ANNUAL REPORT

OF

LIFEPOINT HEALTH, INC.

FOR THE

FISCAL YEAR ENDED DECEMBER 31, 2018

PREPARED IN ACCORDANCE WITH

ANNUAL REPORT ON FORM 10-K
(AS MODIFIED UNDER DEBT AGREEMENTS)

LifePoint Health, Inc.
(Exact Name of Company as Specified in Its Charter)

RegionalCare Hospital Partners Holdings, Inc.
(Former Name of Company)

Delaware	**27-0500485**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**
330 Seven Springs Way Brentwood, Tennessee	**37027**
(Address of Principal Executive Offices)	**(Zip Code)**

(615) 920-7000
(Company's Telephone Number, Including Area Code)

103 Continental Place, Suite 200, Brentwood, Tennessee 37027
(Former Address of Company)

At March 28, 2019, there were 100 outstanding shares of common stock of LifePoint Health, Inc.

LifePoint Health, Inc.

Annual Report

For the fiscal year ended December 31, 2018

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DISCLOSURE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report for the fiscal year ended December 31, 2018 (this "***Report***") contains forward-looking statements that involve risks and uncertainties. Forward-looking statements include any statements that address future results or occurrences. In some cases you can identify forward-looking statements by terminology such as "may," "might," "will," "would," "should," "could" or the negatives thereof. Generally, the words "anticipate," "believe," "continue," "expect," "intend," "estimate," "project," "plan" and similar expressions identify forward-looking statements. In particular, statements about our expectations, beliefs, plans, objectives, assumptions or future events or performance contained elsewhere in this Report are forward-looking statements. These forward-looking statements include statements that are not historical facts, including statements concerning our possible or assumed future actions and business strategies. We have based these forward-looking statements on our current expectations, assumptions, estimates and projections. While we believe these expectations, assumptions, estimates and projections are reasonable, such forward-looking statements are only predictions and involve known and unknown risks, uncertainties and other factors, many of which are outside of our control, which could cause our actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. Such forward-looking statements involve known and unknown risks, uncertainties and other factors that may cause actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. Such factors include, among others, the following:

- the significant costs and substantial indebtedness that were incurred in connection with the closing of the LifePoint/RCCH Merger (as defined herein) and the integration of the businesses of Legacy LifePoint (as defined herein) and RCCH (as defined herein);
- payment changes, including policy considerations and changes resulting from federal and state budgetary restrictions;
- impact from or likelihood of the repeal, replacement or material modification to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "***Affordable Care Act***"), as a result of legislative or court action;
- potential impact from the repeal of the "individual mandate" to purchase health insurance under the Affordable Care Act, included in the Tax Cuts and Jobs Act of 2017 (the "***Tax Act***");
- impact from changes to Medicaid supplemental payment programs;
- our compliance with new and existing laws and regulations as well as costs and benefits associated with compliance;
- any potential action brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the "qui tam" or "whistleblower" provisions of the federal False Claims Act (the "***False Claims Act***");
- impact from the changes in payer mix marked by a shift of patients from private insurance to Medicare and Medicaid programs;
- our acquisition strategy, including integration risks relating to recent historical acquisitions and integration risks relating to future acquisitions that are in addition to those associated with the LifePoint/RCCH Merger;
- the potential material obligations if we acquire facilities with unknown or contingent liabilities;
- claims and legal actions relating to professional liabilities and other litigation risks;
- delayed payments and repayments resulting from reviews of claims to Medicare and Medicaid for our services;
- impact of controls imposed by payers designed to reduce inpatient services;
- our relationships with our joint venture partners, including our Duke LifePoint Healthcare joint venture with Duke University Health System;
- changes in physician employment regulations;
- increases in the amount and risk of collectability of patient accounts receivable;
- our need to make investments continually in our processes and information systems to protect the privacy of patients, employees and other persons and reduce the risk of successful cybersecurity attacks;
- damage to our reputation, regulatory penalties, legal claims and liability under state and federal laws that we could suffer upon any cybersecurity or privacy breaches;
- effects of competition in a facility's market;
- effects of union organizing activities;
- potential recoupment of previously recognized income from electronic health record ("***EHR***") incentive programs;
- anticipated capital expenditures, including routing projects, investments in information systems and capital projects related to acquisitions, construction of new facilities and construction projects and the expectation that capital commitments could be a component of future acquisitions;
- timeframes for completion of capital projects;
- changes in depreciation and amortization expenses;
- costs of providing care to our patients;
- implementation of supply chain management and revenue cycle functions;

- accounting estimates and the impact of accounting methodologies and new accounting pronouncements;
- changes in industry and general economic trends;
- consolidation of commercial insurance companies and patient shifts to lower cost healthcare plans, including association health plans and short term limited duration health insurance plans, which generally provide lower payment for services provided;
- participation in the healthcare exchanges and the impact of increasing enrollment by patients in insurance plans with narrow networks, tiered networks, high deductibles or high co-payments;
- uncertainty of patient volumes and related revenues;
- governmental or third-party investigations, legal actions and voluntary self-disclosures relating to overpayments or other regulatory compliance matters;
- recruitment and retention of senior executives, providers and other healthcare employees;
- our ability to acquire facilities on favorable terms and successfully complete asset sales and divestitures;
- the ability of our local management teams to identify and meet the needs of our patients, medical staffs and their communicates;
- the efforts of insurers, healthcare providers and others to contain healthcare costs;
- our ability to obtain adequate levels of general and professional liability insurance;
- our ability to implement initiatives promoting cost reductions and operational efficiencies;
- possible future indebtedness that may be incurred; and
- other factors referenced under the caption "Risk Factors" contained in this Report.

Given these uncertainties, readers are cautioned not to place undue reliance on such forward-looking statements. We disclaim any obligation to update any such factors or to announce the result of any revisions to any of the forward-looking statements contained herein to reflect future results, events or developments.

Statements in this Report are made as of the date hereof. New factors emerge from time to time that could cause our actual results to differ, and it is not possible to predict all such factors.

EXPLANATORY INFORMATION REGARDING THIS REPORT

This Report has been prepared in accordance with the obligations of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.) (the "***Company***") under (i) Section 4.02 of the Indenture, dated as of April 29, 2016 (the "***8.25% Secured Notes Indenture***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 8.25% Secured Notes due 2023 (the "***8.25% Secured Notes***"), (ii) Section 4.02 of the Indenture, dated April 29, 2016 (the "***11.5% Unsecured Notes Indenture***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 11.5% Unsecured Notes due 2024 (the "***11.5% Unsecured Notes***"), (iii) Section 4.02 of the Indenture, dated November 16, 2018 (the "***9.75% Unsecured Notes Indenture***" and, together with the 8.25% Secured Notes Indenture and the 11.5% Unsecured Notes Indenture, the "***Indentures***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 9.75% Unsecured Notes due 2026 (the "***9.75% Unsecured Notes***" and, together with the 8.25% Secured Notes and the 11.5% Unsecured Notes, the "***Notes***"), (iv) Section 5.04 of the Asset-Based Revolving Credit Agreement, dated as of November 16, 2018 (the "***ABL Agreement***"), among the Company, as Lead Borrower, DSB Acquisition, LLC, a Delaware limited liability company ("***Holdings***"), the lenders party thereto from time to time and Citibank, N.A., as administrative agent and collateral agent, and (v) Section 5.04 of the First Lien Credit Agreement, dated as of November 16, 2018 (the "***Term Loan Agreement***" and, together with the ABL Agreement, the "***Credit Agreements***"), among the Company, as Lead Borrower, Holdings, the lenders party thereto and Citibank, N.A., as administrative agent and collateral agent. This Report has been prepared in all material respects in accordance with the rules and regulations of the Securities and Exchange Commission (the "***SEC***") applicable to an Annual Report on Form 10-K for the fiscal year ended December 31, 2018, except to the extent permitted to be excluded by the Indentures and the Credit Agreements.

USE OF NON-GAAP FINANCIAL INFORMATION

In this Report, we have provided EBITDA and Adjusted EBITDA (collectively, the "***Non-GAAP Measures***") because we believe they provide the Holders with additional information to measure our performance and evaluate our ability to service our indebtedness. We believe that the presentation of Non-GAAP Measures is appropriate to provide additional information to the Holders about certain material non-cash items and about unusual items that we do not expect to continue or to continue at the same level in the future as well as other items. Further, we believe the Non-GAAP Measures provide a meaningful measure of operating profitability because we use them for evaluating our business performance and understanding certain significant items.

The Non-GAAP Measures are not presentations made in accordance with United States ("***U.S.***") generally accepted accounting principles ("***GAAP***"), and our use of these terms may vary from others in our industry. EBITDA and Adjusted EBITDA should not be considered as alternatives to operating income or any other performance measures derived in accordance with GAAP as measures of operating performance or cash flows as measures of liquidity. EBITDA and Adjusted EBITDA have important limitations as analytical tools, and you should not consider them in isolation or as substitutes for analysis of our results as reported under GAAP. Because of these limitations, we rely primarily on our GAAP results and use EBITDA and Adjusted EBITDA only as a supplement. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" for a description of the calculation and limitations of these measures.

DOCUMENT SUMMARIES AND REQUESTS

This Report contains summaries believed to be accurate with respect to certain documents, but reference is made to the actual documents for complete information. All such summaries, which do not purport to be complete, are qualified in their entirety by such reference. Copies of the documents referred to herein will be made available without cost to Holders of the Notes by making a written or oral request to us. Any such request may be made to us at the following address and telephone number:

LifePoint Health, Inc.
330 Seven Springs Way
Brentwood, Tennessee 37027
Attn: General Counsel
Tel. (615) 920-7000

FISCAL YEAR

All references to "fiscal year" are to the twelve months ended December 31 of the year referenced.

OTHER ITEMS

This Report is prepared by LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.), a Delaware corporation, which, along with each of its consolidated subsidiaries, is referred to herein as the "***Company***," "***LifePoint***," "***we***," "***our***," "***us***," and, before giving effect to the LifePoint/RCCH Merger (as defined below), "***RCCH***," in each case, unless the context otherwise requires.

References in this Report to the "***LifePoint/RCCH Merger***" refer to the merger, which was effective on November 16, 2018, of Legend Merger Sub, Inc., a Delaware corporation and wholly-owned subsidiary of RCCH ("***Legend Merger Sub***"), with and into LifePoint Health, Inc., a Delaware corporation ("***Legacy LifePoint***"), with Legacy LifePoint surviving the LifePoint/RCCH Merger as a subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc."

References in this Report to the "***RegionalCare/Capella Merger***" refer to the merger of Crimson Merger Sub, LLC ("***Crimson Merger Sub***"), a Delaware limited liability company and wholly-owned subsidiary of RegionalCare Hospital Partners Inc. ("***Regional Care***"), with and into Capella Health Holdings, LLC ("***Capella***"), with Capella surviving the RegionalCare/Capella Merger as a wholly-owned subsidiary of RegionalCare, which began to do business as RCCH HealthCare Partners. The RegionalCare/Capella Merger was consummated on April 29, 2016; however, for accounting purposes, the RegionalCare/Capella Merger became effective on May 1, 2016.

References in this Report to the "***Apollo/RegionalCare Acquisition***" refer to the merger, which was effective on December 3, 2015, of DSB Merger Sub Inc., a Delaware corporation and wholly-owned subsidiary of Holdings, with and into RegionalCare with RegionalCare surviving such merger as a direct wholly-owned subsidiary of Holdings, which is indirectly controlled by our Sponsor.

References in this Report to the "***Sponsor***" refer to certain funds that are affiliates of the Company (the "***Apollo Funds***") that are ultimately controlled and/or managed by Apollo Management VIII, L.P. ("***Apollo Management***" and, when acting on behalf of the Apollo Funds, "***Apollo***"), which is an affiliate of Apollo Global Management LLC.

PART I

Item 1. *Business*.

Our Company

We own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. As of December 31, 2018, we operated 89 hospital campuses in 30 states throughout the U.S., having a total of 11,876 licensed beds. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a network of hospitals and outpatient facilities.

We seek to fulfill our mission of Making Communities Healthier® by (1) delivering high quality patient care, (2) supporting our physicians, (3) creating excellent workplaces for our employees, (4) taking a leadership role in our communities and (5) ensuring fiscal responsibility. We strive to create places where people choose to come for healthcare, physicians want to practice and employees want to work.

Our Business Strategy

The key elements of our business strategy include:

- *Continue to Grow in Existing Markets by Expanding Services and Access Points to Care*. We regularly conduct in-depth strategic reviews of the major service lines offered at each of our facilities and evaluate additional services through which we could profitably grow in our markets and better serve our communities. We leverage our local market knowledge together with input and guidance from our local physician and community leaders to prioritize the healthcare services our communities are seeking. Focus areas include expansion of specialty service lines to meet unserved patient needs, expansion of access points to care, including outpatient, ancillary and retail health services, and investment in technology and equipment. We invest strategically in our markets in order to increase the quality and scope of services we provide, meet the needs of our communities and maintain our strong reputation as the healthcare provider of choice. This in turn helps us to continue recruiting physicians and growing the revenue and profitability of our facilities.

- *Continue to Recruit and Retain Leading Physicians*. Our physician engagement strategies drive our ability to enhance and expand our services to meet the healthcare needs of our communities. We have a comprehensive recruiting program that is directed by an experienced corporate department and is supported at the local level by our hospital system chief executive officers ("***CEOs***") and Boards of Trustees. We supplement our local teams with experienced corporate office specialists and several third party recruiting firms to assist us in identifying candidates that match the profile of our physician needs. We maintain a flexible approach to aligning our goals with our physician partners, including our willingness to recruit physicians through multi-year employment and/or income guarantee arrangements. In addition, we believe our physicians are attracted to our facilities because of several factors, including our commitment to quality care, our focus on employing and developing high quality nurses and support staff and our integration into, and support of, the communities we serve.

- *Routinely Optimize Our Portfolio to Strengthen Our Position in Existing Markets and Expand into New Markets*. We evaluate and selectively pursue acquisitions of hospitals, outpatient and ancillary clinics and other healthcare facilities in new and existing markets, with the goal of improving our operating performance and better meeting the healthcare needs of our communities. We employ a rigorous and disciplined approach to new market acquisitions and focus on a range of criteria, including expected financial returns and strategic benefits, to evaluate a target's suitability and fit within our portfolio. We seek to operate health systems that are, or have the potential to become, market leaders in non-urban communities with favorable demographic trends. We often acquire underperforming and/or undermanaged facilities where we can drive operating efficiencies in order to realize significant upside potential following an acquisition to generate attractive effective purchase multiples and strong returns on our investment. The recent market trend toward health system consolidation, particularly among underperforming not-for-profit hospital operators without the scale and/or operating discipline to compete, has benefited us and we believe will continue to support our acquisition strategy. Furthermore, we routinely evaluate our existing portfolio to assess whether we are meeting our strategic and financial objectives in our markets. We evaluate and may seek to opportunistically divest assets that do not meet our strategic and/or financial objectives and which may deliver more value to our stakeholders through a sale.

- *Commitment to the Delivery of Exceptional Quality Patient Care*. We believe providing high quality patient care is critical to attracting patients, physicians and employees to our facilities. In addition, providing high quality patient care is increasingly vital to achieving our operating and financial success, including receiving full payment from governmental and commercial payers. We believe several factors contribute to providing high quality patient care, including instilling leadership and accountability at all levels of our organization, aligning ourselves with quality physicians and medical staff, and providing a clinical environment that is satisfactory to our patients, physicians and employees. Furthermore, we strive continually to improve physician and employee satisfaction, which we believe is critical to delivering quality patient care. In addition, we also seek to partner with academic medical centers and regionally significant health systems to better serve our communities and to ensure we are delivering high quality care.

- *Continue to Engage in Strategic Relationships with Local Partners*. We partner with several academic medical centers and regionally significant health systems to better serve our communities. We have established partnerships with Duke University Health System ("***Duke***"), Norton Healthcare, Inc. ("***Norton***"), LHC Group, Inc. ("***LHC***"), University of Washington Health, the University of Alabama at Birmingham, and Billings Clinic. We formed Duke LifePoint Healthcare, a joint venture between us and a wholly-controlled affiliate of Duke, with a mission to own and operate community hospitals and other facilities 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 facilities. Since its formation in 2011 through December 31, 2018, we have completed the acquisition of 14 acute care hospitals and ancillary facilities through Duke LifePoint Healthcare.

- *Continue to Focus on Cost Reduction and Operational Efficiency*. We strive to improve our operating performance by making our revenue cycle processes more efficient, making an even higher level of purchases through our group purchasing organization, operating more efficiently and effectively, and working to appropriately standardize our policies, procedures and practices across all of our affiliated facilities. As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have partnered with a third party to provide certain nonclinical business functions, including payroll processing, supply chain management and revenue cycle functions. We believe this model is the most cost effective and efficient approach to managing these nonclinical business functions across multi-facility enterprises. Additionally, in connection with our efforts to responsibly manage purchasing costs, we participate along with other healthcare companies in a group purchasing organization, HealthTrust Purchasing Group ("***HPG***"), which makes certain national supply and equipment contracts available to our facilities. As of December 31, 2018, we owned an approximate 7.2% equity interest in HPG. We also implement this operating discipline when we enter a new market through acquisitions, where we focus on optimizing staffing levels to reduce labor costs, leveraging our national scale and group purchasing organizations to reduce supply costs and standardizing revenue cycle and information technology ("***IT***") systems. We have made substantial progress implementing these initiatives consistently across our network and we believe that opportunity exists for continued improvement in the near term, particularly among our recently acquired facilities.

- *Experienced Executive Management and Leadership Teams.* Our senior management team has an average of more than 20 years of healthcare industry experience with a proven record of achieving strong operating results. The senior management team is highly respected in the hospital management industry and has significant experience in managing and acquiring hospitals. Our executive management team is led by David Dill, who serves as our Chief Executive Officer. Mr. Dill has more than 20 years of operational and financial leadership experience in the healthcare industry, most recently as President and Chief Operating Officer of Legacy LifePoint.

Our Background

LifePoint/RCCH Merger

Summary

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc."

Equity Contribution

In connection with the LifePoint/RCCH Merger, the Apollo Funds, together with certain other co-investors investing through a co-investment vehicle controlled by our Sponsor or its affiliates, indirectly contributed $1,000.0 million of newly invested capital to DSB Parent L.P., a Delaware limited partnership ("***DSB Parent***"), which is our indirect parent and is owned by the Apollo Funds, such co-investment vehicle and certain current or former directors, members of management, employees and consultants of the Company, and the $1,000.0 million of newly invested capital was further contributed to the Company to be used to partially fund the LifePoint/RCCH Merger.

Financing Transactions

Concurrently with the closing of the LifePoint/RCCH Merger, we (1) issued the 9.75% Unsecured Notes, (2) entered into the ABL Agreement, which provides a senior secured asset-based revolving credit facility (the "***ABL Facility***") in an aggregate principal amount of $800.0 million with a maturity of five years, (3) terminated our existing senior secured asset-based revolving credit facility, which we entered into on April 29, 2016 (the "***Prior ABL Facility***"), (3) entered into the Term Loan Agreement, which provides a senior secured term loan credit facility (the "***Term Loan Facility***") in an aggregate principal amount of $3,550.0 million with a maturity of seven years, and (4) repaid in full our $150.0 million term loan facility, which we entered into on April 25, 2018 (the "***Prior Term Facility***").

RegionalCare/Capella Merger and Apollo/RegionalCare Acquisition

On March 21, 2016, RegionalCare and Capella entered into an agreement and plan of merger, pursuant to which, effective on April 29, 2016 (and effective May 1, 2016 for accounting purposes), Crimson Merger Sub, merged with and into Capella, with Capella continuing as the surviving company in the merger as a wholly-owned subsidiary of RegionalCare. After the RegionalCare/Capella Merger was consummated we began to do business as RCCH HealthCare Partners. Concurrently with the closing of the RegionalCare/Capella Merger, we (i) issued the 8.25% Secured Notes and the 11.5% Unsecured Notes, (ii) entered into the Prior ABL Facility and (iii) refinanced certain indebtedness of DSB Holdings, RegionalCare and Capella.

On November 11, 2015, RegionalCare entered into an agreement and plan of merger with Holdings and the other parties thereto, in which RegionalCare became a direct wholly-owned subsidiary of Holdings on December 3, 2015. Holdings is an indirect wholly-owned subsidiary of DSB Parent, which is controlled by our Sponsor.

In connection with the Apollo/RegionalCare Acquisition and the RegionalCare/Capella Merger, certain Apollo Funds directly or indirectly managed by the Sponsor contributed in the aggregate approximately $380.0 million of invested capital to DSB Parent.

Our Operations

Services

We operate health systems that provide a range of medical, surgical and behavioral health services across inpatient and outpatient settings, including general surgery, internal medicine, cardiology, radiology, oncology, orthopedics, women's services, neurology, rehabilitation services, pediatric services, emergency services and, primarily through our joint venture with LHC, home health and hospice services. In some of our health systems, we offer specialized services such as open heart surgery, skilled nursing, psychiatric care and neurosurgery. In many markets, we also provide outpatient services such as same day surgery, clinical laboratory services, diagnostic imaging services, respiratory therapy services, sports medicine services, urgent care services and lithotripsy. The services provided in any specific health system depend on many factors, including the community need for the service, whether physicians necessary to safely operate the service line are members of the medical staff of that hospital and the existence of any contractual or certificate of need restrictions.

Management and Oversight

Our executive management team has extensive experience in operating multi-facility hospital networks and plays a vital role in the strategic planning for our facilities. A hospital's local management team is typically composed of a CEO, chief operating officer, chief financial officer and a chief nursing officer. Local management teams and the hospital's Board of Trustees and our corporate management teams, develop annual operating plans setting forth growth strategies through the expansion of current services, implementation of new services and the recruitment and retention of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each local management team to identify and meet the needs of our patients, medical staffs and the community as a whole is critical to the success of our facilities. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including quality of care, patient satisfaction and financial measures.

The Board of Trustees at each facility, consisting of local community leaders, members of the medical staff and the facility CEO, advises the local management teams and helps develop the strategic operating plan for their facility. In addition, it plays a key role in providing the patient care excellence that we demand. Members of each Board of Trustees are identified and recommended by our local management teams. The Boards of Trustees oversee policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

The majority of our facilities have a physician engagement group ("***PEG***") or a physician leadership group ("***PLG***") comprised of key physicians and members of the facility's administrative team. The mission of the PEG or PLG is to provide ongoing dialogue between hospital facility administration and members of the medical staff and community physicians primarily in the areas of operations, quality patient care, employee satisfaction and community relations.

We also provide support to the local management teams through our corporate resources in areas such as revenue cycle, business office, legal, managed care, clinical efficiency, physician services and other administrative functions. These resources allow for sharing best practices and standardization of policies and processes among all of our facilities.

Cost Management

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

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

Attracting Patients

We believe that the most important factors affecting a patient's choice in facilities are the reputation of the facility, the availability and expertise of physicians and nurses and the location and convenience of the facility. Other factors that affect utilization include local demographics and population growth, local economic conditions and the facility's success in contracting with a wide range of local payers.

Outpatient Services

The healthcare industry has experienced an accelerated shift during recent years from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology also have supported the shift to outpatient utilization. However, we expect the decline in inpatient admission use rates to moderate over the long term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through expanding service offerings and increasing the throughput and convenience of our emergency departments, outpatient surgery facilities and other ancillary units in our facilities.

Sources of Revenues

General

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 health maintenance organizations ("***HMOs***"), preferred provider organizations ("***PPOs***") and other private insurers, and directly by the patient. The amounts we are paid for providing healthcare services to our patients vary depending upon the payer. Governmental payers 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 payers. However, insured patients are responsible for payments not covered by insurance, such as exclusions, deductibles and co-payments.

The following table summarizes our revenues by payer as approximate percentages of our net patient revenues before the provision for doubtful accounts for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
Medicare	37.6 %	40.4 %	36.4 %
Medicaid	13.1	12.2	12.8
HMOs, PPOs and other private insurers	41.3	40.7	42.5
Self-pay	8.0	6.7	8.3
	100.0 %	100.0 %	100.0 %

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

Medicare

Our revenues from Medicare were approximately 37.6% of our net patient revenues before the provision for doubtful accounts for the year ended December 31, 2018. 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 or Lou Gehrig's disease. All of our hospitals are currently certified as providers of Medicare services.

Over the years, Congress and the Centers for Medicare and Medicaid Services ("***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 numerous changes contained in the Affordable Care Act. Many of these changes have resulted in decreased reimbursement to healthcare providers. For example, 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***") and the Bipartisan Budget Act of 2018 (the "***2018 Act***") extended the 2% reduction in Medicare spending through 2027. Additional reductions in Medicare reimbursement could result from changes to, or the repeal of, the Affordable Care Act, or as a result of the enactment of Medicare reform, deficit reduction, or other legislation.

Medicare Inpatient Prospective Payment System

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

The base MS-DRG operating expense payment rate that is used by the Medicare program in the IPPS is adjusted by an update factor each federal fiscal year ("***FFY***"), which begin on October 1 (for example, FFY 2019 began on October 1, 2018). 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 2019, 2018 and 2017, the hospital market basket index increased 2.9%, 2.7% and 2.7%, respectively. Generally, however, the percentage increase in the MS-DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the hospital market basket increases for FFYs 2019, 2018 and 2017 were reduced by CMS by 0.75%, 0.75% and 0.75%, respectively. As also mandated by the Affordable Care Act, the market basket increase is reduced by a productivity adjustment equal to the Bureau of Labor Statistics' 10-year moving average of changes in annual economy-wide productivity. For FFYs 2019, 2018 and 2017, the productivity adjustment equated to a 0.8%, 0.6% and 0.3% reduction in the market basket increase, respectively. As a result of these reductions and other changes implemented by CMS, the MS-DRG-rate increased by 1.85% for FFY 2019.

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 American Taxpayer Relief Act of 2012 ("***ATRA***") 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. In FFYs 2014, 2015 and 2016, CMS applied negative 0.8% adjustments as part of the recovery process required by ATRA, and it applied a negative 1.5% adjustment in FFY 2017 to recover the remaining outstanding amount. CMS had previously indicated that the reductions required by ATRA would be fully restored in FFY 2018. However, under the Medicare Access and CHIP Reauthorization Act of 2015 ("***MACRA***"), those reductions will be restored in 0.5% increments over a six year period from FFYs 2018 through 2023, which will result in a cumulative 3.0% increase in rates, which is less than the 3.9% reduction that was imposed by CMS in FFYs 2014 through 2017. In addition, the 21st Century Cures Act (the "***Cures Act***") further reduced the restoration for FFY 2018 from 0.5% to 0.4588%.

CMS has implemented a number of programs and requirements that are intended to promote value based purchasing and to link payments to quality and efficiency. For example, the MMA required all acute care hospitals to participate in CMS' Hospital Inpatient Quality Reporting Program (the "***IQR Program***") in order to receive the full hospital market basket update. Hospitals that do not participate in the IQR Program receive a one-fourth reduction in their IPPS annual payment update for the applicable FFY. Our hospitals reported all quality measures required by CMS related to the IQR Program and will receive the full market basket update through FFY 2019. In addition, hospitals that are not meaningful EHR users are also subject to an additional 75% reduction of the hospital market basket increase.

In addition, the Affordable Care Act requires United States Department of Health and Human Services ("***HHS***") to implement a value-based purchasing program for inpatient hospital services. This program rewards hospitals based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period. As part of the program, the Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by 2.0% each FFY. HHS pools the amount collected from these reductions to fund payments to reward hospitals that meet and exceed certain quality performance standards established by HHS. Under the program, each hospital's performance is evaluated during a specified performance period, and hospitals receive points on each of a number of pre-determined measures based on the higher of (i) their level of achievement relative to an established standard or (ii) their improvement in performance from their performance during a prior baseline period. Each hospital's combined scores on all the measures are translated into value-based incentive payments. Hospitals that receive higher total performance scores receive higher incentive payments than those that receive lower total performance scores. Because the Affordable Care Act provides that the funds pooled and otherwise set aside for the value-based purchasing program will be fully distributed, hospitals with high scores may receive greater reimbursement under the value-based purchasing program than they would have otherwise, and hospitals with low scores may receive reduced Medicare inpatient hospital payments.

Medicare also does not allow an inpatient hospital discharge to be assigned to a higher paying MS-DRG if certain designated hospital acquired conditions ("***HACs***") were not present on admission and the identified HAC is the only condition resulting in the assignment of the higher paying MS-DRG. In those situations, the case is paid as though the secondary diagnosis was not present. In addition, 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.

Furthermore, inpatient payments are reduced pursuant to the Affordable Care Act if a hospital experiences "excessive readmissions" within a 30-day period of discharge for certain conditions designated by CMS including heart attack, pneumonia and total hip arthroplasty. 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 is publicly reported by HHS. HHS has the discretion to determine what "excessive readmissions" means, the amount of the payment reduction and other terms and conditions of this program. The basic maximum payment reduction amount is 3.0%. The Cures Act does, however, allow for an adjustment factor that would reduce the penalties imposed on hospitals, based on the portion of beneficiaries the hospitals serve that are eligible for both Medicare and Medicaid, beginning in FFY 2019.

Medicare Hospital Outpatient Prospective Payment System and Other Outpatient Services

CMS reimburses hospital outpatient services under the Medicare hospital outpatient prospective payment system ("***OPPS***"), and uses fee schedules to pay for durable medical equipment and physical, occupational and speech therapy, clinical diagnostic laboratory and independent diagnostic testing facility services. Under the 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 calendar years ("***CYs***") 2019, 2018 and 2017 were $79.490, $78.636 and $75.001, respectively, after the inclusion of the productivity adjustments and other reductions (1.55% for CY 2019, 1.35% for CY 2018 and 1.05% for CY 2017), that were required by the Affordable Care Act. APC classifications and payment rates are reviewed and adjusted on an annual basis, and, historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services. To receive the full increase, hospitals must satisfy the reporting requirements of the Hospital Outpatient Quality Reporting Program (the "***OQR Program***"). Hospitals that do not satisfy the reporting requirements of the OQR Program are subject to a reduction of 2.0% in their annual payment update under the OPPS. Our hospitals reported all quality measures required by CMS for the OQR Program and will receive the full market basket update through CY 2019.

Effective as of January 1, 2017, Section 603 of the BBA limits reimbursement for items and services that are furnished by certain off-campus outpatient provider-based departments ("***off-campus PBDs***") of hospitals. CMS included several provisions implementing Section 603 in the OPPS final rule for CY 2017. Under the final rule, CMS will continue to make OPPS payments to off-campus PBDs that were billing Medicare as hospital departments under the OPPS prior to November 2, 2015 ("***grandfathered PBDs***"). However, grandfathered PBDs will generally not be able to relocate, and CMS has indicated that it may adopt limitations on the expansion of the service lines provided at grandfathered PBDs in the future. In addition to grandfathered PBDs, CMS will also continue to reimburse all items and services that are furnished in a "dedicated emergency department" of a hospital, as such term is defined for the purposes of the Emergency Medical Treatment and Active Labor Act ("***EMTALA***"), regardless of whether the items and services are emergency items and services, and all items and services that are furnished in off-campus PBDs that are located within 250 yards of a remote location of a hospital, which is a facility that is either created or acquired by a hospital for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the hospital, under the OPPS. For CY 2019, all items and services not provided at a grandfathered or otherwise excepted off-campus PBD will generally be paid by CMS under Medicare physician fee schedule ("***PFS***") rates that are approximately 40% of the applicable OPPS rate (the "***PFS Adjusted Rate***"). In addition, in 2018, CMS issued a final rule that will generally reimburse clinic visit services provided at all off-campus PBDs, including grandfathered PBDs, at a reduced Medicare PFS-equivalent payment rate. The payment reduction for clinic visit services provided at off-campus PBDs will be phased in over a two year period beginning in FFY 2019.

As part of the OPPS final rule for CY 2018, CMS finalized a change to the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B Drug Pricing Program (the "***340B Program***"). The 340B Program allows certain non-profit and governmental hospitals and other healthcare providers to obtain substantial discounts on covered outpatient drugs (prescription drugs and biologics other than vaccines) from drug manufacturers. Under the final rule, CMS pays for separately reimbursable, non-pass through drugs and biologicals (other than vaccines) purchased through the 340B Program at the average sales price ("***ASP***") minus 22.5% rather than ASP plus 6%. CMS estimated that this change reduced Medicare payments for drugs and biologicals by $1.6 billion in CY 2018. To maintain budget neutrality, CMS implemented an offsetting increase in the conversion factor, and, as a result, reimbursement rates for non-drug items and services provided by all hospitals, including those not eligible to participate in the 340B program, that are reimbursed under the OPPS. In connection with the OPPS final rule for CY 2019, CMS expanded the 340B Drug Pricing Program payment reductions to drugs that are obtained through the 340B Drug Pricing Program and furnished by non-excepted, off-campus PBDs.

In September 2018, a lawsuit was filed challenging the authority of CMS to make the 340B Program payment reductions set forth in the OPPS final rule for CY 2018. On December 27, 2018, the U.S. District Court for the District of Columbia held that the payment reductions exceeded CMS's statutory authority and entered a permanent injunction against the reductions. However, because the 340B Program payment reductions were made in a budget-neutral manner and the savings derived from the reductions were used to increase reimbursement for all of the other items and services provided under the OPPS, the Court ordered the parties to submit briefs as to how the issue should be remedied. CMS has appealed the Court's ruling. We cannot predict the outcome of CMS's appeal or the remedies, if any, that may be imposed in connection with the 340B Program payment reduction litigation or whether CMS will appeal the Court's ruling. If OPPS payments to hospitals are reduced (either retroactively or prospectively) as a result of the 340B Program payment reduction litigation, we would be materially adversely affected.

Medicare Disproportionate Share Hospital Payments

Hospitals may also qualify for Medicare disproportionate share hospital ("***DSH***") payments, if they treat a high percentage of low-income patients (Medicaid and Medicare patients eligible to receive Supplement Security Income). DSH payments are determined annually based on certain statistical information specified by HHS and are paid as an addition to MS-DRG payments. 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 is reduced by the percentage change in uninsured individuals under the age of 65, and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period. The IPPS final rule for FFY 2019 established the uncompensated care amount which will be distributed to qualifying hospitals in FFY 2019 at approximately $8.3 billion, up from $6.8 billion in FFY 2018.

Medicare Dependent and Low Volume Hospital Programs

On April 16, 2015, MACRA was enacted. Among other things, MACRA extended 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, through September 30, 2017. The 2018 Act extended both of these programs through FFY 2022.

Cost Reports

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

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

Medicare Bad Debt Reimbursement

Under Medicare, the costs attributable to the deductible and coinsurance amounts that remain unpaid by Medicare beneficiaries after reasonable collection efforts 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 Medicare administrative contractor 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%.

Physician Services

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

MACRA replaced the SGR formula with a new system for establishing the annual updates to payments made under the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased by an additional 0.5% for CYs 2016, 2017 and 2018 and, after the adoption of the 2018 Act were increased by 0.25% for CY 2019. PFS payment rates will then remain at their CY 2019 levels through CY 2025. Beginning in CY 2019, amounts paid to individual physicians are subject to adjustment through the Quality Payment Program ("***QPP***") and participation in either the Merit-Based Incentive Payment System ("***MIPS***") or an Advanced Alternative Payment Model ("***APM***") program. Physicians who participate in the MIPS program, which essentially consolidates 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 $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, which, among other things, requires the physicians to receive a substantial amount of their revenue from an APM, would receive, from CYs 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 were approximately 13.1% of our net patient revenues before the provision for doubtful accounts for the year ended December 31, 2018. Included in these payments are DSH and other supplemental payments received under various state Medicaid programs. Medicaid programs are funded by both the federal government and states to provide healthcare benefits to limited categories of low-income individuals under 65 years of age. These programs and the reimbursement methodologies are administered by the states under approved plans 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 program, or some combination of these three methods. All of our hospitals are currently certified to participate in their respective state Medicaid programs.

The Affordable Care Act essentially requires states to expand medical coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level ("***FPL***"). However that portion of the Affordable Care Act was held to be unconstitutional by the U.S. Supreme Court, and, as a result, states may opt out of the expansion without losing their existing Medicaid funding. Therefore, the income level required for individuals to qualify for Medicaid varies widely from state to state. 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. The Enhanced FMAP was 100% for CYs 2014 through 2016; 95% in 2017; 94% in 2018; is 93% in 2019; and will be 90% in 2020 and thereafter.

In recent years, we have benefited from the expansion of Medicaid under the Affordable Care Act, and effective as of January 1, 2019, Virginia, an additional state in which we operate, expanded its Medicaid program. However, a number of states in which we operate have not expanded their Medicaid programs, and several states have adopted or are considering legislation designed to reduce or control their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs, and imposing additional taxes on hospitals to help finance such states' Medicaid systems. Given the reductions in the Enhanced FMAP and in light of the possible repeal, replacement or modification of the Affordable Care Act, we are unable to predict how many, if any, additional states in which we operate will expand their Medicaid programs or how many, if any, of the states in which we operate that have expanded their Medicaid programs will keep their expansions in place in the future.

The Affordable Care Act also included a number of provisions that are intended to improve the quality of care that is provided to Medicaid beneficiaries. Among other things, the Affordable Care Act prohibits federal funds from being used to reimburse providers for services related to provider preventable conditions, such as HACs, wrong site surgeries and other provider preventable conditions that may be designated by each state Medicaid program.

Work Requirements

In addition to implementing value-based purchasing and quality-driven reimbursement requirements, CMS also recently issued new guidance permitting states to impose work and/or community engagement on certain Medicaid beneficiaries. In response to the guidance, a number of states, including several in which the Company has facilities, have requested demonstration waivers from CMS that would allow those states to impose work requirements on their Medicaid beneficiaries. CMS has approved the requests that have been made by Arizona, Arkansas, Indiana, Kentucky, Michigan, New Hampshire and Wisconsin, and the remaining requests are still pending. The approved waivers and work requirements have already been implemented in Arkansas and Indiana, and the other waivers that have been approved are scheduled to take effect in the upcoming months. However, lawsuits have been filed in the U.S. District Court for the District of Columbia challenging the authority of CMS to allow the Arkansas and Kentucky Medicaid programs to impose work requirements on their respective beneficiaries. We cannot predict whether CMS will grant additional waivers that allow for the imposition of work and community engagement requirements on Medicaid beneficiaries or the impact that any such waivers will have on coverage for patients seeking care at our facilities. We also cannot predict whether the legal challenges that have been initiated against the Arkansas and Kentucky demonstration waivers will be successful or whether any legal challenges will be initiated against any other similar demonstration waivers that have been or may be granted by CMS in the future.

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

Medicaid Disproportionate Share Hospital Payments

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.

Pursuant to the Affordable Care Act, as amended by subsequent legislation, funding for Medicaid DSH programs is to be reduced by $4 billion in FFY2020 and $8 billion per year from FFY 2021 through 2025. 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.

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.

Recovery Audit and Other Review Contractors

Recovery audit contractors ("***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. In 2016, in connection with the procurement of the new recovery audit contracts, CMS made a number of enhancements to the RAC program, including the establishment of a RAC program Provider Relations Coordinator, requiring RACs to maintain an overturn rate of less than 10% at the first level of appeal, requiring RACs to maintain an accuracy rate of at least 95%, and establishing additional documentation request limits based on a provider's compliance with Medicare rules, that are intended to address provider and other stakeholder concerns. CMS has also limited the number of claims that RACs may audit by limiting the number of records that RACs may request from hospitals based on each hospital's claim denial rate for the previous year.

In addition to RACs, CMS employs Unified Program Integrity Contractors ("***UPICs***"), which integrate the functions of the former Zone Program Integrity Contractors, Program Safeguard Contractors, and Medicaid Integrity Contractors, to perform post-payment audits of Medicare and Medicaid claims and identify overpayments. A number of state Medicaid agencies and other contractors have also increased their review activities.

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 RAC and other review programs to which our hospitals will be subject.

Utilization and Claim Review

Federal law contains numerous provisions designed to ensure that services rendered to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed on a post-discharge basis by quality improvement organizations ("***QIOs***"), 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. QIOs 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 QIO be excluded from participation in the Medicare program. Utilization review is also a requirement of most non-governmental managed care organizations.

In addition to utilization reviews, CMS has also adopted a nationwide claim review and provider education program known as the Targeted Probe and Educate ("***TPE***") program, which is intended to reduce errors in the claims submission process and focuses on items and services that pose the greatest risk to the Medicare program or that have a high national error rate, such as short inpatient stays. Under the TPE program, Medicare administrative contractors ("***MACs***", and each individually, a "***MAC***") use data analysis to identify providers who, for a particular item or service, have high claim denial rates or billing practices that vary significantly from their peers. Once a provider has been identified, the MAC reviews between 20 and 40 of the provider's claims for the item or service and, if issues are noted, offers the provider an individualized education session that is based on the results of the review. The provider is then generally given 45 days to improve its systems and processes, and, after that period has ended, the MAC conducts another review of the provider's claims. If additional issues are identified, the provider is given the opportunity for another education session. Providers are typically given three rounds of review and education before being referred to CMS for further action, such as pre-payment or RAC review.

HMOs, PPOs and Other Private Insurers

In addition to government programs, our facilities are reimbursed by differing types of private payers including HMOs, PPOs and other private insurers. 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 41.3% of our net patient revenues before the provision for doubtful accounts for the year ended December 31, 2018. 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 or accept fixed, pre-determined fees for our services. These discounted arrangements often limit our ability to increase charges or revenues in response to increasing costs. We actively negotiate with these payers 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 payer 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 Affordable Care Act health insurance marketplace exchanges (the "***Exchanges***") are increasingly using narrow and tiered networks that limit beneficiary provider choices. If we provide services when we are 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 derived from patients who do not have any form of healthcare coverage. Our revenues from self-pay patients were approximately 8.0% of our net patient revenues before the provision for doubtful accounts for the year ended December 31, 2018. 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. Our ability to collect self-pay revenues is dependent on a combination of broad economic factors, including unemployment levels in our markets.

Health Care Reform

The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare by, among other things, requiring most Americans to obtain health insurance (the "***individual mandate***"), providing additional funding for Medicaid in states that choose to expand their programs, reducing IPPS, OPPS and 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, and instituting certain private health insurance reforms. The Affordable Care Act has, however, been subject to a number of legislative and regulatory changes and court challenges and its future is uncertain.

For example, on January 20, 2017, President Trump issued an executive order that, among other things, stated that it was the intent of his administration to repeal the Affordable Care Act and, pending that repeal, instructed the executive branch of the federal government to defer or delay the implementation of any provision or requirement of the Affordable Care Act that would impose a fiscal burden on any state or a cost, fee, tax or penalty on any individual, family, health care provider, or health insurer. On October 12, 2017, President Trump issued another executive order related to the Affordable Care Act that resulted in the issuance of regulations that are intended to encourage the formation of association health plans and increase the maximum duration of and access to short-term limited duration health insurance plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. In addition, a number of bills have been introduced in Congress that would repeal the Affordable Care Act and would replace it with varying health coverage plans, including plans that would allow insurers to sell health insurance across state lines, allow the use of health savings accounts ("***HSAs***") without a high-deductible plan, or give states the option to either keep the coverage framework created by the Affordable Care Act (e.g., expanded Medicaid, individual subsidies, and insurance exchanges) or utilize the increased federal funding that was intended for Medicaid expansion to be provided by the federal government under the Affordable Care Act to create HSAs that can be used by low-income individuals to purchase health insurance. Also, the Tax Act repealed the penalties associated with the individual mandate effective January 1, 2019. We cannot predict whether the Affordable Care Act will be repealed, replaced, or materially modified by Congress or the impact that the repeal of the penalties associated with the individual mandate will have on our facilities.

In addition to the administrative actions and legislative efforts to repeal, replace or modify the Affordable Care Act, there have been and will likely continue to be a number of legal challenges to various provisions of the Affordable Care Act. For example, in 2014, the U.S. House of Representatives (the "***House***") 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 Exchanges. The House lawsuit was ultimately settled after HHS stopped making cost sharing reduction payments to insurance companies based on the determination that these payments had not been appropriated by Congress. A number of insurers have, however, filed litigation against HHS to recover the cost sharing reduction payments that have not been made. In addition, on December 14, 2018, the U.S. District Court for the Northern District of Texas held that, in light of the repeal of the penalties associated with the individual mandate, the entire Affordable Care Act was unconstitutional. The Court did not, however, issue an injunction against the continued enforcement of the Affordable Care Act, and seventeen states and the House have appealed the Court's ruling. We cannot predict the outcome of the litigation that has been filed by insurers relating to the cessation of HHS's cost sharing reduction payments, the impact that the cessation of HHS's cost sharing reduction payments will have on the premiums that are charged by insurers or the outcome of the appeal regarding the constitutionality of the Affordable Care Act.

Unless specifically stated otherwise, our summary of provisions of the Affordable Care Act throughout the remainder of this section and elsewhere in this Report are based on the law as currently in effect. Additionally, refer to the section below captioned "Impact of the Affordable Care Act on the Company" for further discussion about the uncertainty surrounding the Affordable Care Act.

Expanded Coverage

Based on original Congressional Budget Office ("CBO") and CMS estimates, by 2019, the Affordable Care Act was originally 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.

Public program expansion has been driven primarily by expanding the categories of individuals who are eligible for Medicaid coverage and allowing individuals with relatively higher incomes to qualify for Medicaid coverage.

The Affordable Care Act essentially made the expansion of the Medicaid program mandatory, but, 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 chose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. Based on the U.S. Supreme Court's ruling, a number of states, including several in which the Company has facilities, have opted not to expand their Medicaid programs. Public program expansion has also occurred through provisions of the Affordable Care Act that authorize the federal government to 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 and allow 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.

The expansion of health coverage through the private sector as a result of the Affordable Care Act has occurred through new requirements on health insurers, employers and individuals. For example, 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. In addition, 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. Also, 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 are subject to new requirements and incentives to provide health insurance benefits to their full time employees, and, effective January 1, 2016, all employers subject to the requirement are required to offer health insurance coverage to 95% of their full-time employees and their dependents in order to avoid penalties.

To facilitate the purchase of health insurance by individuals and small employers, each state was required to establish an Exchange by January 1, 2014. For individuals and families below 400% of the FPL, the cost of obtaining health insurance through the Exchanges is subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. Health insurers participating in the Exchange must offer a set of minimum benefits to be defined by HHS and may offer more benefits. Any benefits to us from the expansion of private sector coverage depend in large part on our success in contracting with payers whose policies are listed on the Exchanges. We currently have contracts with Exchange payers 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 payers.

Beginning in 2014 and continuing throughout 2018, primarily as a result of the expansion of health insurance coverage, we experienced an increase in revenues from providing care to certain previously uninsured individuals. Although we expect this trend to continue, the future impact and timing of such expansion remains difficult to predict for the reasons discussed above, will be gradual and may not offset scheduled decreases in reimbursement. Additionally, we cannot predict the impact of the cessation of cost sharing reduction payments, the repeal of the individual mandate or any other modifications to the Affordable Care Act that may be adopted.

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.

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***"). ACOs are groups of hospitals, physicians and other designated professionals and suppliers who come together voluntarily 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 are eligible to share in a portion of the amounts saved by the Medicare program. There are several types of ACO programs, and as of January 2018, approximately 560 ACOs had been established to participate in the Medicare Shared Savings Program, and additional ACOs are being established by private payers. A few of our facilities currently participate in ACOs.

Bundled Payment Pilot Programs

The Affordable Care Act created the Center for Medicare & Medicaid Innovation ("***CMMI***") and made it responsible 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. Under these projects and initiatives, participating providers agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care and accept accountability for costs and the quality of care that is provided. By rewarding providers for quality, cost-effective care and penalizing providers when costs exceed a certain amount, these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. In connection with these programs, CMMI has developed a voluntary Bundled Payment for Care Improvement initiative to test innovative payment and service delivery models that have the potential to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care for beneficiaries. Participation in bundled payments programs is generally voluntary, but CMS does currently require hospitals in certain geographic areas to participate in the Comprehensive Care for Joint Replacement model which covers certain extremity joint replacement procedures. CMS has indicated that it expects to increase opportunities for providers to participate in voluntary bundled payment models initiatives and that it may create additional mandatory bundled payment models in the future. Several of our facilities currently participate in bundled payment programs.

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, 2018, we operate four hospitals through joint ventures with physicians in which we own a controlling interest.

Impact of the Affordable Care Act on the Company

The expansion of health insurance coverage under the Affordable Care Act has resulted in an increase in the number of patients using our facilities who have either private or public program coverage. It is difficult to predict with great precision the timing or size of positive or negative impacts on revenue as a result of the Affordable Care Act, because of uncertainty surrounding a number of material factors, including the following:

- the elimination of the penalties associated with the individual mandate;
- the cessation of cost sharing reduction payments to insurers;
- the possibility that the Affordable Care Act will be repealed and/or replaced or further modified by Congress;
- even if the Affordable Care Act is not repealed, replaced or further modified, the level of disruption that may be caused by continuing legal challenges and other efforts to delay, block or eliminate specific provisions of the Affordable Care Act, including the outcome of litigation relating to the continued constitutionality of the Affordable Care Act;
- how many previously uninsured individuals will ultimately obtain coverage as a result of the Affordable Care Act;
- what percentage of the future newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states impose work and community engagement and/or premium requirements on their Medicaid beneficiaries;
- the number of states that ultimately elect to expand their Medicaid programs and when that expansion occurs;
- whether any states that have expanded their Medicaid programs will scale back such expansion through the imposition of work or premium requirements or otherwise as the Enhanced FMAP is reduced;
- the extent to which states will enroll any new Medicaid participants in managed care programs;
- the rates charged by private payers for insurance purchased on the Exchanges;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the future rates paid to hospitals by private payers for newly covered individuals under different plans, including those covered through the newly created Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- increasing self-pay as a result of individuals in the Exchanges who select high deductible plans, and risks presented by their ability to pay such deductibles;
- whether or not private insurers will participate in the Exchanges, and whether such participation is through the use of narrow networks that restrict the number of participating providers or tiered networks that impose significantly higher cost sharing obligations on patients that obtain services from providers in a disfavored tier; and

- whether the net effect of the Affordable Care Act, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business.

Additionally, since approximately 50.7% of our net patient revenues before the provision for doubtful accounts in 2018 were from Medicare and Medicaid, collectively, the reductions in Medicare and Medicaid reimbursement and in the growth of spending by the Medicare and Medicaid programs that are contemplated by the Affordable Care Act will significantly impact us and could offset any positive effects of the Affordable Care Act. It is difficult to predict with great precision the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from Medicare and Medicaid business when the reductions are fully implemented;
- whether reductions required by the Affordable Care Act will be changed by statute;
- whether efforts to reform Medicaid funding into block grants or per capita caps will be successful, and, if implemented, the impact such changes may have on the Medicaid programs of states in which we operate;
- the size of the Affordable Care Act's annual productivity adjustment to the market basket in future years;
- the amount of the Medicare DSH reductions that are made;
- the allocation to our hospitals of the Medicaid DSH reductions, commencing in FFY 2020;
- what the losses in revenues will be, if any, from the Affordable Care Act's quality initiatives;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and
- reductions to Medicare payments CMS may impose for "excessive readmissions."

Because of the many variables involved, we are unable to predict the future effect on the Company of the expected increases or decreases in insured individuals using our facilities, the reductions in Medicare spending and reductions in Medicare and Medicaid DSH funding, and numerous other provisions in the Affordable Care Act that may affect us. Additionally, it is unclear how many states will ultimately implement the Medicaid expansion, whether the Medicaid program will be reformed, or whether the Affordable Care Act will be replaced, further modified or found to be unconstitutional. 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, exemptions from sales, property and income taxes, and participation in the 340B Program. 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 freestanding emergency departments and outpatient surgery, oncology, physical therapy, diagnostic and urgent care 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 facilities must also compete for professional talent. A significant factor in our future success will be the ability of our facilities to attract and retain physicians, as it is physicians who decide whether a patient is admitted to the hospital and the procedures to be performed. We seek to attract physicians by striving to employ excellent nurses, equipping our facilities with technologically advanced equipment and an attractive, up-to-date physical plant, properly maintaining the equipment and physical plant, and otherwise creating an environment within which physicians choose to practice. While physicians may terminate their association with our facilities at any time, we believe that by striving to maintain and improve the quality of care at our facilities and by maintaining ethical and professional standards, our facilities will be better positioned to attract and retain qualified physicians with a variety of specialties.

We also recruit physicians to the communities in which our facilities are located. The types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the federal physician self-referral law (commonly referred to as the "***Stark law***"), the Anti-kickback Statute, state anti-kickback and physician self-referral 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 2018 than at the end of 2017. When employing office-based physicians, we also often employ office employees and other personnel necessary to support these physicians and incur additional expenses as a result. We expect this trend to continue.

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

Employees

At December 31, 2018, we had approximately 56,000 employees, including approximately 12,500 part-time employees. The majority are hospital-based employees, including nursing staff, physical and occupational therapists, laboratory and radiology technicians, pharmacy staff, facility maintenance workers and the administrative staffs of our facilities. Approximately 2,500 of our employees across ten different facilities are unionized. While some of our non-unionized facilities experience union organizing activity from time to time, currently we do not expect these efforts to affect our future operations materially. Our facilities, like most facilities, have experienced rising labor costs. Our labor costs also may increase at higher rates among unionized employees. Unionized employees also may have rights under their collective bargaining agreements that restrict the ability of a facility to take certain actions with respect to these employees.

Government Regulation

Overview

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

Acute care hospitals are subject to periodic inspection by federal, state and local authorities to determine their compliance with applicable regulations and requirements necessary for licensing, certification and accreditation. All of our hospitals are currently licensed under appropriate state laws and are qualified to participate in the Medicare and Medicaid programs. In addition, as of December 31, 2018, with the exception of Bluegrass Community Hospital and Saline Memorial Hospital, all of our hospitals were accredited by the Joint Commission.

Fraud and Abuse Laws

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

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

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

Anti-kickback Statute

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, among other things, criminal fines of up to $100,000 for each violation, substantial civil monetary penalties for each violation that are subject to annual adjustments for inflation, damages equal to three times the total remuneration and/or possible exclusion from participating in Medicare, Medicaid or other governmental healthcare programs.

The Office of Inspector General ("***OIG***") of HHS is responsible for identifying fraud and abuse activities in government healthcare 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 that may be forgiven if a physician refers patients to the hospital;
- payment of the costs for a physician's travel and expenses for conferences;
- payment of services which require few, if any, substantive duties by the physician or which are in excess of the fair market value of the services rendered; or
- purchasing goods or services from physicians at prices in excess of their fair market value.

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

Stark Law

The Stark law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship if those entities provide certain "designated health services" unless an exception applies. The Stark law also prohibits entities that provide designated health services reimbursable by Medicare and Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires entities to refund amounts received for items and services provided pursuant to a prohibited referral on a timely basis. "Designated health services" include, among other things, inpatient and outpatient hospital services, laboratory services and radiology services. A violation of the Stark law may result in (i) a denial of payment, (ii) substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation or circumvention scheme and (iii) exclusion from participation in the Medicare and Medicaid programs and other governmental healthcare programs. In addition, violations of the Stark law could also result in penalties under the 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. Four of our facilities are subject to those requirements. We intend for our financial arrangements with physicians to comply with the exceptions included in the Stark law and regulations. In recent years, CMS has issued a number of proposed and final rules modifying the Stark law exceptions. While some changes have been implemented, others remain in proposed form or have been delayed. Further, the Stark law and related regulations have been subject to little judicial interpretation to date. We anticipate that there will be further changes in the future and those changes may require us to modify our activities.

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

False Claims Act

The False Claims Act prohibits providers from, among other things, knowingly submitting false or fraudulent claims for payment to the federal government and failing to refund identified overpayments received from the government. The 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 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 found liable under the False Claims Act, a provider may be required to pay up to three times the actual damages sustained by the government plus substantial civil monetary penalties that are subject to annual adjustments for inflation for each separate false claim. The government and whistleblowers have used the 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 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 the 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 False Claims Act.

In addition to the changes mentioned above, 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. 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, accurately prepare cost reports and timely resolve credit balances. 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.

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 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 substantial 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 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 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 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 substantial 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 EMTALA and has indicated that it will continue to do so in the future. Although we believe that our hospitals comply with EMTALA, we cannot predict whether CMS will implement new requirements in the future and, if so, whether our hospitals will comply with any new requirements.

Administrative Simplification Provisions and Privacy and Security Requirements

We are subject to the administrative simplification provisions of HIPAA which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. Additionally, we are subject to the privacy, security and breach notification regulations promulgated under HIPAA and the Health Information Technology for Economic and Clinical Health Act (the "***HITECH Act***"), which are designed to protect the confidentiality, availability and integrity of protected health information ("***PHI***") and establish an array of patient rights with respect to such information. The HIPAA privacy, security and breach notification regulations apply to covered entities, which include health plans, health care clearinghouses, and health care providers that conduct certain standard transactions (such as billing insurance) electronically. In addition, certain provisions of the privacy, security and breach notification regulations apply to business associates, which are entities that perform certain functions or activities on behalf of covered entities that require access to or the use or disclosure of protected health information. In certain circumstances, a covered entity may be held liable for the actions of its business associate if HHS determines an agency relationship exists between the covered entity and the business associate under federal agency law.

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

Violations of the HIPAA regulations may result in criminal penalties and substantial civil monetary penalties subject to a limit for violations of the same requirement in a calendar year. The civil monetary penalties are also subject to annual inflation adjustments. In addition, state attorneys general are authorized to bring civil actions seeking either injunction or damages up to $25,000 for violations of the same requirement in a calendar year in response to HIPAA violations that affect their state residents. HHS has the discretion in many cases to resolve HIPAA violations through informal means without the imposition of penalties. However, the HIPAA privacy, security and breach notification regulations have and will continue to impose significant costs on our facilities in order to comply with these standards. We expect increased enforcement of the HIPAA regulations.

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 the HIPAA regulations.

Corporate Practice of Medicine and Fee-Splitting

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

Certificates of Need

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

Not-for-Profit Hospital Conversion Legislation

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

State Hospital Rate-Setting Activity

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

Environmental Regulation

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

Compliance Program

We maintain a company-wide ethics and compliance program designed to ensure that we maintain high standards of ethical conduct in the operation of our business, and to meet or exceed applicable federal guidance and industry standards. We continually implement written policies and procedures for all of our employees to promote compliance with all applicable laws, regulations and Company policies, and to encourage a "culture of compliance" within the Company and its facilities. The organizational structure of our ethics and compliance program includes oversight by our Board of Directors and compliance committees at the Company and facility levels. We have compliance officers and personnel at the Company level and at our facilities. Other features of our compliance program include initial and periodic ethics and compliance training, systems for identifying and tracking compliance issues (including databases and hotlines for employees to report, without fear of retaliation, any suspected legal or ethical violations), regular auditing and monitoring of compliance issues, including coding audits and reviews of our financial relationships with physicians, and prompt review and resolution of identified issues.

Our compliance program also oversees the implementation and monitoring of the standards set forth by HIPAA for privacy. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and oversight by at the Company level.

Risk Management and Insurance

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("***SIR***") and deductible levels. At December 31, 2018, our SIR for professional liability claims is $5.0 million per claim, with a $5.0 million inner aggregate, at the majority of our facilities, and $2.0 million per claim at certain of our facilities. Additionally, we participate in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2018, our deductibles for workers' compensation claims range from $0.5 million to $1.0 million per claim in all states in which we operate except for Montana, Oklahoma, Ohio, Washington and Wyoming. We participate in state-specific programs for our workers' compensation claims arising in these states. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

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

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

Item 1A. ***Risk Factors.***

Any of the following risks could materially and adversely affect our business, financial condition or results of operations. In addition, the risks described below are not the only risks that we face. The following information should be read in conjunction with Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations." Additional risks and uncertainties not currently known to us or those that we currently view to be immaterial could also materially and adversely affect our business, financial condition or results of operations.

We may be unable to achieve some or all of the expected benefits of the LifePoint/RCCH Merger.

We may not be able to achieve projected benefits or cost savings in connection with the LifePoint/RCCH Merger. The success of the LifePoint/RCCH Merger will depend, in part, on our ability to integrate Legacy LifePoint's and RCCH's businesses and operations as well as fully realize the anticipated benefits and synergies from combining these businesses. Mergers inherently involve risks, including those associated with assimilating and integrating different business operations, corporate cultures, personnel, infrastructure and technologies or products and increasing the scope, geographic diversity and complexity of our operations. There may be additional costs or liabilities that are not currently anticipated, including costs resulting from the unexpected loss of key employees or patients of the combined company, the hiring of additional management and other critical personnel, or unknown obligations or liabilities of facilities acquired in the LifePoint/RCCH Merger. The LifePoint/RCCH Merger may also be disruptive to our ongoing business, may divert the attention of our management and may cause patients, payers, joint venture partners, suppliers and employees that deal with us to seek changes to existing business relationships with us. Any of these risks could adversely affect our business, financial condition and results of operations.

Our substantial indebtedness could materially and adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry and prevent us from making debt service payments on the Notes.

We are a highly leveraged company. As of December 31, 2018, we had total outstanding debt of approximately $6,148.0 million, excluding capital and financing leases and unamortized debt issuance costs.

Our substantial indebtedness could have important consequences for the lenders and holders of our indebtedness. For example, it could:

- limit our ability to borrow money for our working capital, capital expenditures, debt service requirements, strategic initiatives or other purposes;
- make it more difficult for us to satisfy our obligations with respect to our indebtedness, including the Notes, and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the indentures governing the Notes and the agreements governing other indebtedness;
- require us to dedicate a substantial portion of our cash flow from operations to the payment of interest and the repayment of our indebtedness, thereby reducing funds available to us for other purposes;
- limit our flexibility in planning for, or reacting to, changes in our operations or business;
- make us more highly leveraged than some of our competitors, which may place us at a competitive disadvantage;
- make us more vulnerable to downturns in our business, our industry or the economy;
- restrict us from making strategic acquisitions, engaging in development activities, introducing new technologies or exploiting business opportunities;
- cause us to make non-strategic divestitures;
- limit, along with the financial and other restrictive covenants in our indebtedness, among other things, our ability to borrow additional funds or dispose of assets;
- prevent us from raising the funds necessary to repurchase all Notes tendered to us upon the occurrence of certain changes of control, which failure to repurchase would constitute an event of default under the Indentures; or
- expose us to the risk of increased interest rates, as certain of our borrowings, including borrowings under the ABL Facility and the Term Loan Facility, are at variable rates of interest.

In addition, the ABL Agreement, the Term Loan Agreement and the Indentures contain restrictive covenants that limit or will limit our ability to engage in activities that may be in our long-term best interest. Our failure to comply with those covenants could result in an event of default which, if not cured or waived, could result in the acceleration of substantially all of our existing and future indebtedness.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness that may not be successful.

Our ability to pay principal and interest and to satisfy our other debt obligations will depend upon, among other things:

- our future financial and operating performance (including the realization of any cost savings described herein), which will be affected by prevailing economic, industry and competitive conditions and financial, business, legislative, regulatory and other factors, many of which are beyond our control; and
- our future ability to borrow under the ABL Facility, the availability of which depends on, among other things, our complying with the covenants in the ABL Agreement.

We cannot assure you that our business will generate cash flow from operations, or that we will be able to draw under the ABL Facility or otherwise, in an amount sufficient to fund our liquidity needs, including the payment of principal and interest on the ABL Facility, the Term Loan Facility and the Notes.

If our cash flows and capital resources are insufficient to service our indebtedness, we may be forced to reduce or delay capital expenditures, sell assets, seek additional capital or restructure or refinance our indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. In addition, the terms of existing or future debt agreements, including the ABL Agreement, the Term Loan Agreement and the Indentures, may restrict us from adopting some of these alternatives. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to dispose of material assets or operations to meet our debt service and other obligations. We may not be able to consummate those dispositions for fair market value or at all. Furthermore, any proceeds that we could realize from any such dispositions may not be adequate to meet our debt service obligations then due. The Sponsor and its affiliates have no continuing obligation to provide us with debt or equity financing. Our inability to generate sufficient cash flow to satisfy our debt obligations, or to refinance our indebtedness on commercially reasonable terms or at all, could result in a material adverse effect on our business, results of operations and financial condition and could negatively impact our ability to satisfy our obligations under our indebtedness.

If we cannot make scheduled payments on our indebtedness, we will be in default, and the lenders under the Term Loan Facility and the holders of the Notes could declare all outstanding principal and interest to be due and payable, the lenders under the ABL Facility could terminate their commitments to loan money, our secured lenders (including the lenders under the ABL Facility and the Term Loan Facility and the holders of the 8.25% Secured Notes) could foreclose against the assets securing their loans and the Notes and we could be forced into bankruptcy or liquidation. All of these events could cause you to lose all or part of your investment in the Notes.

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

In 2018, we derived approximately 50.7% of our net patient revenues before the provision for doubtful accounts from 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 changes, administrative rulings and determinations concerning patient and provider eligibility and requirements for utilization review. Furthermore, the Affordable Care Act and related federal laws provide for material scheduled reductions in the growth rate of Medicare and Medicaid program spending, including reductions in market basket updates and Medicare and Medicaid 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. States may also impose additional taxes on hospitals to help finance such states' Medicaid systems. Some states have also taken steps to implement work and/or community engagement requirements for Medicaid beneficiaries, which could have the effect of reducing the number of individuals eligible for Medicaid in those states.

Recent executive and legislative actions to amend or impede the implementation of the Affordable Care Act and ongoing efforts to repeal, replace or further modify the Affordable Care Act may adversely affect our business, financial condition and results of operations.

The Affordable Care Act dramatically altered the U.S. healthcare system, and we have expended substantial cost and effort to prepare for and comply with the Affordable Care Act. Since its adoption into law in 2010, the Affordable Care Act has been challenged before the U.S. Supreme Court, and several bills have been and continue to be introduced in Congress to delay, defund or repeal implementation of or amend significant provisions of the Affordable Care Act. In addition, there continues to be ongoing litigation over the interpretation, implementation and constitutionality of the law. The net effect of the Affordable Care Act, as currently in effect, on our business is subject to a number of variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. Additional variables of the Affordable Care Act impacting our business will be how states, providers, insurance companies, employers, and other market participants respond during this period of uncertainty surrounding the future of the Affordable Care Act.

In 2017, President Trump issued executive orders that, among other things, expressed the administration's intent to repeal the Affordable Care Act, instructed the executive branch of the federal government to defer or delay the implementation of any provisions of the Affordable Care Act that would impose a fiscal burden on any state or a cost, fee, tax or penalty on any individual, family, health care provider, or health insurer. On October 12, 2017, President Trump issued another executive order related to the Affordable Care Act that resulted in the issuance of regulations that are intended to encourage the formation of association health plans, and increase the maximum duration of and access to short-term limited duration health insurance plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. In 2017, the United States Department of Justice ("***DOJ***") also announced that HHS was immediately ceasing its cost sharing reduction payments to insurance companies based on a determination that those payments had not been appropriated by Congress, and Congress enacted the Tax Act that, in addition to overhauling the federal tax system, repealed the penalties associated with the individual mandate effective as of January 1, 2019. In addition, in December 2018, the U.S. District Court for the Northern District of Texas found that, as a result of the repeal of the penalties associated with individual mandate, the entire Affordable Care Act is unconstitutional.

We cannot predict the impact that the President's executive orders and other administrative actions will have on the implementation and enforcement of the provisions of the Affordable Care Act or the current or pending regulations adopted to implement the law. In addition, we cannot predict the impact that the repeal of the penalties associated with the individual mandate and the cessation of cost sharing reduction payments to insurers will have on the availability and cost of health insurance and the overall number of uninsureds. We also cannot predict the outcome of litigation challenging the constitutionality of the Affordable Care Act or whether the Affordable Care Act will be repealed, replaced, or modified. If the Affordable Care Act is found to be unconstitutional or if it is repealed, replaced or modified, we cannot predict what, if any, the replacement plan or modifications would be, when any such replacement plan or modifications would become effective, or whether any of the existing provisions of the Affordable Care Act would remain in place.

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. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid 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.

The Affordable Care Act called for significant reductions in Medicaid DSH funding to account for decreases in uncompensated care anticipated under the health insurance coverage expansion. Subsequent changes in the law have delayed the implementation of these reductions, but they are scheduled to take effect in FFY 2020. Reductions in Medicaid DSH payments may take place without increases in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

UPL programs have expanded in recent years and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs. We cannot predict whether MSP programs will continue (and, if continued, whether we will qualify for such programs) or guarantee that revenues recognized from these programs will not decrease.

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 criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may 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 providers 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, the OIG, the DOJ, state attorneys general, and contracted auditors, as well as private plaintiffs.

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, which has led to a number of investigations, prosecutions, convictions and settlements in the healthcare industry. Recent enforcement actions have focused on, among other things, financial arrangements between hospitals and providers, 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 OIG Work Plan. Dealing with investigations can be time and resource consuming and can divert management's attention from the business. Any such investigation or settlement could increase our costs or otherwise have an adverse effect on our business. In addition, because of the potential for large monetary exposure under the False Claims Act, which provides for treble damages and substantial civil monetary penalties for each separate false claim or statement, healthcare providers often resolve allegations without admissions of liability for significant and material mounts to avoid the uncertainty of damages and penalties that may be awarded in litigation proceedings. Such settlements often contain additional compliance and reporting requirements as part of a consent decree, settlement agreement or corporate integrity agreement. These additional requirements can result in significant additional and ongoing expenditures. Given the significant size of actual and potential settlements, it is expected that the government will continue to devote substantial resources to investigating healthcare providers' compliance with the healthcare payment rules and fraud and abuse laws. 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.

The laws and regulations with which we must comply continually change. 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. Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws and regulations, many of these laws and regulations are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable laws and regulations. If we fail to comply with applicable laws and regulations, we could suffer substantial civil or criminal penalties, including the loss of our licenses to operate our facilities or loss of our ability to participate in the Medicare, Medicaid and other governmental programs.

Additionally, we are subject to a variety of different federal, state and local employment and wage and hour laws. While we strive to comply with those laws, if we fail to do so, we may be subject to lawsuits by governmental authorities or private plaintiffs. In addition, the Internal Revenue Service ("***IRS***") and/or state taxing authorities may successfully challenge positions taken on our tax returns.

Finally, we are also 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 facilities, 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 False Claims Act prohibits healthcare facilities and providers, as well as other entities or individuals from, among other things, knowingly submitting false claims for payment to the federal government, or knowingly causing the submission of such claims. 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 False Claims Act may be required to pay up to three times the actual damages sustained by the government, plus substantial civil monetary penalties, that are subject to annual inflation adjustments, for each separate false claim.

There are many potential bases for liability under the False Claims Act, including reckless or intentional acts or omissions. The government has used the False Claims Act to prosecute Medicare and other government healthcare program violations 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. The Affordable Care Act also (i) created potential False Claims Act liability for failing to report and repay identified overpayments within sixty (60) days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later, and (ii) provided that claims submitted in connection with patient referrals that result from violations of the Anti-kickback Statute constitute false claims for the purposes of the False Claims Act. Some courts have held that a violation of the Stark law can result in False Claims Act liability as well. In addition, 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 ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable fraud and abuse laws.

Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may limit our revenues and profitability.

The amounts we receive for services provided to patients are determined by a number of factors, including the payer mix of our patients and the reimbursement methodologies and rates utilized by our payers. In recent years, we have seen shifts of patients from commercial and private insurance to Medicare and Medicaid programs and from "traditional" fee-for-service Medicare and Medicaid programs to "managed" Medicare and Medicaid programs. Some members of Congress have also recently proposed measures that would expand government-sponsored coverage, including "Medicare-for-all" or other single-payer proposals. Reimbursement rates generally are lower for (i) Medicare and Medicaid beneficiaries than they are for patients whose care is covered by commercial and private insurance and (ii) managed Medicare and Medicaid beneficiaries than they are for traditional Medicare and Medicaid beneficiaries. We also experience demographic pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs. Our revenues and results of operations may be adversely affected by these shifts.

In addition, our revenues from negotiated rates with HMOs, PPOs, insurance companies, employers and other private payers may decline based on renegotiations and the respective bargaining power of the parties. There is a general trend towards further consolidation among private payers, which may increase their bargaining power over fee structures. As a result, payers 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. These changes include moving away from a percent of charge payment structure to a fixed payment for an episode of care, which typically reduces our payment rate and limits our ability to raise prices going forward. Furthermore, low cost plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices, restrict or exclude our facilities or impose significantly higher cost sharing obligations for care provided by our facilities if they are classified in a disfavored tier. In addition, other healthcare providers, including some with greater financial resources, greater geographic coverage or a wider range of services, may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care plans to contract with us.

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

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

We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. Also, if we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations or it could diminish the anticipated value of the acquired facility.

We may be unable to timely and effectively integrate facilities that we acquire with our ongoing operations. 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. Additionally, we may experience delays in reimbursement from governmental and third-party payers as a result of the change of ownership of our acquired facilities.

We must integrate complex information, accounting and operational systems, compliance programs 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 provider and staff morale and our ability to accurately manage accounting, clinical, compliance and operational functions. As future acquisitions may involve large operations, any such failure could cause a material adverse effect on our results of operations.

Facilities we have acquired, including in connection with the LifePoint/RCCH Merger, or facilities we acquire in the future, may have unknown or contingent liabilities for historical activities or conditions, including liabilities for failure to comply with laws and regulations, retroactive payment adjustments or recoupments from payer audits, medical and general professional malpractice liabilities, unfunded pension liabilities, workers' compensation or other employee-related liabilities, previous tax or environmental liabilities, regulatory and compliance related liabilities, and unacceptable business or accounting practices. Although we endeavor to obtain contractual indemnification from sellers covering these matters in connection with some acquisitions, we have not obtained contractual indemnifications in connection with all of them, and any indemnification obtained from sellers may be insufficient to cover material claims or liabilities for past activities of acquired businesses and the sellers may have insufficient funds to satisfy any claims or liabilities for which we may otherwise be entitled to be reimbursed.

We typically retain and rely on existing local management teams at newly acquired facilities to implement changes to operating procedures and systems. Integrating local management teams can involve cultural and systems challenges that may demand a disproportionate share of our resources and senior management's attention, and we may experience turnover of providers and other key personnel. Our acquisitions have become, and may continue to become larger, and may occur in communities with competing facilities. As a result, the issues surrounding integration may become more complex, expensive and time-consuming and may have a greater impact on our financial performance when we experience delays or difficulties.

If our fair value declines or if our estimated future cash flows decrease, a material non-cash charge to earnings from impairment of our goodwill or our long-lived assets could result.

As of December 31, 2018, we had approximately $2,642.1 million of goodwill and other intangible assets and approximately $4,317.1 million of long-lived assets, net of accumulated depreciation. We expect to recover the carrying values of both our goodwill as well as our long-lived assets through our future cash flows. We evaluate the carrying value of our goodwill at least annually, based on our fair value, to determine whether it is impaired. We evaluate our 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. If the carrying value of our goodwill or our long-lived assets is impaired, we may incur a material non-cash charge to earnings.

We will 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 will be subject to medical malpractice lawsuits and other legal actions arising out of the operations of our facilities and the activities of our employed or affiliated providers. 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. Furthermore, some states in which we operate do not impose caps on non-economic malpractice damages and, even in the states that have imposed caps on such damages, litigants may seek recoveries under alternative theories of liability that might not be subject to such caps. 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 an SIR insurance program administered in-house by our risk department with assistance from our insurance brokers. Any successful claim against us that is within our SIR amounts could have an adverse effect on our 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 attachments. One or more of our insurance carriers may become insolvent and unable to fulfill its obligation to pay or reimburse us when that obligation becomes due. In addition, providers using our facilities may be unable to obtain insurance on acceptable terms, which could result in these providers not being able to meet the minimum insurance requirements in the applicable facilities' 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 and Medicaid 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 patients admitted as inpatients to general acute care hospitals for certain procedures and audits of claims under the RAC programs to detect overpayments not identified through existing claims review mechanisms. RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those 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.

In addition, CMS and the states use UPICs to perform post-payment audits of claims and identify Medicare and Medicaid overpayments. 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 may have a material adverse effect on our results of operations.

Controls designed to reduce inpatient services may reduce our revenues.

Over the last several years, payers have instituted policies and procedures to reduce or limit the use of inpatient services. Controls imposed by Medicare, Medicaid, and commercial third-party payers 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 payment are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by QIOs, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of the MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. QIOs may deny payment for services or assess fines and also have the authority to recommend to HHS that a provider that is in substantial noncompliance with quality standards be excluded from participation in the Medicare program.

Utilization review is also a requirement of most non-governmental managed care organizations and other third-party payers. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Additionally, in some states in which we operate, commercial third-party payers and Medicaid managed care plans have instituted policies that retroactively limit or deny patient coverage for emergency department and certain other services provided at hospitals if the payers believe the services could have been provided in less expensive settings. For example, such payers are increasingly seeking to pay relatively low "triage fees" for patients seen in emergency departments when the payers retrospectively determine the patients' treatment did not qualify as an emergency service. Significant limits on the scope of services reimbursed or on the amounts paid for such services 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.

We outsource selected business functions to third parties. We take steps to monitor and regulate the performance of independent third parties to whom we delegate selected functions, including revenue cycle management, patient access, billing, cash collections, payment compliance and support services, project implementation, supply chain management, payroll system services and parts of cybersecurity. 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, including for violations of HIPAA and other privacy and security laws applicable to healthcare providers, and we may not have effective recourse against the providers for those harms. The expanding role of third party providers may also require changes to our existing operations and the adoption of new procedures and processes for retaining and managing these providers, as well as redistributing responsibilities as needed. 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, transitioning or renegotiating arrangements with key vendors or failure to renegotiate on favorable terms 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 or renegotiation phase.

We conduct a significant portion of our operations through joint ventures. We cannot provide assurances that relationships with our joint venture partners will remain strong, which could negatively affect our joint ventures, affiliations and other strategic alliances as well as our overall business.

We have completed a number of joint ventures, affiliations and other strategic alliances as part of our business strategy. We expect to enter into similar transactions in the future, including joint ventures where we may have a minority or non-controlling interest. We believe our relationships with our joint venture partners are strong; however, any changes in these relationships could disrupt ongoing business, negatively affect cash flow and distract management and other key personnel.

The largest of our joint ventures is Duke LifePoint Healthcare, which is owned by us and a wholly-controlled affiliate of Duke University Health System, and which currently operates 14 hospital campuses in four states. In recent years, many of Legacy LifePoint's 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 University Health System. In the event of a material disagreement with Duke University Health System 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 or another significant joint venture partner is not dissolved or unwound, our inability to involve Duke LifePoint Healthcare or other significant joint venture partners 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.

As a general matter, our joint venture partners may have investment and operational goals that are not consistent with our company-wide objectives, including the timing, terms and strategies for future growth and development opportunities, and we could reach an impasse on certain decisions, which may hinder our ability to pursue preferred strategies for growth and development, could require significant resources and attention from management and key employees to resolve and could have an adverse effect on our operations, cash flow and revenue growth. In addition, our joint venture relationships with not-for-profit partners and the agreements that govern these relationships are structured based on current provisions of the Internal Revenue Code of 1986, as amended (the "***Code***") (and the Treasury Regulations thereunder), published rulings by the IRS, as well as case law relevant to joint ventures between for-profit and not-for-profit entities. Material changes in these legal authorities could adversely affect our relationships with not-for-profit partners and related joint venture arrangements.

Furthermore, joint ventures in which we have a minority equity interest and minority investments inherently involve a lesser degree of control over business operations, thereby potentially increasing the financial, legal, operational and compliance risks associated with the joint venture or minority investment. We may be dependent on joint venture partners or management who may have business interests, strategies or goals that are inconsistent with ours. Business decisions or other acts or omissions of the joint venture partner or management may adversely affect the value of our investment, result in litigation or regulatory action against us, result in reputational harm to us or adversely affect the value of our investment or partnership. To the extent another party makes decisions that negatively impact the joint venture or internal control issues arise within the joint venture, we may have to take responsive or other actions or we may be subject to penalties, fines or other related actions for these activities.

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

We employ a large number of physicians. Physician employment by acute care facilities, where permissible, is a trend in the industry and has become more common as a result of actual and potential reductions in payment amounts for physician services and increasing costs to physicians, such as EHR implementation and professional liability insurance expenses. Employed physicians generally present more direct risks to us than those presented by independent members of our hospitals' medical staffs, such as risks of unsuccessful physician integration, challenges associated with physician practice management and compliance risks arising from the increased billing and coding activities associated with the employment of physicians, the possibility of legal claims under federal and state employment law, and governmental scrutiny of physician employment arrangements. Employed physicians also require us to incur additional expenses, such as increased salary and benefit costs, medical malpractice expense and rent expense. Payments received by us for services provided by our employed physicians, the physicians to whom our facilities have provided recruitment assistance, and the physician members of our medical staffs could be adversely affected as physician payment methodologies move toward pay-for-performance as hospital payment models are doing. The combination of payment cuts, potential liabilities and increased expenses could have an adverse effect on our results of operations.

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 uninsured patient accounts and patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (exclusions, deductibles and co-payments) remain outstanding. The provision for doubtful accounts relates primarily to amounts due directly from patients. The amount of our provision for doubtful accounts is based on management's assessment of historical collection trends, business and economic conditions, trends in federal and state governmental and private employer health coverage, the rate of growth in uninsured patient admissions and other collection indicators. While we have experienced a reduction in uninsured patients as a result of the Affordable Care Act, 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 larger deductibles and/or co-payments, including those purchased on insurance exchanges.

If we experience growth in self-pay volume and revenue, including increased acuity levels for uninsured patients and increases in co-payments and deductibles for insured patients, our revenues and results of operations could be adversely affected. Although we have experienced a reduction in uninsured patients since 2014 as a result of the Affordable Care Act and the expansion of state Medicaid programs, we are unable to predict whether that trend will continue in light of the repeal of the penalties associated with the individual mandate, the cessation of the cost sharing reduction payments to insurers, and the decision by some states not to expand their Medicaid programs. In addition, the risk of collection from insured patients (and the amounts due) has increased, and will likely continue to increase, as a result of more individuals being enrolled in insurance plans with high deductibles and high co-payments. Furthermore, our ability to improve co-insurance collections and collections from self-pay patients may be limited by legislative developments, such as federal and state legislation designed to reduce "surprise billing," or by other regulatory or investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

An increase in the proportion of our accounts receivable being comprised of uninsured accounts and a deterioration in the collectability of these both insured and uninsured accounts could adversely affect our results of operations and revenues. Even if the Affordable Care Act remains implemented in its current form, we may continue to experience bad debts and be required to provide uninsured discounts and charity care for patients who choose not to purchase coverage, are undocumented immigrants who are not permitted to enroll in the Exchanges or government healthcare programs or live in states that do not expand or maintain the expansion of their Medicaid programs.

We are subject to potential legal and reputational risk as a result of our access to personal information of our patients and employees.

HIPAA and numerous other federal and state laws and regulations govern the collection, dissemination, use, privacy, security, confidentiality, integrity, and availability of personally identifiable information ("***PII***") and PHI. HIPAA imposes privacy and security requirements on healthcare providers who are covered entities such as us, including to implement reasonable and appropriate administrative, physical and technical safeguards to protect PHI, including PHI maintained, used and disclosed in electronic form, and data breach notification requirements for certain unauthorized access, acquisition, use or theft of PHI. The safeguards include employee training, identifying "business associates" with whom we need to enter into HIPAA-compliant contractual arrangements, and various other measures. We are required to develop and adopt a comprehensive set of policies and procedures to comply with HIPAA and other privacy and information security laws. Ongoing implementation and oversight of these measures involves significant time, effort and expense. In the ordinary course of our business, we, and vendors acting on our behalf, collect, transmit, share and store sensitive data, including PHI and PII of our patients and employees. Such information is at risk of accidental or intentional misuse or disclosure, and is often targeted by criminal organizations. The secure processing, maintenance and transmission of this information is critical to our operations and business strategy. 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 PHI or PII, such event could disrupt our operations, result in increased data protection costs, damage our reputation, or result in regulatory penalties, legal claims and civil or criminal liability under HIPAA and other state and federal laws, which could have a material adverse effect on our results of operations.

HHS requires covered entities to report breaches of unsecured PHI to affected individuals without unreasonable delay and in no case later than 60 days after the discovery of the breach by the covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HIPAA creates a presumption that all non-permitted uses or disclosures of unsecured PHI are breaches unless the covered entity establishes that there is a low probability the information has been compromised. HHS has imposed substantial mandatory civil and criminal penalties for violations of HIPAA's requirements, with potential civil penalties exceeding $1.7 million in a calendar year for multiple violations of the same requirement in a single year. Moreover, because a single breach incident can result in multiple violations of multiple requirements, potential penalties can range much higher. We are also subject to state breach notification laws which may differ from HIPAA. In addition, state attorneys general and private plaintiffs have brought civil actions seeking injunctions and damages in response to violations of state or federal privacy laws or HIPAA's privacy, security and breach notification rules, as applicable. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for violations of HIPAA's requirements, its standards have been used as a basis for the duty of care in state civil suits, such as those for negligence or recklessness in the handling of PHI. In addition, HIPAA mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities such as us, and has reserved the right to initiate enforcement actions where it discovers noncompliance.

In addition, many states in which we operate may impose laws that are more protective of the privacy and security of PII than HIPAA. Where these state laws are more protective of individual privacy than HIPAA, we have to comply with their stricter provisions. Not only may some of these state laws impose fines and penalties upon violators, but some may also afford private rights of action to individuals who believe their PII has been misused. Both state and federal laws are subject to modification or enhancement of privacy protection at any time. Our facilities will continue to remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These statutes vary and could impose additional requirements on us and more severe penalties for disclosures of confidential health information. New health information standards could have a significant effect on the manner in which we do business, and the cost of complying with new standards could be significant. We may not remain in compliance with the diverse privacy requirements in all of the jurisdictions in which we do business. If we fail to comply with HIPAA or similar state laws, we could incur substantial civil monetary or criminal penalties.

A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

We rely extensively on our information systems and certain systems operated by us and third-parties to manage clinical, financial and employee data, communicate with our patients, payers, vendors and other third parties and summarize and analyze operating results. These systems are at risk from cybersecurity attacks and other intrusions, including attempts to gain unauthorized access to and theft of our confidential data, misuse, corruption or destruction of confidential data and damage, disruptions or shutdowns of these systems due to viruses, malware, ransomware, employee error or malfeasance, and other electronic security breaches. Our systems, which transmit and store sensitive and confidential data, including PHI and other PII of our patients, employees and others, and our proprietary and confidential business performance and other data, will continue to be a target for attempts to gain unauthorized access and data theft due to the valuable nature of the information they contain, as well as at risk for accidental exposure. In addition, certain third-party medical devices and equipment are used at our facilities, and may be vulnerable to cybersecurity attacks or other breaches which could negatively impact our systems or our patients.

Cybersecurity breaches and other unauthorized access to our data can sometimes be difficult to discern, and any delays in detection may lead to increased harm. Such attacks or breaches are common in the healthcare sector and could result in the compromise of health information or other data subject to protection by HIPAA and other laws and regulations, or disrupt our IT systems or business. While we are not aware of having experienced a material cybersecurity breach, there can be no assurance that we will not be subject to material cyber-attacks or security breaches in the future, or that the preventive actions we take to reduce the risk of such incidents and protect our IT and data will be sufficient. We continue to prioritize cybersecurity and the development of practices and controls to protect our systems. However, regardless of the nature, extent and timing of our actions, these measures may not prevent security breaches. If our services are subject to cyber-attacks that impair or deny the ability of patients to access our services, current and potential patients may become unwilling to provide us the information necessary for them to become users of our services or may curtail or stop using our services. As cyber-threats continue to evolve, we may be required to expend significant additional resources to continue to modify or enhance our protective measures and to investigate and remediate any information security vulnerabilities. As we are subjected to cyber-attacks and possible security breaches in the future, this could have an adverse impact on our business, reputation, financial condition and results of operations. See "—We are subject to potential legal and reputational risk as a result of our access to personal information of our patients and employees" for more information.

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

We require substantial capital resources to fund our growth strategy and ongoing capital expenditure programs, including capital expenditure programs for renovation, expansion and construction at our facilities and the addition of equipment and technology at our facilities. We often commit to significant capital expenditures well in advance of the time these expenditures will be made. Our cash flows and available capital resources may be insufficient to fund our capital expenditure programs and commitments, and we may be forced to reduce or delay planned and required capital expenditures. Additionally, we may experience delays or impediments in satisfying the schedule for capital expenditure commitments because of a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions. The failure to satisfy our capital expenditure commitment obligations could also 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.

At December 31, 2018, we estimated our total remaining capital expenditure commitments to be approximately $1,436.3 million, which generally have remaining terms of three to seven years. Of this amount, approximately one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time. 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. As a result, if our cash flows and available capital resources are not sufficient to fund all of our anticipated capital expenditures, it may be necessary for us to give priority to contractual capital expenditure commitment obligations over other elective capital expenditure programs.

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

Competition among hospitals and other healthcare service providers, including outpatient facilities, has intensified in recent years. We also have acquired, and may continue to acquire, larger facilities in more concentrated population centers, which experience greater competition for healthcare services. We compete with other facilities, including larger tertiary and quaternary care centers located in metropolitan areas. Although the facilities 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 providers to, or may be required by their health plan to travel to these facilities. Furthermore, some of the facilities with which we compete may offer more or different services than those available at our facilities, may have more advanced equipment or technology or may have a medical staff that is perceived to be better qualified. We also compete with facilities and health systems that are implementing physician and other provider alignment strategies, such as employing providers, acquiring physician practice groups and participating in ACOs or other clinical integration models, which may impact our competitive position. Also, many of the facilities that compete with our facilities are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions and are eligible to participate in the 340B Program. These facilities, in most instances, are also exempt from paying sales, property and income taxes and have the ability to issue tax-exempt bonds for financing.

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 facilities submit in connection with their Medicare payment. CMS also requires every Medicare participating hospital to establish and update annually a public online listing of the hospital's standard charges for items and services. If the publicly-available performance and charge data become a primary factor in where patients choose to receive care, and if competing facilities have lower charges or better results than our facilities on those measures, our revenues and/or patient volumes could decline.

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

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

There is a trend in the healthcare industry toward value-based purchasing of healthcare services and bundled payment arrangements. Value-based purchasing programs include both public reporting of quality data and payment limitations tied to the incidence of preventable adverse events or the quality and efficiency of care provided by facilities. For example, Medicare, Medicaid and many large commercial payers may require facilities to report certain quality data to receive full payment updates or avoid payment reductions. They may also impose payment reductions in connection with HACs and excessive readmissions for certain conditions designated by HHS. Our revenue may be negatively impacted by the application of one or more of these measures. Bundled payment arrangements generally set target payment amounts for all healthcare services provided to patients during particular episodes of care. They are intended to create incentives for physicians, hospitals and other providers to work together to provide higher quality and more coordinated care at a lower cost. We currently participate in a few ACOs as well as a number of bundled payment programs, and we expect value-based purchasing programs, including programs that condition payment on patient outcome measures, to become more common and to involve a higher percentage of payment amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively affect our revenues.

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

The success of our business operations depends on the number and quality of the physicians and other healthcare providers who perform services at our facilities. Our ability to recruit and retain quality providers in turn depends on several factors, including the actual and perceived quality of services furnished by our facilities, our ability to meet demands for new technology, our ability to identify and communicate with providers who want to practice in our communities and our ability to provide competitive financial compensation packages. Our ability to attract and retain providers is increasingly dependent on the ability of our facilities to offer and sustain employment arrangements. In particular, we face intense competition in the recruitment and retention of specialists and primary care providers. We may not be able to recruit all of the providers we target. In addition, we may incur increased malpractice, compliance or insurance expense depending on the quality of providers' clinical outcomes.

Additionally, our ability to recruit and employ providers 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 and self-referral 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 by them. 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 providers, and this competition continues after the provider is practicing in one of our communities. For example, integrated ACOs and other kinds of "narrow" provider networks or organizations may exclude our providers from their plans' networks of healthcare providers. These contracting networks often organize hospitals, providers and ancillary healthcare providers into exclusive networks involving fewer healthcare providers. If our affiliated providers are excluded from such networks, we may have difficulty recruiting new providers or retaining existing providers.

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

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.

We may have difficulty acquiring facilities on favorable terms. Furthermore, our business could be negatively affected if acquisitions are not successfully completed or if contingent liabilities materialize in connection with such transactions.

A significant element of our business strategy is expansion through the acquisition of acute care facilities, especially those around which a system of facilities and other healthcare services can be created. We face significant competition to acquire attractive facilities, and we may not find suitable acquisitions on favorable terms. Our primary competitors for acquisitions have included for-profit and tax-exempt facilities and hospital systems and privately capitalized start-up companies. Buyers with a strategic desire for any particular facility—for example, a facility located near existing facilities or those who will realize economic synergies—have demonstrated an ability and willingness to pay premium prices for facilities. 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 facility's results of operations, allocation of purchase price, effects of subsequent legislation and limitations on rate increases. As part of our acquisition strategy, we may commit to making significant capital improvements at acquired facilities. Such improvements may be difficult to achieve in the anticipated timeframe, if at all, due to a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions.

Our ability to engage in certain acquisitions in several states may be limited due to exclusivity, non-competition and non-solicitation provisions that we have agreed to in connection with our joint ventures (including Duke LifePoint Healthcare) and previous acquisitions and divestiture transactions. Additionally, certain acquisitions may require the consent of and collaboration with our joint venture partners based upon the applicable governing documents. If we cannot obtain the cooperation of our joint venture partners in certain instances, we may not be able to pursue these opportunities.

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.

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

Many of the non-urban communities in which we operate continue to face challenging economic conditions and demographic trends, which may materially and adversely impede our business strategies intended to generate organic growth and improve operating results at our facilities.

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

- defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for facilities; or
- purchase a high-deductible insurance plan or no insurance at all, which increases a facility's dependence on self-pay revenue. Moreover, a greater number of uninsured patients may seek care in our emergency rooms.

Additionally, non-urban communities are experiencing a much slower rate of growth, if any, as compared to more concentrated population centers. As a result, we may experience payer mix pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs.

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

If we are unable to implement successfully standardized processes, policies and systems throughout our facilities, our operating results could be negatively impacted.

We have initiated a multi-year business initiative to standardize certain processes, policies and systems throughout our facilities, including migrating our multiple IT platforms to a smaller number of enterprise-wide systems solutions. If we do not allocate and effectively manage the resources necessary to build and sustain the proper IT infrastructure and implement standardized systems, or if we fail to achieve the expected benefits from this initiative, it may impact our ability to operate profitably and efficiently, and comply in a timely manner with changing regulatory requirements and with the requests of patients, payers and business partners. The failure to transition to these systems on time, or anticipate necessary readiness and training needs, could lead to business disruption and loss of revenue. In addition, the operating results of newly acquired facilities could be impacted if such facilities are not integrated on a timely basis into our new systems. The actions we take to resolve compliance or regulatory issues within acquired facilities may affect our revenue or results of operations.

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 may require changes to our systems in the future. System conversions are costly, time consuming and disruptive for providers, staff and, in some cases, patients. Some of our facilities have recently converted or are currently converting from their existing system to another third party information system. If such conversions occurred on a large scale or if conversions at our larger facilities experience difficulties, the costs and disruptions could have a material adverse effect on our revenues or results of operations.

If access to our information systems or those provided by our third party vendors 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. In addition to our own systems, we rely on multiple third party providers of financial, clinical, supply chain, 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, regulatory or payer obligations or information requests. Our networks and technology systems are also subject to disruption due to events such as a major earthquake, fire, flood, hurricane, telecommunications failure, terrorist attack or other catastrophic event. 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 more urban healthcare markets and not suited for our facilities, our operations could suffer.

We intend to expand our operations, including by acquiring more facilities, which will require us to integrate and transition certain existing information systems. In addition, as new information systems are developed in the future, we will need to integrate them into our existing systems. Evolving industry and regulatory standards, such as the HITECH Act, HIPAA and EHR meaningful use regulations, also may require changes to our information systems in the future. System conversions are costly, time consuming and disruptive for providers, staff and, in some cases, patients. If such conversions occurred on a large scale or if we are unable to properly integrate other information systems or expand or update our current information systems, the costs and disruptions could have a material adverse effect on our revenues or results of operations.

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

In addition to depending on our physicians and other providers, the operations of our facilities are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians. We compete with other healthcare facilities in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our facilities, including physician assistants, 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 (which may be limited by changes in immigration law, regulation and policy), and hire more expensive temporary or contract personnel. In addition, the states in which we operate could adopt mandatory nurse staffing ratios or could increase mandatory nurse-to-patient 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. Some of the employees at some of our facilities are represented by a union, and others may be in the future, which can also increase the cost of labor. 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.

Labor union activity could raise costs and interfere with our operations. Certain of our employees are union members and subject to the terms of collective bargaining agreements.

Increased or ongoing labor union activity is another factor that could adversely affect our labor costs or otherwise adversely impact us. Several of our facilities have unionized employees. When a new collective bargaining agreement with a union must be negotiated, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur, and our operations could be disrupted or our labor costs increased as a result of these disruptions. Our labor costs also could increase significantly if a substantial number of other employees at our facilities unionize.

If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained.

The terms of the collective bargaining agreements also set forth certain requirements related to the respective facility's employment practices, seniority, hours of work, overtime, holidays, use and redemption of paid time off, extended illness bank, vacation scheduling, compensation, pay practice, health and non-health benefits, leaves of absence, grievance procedures, disability accommodations and the facility's drug and alcohol policies. If these facilities fail to fulfill any of these requirements, it could result in discussions with union representatives or the filing of a grievance that could be costly and time-consuming for those facilities. Furthermore, the terms of the collective bargaining agreements constrain our flexibility with respect to these and other employee issues. The inability to negotiate future collective bargaining agreements on favorable terms with these employees or with other unionized employees could have a material adverse effect on our business, results of operations and financial condition.

If we fail to implement and maintain certified electronic health record and coding systems in an effective and timely manner, our operations could be adversely affected.

The Medicare and Medicaid Promoting Interoperability Programs (formerly known as the Medicare and Medicaid EHR Incentive Programs for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals, and formerly referred to as "***Meaningful Use***") was established in 2011 to encourage eligible professionals, eligible hospitals, and critical access hospitals to adopt, implement, upgrade and demonstrate meaningful use of certified health information technology ("***Certified HIT***") for the purposes of advancing care coordination and improving the quality of care. In 2018, CMS merged the Meaningful Use program into the programs that are being created under MACRA, included this technology requirement as one of the four components of MIPS, and changed the name of the Meaningful Use program to the Promoting Interoperability Program. Each year, HHS and CMS revise standards required for use of Certified HIT, and they periodically revise standards required for a technology's designation as a Certified HIT. In order to meet the requirements for the Promoting Interoperability Program, we must implement, maintain and use technology that meets the Certified HIT standards. In addition, use of Certified HIT is required for reporting under other CMS payment programs, such as ACOs and bundled payment programs. Certain of our EHR's will require software upgrades in the future in order to continue being categorized as Certified HIT as designated by HHS. Failure to effectively comply with the new requirements of the Promoting Interoperability Program, implement EHR systems or maintain current requirements for EHR systems effectively and in a timely manner could have a material adverse effect on our revenue generated from Medicare Part B claims and other CMS QPPs in which we participate.

Under Meaningful Use, we received certain incentive payments related to our efforts to implement our EHR. Incentive payments we have received in prior years for EHR implementation were materially reduced over the program's life to immaterial amounts in 2017 and 2018. 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.

Under Meaningful Use, we received certain incentive payments related to our efforts to implement our EHR. Incentive payments we have received in prior years for EHR implementation were materially reduced over the program's life to immaterial amounts in 2017 and 2018. EHR incentive payments that we have previously recognized are subject to audit by CMS and potential recoupment for up to the past six years if it is determined that we did not meet the applicable Meaningful Use standards required in connection with such incentive payments. To the extent a CMS audit determines that we did not meet the reporting requirements for Meaningful Use, the Company would be subject to the potential recoupment of the incentive and other payments previously received in connection with the Meaningful Use program. In addition, reporting under MIPS results in either a negative or positive per claim payment adjustment by CMS and potential bonus payments, as well. To the extent a CMS audit determines that we did not meet the reporting requirements of the Promoting Interoperability Program, the Company would be subject to potential recoupment of any positive adjustments or bonus payments that were previously made. A determination by CMS that the Company has made a false attestation regarding its Meaningful Use or Promoting Interoperability Program participation could also potentially be grounds for prosecution under the False Claims Act or other applicable federal fraud and abuse laws.

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. Certain states in which we operate facilities require a certificate of need for the purchase, construction or expansion of hospital facilities, capital expenditures exceeding a prescribed amount, changes in bed capacity or services, or for other hospital-related activities. We may not be able to obtain certificates of need required for expansion activities or to effectively compete with competing healthcare providers in the future. In addition, all of the states in which we operate facilities require hospitals, other healthcare facilities, 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.

In the states in which we operate that do not require certificates of need for the purchase, construction and expansion of hospital facilities, competing healthcare facilities face lower regulatory barriers to entry and expansion. If competing healthcare entities 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.

The implementation of participation and quality measurement requirements under the MACRA's Merit-Based Incentive Payment System may affect our revenues.

Under MACRA, CMS updates payment rates for physician services based on inflation, and implements the QPP that rewards value and outcomes through participation in MIPS or an APM program. Beginning in 2017, MIPS started measuring provider performance under four categories: quality, improvement activities, promoting interoperability and cost, and annually establishes a point threshold for each category and overall performance. In 2019, MIPS began rewarding or penalizing providers based on performance reported in CY 2017 and subsequent years. The MIPS adjustment has a more significant impact on claims' payment than the annual inflationary update to the Medicare PFS.

Although CMS estimates that less than half of all clinicians, which includes physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists, who bill Medicare Part B are eligible for MIPS, physicians are required to participate unless they are participants of an APM, are newly enrolled in Medicare, or see a low volume of Medicare patients (i.e., no more than 200 patients in a calendar year or $90,000 in charges for professional services). MIPS eligible clinicians are subject to a payment adjustment of plus or minus 4% in CY 2019 (based on CY 2017 performance) with the payment adjustment increasing each year until it reaches plus or minus 9% in CY 2022 and beyond. MIPS eligible clinicians with exceptional performance may receive up to 10% bonus payment. However, for CY 2019, CMS projects that only 1.5% of participating MIPS eligible clinicians will receive a bonus, with this amount only increasing to 3.6% of MIPS eligible providers in CY 2021 (based on 2019 performance). Providers participating in an APM may be eligible for more advantageous adjustments under MIPS (or avoid any negative adjustment) and receive a 5% bonus. At this time, we have limited participation in APMs.

If an eligible clinician has not been satisfactorily participating in MIPS, his or her claims for Medicare Part B services are likely to be subject to negative payment adjustments in CY 2019 (which is based on 2017 performance), CY 2020 (which is based on CY 2018 performance) and CY 2021 (which will be based on CY 2019 performance). For participating eligible clinicians that meet or exceed the MIPS threshold or APM requirements, claims for payment are likely to be subject to positive adjustments as well as a share of an additional pool of bonus payments. At this time, and as CMS continues to modify MIPS payment policies, it is unclear how MIPS will impact our overall physician payments under the Medicare program. If we have not timely and effectively implemented policies and procedures, quality programs and appropriate clinician contracting to ensure compliance with MACRA and other QPP requirements, we would experience a negative effect on future revenues related to Medicare Part B claims.

MACRA requires that CMS publish each eligible clinician's MIPS score and performance category scores on its Physician Compare website. CMS has stated that it will report scores based on CY 2017 performance in early 2019. Publishing of MIPS scores could have an adverse reputational effect on us if our employed physicians have low scores or scores that are lower than those of the other clinicians in the relevant communities.

If current or future laws or regulations force us or cause us to restructure our arrangements with physicians and other providers, we may incur additional costs, lose contracts and suffer a reduction in net revenue under existing contracts, and we may need to refinance our debt or obtain consent from our lenders.

A number of laws bear on our relationships with our physicians and other providers. There is a risk that state authorities in some jurisdictions may find that our contractual relationships with our physicians violate laws prohibiting the corporate practice of medicine and fee-splitting. These laws generally prohibit the practice of medicine by lay entities or persons and are intended to prevent unlicensed persons or entities from interfering with or inappropriately influencing the physician's professional judgment. They may also prevent the sharing of professional services income with non-professional or business interests. In states that have enacted corporate practice of medicine and fee-splitting prohibitions, we believe that we have structured our physician contracts in an effort to remain compliant with such laws. A regulatory agency, however, could still make a determination that our arrangements constitute a corporate practice of medicine or fee splitting violation. A review or action by regulatory authorities or the courts could force us to terminate or modify our contractual relationships with physicians and affiliated medical groups or revise them in a manner that could be materially adverse to our business.

In addition, we have also entered into a number of joint venture arrangements with physicians and other providers (e.g., hospitals and hospital operators) that are subject to state and federal fraud and abuse laws, including the Anti-kickback Statute and False Claims Act. See "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 criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may reduce our revenues and profitability." To the extent applicable, regulatory agencies may view these transactions as prohibited arrangements that must be restructured, or discontinued, or for which we could be subject to other significant penalties, including debarment, suspension or exclusion from state and federal government healthcare programs. Although compliance programs can mitigate the risk of investigation and prosecution for violations of these laws, the risks cannot be entirely eliminated. Any action against us for violation of these laws, even if we successfully defend against it, could cause us to incur significant legal expenses and loss of revenue from those joint ventures and divert our management's attention from the operation of our business.

We are dependent on our executive management team and the loss of the services of one or more of our executive management team could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our executive management team. In addition, we depend on the ability of our executive officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our executive management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our executive management team, we could experience a significant disruption in our operations and failure of the affected facilities to adhere to their respective business plans.

Difficulties with major expansion projects may involve delays and significant capital expenditures that could have an adverse impact on our operations and liquidity.

We may decide to construct major expansion projects to existing facilities or new facilities, including replacement facilities, in order to achieve our growth objectives. Our ability to complete new expansion projects on budget and on schedule would depend on a number of factors, including, but not limited to:

- our ability to control construction costs;
- adverse weather conditions;
- shortages of labor or materials;
- our ability to obtain necessary licensing and other required governmental authorizations; and
- other unforeseen problems and delays.

As a result of these and other factors, we cannot assure you that if we decide to pursue major expansion projects we will not experience greater construction or other expansion or replacement costs than originally planned in connection with such expansion or replacement projects. Additionally, we cannot assure you that such expansion or replacement projects will be completed in a timely manner. Any delays or other difficulties in our ability to complete new expansion or replacement projects on budget and on schedule could have a material adverse effect on our results of operations and liquidity.

Under the A&R Master Lease (defined below) that governs certain of our facilities, a default with respect to one facility could cause a default under all of the facilities subject to the A&R Master Lease, which would have a material adverse effect on our business, results of operations and financial condition.

If there is a default under that certain Amended and Restated Master Lease Agreement (the "***A&R Master Lease***") with MPT Camaro OpCo, LLC, a Delaware limited liability company and wholly-owned subsidiary of Medical Properties Trust, Inc. ("***MPT***"), a Maryland corporation operating as a real estate investment trust, even if such default relates to one facility, it may terminate the A&R Master Lease in its entirety with respect to all of the facilities governed by the A&R Master Lease.

Under the A&R Master Lease, we are subject to financial covenants based on certain fixed charges, and the failure to meet such covenants results in an event of default. Other events that could trigger a default under the A&R Master Lease if not cured within the time periods required by the A&R Master Lease include, without limitation, (i) failure to pay rent or other amounts due under the lease, (ii) failure to comply with the non-financial covenants under the lease, (iii) the bankruptcy of any facility lessee under the A&R Master Lease or guarantor under a Second Amended and Restated Guaranty, (iv) termination of any licenses necessary for operation of a facility or required for certification under Medicare or Medicaid, (v) a change of control (as defined in the A&R Master Lease) in violation of the A&R Master Lease and (vi) a default under any material documents between any lessee of the facilities and any lessor of any facility. The A&R Master Lease contains cross-default provisions so that a default with respect to one of our facilities may cause a default under the entire A&R Master Lease. Accordingly, a default under the A&R Master Lease that results in a termination of the A&R Master Lease would cause us to lose the ability to operate all of the facilities subject to the A&R Master Lease and to incur substantial costs in restoring the premises, which would have a material adverse effect on our business, results of operations and financial condition.

If the A&R Master Lease is terminated prior to its expiration because of a default and the applicable affiliate of MPT, as lessor, exercises its rights thereunder, in addition to losing the ability to operate our facilities, we may be liable for (i) damages and incur charges such as continued lease payments through the end of the lease term (or such shorter period as proscribed in the A&R Master Lease or by law) and (ii) maintenance costs for the leased property. Upon termination of the A&R Master Lease, we are obligated to restore the premises to its original condition and repair all damage caused by the installation or removal of our personal property, ordinary wear and tear excepted. We also have restoration obligations with respect to certain casualty and condemnation events. In addition, upon termination of the A&R Master Lease, the lessor has the option to purchase all of our personal property at fair market value.

Because the land used by many of the facilities we operate are subject to ground leases, failure to comply with the terms of such leases or failure to renew such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises.

The rights to use the land at many of our facilities are based upon long-term ground leases. Pursuant to the terms of these ground leases, we are required to pay all rent due and comply with all other lessee obligations. As of December 31, 2018, the remaining term of these ground leases (including renewal options) ranged from approximately 6 to 80 years. A pledge of our interest in some of these ground leases may also require the consent of the respective lessor and its lenders. As a result, we may not be able to sell, assign, transfer or convey our interest in certain facilities subject to such ground leases in the future absent consent of such third parties even if such transactions may be in our best interest. Most of the ground leases require that, upon the expiration or termination of the ground leases, we must surrender any improvements to the land to lessor. In addition, some of our ground leases include early termination provisions. We are typically responsible for all taxes, insurance, assessments and maintenance obligations under the ground leases. The ground leases also generally require the lessee to either reconstruct or restore the premises to its original condition following a casualty and to apply in a specified manner any proceeds received in connection therewith. In some leases the ground lessor has the option to purchase some or all of the assets owned by us and used in connection with the operation of the applicable facility. Accordingly, failure to comply with the terms of such leases, the invalidity of or default or termination under such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises, which could have a material adverse effect on our business, results of operations and financial condition.

If certain sale-leaseback transactions are not characterized as "operating leases" under GAAP, this could adversely affect our results of operations and our financial condition.

We have entered into sale-leaseback transactions in the past and may enter into similar sale-leaseback transactions for properties that we acquire in the future, including pursuant to that certain Strategic Agreement, dated as of March 21, 2016, with MPT Operating Partnership, L.P. ("***MPT Op***"), which grants MPT Op and its affiliates certain rights and options to provide future sale-leaseback funding or real estate loans for certain acquisitions of additional properties. Although we may intend, in some cases, for such leases to be accounted for as an "operating lease" pursuant to GAAP, depending on the terms of any specific transaction, our auditors might take the position that the leases should be accounted for as "financing obligations" under Accounting Standards Codification ("***ASC***") 840, "Leases" ("***ASC 840***"). In that event, this may materially affect assets and liabilities in our balance sheet and certain expenses in our income statement, which could have a material adverse effect on our results of operations and our financial condition.

Our debt agreements contain restrictions that will limit our flexibility in operating our business.

The ABL Agreement, the Term Loan Agreement and the Indentures contain, and any other existing or future indebtedness of ours would likely contain, a number of covenants that impose significant operating and financial restrictions on us, including restrictions on our and our subsidiaries ability to, among other things:

- incur additional debt, guarantee indebtedness or issue certain preferred shares;
- pay dividends on or make distributions in respect of, or repurchase or redeem, our capital stock or make other restricted payments;
- prepay, redeem or repurchase certain debt;
- make loans or certain investments;
- sell certain assets;
- create liens on certain assets;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates;
- alter the businesses we conduct;
- enter into agreements restricting our subsidiaries' ability to pay dividends; and
- designate our subsidiaries as unrestricted subsidiaries.

As a result of these covenants, we are limited in the manner in which we conduct our business, and we may be unable to engage in favorable business activities or finance future operations or capital needs.

In addition, the ABL Facility requires us to maintain a minimum fixed charge coverage ratio at any time when the average availability is less than the greater of $65.0 million and 10% of the lesser of the aggregate amount of revolving facility commitments and the borrowing base at such time. In that event, we must satisfy a minimum fixed charge ratio of 1.0 to 1.0. At December 31, 2018 we were in compliance with this financial maintenance covenant.

A failure to comply with the covenants under the ABL Facility, the Term Loan Facility, the Notes or any of our other future indebtedness could result in an event of default, which, if not cured or waived, could have a material adverse effect on our business, financial condition and results of operations. In the event of any such default, the lenders thereunder:

- will not be required to lend any additional amounts to us;
- could elect to declare all borrowings outstanding, together with accrued and unpaid interest and fees, to be due and payable and terminate all commitments to extend further credit;
- could require us to apply all of our available cash to repay these borrowings; or
- could effectively prevent us from making debt service payments on the Term Loan Facility and the Notes (due to a cash sweep feature under the ABL Facility).

Such actions by the lenders could cause cross defaults under our other indebtedness. If we were unable to repay those amounts, the lenders and holders under the ABL Facility, the Term Loan Facility and the Notes could proceed against the collateral granted to them to secure the ABL Facility, the Term Loan Facility or the Notes, respectively. If any of our outstanding indebtedness under the ABL Facility, the Term Loan Facility, the Notes or any of our other existing or future indebtedness were to be accelerated, there can be no assurance that our assets would be sufficient to repay such indebtedness in full.

Repayment of our debt is dependent on cash flow generated by our subsidiaries.

Repayment of our indebtedness, including the ABL Facility, the Term Loan Facility and the Notes, is dependent on the generation of cash flow by our subsidiaries and their ability to make such cash available to us, by dividend, debt repayment or otherwise. Unless they are guarantors of the indebtedness, our subsidiaries do not have any obligation to pay amounts due on such indebtedness or to make funds available for that purpose. Our subsidiaries may not be able to, or may not be permitted to, make distributions to enable us to make payments in respect of our indebtedness. Each subsidiary is a distinct legal entity and, under certain circumstances, legal and contractual restrictions may limit our ability to obtain cash from our subsidiaries. While our debt agreements will limit the ability of our restricted subsidiaries to incur consensual restrictions on their ability to pay dividends or make other intercompany payments to us, these limitations are subject to certain qualifications and exceptions. In the event that we do not receive distributions from our subsidiaries, we may be unable to make required principal and interest payments on our indebtedness. In the event we require restructuring or refinancing, we cannot assure you that we will be able to restructure or refinance any of our debt on commercially reasonable terms or at all.

Despite our substantial indebtedness, we may still be able to incur significantly more debt, which could intensify the risks described above.

We and our subsidiaries may be able to incur substantial indebtedness in the future. Although the terms of the ABL Agreement, the Term Loan Agreement and the Indentures contain restrictions on our and our subsidiaries' ability to incur additional indebtedness, these restrictions are subject to a number of important qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. As of December 31, 2018, we would have had approximately $580.0 million available for additional borrowing under the ABL Facility (without giving effect to letters of credit), all of which would be secured. In addition to the Notes and our borrowings under the ABL Facility and the Term Loan Facility, the covenants under any other existing or future debt instruments could allow us to incur a significant amount of additional indebtedness and, subject to certain limitations, such additional indebtedness could be secured. The more leveraged we become, the more we, and in turn our security holders, will be exposed to certain risks described above under "—Our debt agreements contain restrictions that will limit our flexibility in operating our business."

Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. To manage this risk, we entered into an interest rate swap agreement on December 21, 2018 with Citibank, N.A. as counterparty (the "Interest Rate Swap"). The terms of the Interest Rate Swap require us to pay a fixed rate of 2.63% on a notional amount of $1,100.0 million and, in exchange, we receive one-month London Interbank Offered Rate ("***LIBOR***"). The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. We have not designated our Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging" ("***ASC 815***"). Therefore, all changes in the fair value of our Interest Rate Swap will be recognized through interest expense in our results of operations. Changes in the fair value of our Interest Rate Swap could result in a material effect on our consolidated results of operations and financial position; however, we do not anticipate that changes in the fair value of our Interest Rate Swap will have any impact on our cash flows.

Discontinuation, reform or replacement of LIBOR may adversely affect our results of operations.

The U.K. Financial Conduct Authority announced in 2017 that it intends to phase out LIBOR by the end of 2021. Changes to LIBOR or any other benchmark rate may impact credit markets. Borrowings under our Term Loan Facility and ABL Facility bear interest at rates based on LIBOR. The administrative agent for those facilities may approve a comparable or successor rate with respect to LIBOR or, if not feasible, another accommodation as reasonably determined by the agent. The replacement of LIBOR with a comparable or successor rate could cause the amount of interest payable on our Term Loan Facility and ABL Facility to be different than expected.

Additionally, the notional amount associated with our Interest Rate Swap is based on LIBOR. If LIBOR becomes unavailable, it is unclear how payments under our Interest Rate Swap would be calculated. Relevant industry groups are seeking to create a standard protocol addressing the expected discontinuation of LIBOR, but there can be no assurance that such a protocol will be developed or implemented with respect to our Interest Rate Swap.

Our ability to utilize our net operating loss carryforwards may be limited, and we may not be able to utilize our net operating loss carryforwards as a result of recent U.S. federal tax reform legislation.

As of December 31, 2018, we had net operating loss carryforwards ("***NOLs***") of approximately $342.4 million for federal income tax purposes, which expire at various dates between 2028 through 2037 for NOLs generated prior to 2018, and indefinite lives for NOLs generated in 2018 and future periods. Additionally, we had approximately $2.5 billion in state and local net operating loss carryforwards that expire at various dates between 2019 through 2038. To the extent available and not otherwise utilized, we intend to use any NOL carryforwards to reduce the applicable U.S. or state corporate income tax liability associated with our operations. However, our ability to utilize our NOL carryforwards is based on the extent to which we generate future taxable income and on prevailing corporate income tax rates, and we cannot provide any assurance as to when and to what extent we will generate sufficient future taxable income to realize our deferred tax assets, whether in whole or in part. Furthermore, the utilization of our NOL carryforwards may become subject to an annual limitation under Section 382 of the Code (and similar state provisions) in the event of certain cumulative changes in the ownership interest of significant shareholders in excess of 50 percent over a three-year period. This could limit the amount of NOL carryforwards that can be utilized annually to offset taxable income. The amount of the annual limitation is determined based on the value of a company immediately prior to the ownership change. Subsequent ownership changes may further affect the limitation in future years. For these reasons, our ability to utilize our NOLs may be limited.

Item 2. ***Properties.***

The table below presents certain information with respect to our hospital campuses as of December 31, 2018:

Facility Name	City	Licensed Beds	Ownership and Real Property Status
Alabama			
Andalusia Regional Hospital	Andalusia	88	Own
North Alabama Medical Center	Florence	358	Own
Shoals Hospital	Muscle Shoals	178	Own
Vaughan Regional Medical Center (a)	Selma	175	JV/Own
Arizona			
Canyon Vista Medical Center	Sierra Vista	100	Lease
Havasu Regional Medical Center (b)	Lake Havasu City	171	JV/Own
Valley View Medical Center	Fort Mohave	84	Own
Arkansas			
National Park Medical Center (c) (d)	Hot Springs	163	JV/Lease
Saline Memorial Hospital (a)	Benton	177	JV/Own
St. Mary's Regional Medical Center	Russellville	170	Own
Colorado			
Colorado Plains Medical Center	Fort Morgan	50	Lease
Georgia			
St. Francis Hospital	Columbus	376	Own
Idaho			
St. Joseph Regional Medical Center (e)	Lewiston	145	Lease
Indiana			
Clark Memorial Hospital (f)	Jeffersonville	236	JV/Own
Scott Memorial Hospital (f)	Scottsburg	25	JV/Own
Iowa			
Ottumwa Regional Health Center	Ottumwa	217	Own
Kansas			
Western Plains Medical Complex	Dodge City	99	Own
Kentucky			
Bluegrass Community Hospital	Versailles	25	Own
Bourbon Community Hospital	Paris	58	Own
Clark Regional Medical Center	Winchester	79	Own
Fleming County Hospital	Flemingsburg	52	Own
Georgetown Community Hospital	Georgetown	75	Own
Jackson Purchase Medical Center	Mayfield	107	Own
Lake Cumberland Regional Hospital	Somerset	295	Own
Logan Memorial Hospital	Russellville	75	Own
Meadowview Regional Medical Center	Maysville	100	Own
Spring View Hospital	Lebanon	75	Own
Louisiana			
Teche Regional Medical Center (g)	Morgan City	164	Lease
Michigan			
UP Health System - Bell	Ishpeming	25	Own
UP Health System - Marquette (h)	Marquette	307	JV/Own
UP Health System - Portage (a)	Hancock	96	JV/Own
Mississippi			
Bolivar Medical Center	Cleveland	199	Lease
Montana			
Community Medical Center	Missoula	151	Own
Nevada			
Northeastern Nevada Regional Hospital	Elko	75	Own
New Mexico			
Los Alamos Medical Center	Los Alamos	47	Own
Memorial Medical Center of Las Cruces	Las Cruces	199	Lease

Facility Name	City	Licensed Beds	Ownership and Real Property Status
North Carolina			
Central Carolina Hospital (h)	Sanford	137	JV/Own
Frye Regional Medical Center (h)	Hickory	355	JV/Lease
Harris Regional Hospital (h)	Sylva	86	JV/Own
Haywood Regional Medical Center (h)	Clyde	159	JV/Own
Maria Parham Medical Center (i)	Henderson	185	JV/Own
Person Memorial Hospital (h)	Roxboro	98	JV/Own
Rutherford Regional Medical Center (i)	Rutherfordton	143	JV/Own
Swain County Hospital (h)	Bryson City	48	JV/Own
Wilson Medical Center (i)	Wilson	384	JV/Own
Ohio			
Clinton Memorial Hospital	Wilmington	165	Own
Oklahoma			
Southwestern Medical Center	Lawton	107	Own
Southwestern Behavioral Health Center	Lawton	92	Own
Oregon			
Willamette Valley Medical Center (e)	McMinnville	60	Lease
Pennsylvania			
Conemaugh Memorial Medical Center (h)	Johnstown	537	JV/Own
Meyersdale Medical Center (h)	Meyersdale	20	JV/Own
Miners Medical Center (h)	Hastings	30	JV/Own
Nason Medical Center	Roaring Spring	45	Own
South Carolina			
Carolina Pines Regional Medical Center (c) (e)	Hartsville	116	JV/Lease
KershawHealth (e)	Camden	121	Lease
Providence Hospital - Downtown	Columbia	258	Own
Providence Hospital - Northeast	Columbia	74	Own
Tennessee			
Livingston Regional Hospital	Livingston	114	Own
Riverview Regional Medical Center	Carthage	35	Own
Southern Tennessee Regional Health System - Lawrenceburg	Lawrenceburg	99	Own
Southern Tennessee Regional Health System - Pulaski	Pulaski	95	Own
Southern Tennessee Regional Health System - Sewanee	Sewanee	41	Own
Southern Tennessee Regional Health System - Winchester	Winchester	157	Own
Starr Regional Medical Center - Athens	Athens	118	Own
Starr Regional Medical Center - Etowah	Etowah	160	Own
Sumner Regional Medical Center	Gallatin	155	Own
Trousdale Medical Center	Hartsville	25	Own
Texas			
Ennis Regional Medical Center	Ennis	60	Lease
Palestine Regional Medical Center	Palestine	156	Own
Paris Regional Medical Center	Paris	154	Own
Parkview Regional Hospital	Mexia	58	Lease
Utah			
Ashley Regional Medical Center	Vernal	39	Own
Castleview Hospital	Price	39	Own
Virginia			
Clinch Valley Medical Center	Richlands	175	Own
Fauquier Health	Warrenton	210	Own
Sovah Health - Danville	Danville	250	Own
Sovah Health - Martinsville	Martinsville	220	Own
Twin County Regional Hospital (i)	Galax	141	JV/Own
Wythe County Community Hospital	Wytheville	100	Lease

Facility Name	City	Licensed Beds	Ownership and Real Property Status
Washington			
Capital Medical Center (d) (j)	Olympia	107	JV/Lease
Lourdes Health - Medical Center (e)	Pasco	95	Lease
Lourdes Health - Counseling Center (e)	Pasco	32	Lease
Trios Health - Southridge Hospital (k) (l)	Kennewick	74	JV/Lease
Trios Health - Women's and Children's Hospital (k) (l)	Kennewick	37	JV/Lease
West Virginia			
Logan Regional Medical Center	Logan	140	Own
Raleigh General Hospital	Beckley	300	Own
Wisconsin			
Watertown Regional Medical Center (a)	Watertown	95	JV/Own
Wyoming			
SageWest Healthcare - Lander	Lander	89	Own
SageWest Healthcare - Riverton	Riverton	70	Own
		11,876	

(a) This facility is owned and operated by a joint venture between us and an unrelated third party. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(b) This facility 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 this facility is located is owned by the LifePoint member and leased to the joint venture.
(c) This facility is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest.
(d) This facility is subject to a sale-leaseback arrangement with MPT.
(e) This facility is subject to the A&R Master Lease.
(f) This facility is owned and operated by the Regional Health Network of Kentucky and Southern Indiana ("***RHN***"), a joint venture between us and Norton. A wholly-owned LifePoint affiliate owns a controlling interest in RHN.
(g) Refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report for information regarding ongoing negotiations to divest this facility.
(h) This facility is owned and operated by Duke LifePoint Healthcare. A wholly-owned LifePoint affiliate owns a controlling interest in Duke LifePoint Healthcare.
(i) This facility is owned and operated by a joint venture between a local not-for-profit entity and Duke LifePoint Healthcare.
(j) This facility is owned and operated by a joint venture among us, physicians and a joint venture between us and University of Washington. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(k) This facility is owned and operated by a joint venture between us and University of Washington. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(l) This facility is subject to a sale-leaseback arrangement with a third-party for a hospital building whose rent is contingent on the financial performance of the hospital and a sale-leaseback arrangement for a medical office building.

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

Item 3. ***Legal Proceedings.***

Healthcare facilities are, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, medical malpractice, breach of contracts, wrongful restriction of or interference with physicians' staff privileges and employment related claims. In certain of these actions, plaintiffs request payment for damages, including punitive damages, that may not be covered by insurance. We are currently not a party to any pending proceedings, which, in management's opinion, would have a material adverse effect on our business, financial condition or results of operations.

For more information about legal proceedings and general liability claims, refer to Note 14 to our accompanying consolidated financial statements included elsewhere in this Report.

Item 4. ***Mine Safety Disclosures*****.**

Not applicable.

PART II

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

All of our equity securities are held by Holdings, whose indirect parent is DSB Parent. As of December 31, 2018, our Sponsor beneficially owned approximately 99.5% of the capital units of LifePoint with the remaining approximate 0.5% owned by current or former directors, members of management, employees and consultants of the Company. Because our equity securities are privately held, there is no established public trading market for our equity securities.

Equity Compensation Plan Information

Refer to Note 13 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of profits units issued by DSB Parent to our employees and directors.

Recent Sales of Unregistered Securities

There have been no recent sales of unregistered equity securities of the Company within the period covered by this Report.

Item 6. ***Selected Financial Data.***

Set forth below is the selected historical consolidated financial data of the Company for the periods and as of the dates indicated.

On December 3, 2015, the Apollo/RegionalCare Acquisition was completed. For periods prior to the Apollo/RegionalCare Acquisition, our operations are referred to as the "***Predecessor***". For periods after the Apollo/RegionalCare Acquisition, our operations are referred to as the "***Successor***". Additionally, on April 29, 2016, the RegionalCare/Capella Merger was completed, which, for accounting purposes, became effective on May 1, 2016. Furthermore, on November 16, 2018, the LifePoint/RCCH Merger was completed, which, for accounting purposes became effective on November 17, 2018.

The Apollo/RegionalCare Acquisition, RegionalCare/Capella Merger and LifePoint/RCCH Merger were all significant transactions which affect the comparability of the selected financial data. The following information should be read in conjunction with "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations," as well as our accompanying consolidated financial statements included elsewhere in this Report.

	Successor				Predecessor	
$ in millions	Year Ended December 31, 2018	Year Ended December 31, 2017	Year Ended December 31, 2016	Period From 12/4/2015 through 12/31/2015	Period From 1/1/2015 through 12/3/2015	Year Ended December 31, 2014
Statements of Operations Data:						
Revenues	$ 2,778.1	$ 1,872.8	$ 1,502.7	$ 64.0	$ 770.1	$ 642.5
Net (loss) income attributable to LifePoint Health, Inc.	(293.7)	(45.4)	(44.0)	1.3	(59.3)	(81.8)
Balance Sheet Data (as of end of year):						
Cash and cash equivalents	$ 58.9	$ 16.9	$ 30.4	$ 8.0	$ -	$ 24.7
Working capital	570.3	121.2	199.9	72.5	-	56.2
Total assets	8,991.7	2,057.5	2,060.2	1,043.6	-	778.1
Total debt, excluding unamortized debt issuance costs	6,705.2	1,466.9	1,379.3	570.9	-	507.8
Total LifePoint Health, Inc. stockholders' equity	923.4	220.0	305.1	301.8	-	(259.4)
Statements of Cash Flows Data:						
Net cash (used in) provided by operating activities	$ (73.0)	$ 105.6	$ 54.8	$ (14.1)	$ 35.7	$ 39.1
Purchases of property and equipment	(319.7)	(145.1)	(67.5)	(3.6)	(31.2)	(24.5)
Net cash used in investing activities	(5,645.7)	(151.1)	(715.6)	(3.5)	(88.4)	(15.0)
Net cash provided by (used in) financing activities	5,760.7	32.0	683.2	6.4	47.3	(3.8)

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

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

The following discussion and analysis of our financial condition and results of operations covers periods prior to the consummation of the LifePoint/RCCH Merger, which was effective November 16, 2018, and for accounting purposes, became effective November 17, 2018, and the RegionalCare/Capella Merger, which was effective April 29, 2016, and for accounting purposes, became effective May 1, 2016. In this management's discussion and analysis, (i) the results of operations from January 1, 2018 to November 16, 2018 are those of RCCH only, (ii) the results of operations from November 17, 2018 to December 31, 2018 are those of Legacy LifePoint and RCCH on a combined basis, (iii) the results of operations for the year ended December 31, 2017 are those of RCCH only, (iv) the results of operations from January 1, 2016 to April 30, 2016 are those of RegionalCare only and (v) the results of operations for the period from May 1, 2016 to December 31, 2016 are those of RegionalCare and Capella on a combined basis. Additionally, in this management's discussion and analysis under "Supplemental Results of Operations for Legacy LifePoint and RCCH on a Combined Basis for the Years Ended December 31, 2018 and 2017," we are providing results of operations on a combined basis for the years ended December 31, 2018 and 2017 as if the LifePoint/RCCH Merger had occurred on January 1 for each of the years then ended. GAAP does not allow for such a combination of results of operations; however, we believe the combined results provide information that is useful in evaluating our financial performance.

Overview

We own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. As of December 31, 2018, we operated 89 hospital campuses in 30 states throughout the U.S., having a total of 11,876 licensed beds. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a network of hospitals and outpatient facilities. We generated $2,778.1 million, $1,872.8 million and $1,502.7 million in revenues during the years ended December 31, 2018, 2017 and 2016, respectively. In 2018, we derived approximately 50.7% 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 payers, 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 payers. 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.

Recent Developments

LifePoint/RCCH Merger

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. Our consolidated results of operations for the year ended December 31, 2018 include the results of Legacy LifePoint beginning on November 17, 2018. For more information about the LifePoint/RCCH Merger, refer to "Part 1, Item 1. Business—Our Background" and Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Acquisitions & Divestitures

The following table summarizes our hospital acquisitions and divestitures completed during the years ended December 31, 2018, 2017 and 2016:

Facility	Location	Effective Date
Acquisitions:		
Lourdes Health ("***Lourdes***") (two hospital campuses)	Pasco, Washington	September 1, 2018
Trios Health ("***Trios***") (two hospital campuses) (JV)	Kennewick, Washington	August 4, 2018
St. Joseph Regional Medical Center ("***St. Joseph***")	Lewiston, Idaho	May 1, 2017
Saline Memorial Hospital ("***Saline***") (JV)	Benton, Arkansas	July 1, 2016
Divestitures:		
Sharon Hospital ("***Sharon***")	Sharon, Connecticut	August 1, 2017
EaStar Health System ("***EaStar***")	Muskogee, Oklahoma	April 1, 2017

Additionally, effective April 1, 2018, we acquired Pacific Medical Data Solutions ("***PMDS***"). PMDS is a healthcare technology and software services company that provides revenue cycle, billing automation and software solutions to multi-specialty physician groups, ambulatory surgery centers and urgent care clinics.

Lastly, in August 2018, Legacy LifePoint and certain of its subsidiaries entered into a proposed settlement agreement with The Hospital Service District No. 2 of the Parish of St. Mary ("***HSD***"), a political subdivision of the state of Louisiana, outlining the terms of a definitive settlement agreement to terminate our lease of Teche Regional Medical Center ("***Teche***") located in Morgan City, Louisiana. The proposed settlement agreement provides, among other things, that we will convey to HSD, or its designee, all assets of Teche in accordance with the existing lease agreement, and we will no longer operate Teche upon completion of the transaction. We anticipate this transaction to be completed during the second quarter of 2019, subject to the terms and conditions of a definitive settlement agreement.

For additional information regarding our recent acquisitions and divestitures, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

Health Care Reform Efforts

The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare by, among other things, creating the individual mandate to require most Americans to obtain health insurance, providing additional funding for Medicaid in states that choose to expand their programs, reducing IPPS, OPPS and 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 and instituting certain private health insurance reforms. The Affordable Care Act has, however, been subject to a number of legislative and regulatory changes and court challenges and its future is uncertain.

The net effect of the Affordable Care Act, as currently adopted, on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access and quality. Additional variables related to the Affordable Care Act impacting our business will be how, if at all, Congress repeals, replaces, or otherwise modifies the Affordable Care Act, whether the Affordable Care Act is found to be unconstitutional after the repeal of the penalties associated with the individual mandate, and how states, providers, insurance companies, employers and other market participants respond during this period of uncertainty. As a result, we are unable to predict the effect on our business, financial condition or results of operations, the availability of adequate insurance coverage for patients seeking healthcare at our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions potentially impacted by the repeal of the penalties associated with the individual mandate, the cessation of the cost sharing reduction payments, and the possible repeal, replacement or modification of the Affordable Care Act.

Refer to "Part I, Item 1. Business—Health Care Reform" included elsewhere in this Report for more information about the Affordable Care Act.

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; freestanding emergency departments and outpatient surgery, diagnostic, cancer care and urgent care centers; 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 contributed to decreases in admissions and surgical volumes and 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.

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 or the refund of such payments we previously received.

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, the DOJ and other governmental fraud and abuse programs.

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.

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 payer. Governmental payers 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 payers. 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 payers, 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.

For more information about Medicare and Medicaid reimbursement matters, refer to "Part I, Item 1. Business—Sources of Revenue" included elsewhere in this Report.

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 PFS system. Under the PFS, CMS has assigned a national RVU to most medical services and procedures that reflects the various resources required by a physician to provide the services relative to all other services. Historically, the conversion factor that is used to determine physician payments for each RVU had been updated by the 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 Congress has passed multiple legislative acts delaying application of the SGR to the PFS. For more information, refer to "Part I, Item 1. Business—Sources of Revenue—Physician Services" included elsewhere in this Report.

HMOs, PPOs and Other Private Insurers

In addition to government programs, our facilities are reimbursed by differing types of private payers, including HMOs, 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 or accept fixed, pre-determined fees for our services. These discounted arrangements often limit our ability to increase charges or revenues in response to increasing costs. We actively negotiate with these payers 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 payer 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 Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices. If we provide services when we are 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 as a percentage of overall revenues 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 has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities have experienced in recent years, including increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. Additionally, we cannot predict the impact of the cessation of cost sharing reduction payments, the repeal of the individual mandate or any other modifications to the Affordable Care Act that may be adopted.

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.

Results of Operations

Certain Definitions

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

Adjusted EBITDA. EBITDA adjusted to exclude unusual items and other adjustments required or permitted in calculating debt covenant compliance under the Indentures governing the Notes and/or the Term Loan Facility and ABL Facility. We believe that this inclusion of supplementary adjustments to EBITDA applied in presenting Adjusted EBITDA are appropriate to provide additional information to investors about the impact of certain non-cash items, unusual items that we do not expect to continue at the same level in future and other items.

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

Combined. Combined information for the years ended December 31, 2018 and 2017 includes the results of Legacy LifePoint and RCCH as if the LifePoint/RCCH Merger had occurred on January 1 for each of the years then ended.

Consolidated. Consolidated information includes the results of all hospital operations and corporate overhead costs, including the results of our recent acquisitions and divestitures, and the results of Legacy LifePoint beginning on November 17, 2018.

EBITDA. Earnings before interest, taxes, depreciation and amortization.

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 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.

Outpatient factor. The sum of gross inpatient revenue and gross outpatient revenue divided by gross inpatient revenue.

Same-hospital combined. Same-hospital combined information includes the results of the same 84 hospital campuses operated during the entire years ended December 31, 2018 and 2017 on a combined basis as if the LifePoint/RCCH Merger had occurred on January 1 for each of the years then ended. Same-hospital combined information excludes the results of our recent acquisitions and divestitures completed in 2018 and 2017.

Summary

The following table summarizes our results of operations for the years ended December 31, 2018, 2017 and 2016 (in millions):

	Years Ended December 31,					
	2018		2017		2016	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Revenues before provision for doubtful accounts	$ 3,136.0	112.9 %	$ 2,079.7	111.0 %	$ 1,667.9	111.0 %
Provision for doubtful accounts	357.9	12.9	206.9	11.0	165.2	11.0
Revenues	2,778.1	100.0	1,872.8	100.0	1,502.7	100.0
Salaries and benefits	1,329.4	47.9	874.3	46.7	694.4	46.2
Supplies	484.5	17.4	323.2	17.3	261.3	17.4
Other operating expenses, net	709.2	25.6	469.4	25.0	377.1	25.1
Depreciation and amortization	129.0	4.6	80.6	4.3	57.6	3.8
Interest expense, net	186.1	6.7	126.1	6.7	101.3	6.7
Merger and acquisition costs	141.5	5.1	7.8	0.4	25.1	1.7
Impairments of goodwill and long-lived assets	78.4	2.8	14.1	0.8	11.6	0.8
Other non-operating losses, net	7.8	0.3	16.7	0.9	11.6	0.8
	3,065.9	110.4	1,912.2	102.1	1,540.0	102.5
Loss before income taxes	(287.8)	(10.4)	(39.4)	(2.1)	(37.3)	(2.5)
Provision for (benefit from) income taxes	0.2	-	(1.3)	(0.1)	4.0	0.2
Net loss	(288.0)	(10.4)	(38.1)	(2.0)	(41.3)	(2.7)
Less: Net income attributable to noncontrolling and redeemable noncontrolling interests	(5.7)	(0.2)	(7.3)	(0.4)	(2.7)	(0.2)
Net loss attributable to LifePoint Health, Inc.	$ (293.7)	(10.6)%	$ (45.4)	(2.4)%	$ (44.0)	(2.9)%

For the Years Ended December 31, 2018 and 2017

Revenues

The following table summarizes our key revenue metrics on a consolidated basis for the years ended December 31, 2018 and 2017:

	Years Ended December 31,			
	2018	2017	Increase	% Increase
Consolidated:				
Number of hospital campuses at end of period	89	17	72	423.5 %
Revenues (in millions)	$ 2,778.1	$ 1,872.8	$ 905.3	48.3 %
Admissions	118,366	84,196	34,170	40.6 %
Equivalent admissions	287,619	199,563	88,056	44.1 %
Revenues per equivalent admission	$ 9,659	$ 9,385	$ 274	2.9 %
Inpatient surgeries	33,360	24,102	9,258	38.4 %
Outpatient surgeries	109,759	77,701	32,058	41.3 %
Total surgeries	143,119	101,803	41,316	40.6 %
Emergency department visits	616,150	445,257	170,893	38.4 %

For the year ended December 31, 2018, our consolidated revenues increased $905.3 million, or 48.3%, to $2,778.1 million compared to $1,872.8 million for the prior year. The increase in our revenues was primarily a result of the LifePoint/RCCH Merger and our 2018 and 2017 acquisitions, net of the impact of our 2017 divestitures. Refer to *"Supplemental Results of Operations for Legacy LifePoint and RCCH on a Combined Basis for the Years Ended December 31, 2018 and 2017"* included elsewhere in this Report for a more comparable analysis of our revenues on a combined basis as if the LifePoint/RCCH Merger had occurred on January 1 for each of the years ended December 31, 2018 and 2017.

During the year ended December 31, 2018, we recorded a decrease to revenues of $17.0 million as a result of a change in our accounting estimate of the collectability of accounts receivable. During the year ended December 31, 2018, we identified additional information which indicated that our current collection estimates might be different from our historical collection estimates. We utilized this new information to further refine our estimation procedures to more precisely estimate the collectability of accounts receivable. The change in our estimation procedures of the collectability of our accounts receivable is considered a change in accounting estimate in accordance with ASC 250, "Accounting Changes and Error Corrections" ("***ASC 250***").

The following table summarizes our revenues by payer as approximate percentages of our net patient revenues before the provision for doubtful accounts for the years ended December 31, 2018 and 2017:

	Years Ended December 31,	
	2018	**2017**
Medicare	37.6 %	40.4 %
Medicaid	13.1	12.2
HMOs, PPOs and other private insurers	41.3	40.7
Self-pay	8.0	6.7
	100.0 %	100.0 %

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

Salaries and Benefits

For the year ended December 31, 2018, our consolidated salaries and benefits expense was $1,329.4 million, or 47.9% of revenues, compared to $874.3 million, or 46.7% of revenues, for the prior year. The increase in our salaries and benefits expense was primarily a result of the LifePoint/RCCH Merger and our 2018 and 2017 acquisitions, net of the impact of our 2017 divestitures.

Supplies

For the year ended December 31, 2018, our consolidated supplies expense was $484.5 million, or 17.4% of revenues, compared to $323.2 million, or 17.3% of revenues, for the prior year. The increase in our supplies expense was primarily a result of the LifePoint/RCCH Merger and our 2018 and 2017 acquisitions, net of the impact of our 2017 divestitures.

Other Operating Expenses, Net

Other operating expenses include, among other things, contract services, professional fees, rents and leases, repairs and maintenance, utilities, insurance, non-income taxes, other income and other expenses. For the year ended December 31, 2018, our consolidated other operating expenses were $709.2 million, or 25.6% of revenues, compared to $469.4 million, or 25.0% of revenues, for the prior year. The increase in our other operating expenses was primarily a result of the LifePoint/RCCH Merger and our 2018 and 2017 acquisitions, net of the impact of our 2017 divestitures.

Depreciation and Amortization

For the year ended December 31, 2018, our consolidated depreciation and amortization expense was $129.0 million, or 4.6% of revenues, compared to $80.6 million, or 4.3% of revenues, for the prior year. The increase in our depreciation and amortization expense was primarily a result of the LifePoint/RCCH Merger and our 2018 and 2017 acquisitions, net of the impact of our 2017 divestitures.

Interest Expense, Net

For the year ended December 31, 2018, our consolidated interest expense was $186.1 million, or 6.7% of revenues, compared to $126.1 million, or 6.7% of revenues, for the prior year. The increase in our interest expense was primarily a result of the debt financing activities in connection with the LifePoint/RCCH Merger. For a further discussion of our debt and corresponding interest rates, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Merger and Acquisition Costs

For the year ended December 31, 2018, we recognized merger and acquisition costs of $141.5 million, primarily related to legal and transaction advisory services as well as employee severance and retention costs in connection with the LifePoint/RCCH Merger, in addition to our 2018 acquisitions. For the year ended December 31, 2017, we recognized acquisition costs of $7.8 million, primarily related to our acquisition of St. Joseph.

Impairment of Goodwill and Long-lived Assets

For the year ended December 31, 2018, we recognized impairment charges in the aggregate of $78.4 million, comprised of $53.9 million of goodwill impairments related to three of our facilities, and $24.5 million of long-lived asset impairments primarily related to the write-down of certain assets to their estimated fair values at one of our facilities. For the year ended December 31, 2017, we recognized a goodwill impairment charge of $14.1 million related to one of our facilities.

Other Non-Operating Losses, Net

For the year ended December 31, 2018, our net other non-operating losses were primarily related to the write-off of $8.2 million of previously capitalized debt issuance costs in connection with the termination of our Prior ABL Facility and Prior Term Facility, partially offset by other miscellaneous gains and losses. For the year ended December 31, 2017, our other non-operating losses were comprised of a $7.3 million loss on our divestitures of EaStar and Sharon, a $4.3 million loss on the refinancing of long-term debt, a $3.9 million loss on the conversion of a financing lease to an operating lease at the completion of a construction project to satisfy sale-leaseback accounting, and $1.2 million of contingent consideration expense.

Income Taxes

For the year ended December 31, 2018, we recorded a provision for income taxes of $0.2 million, primarily related to the non-deductibility of certain merger and acquisition costs and a $38.1 million increase in the valuation allowance against our deferred tax assets. For the year ended December 31, 2017, we recognized a benefit from income taxes of $1.3 million, primarily related to the reduction in the net deferred tax liability position as a result of the Tax Act that was signed into law on December 22, 2017. For a further discussion of our income taxes, refer to Note 6 to our accompanying consolidated financial statements included elsewhere in this Report.

For the Years Ended December 31, 2017 and 2016

Revenues

The following table summarizes our key revenue metrics on a consolidated basis for the years ended December 31, 2017 and 2016:

	Years Ended December 31,		Increase	% Increase
	2017	2016	(Decrease)	(Decrease)
Consolidated:				
Number of hospital campuses at end of period	17	18	(1)	(5.6)%
Revenues (in millions)	$ 1,872.8	$ 1,502.7	$ 370.1	24.6 %
Admissions	84,196	72,775	11,421	15.7 %
Equivalent admissions	199,563	168,907	30,656	18.1 %
Revenues per equivalent admission	$ 9,385	$ 8,897	$ 488	5.5 %
Inpatient surgeries	24,102	20,246	3,856	19.0 %
Outpatient surgeries	77,701	64,352	13,349	20.7 %
Total surgeries	101,803	84,598	17,205	20.3 %
Emergency department visits	445,257	366,674	78,583	21.4 %

For the year ended December 31, 2017, our consolidated revenues increased $370.1 million, or 24.6%, to $1,872.8 million compared to $1,502.7 million for the prior year. The increase in our revenues was primarily a result of the RegionalCare/Capella Merger and our 2017 and 2016 acquisitions, net of the impact of our 2017 divestitures.

The following table summarizes our revenues by payer as approximate percentages of our net patient revenues before the provision for doubtful accounts for the years ended December 31, 2017 and 2016:

	Years Ended December 31,	
	2017	2016
Medicare	40.4 %	36.4 %
Medicaid	12.2	12.8
HMOs, PPOs and other private insurers	40.7	42.5
Self-pay	6.7	8.3
	100.0 %	100.0 %

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

Salaries and Benefits

For the year ended December 31, 2017, our consolidated salaries and benefits expense was $874.3 million, or 46.7% of revenues, compared to $694.4 million, or 46.2% of revenues, for the prior year. The increase in our salaries and benefits expense was primarily a result of the RegionalCare/Capella Merger and our 2017 and 2016 acquisitions, net of the impact of our 2017 divestitures.

Supplies

For the year ended December 31, 2017, our consolidated supplies expense was $323.2 million, or 17.3% of revenues, compared to $261.3 million, or 17.4% of revenues, for the prior year. The increase in our supplies expense was primarily a result of the RegionalCare/Capella Merger and our 2017 and 2016 acquisitions, net of the impact of our 2017 divestitures.

Other Operating Expenses, Net

Other operating expenses include, among other things, contract services, professional fees, rents and leases, repairs and maintenance, utilities, insurance, non-income taxes, other income and other expenses. For the year ended December 31, 2017, our consolidated other operating expenses were $469.4 million, or 25.0% of revenues, compared to $377.1 million, or 25.1% of revenues, for the prior year. The increase in our other operating expenses expense was primarily a result of the RegionalCare/Capella Merger and our 2017 and 2016 acquisitions, net of the impact of our 2017 divestitures.

Depreciation and Amortization

For the year ended December 31, 2017, our consolidated depreciation and amortization expense was $80.6 million, or 4.3% of revenues, compared to $57.6 million, or 3.8% of revenues, for the prior year. The increase in our depreciation and amortization expense was primarily a result of the RegionalCare/Capella Merger and our 2017 and 2016 acquisitions, net of the impact of our 2017 divestitures.

Interest Expense, Net

For the year ended December 31, 2017, our consolidated interest expense was $126.1 million, or 6.7% of revenues, compared to $101.3 million, or 6.7% of revenues, for the prior year. The increase in our interest expense was primarily a result of the debt financing activities in connection with the RegionalCare/Capella Merger. For a further discussion of our debt and corresponding interest rates, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Merger and Acquisition Costs

For the year ended December 31, 2017, we recognized acquisition costs of $7.8 million, primarily related to our acquisition of St. Joseph. For the year ended December 31, 2016, we recognized merger and acquisition costs of $25.1 million, primarily related to legal and transaction advisory services in connection with the RegionalCare/Capella Merger and our acquisition of Saline.

Impairment of Goodwill and Long-lived Assets

For the year ended December 31, 2017, we recognized a goodwill impairment charge of $14.1 million related to one of our facilities. For the year ended December 31, 2016, we recognized long-lived asset impairments of $11.6 million primarily related to the write-down of certain assets to their estimated fair values at Sharon.

Other Non-Operating Losses, Net

For the year ended December 31, 2017, our other non-operating losses were comprised of a $7.3 million loss on our divestitures of EaStar and Sharon, a $4.3 million loss on the refinancing of long-term debt, a $3.9 million loss on the conversion of a financing lease to an operating lease at the completion of a construction project to satisfy sale-leaseback accounting, and $1.2 million of contingent consideration expense. For the year ended December 31, 2016, our net other non-operating losses were comprised of an $11.7 million loss on the refinancing of long-term debt, partially offset by $0.1 million of contingent consideration income.

Income Taxes

For the year ended December 31, 2017, we recognized a benefit from income taxes of $1.3 million, primarily related to the reduction in the net deferred tax liability position as a result of the Tax Act that was signed into law on December 22, 2017. For the year ended December 31, 2016, we recognized a provision for income taxes of $4.0 million. For a further discussion of our income taxes, refer to Note 6 to our accompanying consolidated financial statements included elsewhere in this Report.

Supplemental Results of Operations for Legacy LifePoint and RCCH on a Combined Basis for the Years Ended December 31, 2018 and 2017

As discussed above, the results of operations in this section for the years ended December 31, 2018 and 2017 are presented on a combined basis as if the LifePoint/RCCH Merger had occurred on January 1 for each of the years then ended. GAAP does not allow for such a combination of results of operations; however, we believe the combined results provide information that is useful in evaluating our financial performance.

Revenues

The following table summarizes our key revenue metrics on a combined and same-hospital combined basis for the years ended December 31, 2018 and 2017:

	Years Ended December 31,		Increase	% Increase
	2018	2017	(Decrease)	(Decrease)
Combined:				
Number of hospital campuses at end of period	89	88	1	1.1 %
Revenues (in millions)	$ 8,347.9	$ 8,164.2	$ 183.7	2.3 %
Admissions	344,172	351,310	(7,138)	(2.0)%
Equivalent admissions	891,161	906,777	(15,616)	(1.7)%
Revenues per equivalent admission	$ 9,367	$ 9,004	$ 363	4.0 %
Inpatient surgeries	93,713	95,890	(2,177)	(2.3)%
Outpatient surgeries	347,049	352,031	(4,982)	(1.4)%
Total surgeries	440,762	447,921	(7,159)	(1.6)%
Emergency department visits	1,958,555	2,094,886	(136,331)	(6.5)%
Same-hospital combined:				
Number of hospital campuses at end of period	84	84	-	- %
Revenues (in millions)	$ 8,003.3	$ 7,785.7	$ 217.6	2.8 %
Admissions	330,994	331,471	(477)	(0.1)%
Equivalent admissions	855,663	855,961	(298)	(0.0)%
Revenues per equivalent admission	$ 9,353	$ 9,096	$ 257	2.8 %
Inpatient surgeries	89,744	92,019	(2,275)	(2.5)%
Outpatient surgeries	336,928	337,487	(559)	(0.2)%
Total surgeries	426,672	429,506	(2,834)	(0.7)%
Emergency department visits	1,882,308	1,962,657	(80,349)	(4.1)%

For the year ended December 31, 2018, our combined revenues increased $183.7 million, or 2.3%, compared to the prior year. The increase in our combined revenues was primarily attributable to a 2.8% increase in our same-hospital combined revenues, partially offset by the impact of our divestitures completed in 2018 and 2017. The increase in our same-hospital combined revenues for the year ended December 31, 2018 was primarily driven by higher contracted rates from HMOs, PPOs and other private insurers as evidenced by a 2.8% increase in our same-hospital revenues per equivalent admission. Our same-hospital combined equivalent admissions for the year ended December 31, 2018 were consistent with the prior year.

Additionally, during the years ended December 31, 2018 and 2017, we recorded reductions to revenues of $17.0 million and $72.6 million, respectively, as a result of changes in our accounting estimates of the collectability of accounts receivable. The changes in our estimation procedures of the collectability of our accounts receivable is considered a change in accounting estimate in accordance with ASC 250. When adjusted to exclude the impact of the changes in accounting estimates recorded during each of the years ended December 31, 2018 and 2017, our same-hospital combined revenues increased 2.1% for the year ended December 31, 2018 compared to the prior year and our same-hospital combined revenues per equivalent admission increased 2.1% for the year ended December 31, 2018 compared to the prior year.

Non-GAAP Measures

Adjusted EBITDA

The following table presents EBITDA and Adjusted EBITDA on a combined basis for the years ended December 31, 2018 and 2017 (in millions):

		2018		2017
Net (loss) income		$ (424.0)	$	74.8
Interest expense, net		315.9		274.9
Income taxes		0.3		45.6
Depreciation and amortization		413.5		431.2
EBITDA		305.7		826.5
(a)	Stock-based compensation	91.8		26.1
(b)	Change in accounting estimate of collectability of accounts receivable	17.0		72.6
(c)	Merger and acquisition costs	321.0		20.0
(d)	Impairments of goodwill and long-lived assets	204.2		70.0
(e)	Facility lease expense	(28.2)		(38.7)
(f)	Discontinued operations	5.2		10.9
(g)	Non-cash and other items	39.3		(5.7)
(h)	One-time costs and non-recurring items	18.2		(19.6)
(i)	Run rate EBITDA from in-market investments and acquisitions	60.3		22.9
(j)	Pro forma cost savings	67.5		60.0
Adjusted EBITDA		$ 1,102.0	$	1,045.0

(a) Represents the exclusion of stock-based compensation expense.

(b) Represents the exclusion of one-time, non-cash charges recognized by Legacy LifePoint in the fourth quarter of 2017 and RCCH in the fourth quarter of 2018 related to changes in our accounting estimates of the collectability of accounts receivable.

(c) Represents costs associated with the LifePoint/RCCH Merger and other acquisitions that occurred during the years ended December 31, 2018 and 2017, including legal, financing and transaction advisory services, employee severance and retention costs and other integration costs associated with such transactions.

(d) Represents the exclusion of non-cash impairment charges related to goodwill and long-lived assets. For the year ended December 31, 2018, such items consist of (i) losses of approximately $107 million related to the divestiture of certain Legacy LifePoint facilities; (ii) goodwill impairment losses of approximately $54 million related to three of our facilities; and (iii) other long-lived asset impairment losses of approximately $43 million related to certain buildings and equipment. For the year ended December 31, 2017, such items consist of (i) losses of approximately $13 million related to the divestiture of one Legacy LifePoint facility; (ii) other Legacy LifePoint long-lived asset impairment losses of approximately $43 million related to certain buildings and equipment; and (iii) a goodwill impairment loss of approximately $14 million related to one of our facilities.

(e) Represents incremental cash rent expense in connection with certain leases that are recorded as capital and financing leases within our accompanying consolidated financial statements included elsewhere in this Report. Pursuant to the terms of our financial covenants contained in our debt agreements, we are required to consider cash rent expense and capital payments on facility capital leases within the definition of Adjusted EBITDA. Additionally, differences between cash payments and reported rent expense for facility operating leases are reflected within this adjustment, in accordance with our debt agreements.

(f) Represents the elimination of EBITDA associated with facilities that have either been divested or are currently contracted to be divested.

(g) Represents the exclusion of certain non-cash and other items. For the year ended December 31, 2018, such items consist of (i) losses of approximately $26 million related to the write-off of previously capitalized debt issuance costs; and (ii) other miscellaneous non-cash charges. For the year ended December 31, 2017, such items consist of (i) a non-cash gain of approximately $18 million recognized by Legacy LifePoint upon the release of a legal liability reserve; (ii) losses of approximately $11 million recognized by RCCH upon the sale of certain locations and facilities; and (iii) other miscellaneous non-cash charges.

(h) Represents the exclusion of certain one-time costs and non-recurring items. For the year ended December 31, 2018, such items consist of (i) costs of approximately $12 million related to the installation of certain clinical IT systems; and (ii) other miscellaneous one-time charges. For the year ended December 31, 2017, such items consist of (i) a non-cash gain of approximately $29 million recognized by Legacy LifePoint in connection with the transfer of home health agencies and hospices to a non-consolidated joint venture; (ii) costs of approximately $5 million related to the installation of certain clinical IT systems; and (iii) other miscellaneous one-time charges.

(i) Represents the EBITDA of acquired facilities for periods prior to the acquisition date, inclusive of certain run rate cost savings for implemented headcount reductions. Additionally, the net pro forma EBITDA from new or expanded service lines and newly constructed facilities are included within this adjustment.

(j) Represents the estimated unrealized annual cost savings related to certain corporate integration, operational improvements and synergies anticipated from the LifePoint/RCCH Merger. There can be no assurances that these estimated cost savings will be achieved.

Leverage

The following table illustrates our indebtedness and certain leverage ratios prepared in accordance with the calculations set forth in the 9.75% Unsecured Notes Indenture and the ABL Agreement and the Term Loan Agreement as of and for the year ended December 31, 2018 on a combined basis (dollars in millions):

Cash and cash equivalents (a)	$	58.1
ABL Facility	$	20.0
Term Loan Facility		3,550.0
8.25% Secured Notes		800.0
Total Secured Debt (b)	$	4,370.0
Net Secured Debt (b)	$	4,311.9
9.75% Unsecured Notes	$	1,425.0
11.5% Unsecured Notes		350.0
Total Debt (b)	$	6,145.0
Net Debt (b)	$	6,086.9
Adjusted EBITDA	$	1,102.0
Total Secured Debt (b) / Adjusted EBITDA		3.97x
Net Secured Debt (b) / Adjusted EBITDA		3.91x
Total Debt (b) / Adjusted EBITDA		5.58x
Net Debt (b) / Adjusted EBITDA		5.52x

(a) Excludes cash held by unrestricted subsidiaries which is not included as cash for purposes of calculating the ratios set forth in the Indentures governing the Notes, the ABL Agreement and the Term Loan Agreement.

(b) Excludes financing and capital leases, which are not considered indebtedness for purposes of calculating the ratios set forth in the 9.75% Unsecured Notes Indenture, the ABL Agreement and the Term Loan Agreement, as well as unamortized debt issuance costs. Under the 8.25% Secured Notes Indenture and the 11.5% Unsecured Notes Indenture, calculation of leverage ratios only exclude financing and capital leases relating to hospitals and related or ancillary facilities.

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash generated by operations and borrowings under the ABL Facility. Our primary uses of cash are working capital requirements, debt service requirements and capital expenditures. Based on our current level of operations and available cash, we believe our cash flows from operations, combined with availability under the ABL Facility, will provide sufficient liquidity to fund our current obligations, projected working capital requirements, debt service requirements and capital spending requirements over the next twelve months. We cannot assure you, however, that our business will generate sufficient cash flows from operations or that future borrowings will be available to us under the ABL Facility, which is subject to a borrowing base, in an amount sufficient to enable us to pay principal and interest on the ABL Facility, the Term Loan Facility and the Notes, or to fund other liquidity needs. Our ability to do so depends on prevailing economic conditions, many of which are beyond our control. In addition, upon the occurrence of certain events, such as a change of control, we could be required to repay or refinance our indebtedness. We cannot assure you that we will be able to refinance any of our indebtedness on commercially reasonable terms or at all. Any future acquisitions, joint ventures or other similar transactions will likely require additional capital, and there can be no assurance that any such capital will be available to us on acceptable terms or at all.

The following table presents summarized cash flow information for the years ended December 31, 2018, 2017 and 2016 (in millions):

	2018	2017	2016
Net cash (used in) provided by operating activities	$ (73.0)	$ 105.6	$ 54.8
Net cash used in investing activities	(5,645.7)	(151.1)	(715.6)
Net cash provided by financing activities	5,760.7	32.0	683.2
Net change in cash and cash equivalents	$ 42.0	$ (13.5)	$ 22.4

Operating Activities

For the year ended December 31, 2018, our cash flows from operating activities decreased by $178.6 million compared to the prior year, primarily as a result of merger-related expenses including legal and transaction advisory services as well as employee severance and retention costs in connection with the LifePoint/RCCH Merger. For the year ended December 31, 2017, our net cash provided by operating activities increased by $50.8 million compared to the prior year. Our operating performance, adjusted for non-cash items, accounted for $30.0 million of the increase, while the remainder of the increase was primarily related to a decrease in net working capital as a result of improved collections on accounts receivable and the timing of payments on accounts payable and prepaid expenses.

Investing Activities

For the years ended December 31, 2018, 2017 and 2016, we invested $5,345.9 million, $112.9 million and $673.8 million, respectively, in mergers and acquisitions. For the year ended December 31, 2018, our acquisition spend consisted primarily of the LifePoint/RCCH Merger in addition to our acquisitions of Lourdes, Trios and PMDS. For the year ended December 31, 2017, our acquisition spend consisted primarily of our acquisition of St. Joseph. For the year ended December 31, 2016, our acquisition spend consisted primarily of the RegionalCare/Capella Merger and our acquisition of Saline.

For the years ended December 31, 2018, 2017 and 2016, we invested $319.7 million, $145.1 million and $67.5 million, respectively, in purchases of property and equipment. Refer to “Capital Expenditures” for further information.

Financing Activities

For the year ended December 31, 2018, net cash provided by financing activities related primarily to the net increase in borrowings and equity to effectuate the LifePoint/RCCH Merger. Refer to “Capital Resources” for further information regarding our recent debt transactions. For the year ended December 31, 2017, net cash provided by financing activities related primarily to net MPT financing activity to finance our acquisition of St. Joseph and construction projects at two facilities, partially offset by the repayment of the financing lease related to EaStar upon completion of its sale. For the year ended December 31, 2016, net cash provided by financing activities related primarily to the net increase in borrowings and equity to effectuate the RegionalCare/Capella Merger.

Capital Expenditures

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

The following table summarizes our capital expenditures as a percentage of revenues and as a percentage of depreciation expense for the years ended December 31, 2018, 2017 and 2016 (dollars in millions):

	2018		2017		2016	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Capital expenditures	$ 319.7	11.5 %	$ 145.1	7.7 %	$ 67.5	4.5 %
Depreciation expense	128.5		80.1		56.9	
Ratio of capital expenditures to depreciation expense	248.8 %		181.1 %		118.6 %	

On a combined basis, our capital expenditures were elevated in 2018 and 2017 primarily as a result of certain significant capital projects, including the construction of two replacement hospital campuses and the installation of a new clinical system at certain of our facilities.

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. Refer to "Liquidity and Capital Resources Outlook" for further information regarding our long-term capital expenditure commitments.

Capital Resources

ABL Facility

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we entered into the ABL Facility in an aggregate principal amount of up to $800.0 million with a maturity of five years and we terminated our Prior ABL Facility. For further information regarding the ABL Facility, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Term Loan Facility

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we entered into the Term Loan Facility in an aggregate principal amount of $3,550.0 million with a maturity of seven years and we repaid in full our Prior Term Facility. For further information regarding the Term Loan Facility, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

9.75% Unsecured Notes

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we issued the 9.75% Unsecured Notes in an aggregate principal amount of $1,425.0 million with a maturity of eight years. For further information regarding the 9.75% Unsecured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

8.25% Secured Notes

Effective April 29, 2016, concurrently with the closing of the RegionalCare/Capella Merger, we issued the 8.25% Secured Notes in an aggregate principal amount of $800.0 million with a maturity of seven years. For further information regarding the 8.25% Secured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

11.5% Unsecured Notes

Effective April 29, 2016, concurrently with the closing of the RegionalCare/Capella Merger, we issued the 11.5% Unsecured Notes in a private offering in an aggregate principal amount of $350.0 million with a maturity of eight years. For further information regarding the 11.5% Unsecured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

A roll-forward of our long-term debt, including current portions, during 2018 is as follows (in millions):

	December 31, 2017	Proceeds from Borrowings	Payments of Borrowings	Payments of Debt Financing Costs	Amortization of Debt Issuance Costs	New Financing and Capital Leases	Other	December 31, 2018
Senior borrowings:								
ABL Facility	$ -	$ 20.0	$ -	$ -	$ -	$ -	$ -	$ 20.0
Prior ABL Facility	10.0	-	(10.0)	-	-	-	-	-
Term Loan Facility	-	3,550.0	-	-	-	-	-	3,550.0
Prior Term Facility	-	150.0	(150.0)	-	-	-	-	-
9.75% Unsecured Notes	-	1,425.0	-	-	-	-	-	1,425.0
8.25% Secured Notes	800.0	-	-	-	-	-	-	800.0
11.5% Unsecured Notes	350.0	-	-	-	-	-	-	350.0
Unamortized debt issuance costs	(32.9)	-	-	(206.5)	7.2	-	4.8	(227.4)
Financing and capital leases	265.0	-	(10.0)	-	-	302.2	-	557.2
Secured loan from affiliate	37.6	-	(37.6)	-	-	-	-	-
Subordinated borrowings, net	4.3	-	(1.7)	-	-	-	0.4	3.0
	$ 1,434.0	$ 5,145.0	$ (209.3)	$ (206.5)	$ 7.2	$ 302.2	$ 5.2	$ 6,477.8

Liquidity and Capital Resources Outlook

We expect total capital expenditures to continue to be elevated, primarily as a result of ongoing capital commitments in connection with several of our acquired facilities. At December 31, 2018, we estimated our total remaining capital expenditure commitments to be approximately $1,436.3 million, which generally have remaining terms of three to seven years. Of this amount, approximately one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the ABL Facility.

Our business strategy contemplates the selective acquisition of additional hospitals and other healthcare service providers, and we regularly review potential acquisitions. These acquisitions may, however, require additional financing. Our primary sources of liquidity are cash flows provided by our operations and our borrowings available under the ABL Facility. We believe that our internally generated cash flows and borrowing availability under the ABL Facility will be adequate to service existing debt, finance internal growth and fund capital expenditures and small to mid-size hospital acquisitions over the next twelve months and into the foreseeable future prior to maturity dates of our outstanding debt. Certain larger hospital acquisitions may, however, require additional financing.

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.

Contractual Obligations, Commitments and Off-Balance Sheet Arrangements

Contractual Obligations and Commitments

Our contractual obligations and commitments as of December 31, 2018 are materially consistent with disclosure set forth in in the offering memorandum dated November 14, 2018 for the 9.75% Unsecured Notes (the "***November 2018 OM***"), except as otherwise disclosed in this Report, including the financial statements and notes thereto.

Off-Balance Sheet Arrangements

We had letters of credit outstanding of approximately $32.0 million as of December 31, 2018, primarily related to the self-insured retention level of our general and professional liability insurance and workers' compensation programs as security for payment of claims.

Recently Issued Accounting Pronouncements

Refer to Note 1 to our consolidated financial statements included elsewhere in this Report for a discussion of 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 the 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 critical accounting estimates include the following areas:

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

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 payers 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 payers 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 92.0%, 93.3% and 91.7% of our patient revenues recognized during the years ended December 31, 2018, 2017 and 2016, respectively, related to discounted charges, which were comprised of the following sources (as a percentage of our net patient revenues before the provision for doubtful accounts):

	2018	2017	2016
Medicare	37.6 %	40.4 %	36.4 %
Medicaid	13.1	12.2	12.8
HMOs, PPOs and other private insurers	41.3	40.7	42.5

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

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 payer specific identification and payer 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.

The process of determining the allowance requires us to estimate the amount expected to be received based on payer 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, 2018 and 2017 was $403.4 million and $251.9 million, respectively. Our provision for doubtful accounts, included in our consolidated results of operations for the years ended December 31, 2018, 2017 and 2016, was $357.9 million, $206.9 million and $165.2 million, respectively. During the year ended December 31, 2018, we recorded a decrease to revenues of $17.0 million as a result of a change in our accounting estimate of the collectability of accounts receivable. During the year ended December 31, 2018, we identified additional information which indicated that our current collection estimates might be different from our historical collection estimates. We utilized this new information to further refine our estimation procedures to more precisely estimate the collectability of accounts receivable. The change in our estimation procedures of the collectability of our accounts receivable is considered a change in accounting estimate in accordance with ASC 250.

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.

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 payers;
- 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 payer 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, payer mix and trends in federal or state governmental healthcare coverage or other third party payers.

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 sheet as of December 31, 2018 was $2,567.6 million. Refer to Note 5 to our accompanying consolidated financial statements included elsewhere in this Report for a detailed rollforward of our goodwill.

In accordance with ASC 350, "Intangibles — Goodwill and Other" ("***ASC 350***") goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. The impairment evaluation is performed at the individual hospital level as each hospital represents a reporting unit as defined in ASC 350. For the annual impairment evaluation, we may perform an initial qualitative assessment to determine whether it is more likely than not that the fair value of the reporting unit is less than its carrying value. This assessment is used as a basis for determining whether it is necessary to perform the goodwill impairment test. For those reporting units on which we perform the impairment test, we determine fair value using a discounted cash flow ("***DCF***") analysis and consideration of certain market inputs including those of guideline public companies. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing our assumptions. The cash flows employed in the DCF analysis are based on our most recent financial budgets and business plans and, when applicable, various growth rates for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the respective reporting units.

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. Refer to Note 5 to our consolidated financial statements included elsewhere in this Report for further discussion of the results of our annual goodwill impairment evaluation procedures.

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 $456.4 million and $163.9 million as of December 31, 2018 and 2017, respectively. Our valuation allowances for deferred tax assets in our consolidated balance sheets were $274.4 million and $134.1 million as of December 31, 2018 and 2017, 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, “Income Taxes”. We apply the recognition threshold and measurement of a tax position taken or expected to be taken in a tax return and follow the guidance on various matters such as derecognition, interest, penalties and disclosure. We classify interest and penalties as a component of income tax expense.

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

Our deferred tax assets exceeded our deferred tax labilities by $270.4 million as of December 31, 2018, excluding the impact of valuation allowances. Historically, we have not produced federal taxable income, and in connection with the LifePoint/RCCH Merger, the Company became highly leveraged. As such, we believe it is likely that the deferred tax assets will not be realized and thus have established a valuation allowance against the deferred tax assets as of December 31, 2018. In addition, 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 $274.4 million at December 31, 2018.

Additionally, on December 22, 2017, the Tax Act was signed into law. The Tax Act significantly revises the U.S. corporate income tax by, among other things, lowering the statutory corporate tax rate from 35% to 21% and eliminating certain deductions. Due to the timing of the enactment and the complexity involved in applying the provisions of the Tax Act, we have made reasonable estimates of the effects of the Tax Act on our existing deferred tax assets and liabilities and recognized a provisional benefit for income taxes of $57.7 million during the year ended December 31, 2017. We completed our analysis during the year ended December 31, 2018 and determined that no additional adjustment was needed to the $57.7 million provisional expense that we recorded for the year ended December 31, 2017.

Reserves for Self-Insurance Claims

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 SIR and deductible levels. At December 31, 2018, our SIR for professional liability claims is $5.0 million per claim, with a $5.0 million inner aggregate, at the majority of our facilities, and $2.0 million per claim at certain of our facilities. Additionally, we participate in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2018, our deductibles for workers' compensation claims range from $0.5 million to $1.0 million per claim in all states in which we operate except for Montana, Oklahoma, Ohio, Washington and Wyoming. We participate in state-specific programs for our workers' compensation claims arising in these states. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

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

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

Our reserves for professional liability claims are based upon quarterly and/or semi-annual 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 1.8% at December 31, 2018 and in a range of 1.4% to 2.4% at December 31, 2017 and 0.9% to 2.3% at December 31, 2016. 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, 2018 and 2017 (in millions):

	2018	2017
Undiscounted	$ 279.0	$ 70.7
Discounted (as reported)	$ 264.7	$ 65.0

As of December 31, 2018 and 2017, 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 complicate 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 and deductible claims are based upon actuarial calculations and are significantly influenced by key assumptions and other factors. These factors include, but are not limited to: historical paid claims; trending of loss development factors; trends in the frequency and severity of claims, which can differ significantly by jurisdiction as a result of the legislative and judicial climate in such jurisdictions; coverage limits of third-party insurance and actuarial determined statistical confidence levels. Given the number of assumptions and characteristics of each assumption considered in establishing the reserves for self-insured claims, it is difficult to compute the individual financial impact of each assumption or groups of assumptions. Some of the assumptions are dependent upon the quantitative measurement of other assumptions, and therefore are not accurately evaluated in isolation. For example, a change in the frequency of claims assumption is also affected by the estimated severity of these claims resulting in an inability to properly isolate and quantify the impact of a change in this assumption.

Professional and general liability claims are typically resolved over an extended period of time, often as long as five years or more, while workers' compensation claims are typically resolved in one to two years. Our reserves for self-insured claims are comprised of estimated indemnity and expense payments related to reported events and incurred but not reported events as of the end of the period. We have the ability to reliably determine the amount and timing of payments based on sufficient history of our claims development, the use of external actuarial expertise and our rigorous review process. Actuarial payment patterns are based on our individual hospital historical data both prior to and after our inception. 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. A 25% increase in our utilized statistical confidence level would increase our estimated reserve by $30.7 million. 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 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, 2018, 2017 and 2016, our related self-insured claims expense decreased by $3.9 million, $12.1 million and $4.5 million, respectively.

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

Market Risk

Market risk is defined as the risk of loss resulting from changes in market prices as a result of changes in interest rates, credit and liquidity or general economic conditions. Our principal market risks in the ordinary course of business are credit risk, liquidity risk and interest rate risk. We currently do not have direct exposure to either market risk from trading activities or foreign currency exchange rate risk.

Credit Risk

We define credit risk as the risk that amounts payable by uninsured patients and remaining patient responsibility amounts (deductibles and co-payments) for patient accounts where the primary insurance carrier has paid the amounts covered by the applicable agreements will not be paid. 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, may increase as more individuals are enrolled in insurance plans with larger deductibles and/or co-payments, including those purchased on insurance exchanges.

The 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. To date, the Affordable Care Act has decreased the number of uninsured individuals by incentivizing states to expand their Medicaid eligibility requirements, incentivizing employers to offer health insurance, and requiring individuals to carry health insurance or be subject to penalties. However, it is difficult to predict the future impact of the Affordable Care Act on the uninsured population and the collectability of patient receivables because of ongoing state determinations on whether to expand Medicaid, the availability of federal premium subsidies, as well as our inability to foresee how individuals, businesses, private payers and states will respond to the choices afforded them by the Affordable Care Act. If the recent decrease in the uninsured population 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.

The counterparty to our Interest Rate Swap exposes us to credit risk in the event of nonperformance. However, we do not anticipate nonperformance by our counterparty. We do not hold or issue derivative financial instruments for trading purposes.

Liquidity Risk

We define liquidity risk as the risk that we will not meet our payment obligations in a timely manner or the risk that market conditions or institution-specific events may reduce our ability to raise funds from market counterparties. An adverse institution-specific event such as a major loss that causes a perceived or actual deterioration in our financial condition or an adverse systemic event could affect our funding liquidity.

Interest Rate Risk

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. To manage this risk, we entered into an Interest Rate Swap. The terms of the Interest Rate Swap require us to pay a fixed rate of 2.63% on a notional amount of $1,100.0 million and, in exchange, we receive one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. We have not designated our Interest Rate Swap as a cash flow hedge in accordance with ASC 815. Therefore, all changes in the fair value of our Interest Rate Swap will be recognized through interest expense in our results of operations. Changes in the fair value of our Interest Rate Swap could result in a material effect on our consolidated results of operations and financial position; however, we do not anticipate that changes in the fair value of our Interest Rate Swap will have any impact on our cash flows.

As of December 31, 2018, we had total outstanding debt of approximately $6,148.0 million, excluding capital and financing leases and unamortized debt issuance costs, of which $2,470.0 million, or 40.2%, was subject to variable rates of interest after giving effect to our Interest Rate Swap. If the interest rate on our variable rate long-term debt outstanding as of December 31, 2018, not subject to our Interest Rate Swap, were to increase by 100 basis points during any annual period, our cash flows would be negatively impacted by approximately $24.7 million.

Item 8. ***Financial Statements and Supplementary Data.***

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

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

None.

Item 9A. ***Controls and Procedures.***

The information that would be required to be disclosed under Part II, Item 9A of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a**)** of each of the Indentures.

Item 9B. ***Other Information.***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance*.**

The following table provides information regarding our executive officers and the members of our Board of Directors (ages as of March 28, 2019):

Name	Age	Position(s)
David M. Dill	50	President and Chief Executive Officer
Michael S. Coggin	49	Executive Vice President and Chief Financial Officer
John P. Bumpus	58	Executive Vice President, Administration
Victor E. Giovanetti	55	Executive Vice President, Hospital Operations
Robert F. Jay	51	Executive Vice President, Integrated Operations
Jennifer C. Peters	47	Executive Vice President, General Counsel and Corporate Secretary
J. Michael Grooms	41	Senior Vice President and Chief Accounting Officer
Matthew H. Nord	39	Director and Chairman
William F. Carpenter III	64	Director and Chairman Emeritus
Norman Brownstein	75	Director
Christopher J. Christie	56	Director
Maxwell David	28	Director
Michael P. Haley	68	Director
Steve Levin	53	Director
Holly McMullan	42	Director
Daniel Morissette	53	Director
Eric L. Press	53	Director
Martin S. Rash	64	Director
Olivia Wassenaar	39	Director
G. Rodney Wolford	72	Director

David M. Dill became our Chief Executive Officer upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Dill served in various roles at Legacy LifePoint as President since January 2011 and as Chief Operating Officer since April 2009. Mr. Dill served as Executive Vice President from February 2008 to January 2011. Mr. Dill joined Legacy LifePoint in July 2007 as Chief Financial Officer and continued to serve in that role until April 2009. From March 2006 until Mr. Dill joined Legacy LifePoint, he served as executive vice president of Fresenius Medical Care North America and as chief executive officer of one of two United States divisions of Fresenius Medical Care Services, a wholly owned subsidiary of Fresenius Medical Care AG & Co. KGaA. Mr. Dill previously served as executive vice president, chief financial officer and treasurer of Renal Care Group, Inc., a publicly-traded dialysis services company, from November 2003 until Renal Care Group was acquired by Fresenius Medical Care in March 2006. From 1996 to November 2003, Mr. Dill served in various finance and accounting roles with Renal Care Group, Inc. Mr. Dill served as a member of the board of directors of Psychiatric Solutions, Inc., a behavioral health services company, from 2005 until 2010.

Michael S. Coggin became our Executive Vice President and Chief Financial Officer upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Coggin served in various roles at Legacy LifePoint as Executive Vice President, Chief Financial Officer and Chief Accounting Officer, since September 2016. From December 2008 until September 2016, Mr. Coggin served as Senior Vice President and Chief Accounting Officer of Legacy LifePoint. From September 2007 until December 2008, Mr. Coggin served as chief financial officer of Specialty Care Services Group, a multi-service line healthcare provider primarily focused on providing perfusion and auto-transfusion services to hospitals. Mr. Coggin was a senior vice president in the finance, accounting and internal audit groups of Renal Care Group, Inc. from April 2004 until its acquisition by Fresenius Medical Care AG & Co. KGaA in March 2006. Following the acquisition, Mr. Coggin provided finance and accounting oversight for business units within the East Division of Fresenius. Prior to that time, Mr. Coggin was an audit manager at KPMG Peat Marwick in Nashville, Tennessee.

John P. Bumpus became our Executive Vice President, Administration upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Bumpus served as Executive Vice President and Chief Administrative Officer of Legacy LifePoint since 2008. In this role, Mr. Bumpus was responsible for overseeing human resources and talent development; employee and labor relations; compensation and benefits; capital and construction management; communications; administration; and aviation. He previously served as Senior Vice President, Human Resources and Administration of Legacy LifePoint. Prior to joining Legacy LifePoint, Mr. Bumpus served as vice president, human resources for Province Healthcare Company. He also held various leadership positions during his tenure with The Kroger Company, including strategic planning and implementation specialist; manager, human resources; and various positions in operations for the Nashville marketing area.

Victor E. Giovanetti became our Executive Vice President, Hospital Operations upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Giovanetti served as President of Legacy LifePoint's Eastern Group since January 2017. From July 2015 to January 2017, Mr. Giovanetti served as President of Legacy LifePoint's Western Group. Mr. Giovanetti joined Legacy LifePoint in July 2013 as Chief Operating Officer of Legacy LifePoint's Eastern Group. Mr. Giovanetti has more than 25 years of management experience in operations, financial, clinical and strategic aspects of healthcare administration. Prior to joining the Company, his positions included president of HCA Lewis-Gale Regional Health System in Roanoke, Virginia, chief executive officer and chief operating officer of Southern Hills Medical Center in Nashville, Tennessee, and various management roles with HCA, Symbion and other healthcare organizations in Georgia.

Robert F. Jay became our Executive Vice President, Integrated Operations upon consummation of the LifePoint/RCCH Merger. Mr. Jay previously served as RCCH's Executive Vice President and Chief Operating Officer, a position he held from January 2018. Mr. Jay has served in various roles with RCCH, including Executive Vice President Operations Support from May 2016 to September 2016 and Division President from September 2016 to January 2018. Prior to that he served as Chief Operating Officer for RCCH from January 2014 until May 2016. Prior to joining RCCH, he spent seven years at Vanguard Health Systems in a variety of operations and development positions. He joined Vanguard Health Systems as its Corporate Director Operations and Financial Analysis where he was responsible for managing and reporting operational, clinical, and financial results. In 2008, Mr. Jay was promoted to Vice President, Supply Chain Management of Vanguard where he oversaw the overall strategic direction and tactical execution of supply chain operations. In 2009 he transitioned to Vice President, Development of Vanguard where he led acquisition teams that closed on hospital transactions with combined net revenues of over $2.2 billion. Prior to joining Vanguard Health Systems, Mr. Jay worked as the Corporate Controller for Health Management Associates, Inc. in Naples, Florida. He has also served as a Controller in a not-for-profit hospital and also spent time at KPMG as an auditor.

Jennifer C. Peters became our Executive Vice President and General Counsel upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Ms. Peters served as Legacy LifePoint's General Counsel since April 2017 and Corporate Secretary since June 2017. Prior to that, Ms. Peters served as senior vice president and chief operations counsel of Legacy LifePoint, where she was responsible for overseeing the Company's operations lawyers and contract management team to ensure consistent legal guidance across all operational units. Prior to joining Legacy LifePoint in November 2013, Ms. Peters served as general counsel, secretary and chief compliance officer for Simplex Healthcare from October 2010 through November 2013. Ms. Peters has also served as vice president and associate general counsel at Community Health Systems. In addition, Ms. Peters has experience as a hospital administrator.

J. Michael Grooms became our Senior Vice President and Chief Accounting Officer upon consummation of the LifePoint/RCCH Merger. Mr. Grooms previously served as Chief Accounting Officer of Legacy Lifepoint from June 2018 and as Vice President of Accounting and Financial Reporting from March 2012. Additionally, Mr. Grooms served in various other accounting financial reporting roles since joining Legacy Lifepoint in September 2006. Prior to that time, he served as controller with Delek US from 2005 to 2006, and as an auditor with KPMG from 2001 to 2005.

Matthew H. Nord has been our Director since consummation of the Apollo/RegionalCare Acquisition in December 2015 and became Chairman of the Board in December 2018. Mr. Nord is a Senior Partner of Apollo Global Management, LLC, where he has been employed since 2003. From 2001 to 2003, Mr. Nord was a member of the Investment Banking division of Salomon Smith Barney Inc. Mr. Nord serves on several boards of directors, including West Corporation, Presidio, Inc., ADT, and Exela Technologies, Inc. Mr. Nord also serves on the Board of Trustees of Montefiore Health System and on the Board of Overseers of the University of Pennsylvania's School of Design. During the past five years, Mr. Nord has also served as a director of Affinion Group Holdings, Inc. (from October 2006 to November 2015), Constellium N.V. (from May 2010 to November 2015), EVERTEC, Inc. (from September 2010 to December 2013), Hughes Telematics, Inc. (from December 2006 to July 2012), MidCap Financial Holdings, LLC (from December 2013 to January 2015), Noranda Aluminum Holding Corporation (from March 2007 to December 2015) and SourceHOV Holdings, Inc. (from January 2006 to April 2013). Mr. Nord graduated summa cum laude with a B.S. in Economics from the Wharton School of the University of Pennsylvania. Between his work at Apollo and his prior experience in investment banking, Mr. Nord has approximately 15 years of experience analyzing, financing and investing in public and private companies.

William F. Carpenter III became our Director and Chairman Emeritus upon consummation of the LifePoint/RCCH Merger. Mr. Carpenter was a founding member of Legacy LifePoint, having served in various roles as Executive Vice President, Senior Vice President, General Counsel, Secretary and Corporate Governance Officer. In 2006, Mr. Carpenter was appointed Chief Executive Officer and elected to the Board of Directors of Legacy LifePoint and, in 2010, was appointed Chairman of the Board. Mr. Carpenter serves on the board of directors of the American Hospital Association, and formerly served as Chairman and a member of the board of the Federation of American Hospitals, the national public policy organization for investor-owned hospitals. Mr. Carpenter is also a member and past chairman of the Nashville Health Care Council Board of Directors, and serves on the boards of directors of the Nashville Area Chamber of Commerce, NashvilleHealth, the Center for Medical Interoperability, United Way of Nashville, and Nashville Public Radio. A recognized leader in the healthcare industry, he has appeared on *Modern Healthcare* magazine's annual "100 Most Influential People in Healthcare" list numerous times.

Norman Brownstein became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Brownstein is the founding member and chairman of the board of the law firm of Brownstein Hyatt Farber Schreck, LLP. Mr. Brownstein is nationally recognized for his extensive experience in real estate law, commercial transactions and public policy advocacy, which spans the economic spectrum, extending to telecommunications, financial services, agriculture, tax and health care interests. Mr. Brownstein serves on the board of directors of National Jewish Health, and during the past five years has also served as a director of Ardent Healthcare Services. Mr. Brownstein received a B.S. from the University of Colorado and a J.D. from the University of Colorado Law School.

Christopher J. Christie became our Director in December 2018. Mr. Christie served two terms as Governor of New Jersey from 2010 to 2018. Prior to that, Mr. Christie served as U.S. Attorney for the District of New Jersey from 2002 to 2008. During his governorship, Mr. Christie chaired the President's Commission on Combating Drug Addiction and the Opioid Crisis in 2017. He currently serves as a legal and political commentator for ABC News. Mr. Christie is a graduate of the University of Delaware and Seton Hall University School of Law.

Maxwell David became our Director in December 2018. Mr. David is a principal in Apollo Global Management's Private Equity business, having joined in 2014. Prior to that time, Mr. David was a member of the Investment Banking division of Bank of America Merrill Lynch. Mr. David serves on the board of directors of CareerBuilder. Mr. David graduated cum laude from Dartmouth College with a B.A. in Economics.

Michael P. Haley became our Director in December 2018. Prior to that time, Mr. Haley served as a director of Legacy LifePoint since 2005 and as chair of its Audit Committee since 2016. Mr. Haley is also a member of the board of directors of American National Bankshares, Inc., a bank holding company. From 2005 until April 2018, Mr. Haley served as a director of Ply Gem Holdings, Inc., a producer of window, door and siding products for the residential construction industry. Mr. Haley served as an advisor to Fenway Partners, LLC, a private equity investment firm, from April 2006 to June 2015, and was a managing director of its affiliate, Fenway Resources, from 2008 to June 2015. Mr. Haley's previous executive leadership experience includes service as executive chairman of Coach America, a transportation services operator, and as chairman, president and chief executive officer of MW Manufacturers, Inc., a subsidiary of Ply Gem Industries, Inc. In addition, Mr. Haley previously served on the board of the Martinsville-Henry County United Way and as chairman of the board of trustees of Memorial Hospital of Martinsville and of the Martinsville-Henry County Economic Development Corporation.

Steven Levin became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Levin is the chief strategy officer of Waystar, a healthcare revenue cycle technology platform. In 2018, Waystar acquired Connance, an analytics company that delivers workflow optimization technology for healthcare providers, which Mr. Levin founded in collaboration with Tenet Healthcare, FICO and Northbridge Venture Partners following a nearly two decade management consulting career at Monitor Company working with hospitals, HCIT companies and health insurers. Mr. Levin holds a B.A. from Dartmouth College and an M.B.A. from Harvard Business School.

Holly McMullan became our Director in December 2018. Ms. McMullan is a Partner in Apollo Global Management's Marketing and Business Development group, where she is responsible for fundraising efforts, having jointed in 2008. Prior to that time, Ms. McMullan was a Senior Vice President at Pequot Capital and was previously a member of Guggenheim Advisors, Bear Stearns, and Robertson Opp. Capital.

Daniel Morissette became our Director upon consummation of the Transaction in April 2016. Mr. Morissette has served as Senior Executive Vice President/Chief Financial Officer for Dignity Health since February 2016. Previously, Mr. Morissette served as the Chief Financial Officer for Stanford Health Care. Mr. Morissette has over 25 years of experience in health care, consulting and international business development. During the past five years, Mr. Morissette served as a director for Optum360 and University Healthcare Alliance. Mr. Morissette received a B.S. from DePaul University and an M.B.A. from The University of Chicago, Booth School of Business.

Eric L. Press has been our Director since consummation of the Apollo/RegionalCare Acquisition in December 2015. Mr. Press is a senior partner of Apollo Global Management, LLC, where he has been employed since 1998 and has served as an officer of certain affiliates of Apollo. From 1992 to 1998, Mr. Press was associated with the law firm of Wachtell, Lipton, Rosen & Katz specializing in mergers, acquisitions, restructurings and related financing transactions. From 1987 to 1989, Mr. Press was a consultant with The Boston Consulting Group. Mr. Press serves on several boards of directors, including Apollo Commercial Real Estate Finance, Inc., PlayAGS, Inc., Princimar Chemical Holdings, LLC, ADT Inc. and Constellis Holdings, LLC. During the past five years, Mr. Press also served as a director of Affinion Group Holdings, Inc. (from October 2005 to September 2015), Athene Holding Ltd. (from July 2009 to February 2014), Metals USA Holdings Corp. (from May 2005 to April 2013), Noranda Aluminum Holding Corporation (from March 2007 to December 2015), Prestige Cruise Holdings, Inc. (from April 2007 to November 2014), Verso Corporation (from January 2009 to July 2016) and Caesars Entertainment Corporation (from January 2008 to October 2017). Mr. Press graduated magna cum laude from Harvard University with a A.B. in economics and received his JD from Yale Law School. Mr. Press has significant experience making and managing private equity investments on behalf of Apollo. Between his work at Apollo and his prior experience as an attorney and a management consultant, Mr. Press has approximately 28 years of experience in the process of financing, analyzing, and investing in public and private companies and serving on their board of directors.

Martin S. Rash has been our director since October 2015 following the Apollo/RegionalCare Acquisition and served as Executive Chairman following the consummation of the RegionalCare/Capella Merger in April 2016 until the consummation of the LifePoint/RCCH Merger. Additionally, Mr. Rash served as Chief Executive Officer of RegionalCare from October 2015 until the consummation of the LifePoint/RCCH Merger. Mr. Rash served as the Executive Chairman at RegionalCare Hospital Partners, Inc. from March 2013 to October 2015 and served as its Chief Executive Officer from 2009 until March 2013. From December 1996 to 2005, Mr. Rash was Chairman and Chief Executive Officer of Province Healthcare, a $1 billion NYSE company that owned 21 hospitals and managed more than 50 facilities. Prior to his tenure at Province Healthcare, Mr. Rash served as Executive Vice President and Chief Operating Officer for Community Health Systems where he led the growth of the company from 10 to 41 hospitals in 17 states. Earlier in his 39-year healthcare career, he worked at numerous community hospitals in various administrative and financial roles. Mr. Rash's experience and leadership includes Board of Directorships in the past at Healthspring, a NYSE company, and Odyssey Healthcare, a NASDAQ company. He is a past Chairman of the Federation of American Hospitals and currently serves on the board of the Nashville Health Care Council. He holds both a B.A. and M.B.A. from Middle Tennessee State University. He currently serves as Chairman of American Pathology Partners.

Olivia Wassenaar became our Director in December 2018. Ms. Wassenaar is a partner in Apollo Global Management's Natural Resources business, having joined in 2018. Prior to that time, Ms. Wassenaar was a Managing Director at Riverstone Holdings and was previously a member of the Investment Banking division of Goldman Sachs. Ms. Wassenaar also serves on the boards of directors of Talos Energy and Pegasus.

G. Rodney Wolford became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Wolford has over 40 years of wide-ranging experience in the health care industry, having served in leadership roles with health care providers, suppliers, consulting firms, associations and insurers. Redirecting his professional time from active executive leadership, he now focuses his professional time on multiple boards of directors and rural community economic development. Among his many executive positions, Mr. Wolford served as chief executive officer of Alliant Healthcare (now Norton Healthcare), the leading hospital system in Louisville, KY, Sterling Diagnostic, a worldwide manufacturer of x-ray film, Forhealth Technologies, the inventor of the first robot dedicated to hospital IV production, and a senior executive of Blue Cross Tennessee. Mr. Wolford currently serves on the boards of Atlanta based D4C Brands, a pediatric dentistry company, and Liberate Medical, which develops electronic stimulation for ventilator patients, and as a fund manager of Bluegrass Angel Fund III. During the past five years, Mr. Wolford has also served as a director of Haven Behavioral, Laboratory Supply Company, VetCor and Essent Healthcare.

Code of Ethics

Our Board 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.

Board Structure

The Board consists of 13 directors. The Board has the following standing committees: audit; compensation; nominating and governance; compliance; quality; and executive. In addition, the board of directors of our parent company, DSB Parent, also has a compensation committee that administers equity-based compensation plans in which our managers, officers, employees, consultants and directors participate. As a result of the LifePoint/RCCH Merger and the RegionalCare/Capella Merger, Apollo has the power to control us and our affairs and policies, including the designation of a majority of the members of our Board and the appointment of management.

Committees of our Board of Directors

The Board has adopted written charters for each of the following standing committees:

Audit Committee

The current members of our audit committee are Messrs. Morissette, Haley and Wolford. Mr. Morissette is the chairman of our audit committee. The principal duties and responsibilities of our audit committee are to assist the Board in overseeing:

- the integrity of our financial statements;
- the independent auditor's qualifications, independence and performance;
- the performance of our internal audit function; and
- our compliance with certain legal, ethical and regulatory requirements.

The audit committee has the authority to conduct or authorize investigations into or studies of matters within its scope of responsibilities. It also has the authority to retain and determine funding for independent legal, accounting or other advisors (without seeking Board approval) as it determines necessary or appropriate to carry out its duties and responsibilities.

Our Board has determined that each of Messrs. Morissette and Wolford is an "audit committee financial expert" within the meaning of applicable SEC regulations.

Compensation Committee

The current members of our compensation committee are Messrs. Nord and Press. Mr. Press is the chairman of our compensation committee. The principal duties and responsibilities of our compensation committee are as follows:

- approving the non-equity-based compensation of our officers, directors and employees;
- administering our non-equity-based compensation plans; and
- making recommendations to DSB Parent for the equity-based compensation of DSB Parent and its subsidiaries' officers, directors and employees.

Nominating and Governance Committee

The current members of our nominating and governance committee are Messrs. Christie, Press and Rash. Mr. Press is the chairman of our nominating and governance committee. The principal duties and responsibilities of our nominating and governance committee are as follows:

- to assist the Board in identifying individuals qualified to serve as members of the Board and/or its committees; and
- other duties and responsibilities that our Board may delegate to the nominating and governance committee.

Compliance Committee

The current members of our compliance committee are Messrs. Levin, Morissette, Wolford and Rash. Mr. Wolford is the chairman of our compliance committee. The compliance committee is responsible for overseeing our legal and regulatory compliance program, including certain healthcare and regulatory compliance matters that affect us and our business operations.

Quality Committee

The current members of our compliance committee are Messrs. Brownstein, Carpenter, David, Haley and Ms. McMullan. Mr. Carpenter is the chairman of our quality committee. The quality committee is responsible for monitoring and evaluating the adequacy and effectiveness of our quality of care and patient safety programs and initiatives.

Executive Committee

The current members of our executive committee are Messrs. David, Nord and Press. Mr. Nord is the chairman of our executive committee. The principal duties and responsibilities of our executive committee are as follows:

- to advise and counsel the Chief Executive Officer regarding company matters; and
- to take such actions as are necessary due to their urgent or highly confidential nature, or where convening the Board is impracticable, subject to certain limitations.

Item 11. ***Executive Compensation.***

The information that would be required to be disclosed under Part III, Item 11 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

The information that would be required to be disclosed under Part III, Item 12 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

The following discussion reflects certain relationships and related party transactions entered into in connection with the LifePoint/RCCH Merger. For a further discussion of our relationships and related party transactions, refer to the notes to our accompanying consolidated financial statements included elsewhere in this Report and disclosure regarding our relationships and related party transactions contained in the November 2018 OM.

New Employment Agreements

In connection with the consummation of the LifePoint/RCCH Merger, we entered into an employment agreement with each of Messrs. Dill, Bumpus, Coggin and Giovanetti and Ms. Peters. Additionally, we entered an amended and restated employment agreement with Mr. Jay.

Each applicable executive's employment agreement contains an indefinite term of employment. Each employment agreement established the applicable executive's annual base salary (the annual base salary in the employment agreements for each of Messrs. Dill, Bumpus, Coggin, Giovanetti and Jay and Ms. Peters was set at $1,100,000, $550,000, $650,000, $650,000, $650,000 and $550,000, respectively) and his or her eligibility to receive an annual bonus with the target bonus for each fiscal year determined annually by our board of directors or our compensation committee. Pursuant to his or her respective employment agreement, Mr. Dill's target bonus is at least 150% of base salary, and each of Messrs. Bumpus', Coggin's, Giovanetti's and Jay's and Ms. Peters' target bonus is at least 100% of base salary with a maximum of 200% of base salary. The actual bonus payable to each applicable executive will be based upon the level of achievement of annual Company and individual performance objectives, as determined by the board of directors or our compensation committee.

As disclosed in the November 2018 OM, we implemented a transaction severance plan (the "***RCCH Severance Plan***") under which certain employees are eligible to receive severance payments and benefits in connection with their "qualifying termination" (as defined in the November 2018 OM) of employment under the plan within 18 months after the consummation of the LifePoint/RCCH Merger. Under the RCCH Severance Plan and the applicable employment agreement, in the event of his or her qualifying termination under the plan within such 18-month period and execution of a release of claims, each of the executives other than Mr. Bumpus will be entitled to receive the severance payments and benefits provided to "category one" employees as described in the November 2018 OM. Following the expiration of the 18-month period and execution of a release of claims, each of the executives other than Mr. Bumpus will be entitled to receive the severance payments and benefits as described in the applicable employment agreement in the event of his or her termination without cause (other than due to death or disability) or resignation due to good reason. Under his employment agreement, in the event of his termination for any reason other than for cause (including due to retirement) and his execution of a release of claims, Mr. Bumpus will be entitled to receive the same severance payments and benefits payable to "category one" employees under the RCCH Severance Plan and certain additional severance benefits.

Additionally, as disclosed in the November 2018 OM, on November 8, 2018, we entered into an amended and restated employment agreement with Mr. Rash. Mr. Rash's amended and restated employment agreement contains an indefinite term of employment and provides for an annual base salary and payment of an annual fee in connection with his service on our board of directors and severance payments and benefits in the event of his termination of employment without cause (other than due to death or disability) or resignation for good reason and execution of a release of claims. Mr. Rash is not entitled to receive any severance payments or benefits under the RCCH Severance Plan.

Each applicable executive is subject to a (i) 12-month post-termination non-competition covenant relating to competitors of the Company, (ii) 12-month post-termination non-solicitation covenant in respect of our employees, consultants, clients, customers and similar business relationships of the Company and (iii) perpetual confidentiality and non-disparagement covenants.

Retention Bonuses and Severance Payments

As contemplated in the November 2018 OM, in connection with the consummation of the LifePoint/RCCH Merger, we have paid or are paying retention bonuses and severance payments to certain former Legacy LifePoint or RCCH executives and other employees. The aggregate amount for such payments made through the end of December 31, 2018 is included within merger and acquisition costs on our consolidated statement of operations for the year ended December 31, 2018 and are discussed in Note 2 to our accompanying consolidated financial statements included elsewhere in this Report. Certain retention bonuses and severance payments in connection with the LifePoint/RCCH merger are anticipated to continue to be made during 2019 and 2020 and will be reflected within merger and acquisition costs on our consolidated statement of operations for subsequent periods.

DSB Parent L.P. Capital Units and Profits Units

Certain of our executives, employees, consultants and directors, including our new executive officers following the LifePoint/RCCH Merger, have been granted profits units and certain of our executives, employees and directors have purchased capital units in DSB Parent (the "***capital units***"). Further information about such capital unit acquisitions and certain of the profits unit grants is provided below.

The profits units provide the recipients with the opportunity to share in our future appreciation, subject to vesting. In general, 40% of the profits units vest in substantially equal installments on the last day of each of the first twenty (20) calendar quarters commencing on or after the applicable grant date or, in the case of certain grants, November 16, 2018 (the "***time-vested profits units***") and the remaining 60% of the profits units vest based on the achievement of certain investment returns to our Sponsor. The profits units granted to directors (the "***directors profits units***") generally vest on a time basis, either in substantially equal installments on each of the first three anniversaries of the date of grant or on the date that is six months and one day from November 16, 2018. In addition, the time-vested profits units and the director profits units will vest in full on a sale of the Company. Refer to Note 13 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of profits units issued by DSB Parent to our executives, employees, consultants and directors.

The capital units and profits units are generally subject to the terms and condition set forth in the applicable award agreements or subscription agreements, as the case may be, and in the partnership agreement of DSB Parent, including, but not limited to, customary transfer restrictions, redemption rights and obligations, drag-along rights, tag-along rights, and preemptive rights.

Equity Repurchases

As contemplated in the November 2018 OM, in connection with the LifePoint/RCCH Merger, DSB Parent has repurchased or is in process of repurchasing capital units and vested profits units from certain of our former or departing employees, including certain former executive officers. Although none of these repurchases were completed prior to the end of 2018, the aggregate amount of such repurchases is included under the caption "Other current liabilities" in our accompanying consolidated balance sheet as of December 31, 2018 included elsewhere in this Report. Repurchases are ongoing and are anticipated to continue to occur during 2019.

Director Arrangements

Certain members of our Board of Directors are entitled to receive annual retainers and fees in accordance with our director compensation policy in connection with their service on our Board.

In addition, as contemplated in November 2018 OM, we entered into a letter agreement with Mr. Carpenter, dated November 16, 2018, regarding the terms of his stepping down as the chief executive officer and chairman of the board of directors of Legacy LifePoint and the terms of his continued service with us on our board of directors.

Item 14. *Principal Accounting Fees and Services*.

The Audit Committee has appointed Ernst & Young LLP as our independent registered public accounting firm. Services provided to us by Ernst & Young LLP in fiscal 2018 are described below.

Audit Fees. The aggregate audit fees billed by Ernst & Young LLP for professional services rendered for the audit of our annual consolidated financial statements and services that are normally provided by the independent registered public accounting firm in connection with statutory and regulatory filings totaled approximately $6.0 million for 2018 and approximately $1.2 million for 2017.

Audit-Related Fees. The aggregate fees billed by Ernst & Young LLP for assurance and related services other than those described under “Audit Fees” were approximately $0.2 million for 2018.

Tax Fees. The aggregate fees billed by Ernst & Young LLP for professional services rendered for tax compliance, tax advice and tax planning were approximately $0.3 million for 2018 and approximately $0.1 million for 2017.

All Other Fees. There were no fees billed by Ernst & Young LLP for products or services other than those described above in 2018 or 2017.

PART IV

Item 15. ***Exhibits, Financial Statement Schedules*.**

(a) The following documents are filed as part of this Report:

1. *Consolidated Financial Statements*:

2. *Financial Statement Schedule*: All schedules for which provision is made in the applicable accounting regulations of the SEC are omitted because they either are not required under the related instructions, are inapplicable, or the required information is shown in the consolidated financial statements or notes thereto.

3. *Exhibits*: The exhibits required by Item 601 of Regulation S-K that would be disclosed under Part IV, Item 15 of an annual report on Form 10-K filed with the SEC have been omitted as permitted pursuant to Section 4.02(a) of the Indentures.

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Report of Independent Auditors

Board of Directors and Shareholders of
LifePoint Health, Inc.

We have audited the accompanying consolidated financial statements of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.), which comprise the consolidated balance sheets as of December 31, 2018 and 2017, and the related consolidated statements of operations, comprehensive loss, equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the 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 involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.) at December 31, 2018 and 2017, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2018 in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

March 28, 2019

LifePoint Health, Inc.

Consolidated Statements of Operations
For the Years Ended December 31, 2018, 2017 and 2016
(In millions)

	2018	2017	2016
Revenues before provision for doubtful accounts	$ 3,136.0	$ 2,079.7	$ 1,667.9
Provision for doubtful accounts	357.9	206.9	165.2
Revenues	2,778.1	1,872.8	1,502.7
Salaries and benefits	1,329.4	874.3	694.4
Supplies	484.5	323.2	261.3
Other operating expenses, net	709.2	469.4	377.1
Depreciation and amortization	129.0	80.6	57.6
Interest expense, net	186.1	126.1	101.3
Merger and acquisition costs	141.5	7.8	25.1
Impairments of goodwill and long-lived assets	78.4	14.1	11.6
Other non-operating losses, net	7.8	16.7	11.6
	3,065.9	1,912.2	1,540.0
Loss before income taxes	(287.8)	(39.4)	(37.3)
Provision for (benefit from) income taxes	0.2	(1.3)	4.0
Net loss	(288.0)	(38.1)	(41.3)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(5.7)	(7.3)	(2.7)
Net loss attributable to LifePoint Health, Inc.	$ (293.7)	$ (45.4)	$ (44.0)

LifePoint Health, Inc.

Consolidated Statements of Comprehensive Loss
For the Years Ended December 31, 2018, 2017 and 2016
(In millions)

	2018	2017	2016
Net loss	$ (288.0)	$ (38.1)	$ (41.3)
Other comprehensive (loss) income , net of income taxes:			
Unrealized loss on changes in funded status of pension benefit obligations	(3.1)	-	-
Other	-	0.3	(0.4)
Other comprehensive (loss) income	(3.1)	0.3	(0.4)
Comprehensive loss	(291.1)	(37.8)	(41.7)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(5.7)	(7.3)	(2.7)
Comprehensive loss attributable to LifePoint Health, Inc.	$ (296.8)	$ (45.1)	$ (44.4)

LifePoint Health, Inc.

Consolidated Balance Sheets
As of December 31, 2018 and 2017
(In millions, except for share and per share amounts)

	2018	2017
ASSETS		
Current assets:		
Cash and cash equivalents	$ 58.9	$ 16.9
Accounts receivable, less allowances for doubtful accounts of $403.4 and $251.9 at December 31, 2018 and 2017, respectively	1,108.9	256.8
Inventories	224.4	55.5
Prepaid expenses	92.7	18.9
Other current assets	227.8	35.5
	1,712.7	383.6
Property and equipment:		
Land	265.7	55.6
Buildings and improvements	2,784.5	617.1
Equipment	1,079.2	250.9
Construction in progress	436.5	161.8
	4,565.9	1,085.4
Accumulated depreciation	(248.8)	(133.9)
	4,317.1	951.5
Intangible assets, net	74.5	7.3
Other long-term assets	319.8	63.6
Goodwill	2,567.6	651.5
Total assets	$ 8,991.7	$ 2,057.5
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 318.3	$ 115.8
Accrued salaries	343.5	77.7
Other current liabilities	422.2	59.1
Current maturities of long-term debt	58.4	9.8
	1,142.4	262.4
Long-term debt, net	6,419.4	1,424.2
Long-term portion of reserves for self-insurance claims	194.0	50.9
Other long-term liabilities	146.5	39.3
Total liabilities	7,902.3	1,776.8
Redeemable noncontrolling interests	136.1	60.7
Equity:		
LifePoint Health, Inc. stockholders' equity:		
Common stock, $0.01 par value; 30,000 shares authorized; 100 shares issued and outstanding at December 31, 2018 and 2017	-	-
Capital in excess of par value	1,308.3	308.1
Accumulated other comprehensive loss	(3.1)	-
Accumulated deficit	(381.8)	(88.1)
Total LifePoint Health, Inc. equity	923.4	220.0
Noncontrolling interests	29.9	-
Total equity	953.3	220.0
Total liabilities and equity	$ 8,991.7	$ 2,057.5

LifePoint Health, Inc.

Consolidated Statements of Cash Flows
For the Years Ended December 31, 2018, 2017 and 2016
(In millions)

	2018	2017	2016
Cash flows from operating activities:			
Net loss	$ (288.0)	$ (38.1)	$ (41.3)
Adjustments to reconcile net loss to net cash (used in) provided by operating activities:			
Depreciation and amortization	129.0	80.6	57.6
Other non-cash amortization	9.9	5.8	4.0
Stock-based compensation	7.0	0.7	0.6
Impairments of goodwill and long-lived assets	78.4	14.1	11.6
Other non-operating losses, net	7.8	16.7	11.6
Deferred income taxes	(0.6)	(1.7)	4.0
Reserve for self-insurance claims, net of payments	2.3	(3.2)	2.3
Changes in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:			
Accounts receivable	(48.1)	17.8	(8.5)
Inventories, prepaid expenses and other current assets	(0.2)	(15.5)	11.1
Accounts payable, accrued salaries and other current liabilities	(8.9)	37.7	2.1
Income taxes payable/receivable	53.0	(2.9)	2.0
Other	(14.6)	(6.4)	(2.3)
Net cash (used in) provided by operating activities	(73.0)	105.6	54.8
Cash flows from investing activities:			
Acquisitions, net of cash acquired	(5,345.9)	(112.9)	(673.8)
Purchases of property and equipment	(319.7)	(145.1)	(67.5)
Proceeds from sales of hospitals	-	93.5	-
Proceeds from restricted cash for use in construction of replacement hospital	20.3	10.4	-
Proceeds from sales of investments, net of purchases	(0.4)	3.0	25.7
Net cash used in investing activities	(5,645.7)	(151.1)	(715.6)
Cash flows from financing activities:			
Proceeds from borrowings	5,125.0	37.6	1,150.0
Payments of borrowings	(189.3)	(1.7)	(554.9)
Net change in ABL Facility and Prior ABL Facility	10.0	10.0	-
Proceeds from lease financing	38.0	100.5	109.7
Repayment of MPT lease obligation in connection with hospital sale	-	(64.3)	-
Payments of debt financing costs	(207.0)	(0.9)	(54.9)
Cash contributed by (distributed to) parent	1,000.0	(37.6)	46.7
Distributions to noncontrolling interests and redeemable noncontrolling interests, net of proceeds	(6.0)	(3.9)	(8.6)
Financing and capital lease payments and other	(10.0)	(7.7)	(4.8)
Net cash provided by financing activities	5,760.7	32.0	683.2
Change in cash and cash equivalents	42.0	(13.5)	22.4
Cash and cash equivalents at beginning of period	16.9	30.4	8.0
Cash and cash equivalents at end of period	$ 58.9	$ 16.9	$ 30.4
Supplemental disclosure of cash flow information:			
Interest payments	$ 138.1	$ 127.3	$ 81.9
Capitalized interest	$ 17.4	$ 6.1	$ 1.7
Income tax (refunds) payments, net	$ (53.7)	$ 0.8	$ 0.4

LifePoint Health, Inc.

Consolidated Statements of Equity
For the Years Ended December 31, 2018, 2017 and 2016
(Dollars in millions)

	Common Stock		Capital in Excess of	Accumulated Other Comprehensive	Accumulated Earnings	Noncontrolling	
	Shares	Amount	Par Value	Income (Loss)	(Deficit)	Interests	Total
Balance at January 1, 2016	100	$ -	$ 300.4	$ 0.1	$ 1.3	$ -	$ 301.8
Net loss	-	-	-	-	(44.0)	-	(44.0)
Other comprehensive loss	-	-	-	(0.4)	-	-	(0.4)
Stock-based compensation	-	-	0.6	-	-	-	0.6
Capital contribution from parent	-	-	46.7	-	-	-	46.7
Capital contributions from management	-	-	3.3	-	-	-	3.3
Repurchase of parent units	-	-	(2.9)	-	-	-	(2.9)
Balance at December 31, 2016	100	-	348.1	(0.3)	(42.7)	-	305.1
Net loss	-	-	-	-	(45.4)	-	(45.4)
Other comprehensive income	-	-	-	0.3	-	-	0.3
Stock-based compensation	-	-	0.7	-	-	-	0.7
Capital distribution to parent	-	-	(37.6)	-	-	-	(37.6)
Fair value adjustments related to redeemable noncontrolling interests	-	-	(3.1)	-	-	-	(3.1)
Balance at December 31, 2017	100	-	308.1	-	(88.1)	-	220.0
Net loss (income)	-	-	-	-	(293.7)	0.2	(293.5)
Other comprehensive loss	-	-	-	(3.1)	-	-	(3.1)
Stock-based compensation	-	-	7.0	-	-	-	7.0
Reclassification of vested stock-based compensation units to a liability	-	-	(6.8)	-	-	-	(6.8)
Capital contribution from parent	-	-	1,000.0	-	-	-	1,000.0
Noncontrolling interests assumed in LifePoint/RCCH Merger	-	-	-	-	-	29.9	29.9
Distributions to noncontrolling interests	-	-	-	-	-	(0.2)	(0.2)
Balance at December 31, 2018	100	$ -	$ 1,308.3	$ (3.1)	$ (381.8)	$ 29.9	$ 953.3

Note 1. Organization and Summary of Significant Accounting Policies

Organization

LifePoint Health, Inc., a Delaware corporation, acting through its subsidiaries, owns or leases and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. At December 31, 2018, on a consolidated basis, LifePoint Health, Inc. operated 89 hospital campuses in 30 states throughout the United States ("U.S.").

Unless otherwise indicated or the context otherwise requires, references throughout these notes to the consolidated financial statements to the "Company" or "LifePoint" refer to LifePoint Health, Inc., and each of its consolidated subsidiaries after giving effect to the LifePoint/RCCH Merger (defined below) and (ii) "RCCH" refer to RegionalCare Hospital Partners Holdings, Inc. and each of its consolidated subsidiaries before giving effect to the LifePoint/RCCH Merger. References in this Report to the "Sponsor" refer to certain funds that are affiliates of the Company (the "Apollo Funds") that are ultimately controlled and/or managed by Apollo Management VIII, L.P. ("Apollo Management" and, when acting on behalf of the Apollo Funds, "Apollo"), which is an affiliate of Apollo Global Management LLC.

Additionally, references throughout these notes to the consolidated financial statements to the "LifePoint/RCCH Merger" refer to the merger, which was effective on November 16, 2018, of Legend Merger Sub, Inc., a Delaware corporation and wholly owned subsidiary of RCCH ("Legend Merger Sub"), with and into LifePoint Health, Inc., a Delaware corporation ("Legacy LifePoint"), with Legacy LifePoint surviving the LifePoint/RCCH Merger as a subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners, Inc." to "LifePoint Health, Inc."

Furthermore, references throughout these notes to the consolidated financial statements to the "RegionalCare/Capella Merger" refer to the merger of Crimson Merger Sub, LLC ("Crimson Merger Sub"), a Delaware limited liability company and wholly-owned subsidiary of RegionalCare Hospital Partners Inc. ("RegionalCare"), with and into Capella Health Holdings, LLC ("Capella"), with Capella surviving the RegionalCare/Capella Merger as a wholly-owned subsidiary of RegionalCare, which began to do business as RCCH Healthcare Partners. The RegionalCare/Capella Merger was consummated on April 29, 2016; however, for accounting purposes, the RegionalCare/Capella Merger became effective on May 1, 2016.

References throughout these notes to the consolidated financial statements to the "Apollo/RegionalCare Acquisition" refer to the merger, which was effective on December 3, 2015, of DSB Merger Sub Inc., a Delaware corporation and wholly-owned subsidiary of DSB Acquisition LLC, a Delaware limited liability company ("Holdings"), with and into RegionalCare with RegionalCare surviving such merger as a direct wholly-owned subsidiary of Holdings, which is indirectly controlled by our Sponsor.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through majority voting control, and variable interest entities which the Company controls. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation. Noncontrolling interests in non-wholly-owned consolidated subsidiaries of the Company are presented as noncontrolling interests and redeemable noncontrolling interests and distinguish between the interests of the Company and the interests of the noncontrolling owners. Net income attributable to noncontrolling interests and redeemable noncontrolling interests represents the amounts attributable to the noncontrolling interests for each of the applicable periods presented. Investments in entities the Company does not control but does have a substantial ownership interest and can exercise significant influence are accounted for using the equity method.

The Company's financial statements have been presented on the basis of push down accounting in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") No. 805-50-S99. Under the push down basis of accounting, certain transactions incurred by the parent company which would otherwise be accounted for in the accounts of the parent are "pushed down" and recorded on the financial statements of the subsidiary. Accordingly, certain items resulting from the acquisition by Apollo have been recorded on the financial statements of the Company.

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 the consolidated financial statements. Actual results could differ from those estimates.

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 payers 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 payers 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.

Change in Accounting Estimate

During the year ended December 31, 2018, the Company recorded a decrease to revenues of $17.0 million as a result of a change in its accounting estimate of the collectability of accounts receivable. During the year ended December 31, 2018, the Company identified additional information which indicated that its current collection estimates might be different from its historical collection estimates. Management utilized this new information to further refine its estimation procedures to more precisely estimate the collectability of accounts receivable. The Company's change in its estimation procedures of the collectability of its accounts receivable is considered a change in accounting estimate in accordance with ASC 250, "Accounting Changes and Error Corrections."

Payer Mix

The following table summarizes the Company's revenues by payer as approximate percentages of net patient revenues before the provision for doubtful accounts for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
Medicare	37.6 %	40.4 %	36.4 %
Medicaid	13.1	12.2	12.8
HMOs, PPOs and other private insurers	41.3	40.7	42.5
Self-pay	8.0	6.7	8.3
	100.0 %	100.0 %	100.0 %

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

Contractual Discounts and Cost Report Settlements

The Company derives a significant portion of its revenues from Medicare, Medicaid and other payers 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 payer-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 and Medicaid are estimated and recorded in the period the related services are rendered and will be 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. For the year ended December 31, 2018, the net adjustments to estimated cost report settlements resulted in a decrease to revenues of approximately $4.0 million, and for the years ended December 31, 2017 and 2016, the net adjustments to estimated cost report settlements resulted in increases to revenues of approximately $3.6 million and $3.7 million, respectively. The net estimated cost report settlements due to Medicare and Medicaid were approximately $0.5 million and $0.3 million as of December 31, 2018 and 2017, 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 agreements.

The Company believes that it is in compliance with all applicable laws and regulations with regard to its Medicare and Medicaid programs 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 consolidated financial statements. Compliance with such laws and regulations can be subject to future governmental 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, 2018, 2017 and 2016, the Company estimates that its costs of care provided under its charity care programs approximated $16.8 million, $11.7 million and $5.7 million, respectively. 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 payer classification and revenue days in accounts receivable. Accounts receivable are written off after collection efforts have been followed in accordance with the Company's policies.

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

	Balances at Beginning of Year	Additions Recognized as a Reduction to Revenues	Accounts Written Off, Net of Recoveries	Balances at End of Year
Year ended December 31, 2018	$ 251.9	$ 357.9	$ (206.4)	$ 403.4
Year ended December 31, 2017	$ 127.7	$ 206.9	$ (82.7)	$ 251.9
Year ended December 31, 2016	$ 7.9	$ 165.2	$ (45.4)	$ 127.7

The allowances for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts were 26.7% and 49.5% as of December 31, 2018 and 2017, respectively. The decrease in the Company's allowances for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts, is primarily a result of the accounts receivable acquired in connection with the LifePoint/RCCH Merger, which was recognized in the Company's balance sheet net of allowances for doubtful accounts at the effective time of the LifePoint/RCCH Merger. Additionally, as of December 31, 2018 and 2017, the allowances for doubtful accounts plus certain contractual allowances and discounts related to self-pay patients as a percentage of self-pay receivables were 95.3% and 94.1%, respectively.

Concentration of Revenues

During the years ended December 31, 2018, 2017 and 2016, approximately 50.7%, 52.6% and 49.2%, 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. Any changes in the current demographic, economic, competitive or regulatory conditions, or to Medicaid programs could have an adverse effect on the Company's revenues or results of operations. The Company's management does not believe that there are any other significant concentrations of revenues from any particular payer or geographic area that would subject the Company to any significant credit risks in the collection of its accounts receivable.

Other Revenue

Other revenue primarily consists of hospital ancillary sales and services as well as rental income. The Company leases certain real estate assets it owns to unrelated third parties, primarily medical office buildings to non-employed physicians. The Company recognizes rental income for these operating lease arrangements in which the Company is the lessor on a straight-line basis over the lease term in accordance with ASC 840, "Leases" ("ASC 840").

General and Administrative Costs

The majority of the Company's operating expenses are "cost of revenue" items. Operating costs that could be classified as "general and administrative" by the Company would include its corporate overhead costs, excluding depreciation and amortization and merger and acquisition costs, which were $72.4 million, $42.8 million and $29.7 million for the years ended December 31, 2018, 2017 and 2016, respectively.

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 electronic health record ("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, "Gain Contingencies" ("ASC 450"). In accordance with ASC 450, 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.

The Company recognized EHR incentive income under the Medicare and Medicaid HITECH Act programs, collectively, of $9.8 million during the year ended December 31, 2016, which is included under the caption "Other operating expenses, net" in the Company's accompanying consolidated statements of operations. The Company's incentive payments under these programs substantially concluded in 2017.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash on hand and short-term investments 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 of supplies are stated at the lower of cost (first-in, first-out) or market and consist of purchased items. Inventories acquired in connection with business combinations are recorded at fair value which approximates replacement cost. Inventory items are primarily operating supplies used in the direct or indirect treatment of patients.

Investments

The Company accounts for its investments in entities in which the Company exhibits significant influence, but not control, under the equity method of accounting in accordance with ASC 323, "Investments – Equity Method and Joint Ventures" ("ASC 323"). 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. Refer to Note 9 for further discussion of the Company's equity method investments.

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, "Business Combinations" ("ASC 805"). 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. The Company capitalizes interest on funds used to pay for the construction of major capital additions and such interest is included in the cost of each capital addition.

Depreciation is computed by applying the straight-line method over the estimated useful lives of buildings, 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)	3	-	49
Equipment	2	-	12
Equipment under capital leases	3	-	5

Depreciation expense (including lease amortization) totaled $128.5 million, $80.1 million and $56.9 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

For the year ended December 31, 2018, the Company recognized an impairment charge of $24.5 million to reduce the carrying amounts of certain long-lived assets at one of its facilities to their estimated fair values, which is included under the caption "Impairments of goodwill and long-lived assets" in the accompanying consolidated statements of operations for the year ended December 31, 2018. There were no long-lived asset impairments recorded for the years ended December 31, 2017 and 2016.

Goodwill and Intangible Assets

The Company accounts for its acquisitions in accordance with ASC 805 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, Intangibles – Goodwill and Other ("ASC 350"), goodwill and intangible assets with indefinite lives are reviewed by the Company annually for impairment on October 1. The impairment evaluation is performed at the individual hospital level as each hospital represents a reporting unit as defined in ASC 350. For the annual impairment evaluation, the Company may perform an initial qualitative assessment to determine whether it is more likely than not that the fair value of the reporting unit is less than its carrying value. This assessment is used as a basis for determining whether it is necessary to perform the goodwill impairment test. For those reporting units on which the Company performs the impairment test, the Company determines fair value using a discounted cash flow ("DCF") analysis and consideration of certain market inputs including those of guideline public companies. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing the Company's assumptions. The cash flows employed in the DCF analysis are based on the Company's most recent financial budgets and business plans and, when applicable, various growth rates for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the respective reporting units.

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. Refer to Note 5 for further discussion of the Company's goodwill and intangible assets.

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 the income tax provision 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. The establishment or increase in a valuation allowance is included as 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. Refer to Note 6 for further discussion of the Company's accounting for income taxes.

Reserves for Self-Insurance Claims

Given the nature of the Company's operating environment, it is subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("SIR") and deductible levels. At December 31, 2018, the Company's SIR for professional liability claims is $5.0 million per claim, with a $5.0 million inner aggregate, at the majority of its facilities, and $2.0 million per claim at certain of its facilities. Additionally, the Company participates in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2018, the Company's deductibles for workers' compensation claims range from $0.5 million to $1.0 million per claim in all states in which it operates except for Montana, Oklahoma, Ohio, Washington and Wyoming. The Company participates in state-specific programs for its workers' compensation claims arising in these states. The Company's SIR and deductible levels are evaluated annually as a part of its insurance program's renewal process.

The Company's reserves for self-insurance and deductible claims reflect the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The Company's expense for self-insurance and deductible claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of the Company's self-insured retention and deductible levels; the administrative costs of the insurance program; and interest expense related to the discounted portion of the liability. The Company's expense for self-insurance and deductible claims was approximately $20.7 million, $7.7 million and $12.5 million for the years ended December 31, 2018, 2017 and 2016, respectively.

The Company's reserves for professional liability claims are based upon quarterly and/or semi-annual 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 1.8% at December 31, 2018 and in a range of 1.4% to 2.4% at December 31, 2017 and 0.9% to 2.3% at December 31, 2016. 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, 2018 and 2017 (in millions):

	2018	2017
Current portion	$ 70.7	$ 14.1
Long-term portion	194.0	50.9
	$ 264.7	$ 65.0

The following table presents the changes in our reserves for self-insured claims for the years ended December 31, 2018 and 2017 (in millions):

	2018	2017
Reserve at the beginning of the period	$ 65.0	$ 64.5
Liabilities assumed in LifePoint/RCCH Merger	194.7	-
Increase for the provision of current year claims	23.0	19.8
Decrease for the provision of prior year claims	(3.9)	(12.1)
Payments related to current year claims	(1.0)	(0.8)
Payments related to prior year claims	(14.8)	(10.0)
Provision for the change in discount rate	1.6	-
Noncash change in reserve for claims in excess of self-insured retention levels	0.1	3.6
Reserve at the end of the period	$ 264.7	$ 65.0

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 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, 2018, 2017 and 2016, the Company's related self-insured claims expense decreased by $3.9 million, $12.1 million and $4.5 million, respectively.

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 and contracted physicians in addition to providing workers' compensation deductible coverage. Fees charged to these employed physicians and contracted 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.

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 $46.1 million and $7.1 million at December 31, 2018 and 2017, respectively, and is included in the Company's accompanying consolidated balance sheets under the caption "Other current liabilities".

Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to the Company. 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 earnings that portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by the Company. Refer to Note 10 for further discussion of the Company's noncontrolling interests and redeemable noncontrolling interests.

Variable Interest Entities

The Company's consolidated financial statements at December 31, 2018 include eight facilities that qualify as a variable interest entity in which the Company is the primary beneficiary under the provisions of ASC 810, "Consolidation," and in which the Company owns a controlling economic interest.

Stock-Based Compensation

The Company's indirect parent, DSB Parent L.P., a Delaware limited partnership ("DSB Parent"), has issued profits units (the "Units") to certain employees, directors and consultants under the terms and conditions of the Amended and Restated Limited Partnership Agreement of DSB Parent dated of December 3, 2015 (the "DSB Parent Partnership Agreement") and forms of award agreements. The Company accounted for these stock-based awards in accordance with the provisions of ASC 718, "Compensation – Stock Compensation" ("ASC 718"). In accordance with ASC 718, the Company recognized compensation expense based on the estimated grant date fair value of each stock-based award. The Company recognizes forfeitures of Units as they occur. Refer to Note 14 for further discussion of the Company's accounting for Units.

Defined Benefit Pension Plans

In connection with the LifePoint/RCCH Merger, the Company acquired certain assets and assumed certain liabilities associated with two separate defined benefit pension plans covering certain employees at two of Legacy LifePoint's facilities. The Company accounts for its defined benefit pension plans in accordance with ASC 715, "Compensation – Defined Benefit Plans", ("ASC 715"). In accordance with ASC 715, the Company recognizes the unfunded liability of its defined benefit pension plans in the Company's consolidated balance sheets and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the defined benefit pension plans' assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligation is measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality. Refer to Note 12 for further discussion of the Company's defined benefit pension plans.

Defined Contribution Plans

The Company maintains three separate defined contribution retirement plans covering a majority of the Company's employees, including Legacy LifePoint employees, RCCH employees and employees at Community Medical Center. These defined contribution retirement plans contain discretionary matching policies based on the Company's financial performance and definite contribution formulas for employees at certain facilities. Refer to Note 12 for further discussion of the Company's defined contribution plans.

Reclassifications

Certain reclassifications have been made to the prior years to conform to current year presentation. These reclassifications had no effect on net loss or cash flows as previously reported.

Accounting Standards Not Yet Adopted

Accounting Standards Update ("ASU") 2014-9, "Revenue from Contracts with Customers"

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

Step 1: Identify the contract(s) with a customer.
Step 2: Identify the performance obligations in the contract.
Step 3: Determine the transaction price.
Step 4: Allocate the transaction price to the performance obligations in the contract.
Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

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

The provisions of the New Revenue Standard are effective for annual reporting periods beginning after December 15, 2018 by applying either the full retrospective method or the cumulative catch-up transition method. The full retrospective method requires application of the provisions of the New Revenue Standard for all periods presented while the cumulative catch-up transition method requires the application of the provisions of the New Revenue Standard as of the date of adoption with the cumulative effect of the retrospective application of the provisions as an adjustment through retained earnings. Currently, the Company anticipates adopting the provisions of the New Revenue Standard using the full retrospective method.

The Company does not anticipate that the provisions of the New Revenue Standard will have an impact on its current or historical financial position, results of operations or cash flows. Additionally, the Company does not anticipate that the provisions of the New Revenue Standard will have an impact on the amount or timing of when it recognizes revenues prospectively. However, upon adoption of the New Revenue Standard, the Company will recognize the majority of its previously reported provision for doubtful accounts, primarily related to its self-pay patient population, as a direct reduction to revenues as an implicit pricing concession, instead of separately as a discrete deduction to arrive at revenues, and the related presentation of the allowance for doubtful accounts will be eliminated for all periods presented.

ASU 2016-2, "Leases"

In February 2016, the FASB issued ASU 2016-2 "Leases" ("ASU 2016-2"). ASU 2016-2 requires the rights and obligations arising from lease contracts, including existing and new arrangements, to be recognized as assets and liabilities on the balance sheet. ASU 2016-2 is effective for annual reporting periods beginning after December 15, 2019. The Company anticipates that the adoption of ASU 2016-2 will result in an increase in both total assets and total liabilities reflected on the Company's balance sheets. The Company is still evaluating the impact that the adoption of this standard will have on its policies, procedures, financial disclosures, and control framework.

Note 2. Mergers

LifePoint/RCCH Merger

Summary

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc."

Equity Contribution

In connection with the LifePoint/RCCH Merger, the Apollo Funds, together with certain other co-investors investing through a co-investment vehicle controlled by our Sponsor or its affiliates, indirectly contributed $1,000.0 million of newly invested capital to DSB Parent, which is our indirect parent and is owned by the Apollo Funds, such co-investment vehicle and certain current or former directors, members of management, employees and consultants of the Company, and the $1,000.0 million of newly invested capital was further contributed to the Company to be used to partially fund the LifePoint/RCCH Merger.

Financing Transactions

Concurrently with the closing of the LifePoint/RCCH Merger, the Company (1) issued $1,425.0 million principal amount of 9.750% Senior Notes due 2026 (the "9.75% Unsecured Notes"), (2) entered into a new senior secured asset-based revolving credit facility (the "ABL Facility") in an aggregate principal amount of $800.0 million with a maturity of five years, (3) terminated its existing senior secured asset-based revolving credit facility, entered into on April 29, 2016 (the "Prior ABL Facility"), (4) entered into a senior secured term loan credit facility (the "Term Loan Facility") in an aggregate principal amount of $3,550.0 million with a maturity of seven years, and (4) repaid in full its $150.0 million term loan facility, entered into on April 25, 2018 (the "Prior Term Facility").

The Company has accounted for the LifePoint/RCCH Merger in accordance with ASC 805 under the acquisition method of accounting. The following table summarizes the fair values of assets acquired and liabilities assumed on a preliminary basis in connection with the LifePoint/RCCH Merger (in millions):

Cash	$	139.8
Accounts receivable		778.8
Other current assets		479.2
Property and equipment		3,117.3
Goodwill		1,950.1
Intangible assets		60.3
Other long-term assets		240.0
Accounts payable		(185.3)
Accrued salaries		(407.8)
Other current liabilities		(266.0)
Capital and financing leases		(136.1)
Other long-term liabilities		(235.1)
Noncontrolling interests and redeemable noncontrolling interests		(105.6)
Net assets acquired	$	5,429.6

The fair values assigned to certain assets acquired and liabilities assumed in relation to the LifePoint/RCCH Merger 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 property and equipment, goodwill, intangible assets, equity method investments, noncontrolling interests and redeemable noncontrolling interests, as well as deferred income taxes. The Company expects to finalize its analysis during 2019.

The results of operations of Legacy LifePoint are included in the Company's results of operations beginning on November 17, 2018. Revenues from the operations acquired in the LifePoint/RCCH Merger included in the Company's consolidated statements of operations were $754.9 million for the year ended December 31, 2018. Income before income taxes from the operations acquired in the LifePoint/RCCH Merger was $50.9 million for the year ended December 31, 2018.

For the year ended December 31, 2018, the Company recognized merger-related costs of $134.7 million primarily related to legal and transaction advisory services as well as employee severance and retention costs in connection with the LifePoint/RCCH Merger. Included in this amount is a $55.0 million transaction fee paid by the Company to an affiliate of its Sponsor upon the closing of the LifePoint/RCCH Merger.

RegionalCare/Capella Merger

On March 21, 2016, RegionalCare and Capella entered into an agreement and plan of merger, pursuant to which, effective on April 29, 2016, Crimson Merger Sub merged with and into Capella, with Capella continuing as the surviving company in the merger as a wholly-owned subsidiary of RegionalCare. After the RegionalCare/Capella Merger was consummated we began to do business as RCCH HealthCare Partners. Concurrently with the closing of the RegionalCare/Capella Merger, the Company (i) issued the 8.25% Secured Notes due 2023 in an aggregate principal amount of $800.0 million (the "8.25% Secured Notes") and the 11.5% Unsecured Notes due 2024 an aggregate principal amount of $350.0 million (the "11.5% Unsecured Notes") (ii) entered into the Prior ABL Facility and (iii) refinanced certain indebtedness of DSB Holdings Inc., a Delaware corporation and wholly-owned subsidiary of DSB Parent ("DSB Holdings"), RegionalCare and Capella.

The Company accounted for the RegionalCare/Capella Merger in accordance with ASC 805 under the acquisition method of accounting. The following table summarizes the fair values of assets acquired and liabilities assumed in connection with the RegionalCare/Capella Merger (in millions):

Cash	$	16.5
Accounts receivable		116.4
Other current assets		75.6
Property and equipment		397.3
Goodwill		367.0
Other long-term assets		17.1
Accounts payable		(32.6)
Accrued salaries		(27.4)
Other current liabilities		(27.1)
Financing leases		(177.6)
Other long-term liabilities		(32.2)
Redeemable noncontrolling interests		(21.1)
Net assets acquired		671.9
Cash contributed to parent by Capella management		(3.4)
Total merger consideration	$	668.5

The results of operations of Capella are included in the Company's results of operations beginning on May 1, 2016. Revenues from the operations acquired in the RegionalCare/Capella Merger included in the Company's consolidated statements of operations were $578.1 million for the year ended December 31, 2016. Income before income taxes from the operations acquired in the RegionalCare/Capella Merger was $42.8 million for the year ended December 31, 2016.

For the year ended December 31, 2016, the Company recognized merger-related costs of $21.7 million primarily related to legal and transaction advisory services and employee severance costs in connection with the RegionalCare/Capella Merger.

Note 3. Acquisitions & Divestitures

Acquisitions

Lourdes Health ("Lourdes")

At the close of business on August 31, 2018, the Company acquired Lourdes for $21.3 million, of which $17.5 million was financed from a sale-leaseback transaction with an affiliate of Medical Properties Trust ("MPT"), a Maryland corporation operating as a real estate investment trust. Lourdes is comprised of a 95 bed medical center and a 32 bed counseling center each located in Pasco, Washington. The results of operations of Lourdes are included in the Company's results of operations beginning on September 1, 2018.

Trios Health ("Trios")

At the close of business on August 3, 2018, the Company acquired Trios for $18.0 million. Trios is comprised of two hospital campuses with a total of 111 beds each located in Kennewick, Washington. In connection with the Trios acquisition, the Company entered into a sale-leaseback arrangement for a hospital building whose rent is contingent on the financial performance of the hospital and a sale-leaseback arrangement for a medical office building. The results of operations of Trios are included in the Company's results of operations beginning on August 4, 2018. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company's acquisition of Trios 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 as well as obligations assumed. The Company expects to finalize its analysis during 2019.

Pacific Medical Data Solutions ("PMDS")

Effective April 1, 2018, the Company acquired PMDS for $10.7 million. PMDS is a healthcare technology and software services company that provides revenue cycle, billing automation and software solutions to multi-specialty physician groups, ambulatory surgery centers and urgent care clinics.

St. Joseph Regional Medical Center ("St. Joseph")

At the close of business on April 30, 2017, the Company acquired St. Joseph, a 145 bed hospital in Lewiston, Idaho, for $112.2 million of which $87.5 million was financed from a sale-leaseback transaction with MPT. The results of operations of St. Joseph are included in the Company's results of operations beginning on May 1, 2017.

Saline Memorial Hospital ("Saline")

Effective June 30, 2016, the Company acquired a controlling interest in Saline County Medical Center Joint Venture, LLC, ("Saline") which owns and operates a 177 bed hospital in Benton, Arkansas for $16.6 million. The results of operations of Saline are included in the Company's results of operations beginning on July 1, 2016.

Divestitures

Teche Regional Medical Center ("Teche")

In August 2018, Legacy LifePoint and certain of its subsidiaries entered into a proposed settlement agreement with The Hospital Service District No. 2 of the Parish of St. Mary ("HSD"), a political subdivision of the state of Louisiana, outlining the terms of a definitive settlement agreement to terminate the Legacy LifePoint's lease of Teche, located in Morgan City, Louisiana. The proposed settlement agreement provides, among other things, that the Company will convey to HSD, or its designee, all assets of Teche in accordance with the existing lease agreement, and the Company will no longer operate Teche upon completion of the transaction. The Company anticipates this transaction to be completed during the second quarter of 2019 subject to the terms and conditions of a definitive settlement agreement. Included in the Company's consolidated results of operations for the year ended December 31, 2018 is a net operating loss before income taxes attributable to Teche of $0.6 million.

Sharon Hospital ("Sharon")

The Company sold Sharon Hospital, located in Sharon, Connecticut on August 1, 2017 for $3.6 million. The Company recorded an estimated impairment of long-lived assets of $11.6 million during the year ended December 31, 2016, in order to reduce the carrying value of Sharon's property and equipment to its estimated fair value. The Company subsequently recorded a loss on sale of $2.8 million during the year ended December 31, 2017 as the divestiture was finalized. Included in the Company's consolidated results of operations for the year ended December 31, 2017 and 2016 are net operating losses before income taxes attributable to Sharon of $2.1 million and $1.6 million, respectively.

EaStar Health System ("EaStar")

On March 31, 2017, the Company sold EaStar Health System, located in Muskogee, Oklahoma. The total sales price was $89.3 million, plus certain working capital items and sales taxes. Of the proceeds, $68.5 million were paid to MPT to pay off the financing lease obligation and the related prepayment penalty. The remainder of the proceeds of $20.8 million were paid directly to the Company's parent. Included in the Company's consolidated results of operations for the year ended December 31, 2017 and 2016 are net operating losses before income taxes attributable to EaStar of $8.9 million and $1.4 million, respectively.

Note 4. Long-Term Debt

The Company's long-term debt, including current portions and financing and capital leases, consists of the following at December 31, 2018 and 2017 (in millions):

	2018	2017
Senior borrowings:		
ABL Facility	$ 20.0	$ -
Prior ABL Facility	-	10.0
Term Loan Facility	3,550.0	-
9.75% Unsecured Notes	1,425.0	-
8.25% Secured Notes	800.0	800.0
11.5% Unsecured Notes	350.0	350.0
Financing and capital leases	557.2	265.0
Secured loan from affiliate	-	37.6
Unamortized debt issuance costs	(227.4)	(32.9)
	6,474.8	1,429.7
Subordinated borrowings, net	3.0	4.3
Total debt	$ 6,477.8	$ 1,434.0

Maturities of the Company's long-term debt outstanding at December 31, 2018, including financing and capital leases, but excluding unamortized debt issuance costs and other obligations that do not require eventual settlement in cash, are as follows for the years indicated (in millions):

2019	$ 58.4
2020	48.2
2021	50.4
2022	116.7
2023	847.5
Thereafter	5,533.1
	$ 6,654.3

ABL Facility

General

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Co-Borrowers entered into the ABL Facility in an aggregate principal amount of $800.0 million and terminated its Prior ABL Facility. The ABL Facility has a maturity of five years; provided that if more than $200.0 million aggregate principal amount of the 8.25% Secured Notes remain outstanding 91 days before the stated maturity thereof (the "ABL Springing Maturity Date"), then the ABL Facility will mature and the commitments ABL Facility will terminate on the ABL Springing Maturity Date. At the Effective Time, Legacy LifePoint assumed all of the rights and obligations of Legend Merger Sub under the ABL Facility. The ABL Facility also includes both a letter of credit sub-facility and a swingline loan sub-facility (including in its capacity as co-borrower under the Term Loan Facility). In addition, the Company may request one or more incremental revolving commitments in an aggregate principal amount up to the greater of (x) the greater of (i) $255.0 million and (ii) 0.23 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, and (y) the amount by which the borrowing base exceeds the aggregate commitments under the ABL Facility, subject to certain conditions and receipt of commitments by existing or additional lenders.

As of December 31, 2018, the Company had $20.0 million in borrowings outstanding under the ABL Facility and approximately $32.0 in letters of credit outstanding primarily related to the self-insured retention level of its general and professional liability insurance and workers' compensation programs as security for payment of claims. Amounts available for borrowing under the ABL Facility were approximately $548.0 million as of December 31, 2018.

Collateral and Guarantors

All obligations under the ABL Facility are unconditionally guaranteed by Holdings on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the Co-Borrowers, subject to certain exceptions.

The obligations under the ABL Facility are secured by a pledge of the capital stock of the Co-Borrowers and substantially all of their assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company (including Legacy LifePoint) and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the ABL Priority Collateral and a second-priority lien with respect to the Non-ABL Priority Collateral. Additionally, certain of the Company's restricted subsidiaries that are not guarantors will pledge certain of their assets (the "Credit Support Party Collateral") on a first-priority basis, as further security of the obligations under the ABL Facility. The Credit Support Party Collateral will secure only the obligations under the ABL Facility.

All borrowings under the ABL Facility are subject to the satisfaction of customary conditions, including the absence of a default and the accuracy of representations and warranties.

Interest Rates and Fees

Borrowings under the ABL Facility will bear interest at a rate equal to, at the Company's option, either (a) a LIBOR rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an initial applicable margin of 1.75% for LIBOR loans and 0.75% for base rate loans. The applicable margin for borrowings will be subject to step-downs based on average availability thresholds.

In addition to paying interest on outstanding principal under the ABL Facility, the Co-Borrowers will be required to pay a commitment fee under the ABL Facility in respect of the unutilized commitments under the ABL Facility at an initial rate equal to 0.375% per annum. The commitment fee may be subject to one step-down based on the average daily utilization under the ABL Facility. The Co-Borrowers will also be required to pay customary agency fees as well as letter of credit participation fees.

Restrictive Covenants and Other Matters

The ABL Facility contains certain customary affirmative covenants and events of default. The negative covenants in the ABL Facility include, among other things, limitations (none of which are absolute) on the Co-Borrowers and their subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates, enter into sale-leaseback transactions, change their lines of business, restrict dividends from their subsidiaries or restrict liens, change their fiscal year; and modify the terms of certain debt.

The ABL Facility requires that the Co-Borrowers and its restricted subsidiaries maintain a minimum fixed charge coverage ratio at any time when availability is less than an agreed amount.

The ABL Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the ABL Facility are entitled to take various actions, including the acceleration of amounts due under the ABL Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the ABL Facility.

Term Loan Facility

General

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Company and Legend Merger Sub (together, prior to the Effective Time, the "Co-Borrowers") entered into the Term Loan Facility in an aggregate principal amount of $3,550.0 million and repaid in full its Prior Term Facility. The Term Loan Facility has a maturity of seven years; provided that if more than $150.0 million aggregate principal amount of the 11.5% Unsecured Notes remain outstanding 91 days before the stated maturity thereof (the "Term Springing Maturity Date"), then the Term Loan Facility will mature and the commitments under the Term Loan Facility will terminate on the Term Springing Maturity Date. At the Effective Time, Legacy LifePoint assumed all of the rights and obligations of Merger Sub under the Term Loan Facility (including in its capacity as a Co-Borrower under the Term Loan Facility). In addition, the Company may request one or more incremental commitments in an aggregate principal amount up to the sum of (x) the greater of (i) $800.0 million and (ii) 0.75 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, plus additional amounts subject to certain agreed leverage requirements, certain other conditions and receipt of commitments by existing or additional lenders.

The Term Loan Facility requires scheduled quarterly amortization payments on the term loans in an annual amount equal to 1.0% of the original principal amount of the term loans, with the balance to be paid at maturity.

Collateral and Guarantors

All obligations under the Term Loan Facility are unconditionally guaranteed by Holdings on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the Co-Borrowers, subject to certain exceptions.

The obligations under the Term Loan Facility are secured by a pledge of the capital stock of the Company and substantially all of its assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company (including Legacy LifePoint) and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the "Non-ABL Priority Collateral" (which generally includes most inventory and fixed assets, equity interests and intellectual property of the Co-Borrowers and the subsidiary guarantors) and a second-priority lien with respect to the "ABL Priority Collateral" (which generally includes most accounts receivable and certain related assets of the Co-Borrowers and the subsidiary guarantors).

Interest Rates

Borrowings under the Term Loan Facility will bear interest at a rate equal to, at the Company's option, either (a) a LIBOR rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an applicable margin of 4.50% for LIBOR loans and 3.50% for base rate loans.

Restrictive Covenants and Other Matters

The Term Loan Facility contains certain customary affirmative covenants and events of default. The negative covenants in the Term Loan Facility include, among other things, limitations (none of which are absolute) on the Co-Borrowers and their subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates enter into sale-leaseback transactions, change their lines of business, restrict dividends from subsidiaries or restrict liens, change their fiscal year and modify the terms of certain debt or organizational agreements.

The Term Loan Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the Term Loan Facility are entitled to take various actions, including the acceleration of amounts due under the Term Loan Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the Term Loan Facility.

9.75% Unsecured Notes

On November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Company issued $1,425.0 million aggregate principal amount of the 9.75% Unsecured Notes. The 9.75% Unsecured Notes will mature on December 1, 2026. Interest on the 9.75% Unsecured Notes will accrue at 9.750% per annum and will be paid semi-annually, in arrears, on June 1 and December 1 of each year, beginning June 1, 2019.

Prior to December 1, 2021, the Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 9.75% Unsecured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. Additionally, prior to December 1, 2021, the Company may redeem in the aggregate up to 40% of the aggregate principal amount of the 9.75% Unsecured Notes in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 109.750%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 9.75% Unsecured Notes must remain outstanding after each such redemption. On or after December 1, 2021, the Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in indenture governing the 9.75% Unsecured Notes (the "9.75% Unsecured Notes Indenture").

The Company's obligations under the 9.75% Unsecured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantees the Term Loan Facility. The 9.75% Unsecured Notes and the related guarantees are unsecured obligations of the Issuers and the subsidiary guarantors.

The 9.75% Unsecured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 9.75% Unsecured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 9.75% Unsecured Notes Indenture also provides for customary events of default.

8.25% Secured Notes

On April 29, 2016, concurrently with the closing of the RegionalCare/Capella Merger, the Company issued $800.0 million aggregate principal amount of 8.25% Secured Notes. The 8.25% Secured Notes are senior obligations of the Company which mature on May 1, 2023 and bear interest at a rate of 8.25% per annum, payable semiannually on May 1 and November 1 of each year.

Prior to May 1, 2019, the Company may redeem the Secured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the notes redeemed plus an applicable "make-whole" premium and accrued and unpaid interest, if any. Additionally, prior to May 1, 2019, the Company may redeem up to 40% of the aggregate principal amount of the 8.25% Secured Notes in an amount equal to the net proceeds of one or more equity offerings at a price equal to 108.25% of the principal amount thereof, plus accrued and unpaid interest, so long as at least 50% of the 8.25% Secured Notes remain outstanding. On or after May 1, 2019, the Company may redeem the 8.25% Secured Notes at its option, in whole at any time or in part from time to time, at redemption prices set forth in the indenture governing the 8.25% Secured Notes.

The Company's obligations under the 8.25% Secured Notes are fully and unconditionally guaranteed, jointly and severally, by the Company's present and future direct and indirect wholly-owned material domestic subsidiaries that guarantee the Term Loan Facility. The 8.25% Secured Notes are secured by first priority security interests in the Non-ABL Priority Collateral and a second priority security interests in the ABL Priority Collateral.

The indenture governing the 8.25% Secured Notes contains restrictive covenants that are substantially the same as those in the 9.75% Unsecured Notes Indenture.

11.5% Senior Unsecured Notes

Effective April 29, 2016, concurrently with the closing of the RegionalCare/Capella Merger, the Company issued $350.0 million aggregate principal amount of 11.5% Unsecured Notes in a private offering. The 11.5% Unsecured Notes mature on May 1, 2024 and bear interest at a rate of 11.5% per annum, payable semi-annually on May 1 and November 1 of each year.

Prior to May 1, 2019, the Company may redeem some or all of the 11.5% Unsecured Notes at a redemption price equal to 100% of the principal amount of the 11.5% Unsecured Notes, plus accrued and unpaid interest, and the applicable "make-whole" premium and accrued and unpaid interest, if any. Additionally, prior to May 1, 2019, the Company may redeem up to 40% of the aggregate principal amount of the 11.5% Unsecured Notes in an amount equal to the net proceeds of one or more equity offerings at a price equal to 111.5% of the principal amount thereof, plus accrued and unpaid interest, so long as at least 50% of the 11.5% Unsecured Notes remain outstanding. On or after May 1, 2019, the Company may redeem the 11.5% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the indenture governing the 11.5% Unsecured Notes.

The Company's obligations under the 11.5% Unsecured Notes are fully and unconditionally guaranteed, jointly and severally, by the Company's present and future direct and indirect wholly-owned material domestic subsidiaries that guarantee the Term Loan Facility.

The indenture governing the 11.5% Unsecured Notes contains restrictive covenants that are substantially the same as those in the 9.75% Unsecured Notes Indenture.

Financing and Capital Leases

Refer to Note 8 for further discussion of the Company's financing and capital leases.

Secured loan from Affiliate

On October 31, 2017, the Company received $37.6 million from an affiliate in connection with an agreement for the sale and assignment of the accounts receivable of St. Joseph. The transaction did not qualify as a true sale of accounts receivable pursuant to ASC 860, "Transfers and Servicing of Financials Assets." Accordingly, the transaction was accounted for as a secured borrowing. On June 18, 2018, the loan was repaid in full.

Interest Rate Swap Agreement

On December 21, 2018, the Company entered into an interest rate swap agreement with Citibank, N.A. as counterparty (the "Interest Rate Swap") whereby the Company pays a fixed rate of 2.63% on a notional amount of $1,100.0 million and receives one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. Refer to Note 11 for additional information regarding the Company's accounting for its Interest Rate Swap.

Debt Transaction Costs

In connection with the issuance of the Term Loan Facility, the ABL Facility and the 9.75% Unsecured Notes, the Company capitalized $201.7 million of new debt issuance costs associated with these new debt instruments, which are included as a reduction to "Long-term debt, net" on the Company's accompanying consolidated balance sheet. Additionally, during the year ended December 31, 2018, the Company wrote off $8.2 million of previously capitalized debt issuance costs in connection with the extinguishment of the Prior ABL Facility and Prior Term Facility, which is included under the caption "Other non-operating losses, net" in the accompanying consolidated statements of operations for the year ended December 31, 2018. For the years ended December 31, 2017 and 2016, the Company recorded losses on various debt refinancing activities of $4.3 million and $11.7 million, respectively, which are included under the caption "Other non-operating losses, net" in the accompanying consolidated statements of operations for the years ended December 31, 2017 and 2016.

Note 5. Goodwill and Intangible Assets

Goodwill

The following table presents the changes in the carrying amount of goodwill for the year ended December 31, 2018 (in millions):

Balance at December 31, 2017	$	651.5
LifePoint/RCCH Merger		1,950.1
Acquisitions		19.9
Impairments		(53.9)
Balance at December 31, 2018	$	2,567.6

The Company performed its annual goodwill impairment testing as of October 1, 2018. Based on the Company's updated financial projections for each reporting unit developed during the fourth quarter of 2018, the Company concluded that the carrying values of three of its facilities exceeded their estimated fair values. Accordingly, for the year ended December 31, 2018, the Company recorded non-cash impairment charges in the aggregate of $53.9 million. The results of the annual goodwill impairment testing for the year ended December 31, 2018 for the Company's other reporting units indicated varying degrees of excess estimated fair value over carrying value, ranging from approximately 1% to 102% of the respective carrying values, with an average of approximately 36%.

For the year ended December 31, 2017, the Company recorded a non-cash impairment charge of $14.1 million equal to the excess carrying value of one of its facilities as compared to its fair value. There were no impairments of goodwill for the year ended December 31, 2016.

Intangible Assets

The following table provides information regarding the Company's intangible assets, included in the accompanying consolidated balance sheets as of December 31, 2018 and 2017 (in millions):

		2018		2017
Amortizable intangible assets:				
Contract-based physician minimum revenue guarantees				
Gross carrying amount	$	34.0	$	14.7
Accumulated amortization		(7.1)		(7.4)
Net total		26.9		7.3
Non-competition agreements and other				
Gross carrying amount		4.5		-
Accumulated amortization		(0.5)		-
Net total		4.0		-
Total amortizable intangible assets				
Gross carrying amount		38.5		14.7
Accumulated amortization		(7.6)		(7.4)
Net total		30.9		7.3
Indefinite-lived intangible assets:				
Certificates of need and certificates of need exemptions		31.0		-
Licenses, provider numbers, accreditations and other		12.6		-
Net total		43.6		-
Total intangible assets:				
Gross carrying amount		82.1		14.7
Accumulated amortization		(7.6)		(7.4)
Net total	$	74.5	$	7.3

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, "Guarantees" ("ASC 460"). In accordance with ASC 460, 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 income, over the period of the physician contract, which typically ranges from four to five years. As of December 31, 2018 and 2017, the Company's liability for contract-based physician minimum revenue guarantees was $12.6 million and $2.3 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, during the years ended December 31, 2018, 2017 and 2016 was $4.7 million, $3.6 million and $3.5 million, respectively.

Total estimated amortization expense for the Company's intangible assets during the next five years are as follows (in millions):

2019	$	12.5
2020		9.1
2021		5.9
2022		2.7
2023		0.6
Thereafter		0.1
	$	30.9

Note 6. Income Taxes

The provision for (benefit from) income taxes for the years ended December 31, 2018, 2017 and 2016 consisted of the following (in millions):

	2018	2017	2016
Current:			
Federal	$ -	$ -	$ -
State	1.3	0.4	0.3
	1.3	0.4	0.3
Deferred:			
Federal	(27.1)	37.7	17.7
State	(10.0)	(4.4)	3.6
	(37.1)	33.3	21.3
Change in valuation allowance	36.0	(35.0)	(17.6)
Total	$ 0.2	$ (1.3)	$ 4.0

The Tax Cuts and Jobs Act (the "Tax Act") was signed into law on December 22, 2017. The Tax Act significantly revised the U.S. corporate income tax laws. The Company is most notably impacted by the reduction of the U.S. corporate tax rate from 35% to 21% for tax years after December 31, 2017 and limiting certain deductions such as interest expense and net operating loss carryforwards. The Tax Act also enhanced and extended through 2026 the option to claim accelerated depreciation deductions on qualified property. Due to the timing of the enactment and the complexity involved with applying the provisions of the Tax Act, the Company had not completed its determination of the accounting implications of the Tax Act on its income tax accruals for the year ended December 31, 2017. However, the Company reasonably estimated the effects of the Tax Act on its existing deferred tax assets and liabilities and recognized a provisional expense for income taxes of $57.7 million for the year ended December 31, 2017. The Company completed its analysis during the year ended December 31, 2018 and determined that no additional adjustment was needed to the $57.7 million provisional expense recorded for the year ended December 31, 2017.

The following table reconciles the differences between the statutory federal income tax rate to the Company's effective tax rate on net loss from continuing operations before income taxes and including net income attributable to noncontrolling interests and redeemable noncontrolling interests for the years ended December 31, 2018, 2017 and 2016 (in millions):

	2018	2017	2016
Federal statutory rate	21.0 %	35.0 %	35.0 %
State income taxes, net of federal income tax benefits	2.2	23.2	(1.6)
Change in valuation allowance	(12.5)	99.6	(38.1)
Provisional expense resulting from the Tax Act	-	(146.6)	-
Tax effect of impairment on goodwill	(2.3)	(12.5)	-
Noncontrolling interests and redeemable noncontrolling interests	0.4	6.4	2.6
Nondeductible acquisition costs	(6.6)	-	(6.3)
Nondeductible merger compensation costs	(1.6)	-	-
Other items	(0.7)	(1.9)	(2.3)
Effective income tax rate	(0.1) %	3.2 %	(10.7) %

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 were as follows as of December 31, 2018 and 2017 (in millions):

	2018	2017
Deferred income tax liabilities:		
Depreciation and amortization	$ (137.7)	$ (21.7)
Deferred loan costs	(0.4)	(0.8)
Tax deductible goodwill	(11.2)	(11.4)
Debt discount	(0.1)	(0.2)
Equity investments	(32.6)	-
Other	(4.0)	(0.4)
Total deferred income tax liabilities	(186.0)	(34.5)
Deferred income tax assets:		
Provision for doubtful accounts	72.4	10.5
Employee compensation	50.5	5.8
Acquisition and start-up costs	10.2	4.1
Net operating loss carryforwards	195.8	113.9
Insurance reserves	64.4	11.4
Prepaid rent	18.5	2.1
Section 163(j) interest expense carryforward	31.7	-
Investment in Partnerships	-	9.6
Other	12.9	6.5
Total deferred income tax assets	456.4	163.9
Valuation allowance	(274.4)	(134.1)
Net deferred income tax assets	182.0	29.8
Deferred income taxes	$ (4.0)	$ (4.7)

Noncurrent deferred income tax liabilities totaled $4.0 million and $4.7 million at December 31, 2018 and 2017, respectively. As of December 31, 2018, the Company had federal net operating loss carryforwards of $342.4 million and state and local net operating loss carryforwards of approximately $2.5 billion. The federal net operating loss carryforwards generated prior to 2018 expire between 2028 and 2037. The federal net operating loss carryforwards generated in 2018 and forward have an indefinite carryforward period. The state net operating loss carryforwards will expire between 2019 and 2038. As of December 31, 2017, the Company had federal net operating loss carryforwards of $390.2 million and state and local net operating loss carryforwards of $779.0 million. The Company has established a valuation allowance for deferred tax assets at December 31, 2018 and 2017, due to the uncertainty of realizing these assets in the future. The valuation allowance increased $140.3 million during 2018, of which $103.2 million of the increase was a result of the LifePoint/RCCH Merger. The valuation allowance decreased $9.0 million during 2017.

No federal income tax payments were made during the years ended December 31, 2018, 2017 or 2016. State and local income tax payments in the amount of $2.4 million, $0.8 million, and $0.4 million were made during the years ended December 31, 2018, 2017 and 2016, respectively.

The Company’s policy is to accrue interest and penalties related to potential underpayment of income taxes within the provision for income taxes. Interest is computed on the difference between the Company’s uncertain tax benefit positions and the amount deducted or expected to be deducted in our income tax returns. As there were no unrecognized tax benefits at December 31, 2018 and 2017, the Company did not have any amounts accrued for interest and penalties.

The Company files a consolidated U.S. federal income tax return, as well as income tax returns in various state jurisdictions. All of the Company’s tax years are subject to examination by the Internal Revenue Service and various state taxing authorities.

Note 7. Other Current Liabilities

The following table provides information regarding the Company's other current liabilities, which are included in the accompanying consolidated balance sheets at December 31, 2018 and 2017 (in millions):

	2018	2017
Accrued interest	$ 68.9	$ 19.5
Current portion of self-insurance reserves	70.7	14.1
Self-insured medical benefits liabilities	46.1	7.1
Accrued property taxes	19.1	7.7
Accrued expenses and other	217.4	10.7
	$ 422.2	$ 59.1

Note 8. Leases

The Company leases real estate property 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 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. All of the lease agreements generally require the Company to pay maintenance, repairs, taxes and insurance costs. Rental expense of operating leases totaled $57.3 million, $44.0 million and $31.0 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Future minimum lease payments at December 31, 2018, for those leases having an initial or remaining noncancelable lease term in excess of one year, but excluding obligations that do not require eventual settlement in cash, are as follows for the years indicated (in millions):

	Operating Leases	Financing and Capital Leases	Total
2019	$ 55.9	$ 52.9	$ 108.8
2020	43.9	54.2	98.1
2021	34.7	57.6	92.3
2022	26.3	119.2	145.5
2023	21.2	48.5	69.7
Thereafter	92.4	833.8	926.2
	$ 274.4	$ 1,166.2	$ 1,440.6
Less: interest portion		(660.3)	
		$ 505.9	

Sale-Leaseback Transactions

The real estate associated with certain of the Company's facilities and its health support center are leased from various third party entities in connection with sale-leaseback transactions. Certain of these leasing arrangements contain various forms of continuing involvement and resultantly fail sale-leaseback accounting criteria in accordance with ASC 840-40, "Leases – Sale-Leaseback Transactions." Those leases with continuing involvement are accounted for as financing transactions. Additionally, for certain properties which satisfied the sale-leaseback accounting criteria, the sales proceeds received were in excess of the fair value of the properties leased. Accordingly, financing obligations have been recorded for such excess. At December 31, 2018, the Company has recorded $434.7 million of total financing obligations, including current portions, associated with sale-leaseback transactions in its accompanying consolidated balance sheet.

Properties failed sale-leaseback criteria due to several reasons, including fully prepaid arrangements with government authorities, the ability to share in the appreciation rights of the property, involvement in an ongoing build to suit construction project financed by a third party and more than minor subleasing arrangements. One property was previously accounted for as a financing lease due to an ongoing build to suit construction project which was completed during 2017, and the lease is now accounted for as an operating lease. At completion of the construction project, the Company reduced land and buildings by $62.4 million and reduced financing and capital leases by $59.3 million and recognized a loss of $3.9 million, which is included under the caption "Other non-operating losses, net" in the accompanying consolidated statements of operations for the year ended December 31, 2017.

Note 9. Investments

The Company accounts for its investments in entities in which the Company exhibits significant influence, but not control, under the equity method of accounting in accordance with ASC 323. 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. In connection with the LifePoint/RCCH Merger, the Company acquired equity method investments with an estimated fair value of $208.9 million. The Company's equity method investments totaled $231.9 million and $13.8 million at December 31, 2018 and 2017, respectively, and are included under the caption "Other long-term assets" in the accompanying consolidated balance sheets.

Note 10. Noncontrolling Interests and Redeemable Noncontrolling Interests

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 year ended December 31, 2018 (in millions):

Balance at December 31, 2017	$	-
Noncontrolling interests assumed in the LifePoint/RCCH Merger		29.9
Net income attributable to noncontrolling interests		0.2
Distributions		(0.2)
Balance at December 31, 2018	$	29.9

Redeemable Noncontrolling Interests

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 could require the Company to deliver cash, if exercised. 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 year ended December 31, 2018 (in millions):

Balance at January 1, 2017	$	54.2
Net income attributable to redeemable noncontrolling interests		7.3
Fair value adjustments		3.1
Distributions		(3.9)
Balance at December 31, 2017		60.7
Redeemable noncontrolling interests assumed in LifePoint/RCCH Merger		75.7
Net income attributable to redeemable noncontrolling interests		5.5
Distributions, net of proceeds		(5.8)
Balance at December 31, 2018	$	136.1

Note 11. Fair Value of Financial Instruments

Fair Value Hierarchy

Fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, the Company utilizes the fair value hierarchy pursuant to ASC 820, "Fair Value Measurements and Disclosures" ("ASC 820") that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

The inputs used to measure fair value are classified into the following fair value hierarchy:

Level 1: Quoted market prices in active markets for identical assets or liabilities.

Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.

Level 3: Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability.

Cash and Cash Equivalents, Accounts Receivable, Accounts Payable and Other Current Liabilities

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

Long-Term Debt

The carrying amounts and fair values of the Company's ABL Facility, Prior ABL Facility, Term Loan Facility, 9.75% Unsecured Notes, 8.25% Secured Notes and 11.5% Unsecured Notes, excluding unamortized debt issuance costs, as of December 31, 2018 and December 31, 2017 were as follows (in millions):

	Carrying Amount		Fair Value	
	December 31, 2018	December 31, 2017	December 31, 2018	December 31, 2017
ABL Facility	$ 20.0	$ -	$ 20.0	$ -
Prior ABL Facility	$ -	$ 10.0	$ -	$ 10.0
Term Loan Facility	$ 3,550.0	$ -	$ 3,487.9	$ -
9.75% Unsecured Notes	$ 1,425.0	$ -	$ 1,353.8	$ -
8.25% Secured Notes	$ 800.0	$ 800.0	$ 808.0	$ 843.0
11.5% Unsecured Notes	$ 350.0	$ 350.0	$ 359.6	$ 350.0

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.

Interest Rate Swap

The Company measures its Interest Rate Swap at fair value on a recurring basis. The fair value of the Company's Interest Rate Swap is based on quotes from its counterparty. The Company considers those inputs to be Level 2 in the fair value hierarchy. At December 31, 2018, the fair value of the Company's Interest Rate Swap was a total liability of $5.8 million, of which $0.7 million is included under the caption "Other current liabilities" and $5.1 million is included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheet.

The Company has not designated its Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging." Accordingly, all changes in the fair value of the Company's Interest Rate Swap are recognized through interest expense in its results of operations. For the year ended December 31, 2018, the Company recognized additional interest expense of $5.8 million related to changes in the fair value of its Interest Rate Swap.

Changes in the fair value of the Company's Interest Rate Swap could result in a material effect on its consolidated results of operations and financial position; however, the Company does not anticipate that changes in the fair value of its Interest Rate Swap will have any impact on its cash flows. The counterparty to the Interest Rate Swap exposes the Company to credit risk in the event of nonperformance. However, the Company does not anticipate nonperformance by its counterparty. The Company does not hold or issue derivative financial instruments for trading purposes.

Financial Liabilities

The Company has a contingent consideration liability payable to the former owners of Canyon Vista that represents the Level 3 estimated fair value of the contingent consideration using unobservable inputs and assumptions available to the Company. The liability for Canyon Vista is recorded at an estimated fair value of approximately $13.6 million and $13.2 million at December 31, 2018 and 2017, respectively. The key assumptions used in estimating the fair value of the Canyon Vista liability are the range of probabilities that the payments will be earned by the seller and a discount rate adjusted for the Company's credit risk.

Note 12. Employee Benefit Plans

Defined Benefit Pension Plans

In connection with the LifePoint/RCCH Merger, the Company acquired certain assets and assumed certain liabilities associated with two separate defined benefit pension plans (i) associated with certain employees of Marquette General Hospital covered by a collective bargaining agreement (the "Marquette Pension Plan") and (ii) associated with certain non-union employees of Bell Hospital (the "Bell Pension Plan" and, collectively with the Marquette Pension Plan, the "Pension Plans"). Both Pension Plans are closed to new participants. Participants in the Marquette Pension Plan are required to make annual contributions totaling 6% of annual compensation to the Marquette Pension Plan to continue accruing benefits. Participants in the Bell Pension Plan no longer accrue benefits. 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 year ended December 31, 2018 and the unfunded liability of the Pension Plans at December 31, 2018 (in millions):

Change in benefit obligation:	
Benefit obligation at beginning of year	$ -
Benefit obligations assumed in LifePoint/RCCH Merger	56.5
Service costs	0.1
Interest costs	0.3
Participant contributions	0.1
Actuarial loss	1.8
Benefits paid	(0.2)
Benefit obligation at end of year	58.6
Change in plan assets:	
Fair value of plan assets at beginning of year	-
Plan assets acquired in LifePoint/RCCH Merger	39.6
Actual return on plan assets	(1.0)
Participant contributions	0.1
Benefits and expenses paid	(0.2)
Fair value of plan assets at end of year	38.5
Unfunded liability included in other long-term liabilities in the Company's accompanying consolidated balance sheet	$ 20.1

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, 2018, the Company recognized a comprehensive loss of $3.1 million as a decrease in stockholders' equity through accumulated other comprehensive loss. This adjustment was 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, 2018 (in millions):

Projected benefit obligation	$ 58.6
Accumulated benefit obligation	$ 54.9
Fair value of plan assets	$ 38.5

The following table summarizes the weighted-average assumptions used by the Company to determine its benefit obligation as of December 31, 2018 (in millions):

Discount rate	4.1 %
Rate of compensation increases, when applicable	3.0 %

The following table summarizes the components of net periodic costs for the year ended December 31, 2018 (in millions):

Service cost	$ 0.1
Interest cost	0.3
Expected return on plan assets	(0.3)
Amortization of net actuarial loss	-
Total net periodic benefit cost	$ 0.1

The following table summarizes the weighted-average assumptions used by the Company to determine its net periodic benefit costs during the year ended December 31, 2018 (in millions):

Discount rate	4.2 %
Rate of compensation increases, when applicable	3.0 %
Expected long-term return on plan assets	5.8 %

Plan Assets

The investment policy for the Pension Plans has been formulated to achieve a risk adjusted return that balances the need for asset growth against the risk of significant fluctuations in asset prices and the need for significant contributions from the Company. On a quarterly basis, or more frequently as necessary, the current risk levels, asset performance and expected return on assets are reviewed and evaluated against goals and targets by a committee appointed to oversee investment of the Pension Plans' assets (the "Investment Committee"). The Investment Committee strives to maintain a balance between risk and return through the use of modern portfolio theory methods, in conjunction with Monte Carlo modeling to evaluate the behavior of the portfolio under different scenarios. At December 31, 2018, the Pension Plans' investments include a balance of mutual funds and money market funds in order to achieve an overall rate of return that minimizes the need for additional employer contributions. The Company measures the fair value of its Pension Plans' assets in accordance with ASC 820.

The Pension Plans' investments in mutual funds are valued at the net asset value ("NAV") of shares reported in the active market in which the funds are traded. Because quoted prices are available for mutual funds and the markets in which they are traded are generally considered active, the Company has classified each of them as a Level 1 investment. The Pension Plans' investments in money market funds are valued at quoted prices in markets that are not active by a combination of inputs, including but not limited to dealer quotes who are market makers in the underlying funds and other directly and indirectly observable inputs. Because the inputs used to value money market funds are either directly or indirectly observable, but are not quoted prices in active markets, the Company has classified these assets as Level 2 investments.

The following table summarizes the assets of the Pension Plans, measured at fair value as of December 31, 2018, by major asset category and aggregated by level within the fair value hierarchy (in millions):

	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual funds	$ 34.6	$ 34.6	$ -	$ -
Money market funds	3.9	-	3.9	-
Total	$ 38.5	$ 34.6	$ 3.9	$ -

The Company expects to contribute approximately $2.1 million to the Pension Plans during the year ended December 31, 2019. Additionally, the Company expects to make future benefit payments from the Pension Plans as follows for the years indicated (in millions):

2019	2.1
2020	2.3
2021	2.5
2022	2.6
2023	2.9
Five years thereafter	16.7
	$ 29.1

Multiemployer Pension Plan

In connection with the LifePoint/RCCH Merger, the Company assumed the obligation 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.

Defined Contribution Plans

The Company maintains three separate defined contribution retirement plans covering a majority of the Company's employees, including Legacy LifePoint employees, RCCH employees and employees at Community Medical Center. These defined contribution plans contain discretionary matching policies 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 $5.6 million, $3.1 million and $4.3 million for the years ended December 31, 2018, 2017 and 2016, respectively.

The Company maintains a supplemental deferred compensation plan ("the RCCH Deferred Compensation Plan"). As of December 31, 2018 and 2017, the deferred compensation liability was $10.8 million and $7.3 million, respectively. The Company did not make any matching contributions in 2018, 2017 and 2016.

In connection with the LifePoint/RCCH Merger, the Company assumed liabilities under the LifePoint Health Deferred Compensation Plan (the "LifePoint Deferred Compensation Plan") and acquired a rabbi trust holding assets equal to the present value of all liabilities under the LifePoint Deferred Compensation Plan as of the effective time of the LifePoint/RCCH Merger. The assets in the rabbi trust are subject to the claims of the Company's creditors in the event of the Company's insolvency but are otherwise only available to pay liabilities under the LifePoint Deferred Compensation Plan. As of December 31, 2018, the assets and liabilities associated with the LifePoint Deferred Compensation Plan were $23.7 million and $23.3 million, and are included under the captions "Other long-term assets" and "Other long-term liabilities", respectively, on the accompanying consolidated balance sheet at December 31, 2018.

Note 13. Stock-Based Compensation

DSB Parent is authorized to issue Units to employees, executives, consultants and directors of the Company, under the DSB Parent Partnership Agreement. The Company has determined that the Units are a substantive class of members' equity for accounting purposes because the Units are legal equity of DSB Parent, they have participation features, including distribution and liquidation rights which allow them to participate in the residual returns of the DSB Parent and vested interests are retained upon termination. As a result, these awards are accounted for under ASC 718.

There are 35,270,000 aggregate number of Units authorized for issuance. Service Units and Performance Units have been issued under the DSB Parent Partnership Agreement and forms of award agreements.

Service Units

Service Units have been granted to certain members of the board of directors and Tranche A Units to certain employees, executives and consultants. Units that have been granted to members of the board of directors vest on a time-basis only, either in three equal installments on each of the first three anniversaries of the grant date or on the date that is the earliest of (i) six months and one day following November 16, 2018 or (ii) the date of the applicable director's termination of service due to death, disability or as a result of the director's removal from the board of directors other than for cause. Tranche A Units granted to certain employees, executives and consultants vest in equal installments on the last day of each of the first twenty calendar quarters that commence on or after the grant date or, in some cases, November 16, 2018. Service Units will automatically vest upon the sale of the Company. In the event of an ("IPO"), all unvested Service Units will remain outstanding and continue to vest based on the stated vesting pattern. Unvested Service Units are forfeited upon a holder's termination of service.

Service Units are accounted for as equity awards and related compensation expense is recognized ratably over the vesting period. On November 16, 2018, Service Units originally issued to approximately 40 employees and executives were modified in connection with the LifePoint/RCCH Merger. For employees and executives granted Service Units prior to November 16, 2018 who are severed during the 18-month period following the LifePoint/RCCH Merger under certain circumstances, Tranche A Units vest in full upon the eligible employee's termination date. The Company calculated the fair value of the service units before and after the modification and recorded expense of $2.7 million related to the modification and acceleration of service units. Total stock compensation expense, including modification expense, for Service Units was $3.4 million and $0.7 million for 2018 and 2017, respectively. As of December 31, 2018, Service Units had unrecognized compensation expense of $1.4 million. The expense is expected to be recognized over a weighted-average period of 2.5 years from December 31, 2018.

Performance Units

Performance Units, which have been granted as Tranche B Units and Tranche C Units, will vest based upon equity holders of DSB Parent realizing certain targeted multiples of invested capital ("MOIC thresholds"). Performance Units are accounted for as equity awards with expense recognition occurring upon the realization of the stated MOIC thresholds due to a liquidity event. On November 16, 2018, Tranche B Units previously issued to approximately 40 employees and executives were modified in connection with the LifePoint/RCCH Merger. For employees and executives granted Performance Units prior to November 16, 2018 who were severed in connection with the LifePoint/RCCH Merger, Tranche B units vest in full upon the eligible employee's termination date and Tranche C units are forfeited in accordance with the original terms and conditions of the applicable Profits Units award agreement. The Company calculated the fair value of the Tranche B Units before and after the modification and recorded expense of $3.6 million related to the modification and acceleration of Tranche B Units. For Performance Units not modified in connection with the LifePoint/RCCH Merger, the Company determined that a liquidity event was not probable, therefore no compensation expense has been recognized related to the unmodified Performance Units. Performance Units had unrecognized compensation expense of $1.9 million as of December 31, 2018. Unvested Units that do not vest on termination are forfeited upon such termination, subject to certain conditions.

Valuation Assumptions

The fair value of all Units was determined using a Monte Carlo simulation framework. The following table shows the weighted average assumptions the Company used to develop the fair value estimates and the resulting estimates of weighted-average fair value per Unit granted during the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
Common equity value of the Company	$ 624.1	$ 513.8	$ 297.2
Expected volatility	24.0 %	27.5 %	34.0 %
Risk-free interest rate	1.60 %	1.10 %	1.60 %
Expected dividends	-	-	-
Average expected term (years)	3.2	4.1	4.9

Units Activity

The following represents the activity of the Units for the years ended December 31, 2018, 2017 and 2016:

	Service Units		Performance Units			
	Tranche A and Units to the Board	Weighted Average Grant Date Fair Value per Unit	Tranche B	Weighted Average Grant Date Fair Value per Unit	Tranche C	Weighted Average Grant Date Fair Value per Unit
Unvested at January 1, 2016	2,088,792	$ 0.66	2,088,792	$ 0.40	1,044,395	$ 0.30
Granted	4,768,578	0.69	4,480,578	0.41	2,240,289	0.30
Vested	(741,956)	0.67	-	-	-	-
Forfeited	(1,593,281)	0.66	(1,675,801)	0.40	(837,899)	0.30
Unvested at December 31, 2016	4,522,133	$ 0.69	4,893,569	$ 0.41	2,446,785	$ 0.30
Granted	548,200	0.93	548,200	0.47	274,100	0.28
Vested	(1,104,234)	0.64	-	-	-	-
Forfeited	(165,070)	0.84	(179,600)	0.44	(89,800)	0.28
Unvested at December 31, 2017	3,801,029	$ 0.71	5,262,169	$ 0.41	2,631,085	$ 0.30
Granted	1,229,200	1.43	1,229,200	0.68	614,600	0.37
Vested	(2,054,331)	0.82	(1,636,959)	0.46	-	-
Forfeited	(266,140)	0.70	(379,400)	0.41	(1,008,180)	0.31
Unvested at December 31, 2018	2,709,758	$ 0.97	4,475,010	$ 0.47	2,237,505	0.31

During the year ended December 31, 2018, there were no convertible or expired Units.

Note 14. Commitments and Contingencies

Capital Expenditure Commitments

The Company is reconfiguring some of its facilities to more effectively accommodate patient services and to provide for a greater variety of services. The Company has incurred approximately $436.5 million in costs related to uncompleted projects as of December 31, 2018, which is included under the caption "Construction in progress" in the Company's accompanying consolidated balance sheet. At December 31, 2018, these uncompleted projects had an estimated cost to complete of approximately $226.7 million. The estimated timeframe for completion of these projects generally ranges from less than one year up to two years. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities. At December 31, 2018, the Company estimated its total remaining capital expenditure commitments to be approximately $1,436.3 million, which generally have remaining terms of three to seven years. Of this amount, approximately one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time.

Legal Proceedings and General Liability Claims

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

In addition, the Company is subject to the regulation and oversight of various state and federal governmental agencies. Further, under the False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against healthcare facilities that submit false claims for payments to, or improperly retain identified overpayments from, governmental payers. 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. If a provider is found to be liable under the False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus substantial civil monetary penalties that are subject to annual adjustment for inflation for each separate false claim.

Although the healthcare industry has seen numerous ongoing investigations related to compliance and billing practices, hospitals, in particular, continue to be a primary enforcement target for the Office of Inspector General ("OIG"), the Department of Justice ("DOJ") and other governmental agencies and 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 Medicare Administrative Contractors, 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 Company does not control and cannot predict with certainty the progress or final outcome of discussions with government agencies, investigations and legal proceedings against the Company. Therefore, the final amounts paid to resolve such matters, claims and obligations could be material and could materially differ from amounts currently recorded, if any. Any such changes in the Company's estimates or any adverse judgments could materially adversely impact the Company's future results of operations and cash flows.

The Company accrues an estimate for a contingent liability when losses are both probable and reasonably estimable. The Company reviews its accruals each quarter and adjusts them to reflect the impact of developments, advice of legal counsel and other information pertaining to a particular matter.

Note 15. Subsequent Events

In accordance with the provisions of ASC 855, "Subsequent Events," the Company evaluated all material events subsequent to the balance sheet date through March 28, 2019, the date of issuance, for events requiring disclosure or recognition in the Company's consolidated financial statements. There were no subsequent events requiring disclosure or recognition in the Company's consolidated financial statements other than those noted below.

During 2019, the Company borrowed additional amounts under its ABL Facility for general corporate purposes. As of March 28, 2019, the Company had $90.0 million in borrowings outstanding under its ABL Facility.

SIGNATURES

LifePoint Health, Inc. has caused this Report to be signed on its behalf by the undersigned thereunto duly authorized.

LIFEPOINT HEALTH, INC.

Date: March 28, 2019

By: /s/ Michael S. Coggin
Michael S. Coggin
Executive Vice President and Chief Financial Officer