Building permit secured	7	10/17
6. Site preparation completed	0	
7. Building construction commenced	1	10/17
8. Construction 40% complete	48	12/17
9. Construction 80% complete	48	2/18
10. Construction 100% complete (approved for occupancy	24	3/18
11. *Issuance of License	N/A	
12. *Issuance of Service	N/A	
13. Final Architectural Certification of Payment	45	4/18
14. Final Project Report Form submitted (Form HR0055)	300	2/19

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

SUPPLEMENTAL #1
January 25, 2017
4:19 pm

JAN 25 '17 PM

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: STARR REGIONAL MEDICAL CENTER (ETOWAH CAMPUS) CN1701-002

I, KIM H. LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Kim H. Looney

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 25th day of January, 2017, witness my hand at office in the County of Davidson, State of Tennessee.

Laurie A. Glass

NOTARY PUBLIC

My commission expires: January 8, 2019

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON
MY COMMISSION EXPIRES:
JANUARY 8, 2019

HF-0043

Revised 7/02

4819-5278-7008.1

Supplemental #2

-Original-

Starr Regional Medical Center

CN1701-002

waller

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
P.O. Box 198966
Nashville, TN 37219-8966

615.244.6380 main
615.244.6804 fax
wallerlaw.com

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

SUPPLEMENTAL #2

January 30, 2017
1:58 pm

January 30, 2017

VIA HAND DELIVERY

Phillip M. Earhart
HSDA Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Starr Regional Medical Center (Etowah Campus)
Certificate of Need Application CN1701-002
Second Supplemental Request

Dear Phillip:

This letter is submitted as the supplemental response to your letter dated January 30, 2017, wherein additional information or clarification was requested regarding the above-referenced CON application.

---

1. **Section A., Project Details, Name of Management/Operating Entity**

   The management agreement in Attachment Section A-5 is noted. The CON application requests a current management agreement or draft management agreement that at least includes the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. It appears the effective date and term of the agreement and fee schedule is contained in Exhibit B of the Management Agreement. Please provide Exhibit B of the agreement.

   If the effective date and anticipated term of the agreement, and the anticipated management fee payment methodology and schedule is not located in Exhibit B of the management agreement, please note where the items are located in the submitted management agreement.

   Response: The Effective Date is on the first page of the services agreement and is September 1, 2016. The term is contained in Section 5 and states that the initial term is three years from the Effective Date. Please see Exhibit B of the Management Agreement included as Attachment Section A, Project Details, Name of Management/Operating Entity.

2. **Section B, Need, Item l.a. (Psychiatric Inpatient Services-Service Specific Criteria-) Item 1 Determination of Need**

   The table to determine psychiatric bed need is noted. However, the current adult 65+ psychiatric bed need calculates to 14.24 beds not 15 as reflected in the supplemental response. Please clarify.

waller

Response: Because it is not possible to implement a partial bed, and the need is greater than 14 beds, the appropriate number of beds is 15 in this situation.

Historical Data Chart

The Historical Data Chart for the total facility is noted. However, the Earnings Before Interest, Taxes, and Depreciation totaling $19,586,523 for 2014 is incorrect. Please revise and submit revised Historical Data Chart.

Response: While the Earnings Before Interest, Taxes and Depreciation for 2014 is correct, there is a number transposed for 2015 and the correct number should be $19,586,253. Please see revised Page 32, Historical Data Chart, included as Attachment Section B, Need, Item 1(a).

Projected Data Chart

Then Projected Data Chart for the total facility is noted. However, the net income of $9,990,733 for Year 2017 appears incorrect. Please correct and submit a revised Projected Data Chart.

Response: The net income of $9,970,733 appears to be correct.

3. **Section C, Economic Feasibility, Item 5.A. and 5.B.**

The table identifying the project's average gross charge, average deduction from operating revenue, and average net charge is noted. However, the Previous Year Average net Charge of $661.71/day appears incorrect. The amount appears to calculate to $685.79 per day. Please correct and submit a replacement page 41.

Response: It would appear that the number of $661.71 is correct, based on $7,132,160 in gross charges, $5,208,562 in deduction from revenue, and 2,907 patients.

Please contact me if you have any questions or need additional information.

Sincerely,

Kim Harvey Looney

KHL:lag
Enclosures

4851-3452-0129.3

SUPPLEMENTAL #2

January 30, 2017
1:58 pm

Attachment Section A, Project Details, Name of Management/Operating Entity

Exhibit B to Management Agreement

EXHIBIT B
FEES

1. Management Fee. Commencing on the Effective Date, Hospital shall pay Contractor on a monthly basis, a management fee for its services equal to Sixteen Thousand Seven Hundred Forty Three Dollars and Eighty-Nine Cents ($16,743.89) per month. (the "Monthly Management Fee").

2. Continuous Quality Improvement (CQI+SM) Clinical Outcomes Measurement Fee -- The CQI+ training and completion for the CQI+ geropsychiatric module (the "CQI+ Fee") is included in the management fees currently paid to Horizon by Hospital. Accordingly Horizon shall not separately invoice the Hospital for such amounts.

3. Pass-Through Expenses. Beginning on the Effective Date, and for the Term of this Agreement thereafter, in addition to the Monthly Management Fee which shall commence on the Effective Date, the Hospital shall pay to Contractor each month the salary and benefits costs, benefits costs to be calculated at twenty-two percent (22%) of salary (the "Pass-Through Expense") of the active Program Staff listed in Exhibit A. Salary shall include all wages paid to the Program Staff including wages for holidays, sick days, and vacation, provided, however that Hospital shall not be responsible for any of Contractor's costs with respect to Program Staff medical leaves of absence ("LOA") or for any increased costs incurred by Contractor in filling positions on a temporary basis during any Program Staff LOA. Any salary increases or raises of pass-through salaries must be approved in advance by Hospital. In addition, Hospital shall pay to Contractor each month an amount equal to any Hospital approved Medical Director Stipend, The Medical Director stipend and all Program Staff salaries shall be agreed to in advance and in writing by Hospital and Contractor. . Additionally, Hospital agrees that it shall reimburse Contractor for any Hospital approved and necessary expenses related to the travel of any candidates for the purpose of interviewing at the Hospital for the positions listed in Exhibit A. Notwithstanding the aforementioned, the Hospital shall not reimburse Contractor for any pass-through expenses related to vacant staff positions, as defined on Exhibit A.

4. Quality Withholds and Payments. At the beginning of each Term, Contractor's monthly fee shall be prorated in the amount of five percent (5%) per month (the "Quality Withhold"). Hospital and Contractor shall meet within sixty (60) days after the end of each contract year to review the Quality Scorecard results assessed in accordance with Exhibit C to determine which portion, if any, of the Quality Withholds are due and owing to Contractor based upon achievement of the Scorecard results.

SERVICES AGREEMENT

THIS SERVICES AGREEMENT (the "Agreement") is made this 1st day of September, 2016, (the "Effective Date") by and between Horizon Health Behavioral Health Services ("Contractor"), and Athens Regional Medical Center, LLC d/b/a Starr Regional Medical Center Etowah formerly known as Woods Memorial Hospital, LLC, an acute care hospital (the "Hospital").

RECITALS

WHEREAS, Hospital is a general hospital located in Etowah, Tennessee and desires to operate a 10 bed geropsychiatric inpatient service (the "Program") in order to fully utilize Hospital's facilities and provide additional services to the community it serves;

WHEREAS, Contractor is in the business of developing systems, procedures and programs necessary for the operation of psychiatric programs by general hospitals, and Contractor has the expertise necessary for the management and operation of the Program;

WHEREAS, the parties desire to enter into an agreement whereby Contractor will manage the Program for the Hospital.

NOW, THEREFORE, in consideration of the mutual covenants herein contained, and for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto, for themselves, their heirs, successors and assigns, agree as follows:

1. OBLIGATIONS OF CONTRACTOR.

1.1. Management Services. Beginning on the Effective Date, Hospital hereby engages Contractor, and Contractor hereby accepts such engagement, to provide day-to-day management services to and for the Program, pursuant to the following terms and conditions (the "Services"):

(a) During the Term of this Agreement, the Contractor shall be responsible for the day-to-day operations of the Program through its on-site Director, Behavioral Health, provided however, that the Program shall remain all times subject to the ultimate control of the Hospital;

(b) Provide the Hospital's senior management staff with consultation relative to strategic matters associated with the operation of the Program;

(c) Provide personnel as needed for the Program and as further described in Exhibit A (the "Program Staff"), attached hereto and incorporated herein by reference. The Director, Behavioral Health shall function as a departmental head and shall report to Hospital management as such. Contractor shall consult with Hospital in the selection of its Director, Behavioral Health or shall not continue to employ the Director, Behavioral Health or any other Program Staff to whom Hospital reasonably objects. Hospital shall provide Contractor written notice of any Program Staff to which it reasonably objects and Contractor shall have thirty (30) days from the date of such notice to correct the Program Staff job performance deficiencies. In the event that the Hospital still desires that the Program Staff be removed from the Program after such thirty (30) day period, Contractor agrees to remove such employee(s) within fifteen (15) days of such notice. The Program Staff shall be compensated by Contractor and shall be responsible to the Director, Behavioral Health, provided, however, that the Program Staff shall at all times be subject to the Hospital's policies and procedures for its own employees. Contractor shall have the right to terminate the employment of Program Staff and to hire such additional Program Staff

pursuant to this Agreement shall be made in exchange for any referral, directly or indirectly, of any patients to the Hospital.

4. REPRESENTATIONS AND WARRANTIES.

4.1. No Federal Healthcare Exclusion. Each party represents and warrants to the other party that any personnel employed by or otherwise under contract or agreement to provide services to or on behalf of such party are not currently excluded, debarred or otherwise ineligible to participate in any federal healthcare program, as defined in 42 U.S.C. Section 1320a-7b(f), that such party has no knowledge of any basis for such exclusion exists, and that such party has not been subject to any final adverse action as defined under the Health Care Fraud and Abuse Data Collection Program. Each party agrees to notify the other party immediately if the notifying party receives notice or otherwise becomes aware that it is subject to any sanction described in this Section 4.1.

5. TERM AND TERMINATION.

5.1. Term. This Agreement shall commence on the Effective Date and continue for an initial term of three (3) years from the Effective Date unless terminated earlier pursuant to this Agreement (the "Initial Term"). Hospital shall be responsible for the Pass-Through Expenses as contained in Exhibit B. This Agreement will automatically renew for successive twelve (12) month periods after the expiration of the Initial Term (an "Extended Term"), provided, however, that any Extended Term may be terminated upon (a) the full execution of a new agreement between the parties covering the same services; or (b) not less than ninety (90) days prior written notice of termination by either party to the other party during the Extended Term. As used herein, "Term" shall mean the Initial Term and any Extended Term.

5.2. Termination Without Cause. Either party may, following the end of the thirtieth (30th) month following the Effective Date, terminate this Agreement without cause by providing ninety (90) days' prior written notice stating the intended date of termination.

5.3. Termination for Breach. Either party may terminate this Agreement immediately, after providing sixty (60) days' prior written notice to the other party of a material breach of any term or condition of this Agreement specifying with particularity the material term, condition or covenant which has not been performed or has been breached by the other party, provided that the breach is not cured within the sixty (60) day notice period. If the breaching party is unable to cure such breach within the sixty (60) day notice period and has undertaken good faith efforts to cure the breach within a reasonable period of time, the non-breaching party may consent in its sole discretion to a reasonable extension of the cure period.

5.4. Immediate Termination. Notwithstanding any other provision of this Agreement, either party may terminate this Agreement immediately in the event that the other party fails to maintain the insurance coverages required by this Agreement or the other party's representation in Section 4.1 becomes untrue. This Agreement may be terminated immediately, upon the filing, by either party, of a voluntary petition of bankruptcy, or if either party makes an assignment for the benefit of creditors or otherwise seeks relief from creditors under any federal or state bankruptcy, insolvency, reorganization or moratorium statute.

5.5. Immediate Termination by Hospital. Notwithstanding any other provision of this Agreement, Hospital may terminate this Agreement immediately (i) in the event the Hospital closes for any reason, (ii) for units paid by Medicare as an exempt psychiatric unit, upon the loss of distinct part unit designation of the Program from CMS for any reason, provided, however, that should this Agreement

SUPPLEMENTAL #2

January 30, 2017
1:58 pm

Attachment Section C, Economic Feasibility-Items 1(a)

Revised Historical Data Chart

SUPPLEMENTAL #2

HISTORICAL DATA CHART- STARR REGIONAL MEDICAL CENTER

January 30, 2017 1:58 pm

X Total Facility
□ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

		Year 2013	Year 2014	Year 2015
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) ADMISSIONS	3,533	2,808	2,686
	PATIENT DAYS	14,703	12,131	11,398
B.	Revenue from Services to Patients			
	1. Inpatient Services	**$ 78,837,543**	**$ 74,172,151**	**$ 75,783,128**
	2. Outpatient Services	$180,271,920	$195,786,116	$222,745,419
	3. Emergency Services	$0.00	$0.00	$0.00
	4. Other Operating Revenue (Specify) Cafeteria Sales, Release of Information, Rebates, Professional Building Revenue, Grant Revenue, Vending Machine, CPR Classes	$327,086	$272,909	$289,958
	Gross Operating Revenue	**$ 259,436,549**	**$ 270,231,176**	**$ 298,818,505**
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	**$ 180,541,186**	**$ 191,327,718**	**$ 217,323,967**
	2. Provision for Charity Care	$1,385,332	$701,738	$823,163
	3. Provisions for Bad Debt	$14,838,336	$15,367,283	$14,887,942
	Total Deductions	**$ 196,764,854**	**$ 207,396,739**	**$ 233,035,072**
NET OPERATING REVENUE		**$ 62,671,695**	**$ 62,834,437**	**$ 65,783,433**
D.	Operating Expenses			
	1. Salaries and Wages			
	a. Direct Patient Care	$17,375,100	$14,467,833	$14,795,794
	b. Non-Patient Care	$5,019,173	$4,534,492	$3,918,939
	2. Physician's Salaries and Wages			
	3. Supplies	$8,509,847	$6,918,878	$7,269,008
	4. Rent			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates	$286,752	$324,238	$302,882
	5. Management Fees:			
	a. Paid to Affiliates	$2,851,344	$2,946,272	$3,546,426
	b. Paid to Non-Affiliates	$532,937	$0.00	$0.00
	6. Other Operating Expenses	$14,134,506	$ 15,088,684	$16,364,131
	Total Operating Expenses	**$ 48,709,659**	**$ 44,280,397**	**$ 46,197,180**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$ 13,962,036**	**$ 18,554,040**	**$ 19,586,253**
F.	Non-Operating Expenses			
	1. Taxes	**$ 4,393,462**	**$ 4,117,888**	**$ 4,063,923**
	2. Depreciation	$4,087,664	$3,510,918	$3,462,903
	3. Interest	$4,610,371	$4,997,892	$5,377,036
	4. Other Non-Operating Expenses	$360,000	$360,000	$360,000
	Total Non-Operating Expenses	**$13,451,497**	**$12,966,698**	**$13,263,862**
NET INCOME (LOSS)		**$510,539**	**$5,587,342**	**$6,322,390**

Chart Continues Onto Next Page

SUPPLEMENTAL #2
January 30, 2017
1:58 pm

JAN 30 '17 PM 1:58

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: STARR REGIONAL MEDICAL CENTER (ETOWAH CAMPUS) CN1701-002

I, KIM H. LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Kim H. Looney

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 30th day of January, 2017, witness my hand at office in the County of Davidson, State of Tennessee.

Laurie A. Glass

NOTARY PUBLIC

My commission expires: January 8, 2019

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON

MY COMMISSION EXPIRES:
JANUARY 8, 2019

HF-0043

Revised 7/02

4819-5278-7008.2

Supplemental- #3
-Original-

STARR REGIONAL MEDICAL CENTER

CN1701-002

waller

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
P.O. Box 198966
Nashville, TN 37219-8966

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

615.244.6380 main
615.244.6804 fax
wallerlaw.com

SUPPLEMENTAL #3
January 31, 2017
1:42 pm
JAN 31 '17 1:42

January 31, 2017

VIA HAND DELIVERY

Phillip M. Earhart
HSDA Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Starr Regional Medical Center (Etowah Campus)
Certificate of Need Application CN1701-002
Third Supplemental Request

Dear Phillip:

This letter is submitted as the supplemental response to your request today, wherein additional information or clarification was requested regarding the above-referenced CON application.

---

1. **Section B, Need, Item l.a. (Psychiatric Inpatient Services-Service Specific Criteria-) Item 1 Determination of Need**

   Projected Data Chart

   The Projected Data Chart for the total facility is noted. However, the net income of $9,990,733 for Year 2017 appears incorrect. Please correct and submit a revised Projected Data Chart.

   Response: The net income for Year 2017 should be properly reflected as $9,990,653. Please see attached revised pages 37 and 38, included as Attachment Section B, Need-Item 1.a, correcting the Net Income (Loss) category and the subsequent Net Balance and Free Cash Flow.

Please contact me if you have any questions or need additional information.

Sincerely,

Kim Harvey Looney

KHL:lag
Enclosures

4815-0612-7937.3

SUPPLEMENTAL #3
January 31, 2017
1:42 pm

Attachment Section B, Need-Item 1.a

Revised Pages 37 and 38

Projected Data Chart
Starr Regional Medical Center

SUPPLEMENTAL #3

January 31, 2017
1:42 pm

JAN 31 PM 1:42

PROJECTED DATA CHART
STARR REGIONAL MEDICAL CENTER

X Total Facility
□ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 2017	Year 2018
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **ADMISSIONS**	2,496	2,411
	PATIENT DAYS	11,283	10,899
B.	Revenue from Services to Patients		
	1. Inpatient Services	$88,320,673	$92,056,621
	2. Outpatient Services	$278,144,091	$300,733,265
	3. Emergency Services	$0.00	$0.00
	4. Other Operating Revenue (Specify) Cafeteria Sales, Release of Information, Rebates, Professional Building Revenue, Grant Revenue, Vending Machine, CPR Classes	$238,610	$238,610
	Gross Operating Revenue	$366,703,374	$393,028,496
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$281,211,385	$306,254,790
	2. Provision for Charity Care	$1,379,341	$1,450,641
	3. Provisions for Bad Debt	$14,055,962	$14,924,134
	Total Deductions	$296,646,688	$322,629,565
NET OPERATING REVENUE		$70,056,686	$70,398,931
D.	Operating Expenses		
	1. Salaries and Wages		
	a. Direct Patient Care	$14,443,260	$14,377,682
	b. Non-Patient Care	$4,582,076	$4,600,784
	2. Physician's Salaries and Wages		
	3. Supplies	$8,422,391	8,496,552
	4. Rent		
	a. Paid to Affiliates	$0.00	$0.00
	b. Paid to Non-Affiliates	$384,080	$433,430
	5. Management Fees:		
	a. Paid to Affiliates	$0.00	$0.00
	b. Paid to Non-Affiliates	$3,041,395	$3,278,385
	6. Other Operating Expenses	$17,331,173	$18,097,840
	Total Operating Expenses	$ 48,204,375	$ 49,284,673
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 21,852,311	$ 21,114,258
F.	Non-Operating Expenses		
	1. Taxes	$ 3,417,494	$ 3,127,868
	2. Depreciation	$3,095,731	$3,095,731
	3. Interest	$4,988,433	$4,988,433
	4. Other Non-Operating Expenses	$360,000	$360,000
	Total Non-Operating Expenses	$ 11,861,658	$ 11,572,032
NET INCOME (LOSS)		$ 9,990,653	$ 9,542,226

Chart Continues Onto Next Page

SUPPLEMENTAL #3

January 31, 2017

1:42 pm

NET INCOME (LOSS)	$ 9,990,653	$ 9,542,226
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$ 0.00	$ 0.00
2. Annual Capital Expenditure	$550,000	$550,000
Total Other Deductions	$ 550,000	$ 550,000
NET BALANCE	$ 9,440,653	$ 8,992,226
DEPRECIATION	$ 3,095,731	$ 3,095,731
FREE CASH FLOW (Net Balance + Depreciation)	$ 12,536,384	$ 12,087,957

X Total Facility
□ Project Only

PROJECTED DATA CHART-OTHER EXPENSES
Starr Regional Medical Center

OTHER EXPENSES CATEGORIES	Year 2017	Year 2018
1. Professional Services Contract	**$ 5,425,150**	**$ 5,418,086**
2. Contract Labor	$0.00	$0.00
3. Imaging Interpretation Fees	$0.00	$0.00
4. See list of expenses included as Attachment, Economic Feasibility, Projected Data, Item 4	$11,906,023	$12,679,754
5.		
6.		
7.		
Total Other Expenses	**$ 17,331,173**	**$ 18,097,840**

SUPPLEMENTAL #3
January 31, 2017
1:42 pm

JAN 31 '17 PM 1:42

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: STARR REGIONAL MEDICAL CENTER (ETOWAH CAMPUS) CN1701-002

I, KIM H. LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Kim H. Looney

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 31ST day of January, 2017, witness my hand at office in the County of Davidson, State of Tennessee.

Laurie A. Glass

NOTARY PUBLIC

My commission expires: January 8, 2019

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON

MY COMMISSION EXPIRES:
JANUARY 8, 2019

HF-0043

Revised 7/02

4819-5278-7008.3