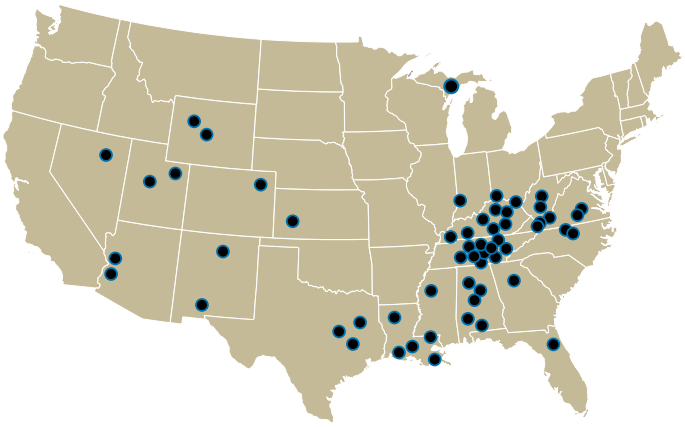

# LifePoint Hospitals, Inc.

2012 ANNUAL REPORT

## About LifePoint

LifePoint Hospitals, Inc. is a leading hospital company focused on providing quality healthcare services close to home. Through its subsidiaries, LifePoint operates 57 hospital campuses in 20 states. With a mission of "Making Communities Healthier®," LifePoint is the sole community hospital provider in the majority of the communities it serves. More information about the Company, which is headquartered in Brentwood, Tennessee, can be found on its website, www.LifePointHospitals.com.

# 57 locations in 20 states



**Alabama**
Andalusia Regional Hospital
Andalusia, Alabama

Lakeland Community Hospital
Haleyville, Alabama

Northwest Medical Center
Winfield, Alabama

Russellville Hospital
Russellville, Alabama

Vaughan Regional Medical Center
Selma, Alabama

**Arizona**
Havasu Regional Medical Center
Lake Havasu City, Arizona

Valley View Medical Center
Fort Mohave, Arizona

**Colorado**
Colorado Plains Medical Center
Fort Morgan, Colorado

**Florida**
Putnam Community Medical Center
Palatka, Florida

**Georgia**
Rockdale Medical Center
Conyers, Georgia

**Indiana**
Scott Memorial Hospital
Scottsburg, Indiana

**Kansas**
Western Plains Medical Complex
Dodge City, Kansas

**Kentucky**
Bluegrass Community Hospital
Versailles, Kentucky

Bourbon Community Hospital
Paris, Kentucky

Clark Regional Medical Center
Winchester, Kentucky

Georgetown Community Hospital
Georgetown, Kentucky

Jackson Purchase Medical Center
Mayfield, Kentucky

Lake Cumberland Regional Hospital
Somerset, Kentucky

Logan Memorial Hospital
Russellville, Kentucky

Meadowview Regional Medical Center
Maysville, Kentucky

Spring View Hospital
Lebanon, Kentucky

**Louisiana**
Acadian Medical Center
Eunice, Louisiana

Mercy Regional Medical Center
Ville Platte, Louisiana

Minden Medical Center
Minden, Louisiana

River Parishes Hospital
LaPlace, Louisiana

Teche Regional Medical Center
Morgan City, Louisiana

**Michigan**
Marquette General Health System
Marquette, Michigan

**Mississippi**
Bolivar Medical Center
Cleveland, Mississippi

**Nevada**
Northeastern Nevada Regional Hospital
Elko, Nevada

**New Mexico**
Los Alamos Medical Center
Los Alamos, New Mexico

Memorial Medical Center
Las Cruces, New Mexico

**North Carolina**
Maria Parham Medical Center
Henderson, North Carolina

Person Memorial Hospital
Roxboro, North Carolina

**Tennessee**
Athens Regional Medical Center
Athens, Tennessee

Crockett Hospital
Lawrenceburg, Tennessee

Emerald-Hodgson Hospital
Sewanee, Tennessee

Hillside Hospital
Pulaski, Tennessee

Livingston Regional Hospital
Livingston, Tennessee

Riverview Regional Medical Center
Carthage, Tennessee

Southern Tennessee Medical Center
Winchester, Tennessee

Sumner Regional Medical Center
Gallatin, Tennessee

Trousdale Medical Center
Hartsville, Tennessee

Woods Memorial Hospital
Etowah, Tennessee

**Texas**
Ennis Regional Medical Center
Ennis, Texas

Palestine Regional Medical Center
Palestine, Texas

Parkview Regional Hospital
Mexia, Texas

**Utah**
Ashley Regional Medical Center
Vernal, Utah

Castleview Hospital
Price, Utah

**Virginia**
Clinch Valley Medical Center
Richlands, Virginia

Danville Regional Medical Center
Danville, Virginia

Memorial Hospital of Martinsville and Henry County
Martinsville, Virginia

Twin County Regional Healthcare
Galax, Virginia

Wythe County Community Hospital
Wytheville, Virginia

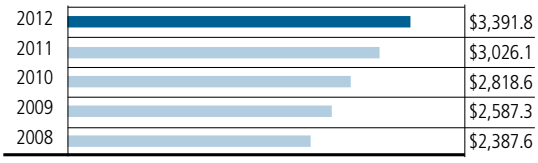
**West Virginia**
Logan Regional Medical Center
Logan, West Virginia

Raleigh General Hospital
Beckley, West Virginia

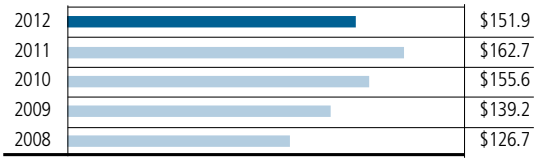
**Wyoming**
Lander Regional Hospital
Lander, Wyoming

Riverton Memorial Hospital
Riverton, Wyoming

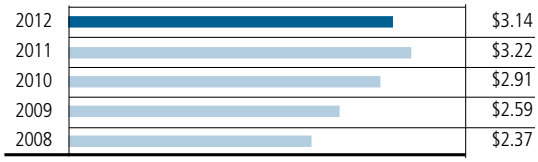
### Revenue (in millions)




### Income from Continuing Operations Attributable to LifePoint Hospitals, Inc. (in millions)




### Diluted Income from Continuing Operations Per Share Attributable to LifePoint Hospitals, Inc.



The past year was one of strategic growth for LifePoint. Much of our growth was the product of Duke LifePoint Healthcare…

**To Our Shareholders:**

I am pleased to report to you that, amid a healthcare landscape fraught with challenges for the hospital industry, LifePoint Hospitals® recorded another strong year in 2012. Though the particulars of our success may have changed from last year, the broader story has remained remarkably the same: we developed a sound strategic plan, and we executed it successfully.

Our work continues to revolve around four strategic priorities: growth – both organically and through acquisitions; the delivery of high-quality care and service to our patients; further advancing our reputation for operational excellence; and attracting, developing and retaining high-performing talent. While our strategies may seem simple, delivering on their promise is anything but. Our performance has been the result of sustained execution – more than 29,000 members of the LifePoint family in 57 hospitals in 20 states working in tandem on these overarching priorities.

Our financial results for 2012 are a direct result of these efforts. For the year, we achieved revenues from continuing operations of $3.4 billion, an increase of 12% from the preceding year. Income from continuing operations attributable to LifePoint Hospitals, Inc. was $151.9 million, or $3.14 per diluted share.

**Growing Larger, Stronger and More Effective**

The past year was one of strategic growth for LifePoint. Much of our growth was the product of Duke LifePoint Healthcare, the innovative joint venture pioneered in 2011 between Duke University Health System and LifePoint Hospitals, in which LifePoint is the majority owner. During 2012, we completed three hospital acquisitions, two by Duke LifePoint that together represent approximately $400 million in annual revenues – more than double the combined revenue of our acquisitions in recent years.

We are growing in ways that reflect our strategic priorities and position our company to capitalize on new opportunities. Increasingly, we are expanding into markets with faster growing populations and a broader employment base than many of our existing markets. We are building regional networks that promote synergies and broaden access to a continuum of care. And we are expanding service lines designed to allow our hospitals to increase their market share, resulting in higher levels of growth going forward. For example, our third acquisition last year, Woods Memorial Hospital in Etowah, Tennessee, allowed us to expand our regional presence and build a stronger, local continuum of care in collaboration with LifePoint's nearby Athens Regional Medical Center.

Not only has our first-of-its-kind joint venture with Duke become an engine that helps propel our acquisition strategy, it has become a national model for transforming the delivery of care. It is a model that will become increasingly important and valuable given the focus of healthcare reform to improve the quality and reduce the cost of the delivery of care.

Through Duke LifePoint Healthcare, we operate a growing regional network of affiliated community hospitals in a relationship that benefits all participants. As we acquire new hospitals in the region, Duke, which serves as the clinical hub of the network, has benefited by expanding its referral base throughout North Carolina and Virginia, which LifePoint then operates as managing partner of the joint venture. Duke LifePoint hospitals benefit from greater access to valuable resources and expertise, plus the prestige and reputation for excellence associated with the Duke brand. Patients and payors benefit from a partnership that fortifies the quality of care and its delivery in the most appropriate and cost-effective settings.

Additionally, LifePoint benefits from synergies that enhance our strategic imperatives of quality, operational effectiveness and recruiting great talent. In addition, the joint venture's unique offering of clinical excellence, operational efficiency and access to resources makes affiliating with Duke LifePoint Healthcare extremely attractive, opening new doors for our company's growth.

Two of the hospitals we acquired last year are part of the Duke LifePoint network. Twin County Regional Healthcare in Galax, Virginia, formed a joint venture with Duke LifePoint Healthcare, a partnership option that is attractive for certain hospitals that want to retain some ownership of their hospital.

In September 2012, we transported Duke LifePoint Healthcare 1,100 miles from North Carolina with the purchase of Marquette General Health System in Marquette, Michigan, a 315-bed, federally designated Regional Referral Center that generates $320 million in net revenue and is the only tertiary hospital serving approximately 300,000 residents of Michigan's Upper Peninsula. This acquisition was another significant milestone, because it demonstrates the national scope and viability of the Duke LifePoint model. Leveraging the strength and synergies of Duke LifePoint Healthcare, Marquette General Health System now gives LifePoint a strong base for building a regional network in an entirely new area that offers very attractive demographic characteristics and significant growth potential.

In addition to our activity with Duke LifePoint, we announced a joint venture with Louisville-based Norton Healthcare, The Regional Health Network of Kentucky and Southern Indiana, which will operate hospitals in non-urban communities throughout the region. Norton is one of the region's most comprehensive healthcare systems with five hospitals, five outpatient centers, 12 immediate care centers and more than 90 physician practices. Hospitals that join The Regional Health Network will enjoy greater access to clinical resources and tertiary and specialty services, which in turn should allow patients to enjoy a full continuum of care. The joint venture's first transaction, Scott Memorial Hospital in Scottsburg, Indiana, is a 25-bed, critical access facility that has been the sole provider in Scott County for more than 50 years. With LifePoint as managing partner and Norton Healthcare as clinical partner, our partnership plans to bring the resources and expertise to secure the hospital's future.

We also continue to grow organically by expanding service lines in our hospitals. As in recent years, we continue to focus on adding high-intensity services, such as cardiology and oncology – two services that in the past required patients to migrate from their communities to larger urban hospitals. We also are working to improve our processes and enhance the patient experience in our emergency departments, the source of more than half of all admissions to our hospitals.

We also continue to grow organically by expanding service lines in our hospitals.

### Growing in Talent and Expertise

In early 2013, LifePoint announced the addition of Russell L. Holman, M.D., as the company's new chief medical officer (CMO), replacing Lanny R. Copeland, M.D., who has served as LifePoint's CMO since the position was created in 2007. Dr. Copeland, who last summer announced his plans to retire, will continue to serve through a transition period as CMO Emeritus. Dr. Holman has more than 15 years of healthcare leadership experience in academic centers, managed care, corporate and community hospital settings. He joined LifePoint from Cogent HMG, a national hospital medicine management company, where he served in executive leadership roles for the past eight years, most recently as chief clinical officer. We look forward to his leadership.

Through a variety of programs, including online training, we are building and strengthening talent throughout our hospitals.

In a rapidly evolving healthcare environment, recruiting and retaining excellent physicians continues to be a crucial imperative. Shortages of both primary care and specialty physicians have exacerbated what was already a formidable challenge for community hospitals. In spite of this challenge, we continue to meet our physician recruitment goals as a company.

In response to rising demand, a growing number of LifePoint physicians are employees. By the end of 2012, employed physicians represented roughly 15% of the medical staffs at our hospitals. Accordingly, we continue to build on our coordinated recruitment efforts by strengthening our physician practice management resources and services to better support the success of our employed physicians. These efforts are beneficial in many ways. For example, implementing comprehensive electronic medical records (EMR) systems and improving the delivery of quality care enhance our ability to compete for the best physicians, while recruiting new physician specialists often enables us to expand particular service lines at our hospitals.

We work hard, of course, to attract and cultivate high-performing talent at all levels throughout our organization, both clinical and non-clinical. Through a variety of programs, including online training, we are building and strengthening talent throughout our hospitals. With a formalized succession planning process for our hospital CEOs, our Hospital Support Center works to align talent with our future development needs. Additionally, our LifePoint Learning Academy helps us train and develop future leaders for our hospitals and for our company.

### Fulfilling a Mission for Quality

We have long prided ourselves on the standards of quality we uphold and on our continual efforts to improve upon them. Those efforts not only better serve our patients, but enhance our ability to recruit and retain physicians. We believe they will also enhance our ability to compete in the emerging healthcare environment, where hospitals will become more and more accountable for quality outcomes.

But our commitment to quality goes beyond competitive advantage. The people we treat in our communities are more than patients. They are our neighbors. In such an environment, the drive to provide the highest quality of care takes an even deeper meaning. We invest heavily in improving the quality of care, the services available, and the overall health of our communities. To us, those are not merely differentiators in the marketplace; they reflect our mission of Making Communities Healthier, both physically and economically.

Because of our history and mission, we were particularly proud that the U.S. Centers for Medicare and Medicaid Services (CMS) awarded a Hospital Engagement Network contract to our company in December 2011. Working with CMS and with our clinical staff across LifePoint, we are creating best practices to improve the delivery of quality care and patient safety, implementing these practices in our facilities, and training our staff across the country to execute on them. We have subcontracted with Duke, adding their clinical expertise, training systems and track record in patient safety systems to this effort. Of the 26 contracts CMS awarded, LifePoint was the only for-profit recipient. To us, that honor is both a point of differentiation and validation of our commitment to outstanding care.

### Achieving Operational Excellence

Over the years, LifePoint has built a reputation for operational excellence, with margins that have always ranked among the best in the industry. As part of our ongoing efforts to improve that excellence, last year we made significant investments in implementing EMR systems in our hospitals that improve the flow of information,

the quality of care provided at our hospitals, and the ability of our physicians to serve patients. By meeting CMS' "meaningful use" criteria for EMR systems, which CMS created to both encourage adoption and ensure the use of EMRs to advance patient care, our hospitals qualify for federal stimulus dollars. Our efforts in this area last year resulted in an additional $32 million in incremental payments to the Company.

We also entered into a shared services agreement with Parallon Business Solutions to provide our hospitals with supply chain, accounts payable, revenue cycle, and payroll services. We began transitioning our hospitals to Parallon's services in late 2012. By utilizing Parallon's expertise and efficiencies in these core business areas, we are enabling our hospitals to focus more time and resources on what they do best – providing high quality patient care close to home.

### Meeting the Challenge through Smart Solutions and Sound Execution

In today's healthcare environment, hospitals of all sizes face an array of challenges: increasing pressure on reimbursement, changing patient mix, physician recruitment, increasing regulatory requirements, access to capital, technology requirements and infrastructure, and bottom-line accountability for quality care and improved outcomes. LifePoint's strategies address each of these challenges, and our experienced team has demonstrated an ability to implement our approaches in ways that turn strategies into solutions.

Our solutions and our industry leadership in forming strategic partnerships with prestigious medical centers position our company to capitalize on the growing trend of community hospitals affiliating with larger organizations like LifePoint. Our pipeline remains very active, and we are selectively acquiring the right hospitals in the right markets. With a strong balance sheet and ready access to capital, we believe we have the financial resources to extend our growth through 2013 and beyond.

We also believe we are exceptionally well positioned to add value not only to the communities we serve, but across our industry. As the sole hospital provider in most of the communities we serve, we are a very significant player in an expanding footprint. With the addition of new physicians and new service lines, we are furthering our efforts to gain market share in those markets and reduce the migration of patients to larger hospitals in more distant towns and cities. In addition, our joint ventures with Duke and Norton are building integrated provider networks that should improve the healthcare landscape across entire regions for years to come.

We also believe we are exceptionally well positioned to add value not only to the communities we serve, but across the industry.

We are excited about what the future holds for LifePoint and our shareholders. As always, we remain grateful for your interest and investment.

Sincerely,

William F. Carpenter III
Chairman and
Chief Executive Officer

**UNITED STATES**
**SECURITIES AND EXCHANGE COMMISSION**
**Washington, D.C. 20549**

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**Form 10-K**

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☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)**
**OF THE SECURITIES EXCHANGE ACT OF 1934**
**For the fiscal year ended December 31, 2012**

**or**

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d)**
**OF THE SECURITIES EXCHANGE ACT OF 1934**
**For the transition period from to**

**Commission file number: 000-51251**

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# LifePoint Hospitals, Inc.

*(Exact Name of Registrant as Specified in its Charter)*

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| **Delaware** | **20-1538254** |
|---|---|
| *(State or Other Jurisdiction of Incorporation or Organization)* | *(I.R.S. Employer Identification No.)* |
| **103 Powell Court**<br>**Brentwood, Tennessee**<br>*(Address Of Principal Executive Offices)* | **37027**<br>*(Zip Code)* |

**(615) 372-8500**
*(Registrant's Telephone Number, Including Area Code)*

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

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

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

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Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

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

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

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

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

The aggregate market value of the shares of registrant's Common Stock held by non-affiliates as of June 30, 2012, was approximately $1.5 billion.

As of February 8, 2013, the number of outstanding shares of the registrant's Common Stock was 46,948,388.

**DOCUMENTS INCORPORATED BY REFERENCE**

Portions of the definitive proxy statement for our 2013 annual meeting of stockholders are incorporated by reference into Part III of this report.

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**LifePoint Hospitals, Inc.**

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### PART II



### PART III



### PART IV

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## PART I

### Item 1. *Business.*

#### Overview of Our Company

LifePoint Hospitals, Inc., a Delaware corporation, acting through its subsidiaries, operates general acute care hospitals primarily in non-urban communities in the United States (''U.S.''). Unless the context otherwise requires, LifePoint and its subsidiaries are referred to herein as ''LifePoint,'' the ''Company,'' ''we,'' ''our'' or ''us.'' At December 31, 2012, on a consolidated basis, we operated 56 hospital campuses in 19 states, having a total of 6,581 licensed beds. We generate revenue primarily through hospital services offered at our facilities. We generated $3,391.8 million, $3,026.1 million and $2,818.6 million in revenues during the years ended December 31, 2012, 2011, and 2010, respectively.

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

#### Business Strategy

##### *Opportunities in Existing Markets*

We believe that growth opportunities remain in our existing markets. Growth at our hospitals is dependent in part on how successful our hospitals are in their efforts to recruit physicians to their respective medical staffs, whether those physicians are active members of their respective medical staffs over a long period of time and whether and to what extent members of our hospitals' medical staffs admit patients to our hospitals. We continue to refine our recruiting process in an effort to better identify and focus on those physicians most likely to desire to practice in our communities.

We believe that growth at our hospitals also is dependent in part on the quality of care provided in our facilities, adding new service lines in our existing markets and investing in new technologies desired by physicians and patients. The quality (both actual and perceived) of healthcare services provided at our hospitals is an increasingly important factor to patients when deciding where to seek care, to physicians when deciding where to practice and to governmental and private third party payors when determining the reimbursement that is paid to our hospitals. Because in virtually every case the Centers for Medicare and Medicaid Services (''CMS'') core measure scores ascribed to our hospitals are impacted by the practice decisions of the physicians on our medical staffs, we have implemented new strategies to work with medical staff members to improve scores at our hospitals, especially those that are below our average or below management's expectation. Recently, we have seen improvements in our CMS core measure scores and Hospital Consumer Assessment of Healthcare Providers & Systems scores, an important measure of patients' perspectives of hospital care. We are committed to further improving our hospitals' scores through targeted strategies, including increased education and awareness campaigns and hospital-specific action plans.

Additionally, in many of our markets, a significant portion of patients who require the services available at acute care hospitals leave our markets to receive such care. We believe this presents an opportunity for growth, and we are working with the hospitals in communities where this phenomenon exists to implement new strategies or enhance existing strategies to attract patients. We continually conduct operating reviews of our hospitals to pinpoint new service lines that could reduce the outmigration of patients leaving our markets to receive healthcare services. Where needed service lines have been identified, we have focused on recruiting the physicians necessary to operate such service lines. For example, our hospitals have responded to physician interest in requests for hospitalists by introducing or strengthening hospitalist programs where appropriate. Our hospitals have taken other steps, such as structured efforts to solicit input from medical staff members and to respond promptly to legitimate unmet physicians' needs, to limit or offset the impact of outmigration and to achieve growth.

While responsibly managing our operating expenses, we have also made significant, targeted investments in our hospitals to add new technologies, modernize facilities and expand the services available. These

investments should assist in our efforts to attract and retain physicians, to offset outmigration of patients and to make our hospitals more desirable to our employees and potential patients.

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

***Opportunities in New Markets***

We believe that strategic acquisitions can supplement the organic growth in our existing markets. We seek to acquire well-positioned hospitals in growing areas of the U.S. that we believe are fairly priced and could benefit from our management and strategic initiatives.

In 2011, we formed Duke LifePoint Healthcare, a joint venture between LifePoint and a wholly-controlled affiliate of Duke University Health System, Inc. (''Duke''), with a mission to own and operate community hospitals as well as improve the delivery of healthcare services. We own a controlling interest in Duke LifePoint Healthcare. We believe this partnership, which combines our operational resources and experience with Duke's expertise in the development of clinical services and quality systems, further strengthens our ability to acquire well-positioned hospitals.

Consistent with our acquisition strategy, and through Duke LifePoint Healthcare, we completed acquisitions of the following:

- Marquette General Health System (''Marquette General''), a 315 bed hospital system located in Marquette, Michigan, effective September 1, 2012;
- an 80% interest in Twin County Regional Hospital (''Twin County''), a 141 bed hospital located in Galax, Virginia, effective April 1, 2012;
- an 80% interest in Maria Parham Medical Center (''Maria Parham''), a 102 bed hospital located in Henderson, North Carolina, effective November 1, 2011; and
- Person Memorial Hospital (''Person Memorial''), a 110 bed hospital located in Roxboro, North Carolina, effective October 1, 2011.

Additionally, effective July 1, 2012, we acquired Woods Memorial Hospital (''Woods Memorial''), a 72 bed hospital and 88 bed long-term care facility located in Etowah, Tennessee.

Furthermore, in May 2012, we entered into a joint venture agreement with Norton Healthcare, Inc. to form the Regional Healthcare Network of Kentucky and Southern Indiana (''RHN''), the purpose of which is to own and operate hospitals in non-urban communities in the Kentucky and Southern Indiana region. Effective January 1, 2013, through RHN, we acquired Scott Memorial Hospital (''Scott Memorial''), a 25 bed critical access hospital located in Scottsburg, Indiana.

**Operations**

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

Our hospitals typically provide the range of medical and surgical services commonly available in hospitals in non-urban markets. These services include general surgery, internal medicine, obstetrics,

emergency room care, radiology, oncology, diagnostic care, coronary care, rehabilitation services, pediatric services, and, in some of our hospitals, specialized services such as open-heart surgery, skilled nursing, psychiatric care and neuro-surgery. In many markets, we also provide outpatient services such as same-day surgery, laboratory, x-ray, respiratory therapy, imaging, sports medicine and lithotripsy. The services provided at any specific hospital depend on factors such as community need for the service, whether physicians necessary to operate the service line safely are members of the medical staff of that hospital, whether the service might be economically viable, and any contractual or certificate of need restrictions that exist. Like most hospitals located in non-urban markets, our hospitals do not engage in extensive medical research and medical education programs. However, two of our hospitals have an affiliation with medical schools, including the clinical rotation of medical students, and one of our hospitals owns and operates a school of health professions with a nursing program and a radiologic technology program.

As of December 31, 2012, with the exception of Bluegrass Community Hospital, all of our hospitals are accredited by the Joint Commission. With such accreditation, our hospitals are deemed to meet the Medicare Conditions of Participation and are, therefore, eligible to participate in government-sponsored provider programs, such as the Medicare and Medicaid programs. Bluegrass Community Hospital participates in the Medicare program by otherwise meeting the Medicare Conditions of Participation.

As noted above, the range of services that can be offered at any of our hospitals depends significantly on the efforts, abilities and experience of the physicians on the medical staffs of our hospitals, most of whom have no long-term contractual relationship with us. Our hospitals are staffed by licensed physicians who have been admitted to the medical staffs of individual hospitals. Under state laws and other licensing standards, hospital medical staffs are generally self-governing organizations subject to ultimate oversight by the hospital's local governing board. Each of our hospitals has a local board of trustees. These boards generally include members of the hospital's medical staff as well as community leaders. These boards establish policies concerning medical, professional and ethical practices, monitor these practices, and are responsible for reviewing these practices in order to determine that they conform to established standards. We maintain quality assurance programs to support and monitor quality of care standards and to meet accreditation and regulatory requirements. We also monitor patient care evaluations and other quality of care assessment activities on a regular basis.

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

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

In connection with our efforts to responsibly manage purchasing costs, we participate along with other healthcare companies in a group purchasing organization, HealthTrust Purchasing Group, which makes certain national supply and equipment contracts available to our facilities. We owned an approximate 4.5% equity interest in this group purchasing organization at December 31, 2012.

**Availability of Information**

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

**Sources of Revenue**

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

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

| | 2012 | | 2011 | | 2010 | |
|---|---|---|---|---|---|---|
| | Amount | Ratio | Amount | Ratio | Amount | Ratio |
| Medicare | $1,170.3 | 34.5% | $1,061.3 | 35.0% | $ 983.7 | 34.9% |
| Medicaid | 488.9 | 14.4 | 432.1 | 14.3 | 410.8 | 14.6 |
| HMOs, PPOs and other private insurers | 1,651.2 | 48.7 | 1,446.6 | 47.8 | 1,360.1 | 48.2 |
| Self-pay | 653.9 | 19.3 | 565.3 | 18.7 | 475.1 | 16.9 |
| Other | 51.9 | 1.5 | 39.3 | 1.3 | 32.7 | 1.1 |
| Revenues before provision for doubtful accounts | 4,016.2 | 118.4 | 3,544.6 | 117.1 | 3,262.4 | 115.7 |
| Provision for doubtful accounts | (624.4) | (18.4) | (518.5) | (17.1) | (443.8) | (15.7) |
| Revenues | $3,391.8 | 100.0% | $3,026.1 | 100.0% | $2,818.6 | 100.0% |

Patients generally are not responsible for any difference between customary hospital charges and amounts reimbursed for the services under Medicare, Medicaid, private insurance plans, HMOs or PPOs, but are responsible for services not covered by these plans, exclusions, deductibles or co-payment features of their coverage. The amount of exclusions, deductibles and co-payments generally has been increasing each year as employers have been shifting a higher percentage of healthcare costs to employees. In some states, the Medicaid program budgets have been cut, which has resulted in limiting the enrollment of participants. This, along with increasing self-pay revenue, has resulted in higher provisions for doubtful accounts at many of our hospitals in the past few years.

***Medicare***

Our revenues from Medicare were approximately $1,170.3 million, or 34.5% of total revenues for the year ended December 31, 2012. Medicare provides hospital and medical insurance benefits, regardless of income, to persons age 65 and over, some disabled persons and persons with end-stage renal disease. All of our hospitals are currently certified as providers of Medicare services. Amounts received under the Medicare program are often significantly less than the hospital's customary charges for the services provided. Since 2003, Congress and CMS have made several sweeping changes to the Medicare program and its reimbursement methodologies, such as the implementation of the prescription drug benefit that was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the ''MMA'') and as the provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the ''Affordable Care Act'') continue to be implemented. Additional changes will likely be made as Congress addresses the spending reductions required by the Budget Control Act of 2011 (the ''BCA'') and takes other steps to reduce the federal deficit, as discussed in further detail throughout this section.

*Medicare Inpatient Prospective Payment System*

Under the Medicare program, hospitals are reimbursed for the costs of acute care inpatient stays under an inpatient prospective payment system (''IPPS''). Under the IPPS, our hospitals are paid a prospectively determined amount for each hospital discharge that is based on the patient's diagnosis. Specifically, each discharge is assigned to a Medicare severity diagnosis related group (''MS-DRG''), which groups patients that have similar clinical conditions and that are expected to require a similar amount of hospital resources. Each MS-DRG is, in turn, assigned a relative weight that is prospectively set and that reflects the average amount of resources, as determined on a national basis, that are needed to treat a patient with that particular diagnosis, compared to the amount of hospital resources that are needed to treat the average Medicare inpatient stay. The

IPPS payment for each discharge is based on two national base payment rates or standardized amounts, one that covers hospital operating expenses and another that covers hospital capital expenses. The base MS-DRG payment rate for operating expenses has two components, a labor share and a non-labor share. Although the labor share is adjusted by a wage index to reflect geographical differences in the cost of labor, the base MS-DRG payment rate does not consider the actual costs incurred by an individual hospital in providing a particular inpatient service.

The base MS-DRG operating expense payment rate that is used by the Medicare program in the IPPS is adjusted by an update factor on an annual basis. The index used to adjust the base MS-DRG payment rate, which is known as the ''hospital market basket index,'' gives consideration to the inflation experienced by hospitals in purchasing goods and services. For federal fiscal years (''FFYs'') 2013 (which began on October 1, 2012), 2012 (which began on October 1, 2011 and ended on September 30, 2012), and 2011 (which began on October 1, 2010 and ended on September 30, 2011), the hospital market basket index increased 2.6%, 3,0% and 2.6%, respectively. Generally, however, the percentage increase in the DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the hospital market basket increases for FFY 2013, FFY 2012 and FFY 2011 were reduced by CMS by 0.10%, 0.10% and 0.25%, respectively. For FFY 2012 and each subsequent fiscal year, as also mandated by the Affordable Care Act, the market basket increase is reduced by a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity. For FFY 2013 and FFY 2012, the productivity adjustment equated to a 0.7% and 1.0% reduction in the market basket increase, respectively. In addition, in FFY 2013, FFY 2012 and FFY 2011, IPPS payment rates to hospitals were increased by 1.0%, decreased by 2.0% and decreased by 2.9%, respectively, for documentation and coding adjustments that were required by the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007 (the ''TMA Act'').

From FFY 2005 through 2007, the MMA required all acute care hospitals to participate in CMS's Hospital Inpatient Quality Reporting Program (the ''IQR Program'') in order to receive the full hospital market basket update. Beginning in FFY 2007, the Deficit Reduction Act of 2005 (the ''DRA'') expanded the number of quality measures that were required to be reported and increased the reduction in reimbursement to hospitals that do not participate in the IQR Program from 0.4% to 2.0%. Through FFY 2012, our hospitals reported all quality measures required by CMS and received the full market basket update.

On October 1, 2007, CMS replaced the previously existing 538 diagnosis related groups with 745 MS-DRGs. The MS-DRGs are intended to more accurately reflect the cost of providing inpatient services and eliminate any incentives that hospitals may have to only treat the healthiest and most profitable patients. The MS-DRGs were phased-in over a two year period, with FFY 2009, which began on October 1, 2008, being the first year that IPPS payments to hospitals were based entirely on the new MS-DRGs.

To offset the effect of the coding and discharge classification changes that CMS believed would occur as hospitals implemented the MS-DRG system, CMS established prospective documentation and coding adjustments to the national standardized amounts of (1.2%) in FFY 2008 and (1.8%) in both FFYs 2009 and 2010. However, the TMA Act, which was enacted on September 29, 2007, effectively decreased the reductions for FFYs 2008 and 2009 to (0.6%) and (0.9%), respectively. In addition, the TMA Act required CMS to conduct a ''look-back'' beginning in FFY 2010 and make appropriate changes to the reduction percentages based on actual FFY 2008 and 2009 claims data. Based on its evaluation, CMS determined that IPPS payments increased by 2.5% in FFY 2008 and 5.4% in FFY 2009 due solely to the implementation of the MS-DRG System. The increases exceeded the cumulative prospective adjustments by 5.8% for FFYs 2008 and 2009. The TMA Act required CMS to recoup the increase in spending in FFYs 2008 and 2009 by FFY 2012. In the IPPS final rule for FFY 2011, CMS reduced the standardized amount by (2.9%), which represented half of the required retrospective adjustment. The remaining (2.9%) retrospective reduction was implemented in FFY 2012. However, because the (2.9%) retrospective reduction that was made in FFY 2011 was restored in FFY 2012, the retrospective adjustment that was made in FFY 2012 was essentially negated. The (2.9%) retrospective reduction that was made in FFY 2012 was restored in FFY 2013.

The TMA Act also required CMS to make an additional prospective cumulative adjustment of (3.9%) to eliminate the full effect of the documentation and coding changes on future payments. The TMA Act gave CMS discretion as to the timing of the implementation of the prospective documentation and coding adjustment, and CMS did not implement any portion of the adjustment in FFYs 2010 and 2011. CMS did, however, implement a (2.0%) prospective documentation and coding adjustment in FFY 2012 and completed the remaining (1.9%) prospective adjustment in FFY 2013.

In addition to the adjustments that were required by the TMA Act, the American Taxpayer Relief Act of 2012 (''ATRA''), which was enacted on January 1, 2013, requires CMS to recoup $11 billion from IPPS payments in FFYs 2014 through 2017 to offset an additional increase in aggregate payments to hospitals that Congress believes occurred from FFY 2008 through 2013 solely as the result of the transition to the MS-DRG system and was not recaptured by the adjustments that were mandated by the TMA Act. CMS has not yet indicated how or when the additional adjustments required by ATRA will be implemented.

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

| | Medicare MS-DRG Payments | Medicare Capital Payments |
|---|---|---|
| 2012 | $517.0 | $41.1 |
| 2011 | $503.9 | $40.7 |
| 2010 | $481.4 | $40.5 |

In addition to MS-DRG and capital payments, hospitals may qualify for outlier payments for cases involving patients whose treatment costs are extraordinarily high when compared to the costs of treating an average patient in the same DRG.

Hospitals may also qualify for Medicare disproportionate share hospital (''DSH'') payments, if they treat a high percentage of low-income patients. The adjustment is generally based on the hospital's disproportionate patient percentage (''DPP''), which is the sum of the number of inpatient days for patients who were entitled to both Medicare Part A and Supplemental Security Income benefits, divided by the total number of Medicare Part A inpatient days and the number of inpatient days for patients who were eligible for Medicaid (but not Medicare) divided by the total number of hospital inpatient days. Hospitals whose DPP meets or exceeds a specified threshold amount are eligible for a DSH payment adjustment. Medicare DSH payments received in the aggregate by our hospitals for 2012, 2011, and 2010, were approximately $68.8 million, $70.7 million and $65.0 million, respectively. However, 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.

*Medicare Hospital Outpatient Prospective Payment System*

The Balanced Budget Refinement Act of 1999 (''BBRA'') established a prospective payment system for outpatient hospital services that commenced on August 1, 2000. Under Medicare's hospital outpatient prospective payment system (''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'') 2013, 2012, and 2011 were $71.313, $70.016, and $68.876, respectively, after the inclusion of the 0.8% reduction for CY 2013, the 1.1% reduction for CY 2012, and the 0.25% reduction for CY 2011 that were required by the Affordable Care Act. APC classifications and payment rates are reviewed and adjusted on an annual basis, and, historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services. To receive the full increase, hospitals must satisfy the reporting requirements of the Hospital Outpatient Quality Data Reporting Program (the ''HOPQDRP''). Hospitals that do not satisfy the

reporting requirements of the HOPQDRP are subject to a reduction of 2.0% from the fee schedule increase factor. For CY 2012, our hospitals reported all quality measures required by CMS and received the full market basket update.

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

| | Medicare APC Payments |
|---|---|
| 2012 | $309.2 |
| 2011 | $260.9 |
| 2010 | $248.6 |

*Budget Control Act of 2011*

On August 2, 2011, the BCA was enacted. The BCA increased the nation's debt ceiling while taking steps to reduce the federal deficit. The BCA requires $1.2 trillion in automatic across-the-board spending reductions for FFY 2013 through 2021, split evenly between domestic and defense spending. While certain programs (including the Medicaid program) are protected from these automatic spending reductions, the Medicare program is subject to reductions, capped at 2%. The BCA's automatic spending reductions were set to begin on January 2, 2013. However, the ATRA postponed the implementation of the automatic spending reductions required by the BCA until March 1, 2013.

*Medicare Bad Debt Reimbursement*

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

The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases, an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period. In these cases, the recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made. In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs is reduced by 35%. Under this program, our hospitals received an aggregate of approximately $20.2 million, $19.5 million and $17.5 million for 2012, 2011, and 2010, respectively.

*Physician Services*

Physician services are reimbursed under the Medicare physician fee schedule (''PFS'') system, under which CMS has assigned a national relative value unit (''RVU'') to most medical procedures and services that reflects the various resources required by a physician to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service, practice expense (overhead) attributable to the service and malpractice insurance expense attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs then aggregated. The aggregated amount is 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. While RVUs for various services may change in a given year, any alterations are required by statute to be virtually budget neutral.

The PFS rates are adjusted each year, and reductions in both current and future payments are anticipated. The SGR formula, if implemented as mandated by statute, would result in significant reductions to payments under the PFS. Since 2003, Congress has passed multiple legislative acts delaying application of the SGR to the PFS. For CY 2013, CMS issued a final rule that would have applied the SGR and resulted in an aggregate reduction of 26.5% to all physician payments under the PFS for CY 2013. The ATRA delayed application of the SGR and extended CY 2011 PFS payment rates through December 31, 2013. We cannot predict whether Congress will enact legislation to temporarily avoid or permanently prevent the application of SGR reductions to PFS rates in the future.

***Medicaid***

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

Our revenues under the various state Medicaid programs, including state-funded managed care programs, were approximately $488.9 million, or 14.4% of total revenues for the year ended December 31, 2012. These payments are typically based on fixed rates determined by the individual states. Included in these payments are DSH and other supplemental payments received under various state Medicaid programs. For 2012, 2011, and 2010, our revenue attributable to DSH and other supplemental payments was approximately $119.7 million, $74.2 million and $61.1 million, respectively. The increase in revenue from DSH and other supplemental payments is primarily attributable to additional funding provided by certain states, which was made available in part by additional annual state provider taxes on certain of our hospitals and changes in classification of state programs.

Many states in which we operate are facing budgetary challenges and have adopted, or may be considering, legislation that is intended to control or reduce Medicaid expenditures, enroll Medicaid recipients in managed care programs, and/or impose additional taxes on hospitals to help finance or expand their Medicaid programs. Budget cuts, federal or state legislation, or other changes in the administration or interpretation of government health programs by government agencies or contracted managed care organizations could have a material adverse effect on our financial position and results of operations.

***Annual Cost Reports***

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

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

***Recovery Audit Contractors***

In 2005, CMS began using recovery audit contractors (''RACs'') to detect Medicare overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare claims filed by healthcare providers. RACs perform post-discharge audits of medical records to identify Medicare 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. RACs have the authority to look back at claims up to five years old, provided that the claim was paid on or after October 1, 2007. Any claims identified as overpayments are subject to a RAC program appeals process. The RAC program began as a demonstration project in five states and was made permanent by the Tax Relief and Health Care Act of 2006. The permanent RAC program was gradually expanded across the U.S. in 2008 and 2009 and is currently operating in all 50 states. The Affordable Care Act further expanded the use of RACs by requiring each state to establish a Medicaid RAC program by January 1, 2012. Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs are accurate, many of our hospitals have had Medicare claims audited by the RAC program. While our hospitals have successfully appealed many of the adverse determinations raised by Medicare RAC audits, we cannot predict if this trend will continue or the results of any future audits. We cannot predict the volume or outcome of any future audits conducted by the various state Medicaid RAC programs to which our hospitals will be subject. We estimate that RAC audits have resulted in additional revenue reductions of approximately $16.9 million, $5.3 million and $0.6 million during 2012, 2011 and 2010, respectively.

***HMOs, PPOs and Other Private Insurers***

In addition to government programs, our hospitals are reimbursed by differing types of private payors including HMOs, PPOs, other private insurance companies and employers. Our revenues from HMOs, PPOs and other private insurers were approximately $1,651.2 million, or 48.7% of total revenues for the year ended December 31, 2012. To attract additional volume, most of our hospitals offer discounts from established charges to certain large group purchasers of healthcare services. These discount programs often limit our ability to increase charges in response to increasing costs. Generally, patients covered by HMOs, PPOs and other private insurers will be responsible for certain co-payments and deductibles.

***Self-Pay and Charity Care***

Self-pay revenues are derived from patients who do not have any form of healthcare coverage. Our revenues from self-pay patients were approximately $653.9 million, or 19.3% of total revenues for the year ended December 31, 2012. 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 provide care to certain patients that qualify under the local charity care policy at each of our hospitals. We do not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is our policy not to pursue collection of amounts related to these patients.

A significant portion of self-pay patients are admitted through the emergency department and often require high-acuity treatment. High-acuity treatment is more costly to provide and, therefore, results in higher billings. We continue to experience increases in the amount of self-pay revenues at our hospitals, which are the least collectible of all accounts. The increase in self-pay revenues has resulted in an increase in our provision for doubtful accounts. Additionally, we have recently experienced an increase in our charity care write-offs as a result of a decrease in our reimbursement under a program in the state of New Mexico that provides for supplemental support and funding for the care of indigent patients in that state.

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

| | Self-Pay Revenues | Charity Care Write-Offs | Combined Total |
|---|---|---|---|
| 2012 | $653.9 | $112.5 | $766.4 |
| 2011 | $565.3 | $ 89.4 | $654.7 |
| 2010 | $475.1 | $ 62.3 | $537.4 |

***Provision for Doubtful Accounts***

To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. The primary uncertainty lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients. Our provision for doubtful accounts had the effect of reducing total revenues by approximately $624.4 million, or 18.4% of total revenues for the year ended December 31, 2012.

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

We have experienced an increase in our self-pay revenues over the past several years which has primarily been driven by the impact of pricing increases and overall high levels of unemployment in the majority of our communities. The increase in self-pay revenues has resulted in an increase in our provision for doubtful accounts.

**Health Care Reform**

The Affordable Care Act was signed into law, in two parts, on March 23, 2010 and March 30, 2010. The Affordable Care Act dramatically alters the U.S. healthcare system and is intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicare and Medicaid eligibility, reducing Medicare payments and Medicaid DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, and instituting certain private health insurance reforms. Although a majority of the measures contained in the Affordable Care Act do not take effect until 2013 and 2014, certain of the reductions in Medicare spending, such as negative adjustments to the Medicare hospital inpatient and outpatient prospective payment system market basket updates and the incorporation of productivity adjustments to the Medicare program's annual inflation updates, became effective in 2010, 2011 and 2012.

On June 28, 2012, the U.S. Supreme Court upheld the ''individual mandate'' provision of the Affordable Care Act that generally requires all individuals to obtain healthcare insurance or pay a penalty. However, the U.S. Supreme Court also held that the provision of the Affordable Care Act that authorized the Secretary of the Department of Health and Human Services (''HHS'') to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. In response to the ruling, a number of states have already indicated that they will not expand their Medicaid programs, which would result in the Affordable Care Act not providing coverage to some low-income persons in those states. In addition, several bills have been and may continue to be introduced in Congress to repeal or amend all or significant provisions of the Affordable Care Act. It is difficult to predict the full impact of the Affordable Care Act on our revenue and results of operations due to its complexity, lack of implementing regulations and interpretive guidance, gradual and potentially delayed implementation, potential future legal challenges, and possible repeal and/or amendment, as well as our inability to foresee how many states will expand their Medicaid programs and how individuals and businesses will respond to the choices afforded them by the Affordable Care Act.

***Expanded Coverage***

Based on original Congressional Budget Office (''CBO'') and CMS estimates, by 2019, the Affordable Care Act was expected to expand coverage to 32 to 34 million additional individuals (resulting in coverage of an estimated 94% of the legal U.S. population). This increased coverage was expected to occur through a combination of public program expansion and private sector health insurance and other reforms. However, in July 2012, the CBO revised its estimate to reflect the impact of the U.S. Supreme Court's determination that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program was unconstitutional. The CBO now projects that there will be 4 million more uninsured individuals in 2014 and 3 million more uninsured individuals in 2022 than previously projected as a result of the U.S. Supreme Court's decision.

*Medicaid Expansion*

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

The Affordable Care Act materially changed the requirements for Medicaid eligibility. As originally enacted, commencing January 1, 2014, the Affordable Care Act essentially required all state Medicaid programs to provide Medicaid coverage to virtually all adults under 65 years old with incomes at or under 133% of the federal poverty level (''FPL''). In addition, the Affordable Care Act also required states to apply a ''5% income disregard'' to the Medicaid eligibility standard, so that Medicaid eligibility would effectively be

extended to those with incomes up to 138% of the FPL. To offset the cost of the Medicaid program's expansion, the Affordable Care Act authorized the federal government to provide states with ''matching funds'' (referred to as ''Enhanced FMAP'') to cover the costs of covering the newly eligible individuals. Beginning in 2014, states would receive an Enhanced FMAP for the individuals enrolled in Medicaid pursuant to the Affordable Care Act. The Enhanced FMAP percentage is as follows: 100% for CYs 2014 through 2016; 95% for 2017; 94% in 2018; 93% in 2019; and 90% in 2020 and thereafter. It was anticipated that the new eligibility requirements would expand Medicaid and CHIP coverage by an estimated 7 million individuals in 2014 and 11 million individuals in 2022, with a disproportionately large percentage of the new Medicaid coverage likely to be in states that currently have relatively low income eligibility requirements.

However, on June 28, 2012, the U.S. Supreme Court held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. As a result, the expansion of the Medicaid program to all individuals under 65 years old with incomes at or under 133% of FPL is now optional. CMS has stated that there is no deadline for states to determine whether they will expand their Medicaid programs and has indicated that if a state does decide to expand its Medicaid program, it may also decide to drop the expanded coverage at a later date. In response to the ruling, a number of states, including several in which the Company has facilities, have preliminarily indicated that they will not expand their Medicaid programs, which would result in the Affordable Care Act not providing coverage to some low-income persons in those states. While the CBO estimates that the U.S. Supreme Court's decision will likely result in the Medicaid and CHIP programs covering six million fewer individuals in 2022, it is unclear how many states will elect to implement the Medicaid expansion and when that expansion will occur. Therefore, we are unable to predict the likely impact of the Medicaid expansion on our business model, financial condition or result of operations.

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

Historically, states often have attempted to reduce Medicaid spending by limiting benefits and tightening Medicaid eligibility requirements. Effective March 23, 2010, the Affordable Care Act requires states to at least maintain Medicaid eligibility standards established prior to the enactment of the law for adults until January 1, 2014 and for children until October 1, 2019. States with budget deficits may, however, seek exemptions from this requirement, but only to address eligibility standards that apply to adults making more than 133% of the FPL.

*Private Sector Expansion*

The expansion of health coverage through the private sector as a result of the Affordable Care Act will occur through new requirements on health insurers, employers and individuals. Commencing January 1, 2014, health insurance companies will be 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. Effective January 1, 2011, each health plan must keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual markets or rebate its enrollees the amount spent in excess of the percentage. In addition, effective September 23, 2010, health insurers are not permitted to deny coverage to children based upon a pre-existing condition and must allow dependent care coverage for children up to 26 years old.

Larger employers will be subject to new requirements and incentives to provide health insurance benefits to their full time employees. Effective January 1, 2014, employers with 50 or more employees that do not offer health insurance will be held subject to a penalty if an employee obtains coverage through one of the newly created American Health Benefit Exchanges (''Exchanges'') and the coverage is subsidized by the government. The employer penalties will range from $2,000 to $3,000 per employee, subject to certain thresholds and conditions.

As enacted, the Affordable Care Act uses various means to induce individuals who do not have health insurance to obtain coverage. By January 1, 2014, individuals will be required to maintain health insurance for a minimum defined set of benefits or pay a tax penalty. The penalty in most cases is $95 in 2014, $325 in 2015, $695 in 2016, and indexed to a cost of living adjustment in subsequent years. The Internal Revenue Service (''IRS''), in consultation with HHS, is responsible for enforcing the tax penalty, although the Affordable Care Act limits the availability of certain IRS enforcement mechanisms. In addition, for individuals and families below 400% of the FPL, the cost of obtaining health insurance will be subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. It is anticipated that those at the lowest income levels will have the majority of their premiums subsidized by the federal government, in some cases in excess of 95% of the premium amount. To facilitate the purchase of health insurance by individuals and small employers, each state must establish an Exchange by January 1, 2014. Based on original CBO and CMS estimates, between 29 and 31 million individuals will obtain their health insurance coverage through an Exchange by 2019. Of that amount, an estimated 16 million will be individuals who were previously uninsured, and 13 to 15 million will be individuals who switched from their prior insurance coverage to a plan obtained through the Exchange. In July 2012, the CBO estimated that the U.S. Supreme Court's ruling regarding the expansion of the Medicaid program will result in an additional 3 million individuals obtaining their health insurance coverage through an Exchange. The Affordable Care Act requires that the Exchanges be designed to make the process of evaluating, comparing and acquiring coverage simple for consumers. Health insurers participating in the Exchange must offer a set of minimum benefits to be defined by HHS and may offer more benefits, and must offer at least two, and up to five, levels of plans that vary by the percentage of medical expenses that must be paid by the enrollee. Each level of plan must require the enrollee to share certain specified percentages of medical expenses up to the deductible/co-payment limit. Health insurers may establish varying deductible/co-payment levels, up to the statutory maximum (estimated to be between $6,000 and $7,000 for an individual). The health insurers must cover 100% of the amount of medical expenses in excess of the deductible/co-payment limit. For example, an individual making 100% to 200% of the FPL will have co-payments and deductibles reduced to about one-third of the amount payable by those with the same plan with incomes at or above 400% of the FPL.

*Public Program Spending*

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

*Payments for Hospitals*

Under the Medicare program, hospitals receive reimbursement for general, acute care hospital inpatient services under the IPPS. CMS establishes fixed IPPS payment amounts per inpatient discharge based on the patient's assigned MS-DRG. These MS-DRG rates are updated each FFY, which begins October 1, using the hospital market basket index, which takes into account inflation experienced by hospitals and other entities outside the healthcare industry in purchasing goods and services.

The Affordable Care Act provides for four types of annual reductions in the market basket. The first is a general reduction of a specified percentage each FFY starting in 2010 and extending through 2019. These reductions are as follows: FFY 2010, 0.25% for discharges occurring on or after April 1, 2010; 2011 (0.25%); 2012 (0.1%); 2013 (0.1%); 2014 (0.3%); 2015 (0.2%); 2016 (0.2%); 2017 (0.75%); 2018 (0.75%); and 2019 (0.75%).

The second type of reduction to the market basket is a ''productivity adjustment'' that was implemented by HHS beginning in FFY 2012. The amount of that reduction is the projected nationwide productivity gains over the preceding 10 years. To determine the projection, HHS uses the Bureau of Labor Statistics (''BLS'') 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Affordable Care Act does not contain guidelines for HHS to use in projecting the productivity

figure. The market basket update for FFY 2013 and FFY 2012 was reduced by 0.7% and 1.0%, respectively, as a result of this productivity adjustment.

The third type of reduction is in connection with the value-based purchasing program discussed in more detail below. Beginning in FFY 2013, CMS will reduce the IPPS payment amount for all discharges by the following: 1% for 2013; 1.25% for 2014; 1.5% for 2015; 1.75% for 2016; and 2% for 2017 and subsequent years. For each FFY, the total amount collected from these reductions will be pooled and used to fund payments to hospitals that satisfy certain quality metrics. While some or all of these reductions may be recovered if a hospital satisfies these quality metrics, the recovery amounts may be delayed.

The fourth type of reduction to the market basket is a penalty to hospitals that experience excessive readmissions within a thirty day period of discharge for certain conditions designated by HHS further explained below. The basic maximum reduction amount is 1.0% for FFY 2013, 2.0% for FFY 2014 and 3.0% for FFY 2015 and beyond.

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

*Quality-Based Payment Adjustments and Reductions for Inpatient Services*

The Affordable Care Act establishes or expands provisions to promote value-based purchasing and to link payments to quality and efficiency. HHS is directed to implement a value-based purchasing program for inpatient hospital services. This program applies beginning in FFY 2013 to payments for discharges occurring on or after October 1, 2012, and rewards hospitals based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period. CMS will evaluate hospitals' performance during a performance period, and hospitals will 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 will be translated into value-based incentive payments beginning with inpatient discharges occurring on or after October 1, 2012. Hospitals that receive higher total performance scores will receive higher incentive payments than those that receive lower total performance scores. Because the Affordable Care Act provides that the funds 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.

Beginning in FFY 2013, inpatient payments will be reduced if a hospital experiences ''excessive readmissions'' within a 30-day period of discharge for heart attack, heart failure, pneumonia or other conditions designated by HHS. Hospitals with what HHS defines as ''excessive readmissions'' for these conditions will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Each hospital's performance will be publicly reported by HHS. HHS has the discretion to determine what ''excessive readmissions'' means, the amount of the payment reduction and other terms and conditions of this program.

*Outpatient Market Basket and Productivity Adjustment*

Hospital outpatient services paid under OPPS are classified into APCs. The APC payment rates are updated each calendar year based on the market basket. The first two market basket changes outlined above — the general reduction and the productivity adjustment — apply to outpatient services as well as inpatient services, although these are applied on a calendar year basis. The percentage changes specified in the Affordable Care Act summarized above as the general reduction for inpatients — e.g., 0.2% in 2015 — are the same for outpatients.

*Medicare and Medicaid Disproportionate Share Hospital Payments*

The Medicare DSH program provides for additional payments to hospitals that treat a disproportionate share of low-income patients. Under the Affordable Care Act, beginning in FFY 2014, Medicare DSH payments will be reduced to 25% of the amount they otherwise would have been absent the new law. The remaining 75% of the amount that would otherwise be paid under Medicare DSH will be effectively pooled,

and this pool will be reduced further each year by a formula that reflects reductions in the national level of uninsured who are under 65 years of age. In other words, the greater the level of coverage for the uninsured nationally, the more the Medicare DSH payment pool will be reduced. Each hospital will then be paid, out of the reduced DSH payment pool, an amount allocated based upon its level of uncompensated care.

CBO and CMS estimates differ by $38 billion. The Affordable Care Act does not mandate what data source HHS must use to determine the reduction, if any, in the uninsured population nationally. In addition, CMS has not yet finalized how it will define ''uncompensated care'' for purposes of the DSH reductions. As a result, it is unclear how a hospital's share of the Medicare DSH payment pool will be calculated. On January 18, 2012, CMS published a proposed rule, which proposes a service-specific definition of ''uncompensated care.'' Under this definition, ''uncompensated care'' would include services provided to insured individuals whose insurance does not cover a particular service or who have exhausted their insurance benefits. Costs associated with bad debt, including unpaid coinsurance and deductibles and payer discounts would not be considered ''uncompensated care'' under the proposed rule. How CMS ultimately defines ''uncompensated care'' for purposes of these DSH funding provisions could have a material effect on a hospital's Medicare DSH reimbursements. It is difficult to predict the full impact of the Medicare DSH reductions.

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. The Affordable Care Act will reduce funding for the Medicaid DSH hospital program in FFYs 2014 through 2020 by the following amounts: 2014 ($500 million); 2015 ($600 million); 2016 ($600 million); 2017 ($1.8 billion); 2018 ($5 billion); 2019 ($5.6 billion); and 2020 ($4 billion). In addition, the Middle Class Tax Relief and Job Creation Act of 2012 (the ''Tax Relief Act'') and the ATRA provide for additional Medicaid DSH reductions of $4.1 billion in FFY 2021 and $4.2 billion in FFY 2022, respectively. How such cuts are allocated among the states, and how the states allocate these cuts among providers, have yet to be determined.

***Accountable Care Organizations***

The Affordable Care Act requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations (''ACOs''). The ACO program allows providers (including hospitals), physicians and other designated professionals and suppliers to voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program. To date more than 250 ACOs have been established to participate in the Medicare program, and additional ACO programs are being established by private payors.

***Bundled Payment Pilot Programs***

The Affordable Care Act requires HHS to establish a five-year, voluntary national bundled payment pilot program for Medicare services beginning no later than January 1, 2013. Under the program, providers would agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care. HHS will have the discretion to determine how the program will function. CMS finalized the implementation of the Medicare program's Bundled Payments for Care Improvement (''BPCI'') initiative in the IPPS final rule for FFY 2013 and announced the healthcare organizations that were selected to participate in BPCI initiative on January 31, 2013. In addition, the Affordable Care Act provides for a five-year bundled payment pilot program for Medicaid services to begin January 1, 2012. HHS will select up to eight states to participate based on the potential to lower costs under the Medicaid program while improving care. State programs may target particular categories of beneficiaries, selected diagnoses or geographic regions of the state. The selected state programs will provide one payment for both hospital and physician services provided to Medicaid patients for certain episodes of inpatient care. For both pilot programs, HHS will determine the

relationship between the programs and restrictions in certain existing laws, including the Civil Monetary Penalty Law, the anti-kickback provision of the Social Security Act (the ''Anti-kickback Statute''), the Stark law and the Health Insurance Portability and Accountability Act of 1996 (''HIPAA'') privacy, security and transaction standard requirements. However, the Affordable Care Act does not authorize HHS to waive other laws that may impact the ability of hospitals and other eligible participants to participate in the pilot programs, such as antitrust laws.

***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 services. As of December 31, 2012, we operate one hospital through a joint venture with physicians in which we own a controlling interest.

**Impact of Affordable Care Act on the Company**

The expansion of health insurance coverage under the Affordable Care Act may result in a material increase in the number of patients using our facilities who have either private or public program coverage. In addition, a disproportionately large percentage of the new Medicaid coverage is likely to be in states that currently have relatively low income eligibility requirements. Further, the Affordable Care Act provides for a value-based purchasing program, the establishment of ACOs and bundled payment pilot programs, which will create possible sources of additional revenue.

However, it is difficult to predict the size of the potential revenue gains to the Company as a result of these elements of the Affordable Care Act, because of uncertainty surrounding a number of material factors, including the following:

- how many previously uninsured individuals will obtain coverage as a result of the Affordable Care Act (the CBO made a number of assumptions to derive an estimate of 26 million, including how many individuals will ignore substantial subsidies and decide to pay the penalty rather than obtain health insurance, the number of individuals who will obtain insurance through an Exchange and the number of states that will expand their Medicaid programs);
- what percentage of the newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the number of states that elect to expand their Medicaid programs and when that expansion occurs;
- the extent to which states will enroll any new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the rate paid to hospitals by private payers for newly covered individuals, including those covered through the newly created Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- the rate paid by state governments under the Medicaid program for newly covered individuals;
- how the value-based purchasing and other quality programs will be implemented;
- the percentage of individuals in the Exchanges who select the high deductible plans, since health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;
- whether the net effect of the Affordable Care Act, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified

percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and

- the possibility that implementation of provisions expanding health insurance coverage will be delayed or even blocked due to court challenges or revised or eliminated as a result of court challenges and efforts to repeal or amend the new law.

On the other hand, the Affordable Care Act provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. Since 48.9% of our revenues in 2012 was from Medicare and Medicaid, collectively, reductions to these programs may significantly impact us and could offset any positive effects of the Affordable Care Act. It is difficult to predict 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 implemented;
- whether reductions required by the Affordable Care Act will be changed by statute prior to becoming effective;
- the size of the Affordable Care Act's annual productivity adjustment to the market basket in future years;
- the amount of the Medicare DSH reductions that will be made, commencing in FFY 2014;
- the allocation to our hospitals of the Medicaid DSH reductions, commencing in FFY 2014;
- what the losses in revenues will be, if any, from the Affordable Care Act's quality initiatives;
- how successful ACOs in which we participate will be at coordinating care and reducing costs;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and
- reductions to Medicare payments CMS may impose for ''excessive readmissions.''

Because of the many variables involved, we are unable to predict the net effect on the Company of the expected increases in insured individuals using our facilities, the reductions in Medicare spending and reductions in Medicare and Medicaid DSH funding, and numerous other provisions in the Affordable Care Act that may affect us. Additionally, in light of the U.S. Supreme Court's ruling on the constitutionality of the Affordable Care Act, it is unclear how many states will decline to implement the Medicaid expansion. Due to these factors, we are unable to predict with any reasonable certainty or otherwise quantify the likely 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 staffs of our hospitals; and
- the charges for its services.

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

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

**Competition for Professionals**

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

We also recruit physicians to the communities in which our hospitals are located. The types, amount and duration of assistance we can provide to recruited physicians are limited by the federal physician self-referral (Stark law) law, the Anti-kickback Statute, state anti-kickback statutes, and related regulations. For example, 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 2012 than at the end of 2011. 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. At December 31, 2012, we employed approximately 1,900 physicians, hospitalists and their related support staff.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including nurses and other

non-physician healthcare professionals. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue. This shortage may require us to enhance wages and benefits to recruit and retain nurses and other medical support personnel, recruit personnel from foreign countries, and hire more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate.

**Employees**

At December 31, 2012, we had approximately 28,000 employees. The majority are hospital-based employees, including nursing staff, physical and occupational therapists, laboratory and radiology technicians, pharmacy staff, facility maintenance workers and the administrative staffs of our hospitals. Additionally, we employ a number of physicians. We are subject to federal minimum wage and hour laws and various state labor laws, and we maintain a number of different employee benefit plans. Approximately 775 of our employees are subject to collective bargaining agreements. We consider our employee relations to be generally good. Some of our hospitals experience union organizing activity from time to time; however, we do not currently expect any of these efforts to materially affect our future operations.

**Government Regulation**

***Overview***

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

Acute care hospitals are subject to periodic inspection by federal, state and local authorities to determine their compliance with applicable regulations and requirements necessary for licensing, certification and accreditation. All of our hospitals are currently licensed under appropriate state laws and are qualified to participate in the Medicare and Medicaid programs. In addition, as of December 31, 2012, with the exception of Bluegrass Community Hospital, all of our hospitals were accredited by the Joint Commission.

***Utilization Review***

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

***Value-Based Purchasing***

There is a trend in the healthcare industry toward value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates.

In addition, Medicare does not reimburse for care related to certain preventable adverse events. Many large commercial payers currently require hospitals to report quality data, and several commercial payers do not reimburse hospitals for certain preventable adverse events.

The Affordable Care Act contains a number of provisions intended to promote value-based purchasing. The Affordable Care Act prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. Beginning in FFY 2015, hospitals that fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. Hospitals with excessive readmissions for conditions designated by HHS will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard.

The Affordable Care Act also requires HHS to implement a value-based purchasing program for inpatient hospital services. The Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1% in FFY 2013 and increasing by 0.25% each fiscal year up to 2% in FFY 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions.

In 2011, we were selected by HHS to participate in the Hospital Engagement Network as part of the nationwide Partnership for Patients Initiative designed to reduce injuries to patients in a hospital setting as well as minimize exposure to preventable illnesses. As part of our participation in the project, we will receive funding from HHS through 2013 to sponsor various types of training and education focused on patient safety and quality of care.

***Fraud and Abuse Laws***

Participation in the 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 the Medicare and/or Medicaid programs if it performs any of the following acts:

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

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

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

The Office of Inspector General (''OIG'') of HHS is responsible for identifying fraud and abuse activities in government programs. In order to fulfill its duties, the OIG performs audits, investigations and inspections.

In addition, it provides guidance to healthcare providers by identifying types of activities that could violate the Anti-kickback Statute. The OIG has identified the following hospital/physician incentive arrangements as potential violations:

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

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

The Stark law prohibits physicians from referring Medicare and Medicaid patients to selected types of healthcare entities in which they or any of their immediate family members have ownership or a compensation relationship unless an exception applies. These types of referrals are commonly known as ''self referrals''. A violation of the Stark law may result in a denial of payment and require refunds to patients and the Medicare program for all claims that were unlawfully submitted during the entire period that the violation existed, civil monetary penalties of up to $15,000 for each violation, civil monetary penalties of up to $100,000 for circumvention schemes, civil monetary penalties of up to $10,000 for each day that an entity fails to report required information to HHS, and exclusion from participation in the Medicare and Medicaid programs and other federal programs. In addition, violations of the Stark law could also result in penalties under the federal False Claims Act. There are ownership and compensation arrangement exceptions to the self-referral prohibition. There are also exceptions for many of the customary financial arrangements between physicians and facilities, including employment contracts, leases and recruitment agreements, and there is a ''whole hospital exception,'' which allows a physician to make a referral to a hospital if the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. The Affordable Care Act significantly modified the requirements of the whole hospital exception and placed a number of restrictions on the ownership structure, operations, and expansion of physician owned hospitals. One of our

facilities is subject to those requirements. We intend for our financial arrangements with physicians to comply with the exceptions included in the Stark law and regulations. In recent years, CMS has issued a number of proposed and final rules modifying the Stark law exceptions. While some changes have been implemented, others remain in proposed form or have been delayed. Further, the Stark law and related regulations have been subject to little judicial interpretation to date. We anticipate that there will be further changes in the future that will require us to continue to modify our activities.

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

***Federal False Claims Act***

The federal False Claims Act prohibits providers from, among other things, knowingly submitting false or fraudulent claims for payment to the federal government. The federal False Claims Act defines the term ''knowingly'' broadly, and while simple negligence generally will not give rise to liability, submitting a claim with reckless disregard to its truth or falsity can constitute the ''knowing'' submission of a false or fraudulent claim for the purposes of the False Claims Act. The ''qui tam'' or ''whistleblower'' provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of ''whistleblower'' lawsuits that have been filed against providers has increased significantly in recent years. When a private party brings a qui tam action under the federal False Claims Act, the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation. If a provider is found to be liable under the federal False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus mandatory civil monetary penalties of between $5,500 to $11,000 for each separate false claim. The government has used the federal False Claims Act to prosecute Medicare and other government healthcare program fraud such as coding errors, billing for services not provided, submitting false cost reports, and providing care that is not medically necessary or that is substandard in quality.

***Changes in the Regulatory Environment***

The Fraud Enforcement and Recovery Act of 2009 (''FERA'') expanded the scope of the federal False Claims Act by, among other things, creating liability for knowingly and improperly avoiding or decreasing an obligation to pay money to the federal government. In addition, the Affordable Care Act created federal False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later. The Affordable Care Act also provides that claims submitted in connection with patient referrals that result from violations of the Stark law or the Anti-kickback Statute constitute false claims for the purposes of the federal False Claims Act.

The Affordable Care Act makes several significant changes to healthcare fraud and abuse laws, provides additional enforcement tools to the government, increases cooperation between agencies by establishing mechanisms for the sharing of information and enhances 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. 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 health care providers have self-reported potential violations of law 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 federal False Claims Act or that otherwise prohibit the submission of false or fraudulent claims to the state government or Medicaid program. Violations of these laws are punishable by civil and/or criminal penalties and, in many cases, the loss of the facility's license. Although we believe that our operations and arrangements with physicians and other referral sources comply with the applicable state fraud and abuse laws, most of these laws have not been interpreted by any court or governmental agency, and there can be no assurance that the regulatory authorities responsible for enforcing these laws will determine that our arrangements comply with the applicable requirements.

***Emergency Medical Treatment and Active Labor Act***

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

***Administrative Simplification Provisions and Privacy and Security Requirements***

We are subject to the administrative simplification provisions of HIPAA which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. In January 2009, CMS published its 10$^{th}$ revision of International Statistical Classification of Diseases and Related Health Problems (''ICD-10'') and related changes to the formats used for certain electronic transactions. ICD-10 contains significantly more diagnostic and procedural codes than the existing ICD-9 coding system, and as a result, the coding for the services provided in our hospitals and clinics will require much greater specificity. Implementation of ICD-10 will require a significant investment in technology and training. We may experience delays in reimbursement while our facilities and the payors from which we seek reimbursement make the transition to ICD-10. While HIPAA originally required implementation of ICD-10 to be achieved by October 1, 2013, CMS extended this deadline to October 1, 2014. If any of our hospitals fail to implement the new coding system by the deadline, the affected hospital will not be paid for services. We are not able to predict the overall financial impact of the Company's transition to ICD-10.

Additionally, we are subject to the privacy and security requirements of HIPAA and the Health Information Technology for Economic and Clinical Health Act (the ''HITECH Act''), which was enacted as part of ARRA. Among other things, the HITECH Act strengthened the requirements and significantly increased the penalties for violations of the HIPAA privacy and security regulations. The privacy regulations of HIPAA apply to all health plans, all healthcare clearinghouses and healthcare providers that transmit health

information in an electronic form in connection with HIPAA standard transactions. Our facilities are subject to the HIPAA privacy regulations. The privacy standards apply to individually identifiable information held or disclosed by a covered entity in any form, whether communicated electronically, on paper or orally. These standards impose extensive administrative requirements on us, require our compliance with rules governing the use and disclosure of this health information, and require us to impose these rules, by contract, on any business associate to whom we disclose such information in order to perform functions on our behalf. They also create rights for patients in their health information, such as the right to amend their health information. In addition, our facilities will continue to remain subject to any state laws that are more restrictive than the privacy regulations issued under HIPAA.

We also are subject to the HIPAA security regulations that are designed to protect the confidentiality, availability and integrity of health information. These security standards require us to establish and maintain reasonable and appropriate administrative, technical and physical safeguards to ensure the integrity, confidentiality and the availability of electronic health and related financial information. We believe that we are in material compliance with the privacy and security requirements of HIPAA.

The HITECH Act also creates a federal breach notification law that mirrors protections that many states have passed in recent years. This law requires us to notify patients of any unauthorized access, acquisition, or disclosure of their unsecured protected health information that poses significant risk of financial, reputational or other harm to a patient. In addition, a new breach notification requirement was established requiring reporting of certain unauthorized access, acquisition, or disclosure of unsecured protected health information that poses significant risk of financial, reputational or other harm to a patient to the Secretary of HHS and, in some cases, local media outlets. In 2009, HHS issued regulations implementing certain of the requirements of the HITECH Act, including the breach notification requirements providing obligations for compiling and reporting of certain information relating to breaches by providers and their business associates (the ''Interim Final Breach Rule''), effective September 23, 2009. HHS subsequently promulgated and withdrew a final breach notification rule for review, but it intends to publish a final data breach rule in the coming months. Until such time as a new final breach rule is issued, the Interim Final Breach Rule remains in effect. In addition, our facilities remain subject to any state laws that relate to the reporting of data breaches that are more restrictive than the regulations issued under HIPAA and the requirements of the HITECH Act.

On July 14, 2010, HHS issued a notice of proposed rulemaking to modify the HIPAA privacy, security and enforcement regulations. These changes may require substantial operational changes for HIPAA covered entities and their business associates, including, in part, new requirements for business associate agreements and a transition period for compliance, new limits on the use and disclosure of health information for marketing and fundraising, enhanced individuals' rights to obtain electronic copies of their medical records and restricted disclosure of certain information, new requirements for notices of privacy practices, modified restrictions on authorizations for the use of health information for research, and new changes to the HIPAA enforcement regulations. HHS has not yet released the final version of these rules, and, as a result, we cannot quantify the financial impact of compliance with these new regulations. We could, however, incur expenses associated with such compliance.

Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties. The HITECH Act significantly increased the penalties for violations by introducing a tiered penalty system, with penalties of up to $50,000 per violation with a maximum civil penalty of $1.5 million in a calendar year for violations of the same requirement. The HITECH Act also extended the application of certain provisions of the security and privacy regulations to business associates and subjects business associates to civil and criminal penalties for violation of the regulations. Under the HITECH Act, HHS is required to conduct periodic compliance audits of covered entities and their business associates. The Secretary of HHS issued an interim final rule conforming HIPAA's enforcement regulations to the HITECH Act's statutory revisions (the ''Interim Final Enforcement Rule''). This interim final rule also set forth guidance on, among other things, how the tiered penalty structure will reflect increasing levels of culpability and provides a prohibition on the imposition of penalties for any violation that is corrected within a 30-day time period, as long as the violation was not due to willful neglect. This interim final rule became effective on November 30, 2009. The applicable state laws regulating the privacy of patient health information could impose additional penalties.

On January 17, 2013, HHS issued a final HIPAA omnibus rule (the "Final HIPAA Rule") that modified the privacy and security regulations, the Interim Final Breach Rule and the Interim Final Enforcement Rule. Our facilities must comply with the applicable requirements of the Final HIPAA Rule by September 23, 2013. The Final HIPAA Rule modifications include: making our facilities' business associates directly liable for compliance with certain of the privacy and security rules' requirements; making our facilities' liable for violations by their business associates if HHS determines an agency relationship exists between the facility and the business associate under federal agency law; adding limitations on the use and disclosure of health information for marketing and fundraising purposes, and prohibiting the sale of health information without individual authorization; expanding our patients' rights to receive electronic copies of their health information and to restrict disclosures to a health plan concerning treatment for which our patient has paid out of pocket in full; requiring modifications to, and redistribution of, our facilities' notice of privacy practices; rules addressing enforcement of noncompliance with HIPAA due to willful neglect; an increased and tiered civil money penalty structure; and modifications to the Interim Final Breach Notification Rule that replace the "risk of harm" standard with a "low probability of compromise" standard, which would require our facilities to prepare a four factor risk assessment for impermissible uses and disclosures of health information. We cannot predict the financial impact to our hospitals in implementing the provisions of the Final HIPAA Rule.

The HITECH Act also authorizes State Attorneys General to bring civil actions seeking either an injunction or damages in response to violations of HIPAA privacy and security regulations or the new data breach law that affects the privacy of their state residents. We expect vigorous enforcement of the HITECH Act's requirements by HHS and State Attorneys General. Additional final rules relating to the HITECH Act, HIPAA enforcement and breach notification are expected to be published in the near future. Additionally, HHS announced a pilot audit program that will run until December 2012 in the first phase of HHS implementation of the HITECH Act's requirements of periodic audits of covered entities and business associates to ensure their compliance with the HIPAA privacy and security regulations. We cannot predict whether our hospitals will be able to comply with the final rules or the financial impact to our hospitals in implementing the requirements under the final rules if and when they take effect, or whether our hospitals will be selected for an audit and the results of such an audit.

***Red Flags Rule***

In addition, the Federal Trade Commission (''FTC'') issued a final rule, known as the Red Flags Rule, in October 2007 requiring financial institutions and businesses that maintain accounts that permit multiple payments for primarily individual purposes. The Red Flag Program Clarification Act of 2010, signed on December 18, 2010, appears to exclude certain healthcare providers from the Red Flags Rule, but permits the FTC or relevant agencies to designate additional creditors subject to the Red Flags Rule through future rulemaking if the agencies determine that the person in question maintains accounts subject to foreseeable risk of identity theft. Compliance with any such future rulemaking may require additional expenditures in the future.

***Corporate Practice of Medicine and Fee-Splitting***

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

***Certificates of Need***

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and expensive equipment at our facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of the new

equipment or services and allow competing healthcare providers to challenge the need for the facility, service or equipment. We operate hospitals in twelve states that have adopted certificate of need laws — Alabama, Florida, Georgia, Kentucky, Louisiana, Michigan, Mississippi, Nevada, North Carolina, Tennessee, Virginia and West Virginia. 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. All other states in which we operate do not require a certificate of need prior to the initiation of new healthcare services. In these other states, our facilities are subject to competition from other providers who may choose to enter the market by developing new facilities or services.

***Not-for-Profit Hospital Conversion Legislation***

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

***State Hospital Rate-Setting Activity***

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

***Medical Malpractice Tort Law Reform***

Medical malpractice tort law has historically been maintained at the state level. All states have laws governing medical liability lawsuits. Over half of the states have limits on damages awards. Almost all states have eliminated joint and several liability in malpractice lawsuits, and many states have established limits on attorney fees. Recently, many states had bills introduced in their legislative sessions to address medical malpractice tort reform. Proposed solutions include enacting limits on non-economic damages, malpractice insurance reform, and gathering lawsuit claims data from malpractice insurance companies and the courts for the purpose of assessing the connection between malpractice settlements and premium rates. Reform legislation has also been proposed, but not adopted, at the federal level that could preempt additional state legislation in this area.

***Environmental Regulation***

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

**Regulatory Compliance Program**

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

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

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

**Risk Management and Insurance**

We retain a substantial portion of our professional and general liability risks through a self insurance retention (''SIR'') insurance program administered in-house by our risk and insurance department with assistance from our insurance brokers. At December 31, 2012, our SIR is $5.0 million per claim. Our SIR level is evaluated annually as a part of our insurance program's renewal process. We maintain professional and general liability insurance with unrelated commercial insurance carriers to provide for losses in excess of the SIR.

Our workers' compensation program has a $1.0 million deductible for each loss in all states except for Wyoming. Workers' compensation in Wyoming operates under a state specific program.

We also maintain directors' and officers', property and other types of insurance coverage with unrelated commercial carriers. Our directors' and officers' liability insurance coverage for current officers and directors is a program that protects us as well as the individual director or officer. We maintain property insurance through an unrelated commercial insurance company. We maintain large property insurance deductibles with respect to our facilities in coastal regions because of the high wind exposure and the related cost of such coverage. We have three locations that are considered a high exposure to named-storm risk and carry a deductible of 3% of their respective property values.

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

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

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

***We cannot predict the effect that the Affordable Care Act and its implementation may have on our business, financial condition or results of operations.***

The Affordable Care Act was signed into law, in two parts, on March 23, 2010 and March 30, 2010. The Affordable Care Act dramatically alters the U.S. healthcare system and is intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicare and Medicaid eligibility, reducing Medicare and Medicaid DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, and instituting certain private health insurance reforms. Although a majority of the measures contained in the Affordable Care Act do not take effect until 2013 and 2014, certain of the reductions in Medicare spending, such as negative adjustments to the Medicare hospital inpatient and outpatient prospective payment system market basket updates and the incorporation of productivity adjustments to the Medicare program's annual inflation updates, became effective in 2010, 2011 and 2012. Although the expansion of health insurance coverage should increase revenues from providing care to certain previously uninsured individuals, many of these provisions of the Affordable Care Act will not become effective until 2014 or later, and the impact of such expansion may be gradual and may not offset scheduled decreases in reimbursement.

On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of the Affordable Care Act, including the ''individual mandate'' provisions of the Affordable Care Act that generally require all individuals to obtain healthcare insurance or pay a penalty. However, the U.S. Supreme Court also held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. In response to the ruling, a number of U.S. governors, including those of some states in which we operate, have stated that they oppose their state's participation in the expanded Medicaid program, which could result in the Affordable Care Act not providing coverage to some low-income persons in those states. In addition, several bills have been and may continue to be introduced in Congress to repeal or amend all or significant provisions of the Affordable Care Act.

The Affordable Care Act changes how healthcare services are covered, delivered, and reimbursed. The net effect of the Affordable Care Act on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, gradual and potentially delayed implementation or possible amendment, as well as the uncertainty as to the extent to which states will choose to participate in the expanded Medicaid program. As a result, we are unable to predict the net effect on our business, financial condition or results of operations of the expected increases in insured individuals using our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions of the Affordable Care Act that may affect us. We are also unable to predict how providers, payors, employers and other market participants will respond to the various reform provisions because many provisions will not be implemented for several years under the Affordable Care Act's implementation schedule. Further, we are unable to predict the outcome of new or remaining court challenges and the impact of continued legislative efforts to delay implementation of or amend the Affordable Care Act.

***Our revenues will decline if federal or state programs reduce our Medicare or Medicaid payments or if managed care companies reduce reimbursement amounts. In addition, the financial condition of payors and healthcare cost containment initiatives may limit our revenues and profitability.***

In 2012, we derived 48.9% of our revenues from the Medicare and Medicaid programs, collectively. The Medicare and Medicaid programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements and requirements for utilization review, among other things, and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the timing of payments to our facilities.

We are unable to predict the effect of future government healthcare funding policy changes on our operations. If the rates paid by governmental payors are reduced, if the scope of services covered by governmental payors is limited or if we or one or more of our hospitals are excluded from participation in the Medicare or Medicaid program or any other government healthcare program, there could be a material adverse effect on our business, financial condition, results of operations or cash flows. In addition, revenues from HMOs, PPOs and other private payors are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services.

During the past several years, healthcare payors, such as federal and state governments, insurance companies and employers, have undertaken initiatives to revise payment methodologies and monitor healthcare costs. As part of their efforts to contain healthcare costs, payors increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk related to paying for care provided, often in exchange for exclusive or preferred participation in their benefit plans. Similarly, many individuals and employers have attempted to reduce their healthcare costs by moving to private payor plans that reimburse our facilities at significantly lower rate than other competing private payors. We expect efforts to impose greater discounts and more stringent cost controls by government and private payors to continue, thereby reducing the payments we receive for our services. In addition, payors have instituted policies and procedures to substantially reduce or limit the use of inpatient services. For example, CMS has transitioned to full implementation of the MS-DRG system, which represents a refinement to the existing diagnosis-related group system. Future realignments in the MS-DRG system could impact the margins we receive for certain services. Furthermore, the Affordable Care Act, the Tax Relief Act and the ATRA provide for material reductions in the growth of Medicare program spending, including reductions in Medicare market basket updates, and Medicare DSH funding.

All of our hospitals are certified as providers of Medicaid services. Medicaid programs are jointly funded by federal and state governments and are administered by states under an approved plan that provides hospital and other healthcare benefits to qualifying individuals who are unable to afford care. A number of states, however, are experiencing budget problems and have adopted or are considering legislation designed to reduce their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs and imposing additional taxes on hospitals to help finance or expand such states' Medicaid systems. It is possible that budgetary pressures will force states to resort to some of the cost saving measures mentioned above. These efforts could have a material adverse effect on our business, financial condition, results of operations or cash flows.

***Changes to Medicaid supplemental payment programs may materially and adversely affect our revenues and profitability.***

Medicaid supplemental payments (''MSPs'') are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. The two most prevalent forms of MSPs are DSH and Upper Payment Limit (''UPL'') payments. 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 DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law. Unlike DSH, 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. Most states create a UPL

program to help offset the shortfall caused when the state funds inpatient and outpatient Medicaid hospital rates at levels that do not cover the hospitals' costs for treating Medicaid patients.

Both DSH and UPL 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 health care related taxes (''Provider Taxes''). Provider Taxes are imposed by states in the form of a licensing fee, assessment or other mandatory payment which are related to: (i) healthcare items or services; (ii) the provision of, or the authority to provide, health care items or services; or (iii) the payment for health care items or services.

Pursuant to the Affordable Care Act, funding for Medicaid DSH programs is to be significantly reduced beginning in 2014. Because of the U.S. Supreme Court decision that states are not required to expand Medicaid programs, the reduction in Medicaid DSH payments may take place without a coupled increase in the Medicaid eligible population, potentially increasing the amount of uncompensated care we provide.

UPL programs have expanded in recent years and related MSPs to our hospitals have similarly increased as states use UPL programs as a way to avoid or mitigate reimbursement cuts to providers. There are several factors that could adversely affect a state's UPL program and the UPL MSPs hospitals receive. In calculating a state's UPL, only services utilized by Medicaid beneficiaries paid on a fee-for-service basis may be counted. Services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, and as many states increase the use of managed care Medicaid programs UPL MSPs could be reduced. In addition, state UPL funding, and matching federal funds, may be reduced if local governmental units are unable to (or simply decide not to) sustain historical funding levels or if Provider Taxes, which are currently subject to various federal regulations, are limited or eliminated by legislative or regulatory action.

For example, one of our hospitals, Memorial Medical Center of Las Cruces, New Mexico (''MMC''), received approximately $34.0 million during 2012 under the New Mexico Sole Community Provider Program (the ''SCPP''), a UPL MSP program. There is a general concern in New Mexico that the SCPP cannot be sustained at current funding levels as a result of budget concerns and other factors. It seems likely, as a result, that the SCPP will soon be reconfigured. We are not able to predict what changes may be made to the SCPP, but any change in the SCPP is likely to reduce payments made to MMC.

Reductions in MSP programs at MMC or other facilities could have a material adverse effect on our financial position or results of operations.

***Spending cuts resulting from the Budget Control Act of 2011 may have a material adverse effect on our financial position, results of operations or cash flow.***

On August 2, 2011, the Budget Control Act of 2011, or BCA, was enacted. The BCA increased the nation's debt ceiling while taking steps to reduce the federal deficit. The deficit reduction component was implemented in two phases. In the first phase, the BCA imposed caps that reduced discretionary (non-entitlement) spending by more than $900 billion over 10 years, beginning in FFY 2012. Second, a bipartisan Congressional Joint Select Committee on Deficit Reduction (the ''Committee'') was charged with identifying at least $1.5 trillion in deficit reduction, which could include entitlement provisions like Medicare reimbursement to providers. On November 21, 2011, the Committee announced that its members were unable to agree on any measures to reduce the deficit, and as a result, $1.2 trillion in across-the-board spending reductions required by the BCA are scheduled to be imposed automatically for FFY 2013 through 2021, split evenly between domestic and defense spending. Certain programs (including the Medicaid program) are protected from these automatic spending reductions. While provider payments under the Medicare program would be subject to reduction under this enforcement mechanism, those reductions would be capped at 2%. On January 1, 2013, the ATRA delayed the imposition of the BCA's automatic spending reductions from January 2, 2013 to March 1, 2013. These automatic spending cuts or Congressional action on other spending cuts may reduce the revenues we receive from governmental payment programs or impose additional restrictions on those programs, which may have a material adverse effect on our financial position, results of operations or cash flow. We cannot predict whether these cuts will be imposed on March 1, 2013 or if they will be averted by future legislative action.

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

All participants in the healthcare industry are required to comply with many 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 hospitals' relationships with physicians and other referral sources, the adequacy and quality of medical care, inpatient admission criteria, privacy and security of health information, standards for equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, compliance with building codes and environmental protection, among other matters. Many of the laws and regulations applicable to the healthcare industry are complex, and there are numerous enforcement authorities, including CMS, OIG, State Attorneys General, and contracted auditors, as well as whistleblowers. Some positions taken in connection with enforcement appear to be inconsistent with historical common practices within the industry but have not previously been challenged. Moreover, as a result of the provisions of the Affordable Care Act that created potential False Claims Act liabilities for failing to report and repay known overpayments and return an overpayment within sixty (60) days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later, hospitals and other healthcare providers are encouraged to disclose potential violations of law.

The healthcare industry has seen a number of investigations by state and federal enforcement authorities related to patient referrals, cost reporting and billing practices. For example, our hospital, Jackson Purchase Medical Center in Mayfield, Kentucky, entered into a five-year Corporate Integrity Agreement with the OIG on June 27, 2011 following an investigation of certain billing practices. This investigation was initiated after a Medicare beneficiary made a complaint to an Assistant U.S. Attorney. With an increased public emphasis on enforcement being made by state and federal agencies, including changes in laws that encourage and facilitate whistleblowers to make complaints, we anticipate that hospitals and healthcare providers, including those owned by the Company, will face an increased number of governmental inquiries arising out of complaints made by program beneficiaries or other individuals.

Hospitals continue to be one of the primary focal areas of the OIG and other governmental fraud and abuse programs. In January 2005, the OIG issued Supplemental Compliance Program Guidance for Hospitals that focuses on hospital compliance risk areas. Some of the risk areas highlighted by the OIG include correct outpatient procedure coding, revising admission and discharge policies to reflect current CMS rules, submitting appropriate claims for supplemental payments such as pass-through costs and outlier payments and a general discussion of the fraud and abuse risks related to financial relationships with referral sources. Each FFY, the OIG also publishes a General Work Plan that provides a brief description of the activities that the OIG plans to initiate or continue with respect to the programs and operations of HHS and details the areas that the OIG believes are prone to fraud and abuse.

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

Finally, we are subject to various federal, state and local statutes and ordinances regulating the discharge of materials into the environment. 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. Our operations are also subject to various other environmental laws, rules and regulations. Environmental regulations also may apply when we renovate or refurbish hospitals, particularly older facilities.

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

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare for payment for our services. These post-payment reviews are increasing as a result of government cost-containment initiatives, including enhanced medical necessity reviews for Medicare patients admitted as inpatients to general acute care hospitals for certain procedures (e.g., cardiovascular procedures) and audits of Medicare claims under the RAC programs. RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those Medicare claims most likely to contain overpayments, such as incorrectly coded services, short stays, incorrect payment amounts, non-covered services and duplicate payments. The claims review strategies used by the RACs generally include a review of high dollar claims, including inpatient hospital claims. As a result, a large majority of the total amounts recovered by RACs has come from hospitals. In addition, CMS has announced a pre-payment demonstration project that will allow RACs to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. Under the demonstration project, RACs conduct prepayment reviews on certain types of claims that historically result in high rates of improper payments, beginning with those involving short stay inpatient hospital services. These reviews will focus on certain states with high populations of fraud and error-prone providers (including the states of Florida, Michigan, Texas and Louisiana in which we operate) and other states (including the state of North Carolina in which we operate) with high claims volumes of short inpatient hospital stays. The demonstration project began on August 27, 2012 and will run for a three year period.

The Affordable Care Act expanded the RAC program's scope to include managed Medicare and to include Medicaid claims, and all states are now required to establish programs to contract with RACs. In addition, CMS employs Medicaid Integrity Contractors (''MICs'') to perform post-payment audits of Medicaid claims and identify overpayments. The Affordable Care Act increases federal funding for the MIC program for FFY 2011 and later years. In addition to RACs and MICs, the state Medicaid agencies and other contractors have also increased their review activities. Any such audit or investigation could have a material adverse effect on the results of our operations.

***We may continue to see the growth of uninsured and "patient due" accounts, and deterioration in the collectability of these accounts could adversely affect our collections of accounts receivable, revenues, results of operations and cash flows.***

The primary collection risks associated with our accounts receivable relate to the uninsured patient accounts and patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and co-payments) remain outstanding. The provision for doubtful accounts relates primarily to amounts due directly from patients. This risk has increased, and will likely continue to increase, as more individuals enroll in high deductible insurance plans or those with high co-payments or who have no insurance coverage. These trends will likely be exacerbated if general economic conditions remain challenging or if unemployment levels in the communities in which we operate rise. As unemployment rates increase, our business strategies to generate organic growth and to improve admissions and adjusted admissions at our hospitals could become more difficult to accomplish.

The amount of our provision for doubtful accounts is based on our assessments of historical collection trends, business and economic conditions, trends in federal and state governmental and private employer health coverage and other collection indicators. A continuation in trends that results in increasing 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 cash flows. As enacted, the Affordable Care Act seeks to decrease, over time, the number of uninsured individuals. Among other things, the Affordable Care Act will, beginning in 2014, incentivize states to expand their Medicaid eligibility requirements and incentivize employers to offer, and require individuals to carry, health insurance or be subject to penalties. However, it is difficult to predict the full impact of the Affordable Care Act due to its complexity, lack of implementing regulations and interpretive guidance, gradual and potentially delayed implementation, and possible amendment, as well as our inability to foresee how individuals, businesses and states will respond to the choices afforded them by the Affordable Care Act. In addition, even after implementation of the Affordable Care Act, we may continue to experience bad debts and be required to

provide uninsured discounts and charity care for undocumented aliens who are not permitted to enroll in a health insurance exchange or government healthcare programs.

***Controls designed to reduce inpatient services may reduce our revenues.***

Controls imposed by Medicare, Medicaid, and commercial third-party payors designed to reduce admissions and lengths of stay, commonly referred to as ''utilization review,'' have affected and are expected to continue to affect our facilities. Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by quality improvement organizations, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. Quality improvement organizations may deny payment for services or assess fines and also have the authority to recommend to HHS that a provider which is in substantial noncompliance with the standards of the quality improvement organization be excluded from participation in the Medicare program. The Affordable Care Act potentially expands the use of prepayment review by Medicare contractors by eliminating statutory restrictions on their use, and, as a result, efforts to impose more stringent cost controls are expected to continue. Utilization review is also a requirement of most non-governmental managed care organizations and other third-party payors. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payor-required preadmission authorization and utilization review and by third party payor pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Although we are unable to predict the effect these controls and changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

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

The federal False Claims Act prohibits providers from, among other things, knowingly submitting false claims for payment to the federal government. The ''qui tam'' or ''whistleblower'' provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of ''whistleblower'' lawsuits that have been filed against providers has increased significantly in recent years. Defendants found to be liable under the federal False Claims Act may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties ranging between $5,500 and $11,000 for each separate false claim.

There are many potential bases for liability under the False Claims Act. The government has 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. The Affordable Care Act also provides 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 federal False Claims Act, and 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. We are required to provide information to our employees and certain contractors about state and federal false claims laws and whistleblower provisions and protections.

Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state fraud and abuse 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 not be subject to government scrutiny or be found to be in compliance with applicable fraud and abuse laws.

***The industry trend towards value-based purchasing may negatively impact our revenues.***

There is a trend in the healthcare industry toward value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events. Many large commercial payors currently require hospitals to report quality data, and several commercial payors do not reimburse hospitals for certain preventable adverse events.

The Affordable Care Act contains a number of provisions intended to promote value-based purchasing. Effective July 1, 2011, the Affordable Care Act prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. Beginning in FFY 2015, hospitals that fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. Another provision reduces payments for all inpatient discharges for hospitals that experience excessive readmissions for certain conditions designated by HHS.

The Affordable Care Act also requires HHS to implement a value-based purchasing program for inpatient hospital services. The Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1% in FFY 2013 and increasing by 0.25% each fiscal year up to 2% in FFY 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our revenues.

***The lingering effects of the economic recession could materially adversely affect our financial position, results of operations or cash flows.***

The U.S. economy continues to experience the negative effects from an economic recession, and unemployment levels remain high. While certain healthcare spending is considered non-discretionary and may not be significantly impacted by economic downturns, other types of healthcare spending may be adversely impacted by such conditions. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose:

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

We are unable to determine the specific impact of these economic conditions on our business at this time, but we believe that the lingering effects of the economic recession could have an adverse impact on our operations and could impact not only the healthcare decisions of our patients, but also the solvency of managed care providers and other counterparties to transactions with us.

***The failure of certain employers, or the closure of certain manufacturing and other facilities in our markets, can have a disproportionate impact on our hospitals.***

The economies in the non-urban communities in which our hospitals primarily operate are often dependent on a small number of large employers, especially manufacturing or other facilities. These employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our hospitals for care. The failure of one or more large employers, or the closure or substantial reduction in the number of individuals employed at manufacturing or other facilities

located in or near many of the non-urban communities in which our hospitals primarily operate, could cause affected employees to move elsewhere for employment or lose insurance coverage that was otherwise available to them. The occurrence of these events may cause a material reduction in our revenues and results of operations or impede our business strategies intended to generate organic growth and improve operating results at our hospitals.

***We may have difficulty acquiring hospitals on favorable terms.***

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

Given the increasingly challenging regulatory and enforcement environment, our ability to acquire hospitals could be negatively impacted if targets are found to have material unresolved compliance issues. We may condition our purchase on the resolution of such issues by reporting or refunding amounts under the voluntary self-disclosure protocols. We could experience delays in closing or fail to close transactions with targets that initially were attractive but became unattractive as a result of a poor compliance program, material non-compliance with laws or failure to timely address compliance risks.

The cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired hospital's results of operations, allocation of purchase price, effects of subsequent legislation and limitations on rate increases. In the past, we have occasionally experienced temporary delays in improving the operating margins or effectively integrating the operations of our acquired hospitals. In the future, if we are unable to improve the operating margins of acquired hospitals, operate them profitably or effectively integrate their operations, we may be unable to achieve our growth strategy.

Even if we are able to identify an attractive target, we may not be able to obtain financing, if necessary, for any acquisitions or joint ventures that we might make or may be required to borrow at higher rates and on less favorable terms. We may incur or assume additional indebtedness as a result of acquisitions. Our failure to acquire non-urban hospitals consistent with our growth plans could prevent us from increasing our revenues.

In recent years, the legislatures and attorneys general of several states have become more interested in sales of hospitals by tax-exempt entities. This heightened scrutiny may increase the cost and difficulty, or prevent the completion, of transactions with tax-exempt organizations in the future.

***We may encounter difficulty operating, integrating and improving financial performance at acquired hospitals.***

We may be unable to timely and effectively integrate any hospitals that we acquire with our ongoing operations. We may experience delays in implementing operating procedures and systems in newly acquired hospitals. Integrating an acquired hospital could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel. In addition, acquisition activity requires transitions from, and the integration of, operations and, usually, information systems that are used by acquired hospitals. We will rely heavily on HCA-IT and other third parties for information systems integration as part of a contractual arrangement for information technology services. We may not be successful in causing HCA-IT and other third parties to convert our newly acquired hospitals' information systems in a timely manner. In addition, we may not be able to achieve improved financial performance at acquired hospitals within our targeted time frames, or continue to improve financial performance for sustained periods following the acquisition.

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

As a general matter, only physicians on our medical staffs may direct hospital admissions and the services ordered once a patient is admitted to a hospital. As a result, the success of our hospitals depends in part on the number and quality of the physicians on the medical staffs of our hospitals, the admitting practices of those physicians and maintaining good relations with those physicians.

The success of our efforts to recruit and retain quality physicians depends on several factors, including the actual and perceived quality of services provided by our hospitals, our ability to meet demands for new technology and our ability to identify and communicate with physicians who want to practice in non-urban communities. In particular, we face intense competition in the recruitment and retention of specialists because of the difficulty in convincing these individuals of the benefits of practicing or remaining in practice in non-urban communities. If the non-urban communities in which our hospitals primarily operate are not seen as attractive, then we could experience difficulty attracting and retaining physicians to practice in our communities. We may not be able to recruit all of the physicians we target. In addition, we may incur increased malpractice expense if the quality of physicians we recruit does not meet our expectations.

Additionally, our ability to recruit physicians is closely regulated. For example, the types, amount and duration of assistance we can provide to recruited physicians are limited by the Stark law, the Anti-kickback Statute, state anti-kickback statutes, and related regulations. For example, 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. In addition to these legal requirements, there is competition from other communities and facilities for these physicians, and this competition continues after the physician is practicing in one of our communities.

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

In recent years, physician payment amounts have been determined on a year by year basis. For CY 2013, CMS issued a final rule that would have applied the SGR and resulted in an aggregate reduction of 26.5% to all physician payments under the PFS for CY 2013. The ATRA delayed application of the SGR until January 1, 2014. At this time, it is unclear whether Congress will enact legislation that would permanently prevent the SGR reductions to PFS rates. Therefore, we cannot predict the impact this may have on our Medicare revenues past 2013. We believe that physician employment by acute care hospitals has become more common as a result of actual and potential reductions in payment amounts for physician services. Our experience in employing physicians is consistent with industry trends. Employed physicians could present more direct risks to us than those presented by independent members of our hospitals' medical staffs, as well as require us to incur additional expenses. The combination of reimbursement cuts, potential liabilities and increased expenses could have an adverse effect on our results of operations if current trends continue.

***Our hospitals face competition for staffing, which may increase labor costs and reduce profitability.***

In addition to our physicians, the operations of our hospitals are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians. We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including nurses and other non-physician healthcare professionals. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue. 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 or contract personnel. In addition, the states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. If our labor costs increase, we may not be able to raise rates to offset these increased costs. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Because a significant

percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs could have a material adverse effect on our financial condition or results of operations.

***The loss of certain physicians can have a disproportionate impact on certain of our hospitals.***

Generally, the top ten 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.

***If our access to licensed information systems is interrupted or restricted, or if we are not able to integrate changes to our existing information systems or information systems of acquired hospitals, our operations could suffer.***

Our business depends significantly on effective information systems to process clinical and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems in order to keep pace with continuing changes in information processing technology. We rely heavily on HCA-Information Technology and Services, Inc., (''HCA-IT''), for information systems. HCA-IT provides us with financial, clinical, patient accounting and network information services. HCA's primary business is to own and operate hospitals, not to provide information systems. We do not control HCA-IT's systems. If these systems fail or are interrupted, if our access to these systems is limited in the future or if HCA-IT develops systems more appropriate for the urban healthcare market and not suited for our hospitals, our operations could suffer. Our existing contract with HCA-IT, expires on December 31, 2021 (including a wind-down period) unless extended by the parties.

System conversions are costly, time consuming and disruptive for physicians and employees. Some of our hospitals have recently converted or are currently converting from the system provided by HCA-IT to another third party information system. Implementation of such conversions are very costly and, if such conversions occurred on a large scale, could have a material adverse effect on our business, financial condition, results of operations or cash flows.

In addition, as new information systems are developed in the future, we will need to integrate them into our existing systems. Evolving industry and regulatory standards, such as HIPAA and meaningful use regulations, may require changes to our information systems in the future. We may not be able to integrate new systems or changes required to our existing systems or systems of acquired hospitals in the future effectively or on a cost-efficient basis.

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

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

Arrangements with third party service providers may make our operations vulnerable if vendors fail to satisfy their obligations to us as a result of their performance, changes in their own operations, financial condition, or other matters outside of our control. 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, in order to realize the potential productivity and operational efficiencies. Effective management, development and implementation of our outsourcing strategies are important to our business and strategy. If there are delays or difficulties in enhancing business processes or our third party providers do not perform as anticipated, we may not fully realize on a timely basis the anticipated economic and other benefits of the outsourcing projects or other relationships we enter into with key vendors, which could result in substantial costs, divert management's attention from other strategic activities, negatively affect employee morale or create other operational or financial problems for us.

Terminating or transitioning arrangements with key vendors could result in additional costs and a risk of operational delays, potential errors and possible control issues as a result of the termination or during the transition phase.

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

As required by ARRA, the Secretary of HHS has developed and implemented an incentive payment program for eligible hospitals and healthcare professionals that adopt and meaningfully use electronic health record (''EHR'') technology. HHS uses the Provider Enrollment, Chain and Ownership System (''PECOS'') to verify Medicare enrollment prior to making EHR incentive program payments. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, including having an enrollment record in PECOS, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. Further, beginning in FFY 2015, eligible hospitals and professionals that fail to demonstrate meaningful use of certified EHR technology will be subject to reduced payments from Medicare. System conversions to comply with EHR could be time consuming and disruptive for physicians and employees. Failure to implement EHR systems effectively and in a timely manner could have a material adverse effect on our financial position and results of operations.

We are in process of converting certain of our clinical and patient accounting information system applications to newer versions of existing applications or all together new applications at several of our facilities. In connection with our implementations and conversions, we have incurred significant capitalized costs and additional training and implementation expenses. In addition, EHR incentive payments previously recognized are subject to audit and potential recoupment if it is determined that we did not meet the applicable meaningful use standards required in connection with such incentive payments.

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

There are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access to or theft of personal information. In the ordinary course of our business, we, and vendors on our behalf, collect and store sensitive data, including personal health data and other personally identifiable information of our patients. The secure processing, maintenance and transmission of this information are critical to our operations and business strategy. We have developed a comprehensive set of policies and procedures in our efforts to comply with HIPAA and other privacy laws. The HHS Office for Civil Rights has imposed civil monetary penalties and corrective action plans on covered entities for violating HIPAA's privacy rule. If, in spite of our compliance efforts we were to experience a breach, loss, or other compromise of such personal health information, such event could disrupt our operations, damage our reputation, result in regulatory penalties, legal claims and liability under HIPAA and other state and federal laws, which could have a material adverse effect on our business, financial condition and results of operations.

***If we acquire hospitals with unknown or contingent liabilities, we could become liable for material obligations.***

Businesses we have acquired, or businesses we may acquire may have unknown or contingent liabilities for past activities of acquired businesses, including liabilities for failure to comply with healthcare laws and regulations, medical and general professional liabilities, worker's compensation liabilities, previous tax liabilities and unacceptable business practices. Although we endeavor to continue to obtain contractual indemnification from sellers covering these matters, any indemnification obtained from sellers may be insufficient to cover material claims or liabilities for past activities of acquired businesses.

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

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

Quality of care and value-based purchasing have also become significant trends and competitive factors in the healthcare industry. In 2005, CMS began making public performance data relating to ten quality measures that hospitals submit in connection with their Medicare reimbursement. Since that time, CMS has on several occasions increased the number of quality measures hospitals are required to report in order to receive the full IPPS and OPPS market basket updates. In addition, the Medicare program no longer reimburses hospitals for care relating to certain preventable adverse events, and many private healthcare payors have adopted similar policies. If the public performance data become a primary factor in where patients choose to receive care, and if competing hospitals have better results than our hospitals on those measures, we would expect that our patient volumes could decline.

We also face very significant and increasing competition from services offered by physicians (including physicians on our medical staffs) in their offices and from other specialized care providers, including outpatient surgery, oncology, physical therapy and diagnostic centers (including many in which physicians may have an ownership interest). Some of our hospitals have and will seek to develop outpatient facilities where necessary to compete effectively. However, to the extent that other providers are successful in developing outpatient facilities or physicians are able to offer additional, advanced services in their offices, our market share for these services will likely decrease in the future.

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

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

| | Hospitals in State as of December 31, 2012 | Revenue Concentration by State | | | | | |
|---|---|---|---|---|---|---|---|
| | | 2012 | | 2011 | | 2010 | |
| | | Amount | % of Revenues | Amount | % of Revenues | Amount | % of Revenues |
| Kentucky | 9 | $510.9 | 15.1% | $501.5 | 16.6% | $478.9 | 17.0% |
| Virginia | 5 | 413.6 | 12.2 | 369.0 | 12.2 | 345.4 | 12.3 |
| Tennessee | 11 | 375.3 | 11.1 | 345.1 | 11.4 | 257.5 | 9.1 |
| New Mexico | 2 | 299.6 | 8.8 | 291.3 | 9.6 | 277.1 | 9.8 |
| West Virginia | 2 | 266.2 | 7.8 | 252.1 | 8.3 | 246.2 | 8.7 |
| Louisiana | 5 | 206.1 | 6.1 | 195.4 | 6.5 | 177.8 | 6.3 |
| Arizona | 2 | 204.4 | 6.0 | 199.1 | 6.6 | 201.2 | 7.1 |
| Alabama | 5 | 165.5 | 4.9 | 178.2 | 5.9 | 187.3 | 6.6 |

Accordingly, any change in the current demographic, economic, competitive or regulatory conditions in the above-mentioned states or in Michigan, where we anticipate Marquette General will generate significant revenue, could have an adverse effect on our business, financial condition, results of operations and/or prospects. Medicaid changes in these states could also have a material adverse effect on our business, financial condition, results of operations or cash flows.

***If we do not continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets may be adversely affected.***

Technological advances, including with respect to computer-assisted tomography scanner (CTs), magnetic resonance imaging (MRIs) and positron emission tomography scanner (PETs) equipment, continue to evolve. In addition, the manufacturers of such equipment often provide incentives to try to increase their sales, including providing favorable financing to higher credit risk organizations. In an effort to compete, we must continually assess our equipment needs and upgrade our equipment as a result of technological improvements. We believe that the direction of the patient flow correlates directly to the level and intensity of such diagnostic equipment.

***We may be subject to liabilities because of malpractice and related legal claims brought against our hospitals or our employed physicians. If we become subject to these claims, we could be required to pay significant damages, which may not be covered by insurance.***

We may be subject to medical malpractice lawsuits and other legal actions arising out of the operations of our owned and leased hospitals and the activities of our employed physicians. These actions may involve large claims and significant defense costs. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement. Amounts we pay to settle any of these matters may be material. We maintain professional and general liability insurance with unrelated commercial insurance carriers to provide for losses in excess of our SIR amount. As a result, one or more successful claims against us that are within our SIR amounts could have an adverse effect on our results of operations, cash flows, financial condition or liquidity. Also, some of these claims could exceed the scope of the coverage in effect, or coverage of particular claims could be denied. In addition, we operate a wholly-owned captive insurance company under the name Point of Life Indemnity, Ltd., which, issues malpractice insurance policies to our employed physicians.

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

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

As of December 31, 2012, our consolidated debt, excluding the unamortized discount of convertible debt instruments, was approximately $1,739.3 million. We also have the ability to incur significant amounts of additional indebtedness, subject to the conditions imposed by the terms of our credit agreement and the agreements or indentures governing any additional indebtedness that we incur in the future. The term loan facility (the ‘‘Term Facility’’) and senior secured revolving credit facility (the ‘‘Revolving Facility’’) under our senior credit agreement with, among others, Citibank, N.A. (‘‘Citibank’’), as administrative agent, and the lenders party thereto (the ‘‘Senior Credit Agreement’’) matures on July 24, 2017 and provides for a $450.0 million Term Facility and a $350.0 million Revolving Facility. The Term Facility requires scheduled quarterly repayments in an amount equal to 2.5% per annum for each of the first, second and third years and 5.0% per annum for the fourth year and first three quarters of the fifth year, with the balance due at maturity. Additionally, the Term Facility is subject to mandatory prepayments based on excess cash flow, as well as upon the occurrence of certain other events, as specifically described in the Senior Credit Agreement.

As of December 31, 2012, we had outstanding borrowings of $85.0 million under the Revolving Facility for general purposes. Under the terms of the Senior Credit Agreement, amounts available for borrowing under the Revolving Facility were $235.2 million as of December 31, 2012.

The Senior Credit Agreement may, subject to certain conditions and to receipt of commitments from new or existing lenders, be increased up to a total of (i) $800.0 million and (ii) an amount such that, after giving pro forma effect to such increase and to the use of proceeds therefrom, our secured leverage ratio does not exceed 3.50:1.00; provided that no lender is obligated to participate in any such increase.

On February 6, 2013, we amended our Senior Credit Agreement pursuant to which we issued $325.0 million of incremental term loans (the ''Incremental Term Loans''). The proceeds of the Incremental Term Loans were used to repurchase $223.0 million of our 3¼% Convertible Senior Subordinated Debentures due August 15, 2025 (the ''3¼% Debentures''), plus accrued and unpaid interest, following the exercise by the holders thereof of their right to require us to repurchase the 3¼% Debentures on February 15, 2013, as well as to pay fees and expenses related to the issuance of the Incremental Term Loans. We currently intend, subject to market conditions, to redeem the remaining $2.0 million of the outstanding 3¼% Debentures with the proceeds of the Incremental Term Loans on or after February 20, 2013. We intend to use the remaining proceeds of the Incremental Term Loan for general corporate purposes.

Borrowings under the Incremental Term Loans initially bear interest at an adjusted 30-day London Interbank Offer Rate (''LIBOR'') plus an applicable margin of 2.50% per annum and mature on July 24, 2017. We may prepay the Incremental Term Loans at any time prior to the six-month anniversary of their issuance, subject to a 1.0% prepayment premium if such prepayment is made from proceeds of long-term bank debt financing having an effective interest rate or weighted average yield that is less than the interest rate for or weighted average yield of such Incremental Term Loans. We may prepay the Incremental Term Loans at any time after the six-month anniversary of their issuance without any prepayment premium.

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

- Under the Senior Credit Agreement, we are required to satisfy and maintain specified financial ratios and tests. Failure to comply with these obligations may cause an event of default which, if not cured or waived, could require us to repay substantial indebtedness immediately. Moreover, if debt repayment is accelerated, we will be subject to higher interest rates on our debt obligations as a result of these covenants, and our credit ratings may be adversely impacted.
- We may be vulnerable in the event of downturns and adverse changes in the general economy or our industry. Specific examples of industry changes that could have an adverse impact on our cash flow include the implementation by the government of further limitations on reimbursement under Medicare and Medicaid.
- We may have difficulty obtaining additional financing at favorable interest rates to meet our requirements for working capital, capital expenditures, acquisitions, general corporate or other purposes.
- We will be required to dedicate a substantial portion of our cash flow to the payment of principal and interest on indebtedness, which will reduce the amount of funds available for operations, capital expenditures and future acquisitions.
- Any borrowings we incur at variable interest rates expose us to increases in interest rates generally.
- A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. We may be required to pay our indebtedness immediately if we default on any of the numerous financial or other restrictive covenants contained in the debt agreements. It is not certain whether we will have, or will be able to obtain, sufficient funds to make these accelerated payments. If any senior debt is accelerated, our assets may not be sufficient to repay such indebtedness and our other indebtedness.

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

***Covenant restrictions under our senior secured credit facilities and our indenture will impose operating and financial restrictions on us and may limit our ability to operate our business and to make payments on the notes and other outstanding indebtedness. The exceptions to the covenants in our indenture may allow us to refinance subordinated indebtedness with senior indebtedness.***

The Senior Credit Agreement and indenture contain covenants that restrict our ability to finance future operations or capital needs, to take advantage of other business opportunities that may be in our interest or to satisfy our obligations under the notes. These covenants restrict our ability to, among other things:

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

The limitations in the Senior Credit Agreement, our indenture or other instruments governing indebtedness that we may incur in the future may restrict our ability to repay existing outstanding indebtedness. Subject to certain conditions, holders of the 3½% convertible senior subordinated notes due May 15, 2014 (the ''3½% Notes) and the 3¼% Debentures may convert their securities for cash, and if applicable, shares in common stock prior to the maturation of the notes offered hereby. Failure to repay the 3½% Notes or 3¼% Debentures upon maturity or upon conversion of the securities may result in a default.

On February 15, 2013, we repurchased $223.0 million of our 3¼% Debentures, plus accrued and unpaid interest, following the exercise by the holders thereof of their right to require us to repurchase the 3¼% Debentures on February 15, 2013 with the proceeds from our issuance of $325.0 million in Incremental Term Loans available for issuance under our Senior Credit Agreement. We currently intend, subject to market conditions, to redeem the remaining $2.0 million of the outstanding 3¼% Debentures with the proceeds of the Incremental Term Loans on or after February 20, 2013.

***Our revenues and volume trends may be adversely affected by certain factors over which we have no control.***

Our revenues and volume trends are dependent on many factors, including physicians' clinical decisions and availability, payor programs shifting to a more outpatient-based environment, whether or not certain services are offered, seasonal and severe weather conditions, including the effects of extreme low temperatures, hurricanes and tornados, earthquakes, current local economic and demographic changes, and the intensity and timing of yearly flu outbreaks. In addition, technological developments and pharmaceutical improvements may reduce the demand for healthcare services or the profitability of the services we offer.

***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, 2012, we had approximately $1,611.8 million of goodwill and approximately $2,030.9 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.

***Certificate of need laws and regulations regarding licenses, ownership and operation may impair our future expansion in some states.***

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

***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.***

In the seven states in which we operate that do not require certificates of need for the purchase, construction and expansion of healthcare facilities or services, competing healthcare providers face low barriers to entry and expansion. If competing providers of healthcare services are able to purchase, construct or expand healthcare facilities without the need for regulatory approval, we may face decreased market share and revenues in those markets.

***Different interpretations of accounting principles could have a material adverse effect on our results of operations or financial condition.***

Generally accepted accounting principles are complex, continually evolving and may be subject to varied interpretation by us, our independent registered public accounting firm and the SEC. Such varied interpretations could result from differing views related to specific facts and circumstances. Differences in interpretation of generally accepted accounting principles could have a material adverse effect on our results of operations or financial condition.

***Our stock price has been and may continue to be volatile; any significant decline may result in litigation.***

The trading price of our common stock has been and may continue to be subject to wide fluctuations. This may result in stockholder lawsuits, which could divert management's time away from operations and could result in higher legal fees and proxy costs.

Our stock price may fluctuate in response to the results or our operations and to a number of events and factors, including:

- actual or anticipated quarterly variations in operating results, particularly if they differ from investors' expectations;
- changes in financial estimates and recommendations by securities analysts;
- changes in government regulations including those relating to reimbursement and operational policies and procedures;
- the operating and stock price performance of other companies that investors may deem comparable;
- changes in overall economic factors in our markets;
- news reports relating to trends or events in our markets; and
- issues associated with integration of the hospitals that we acquire.

Broad market and industry fluctuations may adversely affect the price of our common stock, regardless of our operating performance.

As a result of the above factors, we could be subjected to potential stockholder lawsuits. Such lawsuits are time consuming and expensive. Among other things, such lawsuits divert management's time and attention from operations. Such lawsuits also force us to incur substantial legal fees and proxy costs in defending our position.

**Item 1B.** ***Unresolved Staff Comments.***

We have no unresolved SEC staff comments.

**Item 2.** ***Properties.***

The following table presents certain information with respect to our hospitals as of December 31, 2012:

| Hospital | City | Acquisition/Opening/ Lease Date | Licensed Beds | Real Property Status |
|---|---|---|---|---|
| **Alabama** | | | | |
| Andalusia Regional Hospital | Andalusia | HCA Spin-off[(a)] | 88 | Own |
| Lakeland Community Hospital | Haleyville | December 1, 2002 | 59 | Own |
| Northwest Medical Center | Winfield | December 1, 2002 | 71 | Own |
| Russellville Hospital | Russellville | October 3, 2002 | 100 | Own |
| Vaughan Regional Medical Center[(b)] | Selma | April 15, 2005 | 175 | Own[(b)] |
| **Arizona** | | | | |
| Havasu Regional Medical Center[(c)] | Lake Havasu City | April 15, 2005 | 181 | Own[(c)] |
| Valley View Medical Center | Fort Mohave | November 8, 2005 | 90 | Own |
| **Colorado** | | | | |
| Colorado Plains Medical Center | Fort Morgan | April 15, 2005 | 50 | Lease |
| **Florida** | | | | |
| Putnam Community Medical Center | Palatka | June 16, 2000 | 99 | Own |
| **Georgia** | | | | |
| Rockdale Medical Center | Conyers | February 1, 2009 | 146 | Own |
| **Kansas** | | | | |
| Western Plains Medical Complex | Dodge City | HCA Spin-off[(a)] | 99 | Own |
| **Kentucky** | | | | |
| Bluegrass Community Hospital | Versailles | January 2, 2001 | 25 | Own |
| Bourbon Community Hospital | Paris | HCA Spin-off[(a)] | 58 | Own |
| Clark Regional Medical Center | Winchester | May 1, 2010 | 79 | Own |
| Georgetown Community Hospital | Georgetown | HCA Spin-off[(a)] | 75 | Own |
| Jackson Purchase Medical Center | Mayfield | HCA Spin-off[(a)] | 107 | Own |
| Lake Cumberland Regional Hospital | Somerset | HCA Spin-off[(a)] | 295 | Own |
| Logan Memorial Hospital | Russellville | HCA Spin-off[(a)] | 75 | Own |
| Meadowview Regional Medical Center | Maysville | HCA Spin-off[(a)] | 100 | Own |
| Spring View Hospital | Lebanon | October 1, 2003 | 75 | Own |
| **Louisiana** | | | | |
| Acadian Medical Center | Eunice | April 15, 2005 | 42 | Own |
| Minden Medical Center | Minden | April 15, 2005 | 161 | Own |
| River Parishes Hospital | LaPlace | July 1, 2004 | 106 | Own |
| Teche Regional Medical Center | Morgan City | April 15, 2005 | 165 | Lease |
| Ville Platte Medical Center | Ville Platte | December 1, 2001 | 67 | Own |
| **Michigan** | | | | |
| Marquette General Hospital[(d)] | Marquette | September 1, 2012 | 315 | Own[(d)] |
| **Mississippi** | | | | |
| Bolivar Medical Center | Cleveland | April 15, 2005 | 200 | Lease |
| **Nevada** | | | | |
| Northeastern Nevada Regional Hospital | Elko | April 15, 2005 | 75 | Own |

| Hospital | City | Acquisition/Opening/ Lease Date | Licensed Beds | Real Property Status |
|---|---|---|---|---|
| **New Mexico** | | | | |
| Los Alamos Medical Center | Los Alamos | April 15, 2005 | 47 | Own |
| Memorial Medical Center of Las Cruces | Las Cruces | April 15, 2005 | 298 | Lease |
| **North Carolina** | | | | |
| Maria Parham Medical Center[e] | Henderson | November 1, 2011 | 102 | Own[e] |
| Person Memorial Hospital[d] | Roxboro | October 1, 2011 | 110 | Own[d] |
| **Tennessee** | | | | |
| Athens Regional Medical Center | Athens | October 1, 2001 | 118 | Own |
| Crockett Hospital | Lawrenceburg | HCA Spin-off[a] | 99 | Own |
| Emerald-Hodgson Hospital | Sewanee | HCA Spin-off[a] | 41 | Own |
| Hillside Hospital | Pulaski | HCA Spin-off[a] | 95 | Own |
| Livingston Regional Hospital | Livingston | HCA Spin-off[a] | 114 | Own |
| Riverview Regional Medical Center | Carthage | September 1, 2010 | 35 | Own |
| Southern Tennessee Medical Center | Winchester | HCA Spin-off[a] | 157 | Own |
| Sumner Regional Medical Center | Gallatin | September 1, 2010 | 155 | Own |
| Trousdale Medical Center | Hartsville | September 1, 2010 | 25 | Own |
| Woods Memorial Hospital | Etowah | July 1, 2012 | 160 | Own |
| **Texas** | | | | |
| Ennis Regional Medical Center | Ennis | April 15, 2005 | 60 | Lease |
| Palestine Regional Medical Center | Palestine | April 15, 2005 | 156 | Own |
| Parkview Regional Hospital | Mexia | April 15, 2005 | 58 | Lease |
| **Utah** | | | | |
| Ashley Regional Medical Center | Vernal | HCA Spin-off[a] | 39 | Own |
| Castleview Hospital | Price | HCA Spin-off[a] | 49 | Own |
| **Virginia** | | | | |
| Clinch Valley Medical Center | Richlands | July 1, 2006 | 175 | Own |
| Danville Regional Medical Center | Danville | July 1, 2005 | 250 | Own |
| Memorial Hospital of Martinsville and Henry County | Martinsville | April 15, 2005 | 220 | Own |
| Twin County Regional Hospital[e] | Galax | April 1, 2012 | 141 | Own[e] |
| Wythe County Community Hospital | Wytheville | June 1, 2005 | 100 | Lease |
| **West Virginia** | | | | |
| Logan Regional Medical Center | Logan | December 1, 2002 | 140 | Own |
| Raleigh General Hospital | Beckley | July 1, 2006 | 300 | Own |
| **Wyoming** | | | | |
| Lander Regional Hospital | Lander | July 1, 2000 | 89 | Own |
| Riverton Memorial Hospital | Riverton | HCA Spin-off[a] | 70 | Own |
| | | | 6,581 | |

(a) We were formerly a division of HCA, Inc. (''HCA'') and were spun-off as an independent publicly-traded company on May 11, 1999.

(b) The hospital is owned and operated by a joint venture between us and a local not-for-profit entity. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.

(c) The hospital is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest. The real property on which the hospital is located is owned by the LifePoint member and leased to the joint venture.

(d) The hospital is owned and operated by Duke LifePoint Healthcare, a joint venture between us and a wholly-controlled affiliate of Duke University Health System, Inc. in which we own a controlling interest. A wholly-owned LifePoint affiliate owns a controlling interest in Duke LifePoint Healthcare.

(e) The hospital is owned and operated by a joint venture between a local not-for-profit entity and Duke LifePoint Healthcare, a joint venture between us and a wholly-controlled affiliate of Duke University Health System, Inc. A wholly-owned LifePoint affiliate owns a controlling interest in Duke LifePoint Healthcare.

We operate medical office buildings in conjunction with many of our hospitals. We own the majority of these medical office buildings. These office buildings are primarily occupied by physicians who practice at our hospitals. Our hospital support center is located in approximately 178,000 square feet of leased space in Brentwood, Tennessee. Our hospital support center, hospitals and other facilities are suitable for their respective uses and are generally adequate for our present needs. In late 2011, we announced plans to relocate and consolidate our entire hospital support center into a single location in Brentwood, Tennessee. The construction of the new hospital support center began in 2012 with a targeted completion date in the fourth quarter of 2013.

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

Hospitals are subject to the regulation and oversight of various state and federal governmental agencies. Further, under the federal False Claims Act, private parties have the right to bring qui tam, or ''whistleblower,'' suits against hospitals that submit false claims for payments to, or improperly retain overpayments from, governmental payors. Some states have adopted similar state whistleblower and false claims provisions. The healthcare industry has seen a number of ongoing investigations related to patient referrals, physician recruiting practices, cost reporting and billing practices, 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 Department of Justice (''DOJ'') and other governmental fraud and abuse programs. Certain of our individual facilities have received, and from time to time, other facilities may receive, government inquiries from federal and state agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on our financial position, results of operations and liquidity.

In May 2009, our hospital in Andalusia, Alabama (''Andalusia Regional Hospital'') produced documents responsive to a request received from the U.S. Attorney's Office for the Western District of New York (''AUSA-NY'') regarding an investigation they are conducting with respect to the billing of kyphoplasty (spine-related) procedures. Based on a review of the number of the kyphoplasty procedures performed at all of our other hospitals, as part of our effort to cooperate with the U.S. Attorney's Office, by letter dated January 20, 2010 we identified to the U.S. Attorney's Office four additional facilities at which the number of inpatient kyphoplasty procedures approximated those performed at Andalusia Regional Hospital. We have completed our review of the relevant medical records and we are continuing to cooperate with the government's investigation. In January 2013, we reached a settlement in principle with the AUSA-NY that will, if effectuated, settle this matter for approximately $2.6 million.

In January 2013, Jackson Purchase Medical Center (''Jackson Purchase'') entered into a voluntary settlement agreement with the DOJ and the OIG for a cash payment of approximately $0.9 million. The settlement relates to the relationship between the hospital and a physician on its medical staff and that physician's use of a hospital-employed advanced nurse practitioner, as well as lease arrangements between the hospital and physician. Jackson Purchase is currently subject to a five-year Corporate Integrity Agreement with the OIG, which became effective June 26, 2011.

In addition to legal proceedings initiated by government agencies and third parties, all hospitals have an obligation to report and refund promptly any overpayments received once identified. ''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 become obligations in violation of the False Claims Act if not reported and refunded within 60 days of identification. Hospitals can meet the obligation to report and refund in three ways: (1) refunding overpayments directly to the program, (2) self-disclosing the overpayment to the OIG via its voluntary self-disclosure protocol (with respect to False Claims Act and other violations not related to the Stark law), and (3) self-disclosing to CMS via the self-referral disclosure protocol (with respect to overpayments caused by potential violations of the Stark law only) for which CMS has the authority to reduce the amounts otherwise owed.

In connection with our acquisition of Marquette General, Marquette General self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. This self-disclosure is pending with CMS. To the extent that Marquette General Hospital, Inc.'s (the ''Marquette Seller'') satisfaction of its retained liabilities, which include the CMS voluntary self disclosure as well as other obligations (''Marquette Contingent Obligations''), causes its net proceeds to be reduced to less than $15.0 million, we would pay additional purchase consideration to the Marquette Seller. We believe we made reasonable estimates of these potential liabilities and recorded an aggregate of $31.3 million (a portion of which relates to Marquette General's CMS voluntary self-disclosure) representing the preliminary fair values of our potential obligation to the Marquette Seller related to the Marquette Contingent Obligations. We do not control and cannot predict with certainty the amount the Marquette Seller will owe any agency or creditor. Therefore, the final amounts paid in settlement, if any, could materially differ from amounts currently recorded. To the extent we are required to pay additional purchase consideration pursuant to the Marquette Contingent Obligations, the amounts paid will reduce on a dollar-for-dollar basis, the remaining $318.6 million of the initial $350.0 million in capital improvements and physician recruitment commitment at Marquette General. Our Marquette Contingent Obligations are further described in Notes 2 and 10 to our consolidated financial statements included elsewhere in this report.

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

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

Not applicable.

## PART II

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

### Market Information for Common Stock

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

| | High | Low |
|---|---|---|
| **2013** | | |
| First Quarter (through February 14, 2013) | $44.45 | $38.08 |
| **2012** | | |
| First Quarter | $42.19 | $34.91 |
| Second Quarter | $41.80 | $34.32 |
| Third Quarter | $43.87 | $36.62 |
| Fourth Quarter | $43.86 | $34.37 |
| **2011** | | |
| First Quarter | $40.48 | $34.63 |
| Second Quarter | $43.45 | $37.19 |
| Third Quarter | $40.59 | $28.95 |
| Fourth Quarter | $41.97 | $32.61 |

On February 14, 2013, the last reported sales price for our common stock on the NASDAQ Global Select Market was $44.21 per share.

### Stockholders

As of February 8, 2013, there were 10,016 holders of record of shares of our common stock.

### Dividends

We have never declared or paid cash dividends on our common stock. We intend to retain future earnings to finance the growth and development of our business and, accordingly, do not currently intend to declare or pay any cash dividends on our common stock. Our Board of Directors will evaluate our future earnings, results of operations, financial condition and capital requirements in determining whether to declare or pay cash dividends. Delaware law prohibits us from paying any dividends unless we have capital surplus or net profits available for this purpose. In addition, the Senior Credit Agreement and certain other indebtedness of the Company impose restrictions on our ability to pay dividends.

### Recent Sales of Unregistered Securities

None.

### Recent Purchases of Equity Securities by the Issuer and Affiliated Purchasers

Our Board of Directors has authorized the repurchase of outstanding shares of our common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other customary factors in accordance with a repurchase plan adopted in 2011. The repurchase plan provides for the repurchase of up to $250.0 million in shares of our common stock through March 2013, although it does not obligate us to repurchase any specific number of shares. Through December 31, 2012, we have repurchased approximately 4.3 million shares in accordance with the repurchase plan and as of December 31, 2012 we had remaining authority to repurchase up to an additional $95.4 million in shares. We have designated repurchased shares as treasury stock.

In connection with the repurchase plan, we have entered into a trading plan in accordance with SEC Rule 10b5-1 of the Exchange Act to facilitate repurchases of our common stock during our current black out period (the ''10b5-1 Trading Plan''). The 10b5-1 Trading Plan became effective on December 17, 2012 and will expire on February 19, 2013.

Additionally, we redeem shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to our Amended and Restated 1998 Long Term Incentive Plan (the ''LTIP'') and Amended and Restated Management Stock Purchase Plan (the ''MSPP''). We redeemed approximately 0.1 million shares of certain vested LTIP and MSPP shares during the year ended December 31, 2012. We have designated these shares as treasury stock.

Our repurchase activity in accordance with the repurchase plan and the shares that we redeem from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to our various stockholder-approved stock-based compensation plans are more fully discussed in Note 7 to our consolidated financial statements included elsewhere in this report.

The following table summarizes our share repurchase activity by month for the three months ended December 31, 2012:

| | Total Number of Shares Purchased | Weighted Average Price Paid per Share | Total Number of Shares Purchased as Part of a Publicly Announced Program | Approximate Dollar Value of Shares that May Yet Be Purchased Under the Program (In millions) |
|---|---|---|---|---|
| October 1, 2012 to October 31, 2012 | 135,686 | $38.53 | 135,686 | $179.6 |
| November 1, 2012 to November 30, 2012 | 1,443,003 | $36.33 | 1,443,003 | $127.1 |
| December 1, 2012 to December 31, 2012[(a)] | 882,134 | $35.86 | 881,746 | $ 95.4 |
| Total | 2,460,823 | $36.28 | 2,460,435 | $ 95.4 |

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

**Equity Compensation Plan Information**

The following table provides aggregate information as of December 31, 2012, with respect to shares of common stock that may be issued in accordance with our existing equity compensation plans, including the LTIP, the MSPP and our Outside Directors Stock and Incentive Compensation Plan (the ''Outside Directors Plan''):

| Plan Category | Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a) | Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights (b) | Number of Securities Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c) |
|---|---|---|---|
| Equity Compensation Plans Approved by Security Holders | 3,678,124[(1)] | $34.12[(2)] | 2,204,262[(3)] |
| Equity Compensation Plans not Approved by Security Holders | None | None | None |
| Total | 3,678,124 | $34.12 | 2,204,262 |

(1) Includes the following:

- 3,667,045 shares of common stock to be issued upon exercise of outstanding stock options granted in accordance with the LTIP; and
- 11,079 shares of common stock to be issued upon the vesting of deferred stock units outstanding in accordance with the Outside Directors Plan.

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

(3) Includes the following:

- 2,141,546 shares of common stock available for issuance in accordance with the LTIP;
- 58,333 shares of common stock available for issuance in accordance with the Outside Directors Plan; and
- 4,383 shares of common stock available for issuance in accordance with the MSPP.

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

The table below contains our selected financial data for, or as of the end of, the last five years ended December 31, 2012. The selected financial data is derived from our consolidated financial statements. The timing of acquisitions and divestitures completed during the years presented affects the comparability of the selected financial data. The selected financial data excludes the operations as well as assets and liabilities of our discontinued operations in our consolidated financial statements. Additionally, we have recognized certain transaction and debt retirement costs during certain of the periods presented that affected the comparability of the selected financial data. You should read this table in conjunction with the consolidated financial statements and related notes included elsewhere in this report and in Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations.*

| | Years Ended December 31, | | | | |
|---|---|---|---|---|---|
| | 2012 | 2011 | 2010 | 2009 | 2008 |
| | (In millions, except per share amounts) | | | | |
| **Statements of Operations Data:** | | | | | |
| Revenues | $3,391.8 | $3,026.1 | $2,818.6 | $2,587.3 | $2,387.6 |
| Income from continuing operations attributable to LifePoint Hospitals, Inc. stockholders | 151.9 | 162.7 | 155.6 | 139.2 | 126.7 |
| Income from continuing operations per share: | | | | | |
| Basic | $ 3.22 | $ 3.30 | $ 2.98 | $ 2.64 | $ 2.41 |
| Diluted | $ 3.14 | $ 3.22 | $ 2.91 | $ 2.59 | $ 2.37 |
| Weighted average shares outstanding: | | | | | |
| Basic | 47.2 | 49.3 | 52.2 | 52.7 | 52.5 |
| Diluted | 48.4 | 50.5 | 53.5 | 53.8 | 53.5 |
| **Balance Sheet Data (as of end of year):** | | | | | |
| Working capital | $ 480.4 | $ 467.2 | $ 498.8 | $ 485.9 | $ 376.2 |
| Property and equipment, net | 2,030.9 | 1,830.4 | 1,668.6 | 1,499.4 | 1,416.0 |
| Total assets | 4,722.2 | 4,370.1 | 4,162.9 | 3,882.2 | 3,688.4 |
| Long-term debt, including amounts due within one year but excluding unamortized discounts of convertible debt instruments | 1,739.3 | 1,652.8 | 1,651.7 | 1,502.2 | 1,516.7 |
| Total LifePoint Hospitals, Inc. stockholders' equity | 2,050.5 | 1,945.2 | 1,887.5 | 1,827.7 | 1,652.0 |

| | Years Ended December 31, | | | | |
|---|---|---|---|---|---|
| | 2012 | 2011 | 2010 | 2009 | 2008 |
| | | | (In millions) | | |
| **Other Financial Data:** | | | | | |
| Adjusted EBITDA[(a)] | $545.6 | $536.2 | $500.1 | $469.3 | $449.8 |
| Capital expenditures | 221.4 | 219.9 | 168.7 | 166.6 | 157.6 |
| Cash provided by operating activities – continuing operations | 382.9 | 401.2 | 375.7 | 350.3 | 346.6 |
| Cash used in investing activities – continuing operations | 422.1 | 342.1 | 353.6 | 244.1 | 185.3 |
| Cash used in financing activities – continuing operations | 1.3 | 140.6 | 0.3 | 13.9 | 119.3 |

(a) We define Adjusted EBITDA as earnings before depreciation and amortization; interest expense, net; debt extinguishment costs; impairment charges; provision for income taxes; (income) loss from discontinued operations, net of income taxes and net income attributable to noncontrolling interests. We use Adjusted EBITDA to evaluate our operating performance and as a measure of performance for incentive compensation purposes. Additionally, our credit facility uses Adjusted EBITDA for certain financial covenants. We believe Adjusted EBITDA is a measure of performance used by some investors, equity analysts and others to make informed investment decisions. In addition, multiples of current or projected Adjusted EBITDA are used to estimate current or prospective enterprise value. Adjusted EBITDA should not be considered as a measure of financial performance in accordance with U.S. generally accepted accounting principles (''GAAP''), and the items excluded from Adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA should not be considered in isolation or as an alternative to net income, cash flows generated by operating, investing or financing activities or other financial statement data presented in the consolidated financial statements as an indicator of financial performance or liquidity. Because Adjusted EBITDA is not a measurement determined in accordance with GAAP and is susceptible to varying calculations, Adjusted EBITDA as presented may not be comparable to other similarly titled measures of other companies.

The following table reconciles Adjusted EBITDA as presented above to net income attributable to LifePoint Hospitals, Inc. for the periods presented (in millions):

| | Years Ended December 31, | | | | |
|---|---|---|---|---|---|
| | 2012 | 2011 | 2010 | 2009 | 2008 |
| | | | (In millions) | | |
| Adjusted EBITDA | $545.6 | $536.2 | $500.1 | $469.3 | $449.8 |
| Less: | | | | | |
| Depreciation and amortization | 193.1 | 165.8 | 148.5 | 143.0 | 132.1 |
| Interest expense, net | 100.0 | 107.1 | 108.1 | 103.2 | 107.7 |
| Debt extinguishment costs | 4.4 | — | 2.4 | — | — |
| Impairment charges | 4.0 | — | — | 1.1 | 1.2 |
| Provision for income taxes | 88.5 | 97.8 | 82.4 | 80.3 | 79.9 |
| (Income) loss from discontinued operations, net of income taxes | — | (0.2) | 0.1 | 5.1 | 23.7 |
| Net income attributable to noncontrolling interests | 3.7 | 2.8 | 3.1 | 2.5 | 2.2 |
| Net income attributable to LifePoint Hospitals, Inc. | $151.9 | $162.9 | $155.5 | $134.1 | $103.0 |

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

We recommend that you read this discussion together with our consolidated financial statements and related notes included elsewhere in this report. Unless otherwise indicated, all relevant financial and statistical information included herein relates to our continuing operations.

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

In this report, for example, we make forward-looking statements, including statements discussing our expectations about: future financial performance and condition; future liquidity and capital resources; future cash flows; existing and future debt and equity structure; our strategic goals; future acquisitions; our business strategy and operating philosophy, including an evaluation of growth strategies for existing markets and for potential acquisitions; effects of competition in a hospital's market; costs of providing care to our patients; increasing risk of collection of amounts due directly from patients; changes in interest rates; our compliance with new and existing laws and regulations and the increasing costs associated with compliance; the impact of national healthcare reform; professional fees; increased costs of salaries and benefits; industry and general economic trends; reimbursement changes; patient volumes and related revenues; access to the HCA-IT information systems and other third party providers; future capital expenditures; claims and legal actions relating to professional liabilities, governmental investigations and other matters; accounting policies; and physician recruiting and retention, including trends in physician employment.

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

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

**Overview**

We operate general acute care hospitals primarily in non-urban communities in the U.S. At December 31, 2012, on a consolidated basis, we operated 56 hospital campuses in 19 states, having a total of 6,581 licensed beds. We generate revenues primarily through hospital services offered at our facilities. We generated $3,391.8 million, $3,026.1 million, and $2,818.6 million, respectively, in revenues during the years ended December 31, 2012, 2011, and 2010. In 2012, we derived 48.9% of our revenues from the Medicare and Medicaid programs, collectively. Payments made to our hospitals pursuant to the Medicare and Medicaid programs for services rendered rarely exceed our costs for such services. As a result, we rely largely on payments made by private or commercial payors, together with certain limited services provided to Medicare recipients, to generate an

operating profit. The hospital industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial payors. This places a premium on efficient operation, the ability to reduce or control costs and the need to leverage the benefits of our organization across all of our hospitals.

***Competitive and Structural Environment***

The environment in which our hospitals operate is extremely competitive. 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 primarily as a result of poor economic conditions because the economies in the non-urban communities in which our hospitals 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 in the manufacturing sector than other parts of the U.S., generally.

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

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

We believe other key factors in our competition for patients is the quality of our patient care and the perception of that quality in the communities where our hospitals 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.

***Business Strategy***

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

- Measurement and improvement of quality of patient care and perceptions of such quality in communities where our hospitals are located;
- Targeted recruiting of primary care physicians and physicians in key specialties;
- Retention of physicians and efforts to improve physician satisfaction, including employing a greater number of primary care physicians as well as physicians in certain specialties;
- Retention and, where needed, recruitment of non-physician employees involved in patient care and efforts to improve employee satisfaction;
- Targeted investments in new technologies, new service lines and capital improvements at our facilities;

- Improvements in management of expenses and revenue cycle;
- Negotiation of improved reimbursement rates with non-governmental payors;
- Strategic growth through acquisition and integration of hospitals and other healthcare facilities where valuations are attractive and we can identify opportunities for improved financial performance through our management or ownership; and
- Developing strategic partnerships with not-for-profit healthcare providers to achieve growth in new regions.

As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have entered into agreements with a third party to provide certain nonclinical business functions, including supply chain management and revenue cycle functions. These agreements are in addition to our existing agreement with this third party to provide payroll processing services. We believe this model of sharing centralized resources to support common business functions across multi-facility enterprises provides us efficiencies and is the most cost effective approach to managing these nonclinical business functions. We expect to implement the supply chain management and revenue cycle functions over the next 18 to 24 months.

***Regulatory Environment***

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

Not only are our hospitals 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 hospitals to make changes in their facilities, 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 practices, cost reporting and billing practices, 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 and other governmental fraud and abuse programs.

***Health Care Reform***

The Affordable Care Act dramatically alters the U.S. healthcare system and is intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicare and Medicaid eligibility, reducing Medicare and Medicaid DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, and instituting certain private health insurance reforms. Although a majority of the measures contained in the Affordable Care Act do not take effect until 2013 and 2014, certain of the reductions in Medicare spending, such as negative adjustments to the Medicare hospital inpatient and outpatient prospective payment system market basket updates and the incorporation of productivity adjustments to the Medicare program's annual inflation updates, became effective in 2010, 2011 and 2012. Although the expansion of health insurance coverage should increase revenues from providing care to certain previously uninsured individuals, many of these provisions of the Affordable Care

Act will not become effective until 2014 or later, and the impact of such expansion may be gradual and may not offset scheduled decreases in reimbursement.

On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of the Affordable Care Act, including the ''individual mandate'' provisions of the Affordable Care Act that generally require all individuals to obtain healthcare insurance or pay a penalty. However, the U.S. Supreme Court also held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. In response to the ruling, a number of U.S. governors, including those of some states in which we operate, have stated that they oppose their state's participation in the expanded Medicaid program, which could result in the Affordable Care Act not providing coverage to some low-income persons in those states. In addition, several bills have been and may continue to be introduced in Congress to repeal or amend all or significant provisions of the Affordable Care Act.

The Affordable Care Act changes how healthcare services are covered, delivered, and reimbursed. The net effect of the Affordable Care Act on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, gradual and potentially delayed implementation or possible amendment, as well as the uncertainty as to the extent to which states will choose to participate in the expanded Medicaid program. As a result, we are unable to predict the net effect on our business, financial condition or results of operations of the expected increases in insured individuals using our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions of the Affordable Care Act that may affect us. We are also unable to predict how providers, payors, employers and other market participants will respond to the various reform provisions because many provisions will not be implemented for several years under the Affordable Care Act's implementation schedule. Further, we are unable to predict the outcome of new or remaining court challenges and the impact of continued legislative efforts to delay implementation of or amend the Affordable Care Act.

***Medicare and Medicaid Reimbursement***

Medicare payment methodologies have been, and are expected to continue to be, revised significantly based on cost containment and policy considerations. CMS has already begun to implement some of the Medicare reimbursement reductions required by the Affordable Care Act. These revisions will likely be more frequent and significant as more of the Affordable Care Act's changes and cost-saving measures become effective. Additionally, the Tax Relief Act and ATRA require further reductions in Medicare payments, and the BCA will impose a 2% reduction in Medicare spending effective as of April 1, 2013, unless the reduction is averted by Congressional action. Future efforts to reduce the federal deficit may result in additional revisions to and payment reductions for the Medicare Program.

In addition, many states in which we operate are facing budgetary challenges and have adopted, or may be considering, legislation that is intended to control or reduce Medicaid expenditures, enroll Medicaid recipients in managed care programs, and/or impose additional taxes on hospitals to help finance or expand their Medicaid programs. Budget cuts, federal or state legislation, or other changes in the administration or interpretation of government health programs by government agencies or contracted managed care organizations could have a material adverse effect on our financial position and results of operations.

***Physician Services***

Physician services are reimbursed under the Medicare PFS system, under which CMS has assigned a national 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 is multiplied by a conversion factor that accounts for inflation and targeted growth in Medicare expenditures (as calculated by the SGR) to arrive at the payment amount for each service.

The PFS rates are adjusted each year, and reductions in both current and future payments are anticipated. The SGR formula has resulted in payment decreases to physicians every year since 2002. However, all but

one of those payment decreases has been averted by Congressional action. For CY 2013, CMS issued a final rule that would have applied the SGR and resulted in an aggregate reduction of 26.5% to all physician payments under the PFS for CY 2013. The ATRA delayed application of the SGR and extended CY 2011 PFS payment rates through December 31, 2013. We cannot predict whether Congress will pass legislation to avert any rate cuts in calendar year 2014 or will otherwise adopt a permanent fix for the issues that are created by the application of the SGR. If the payment reduction contained in the proposed rule is not averted, the reimbursement received by our employed physicians, the physicians to whom our hospitals have provided recruitment assistance, and the physician members of our medical staffs would be adversely affected.

***Adoption of Electronic Health Records***

The HITECH Act was enacted into law on February 17, 2009 as part of ARRA. The HITECH Act includes provisions designed to increase the use of EHR by both physicians and hospitals. EHR meaningful use objectives and measures that hospitals and physicians must meet in order to qualify for incentive payments will be implemented in three stages. Stage 1 has been in effect since 2011; however, on August 23, 2012, HHS released final requirements for Stage 2, which will take effect starting in 2014. We strive to comply with the EHR meaningful use requirements of the HITECH Act in time to qualify for the maximum available incentive payments. Our compliance has and will continue to result in significant costs including business process changes, professional services focused on successfully designing and implementing our EHR solutions along with costs associated with the hardware and software components of the project. We currently estimate that at a minimum total costs incurred to comply will be recovered through the total EHR incentive payments over the projected lifecycle of this initiative.

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

***Privacy and Security Requirements and Administrative Simplification Provisions***

We are subject to the privacy and security requirements of HIPAA that are designed to protect the confidentiality, availability and integrity of health information. The privacy standards apply to individually identifiable information held or disclosed by a covered entity in any form, whether communicated electronically, on paper or orally, impose extensive administrative requirements on us, require our compliance with rules governing the use and disclosure of this health information, and require us to impose these rules, by contract, on any business associate to whom we disclose such information in order to perform functions on our behalf. The security standards require us to establish and maintain reasonable and appropriate administrative, technical and physical safeguards to ensure the integrity, confidentiality and the availability of electronic health and related financial information. In addition, our facilities will continue to remain subject to any state laws that are more restrictive than the privacy regulations issued under HIPAA.

The HITECH Act, among other things, strengthened the HIPAA privacy and security requirements, significantly increased the penalties for violations of the HIPAA privacy and security regulations, imposed varying civil monetary penalties and created a private cause of action for state attorneys general for certain HIPAA violations, extended HIPAA's security provisions to business associates, and created new security breach notification requirements. The HITECH Act also created a federal breach notification law that mirrors protections that many states have passed in recent years. In 2011, HHS initiated a pilot audit program that ran through December 2012 in the first phase of HHS implementation of the HITECH Act's requirements of periodic audits of covered entities and business associates to ensure their compliance with the HIPAA privacy and security regulations. We cannot predict whether our hospitals will be selected for an audit or the results of such an audit.

On January 17, 2013, HHS issued a final HIPAA omnibus rule (the "Final HIPAA Rule") that modified prior HIPAA regulations. Our facilities must comply with the applicable requirements of the Final HIPAA Rule by September 23, 2013. The Final HIPAA Rule modifications include: making our facilities' business associates directly liable for compliance with certain of the privacy and security rules' requirements; making our facilities' liable for violations by their business associates if HHS determines an agency relationship exists between the facility and the business associate under federal agency law; adding limitations on the use and disclosure of health information for marketing and fundraising purposes, and prohibiting the sale of health information without individual authorization; expanding our patients' rights to receive electronic copies of their health information and to restrict disclosures to a health plan concerning treatment for which our patient has paid out of pocket in full; requiring modifications to, and redistribution of, our facilities' notice of privacy practices; rules addressing enforcement of noncompliance with HIPAA due to willful neglect; an increased and tiered civil money penalty structure; and modifications to the breach notification rules that replace the "risk of harm" standard with a "low probability of compromise" standard, which would require our facilities to prepare a four factor risk assessment for impermissible uses and disclosures of health information. We cannot predict the financial impact to our hospitals in implementing the provisions of the Final HIPAA Rule.

In addition to the privacy and security requirements, we also are subject to the administrative simplification provisions of HIPAA, which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. In January 2009, CMS published its ICD-10 and related changes to the formats used for certain electronic transactions. ICD-10 contains significantly more diagnostic and procedural codes than the existing ICD-9 coding system, and as a result, the coding for the services provided in our hospitals and clinics will require much greater specificity. Implementation of ICD-10 will require a significant investment in technology and training. We may experience delays in reimbursement while our facilities and the payors from which we seek reimbursement make the transition to ICD-10. On August 24, 2012, CMS released a final rule that revised the effective date of the ICD-10 transition to October 1, 2014. If any of our hospitals fail to implement the new coding system by the deadline, the affected hospital will not be paid for services. We are not able to predict the overall financial impact of the Company's transition to ICD-10.

***Revenue Sources***

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

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

Revenues from HMOs, PPOs and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services. These discounted arrangements often limit our ability to increase charges in response to increasing costs. We actively negotiate with these payors in an effort to maintain or increase the pricing of our healthcare services; however, we have no control over patients switching their healthcare coverage to a payor with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower cost

healthcare coverage plans, and such plans generally provide lower reimbursement rates, and require patients to pay an increased portion of the costs of case through deductibles, co-payments or exclusions. We expect this trend to continue in the coming years.

Self-pay revenues are primarily generated through the treatment of uninsured patients. Our hospitals have experienced an increase in self-pay revenues over the past several years as a result of the impact of pricing increases and due to a combination of broad economic factors, including rising unemployment in many of our markets, reductions in state Medicaid budgets and increasing numbers of individuals and employers who choose not to purchase insurance. Additionally, certain of our hospitals participate in federal, state and local programs that provide for supplemental support and funding for the care of indigent patients. During the second half of 2012, as a result of a decrease in our reimbursement under one such program in New Mexico, we experienced an increase of approximately $5.6 million in our charity care write-offs. As a result of this decrease in our reimbursement under this program, we have experienced and will continue to experience an increase in our charity care write-offs prospectively. Because we cannot predict what actions the federal government or the states may take under existing legislation and future legislation to address budget gaps or deficits, we are unable to assess the effect that any such legislation might have on our business, but the impact on our future financial position, results of operations or cash flows could be material.

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**

The following definitions apply throughout the remaining portion of *Management's Discussion and Analysis of Financial Condition and Results of Operations.* Additionally, unless noted otherwise, discussions throughout the remaining portion of *Management's Discussion and Analysis of Financial Condition and Results of Operations* relate to the Company's continuing operations.

*Admissions.* Represents the total number of patients admitted (in the facility for a period in excess of 23 hours) to our hospitals and used by management and investors as a general measure of inpatient volume.

*bps.* Basis point change.

*Continuing operations.* Continuing operations information includes the results of (i) our hospital support center, (ii) our same-hospital operations, (iii) the results of Marquette General, which we acquired effective September 1, 2012, Twin County, in which we acquired an 80% interest effective April 1, 2012, Maria Parham, in which we acquired an 80% interest effective November 1, 2011, and Person Memorial, which we acquired effective October 1, 2011, each through Duke LifePoint Healthcare and (iv) Woods Memorial, which we acquired effective July 1, 2012.

*Effective tax rate*. Provision for income taxes as a percentage of income from continuing operations before income taxes less net income attributable to noncontrolling interests.

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

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

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

*N/A.* Not applicable.

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

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

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

*Same-hospital*. Same-hospital information includes the results of our hospital support center and the same 51 hospitals operated during the years ended December 31, 2012 and 2011. Same-hospital information excludes the results of Marquette General, Woods Memorial, Twin County, Maria Parham and Person Memorial.

***For the Three Months Ended December 31, 2012 and 2011***

The following table summarizes the results of operations for the three months ended December 31, 2012 and 2011 (dollars in millions):

| | Three Months Ended December 31, | | | |
|---|---|---|---|---|
| | 2012 | | 2011 | |
| | Amount | % of Revenues | Amount | % of Revenues |
| Revenues before provision for doubtful accounts | $1,053.1 | 117.9% | $916.4 | 117.3% |
| Provision for doubtful accounts | 159.8 | 17.9 | 135.1 | 17.3 |
| Revenues | 893.3 | 100.0 | 781.3 | 100.0 |
| Salaries and benefits | 424.3 | 47.5 | 353.5 | 45.2 |
| Supplies | 141.9 | 15.9 | 122.8 | 15.7 |
| Other operating expenses | 209.6 | 23.4 | 186.6 | 24.0 |
| Other income | (17.3) | (1.9) | (11.5) | (1.5) |
| Depreciation and amortization | 53.4 | 6.0 | 44.8 | 5.7 |
| Interest expense, net | 24.3 | 2.7 | 25.5 | 3.3 |
| Impairment charges | 0.9 | 0.1 | — | — |
| | 837.1 | 93.7 | 721.7 | 92.4 |
| Income from continuing operations before income taxes | 56.2 | 6.3 | 59.6 | 7.6 |
| Provision for income taxes | 18.7 | 2.1 | 21.3 | 2.7 |
| Income from continuing operations | 37.5 | 4.2 | 38.3 | 4.9 |
| Less: Net income attributable to noncontrolling interests | (1.0) | (0.1) | (0.6) | (0.1) |
| Income from continuing operations attributable to LifePoint Hospitals, Inc. | $ 36.5 | 4.1% | $ 37.7 | 4.8% |

***Revenues***

The following table presents the components of revenues from continuing operations and on a same-hospital basis for the three months ended December 31, 2012 and 2011 (dollars in millions):

| | Three Months Ended December 31, | | | |
|---|---|---|---|---|
| | 2012 | 2011 | Increase | % Increase |
| Continuing operations: | | | | |
| Revenues before provision for doubtful accounts | $1,053.1 | $916.4 | $136.7 | 14.9% |
| Provision for doubtful accounts | 159.8 | 135.1 | 24.7 | 18.3 |
| Revenues | $ 893.3 | $781.3 | $112.0 | 14.3 |
| Same-hospital: | | | | |
| Revenues before provision for doubtful accounts | $ 912.0 | $889.7 | $ 22.3 | 2.5% |
| Provision for doubtful accounts | 147.9 | 129.3 | 18.6 | 14.3 |
| Revenues | $ 764.1 | $760.4 | $ 3.7 | 0.5 |

The following table shows the sources of our revenues by payor, including adjustments to estimated reimbursement amounts and provision for doubtful accounts, for the three months ended December 31, 2012 and 2011 (in millions):

| | Three Months Ended December 31, | | | |
|---|---|---|---|---|
| | 2012 | | 2011 | |
| | Amount | % of Revenues | Amount | % of Revenues |
| Medicare | $ 289.0 | 32.4% | $ 272.8 | 34.9% |
| Medicaid | 126.3 | 14.1 | 107.6 | 13.8 |
| HMOs, PPOs and other private insurers | 459.6 | 51.4 | 380.3 | 48.7 |
| Self-pay | 162.8 | 18.2 | 145.9 | 18.7 |
| Other | 15.4 | 1.8 | 9.8 | 1.2 |
| Revenues before provision for doubtful accounts | 1,053.1 | 117.9 | 916.4 | 117.3 |
| Provision for doubtful accounts | (159.8) | (17.9) | (135.1) | (17.3) |
| Revenues | $ 893.3 | 100.0% | $ 781.3 | 100.0% |

Our revenues per equivalent admission from continuing operations and on a same-hospital basis were as follows for the three months ended December 31, 2012 and 2011:

| | Three Months Ended December 31, | | | |
|---|---|---|---|---|
| | 2012 | 2011 | Increase | % Increase |
| Revenues per equivalent admission – continuing operations | $7,608 | $7,313 | $295 | 4.0 |
| Revenues per equivalent admission – same-hospital | $7,412 | $7,364 | $ 48 | 0.7 |

*Revenues Before Provision for Doubtful Accounts*

The following table shows the key drivers of our revenues before provision for doubtful accounts from continuing operations and on a same-hospital basis for the three months ended December 31, 2012 and 2011:

| | Three Months Ended December 31, | | Increase (Decrease) | % Increase (Decrease) |
|---|---|---|---|---|
| | 2012 | 2011 | | |
| Continuing operations: | | | | |
| Admissions | 51,488 | 48,354 | 3,134 | 6.5 |
| Equivalent admissions | 117,414 | 106,850 | 10,564 | 9.9 |
| Medicare case mix index | 1.35 | 1.30 | 0.05 | 3.4 |
| Average length of stay (days) | 4.5 | 4.4 | 0.1 | 2.3 |
| Inpatient surgeries | 13,688 | 13,055 | 633 | 4.8 |
| Outpatient surgeries | 43,844 | 40,404 | 3,440 | 8.5 |
| Emergency room visits | 298,119 | 257,046 | 41,073 | 16.0 |
| Outpatient factor | 2.28 | 2.21 | 0.07 | 3.5 |
| Same-hospital: | | | | |
| Admissions | 46,081 | 47,061 | (980) | (2.1) |
| Equivalent admissions | 103,086 | 103,269 | (183) | (0.2) |
| Medicare case mix index | 1.32 | 1.31 | 0.01 | 1.5 |
| Average length of stay (days) | 4.2 | 4.3 | (0.1) | (2.3) |
| Inpatient surgeries | 11,846 | 12,756 | (910) | (7.1) |
| Outpatient surgeries | 38,707 | 39,348 | (641) | (1.6) |
| Emergency room visits | 266,313 | 246,185 | 20,128 | 8.2 |
| Outpatient factor | 2.24 | 2.19 | 0.05 | 2.1 |

For the three months ended December 31, 2012, our same-hospital revenues before provision for doubtful accounts increased by $22.3 million, or 2.5%, to $912.0 million as compared to $889.7 million for the same period last year. Same-hospital admissions decreased 2.1% over the same period in the prior year while same-hospital equivalent admissions were relatively flat at 103,086 for the three months ended December 31, 2012 as compared to 103,269 for the same period last year. The decrease in same-hospital admissions was primarily a result of a significant decrease in our one day stay admissions. During the three months ended December 31, 2012, we continued to experience growth in our observation visits indicating an overall shift to an outpatient setting. The same-hospital equivalent admissions continue to be favorably impacted by higher emergency room visits and overall growth in our cardiology services.

The majority of our increase in same-hospital revenues before the provision for doubtful accounts related to HMO, PPO's and other private insurers, self-pay payors and Medicaid. Our same-hospital HMO, PPO's and other private insurer revenue generally increased as a result of higher contracted rates. Self-pay revenue increases were primarily driven by pricing increases and higher self-pay volumes. These increases in self-pay revenues were partially offset by an approximate $2.8 million reduction in funding during the three months ended December 31, 2012 as compared to the same period in the prior year as a result of a decrease in our reimbursement under a New Mexico state program that provides for supplemental support and funding for the care of indigent patients. Medicaid increases were generally due to the expansion of DSH and UPL programs in certain states in which our hospitals are located.

These increases were partially offset by a decrease in our Medicare revenue due to the absence of favorable cost report adjustments during the three months ended December 31, 2012 that were recognized in the same period in the prior year, as well as the negative impact of a higher level of denials as a result of RAC audits as compared to the same period last year. For the three months ended December 31, 2012, our RAC audits resulted in approximately $2.8 million of higher revenue reductions as compared to the same period in the prior year.

For the three months ended December 31, 2012, on a continuing operations basis, our Medicare case mix index increased by 3.4% to 1.35 as compared to 1.30 for the same period last year primarily as a result of our recent Marquette General acquisition.

*Provision for Doubtful Accounts*

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts from continuing operations and on a same-hospital basis for the three months ended December 31, 2012 and 2011 (dollars in millions):

| | Three Months Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2012 | % of Revenues | 2011 | % of Revenues | Increase | % Increase |
| Continuing operations: | | | | | | |
| Related key indicators: | | | | | | |
| Charity care write-offs | $ 31.8 | 3.6% | $ 21.7 | 2.8% | $10.1 | 46.2% |
| Self-pay revenues, net of charity care write-offs and uninsured discounts | $162.8 | 18.2% | $145.9 | 18.7% | $16.9 | 11.6% |
| Net revenue days outstanding (at end of period) | 54.7 | N/A | 52.3 | N/A | 2.4 | 4.6% |
| Same-hospital: | | | | | | |
| Related key indicators: | | | | | | |
| Charity care write-offs | $ 29.1 | 3.8% | $ 21.4 | 2.8% | $ 7.7 | 35.9% |
| Self-pay revenues, net of charity care write-offs and uninsured discounts | $149.8 | 19.6% | $140.0 | 18.4% | $ 9.8 | 7.0% |
| Net revenue days outstanding (at end of period) | 53.6 | N/A | 51.1 | N/A | 2.5 | 4.9% |

For the three months ended December 31, 2012, our provision for doubtful accounts increased by $24.7 million, or 18.3%, to $159.8 million on a continuing operations basis and by $18.6 million, or 14.3%, to $147.9 million on a same-hospital basis as compared to the same period last year. This increase was primarily the result of an increase in self-pay revenues during the three months ended December 31, 2012, as compared to the same period last year. Same-hospital self-pay revenues increased by $9.8 million over the same period last year and represented 19.6% of revenues, as compared to 18.4% of revenues in the same period last year. Self- pay revenues continued to increase for both our inpatient and outpatient services, which were primarily driven by higher self-pay volumes and pricing increases. Additionally, as a result of a decrease in our reimbursement under a New Mexico state program that provides for supplemental support and funding for the care of indigent patients, we have experienced an increase of approximately $2.8 million in our charity care write-offs during the three months ended December 31, 2012, as compared to the same period in the prior year.

Our increased provision for doubtful accounts was partially offset by an increase in both up-front cash collections and cash collections related to our insured receivables for the three months ended December 31, 2012, as compared to the same period last year. The provision for doubtful accounts relates principally to self-pay amounts due from patients. The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*, ''Critical Accounting Estimates.''

We have changed our historical calculation of net revenue days outstanding in the table above to be consistent with our current period computation and presentation. Specifically, the impact of certain non-healthcare services revenues has been excluded from our calculation of revenue per day, the denominator in this computation. The recognition of certain non-healthcare services revenues does not generally result in accounts receivable from third-party payors or patients. Accordingly, we have determined that it is more appropriate to exclude these non-healthcare services revenues from our revenue per day calculation. This change had the impact of decreasing our revenue per day calculation and resulted in an overall higher computation of net revenue days outstanding as of period end. This change had no impact on our historical results of operations.

***Expenses and Other Income***

*Salaries and Benefits*

The following table summarizes our salaries and benefits, man-hours per equivalent admission and salaries and benefits per equivalent admission for the three months ended December 31, 2012 and 2011:

| | Three Months Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2012 | % of Revenues | 2011 | % of Revenues | Increase | % Increase |
| Salaries and benefits (dollars in millions). . | $424.3 | 47.5% | $353.5 | 45.2% | $70.8 | 20.0% |
| Man-hours per equivalent admission . . . . . | 106.7 | N/A | 101.5 | N/A | 5.2 | 5.2% |
| Salaries and benefits per equivalent admission . . . . . | $3,555 | N/A | $3,286 | N/A | $ 269 | 8.2% |

For the three months ended December 31, 2012, our salaries and benefits expense increased to $424.3 million, or 20.0%, as compared to $353.5 million for the same period last year. This increase in our salaries and benefits expense is primarily a result of our recent acquisitions, the impact of an increasing number of employed physicians and their related support staff and the impact of compensation increases for our employees. These increases contributed to an increase in our man-hours per equivalent admission to 106.7, or 5.2% as compared to 101.5 for the same period last year.

Additionally, our salaries and benefits expense increased as a result of severance costs related to our shared centralized resource initiatives. In connection with our shared centralized resource initiatives implementation process, we incurred severance and retention costs for our affected workforce of approximately $1.8 million for the three months ended December 31, 2012. We estimate we will recognize approximately $4.6 million of additional severance and retention costs over the remaining implementation periods of 18 to 24 months.

Furthermore, for the three months ended December 31, 2012, we estimate that we incurred approximately $4.2 million of salaries and benefits expense related to the implementation of our EHR initiatives as compared to $1.3 million for the same period last year.

*Supplies*

The following table summarizes our supplies and supplies per equivalent admission for the three months ended December 31, 2012 and 2011:

| | Three Months Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2012 | % of Revenues | 2011 | % of Revenues | Increase | % Increase |
| Supplies (dollars in millions) . . . . . | $141.9 | 15.9% | $122.8 | 15.7% | $19.1 | 15.5% |
| Supplies per equivalent admission . . . . | $1,207 | N/A | $1,151 | N/A | $ 56 | 4.9% |

For the three months ended December 31, 2012, our supplies expense increased to $141.9 million, or 15.5%, as compared to $122.8 million for the same period last year and our supplies per equivalent admission increased to $1,207, or 4.9% as compared to $1,151 for the same period last year. These increases were the result of our recent acquisitions, partially offset by a decrease in our same-hospital supplies expense and supplies per equivalent admission as a result of our continuing efforts to effectively manage our supply costs and increased cost savings associated with participation in a group purchasing organization.

*Other Operating Expenses*

The following table summarizes our other operating expenses for the three months ended December 31, 2012 and 2011 (dollars in millions):

| | Three Months Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2012 | % of Revenues | 2011 | % of Revenues | Increase (Decrease) | % Increase (Decrease) |
| Professional fees | $ 31.1 | 3.5% | $ 26.8 | 3.4% | $ 4.3 | 16.9% |
| Utilities | 16.0 | 1.8 | 14.3 | 1.8 | 1.7 | 11.9 |
| Repairs and maintenance | 22.8 | 2.6 | 21.5 | 2.8 | 1.3 | 6.0 |
| Rents and leases | 9.5 | 1.1 | 7.8 | 1.0 | 1.7 | 20.7 |
| Insurance | 8.9 | 1.0 | 14.1 | 1.8 | (5.2) | (37.2) |
| Physician recruiting | 7.2 | 0.8 | 8.0 | 1.0 | (0.8) | (11.3) |
| Contract services | 62.8 | 7.0 | 49.2 | 6.3 | 13.6 | 27.9 |
| Non-income taxes | 21.8 | 2.4 | 18.7 | 2.4 | 3.1 | 16.6 |
| Other | 29.5 | 3.2 | 26.2 | 3.5 | 3.3 | 12.7 |
| | $209.6 | 23.4 | $186.6 | 24.0 | $23.0 | 12.4% |

For the three months ended December 31, 2012, our other operating expenses increased to $209.6 million, or 12.4%, as compared to $186.6 million for the same period last year. This increase for the three months ended December 31, 2012 was primarily a result of our recent acquisitions as well as increases in our same-hospital professional fees and contract services, partially offset by a decrease in insurance expense.

As a shortage of physicians continues to become more acute, we have experienced increasing professional fees in areas such as emergency room physician coverage, hospitalists and other specialists such as anesthesiologists. We expect this trend to continue and that professional fees as a percentage of revenues will increase in future periods.

Our contract services expense increased primarily as a result of increased fees and expenses related to our conversion of the clinical and patient accounting information system applications at several of our hospitals. For the three months ended December 31, 2012, we estimate that we incurred approximately $4.3 million of operating expenses related to the implementation of our EHR initiatives as compared to $2.0 million for the same period last year.

For the three months ended December 31, 2012, our insurance expense decreased compared to the same period last year primarily because of favorable claim development in the current period coupled with unfavorable claim development in the prior period for our professional and general liability claims.

*Other Income*

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income in accordance with Accounting Standards Codification (''ASC'') 450-30, ''Gain Contingencies'' (''ASC 450-30'') when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the three months ended December 31, 2012, we recognized $10.3 million and $7.0 million in Medicare and Medicaid EHR incentive payments, respectively, as compared to $11.5 million in Medicaid EHR incentive payments recognized in the same period last year. We did not recognize any Medicare EHR incentive payments during the three months ended December 31, 2011.

*Depreciation and Amortization*

For the three months ended December 31, 2012, our depreciation and amortization expense increased by $8.6 million, or 19.2% to $53.4 million, or 6.0% of revenues, as compared to $44.8 million, or 5.7% of revenues for the same period last year. Our depreciation and amortization expense increased primarily as a result of our recent acquisitions as well as a result of significant increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the

HITECH Act. Additionally, we have experienced increases in depreciation expense relating to capital improvement projects completed during 2012. We anticipate that our depreciation and amortization expense as a percentage of revenues will continue to increase in future periods.

*Interest Expense*

For the three months ended December 31, 2012, our interest expense decreased by $1.2 million, or 4.3% to $24.3 million as compared to $25.5 million for the same period last year. Effective July 24, 2012, we replaced our credit agreement with Citicorp North America, Inc., as administrative agent, and a syndicate of lenders (the ''Prior Credit Agreement'') with the Senior Credit Agreement. The decrease in our interest expense is primarily attributable to a decrease in the applicable effective interest on the Senior Credit Agreement for the three months ended December 31, 2012 as compared to the applicable effective interest on the Prior Credit Agreement for the same period last year. For a further discussion of our debt and corresponding interest rates, see ''Liquidity and Capital Resources — Debt.''

*Impairment Charges*

During the three months ended December 31, 2012, we incurred a $0.9 million impairment charge from continuing operations. This impairment charge primarily relates to the write-off of certain capitalized information system costs which we have determined are no longer a necessary component of our ongoing information technology strategy.

*Provision for Income Taxes*

Our provision for income taxes was $18.7 million, or 2.1% of revenues, for the three months ended December 31, 2012, as compared to $21.3 million, or 2.7% of revenues, for the same period last year. The effective tax rate decreased to 33.9% for the three months ended December 31, 2012, compared to 36.1% for the same period last year. Our effective tax rate was lower during the three months ended December 31, 2012 as compared to the three months ended December 31, 2011, primarily as a result of state tax credits earned on the required capital investment in connection with the relocation and consolidation of the hospital support center into a qualifying headquarter support facility in Brentwood, Tennessee.

***For the Years Ended December 31, 2012 and 2011***

On April 5, 2012, a settlement agreement (the ''Rural Floor Settlement'') was signed between HHS, the Secretary of HHS, CMS and a large number of healthcare service providers, including our hospitals. The Rural Floor Settlement is intended to resolve all claims that have been brought or could have been brought relating to CMS's calculation of the rural floor budget neutrality adjustment that was created by the Balanced Budget Act of 1997 from federal fiscal year 1998 through and including federal fiscal year 2011 for healthcare service providers that participated in certain court cases and group appeals. As a result of the Rural Floor Settlement, we recognized $33.0 million of additional Medicare revenue included under the caption ''Revenues before provision for doubtful accounts'' and approximately $6.0 million of costs, which are included under the captions ''Other operating expenses'' and ''Salaries and benefits'' for the year ended December 31, 2012.

The following table summarizes the results of operations for the years ended December 31, 2012 and 2011 (dollars in millions):

| | Years Ended December 31, | | | |
|---|---|---|---|---|
| | 2012 | | 2011 | |
| | Amount | % of Revenues | Amount | % of Revenues |
| Revenues before provision for doubtful accounts | $4,016.2 | 118.4% | $3,544.6 | 117.1% |
| Provision for doubtful accounts | 624.4 | 18.4 | 518.5 | 17.1 |
| Revenues | 3,391.8 | 100.0 | 3,026.1 | 100.0 |
| Salaries and benefits | 1,554.5 | 45.8 | 1,364.7 | 45.1 |
| Supplies | 524.6 | 15.5 | 469.5 | 15.5 |
| Other operating expenses | 799.1 | 23.5 | 682.4 | 22.6 |
| Other income | (32.0) | (0.9) | (26.7) | (0.9) |
| Depreciation and amortization | 193.1 | 5.7 | 165.8 | 5.5 |
| Interest expense, net | 100.0 | 3.0 | 107.1 | 3.5 |
| Debt extinguishment costs | 4.4 | 0.1 | — | — |
| Impairment charges | 4.0 | 0.1 | — | — |
| | 3,147.7 | 92.8 | 2,762.8 | 91.3 |
| Income from continuing operations before income taxes | 244.1 | 7.2 | 263.3 | 8.7 |
| Provision for income taxes | 88.5 | 2.6 | 97.8 | 3.2 |
| Income from continuing operations | 155.6 | 4.6 | 165.5 | 5.5 |
| Less: Net income attributable to noncontrolling interests | (3.7) | (0.1) | (2.8) | (0.1) |
| Income from continuing operations attributable to LifePoint Hospitals, Inc. | $ 151.9 | 4.5% | $ 162.7 | 5.4% |

***Revenues***

The following table presents the components of revenues from continuing operations and on a same-hospital basis for the years ended December 31, 2012 and 2011 (dollars in millions):

| | Years Ended December 31, | | | |
|---|---|---|---|---|
| | 2012 | 2011 | Increase | % Increase |
| Continuing operations: | | | | |
| Revenues before provision for doubtful accounts | $4,016.2 | $3,544.6 | $471.6 | 13.3% |
| Provision for doubtful accounts | 624.4 | 518.5 | 105.9 | 20.4 |
| Revenues | $3,391.8 | $3,026.1 | $365.7 | 12.1 |
| Same-hospital: | | | | |
| Revenues before provision for doubtful accounts | $3,693.3 | $3,517.9 | $175.4 | 5.0% |
| Provision for doubtful accounts | 585.2 | 512.7 | 72.5 | 14.1 |
| Revenues | $3,108.1 | $3,005.2 | $102.9 | 3.4 |

The following table shows the sources of our revenues by payor, including adjustments to estimated reimbursement amounts and provision for doubtful accounts, for the years ended December 31, 2012 and 2011 (in millions):

| | Years Ended December 31, | | | |
|---|---|---|---|---|
| | 2012 | | 2011 | |
| | Amount | % of Revenues | Amount | % of Revenues |
| Medicare | $1,170.3 | 34.5% | $1,061.3 | 35.0% |
| Medicaid | 488.9 | 14.4 | 432.1 | 14.3 |
| HMOs, PPOs and other private insurers | 1,651.2 | 48.7 | 1,446.6 | 47.8 |
| Self-pay | 653.9 | 19.3 | 565.3 | 18.7 |
| Other | 51.9 | 1.5 | 39.3 | 1.3 |
| Revenues before provision for doubtful accounts | 4,016.2 | 118.4 | 3,544.6 | 117.1 |
| Provision for doubtful accounts | (624.4) | (18.4) | (518.5) | (17.1) |
| Revenues | $3,391.8 | 100.0% | $3,026.1 | 100.0% |

Our revenues per equivalent admission from continuing operations and on a same-hospital basis were as follows for the years ended December 31, 2012 and 2011:

| | Years Ended December 31, | | | |
|---|---|---|---|---|
| | 2012 | 2011 | Increase | % Increase |
| Revenues per equivalent admission – continuing operations | $7,491 | $7,126 | $365 | 5.1 |
| Revenues per equivalent admission – same-hospital | $7,462 | $7,137 | $325 | 4.6 |

*Revenues Before Provision for Doubtful Accounts*

The following table shows the key drivers of our revenues before provision for doubtful accounts from continuing operations and on a same-hospital basis for the years ended December 31, 2012 and 2011:

| | Years Ended December 31, | | Increase (Decrease) | % Increase (Decrease) |
|---|---|---|---|---|
| | 2012 | 2011 | | |
| Continuing operations: | | | | |
| Admissions | 199,814 | 195,974 | 3,840 | 2.0 |
| Equivalent admissions | 452,779 | 424,676 | 28,103 | 6.6 |
| Medicare case mix index | 1.31 | 1.29 | 0.02 | 1.6 |
| Average length of stay (days) | 4.4 | 4.3 | 0.1 | 2.3 |
| Inpatient surgeries | 53,696 | 53,017 | 679 | 1.3 |
| Outpatient surgeries | 171,246 | 158,240 | 13,006 | 8.2 |
| Emergency room visits | 1,149,301 | 1,024,273 | 125,028 | 12.2 |
| Outpatient factor | 2.27 | 2.17 | 0.10 | 4.6 |
| Same-hospital: | | | | |
| Admissions | 186,447 | 194,681 | (8,234) | (4.2) |
| Equivalent admissions | 416,523 | 421,095 | (4,572) | (1.1) |
| Medicare case mix index | 1.31 | 1.29 | 0.02 | 1.1 |
| Average length of stay (days) | 4.2 | 4.3 | (0.1) | (2.3) |
| Inpatient surgeries | 49,564 | 52,718 | (3,154) | (6.0) |
| Outpatient surgeries | 158,954 | 157,184 | 1,770 | 1.1 |
| Emergency room visits | 1,054,501 | 1,013,412 | 41,089 | 4.1 |
| Outpatient factor | 2.23 | 2.16 | 0.07 | 3.2 |

For the year ended December 31, 2012, our same-hospital revenues before provision for doubtful accounts increased by $175.4 million, or 5.0%, to $3,693.3 million as compared to $3,517.9 million for the same period last year. Same-hospital admissions decreased 4.2% over the same period in the prior year while same-hospital equivalent admissions decreased at a more modest 1.1%. The decrease in same-hospital admissions was primarily a result of decreases in our one day stay admissions that started in the second quarter of 2012 and continued through the end of the year. The same-hospital equivalent admissions continue to be favorably impacted by stronger outpatient surgeries, higher emergency room visits and overall growth in our oncology, cardiology and imaging services.

The majority of our increase in same-hospital revenues before the provision for doubtful accounts related to HMO, PPO's and other private insurers, self-pay payors and Medicare. Our same-hospital HMO, PPO's and other private insurer revenue generally increased as a result of higher contracted rates. Self-pay revenue increases were primarily driven by pricing increases and higher self-pay volumes. These increases in self-pay revenues were partially offset by an approximate $5.6 million reduction in funding during the second half of 2012 as compared to the prior year, as a result of a decrease in our reimbursement under a New Mexico state program that provides for supplemental support and funding for the care of indigent patients.

Finally, Medicare revenue increases were largely driven by the impact of recognizing $33.0 million related to the Rural Floor Settlement during the year ended December 31, 2012, and due to increases in the overall acuity of patient care as evidenced by higher Medicare case mix index compared to the prior year. These increases in Medicare revenue were partially offset by decreases due to the absence of favorable cost report adjustments during the current year that were recognized in the prior year, as well as the negative impact of a higher level of denials as a result of RAC audits as compared to the same period last year. For the year ended December 31, 2012, our RAC audits resulted in approximately $11.6 million of higher revenue reductions as compared to the prior year.

*Provision for Doubtful Accounts*

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts from continuing operations and on a same-hospital basis for the years ended December 31, 2012 and 2011 (dollars in millions):

| | Years Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2012 | % of Revenues | 2011 | % of Revenues | Increase | % Increase |
| Continuing operations: | | | | | | |
| Related key indicators: | | | | | | |
| Charity care write-offs | $112.5 | 3.3% | $ 89.4 | 3.0% | $23.1 | 25.8% |
| Self-pay revenues, net of charity care write-offs and uninsured discounts | $653.9 | 19.3% | $565.3 | 18.7% | $88.6 | 15.7% |
| Net revenue days outstanding (at end of period) | 54.7 | N/A | 52.3 | N/A | 2.4 | 4.6% |
| Same-hospital: | | | | | | |
| Related key indicators: | | | | | | |
| Charity care write-offs | $106.0 | 3.4% | $ 89.1 | 3.0% | $16.9 | 19.0% |
| Self-pay revenues, net of charity care write-offs and uninsured discounts | $610.4 | 19.6% | $559.4 | 18.6% | $51.0 | 9.1% |
| Net revenue days outstanding (at end of period) | 53.6 | N/A | 51.1 | N/A | 2.5 | 4.9% |

For the year ended December 31, 2012, our provision for doubtful accounts increased by $105.9 million, or 20.4%, to $624.4 million on a continuing operations basis and by $72.5 million, or 14.1%, to $585.2 million on a same-hospital basis as compared to the prior year. This increase was primarily the result of increases in self-pay revenues during the year ended December 31, 2012. Same-hospital self-pay revenues increased by $51.0 million over the prior year and represents 19.6% of revenues as compared to 18.6% of revenues in the prior year. Self-pay revenues continued to increase for both our inpatient and outpatient services, which were primarily driven by higher self-pay volumes and pricing increases. Additionally, as a result of a decrease in our reimbursement under a New Mexico state program that provides for supplemental support and funding for the care of indigent patients we have experienced an increase of approximately $5.6 million in our charity care write-offs during the year ended December 31, 2012, as compared to the prior year.

Our increased provision for doubtful accounts was partially offset by an increase in both up-front cash collections and cash collections related to our insured receivables for the year ended December 31, 2012, as compared to the prior year. The provision for doubtful accounts relates principally to self-pay amounts due from patients. The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Critical Accounting Estimates."

We have changed our historical calculation of net revenue days outstanding in the table above to be consistent with our current period computation and presentation. Specifically, the impact of certain non-healthcare services revenues has been excluded from our calculation of revenue per day, the denominator in this computation. The recognition of certain non-healthcare services revenues does not generally result in accounts receivable from third-party payors or patients. Accordingly, we have determined that it is more appropriate to exclude these non-healthcare services revenues from our revenue per day calculation. This change had the impact of decreasing our revenue per day calculation and resulted in an overall higher computation of net revenue days outstanding as of period end. This change had no impact on our historical results of operations.

***Expenses and Other Income***

*Salaries and Benefits*

The following table summarizes our salaries and benefits, man-hours per equivalent admission and salaries and benefits per equivalent admission for the years ended December 31, 2012 and 2011:

| | Years Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2012 | % of Revenues | 2011 | % of Revenues | Increase | % Increase |
| Salaries and benefits (dollars in millions) . . | $1,554.5 | 45.8% | $1,364.7 | 45.1% | $189.8 | 13.9% |
| Man-hours per equivalent admission . . . . . | 103.1 | N/A | 98.7 | N/A | 4.4 | 4.5% |
| Salaries and benefits per equivalent admission. . . . . | $ 3,424 | N/A | $ 3,201 | N/A | $ 223 | 7.0% |

For the year ended December 31, 2012, our salaries and benefits expense increased to $1,554.5 million, or 13.9%, as compared to $1,364.7 million for the prior year. This increase in our salaries and benefits expense is primarily a result of our recent acquisitions, the impact of an increasing number of employed physicians and their related support staff and the impact of compensation increases for our employees. These increases contributed to an increase in man-hours per equivalent admission to 103.1, or 4.5%, as compared to 98.7 for the prior year.

Additionally, our salaries and benefits expense increased as a result of severance costs related to our shared centralized resource initiatives. Primarily in connection with our shared centralized resource initiatives implementation process, we incurred severance and retention costs for our affected workforce of approximately $3.8 million for the year ended December 31, 2012. We estimate we will recognize approximately $4.6 million of additional severance and retention costs over the remaining implementation periods of 18 to 24 months.

Furthermore, for the year ended December 31, 2012, we estimate that we incurred approximately $10.8 million of salaries and benefits expense related to the implementation of our EHR initiatives as compared to $5.9 million for the prior year.

*Supplies*

The following table summarizes our supplies and supplies per equivalent admission for the years ended December 31, 2012 and 2011:

| | Years Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2012 | % of Revenues | 2011 | % of Revenues | Increase | % Increase |
| Supplies (dollars in millions) | $524.6 | 15.5% | $469.5 | 15.5% | $55.1 | 11.7% |
| Supplies per equivalent admission | $1,158 | N/A | $1,106 | N/A | $ 52 | 4.8% |

For the year ended December 31, 2012, our supplies expense increased to $524.6 million, or 11.7%, as compared to $469.5 million for the prior year and our supplies per equivalent admission increased to $1,158, or 4.8% as compared to $1,106 for the prior year. These increases were primarily a result of our recent acquisitions.

*Other Operating Expenses*

The following table summarizes our other operating expenses for the years ended December 31, 2012 and 2011 (dollars in millions):

| | Years Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2012 | % of Revenues | 2011 | % of Revenues | Increase (Decrease) | % Increase (Decrease) |
| Professional fees | $115.5 | 3.4% | $ 97.8 | 3.2% | $ 17.7 | 18.2% |
| Utilities | 62.8 | 1.9 | 58.0 | 1.9 | 4.8 | 8.3 |
| Repairs and maintenance | 86.4 | 2.5 | 80.2 | 2.7 | 6.2 | 7.7 |
| Rents and leases | 34.3 | 1.0 | 30.0 | 1.0 | 4.3 | 14.1 |
| Insurance | 38.6 | 1.1 | 39.5 | 1.3 | (0.9) | (2.4) |
| Physician recruiting | 29.1 | 0.9 | 28.6 | 0.9 | 0.5 | 1.5 |
| Contract services | 219.3 | 6.5 | 180.7 | 6.0 | 38.6 | 21.4 |
| Non-income taxes | 89.8 | 2.6 | 74.1 | 2.4 | 15.7 | 21.2 |
| Other | 123.3 | 3.6 | 93.5 | 3.2 | 29.8 | 32.0 |
| | $799.1 | 23.5 | $682.4 | 22.6 | $116.7 | 17.1% |

For the year ended December 31, 2012, our other operating expenses increased to $799.1 million, or 17.1%, as compared to $682.4 million for the prior year. This increase in our other operating expenses for the year ended December 31, 2012 was primarily a result of our recent acquisitions as well as increases in our same-hospital professional fees, contract services, non-income taxes and other expenses.

As a shortage of physicians continues to become more acute, we have experienced increasing professional fees in areas such as emergency room physician coverage and hospitalists. We expect this trend to continue and that professional fees as a percentage of revenues will increase in future periods.

Our contract services expense increased primarily as a result of increased fees and expenses related to our conversion of the clinical and patient accounting information system applications at several of our hospitals. For the year ended December 31, 2012, we estimate that we incurred approximately $12.1 million of operating expenses related to the implementation of our EHR initiatives as compared to $5.3 million for the prior year.

Our non-income taxes increased primarily as a result of increases in state provider tax assessments for those supplemental payment programs in which we participate.

Our other expenses increased primarily as a result of additional legal fees incurred in connection with the Rural Floor Settlement and approximately $10.1 million in legal and consulting fees related to our recent acquisitions. Additional increases in other expenses are the result of an increase in our estimated legal reserves related to a billing matter at one of our hospitals as well as higher and additional software maintenance expense as a result of our ongoing investments in information systems as the result of various initiatives and requirements, including compliance with the HITECH Act.

*Other Income*

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income in accordance with ASC 450-30 when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the year ended December 31, 2012, we recognized $15.1 million and $16.9 million in Medicare and Medicaid EHR incentive payments, respectively, as compared to $26.7 million in Medicaid EHR incentive payments recognized in the prior year. We did not recognize any Medicare EHR incentive payments during the year ended December 31, 2011.

*Depreciation and Amortization*

For the year ended December 31, 2012, our depreciation and amortization expense increased by $27.3 million, or 16.5% to $193.1 million, or 5.7% of revenues, as compared to $165.8 million, or 5.5% of revenues for the prior year. Our depreciation and amortization expense increased primarily as a result of our recent acquisitions as well as a result of significant increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. Additionally, we have experienced increases in depreciation expense relating to capital improvement projects completed during 2012 and 2011. We anticipate that our depreciation and amortization expense as a percentage of revenues will continue to increase in future periods.

*Interest Expense*

Our interest expense decreased by $7.1 million, or 6.6%, to $100.0 million, for the year ended December 31, 2012, as compared to $107.1 million for the prior year. This decrease was primarily a result of the maturity of our interest rate swap effective May 30, 2011. With the maturity of our interest rate swap a larger portion of our total outstanding debt has become subject to floating interest rates that are lower than the previously fixed rate under the interest rate swap agreement of 5.585%. Additionally, effective July 24, 2012, we replaced the Prior Credit Agreement with the Senior Credit Agreement. The applicable effective interest on the Senior Credit Agreement was lower than the applicable effective interest on the Prior Credit Agreement. For a further discussion of our debt and corresponding interest rates, see ‘‘Liquidity and Capital Resources — Debt.’’

*Debt Extinguishment Costs*

In connection with our replacement of the Prior Credit Agreement with the Senior Credit Agreement during the year ended December 31, 2012, we recorded $4.4 million of debt extinguishment costs. The debt extinguishment costs include $2.4 million of previously capitalized loan costs and $2.0 million of loan costs related to the issuance of the Senior Credit Agreement.

*Impairment Charges*

During the year ended December 31, 2012, we incurred a $4.0 million impairment charge from continuing operations. This impairment charge primarily relates to the write-off of certain capitalized information system costs which we have determined are no longer a necessary component of our ongoing information technology strategy.

*Provision for Income Taxes*

Our provision for income taxes was $88.5 million, or 2.6% of revenues, for the year ended December 31, 2012, as compared to $97.8 million, or 3.2% of revenues, for the prior year. The effective tax rate decreased to 36.8% for the year ended December 31, 2012, compared to 37.6% for the prior year. Our effective tax rate was lower during the year ended December 31, 2012 as compared to the year ended December 31, 2011 primarily as a result of state tax credits earned on the required capital investment in connection with the relocation and consolidation of the hospital support center into a qualifying headquarter support facility in Brentwood, Tennessee.

***For the Years Ended December 31, 2011 and 2010***

The following table summarizes the results of operations for the years ended December 31, 2011 and 2010 (dollars in millions):

| | Years Ended December 31, | | | |
|---|---|---|---|---|
| | 2011 | | 2010 | |
| | Amount | % of Revenues | Amount | % of Revenues |
| Revenues before provision for doubtful accounts | $3,544.6 | 117.1% | $3,262.4 | 115.7% |
| Provision for doubtful accounts | 518.5 | 17.1 | 443.8 | 15.7 |
| Revenues | 3,026.1 | 100.0 | 2,818.6 | 100.0 |
| Salaries and benefits | 1,364.7 | 45.1 | 1,270.3 | 45.1 |
| Supplies | 469.5 | 15.5 | 443.0 | 15.7 |
| Other operating expenses | 682.4 | 22.6 | 605.2 | 21.5 |
| Other income | (26.7) | (0.9) | — | — |
| Depreciation and amortization | 165.8 | 5.5 | 148.5 | 5.2 |
| Interest expense, net | 107.1 | 3.5 | 108.1 | 3.8 |
| Debt extinguishment costs | — | — | 2.4 | 0.1 |
| | 2,762.8 | 91.3 | 2,577.5 | 91.4 |
| Income from continuing operations before income taxes | 263.3 | 8.7 | 241.1 | 8.6 |
| Provision for income taxes | 97.8 | 3.2 | 82.4 | 3.0 |
| Income from continuing operations | 165.5 | 5.5 | 158.7 | 5.6 |
| Less: Net income attributable to noncontrolling interests | (2.8) | (0.1) | (3.1) | (0.1) |
| Income from continuing operations attributable to LifePoint Hospitals, Inc. | $ 162.7 | 5.4% | $ 155.6 | 5.5% |

***Revenues***

The following table presents the components of revenues for the years ended December 31, 2011 and 2010 (dollars in millions):

| | Years Ended December 31, | | | |
|---|---|---|---|---|
| | 2011 | 2010 | Increase | % Increase |
| Revenues before provision for doubtful accounts | $3,544.6 | $3,262.4 | $282.2 | 8.6% |
| Provision for doubtful accounts | 518.5 | 443.8 | 74.7 | 16.8 |
| Revenues | $3,026.1 | $2,818.6 | $207.5 | 7.4 |

The following table shows the sources of our revenues by payor, including adjustments to estimated reimbursement amounts and provision for doubtful accounts, for the years ended December 31, 2011 and 2010 (dollars in millions):

| | Years Ended December 31, | | | |
|---|---|---|---|---|
| | 2011 | | 2010 | |
| | Amount | % of Revenues | Amount | % of Revenues |
| Medicare | $1,061.3 | 35.0% | $ 983.7 | 34.9% |
| Medicaid | 432.1 | 14.3 | 410.8 | 14.6 |
| HMOs, PPOs and other private insurers | 1,446.6 | 47.8 | 1,360.1 | 48.2 |
| Self-pay | 565.3 | 18.7 | 475.1 | 16.9 |
| Other | 39.3 | 1.3 | 32.7 | 1.1 |
| Revenues before provision for doubtful accounts | 3,544.6 | 117.1 | 3,262.4 | 115.7 |
| Provision for doubtful accounts | (518.5) | (17.1) | (443.8) | (15.7) |
| Revenues | $3,026.1 | 100.0% | $2,818.6 | 100.0% |

For the year ended December 31, 2011, our revenues per equivalent admission increased by $201, or 2.9%, to $7,126 as compared to $6,925 for the prior year.

*Revenues Before Provision for Doubtful Accounts*

The following table shows the key drivers of our revenues before provision for doubtful accounts for the years ended December 31, 2011 and 2010:

| | Years Ended December 31, | | Increase (Decrease) | % Increase (Decrease) |
|---|---|---|---|---|
| | 2011 | 2010 | | |
| Admissions | 195,974 | 188,875 | 7,099 | 3.8 |
| Equivalent admissions | 424,676 | 407,026 | 17,650 | 4.3 |
| Medicare case mix index | 1.29 | 1.30 | (0.01) | (0.8) |
| Average length of stay (days) | 4.3 | 4.4 | (0.1) | (2.3) |
| Inpatient surgeries | 53,017 | 53,914 | (897) | (1.7) |
| Outpatient surgeries | 158,240 | 155,691 | 2,549 | 1.6 |
| Emergency room visits | 1,024,273 | 952,449 | 71,824 | 7.5 |
| Outpatient factor | 2.17 | 2.16 | 0.01 | 0.6 |

For the year ended December 31, 2011, our revenues before provision for doubtful accounts increased by $282.2 million, or 8.6%, to $3,544.6 million as compared to $3,262.4 million for the prior year. This increase is attributable to our acquisitions completed in 2011 and 2010 in addition to increases in same-hospital revenues before provision for doubtful accounts related to increases in Medicare, HMOs, PPOs and other private insurers and self-pay payors during the year ended December 31, 2011 as compared to the prior year.

Increases in our same-hospital Medicare revenues were largely driven by higher Medicare equivalent admissions, benefits associated with improved Medicare reimbursement rates such as the market basket update and budget neutrality indices combined with an increase in anticipated cost report settlements. Our same-hospital HMOs, PPOs and other private insurers revenue increased primarily as a result of higher contracted rates partially offset by unfavorable equivalent admission volumes compared to the same period of the prior year. Finally, same-hospital self-pay revenues increased primarily as a result of higher emergency room visits from our self-pay population, overall high levels of unemployment in the majority of our communities and pricing increases. Increases in our self-pay revenues contributed to an increase in our provision for doubtful accounts, as further discussed in our analysis of our provision for doubtful accounts.

*Provision for Doubtful Accounts*

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts for the years ended December 31, 2011 and 2010 (dollars in millions):

| | Years Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2011 | % of Revenues | 2010 | % of Revenues | Increase | % Increase |
| Related key indicators: | | | | | | |
| Charity care write-offs | $ 89.4 | 3.0% | $ 62.3 | 2.2% | $27.1 | 43.5% |
| Self-pay revenues, net of charity care write-offs and uninsured discounts | $565.3 | 18.7% | $475.1 | 16.9% | $90.2 | 19.0% |
| Net revenue days outstanding (at end of period) | 52.3 | N/A | 50.5 | N/A | 1.8 | 3.6% |

For the year ended December 31, 2011, our provision for doubtful accounts increased by $74.7 million, or 16.8%, to $518.5 million as compared to the prior year. This increase was primarily the result of our acquisitions completed in 2011 and 2010 as well as increases in self-pay revenues during the year ended December 31, 2011. Self-pay revenues increased by $90.2 million over the prior year and represents 18.7% of revenues as compared to 16.9% of revenues in the prior year. Self-pay revenues continued to increase for both our inpatient and outpatient services which were primarily driven by high levels of unemployment in the majority of our communities. Our increased provision for doubtful accounts was partially offset by an increase in both up-front cash collections and cash collections related to our insured receivables for the year ended December 31, 2011, as compared to the prior year. The provision for doubtful accounts relates principally to self-pay amounts due from patients. The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*, ''Critical Accounting Estimates.''

We have changed our historical calculation of net revenue days outstanding in the table above to be consistent with our current period computation and presentation. Specifically, the impact of certain non-healthcare services revenues has been excluded from our calculation of revenue per day, the denominator in this computation. The recognition of certain non-healthcare services revenues does not generally result in accounts receivable from third-party payors or patients. Accordingly, we have determined that it is more appropriate to exclude these non-healthcare services revenues from our revenue per day calculation. This change had the impact of decreasing our revenue per day calculation and resulted in an overall higher computation of net revenue days outstanding as of period end. This change had no impact on our historical results of operations.

***Expenses and Other Income***

*Salaries and Benefits*

The following table summarizes our salaries and benefits, man-hours per equivalent admission and salaries and benefits per equivalent admission for the years ended December 31, 2011 and 2010:

| | Years Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2011 | % of Revenues | 2010 | % of Revenues | Increase | % Increase |
| Salaries and benefits (dollars in millions) | $1,364.7 | 45.1% | $1,270.3 | 45.1% | $94.4 | 7.4% |
| Man-hours per equivalent admission | 98.7 | N/A | 96.3 | N/A | 2.4 | 2.5% |
| Salaries and benefits per equivalent admission | $ 3,201 | N/A | $ 3,112 | N/A | $ 89 | 2.9% |

For the year ended December 31, 2011, our salaries and benefits expense increased to $1,364.7 million, or 7.4%, as compared to $1,270.3 million for the prior year. This increase in our salaries and benefits expense is primarily a result of the impact of our 2011 and 2010 acquisitions, the impact of compensation increases for our employees and an increase in man-hours per equivalent admission to 98.7, or 2.4% as compared to 96.3 for the same period last year. These increases were partially offset by lower employee benefits costs.

Furthermore, for the year ended December 31, 2011, we estimate that we incurred approximately $5.9 million of salaries and benefits expense related to the implementation of our EHR initiatives.

*Supplies*

The following table summarizes our supplies and supplies per equivalent admission for the years ended December 31, 2011 and 2010:

| | Years Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2011 | % of Revenues | 2010 | % of Revenues | Increase | % Increase |
| Supplies (dollars in millions) | $469.5 | 15.5% | $443.0 | 15.7% | $26.5 | 6.0% |
| Supplies per equivalent admission | $1,106 | N/A | $1,088 | N/A | $ 18 | 1.6% |

For the year ended December 31, 2011, our supplies expense increased to $469.5 million, or 6.0%, as compared to $443.0 million for the prior year. This increase in our supplies expense for the year ended December 31, 2011 was primarily a result of our 2011 and 2010 acquisitions and an increase in our supplies expense per equivalent admission to $1,106, or 1.6%, as compared to $1,088 for the prior year. Supplies per equivalent admission increased as a result of a higher utilization of more expensive supplies in areas such as orthopedics, cardiac devices and spine and bone as well as an increase in our pharmacy supplies expense.

*Other Operating Expenses*

The following table summarizes our other operating expenses for the years ended December 31, 2011 and 2010 (dollars in millions):

| | Years Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2011 | % of Revenues | 2010 | % of Revenues | Increase (Decrease) | % Increase (Decrease) |
| Professional fees | $ 97.8 | 3.2% | $ 82.9 | 2.9% | $14.9 | 17.9% |
| Utilities | 58.0 | 1.9 | 53.8 | 1.9 | 4.2 | 7.9 |
| Repairs and maintenance | 80.2 | 2.7 | 71.8 | 2.5 | 8.4 | 11.7 |
| Rents and leases | 30.0 | 1.0 | 27.0 | 1.0 | 3.0 | 11.3 |
| Insurance | 39.5 | 1.3 | 42.8 | 1.5 | (3.3) | (7.7) |
| Physician recruiting | 28.6 | 0.9 | 24.1 | 0.9 | 4.5 | 18.6 |
| Contract services | 180.7 | 6.0 | 156.5 | 5.6 | 24.2 | 15.4 |
| Non-income taxes | 74.1 | 2.4 | 65.9 | 2.3 | 8.2 | 12.5 |
| Other | 93.5 | 3.2 | 80.4 | 2.9 | 13.1 | 16.3 |
| | $682.4 | 22.6 | $605.2 | 21.5 | $77.2 | 12.8% |

For the year ended December 31, 2011, our other operating expenses increased to $682.4 million, or 12.8%, as compared to $605.2 million for the prior year. This increase in other operating expenses for the year ended December 31, 2011 was primarily a result of our 2011 and 2010 acquisitions as well as increases in professional fees, contract services and other expenses.

As a shortage of physicians continues to become more acute, we have experienced increasing professional fees in areas such as emergency room physician coverage and hospitalists.

Our contract services expense increased primarily as a result of increased accounts receivable collection fees and fees related to our conversion of the clinical and patient accounting information system applications at certain hospitals. For the year ended December 31, 2011, we estimate we incurred approximately $5.3 of additional operating expenses related to the implementation of our EHR initiatives.

Finally, our other expenses increased primarily as a result of increases in our charitable program expense as well as additional legal and consulting fees related to our 2011 acquisitions.

*Other Income*

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income in accordance with ASC 450-30 when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report

information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the year ended December 31, 2011, we recognized $26.7 million in Medicaid EHR incentive payments which was not available in the prior year.

*Depreciation and Amortization*

For the year ended December 31, 2011, our depreciation and amortization expense increased by $17.3 million, or 11.7% to $165.8 million, or 5.5% of revenues, as compared to $148.5 million, or 5.2% of revenues for the prior year. Our depreciation and amortization expense increased primarily as a result of our 2011 and 2010 acquisitions as well as a result of significant increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. Additionally, we have experienced increases in depreciation expense relating to capital improvement projects completed during 2011 and 2010.

*Interest Expense*

Our interest expense decreased by $1.0 million, or 0.9%, to $107.1 for the year ended December 31, 2011, as compared to $108.1 million for the prior year as a result of several factors. Effective September 23, 2010, we issued $400.0 million of 6.625% unsecured senior notes due October 1, 2020 (the ''6.625% Senior Notes''). The net proceeds from this issuance were used to repay $249.2 million of our outstanding borrowings under the term B loans (the ''Term B Loans'') provided pursuant to our Prior Credit Agreement and $6.0 million of our outstanding borrowings under our Province 7½% senior subordinated notes due 2013 (the ''Province 7½% Notes''). Interest on the 6.625% Senior Notes is payable at an annual fixed rate of 6.625% as compared to a variable rate under our Term B Loans, which for the year ended December 31, 2011, on a weighted average basis, was 3.11%. On November 30, 2010, the notional amount of our interest rate swap decreased from $450.0 million to $300.0 million and effective May 30, 2011 our interest rate swap agreement matured. As the notional amount of our interest rate swap declined and then matured, a larger portion of our total outstanding debt has become subject to floating interest rates that are lower than the previously fixed rate under the agreement of 5.585% for the year ended December 31, 2011 as compared to the same period last year. For a further discussion of our debt and corresponding interest rates, see ''Liquidity and Capital Resources — Debt.''

*Provision for Income Taxes*

Our provision for income taxes was $97.8 million, or 3.2% of revenues, for the year ended December 31, 2011, as compared to $82.4 million, or 3.0% of revenues, for the prior year. The effective tax rate increased to 37.6% for the year ended December 31, 2011, compared to 34.6% for the prior year. Our effective tax rate was lower during the year ended December 31, 2010 as compared to the year ended December 31, 2011 primarily as a result of decreases in income tax liabilities due to a tax accounting method change and the expiration of statutes of limitations on various income tax returns.

## Liquidity and Capital Resources

### *Liquidity*

Our primary sources of liquidity are cash flows provided by our operations and our debt borrowings. We believe that our internally generated cash flows and the amounts available under our debt agreements will be adequate to service existing debt, finance internal growth and fund capital expenditures and certain small to mid-size hospital acquisitions.

The following table presents summarized cash flow information for the years ended December 31, 2012, 2011 and 2010 (in millions):

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Net cash flows provided by continuing operations | $ 382.9 | $ 401.2 | $ 375.7 |
| Less: Purchases of property and equipment | (221.4) | (219.9) | (168.7) |
| Free operating cash flow | 161.5 | 181.3 | 207.0 |
| Acquisitions, net of cash acquired | (199.7) | (121.0) | (184.9) |
| Proceeds from borrowings | 555.0 | — | 400.0 |
| Payments of borrowings | (469.3) | (0.1) | (255.2) |
| Repurchases of common stock | (95.5) | (174.6) | (152.1) |
| Payment of debt financing costs | (10.0) | (0.4) | (13.7) |
| Proceeds from exercise of stock options | 21.8 | 39.0 | 20.4 |
| Other | (4.3) | (5.7) | 0.3 |
| Cash flows from operations provided by (used in) discontinued operations | (0.7) | 0.3 | (1.6) |
| Net (decrease) increase in cash and cash equivalents | $ (41.2) | $ (81.2) | $ 20.2 |

The non-GAAP metric of free operating cash flow is an important liquidity measure for us. Our computation of free operating cash flow consists of net cash flows provided by continuing operations less cash flows used for the purchase of property and equipment.

Our net cash flows provided by continuing operations for the year ended December 31, 2012 as compared to 2011 were negatively impacted by increases in the amount and timing of cash payments made for income taxes and self-insurance claims as well as an increase in our insured accounts receivable and outstanding accounts receivable for certain of our recent acquisitions. These decreases were partially offset by increases as a result of the receipt of approximately $33.0 million related to the Rural Floor Settlement during the year ended December 31, 2012.

Our net cash flows provided by continuing operations for the year ended December 31, 2011 as compared to 2010 were positively impacted by an increase in net income. This increase was partially offset by increases in the amount and timing of cash payments made for interest and income taxes. Our free operating cash flows for the year ended December 31, 2011 were lower as compared to 2010 because of a significant increase in our purchases of property and equipment related to building and equipping a replacement hospital for one of our facilities and an increase in our purchases of information systems as the result of various initiatives and requirements, including compliance with the HITECH Act.

We believe that free operating cash flow is useful to investors and management as a measure of the ability of our business to generate cash and to repay and incur additional debt. Computations of free operating cash flow may differ from company to company. Therefore, free operating cash flow should be used as a complement to, and in conjunction with, our consolidated statements of cash flows presented in our consolidated financial statements included elsewhere in this report.

***Capital Expenditures***

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

The following table reflects our capital expenditures for the years ended December 31, 2012, 2011 and 2010 (dollars in millions):

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Capital projects | $ 77.2 | $ 80.4 | $ 67.6 |
| Routine | 43.6 | 57.0 | 56.7 |
| Information systems | 100.6 | 82.5 | 44.4 |
| | 221.4 | 219.9 | 168.7 |
| Depreciation expense | 187.1 | 162.2 | 145.9 |
| Ratio of capital expenditures to depreciation expense | 118% | 136% | 116% |

We have a formal and intensive review procedure for the authorization of capital expenditures. The most important financial measure 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. Throughout 2011 and 2012, we have experienced a significant increase in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. We anticipate a reduction in these types of expenditures for 2013 as compared to 2012.

***Debt***

An analysis and roll-forward of our long-term debt during 2012 is as follows (in millions):

| | December 31, 2011 | Proceeds from Borrowings | Payments of Borrowings | Other[(a)] | Amortization of Convertible Debt Discounts | December 31, 2012 |
|---|---|---|---|---|---|---|
| Senior Credit Agreement: | | | | | | |
| Term Facility | $ — | $450.0 | $ (5.6) | $ — | $ — | $ 444.4 |
| Revolving Facility | — | 105.0 | (20.0) | — | — | 85.0 |
| Term B Loans | 443.7 | — | (443.7) | — | — | — |
| 6.625% Senior Notes | 400.0 | — | — | — | — | 400.0 |
| 3½% Notes | 575.0 | — | — | — | — | 575.0 |
| 3¼% Debentures | 225.0 | — | — | — | — | 225.0 |
| Unamortized discounts on 3¼% Debentures and 3½% Notes | (55.5) | — | — | — | 26.0 | (29.5) |
| Capital leases | 9.1 | 2.6 | (2.3) | 0.5 | — | 9.9 |
| | $1,597.3 | $557.6 | $(471.6) | $0.5 | $26.0 | $1,709.8 |

(a) Represents the assumption of capital leases obligations in connection with certain acquisitions completed during the year ended December 31, 2012.

We use leverage, or our total debt to total capitalization ratio, to make financing decisions. The following table illustrates our financial statement leverage and the classification of our debt at December 31, 2012 and 2011 (dollars in millions):

| | December 31, 2012 | December 31, 2011 | Increase (Decrease) |
|---|---|---|---|
| Current portion of long-term debt | $ 13.3 | $ 1.9 | $ 11.4 |
| Long-term debt | 1,696.5 | 1,595.4 | 101.1 |
| Unamortized discounts of convertible debt instruments | 29.5 | 55.5 | (26.0) |
| Total debt, excluding unamortized discounts of convertible debt instruments | 1,739.3 | 1,652.8 | 86.5 |
| Total LifePoint Hospitals, Inc. stockholders' equity | 2,050.5 | 1,945.2 | 105.3 |
| Total capitalization | $3,789.8 | $3,598.0 | $191.8 |
| Total debt to total capitalization | 45.9% | 45.9% | —bps |
| Percentage of: | | | |
| Fixed rate debt, excluding unamortized discounts of convertible debt instruments | 69.6% | 73.2% | |
| Variable rate debt | 30.4 | 26.8 | |
| | 100.0% | 100.0% | |
| Percentage of: | | | |
| Senior debt | 54.0% | 51.6% | |
| Subordinated debt, excluding unamortized discounts of convertible debt instruments | 46.0 | 48.4 | |
| | 100.0% | 100.0% | |

***Liquidity and Capital Resources Outlook***

We expect the level of spending for capital expenditures in 2013 to be slightly higher than in 2012. We are reconfiguring some of our hospitals to more effectively accommodate patient services and to provide for a greater variety of services, as well as implementing various information system initiatives in our efforts to comply with the HITECH Act. For the year ended December 31, 2012, we spent $100.6 million on information systems. At December 31, 2012, we had uncompleted projects with an estimated additional cost to complete and equip of approximately $68.8 million. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the Senior Credit Agreement.

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

In connection with our acquisition of Marquette General, through our Duke LifePoint Healthcare joint venture, we have committed to invest the remaining $318.6 million of an initial $350.0 million over the next ten years, subject to certain offsets, in capital expenditures and improvements as well as for the continuation of existing or initiation of new physician recruiting activities. Additionally, in connection with our acquisition of Twin County, also through our Duke LifePoint Healthcare joint venture, we have committed to invest an additional $20.0 million in capital expenditures and improvements over the next ten years as well as an additional $3.0 million for the continuation of existing or initiation of new physician recruiting activities over the next five years. These commitments are in addition to our existing annual capital expenditure and physician recruiting commitments in connection with several other previously acquired facilities.

On February 6, 2013, we amended our Senior Credit Agreement pursuant to which we issued $325.0 million of Incremental Term Loans. The proceeds of the Incremental Term Loans were used to

repurchase $223.0 million of our 3¼% Debentures, plus accrued and unpaid interest, following the exercise by the holders thereof of their right to require us to repurchase the 3¼% Debentures on February 15, 2013, as well as to pay fees and expenses related to the issuance of the Incremental Term Loans. We currently intend, subject to market conditions, to redeem the remaining $2.0 million of the outstanding 3¼% Debentures with the proceeds of the Incremental Term Loans on or after February 20, 2013. We intend to use the remaining proceeds of the Incremental Term Loan for general corporate purposes.

We believe that cash generated from our operations and borrowings available under the Senior Credit Agreement will be sufficient to meet our working capital needs, the purchase prices for any potential facility acquisitions, planned capital expenditures and other expected operating needs over the next twelve months and into the foreseeable future prior to the maturity dates of our outstanding debt.

**Contractual Obligations, Commitments and Off-Balance Sheet Arrangements**

***Contractual Obligations***

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

The following table summarizes our significant contractual obligations as of December 31, 2012 and the future periods in which such obligations are expected to be settled in cash (in millions):

| | Payment Due by Period | | | | |
|---|---|---|---|---|---|
| **Contractual Obligations** | **Total** | **2013** | **2014 – 2015** | **2016 – 2017** | **After 2017** |
| Long-term debt obligations[(a)] | $2,026.6 | $298.3 | $ 689.0 | $ 559.8 | $ 479.5 |
| Capital lease obligations[(b)] | 90.0 | 3.6 | 12.1 | 11.5 | 62.8 |
| Operating lease obligations[(c)] | 80.5 | 23.4 | 21.5 | 11.5 | 24.1 |
| Other long-term liabilities[(d)] | 191.6 | 42.5 | 69.3 | 40.3 | 39.5 |
| Purchase obligations[(e)] | 2,241.8 | 289.4 | 448.9 | 430.1 | 1,073.4 |
| Total | $4,630.5 | $657.2 | $1,240.8 | $1,053.2 | $1,679.3 |

(a) Included in long-term debt obligations are principal and interest owed on our outstanding debt obligations. These amounts exclude our unamortized convertible debt discounts and related non-cash amortization. These obligations are explained further in Note 4 to our consolidated financial statements included elsewhere in this report. We used the 1.97% effective interest rate at December 31, 2012 for our $444.4 million outstanding Term Facility and $85.0 million outstanding Revolving Facility to estimate interest payments on these variable rate debt instruments. On February 6, 2013 we amended our Senior Credit Agreement pursuant to which we issued $325.0 million of Incremental Term Loans. Borrowings under the Incremental Term Loans initially bear interest at an adjusted 30-day LIBOR plus an applicable margin of 2.50% per annuity and mature on July 24, 2017. The proceeds of the Incremental Term Loans were used to repurchase $223.0 million of our 3¼% Debentures, plus accrued and unpaid interest, following the exercise by the holders thereof of their right to require us to repurchase the 3¼% Debentures on February 15, 2013, as well as to pay fees and expenses related to the issuance of the Incremental Term Loans. We currently intend, subject to market conditions, to redeem the remaining $2.0 million of the outstanding 3¼% Debentures with the proceeds of the Incremental Term Loans on or after February 20, 2013. We intend to use the remaining proceeds of the Incremental Term Loan for general corporate purposes. Please refer to Note 13 to our consolidated financial statements included elsewhere in this report for more information regarding our Incremental Term Loans and the repurchase option. Our issuance of $325.0 million of Incremental Term Loans in February 2013 has been excluded from the above table for presentation of long-term debt obligations as of December 31, 2012. However, for purposes of the above table, we assumed that all of our 3¼% Debentures would either be repurchased or redeemed by us during the year ended December 31, 2013.

(b) Included in capital lease obligations are the future payments, including interest, due under our capital lease agreements. Additionally, as of December 31, 2012, we have included our future financing obligation of approximately $68.6 million related to an agreement with an unrelated third party to lease a new hospital support center with a targeted occupancy date in the fourth quarter of 2013. Under the terms of the lease agreement, we will lease from the third party the newly constructed hospital support center for a period of just over 15 years following construction completion. Currently, we anticipate that our lease agreement will qualify as a financing lease in accordance with ASC 840-40, ''Leases – Sale-Leaseback Transactions'' and accordingly, we will depreciate the completed hospital support center and amortize the related financing obligation over the expected lease agreement term.

(c) This reflects our future minimum operating lease payments. We enter into operating leases in the normal course of business. Substantially all of our operating lease agreements have fixed payment terms based on the passage of time. Some lease agreements provide us with the option to renew the lease. Our future operating lease obligations would change if we exercised these renewal options and if we entered into additional operating lease agreements. Please refer to Note 10 to our consolidated financial statements included elsewhere in this report for more information regarding our operating leases.

(d) Included in other long-term liabilities are the current and long-term portions of our reserves for self-insurance claims of $27.2 million and $133.0 million, respectively, but excluding the portion of the reserve related to our estimate of recoveries for certain claims in excess of our self-insured retention levels that do not require us to make cash payments. Please refer to ''Critical Accounting Estimates — Reserves for Self-Insurance Claims'' in this report for more information on our reserves for self-insurance claims. Additionally, included in other long-term liabilities are the estimated cash contributions we expect to make to our defined benefit pension plan sufficient to meet our minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended, and our other long-term obligations which require the delivery of cash and for which we can reasonably estimate the timing of such payments.

(e) The following table summarizes our significant purchase obligations as of December 31, 2012 and the future periods in which such obligations are expected to be settled in cash (in millions):

| | Payment Due by Period | | | | |
|---|---|---|---|---|---|
| **Purchase Obligations** | **Total** | **2013** | **2014 – 2015** | **2016 – 2017** | **After 2017** |
| HCA-IT Services[f] | $ 160.6 | $ 29.9 | $ 63.0 | $ 67.7 | $ — |
| Capital expenditure obligations[g] | 1,055.8 | 71.1 | 142.3 | 135.1 | 707.3 |
| Physician commitments[h] | 78.2 | 22.6 | 14.7 | 13.4 | 27.5 |
| GEMS obligations[i] | 178.2 | 29.7 | 59.4 | 59.4 | 29.7 |
| Shared centralized resource model agreements[j] | 561.5 | 25.6 | 112.4 | 124.7 | 298.8 |
| Other purchase obligations[k] | 207.5 | 110.5 | 57.1 | 29.8 | 10.1 |
| Total | $2,241.8 | $289.4 | $448.9 | $430.1 | $1,073.4 |

(f) HCA-IT provides various information systems services, including, but not limited to, financial, clinical, patient accounting and network information services to us under a contract that expires on December 31, 2017 (excluding a four-year wind-down period). The amounts are based on estimated fees that will be charged to our hospitals with an annual fee increase that is capped by the consumer price index increase. We used a 3.5% annual rate increase as the estimated consumer price index increase for the contract period. These fees will increase if we acquire additional hospitals and use HCA-IT for information system conversion services at the acquired hospitals, or if we exercise our renewal option during the four-year wind-down period.

(g) We had projects under construction with an estimated additional cost to complete and equip of approximately $68.8 million as of December 31, 2012. Because we can terminate substantially all of the related construction contracts at any time without paying a termination fee, these costs are excluded from the above table except for amounts contractually committed by us. We are subject to annual capital expenditure commitments in connection with several of our facilities, including our recent acquisitions of Marquette General and Twin County.

(h) In consideration for a physician relocating to one of the communities in which our hospitals are located and agreeing to engage in private practice for the benefit of the respective community, we may advance certain amounts of money to that physician, normally over a period of one year, to assist in establishing

the physician's practice. Our liability balance for contract-based physician minimum revenue guarantees was $15.2 million at December 31, 2012 and depends upon the cash collections of a physician's private practice during the guarantee period. Additionally, we are subject to annual commitments for certain physician recruiting activities, including the continuation of existing or initiation of new activities with several of our facilities, including our recent acquisitions of Marquette General and Twin County.

(i) General Electric Medical Services (''GEMS'') provides diagnostic imaging equipment maintenance and bio-medical services to us pursuant to a contract that expires on December 31, 2018.

(j) We have various arrangements with a third party to provide certain nonclinical business functions to us, including payroll, supply chain management and revenue cycle functions under a shared centralized resource model for periods ranging from six to ten years.

(k) Reflects our minimum commitments to purchase goods or services under non-cancelable contracts as of December 31, 2012. In connection with the ongoing implementation of our initiatives to comply with EHR, we have made substantial commitments to purchase goods and services to facilitate our conversions of the clinical and patient accounting information system applications at our hospitals.

***Off-Balance Sheet Arrangements***

We had standby letters of credit outstanding of approximately $29.8 million as of December 31, 2012, all of which relates to the self-insured retention levels of our professional and general liability insurance and workers' compensation programs as security for the payment of claims.

***Recently Issued Accounting Pronouncements***

In February 2013, the Financial Accounting Standards Board issued Accounting Standards Update (''ASU'') No. 2013-2, ''Comprehensive Income — Reporting of Amounts Reclassified Out of Accumulated Other Comprehensive Income'' (''ASU 2013-2''). ASU 2013-2 requires entities to report the effect of significant reclassifications out of accumulated other comprehensive income on the respective line items in net income if the amount being reclassified is required under GAAP to be reclassified in its entirety to net income. For other amounts that are not required under GAAP to be reclassified in their entirety to net income in the same reporting period, an entity is required to cross-reference other disclosures required under GAAP that provide additional detail about those amounts. At December 31, 2012, our only component of accumulated other comprehensive income relates to the unrealized gains on changes in the funded status of our pension benefit obligation. ASU 2013-2 is effective for our three month period ending March 31, 2013. We do not expect the adoption of ASU 2013-2 to impact our financial position, results of operations or cash flows.

**Critical Accounting Estimates**

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

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

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

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

The following discussion of critical accounting estimates is not intended to be a comprehensive list of all of our accounting policies that require estimates. We believe that of our significant accounting policies, as discussed in Note 1 to our consolidated financial statements included elsewhere in this report, the estimates discussed below involve a higher degree of judgment and complexity. We believe the current assumptions and other considerations used to estimate amounts reflected in our consolidated financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in our consolidated financial statements, the resulting changes could have a material adverse effect on our consolidated results of operations and our financial condition.

The discussion that follows presents information about our critical accounting estimates, as well as the effects of hypothetical changes in the material assumptions used to develop each estimate.

***Revenue Recognition and Accounts Receivable***

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

Approximately 97.6%, 97.1%, and 97.7% of our revenues during the years ended December 31, 2012, 2011, and 2010, respectively, relate to discounted charges, which were comprised of the following sources (as a percentage of revenues):

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Medicare | 34.5% | 35.0% | 34.9% |
| Medicaid | 14.4 | 14.3 | 14.6 |
| HMO's, PPO's and other private insurers | 48.7 | 47.8 | 48.2 |

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

We monitor our processes for calculating contractual allowances through:

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

*Medicare and Medicaid*

The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e., gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under the Medicaid program's prospective reimbursement systems, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates.

Discounts for retrospectively cost-based revenues are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under these programs are subject to adjustment based on administrative review and audit by third party intermediaries, which can take several years to resolve completely. Adjustments related to final settlements increased our revenues by $7.0 million, $13.1 million, and $4.9 million for the years ended December 31, 2012, 2011, and 2010, respectively.

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

*HMOs, PPOs and Other Private Insurers*

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

If our overall estimated contractual discount percentage on our managed care program revenues for the year ended December 31, 2012 were changed by 1%, our after-tax income from continuing operations would change by approximately $17.5 million, or diluted earnings per share of $0.36. This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate the amount expected to be received based on payor contract provisions, historical collection data as well as other factors and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts for managed care plans would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

*Provision and Allowance for Doubtful Accounts*

To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts. Our allowance for doubtful accounts, included in our consolidated balance sheets as of December 31, 2012 and 2011 was $558.4 million and $537.4 million, respectively. Our provision for doubtful accounts, included in our consolidated results of operations for the years ended December 31, 2012, 2011, and 2010, was $624.4 million, $518.5 million, and $443.8 million, respectively.

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

The approximate amounts and percentages of billed insured and uninsured (including self-pay, co-payments, deductibles and Medicaid pending) gross accounts receivable (prior to allowance for contractual discounts and allowance for doubtful accounts) in summarized aging categories are as follows for the periods presented (in millions):

| | December 31, 2012 | | | | | |
|---|---|---|---|---|---|---|
| | Insured Receivables | | Uninsured Receivables | | Combined | |
| | Amount | Percent of Receivables | Amount | Percent of Receivables | Amount | Percent of Receivables |
| 0 to 90 days . . . . | $603.7 | 83.0% | $212.6 | 30.4% | $ 816.3 | 57.2% |
| 91 to 150 days . . | 64.0 | 8.8 | 124.0 | 17.7 | 188.0 | 13.2 |
| 151 to 360 days . | 50.9 | 7.0 | 272.5 | 38.9 | 323.4 | 22.7 |
| Over 361 . . . . . | 8.4 | 1.2 | 90.7 | 13.0 | 99.1 | 6.9 |
| | $727.0 | 100.0% | $699.8 | 100.0% | $1,426.8 | 100.0% |

| | December 31, 2011 | | | | | |
|---|---|---|---|---|---|---|
| | Insured Receivables | | Uninsured Receivables | | Combined | |
| | Amount | Percent of Receivables | Amount | Percent of Receivables | Amount | Percent of Receivables |
| 0 to 90 days . . . . | $524.8 | 90.2% | $175.8 | 26.9% | $ 700.6 | 56.7% |
| 91 to 150 days . . | 31.7 | 5.5 | 105.8 | 16.2 | 137.5 | 11.1 |
| 151 to 360 days . | 20.4 | 3.5 | 238.6 | 36.5 | 259.0 | 21.0 |
| Over 361 . . . . . | 4.8 | 0.8 | 132.9 | 20.4 | 137.7 | 11.2 |
| | $581.7 | 100.0% | $653.1 | 100.0% | $1,234.8 | 100.0% |

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

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

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

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

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

The process of determining our allowance for doubtful accounts requires us to estimate uncollectible self-pay accounts. Our estimate of uncollectible self-pay accounts is primarily based on our collection history, adjusted for anticipated changes in collection trends, if significant. Our estimate may be impacted by changes in regional economic conditions, business office operations, payor mix and trends in federal or state governmental healthcare coverage or other third party payors. If the actual self-pay collection percentage would change by 1.5% from our estimated self-pay collection percentage for the year ended December 31, 2012, our after-tax income from continuing operations would change by approximately $6.3 million, or diluted earnings per share of $0.13, and our net accounts receivable would change by $2.4 million at December 31, 2012. The resulting change in this analytical tool is considered to be a reasonably likely change that would affect our overall assessment of this critical accounting estimate.

***Goodwill Impairment Analysis***

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired businesses. Our goodwill included in our consolidated balance sheets as of December 31, 2012 and 2011 was $1,611.8 million and $1,568.7 million, respectively. Please refer to Note 3 to our consolidated financial statements included elsewhere in this report for a detailed rollforward of our goodwill.

In accordance with ASC 350-10, ''Intangibles — Goodwill and Other'' (''ASC 350-10'') goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. Our business comprises a single operating reporting unit for impairment test purposes. For the purposes of these analyses, our estimate of fair value are based on a combination of the income approach, which estimates the fair value of us based on our future discounted cash flows, and the market approach, which estimates the fair value of us based on comparable market prices. Our estimate of future discounted cash flows is based on assumptions and projections we believe to be currently reasonable and supportable. Our assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix, and changes in legislation and other payor payment patterns.

If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. During the years ended December 31, 2012, 2011 and 2010, we performed our annual impairment tests as of October 1, and did not incur an impairment charge.

***Reserves for Self-Insurance Claims***

We are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding a self-insured retention level. Our self-insured retention level for professional liability claims is $5.0 million per claim at December 31, 2012. Our self-insured retention level is evaluated annually as a part of our insurance program's renewal process.

Additionally, as of December 31, 2012, our self-insured retention level for workers' compensation claims is $1.0 million per claim in all states in which we operate except for Wyoming. We participate in a state specific program in Wyoming for our workers' compensation claims arising in this state.

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

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

Our reserves for professional liability claims are based upon quarterly actuarial calculations. Our reserves for employee worker's compensation claims are based upon semiannual 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 1.80%, 2.50%, and 3.15% at December 31, 2012, 2011, and 2010, respectively. As a result of the decreases in our applied discount rate, our self-insurance claims expense increased by approximately $2.9 million, $2.5 million, and $1.6 million which decreased our net income by approximately $1.8 million, $1.6 million, $1.0 million and decreased our diluted earnings per share by $0.04, $0.03, and $0.02 during the years ended December 31, 2012, 2011 and 2010, respectively. We select a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

The following table provides information regarding our reserves for self-insured claims at December 31, 2012 and 2011 (in millions):

| | December 31, 2012 | December 31, 2011 |
|---|---|---|
| Undiscounted | $166.7 | $170.4 |
| Discounted (as reported) | $160.2 | $159.9 |

The following table presents the changes in our reserves for self-insured claims for the years ended December 31, 2012, 2011 and 2010 (in millions):

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Reserve at the beginning of the period | $159.9 | $139.2 | $128.2 |
| Increase for the provision of current year claims, including discontinued operations | 45.0 | 45.7 | 46.1 |
| Decrease for the provision of prior year claims, including discontinued operations | (9.1) | (6.2) | (3.7) |
| Payments related to current year claims | (4.3) | (3.5) | (4.0) |
| Payments related to prior year claims | (33.6) | (20.3) | (30.6) |
| Provision for the change in discount rate | 2.9 | 2.5 | 1.6 |
| Noncash change in reserve for claims in excess of self-insured retention levels | (0.6) | 2.5 | 1.6 |
| Reserve at the end of the period | $160.2 | $159.9 | $139.2 |

As of December 31, 2012 and 2011, less than 1% of our reserves for self-insured claims represents reserves for settled and unpaid claims. Our average lag time between the settlement and payment of a self-insured claim ranges from 1 to 2 weeks.

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

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

assumption is also affected by the estimated severity of these claims resulting in an inability to properly isolate and quantify the impact of a change in this assumption.

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

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

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

| | |
|---|---|
| December 31, 2012 reserve: | |
| As reported | $160.2 |
| With 70% Confidence Level | $169.0 |
| With 80% Confidence Level | $178.6 |
| With 90% Confidence Level | $200.8 |
| December 31, 2011 reserve: | |
| As reported | $159.9 |
| With 70% Confidence Level | $168.9 |
| With 80% Confidence Level | $178.1 |
| With 90% Confidence Level | $204.2 |

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of our quarterly and semi-annually completed actuarial calculations decreased our self-insured claims expense by $9.1 million, $6.2 million and $3.7 million, which increased our net income by approximately $5.8 million, $3.9 million and $2.4 million, or $0.12, $0.08 and $0.05 per diluted share, during the years ended December 31, 2012, 2011 and 2010, respectively.

***Accounting for Stock-Based Compensation***

We issue stock-based awards, including stock options and other stock-based awards (nonvested stock, restricted stock, restricted stock units, performance shares and deferred stock units) to certain officers, employees and non-employee directors in accordance with our various stockholder-approved stock-based compensation plans. We account for our stock-based awards in accordance with the provisions of ASC 718-10, ''Compensation — Stock Compensation'' (''ASC 718-10'') and accordingly recognize compensation expense over each of the stock-based award's requisite service period based on the estimated grant date fair value. Our stock-based compensation expense was $27.4 million, $24.0 million, and $22.4 million for the years ended December 31, 2012, 2011, and 2010, respectively.

The fair value of other stock-based awards is determined based on the closing price of our common stock on the day prior to the grant date. Stock-based compensation expense for our other stock-based awards is recorded equally over the vesting periods of such awards generally ranging from six months to three years.

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

The following table shows the weighted average assumptions we used to develop the fair value estimates under our HW-II option valuation model and the resulting estimates of weighted-average fair value per share of stock options granted during the years ended December 31, 2012, 2011 and 2010:

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Expected volatility | 36.0% | 36.0% | 39.9% |
| Risk free interest rate (range) | 0.03% – 1.97% | 0.01% – 3.58% | 0.06% – 3.69% |
| Expected dividends | — | — | — |
| Average expected term (years) | 5.3 | 5.4 | 5.4 |
| Fair value per share of stock options granted | $12.18 | $11.73 | $11.22 |

*Population Stratification*

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

*Expected Volatility*

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

*Risk-Free Interest Rate*

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

*Expected Dividends*

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

*Pre-Vesting Forfeitures*

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

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

*Post-Vesting Cancellations*

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

*Expected Term*

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

The fair value calculations of our stock option grants are affected by assumptions that are believed to be reasonable based upon the facts and circumstances at the time of grant. Changes in our volatility estimates can materially affect the fair values of our stock option grants. If our estimated weighted-average volatility for the year ended December 31, 2012 were 10% higher, our after-tax income from continuing operations would decrease by approximately $0.4 million, or less than $0.01 per diluted share.

***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 $283.5 million and $255.3 million as of December 31, 2012 and 2011, respectively. Our valuation allowances for deferred tax assets in our consolidated balance sheets were $61.4 million and $59.8 million as of December 31, 2012 and 2011, respectively.

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

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

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

allowance by the amount of the deferred tax liabilities depending on the nature and timing of future taxable income attributable to deferred tax liabilities.

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

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

Our deferred tax liabilities exceeded our deferred tax assets by $45.3 million as of December 31, 2012, excluding the impact of valuation allowances. Historically, we have produced federal taxable income. Therefore, we believe that the likelihood of not realizing the federal tax benefit of our deferred tax assets is remote. However, we do have subsidiaries with a history of tax losses in certain state jurisdictions and, based upon those historical tax losses, we assumed that the subsidiaries would not be profitable in the future for those states' tax purposes. If our assertion regarding the future profitability of those subsidiaries was incorrect, then our deferred tax assets would be understated by the amount of the valuation allowance of $61.4 million at December 31, 2012.

The IRS may propose adjustments for items we have failed to identify as tax contingencies. If the IRS were to propose and sustain assessments equal to 10% of our taxable income for 2012, we would incur approximately $8.8 million of additional tax payments for 2012 plus interest and penalties, if applicable.

**Segment Reporting**

We have five operating divisions as of December 31, 2012. We realign these operating divisions frequently based upon changing circumstances, including acquisition and divestiture activity. We consider these five operating divisions as one operating segment, healthcare services, for segment reporting purposes and as one reporting unit for goodwill impairment testing in accordance with ASC 280-10, ''Segment Reporting'' (''ASC 280-10''), and ASC 350-10.

In accordance with ASC 350-10, we determined that our five operating divisions and related acute care hospitals comprise one reporting unit because of their similar economic characteristics in each of the following areas:

- the way we manage our operations and extent to which our acquired facilities are integrated into our existing operations as a single reporting unit;
- our goodwill is recoverable from the collective operations of our five operating divisions and related acute care hospitals and not individually from one single operating division or hospital;
- our operating divisions are frequently realigned based upon changing circumstances, including acquisition and divestiture activity; and
- because of the collective size of our five operating divisions, each division and acute care hospital benefits from its participation in a group purchasing organization.

**Inflation**

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

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

**Interest Rates**

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

***Outstanding Debt***

As of December 31, 2012, we had outstanding debt, excluding $29.5 million of unamortized discounts on our convertible debt instruments, of $1,739.3 million, 30.4%, or $529.4 million, of which was subject to variable rates of interest.

The carrying amounts and fair values of the Term Facility and the Revolving Facility under the Senior Credit Agreement, the Term B Loans under the Prior Credit Agreement, the 6.625% Senior Notes, the 3½% Notes and the 3¼% Debentures as of December 31, 2012 and December 31, 2011 were as follows (in millions):

| | Carrying Amount | | Fair Value | |
|---|---|---|---|---|
| | December 31, 2012 | December 31, 2011 | December 31, 2012 | December 31, 2011 |
| Term Facility | $444.4 | $ — | $437.7 | $ — |
| Revolving Facility | $ 85.0 | $ — | $ 83.7 | $ — |
| Term B Loans | $ — | $443.7 | $ — | $432.6 |
| 6.625% Senior Notes | $400.0 | $400.0 | $431.0 | $413.0 |
| 3½% Notes, excluding unamortized discount | $575.0 | $575.0 | $592.3 | $592.3 |
| 3¼% Debentures, excluding unamortized discount | $225.0 | $225.0 | $225.0 | $230.3 |

The fair values of the Term Facility, the Revolving Facility, the Term B Loans and the 6.625% Senior Notes were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10, ''Fair Value Measurements and Disclosures'' (''ASC 820-10''). The fair values of the 3½% Notes and the 3¼% Debentures were estimated based on the quoted market prices determined using the closing share price of our common stock and categorized as Level 1 within the fair value hierarchy in accordance with ASC 820-10. Effective July 24, 2012, we repaid the $443.7 million outstanding Term B Loans with the issuance of the $450.0 million Term Facility.

***Cash Balances***

Certain of our outstanding cash balances are invested overnight with high credit quality financial institutions. We do not hold direct investments in auction rate securities, collateralized debt obligations, structured investment vehicles or mortgage-backed securities. We do not have significant exposure to changing interest rates on invested cash at December 31, 2012. As a result, the interest rate market risk implicit in these investments at December 31, 2012, if any, is low.

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

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

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

We did not experience a change in or disagreement with our accountants during the year ended December 31, 2012.

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

**Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures**

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

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

**Changes in Internal Control Over Financial Reporting**

There has been no change in our internal control over financial reporting during the fourth quarter ended December 31, 2012 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

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

On December 19, 2012, the Company entered into an Indemnification Agreement with Leif M. Murphy (the Indemnitee). All of the current directors of the Company and certain of its officers executed a similar form on each of August 29, 2008 and August 12, 2012. The Indemnification Agreement provides that the Company shall indemnify the Indemnitee, to the fullest extent permitted by Delaware law, subject to certain exceptions, against expenses, judgments, fines and other amounts actually and reasonably incurred in connection with his or her service as a director or officer, as the case may be, and provides for rights to advancement of expenses and contribution. The foregoing description of the Indemnification Agreement is not complete and is qualified in its entirety by reference to the full text of the form of Indemnification Agreement, which is filed as Exhibit 10.24, and which is incorporated herein by reference.

## PART III

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

**Executive Officers**

This information is incorporated by reference to the information contained under the caption ''Executive Compensation — Executive Officers of the Company'' included in our proxy statement relating to our 2013 annual meeting of stockholders.

**Code of Ethics**

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

**Directors**

This information is incorporated by reference to the information contained under the caption ''Proposal 1: Election of Directors'' included in our proxy statement relating to our 2013 annual meeting of stockholders.

**Compliance with Section 16(a) of the Exchange Act**

This information is incorporated by reference to the information contained under the caption ''Section 16(a) Beneficial Ownership Reporting Compliance'' included in our proxy statement relating to our 2013 annual meeting of stockholders.

**Stockholder Nominees**

This information is incorporated by reference to the information contained under the caption ''Corporate Governance — Director Nomination Process'' included in our proxy statement relating to our 2013 annual meeting of stockholders.

**Audit and Compliance Committee**

This information is incorporated by reference to the information contained under the caption ''Audit and Compliance Committee Report'' included in our proxy statement relating to our 2013 annual meeting of stockholders.

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

This information is incorporated by reference to the information contained under the captions ''Compensation Committee Report,'' ''Compensation Discussion and Analysis,'' ''Executive Compensation,'' ''Compensation Committee Interlocks and Insider Participation,'' and ''Director Compensation,'' included in our proxy statement relating to our 2013 annual meeting of stockholders.

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

This information is incorporated by reference to the information contained under the captions ''Ownership of Equity Securities of the Company'' and ''Executive Compensation — Potential Payments upon Termination or Change in Control'' included in our proxy statement relating to our 2013 annual meeting of stockholders.

Information concerning our equity compensation plans is included in Part II, Item 5. of this report under the caption ''Equity Compensation Plan Information.''

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

This information is incorporated by reference to the information contained under the captions ''Corporate Governance — Independence and Related Person Transactions'' and ''Corporate Governance — Board Meetings and Committees'' included in our proxy statement relating to our 2013 annual meeting of stockholders.

**Item 14.** ***Principal Accountant Fees and Services.***

This information is incorporated by reference to the information contained under the caption ‘‘Proposal 2: Ratification of Selection of Independent Registered Public Accounting Firm’’ and ‘‘Fees and Services of the Independent Registered Public Accounting Firm’’ included in our proxy statement relating to our 2013 annual meeting of stockholders.

## PART IV

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

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

(1) ***Consolidated Financial Statements:***

The consolidated financial statements required to be included in Part II, Item 8, *Financial Statements and Supplementary Data*, begin on Page 93 and are submitted as a separate section of this report.

(2) ***Consolidated Financial Statement Schedules:***

All schedules are omitted because they are not applicable or not required, or because the required information is included in the consolidated financial statements or notes in this report.

(3) ***Exhibits:***

| Exhibit Number | | Description of Exhibits |
|---|---|---|
| 3.1 | — | Amended and Restated Certificate of Incorporation (incorporated by reference from exhibits to the Registration Statement on Form S-8 filed by LifePoint Hospitals, Inc. on April 19, 2005, File No. 333-124151). |
| 3.2 | — | Fourth Amended and Restated By-Laws of LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 15, 2010, File No. 000-51251). |
| 4.1 | — | Form of Specimen Stock Certificate (incorporated by reference from exhibits to the Registration Statement on Form S-4, as amended, filed by Historic LifePoint Hospitals, Inc. on October 25, 2004, File No. 333-119929). |
| 4.2 | — | Form of 3.25% Convertible Senior Subordinated Debenture due 2025 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated August 10, 2005, File No. 000-51251). |
| 4.3 | — | Registration Rights Agreement, dated August 10, 2005, between LifePoint Hospitals, Inc. and Citigroup Global Markets Inc. as Representatives of the Initial Purchasers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated August 10, 2005, File No. 000-51251). |
| 4.4 | — | Amended and Restated Rights Agreement, dated February 25, 2009, by and between LifePoint Hospitals, Inc. and American Stock Transfer & Trust Company, LLC (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated February 25, 2009, File No. 000-51251). |
| 4.5 | — | Indenture, dated August 10, 2005, between LifePoint Hospitals, Inc. and Citibank, N.A., as Trustee (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated August 10, 2005, File No. 000-51251). |
| 4.6 | — | Indenture, dated May 29, 2007, by and between LifePoint Hospitals, Inc. as Issuer and The Bank of New York Trust Company, N.A., as Trustee (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated May 31, 2007, File No. 000-51251). |
| 4.7 | — | Indenture, dated September 23, 2010, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Bank of New York Mellon Trust Company, N.A. as trustee (including the Form of 6.625% Senior Notes due 2020) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated September 27, 2010, File No. 000-51251). |

| Exhibit Number | | Description of Exhibits |
|---|---|---|
| 4.8 | — | Registration Rights Agreement, dated September 23, 2010, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Barclays Capital Inc. as representative of the several initial purchasers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated September 27, 2010, File No. 000-51251). |
| 10.1 | — | Computer and Data Processing Services Agreement dated May 19, 2008, by and between HCA Information Technology Services, Inc. and LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated May 21, 2008, File No. 000-51251). |
| 10.2 | — | Amendment to the Computer and Data Processing Services Agreement, dated June 13, 2012, by and between HCA — Information Technology & Services, Inc. and LifePoint Corporate Services, General Partnership (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2012, File No. 000-51251). |
| 10.3 | — | LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan, dated June 30, 2005, as amended by the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010, the Amendment dated April 23, 2012 and the Amendment dated June 5, 2012 (incorporated by reference from Appendix A and B to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).* |
| 10.4 | — | Form of LifePoint Hospitals, Inc. Nonqualified Stock Option Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).* |
| 10.5 | — | Form of LifePoint Hospitals, Inc. Restricted Stock Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).* |
| 10.6 | — | LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from Appendix C to the Historic LifePoint Hospitals, Inc. Proxy Statement dated April 28, 2004, File No. 000-29818).* |
| 10.7 | — | First Amendment, dated December 10, 2008, to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).* |
| 10.8 | — | Form of LifePoint Hospitals, Inc. Performance Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).* |
| 10.9 | — | LifePoint Hospitals, Inc. Change in Control Severance Plan, as amended and restated (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 16, 2008, File No. 000-51251).* |

| Exhibit Number | | Description of Exhibits |
|---|---|---|
| 10.10 | — | LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan, dated January 1, 2003, as amended by the Amendment dated May 22, 2003, the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated March 24, 2009, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 29, 2010, File No. 000-51251).* |
| 10.11 | — | Amendment, dated April 18, 2012 to the LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan (incorporated by reference from exhibits to LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2012, File No. 000-51251).* |
| 10.12 | — | Form of Outside Directors Restricted Stock Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2006, File No. 000-51251).* |
| 10.13 | — | LifePoint Hospitals, Inc. Amended and Restated Outside Directors Stock and Incentive Compensation Plan, dated May 12, 2009, as amended by the Amendment dated April 27, 2010, the Amendment dated June 8, 2010 and the Amendment dated June 5, 2012 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).* |
| 10.14 | — | Form of LifePoint Hospitals, Inc. Deferred Restricted Stock Award (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).* |
| 10.15 | — | LifePoint Hospitals Deferred Compensation Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 15, 2009, File No. 000-51251).* |
| 10.16 | — | Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated December 22, 2010 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, File No. 000-51251).* |
| 10.17 | — | Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated March 14, 2011 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, File No. 000-51251).* |
| 10.18 | — | Credit Agreement, dated as of July 24, 2012, among LifePoint Hospitals, Inc., as borrower, the lenders referred to therein, Citibank, N.A. as administrative agent, Bank of America, N.A. and Barclays Bank PLC, as co-syndication agents, and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and Barclays Bank PLC, as joint lead arrangers and joint bookrunners (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2012, File No. 000-51251). |

| Exhibit Number | | Description of Exhibits |
|---|---|---|
| 10.19 | — | Incremental Facility Amendment No. 1, dated as of February 6, 2013, by and among LifePoint Hospitals, Inc., as borrower, the lenders referred to therein, Citibank, N.A., as administrative agent, and consented to by Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as leads arrangers, to the Credit Agreement, dated as of July 24, 2012, among Borrower, the lenders referred to therein, Citibank, N.A. as administrative agent, Bank of America, N.A. and Barclays Bank PLC as co-syndication agents and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as joint lead arrangers and joint bookrunners (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated February 7, 2013, File No. 000-51251). |
| 10.20 | — | ISDA 2002 Master Agreement, dated as of June 1, 2006, between Citibank, N.A. and LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K/A dated September 8, 2006, File No. 000-51251). |
| 10.21 | — | Schedule to the ISDA 2002 Master Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K/A dated September 8, 2006, File No. 000-51251). |
| 10.22 | — | Executive Severance and Restrictive Covenant Agreement, dated December 11, 2008, by and between LifePoint CSGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).* |
| 10.23 | — | First Amendment to the Amended and Restated Executive Severance and Restrictive Covenant Agreement, dated December 11, 2012, by and between HSCGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 17, 2012, File No. 000-51251).* |
| 10.24 | — | Form of Indemnification Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, File No. 000-51251).* |
| 10.25 | — | Recoupment Policy Relating to Unearned Incentive Compensation of Executive Officers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated May 20, 2008, File No. 000-51251).* |
| 12.1 | — | Ratio of Earnings to Fixed Charges |
| 21.1 | — | List of Subsidiaries |
| 23.1 | — | Consent of Independent Registered Public Accounting Firm |
| 31.1 | — | Certification of the Chief Executive Officer of LifePoint Hospitals, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 |
| 31.2 | — | Certification of the Chief Financial Officer of LifePoint Hospitals, Inc. pursuant to Section 302 of the Sarbanes Oxley Act of 2002 |
| 32.1 | — | Certification of the Chief Executive Officer of LifePoint Hospitals, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 |
| 32.2 | — | Certification of the Chief Financial Officer of LifePoint Hospitals, Inc. pursuant to Section 906 of the Sarbanes Oxley Act of 2002 |

| Exhibit Number | | Description of Exhibits |
|---|---|---|
| 101.INS | — | XBRL Instance Document** |
| 101.SCH | — | XBRL Taxonomy Extension Schema Document** |
| 101.CAL | — | XBRL Taxonomy Calculation Linkbase Document** |
| 101.DEF | — | XBRL Taxonomy Definition Linkbase Document** |
| 101.LAB | — | XBRL Taxonomy Label Linkbase Document** |
| 101.PRE | — | XBRL Taxonomy Presentation Linkbase Document** |

* — Management Compensation Plan or Arrangement

** — Furnished electronically herewith

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## INDEX TO FINANCIAL STATEMENTS

## Management's Report on Internal Control Over Financial Reporting

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

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

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

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

The Company assessed its internal control system as of December 31, 2012 in relation to criteria for effective internal control over financial reporting described in ''Internal Control — Integrated Framework'' issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on its assessment, the Company has determined that, as of December 31, 2012, its system of internal control over financial reporting was effective.

The Company acquired three hospitals, in the aggregate, effective April 1, 2012, July 1, 2012 and September 1, 2012. The Company excluded these three hospitals from its assessment of and conclusion on the effectiveness of its internal control over financial reporting. For the year end December 31, 2012, these hospitals contributed approximately $151.6 million or 4.5% of the Company's total revenues and, as of December 31, 2012, accounted for approximately $308.9 million or 6.5% of its total assets.

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

| | |
|---|---|
| /s/ William F. Carpenter III | /s/ Jeffrey S. Sherman |
| Chief Executive Officer and<br>Chairman of the Board of Directors | Executive Vice President and<br>Chief Financial Officer |

Brentwood, Tennessee
February 15, 2013

## Report of Independent Registered Public Accounting Firm

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

We have audited LifePoint Hospitals, Inc.'s (the ''Company'') internal control over financial reporting as of December 31, 2012, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

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

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

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

As indicated in the accompanying Management's Report on Internal Control over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of three hospitals acquired during the year ended December 31, 2012, which are included in the 2012 consolidated financial statements of LifePoint Hospitals, Inc. and constituted $308.9 million and $149.4 million of total and net assets, respectively, as of December 31, 2012 and $151.6 million of revenues for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of these three hospitals.

In our opinion, LifePoint Hospitals, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2012, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of LifePoint Hospitals, Inc. as of December 31, 2012 and 2011 and the related consolidated statements of operations, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2012 of LifePoint Hospitals, Inc. and our report dated February 15, 2013 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 15, 2013

## Report of Independent Registered Public Accounting Firm

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

We have audited the accompanying consolidated balance sheets of LifePoint Hospitals, Inc. (the ''Company'') as of December 31, 2012 and 2011, and the related consolidated statements of operations, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2012. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of LifePoint Hospitals, Inc. at December 31, 2012 and 2011, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2012, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), LifePoint Hospitals, Inc.'s internal control over financial reporting as of December 31, 2012, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 15, 2013 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 15, 2013

**LIFEPOINT HOSPITALS, INC.**

**CONSOLIDATED STATEMENTS OF OPERATIONS**
**For the Years Ended December 31, 2012, 2011 and 2010**
**(In millions, except per share amounts)**

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Revenues before provision for doubtful accounts | $4,016.2 | $3,544.6 | $3,262.4 |
| Provision for doubtful accounts | 624.4 | 518.5 | 443.8 |
| Revenues | 3,391.8 | 3,026.1 | 2,818.6 |
| Salaries and benefits | 1,554.5 | 1,364.7 | 1,270.3 |
| Supplies | 524.6 | 469.5 | 443.0 |
| Other operating expenses | 799.1 | 682.4 | 605.2 |
| Other income | (32.0) | (26.7) | — |
| Depreciation and amortization | 193.1 | 165.8 | 148.5 |
| Interest expense, net | 100.0 | 107.1 | 108.1 |
| Debt extinguishment costs | 4.4 | — | 2.4 |
| Impairment charges | 4.0 | — | — |
| | 3,147.7 | 2,762.8 | 2,577.5 |
| Income from continuing operations before income taxes | 244.1 | 263.3 | 241.1 |
| Provision for income taxes | 88.5 | 97.8 | 82.4 |
| Income from continuing operations | 155.6 | 165.5 | 158.7 |
| Income (loss) from discontinued operations, net of income taxes | — | 0.2 | (0.1) |
| Net income | 155.6 | 165.7 | 158.6 |
| Less: Net income attributable to noncontrolling interests | (3.7) | (2.8) | (3.1) |
| Net income attributable to LifePoint Hospitals, Inc. | $ 151.9 | $ 162.9 | $ 155.5 |
| Earnings per share attributable to LifePoint Hospitals, Inc. stockholders: | | | |
| Basic | $ 3.22 | $ 3.30 | $ 2.98 |
| Diluted | $ 3.14 | $ 3.22 | $ 2.91 |
| Weighted average shares and dilutive securities outstanding: | | | |
| Basic | 47.2 | 49.3 | 52.2 |
| Diluted | 48.4 | 50.5 | 53.5 |
| Amounts attributable to LifePoint Hospitals, Inc. stockholders: | | | |
| Income from continuing operations, net of income taxes | $ 151.9 | $ 162.7 | $ 155.6 |
| Income (loss) from discontinued operations, net of income taxes | — | 0.2 | (0.1) |
| Net income | $ 151.9 | $ 162.9 | $ 155.5 |

**LIFEPOINT HOSPITALS, INC.**

**CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME**
**For the Years Ended December 31, 2012, 2011 and 2010**
**(In millions)**

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Net income | $155.6 | $165.7 | $158.6 |
| Other comprehensive income, net of income taxes: | | | |
| Unrealized gains on changes in funded status of pension benefit obligation, net of provision for income taxes | 0.2 | — | — |
| Unrealized gains on changes in fair value of interest rate swap, net of provisions for income taxes of $2.8 and $7.1 for the years ended December 31, 2011, and 2010, respectively | — | 4.0 | 13.4 |
| Other comprehensive income | 0.2 | 4.0 | 13.4 |
| Comprehensive income | 155.8 | 169.7 | 172.0 |
| Less: Net income attributable to noncontrolling interests | (3.7) | (2.8) | (3.1) |
| Comprehensive income attributable to LifePoint Hospitals, Inc. | $152.1 | $166.9 | $168.9 |

**LIFEPOINT HOSPITALS, INC.**

**CONSOLIDATED BALANCE SHEETS**
**December 31, 2012 and 2011**
**(Dollars in millions, except per share amounts)**

| | 2012 | 2011 |
|---|---|---|
| **ASSETS** | | |
| Current assets: | | |
| Cash and cash equivalents | $ 85.0 | $ 126.2 |
| Accounts receivable, less allowances for doubtful accounts of $558.4 and $537.4 at December 31, 2012 and 2011, respectively | 518.8 | 430.6 |
| Inventories | 97.0 | 87.2 |
| Prepaid expenses | 31.8 | 26.4 |
| Deferred tax assets | 142.5 | 125.7 |
| Other current assets | 50.2 | 43.9 |
| | 925.3 | 840.0 |
| Property and equipment: | | |
| Land | 101.9 | 93.5 |
| Buildings and improvements | 1,815.2 | 1,631.6 |
| Equipment | 1,289.7 | 1,084.0 |
| Construction in progress (estimated costs to complete and equip after December 31, 2012 is $68.8) | 81.0 | 105.7 |
| | 3,287.8 | 2,914.8 |
| Accumulated depreciation | (1,256.9) | (1,084.4) |
| | 2,030.9 | 1,830.4 |
| Deferred loan costs, net | 21.9 | 21.7 |
| Intangible assets, net | 84.5 | 89.5 |
| Other | 47.8 | 19.8 |
| Goodwill | 1,611.8 | 1,568.7 |
| Total assets | $ 4,722.2 | $ 4,370.1 |
| **LIABILITIES AND EQUITY** | | |
| Current liabilities: | | |
| Accounts payable | $ 117.4 | $ 99.6 |
| Accrued salaries | 128.2 | 103.1 |
| Other current liabilities | 186.0 | 168.2 |
| Current maturities of long-term debt | 13.3 | 1.9 |
| | 444.9 | 372.8 |
| Long-term debt | 1,696.5 | 1,595.4 |
| Deferred income tax liabilities | 249.2 | 259.0 |
| Long-term portion of reserves for self-insurance claims | 133.0 | 118.3 |
| Other long-term liabilities | 79.2 | 20.8 |
| Long-term income tax liability | 16.9 | 18.0 |
| Total liabilities | 2,619.7 | 2,384.3 |
| Redeemable noncontrolling interests | 29.4 | 26.2 |
| Equity: | | |
| LifePoint Hospitals, Inc. stockholders' equity: | | |
| Preferred stock, $0.01 par value; 10,000,000 shares authorized; no shares issued | — | — |
| Common stock, $0.01 par value; 90,000,000 shares authorized; 64,472,700 and 63,233,088 shares issued at December 31, 2012 and 2011, respectively | 0.6 | 0.6 |
| Capital in excess of par value | 1,403.5 | 1,354.8 |
| Accumulated other comprehensive income | 0.2 | — |
| Retained earnings | 1,218.8 | 1,066.9 |
| Common stock in treasury, at cost, 17,544,668 and 14,925,875 shares at December 31, 2012 and 2011, respectively | (572.6) | (477.1) |
| Total LifePoint Hospitals, Inc. stockholders' equity | 2,050.5 | 1,945.2 |
| Noncontrolling interests | 22.6 | 14.4 |
| Total equity | 2,073.1 | 1,959.6 |
| Total liabilities and equity | $ 4,722.2 | $ 4,370.1 |

**LIFEPOINT HOSPITALS, INC.**

**CONSOLIDATED STATEMENTS OF CASH FLOWS**
**For the Years Ended December 31, 2012, 2011 and 2010**
**(In millions)**

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Cash flows from operating activities: | | | |
| Net income | $ 155.6 | $ 165.7 | $ 158.6 |
| Adjustments to reconcile net income to net cash provided by operating activities: | | | |
| (Income) loss from discontinued operations | — | (0.2) | 0.1 |
| Stock-based compensation | 27.4 | 24.0 | 22.4 |
| Depreciation and amortization | 193.1 | 165.8 | 148.5 |
| Amortization of physician minimum revenue guarantees | 19.6 | 19.8 | 17.1 |
| Amortization of convertible debt discounts | 26.0 | 24.3 | 22.6 |
| Amortization of deferred loan costs | 5.4 | 5.9 | 7.1 |
| Debt extinguishment costs | 4.4 | — | 2.4 |
| Impairment charge | 4.0 | — | — |
| Deferred income taxes (benefit) | (24.2) | 23.1 | (29.0) |
| Reserve for self-insurance claims, net of payments | 1.6 | 18.0 | 10.3 |
| Increase (decrease) in cash from operating assets and liabilities, net of effects from acquisitions and divestitures: | | | |
| Accounts receivable | (43.3) | (29.5) | (39.1) |
| Inventories and other current assets | (9.7) | (20.1) | (5.4) |
| Accounts payable and accrued expenses | 19.5 | 2.9 | 13.2 |
| Income taxes payable/receivable | 2.3 | 3.9 | 48.8 |
| Other | 1.2 | (2.4) | (1.9) |
| Net cash provided by operating activities – continuing operations | 382.9 | 401.2 | 375.7 |
| Net cash (used in) provided by operating activities – discontinued operations | (0.7) | 0.3 | (1.6) |
| Net cash provided by operating activities | 382.2 | 401.5 | 374.1 |
| Cash flows from investing activities: | | | |
| Purchases of property and equipment | (221.4) | (219.9) | (168.7) |
| Acquisitions, net of cash acquired | (199.7) | (121.0) | (184.9) |
| Other | (1.0) | (1.2) | — |
| Net cash used in investing activities | (422.1) | (342.1) | (353.6) |
| Cash flows from financing activities: | | | |
| Proceeds from borrowings | 555.0 | — | 400.0 |
| Payments of borrowings | (469.3) | (0.1) | (255.2) |
| Repurchases of common stock | (95.5) | (174.6) | (152.1) |
| Payment of debt financing costs | (10.0) | (0.4) | (13.7) |
| Proceeds from exercise of stock options | 21.8 | 39.0 | 20.4 |
| Proceeds from employee stock purchase plans | 1.2 | 1.2 | 1.0 |
| Distributions to noncontrolling interests | (3.8) | (1.8) | (2.4) |
| Sales (repurchases) of redeemable noncontrolling interests | 1.6 | (2.3) | 3.1 |
| Capital lease payments and other | (2.3) | (1.6) | (1.4) |
| Net cash used in financing activities | (1.3) | (140.6) | (0.3) |
| Change in cash and cash equivalents | (41.2) | (81.2) | 20.2 |
| Cash and cash equivalents at beginning of period | 126.2 | 207.4 | 187.2 |
| Cash and cash equivalents at end of period | $ 85.0 | $ 126.2 | $ 207.4 |
| Supplemental disclosure of cash flow information: | | | |
| Interest payments | $ 70.0 | $ 79.2 | $ 71.0 |
| Capitalized interest | $ 2.3 | $ 2.0 | $ 0.8 |
| Income tax payments, net | $ 110.5 | $ 71.0 | $ 62.5 |

## LIFEPOINT HOSPITALS, INC.

## CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
## For the Years Ended December 31, 2012, 2011 and 2010
## (In millions)

| | LifePoint Hospitals, Inc. Stockholders | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Common Stock | | Capital in Excess of Par Value | Accumulated Other Comprehensive Income (Loss) | Retained Earnings | Treasury Stock | Noncontrolling Interests | Total |
| | Shares | Amount | | | | | | |
| Balance at January 1, 2010 | 54.8 | $0.6 | $1,246.4 | $(17.4) | $ 748.5 | $(150.4) | $ 3.1 | $1,830.8 |
| Net income | — | — | — | — | 155.5 | — | 3.1 | 158.6 |
| Other comprehensive income | — | — | — | 13.4 | — | — | — | 13.4 |
| Exercise of stock options and tax benefits of stock-based awards | 0.7 | — | 19.7 | — | — | — | — | 19.7 |
| Stock activity in connection with employee stock purchase plan | 0.1 | — | 1.0 | — | — | — | — | 1.0 |
| Stock-based compensation | 0.4 | — | 22.4 | — | — | — | — | 22.4 |
| Repurchases of common stock, at cost | (4.5) | — | — | — | — | (152.1) | — | (152.1) |
| Cash distributions to noncontrolling interests | — | — | (0.1) | — | — | — | (2.4) | (2.5) |
| Balance at December 31, 2010 | 51.5 | 0.6 | 1,289.4 | (4.0) | 904.0 | (302.5) | 3.8 | 1,891.3 |
| Net income | — | — | — | — | 162.9 | — | 2.8 | 165.7 |
| Other comprehensive income | — | — | — | 4.0 | — | — | — | 4.0 |
| Exercise of stock options and tax benefits of stock-based awards | 1.3 | — | 43.5 | — | — | — | — | 43.5 |
| Stock activity in connection with employee stock purchase plan | — | — | 1.2 | — | — | — | — | 1.2 |
| Stock-based compensation | 0.4 | — | 24.0 | — | — | — | — | 24.0 |
| Repurchases of common stock, at cost | (4.9) | — | — | — | — | (174.6) | — | (174.6) |
| Noncash change in noncontrolling interests as a result of acquisition and other | — | — | (3.7) | — | — | — | 10.0 | 6.3 |
| Cash proceeds from (distributions to) noncontrolling interests | — | — | 0.4 | — | — | — | (2.2) | (1.8) |
| Balance at December 31, 2011 | 48.3 | 0.6 | 1,354.8 | — | 1,066.9 | (477.1) | 14.4 | 1,959.6 |
| Net income | — | — | — | — | 151.9 | — | 3.7 | 155.6 |
| Other comprehensive income | — | — | — | 0.2 | — | — | — | 0.2 |
| Exercise of stock options and tax benefits of stock-based awards | 0.7 | — | 25.3 | — | — | — | — | 25.3 |
| Stock activity in connection with employee stock purchase plan | — | — | 1.2 | — | — | — | — | 1.2 |
| Stock-based compensation | 0.5 | — | 27.4 | — | — | — | — | 27.4 |
| Repurchases of common stock, at cost | (2.6) | — | — | — | — | (95.5) | — | (95.5) |
| Noncash change in noncontrolling interests as a result of acquisition and other | — | — | (5.2) | — | — | — | 8.3 | 3.1 |
| Cash distributions to noncontrolling interests | — | — | — | — | — | — | (3.8) | (3.8) |
| Balance at December 31, 2012 | 46.9 | $0.6 | $1,403.5 | $ 0.2 | $1,218.8 | $(572.6) | $22.6 | $2,073.1 |

## Note 1. Organization and Summary of Significant Accounting Policies

### *Organization*

LifePoint Hospitals, Inc., a Delaware corporation, acting through its subsidiaries, operates general acute care hospitals primarily in non-urban communities in the United States (''U.S.''). Unless the context otherwise indicates, LifePoint Hospitals, Inc. and its subsidiaries are referred to herein as ''LifePoint'' or the ''Company.'' At December 31, 2012, on a consolidated basis, the Company operated 56 hospital campuses in 19 states. Unless noted otherwise, discussions in these notes pertain to the Company's continuing operations.

### *Principles of Consolidation*

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through the Company's direct or indirect ownership of a majority interest and exclusive rights granted to the Company as the sole general partner or controlling member of such entities. Additionally, the Company consolidates any entities for which it receives the majority of the entity's expected returns or is at risk for the majority of the entity's expected losses based upon its investment or financial interest in the entity. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation.

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

### *Use of Estimates*

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

### *Discontinued Operations*

In accordance with the provisions of Accounting Standards Codification (''ASC'') 360-10, ''Property, Plant and Equipment'', (''ASC 360-10''), the Company has presented the operating results, financial position and cash flows of its previously disposed facilities as discontinued operations, net of income taxes, in the accompanying consolidated financial statements.

### *General and Administrative Costs*

The majority of the Company's expenses are ''cost of revenue'' items. Costs that could be classified as ''general and administrative'' by the Company would include its hospital support center overhead costs, which were $173.6 million, $136.4 million and $120.6 million for the years ended December 31, 2012, 2011 and 2010, respectively. Included in the Company's hospital support center overhead costs are the transactional expenses related to the Company's recent acquisitions, including legal and consulting fees, which were $10.1 million, $4.3 million and $4.3 million for the years ended December 31, 2012, 2011 and 2010, respectively. See Note 2 for a further discussion of the Company's recent acquisition activity.

### *Fair Value of Financial Instruments*

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

*Cash and Cash Equivalents, Accounts Receivable and Accounts Payable*

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

**Note 1. Organization and Summary of Significant Accounting Policies – (continued)**

*Long-Term Debt*

The carrying amounts and fair values of the Company's senior secured term loan facility (the "Term Facility") and senior secured revolving credit facility (the "Revolving Facility") under its senior secured credit agreement with, among others, Citibank, N.A. ("Citibank"), as administrative agent, and the lenders party thereto (the "Senior Credit Agreement"), term B loans (the "Term B Loans") under its prior credit agreement with Citicorp North America, Inc., as administrative agent and a syndicate of lenders (the "Prior Credit Agreement"), 6.625% unsecured senior notes due October 1, 2020 (the "6.625% Senior Notes"), 3½% convertible senior subordinated notes due May 15, 2014 (the "3½% Notes") and 3¼% convertible senior subordinated debentures due August 15, 2025 (the "3¼% Debentures") as of December 31, 2012 and December 31, 2011 were as follows (in millions):

| | Carrying Amount | | Fair Value | |
|---|---|---|---|---|
| | December 31, 2012 | December 31, 2011 | December 31, 2012 | December 31, 2011 |
| Term Facility | $444.4 | $ — | $437.7 | $ — |
| Revolving Facility | $ 85.0 | $ — | $ 83.7 | $ — |
| Term B Loans | $ — | $443.7 | $ — | $432.6 |
| 6.625% Senior Notes | $400.0 | $400.0 | $431.0 | $413.0 |
| 3½% Notes, excluding unamortized discount | $575.0 | $575.0 | $592.3 | $592.3 |
| 3¼% Debentures, excluding unamortized discount | $225.0 | $225.0 | $225.0 | $230.3 |

The fair values of the Term Facility, the Revolving Facility, the Term B Loans and the 6.625% Senior Notes were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10, "Fair Value Measurements and Disclosures" ("ASC 820-10"). The fair values of the 3½% Notes and the 3¼% Debentures were estimated based on the quoted market prices determined using the closing share price of the Company's common stock and categorized as Level 1 within the fair value hierarchy in accordance with ASC 820-10. Effective July 24, 2012, the Company repaid the $443.7 million outstanding Term B Loans with the issuance of the $450.0 million Term Facility, as more fully discussed in Note 4.

***Revenue Recognition and Accounts Receivable***

The Company recognizes revenues in the period in which services are performed. Accounts receivable primarily consist of amounts due from third-party payors and patients. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. Amounts the Company receives for treatment of patients covered by governmental programs such as Medicare and Medicaid and other third-party payors such as health maintenance organizations, preferred provider organizations 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.

On April 5, 2012, a settlement agreement (the "Rural Floor Settlement") was signed between the Department of Health and Human Services ("HHS"), the Secretary of HHS, Centers for Medicare and Medicaid Services ("CMS") and a large number of healthcare service providers, including the Company's hospitals. The Rural Floor Settlement is intended to resolve all claims that have been brought or could have been brought relating to CMS's calculation of the rural floor budget neutrality adjustment that was created by the Balanced Budget Act of 1997 from federal fiscal year 1998 through and including federal fiscal year 2011

**Note 1. Organization and Summary of Significant Accounting Policies – (continued)**

for healthcare service providers that participated in certain court cases and group appeals. As a result of the Rural Floor Settlement, the Company recognized $33.0 million of additional Medicare revenue during the year ended December 31, 2012.

The Company's revenues by payor and approximate percentages of revenues were as follows for the years ended December 31, 2012, 2011 and 2010 (in millions):

| | 2012 | | 2011 | | 2010 | |
|---|---|---|---|---|---|---|
| | Amount | Ratio | Amount | Ratio | Amount | Ratio |
| Medicare | $1,170.3 | 34.5% | $1,061.3 | 35.0% | $ 983.7 | 34.9% |
| Medicaid | 488.9 | 14.4 | 432.1 | 14.3 | 410.8 | 14.6 |
| HMOs, PPOs and other private insurers | 1,651.2 | 48.7 | 1,446.6 | 47.8 | 1,360.1 | 48.2 |
| Self-pay | 653.9 | 19.3 | 565.3 | 18.7 | 475.1 | 16.9 |
| Other | 51.9 | 1.5 | 39.3 | 1.3 | 32.7 | 1.1 |
| Revenues before provision for doubtful accounts | 4,016.2 | 118.4 | 3,544.6 | 117.1 | 3,262.4 | 115.7 |
| Provision for doubtful accounts | (624.4) | (18.4) | (518.5) | (17.1) | (443.8) | (15.7) |
| Revenues | $3,391.8 | 100.0% | $3,026.1 | 100.0% | $2,818.6 | 100.0% |

*Contractual Discounts and Cost Report Settlements*

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

Cost report settlements under reimbursement agreements with Medicare and Medicaid are estimated and recorded in the period the related services are rendered and are adjusted in future periods as final settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. The net adjustments to estimated cost report settlements resulted in increases to revenues of approximately $7.0 million, $13.1 million and $4.9 million, increases to net income of approximately $4.4 million, $8.4 million and $3.2 million, and increases to diluted earnings per share of approximately $0.09, $0.17 and $0.06 for the years ended December 31, 2012, 2011 and 2010, respectively. The net cost report settlements due from the Company included as a current liability under the caption ''Other current liabilities'' in the accompanying consolidated balance sheets, were approximately $7.2 million and $4.1 million at December 31, 2012 and 2011, respectively. The Company's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs.

Laws and regulations governing Medicare and Medicaid programs are complex and subject to interpretation. The Company believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Company's financial statements. Compliance with such laws and

**Note 1. Organization and Summary of Significant Accounting Policies – (continued)**

regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

*Charity Care*

Self-pay revenues are derived primarily from patients who do not have any form of healthcare coverage. The revenues associated with self-pay patients are generally reported at the Company's gross charges. The Company evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the local hospital's policy for charity care. The Company provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the years ended December 31, 2012, 2011 and 2010, the Company estimates that its costs of care provided under its charity care programs approximated $30.9 million, $25.0 million and $18.4 million, respectively.

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. Additionally, 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.

*Provision and Allowance for Doubtful Accounts*

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

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

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

| | Balances at Beginning of Year | Additions Recognized as a Reduction to Revenues | Accounts Written Off, Net of Recoveries | Balances at End of Year |
|---|---|---|---|---|
| Year ended December 31, 2012 . . . . . | $537.4 | $624.4 | $(603.4) | $558.4 |
| Year ended December 31, 2011 . . . . . | $459.8 | $517.7[(a)] | $(440.1) | $537.4 |
| Year ended December 31, 2010 . . . . . | $433.2 | $442.7[(a)] | $(416.1) | $459.8 |

(a) Additions recognized as a reduction to revenues include amounts related to the Company's continuing and discontinued operations in the Company's accompanying consolidated financial statements.

The allowances for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts were 51.8% and 55.5% as of December 31, 2012 and 2011, respectively. Additionally, as of

**Note 1. Organization and Summary of Significant Accounting Policies – (continued)**

December 31, 2012 and 2011, the allowances for doubtful accounts plus certain contractual allowances and discounts related to self-pay patients as a percentage of self-pay receivables were 85.0% and 86.7%, respectively. The decreases in the resulting ratios of the allowances for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts, and as a percentage of self-pay receivables as of December 31, 2012 as compared to December 31, 2011 are primarily the result of net write off activity of aged and fully reserved accounts receivable during the year ended December 31, 2012.

***Concentration of Revenues***

During the years ended December 31, 2012, 2011 and 2010, approximately 48.9%, 49.3% and 49.5%, respectively, of the Company's revenues related to patients participating in the Medicare and Medicaid programs, collectively. The Company's management recognizes that revenues and receivables from government agencies are significant to the Company's operations, but it does not believe that there are significant credit risks associated with these government agencies. The Company's management does not believe that there are any other significant concentrations of revenues from any particular payor that would subject the Company to any significant credit risks in the collection of its accounts receivable.

The Company's revenues are particularly sensitive to regulatory and economic changes in certain states where the Company generates significant revenues. The following is an analysis by state of revenues as a percentage of the Company's total revenues for those states in which the Company generates significant revenues for the years ended December 31, 2012, 2011 and 2010:

| | Hospitals in State as of December 31, 2012 | Revenue Concentration by State | | | | | |
|---|---|---|---|---|---|---|---|
| | | 2012 | | 2011 | | 2010 | |
| | | Amount | % of Revenues | Amount | % of Revenues | Amount | % of Revenues |
| Kentucky | 9 | $510.9 | 15.1% | $501.5 | 16.6% | $478.9 | 17.0% |
| Virginia | 5 | 413.6 | 12.2 | 369.0 | 12.2 | 345.4 | 12.3 |
| Tennessee | 11 | 375.3 | 11.1 | 345.1 | 11.4 | 257.5 | 9.1 |
| New Mexico | 2 | 299.6 | 8.8 | 291.3 | 9.6 | 277.1 | 9.8 |
| West Virginia | 2 | 266.2 | 7.8 | 252.1 | 8.3 | 246.2 | 8.7 |
| Louisiana | 5 | 206.1 | 6.1 | 195.4 | 6.5 | 177.8 | 6.3 |
| Arizona | 2 | 204.4 | 6.0 | 199.1 | 6.6 | 201.2 | 7.1 |
| Alabama | 5 | 165.5 | 4.9 | 178.2 | 5.9 | 187.3 | 6.6 |

***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 450-30, ''Gain Contingencies'' (''ASC 450-30''). In accordance with ASC 450-30, the Company recognizes a gain for EHR incentive payments when its eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. The demonstration of meaningful use is based on meeting a series of objectives and varies among hospitals and physician practices, between the Medicare and Medicaid programs and within the Medicaid program from state to state.

**Note 1. Organization and Summary of Significant Accounting Policies – (continued)**

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 CMS.

For the years ended December 31, 2012 and 2011, the Company recognized $16.9 million and $26.7 million in EHR incentive payments in accordance with the HITECH Act under the Medicaid program, respectively. For the year ended December 31, 2012, the Company recognized $15.1 million in EHR incentive payments in accordance with the HITECH Act under the Medicare program. There were no amounts recognized under the Medicare program during the year ended December 31, 2011. These payments are reflected separately in the accompanying consolidated statement of operations under the caption ''Other income''. Amounts recognized as other income that the Company anticipates collecting in future periods, but that were uncollected as of the balance sheet date totaled approximately $18.5 million and $14.9 million as of December 31, 2012 and 2011, respectively, are included in the accompanying consolidated balance sheets under the caption ''Other current assets''. Amounts received prior to December 31, 2012 but not yet recognized as other income totaled approximately $12.6 million as of December 31, 2012 and are included as EHR deferred income in the accompanying consolidated balance sheet under the caption ''Other current liabilities''.

The Company incurs both capital expenditures and operating expenses in connection with the implementation of its various EHR initiatives. The amount and timing of these expenditures does not directly correlate with the timing of the Company's receipt or recognition of the EHR incentive payments.

***Cash and Cash Equivalents***

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

***Inventories***

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

***Long-Lived Assets***

*Property and Equipment*

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

**Note 1. Organization and Summary of Significant Accounting Policies – (continued)**

Depreciation is calculated by applying the straight-line method over the estimated useful lives of buildings and improvements and equipment. Assets under capital leases are 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) | 10 – 40 |
| Equipment | 3 – 10 |
| Equipment under capital leases | 3 – 5 |

Depreciation expense was $187.1 million, $162.2 million and $145.9 million for the years ended December 31, 2012, 2011 and 2010, respectively. Amortization expense related to assets under capital leases and capitalized internal-use software costs are included in depreciation expense.

As of December 31, 2012, the majority of the Company's assets under capital leases are primarily comprised of prepaid capital leases. The Company's assets under capital leases are set forth in the following table at December 31, 2012 and 2011 (in millions):

| | 2012 | 2011 |
|---|---|---|
| Buildings and improvements | $228.6 | $221.1 |
| Equipment | 36.6 | 34.2 |
| | 265.2 | 255.3 |
| Accumulated amortization | (85.5) | (71.3) |
| | $179.7 | $184.0 |

The Company evaluates its long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows, in accordance with ASC 360-10. Fair value estimates are derived from established market values of comparable assets or internal calculations of estimated future net cash flows. The Company's estimates of future cash flows are based on assumptions and projections it believes to be reasonable and supportable. The Company's assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix and changes in legislation and other payor payment patterns. These assumptions vary by type of facility. The Company incurred a $4.0 million pre-tax impairment charge in continuing operations during the year ended December 31, 2012 primarily related to the write-off of certain capitalized information system costs which the Company determined were no longer a necessary component of its ongoing information technology strategy.

*Deferred Loan Costs*

The Company records deferred loan costs for expenditures related to acquiring or issuing new debt instruments. These expenditures include bank fees and premiums as well as attorney's and filing fees. The Company amortizes these deferred loan costs over the life of the respective debt instrument using the effective interest method.

*Goodwill and Intangible Assets*

The Company accounts for its acquisitions in accordance with ASC 805-10 using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350-10, ''Intangibles — Goodwill and Other'' (''ASC 350-10''), goodwill and intangible assets with indefinite lives are reviewed by the Company at least annually for impairment. The Company's business comprises a single operating reporting unit for impairment test purposes. For the purposes of these analyses, the Company's estimates of fair value are based

**Note 1. Organization and Summary of Significant Accounting Policies – (continued)**

on a combination of the income approach, which estimates the fair value of the Company based on its future discounted cash flows, and the market approach, which estimates the fair value of the Company based on comparable market prices. During the years ended December 31, 2012, 2011 and 2010, the Company performed its annual impairment tests as of October 1 and did not incur an impairment charge.

The Company's intangible assets relate to contract-based physician minimum revenue guarantees; non-competition agreements; certificates of need and certificates of need exemptions; and licenses, provider numbers, accreditations and other. Contract-based physician minimum revenue guarantees and non-competition agreements are amortized over the terms of the agreements. The certificates of need, certificates of need exemptions, licenses, provider numbers, accreditations and other have been determined to have indefinite lives and, accordingly, are not amortized. The Company's goodwill and intangible assets are further described in Note 3.

***Income Taxes***

The Company accounts for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income. To the extent the Company believes that recovery is not likely, a valuation allowance is established. To the extent the Company establishes a valuation allowance or increases this allowance, the Company must include an expense within the provision for income taxes in the consolidated statements of operations. The Company classifies interest and penalties related to its tax positions as a component of income tax expense. Income taxes are further described in Note 5.

***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. Fees charged to these employed physicians are eliminated in consolidation. Reserves for the Company's estimate of the related outstanding claims, including incurred but not reported losses, are actuarially determined and are included as a component of the Company's reserves for professional liability self-insurance claims, as further discussed in this note.

***Reserves for Self-Insurance Claims***

Given the nature of the Company's operating environment, it is subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding a self-insured retention level. The Company's self-insured retention level for professional liability claims is $5.0 million per claim at December 31, 2012. Additionally, the Company's self-insured retention level for workers' compensation claims is $1.0 million per claim in all states in which it operates except for Wyoming. The Company participates in a state specific program in Wyoming for its workers' compensation claims arising in this state. The Company's self-insured retention levels are evaluated annually as a part of its insurance program's renewal process.

The Company's reserves for self-insurance claims reflects the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and

**Note 1. Organization and Summary of Significant Accounting Policies – (continued)**

circumstances. The Company's expense for self-insurance claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of the Company's self-insured retention levels; the administrative costs of the insurance program; and interest expense related to the discounted portion of the liability. The Company's expense for self-insurance claims was approximately $42.8 million, $45.3 million and $47.1 million for the years ended December 31, 2012, 2011, and 2010, respectively.

The Company's reserves for professional liability claims are based upon quarterly actuarial calculations. The Company's reserves for employee worker's compensation claims are based upon semiannual 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 1.80%, 2.50% and 3.15% at December 31, 2012, 2011, and 2010, respectively. As a result of the decreases in the applied discount rate during the years ended December 31, 2012, 2011, and 2010, the Company's self-insurance claims expense increased by approximately $2.9 million, $2.5 million and $1.6 million which decreased the Company's net income by approximately $1.8 million, $1.6 million and $1.0 million, or $0.04, $0.03 and $0.02 per diluted share, respectively. The Company's management selects a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

Professional and general liability claims are typically resolved over an extended period of time, often as long as five years or more, while workers' compensation claims are typically resolved in one to two years. Accordingly, the Company's reserves for self-insured claims, comprised of estimated indemnity and expense payments related to reported events and incurred but not reported events as of the end of the period, include both a current and long-term component. The current portion of the Company's reserves for self-insured claims is included under the caption ''Other current liabilities'' and the long-term portion is included under the caption ''Reserves for self-insurance claims and other liabilities'' 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, 2012 and 2011 (in millions):

| | 2012 | 2011 |
|---|---|---|
| Current portion | $ 27.2 | $ 41.6 |
| Long-term portion | 133.0 | 118.3 |
| | $160.2 | $159.9 |

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 semiannual actuarial calculations resulted in changes to its reserves for self-insured claims for prior years. As a result, for the years ended December 31, 2012, 2011 and 2010, the Company's related self-insured claims expense decreased by $9.1 million, $6.2 million and $3.7 million, which increased net income by approximately $5.8 million, $3.9 million and $2.4 million, or $0.12, $0.08 and $0.05 per diluted share, respectively.

**Note 1. Organization and Summary of Significant Accounting Policies – (continued)**

***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 $20.9 million and $21.9 million at December 31, 2012 and 2011, respectively, and are included in the Company's accompanying consolidated balance sheets under the caption ''Other current liabilities''.

***Noncontrolling Interests and Redeemable Noncontrolling Interests***

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

The Company's joint venture with a wholly controlled affiliate of Duke University Health System, Inc. (''Duke'') was formed in January, 2011, with a mission to own and operate community hospitals as well as improve the delivery of healthcare services. The Company, through its joint venture with Duke, acquired two hospitals, in each of the years ended December 31, 2012 and 2011, as more fully discussed in Note 2.

The following table presents the changes in the Company's noncontrolling interests during the years ended December 31, 2012 and 2011 (in millions):

| | |
|---|---|
| Balance at January 1, 2011 | $ 3.8 |
| Net income attributable to noncontrolling interests | 2.8 |
| Acquisition of Person Memorial | 0.7 |
| Acquisition of Maria Parham | 1.7 |
| Acquisition of ancillary service-lines | 7.6 |
| Distributions | (2.2) |
| Balance at December 31, 2011 | 14.4 |
| Net income attributable to noncontrolling interests | 3.7 |
| Acquisition of Twin County | 4.3 |
| Acquisition of Marquette General | 4.0 |
| Distributions | (3.8) |
| Balance at December 31, 2012 | $22.6 |

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 of these interests features would require the delivery of cash. Accordingly, these redeemable noncontrolling interests are classified in the mezzanine section of the Company's accompanying consolidated balance sheets under the caption ''Redeemable noncontrolling interests''. Changes in the fair value of the Company's redeemable noncontrolling interests are recognized as adjustments to consolidated stockholders' equity.

**Note 1. Organization and Summary of Significant Accounting Policies – (continued)**

The following table presents the changes in the Company's redeemable noncontrolling interests during the years ended December 31, 2012 and 2011 (in millions):

| | |
|---|---|
| Balance at January 1, 2011 | $15.3 |
| Acquisition of Maria Parham | 11.9 |
| Noncash adjustments to redemption amounts | 1.3 |
| Repurchases | (2.3) |
| Balance at December 31, 2011 | 26.2 |
| Acquisition of ancillary service-line | 0.4 |
| Sales | 1.6 |
| Noncash adjustments to redemption amounts | 1.2 |
| Balance at December 31, 2012 | $29.4 |

Redemption features related to the Company's redeemable noncontrolling interests, if exercised, would require the Company to deliver cash in the following amounts for the years indicated (in millions):

| | |
|---|---|
| 2013 | $29.0 |
| 2014 | 0.4 |
| | $29.4 |

***Segment Reporting***

The Company has five operating divisions as of December 31, 2012. The Company realigns these operating divisions frequently based upon changing circumstances, including acquisition and divestiture activity. The Company considers these five operating divisions as one operating segment, healthcare services, for segment reporting purposes and as one reporting unit for goodwill impairment testing in accordance with ASC 280-10, ''Segment Reporting'', (''ASC 280-10'') and ASC 350-10.

In accordance with ASC 350-10, the Company has determined that its five operating divisions and related acute care hospitals comprise one reporting unit because of their similar economic characteristics in each of the following areas:

- the way the Company manages its operations and extent to which its acquired facilities are integrated into its existing operations as a single reporting unit;
- the Company's goodwill is recoverable from the collective operations of its five operating divisions and related acute care hospitals and not individually from one single operating division or hospital;
- its operating divisions are frequently realigned based upon changing circumstances, including acquisition and divestiture activity; and
- because of the collective size of its five operating divisions, each division and acute care hospital benefits from its participation in a group purchasing organization.

***Stock-Based Compensation***

The Company issues stock options and other stock-based awards to key employees and directors under various stockholder-approved stock-based compensation plans, as further described in Note 8. The Company accounts for its stock-based awards in accordance with the provisions of ASC 718-10 ''Compensation — Stock Compensation'', (''ASC 718-10''). In accordance with ASC 718-10, the Company recognizes compensation expense over each of the stock-based award's requisite service period based on the estimated grant date fair value of each stock-based award.

**Note 1. Organization and Summary of Significant Accounting Policies – (continued)**

***Deferred Cash Awards***

The Company grants deferred cash awards to certain employees that are subject to continuing service requirements and a ratable vesting term of three years. The Company recognizes compensation expense for these awards over their requisite service period. For the years ended December 31, 2012, 2011 and 2010, expense related to the Company's deferred cash awards was approximately $5.6 million, $3.2 million and $1.4 million, respectively. As of December 31, 2012, there was $8.7 million of total estimated unrecognized compensation costs related to deferred cash awards arrangements. The Company expects to recognize this cost over a weighted average period of 1.4 years.

***Defined Contribution Plan***

The Company has a defined contribution retirement plan that covers substantially all of the Company's employees. The Company's defined contribution plan expense was $8.7 million, $4.3 million and $11.7 million for the years ended December 31, 2012, 2011 and 2010, respectively. Effective January 1, 2011, the Company changed its discretionary matching policy from a pre-determined matching percentage to a discretionary match based on the Company's performance, among other considerations within management's judgment.

***Defined Benefit Pension Plan***

In connection with its acquisition of Marquette General Health System (''Marquette General''), a 315 bed hospital system located in Marquette, Michigan, effective September 1, 2012, through the Company's joint venture with Duke, the Company acquired certain assets and assumed certain liabilities associated with the benefits in the seller's defined benefit pension plan of certain employees covered by a collective bargaining agreement. The Company has established a separate defined benefit pension plan, the LifePoint Marquette Pension Plan (the ''Pension Plan''), to facilitate its administration of the assumed portion of the seller's defined benefit pension plan.

The Company accounts for its Pension Plan in accordance with ASC 715-30 ''Compensation — Defined Benefit Plans'', (''ASC 715-30''). In accordance with ASC 715-30, the Company recognizes the unfunded status of its Pension Plan in the Company's consolidated balance sheet and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the Pension Plan's 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, compensation rate increases, expected long-term returns on plan assets and consider expected age of retirement and mortality.

***Earnings Per Share ("EPS")***

EPS is based on the weighted average number of common shares outstanding and dilutive stock options, convertible notes, when dilutive, and nonvested shares. In addition, the numerator of EPS, net income, is adjusted for interest expense related to the Company's convertible notes, when dilutive, as more fully discussed in Note 4 and Note 11. The computation of the Company's basic and diluted EPS is set forth in Note 11.

***Recently Issued Accounting Pronouncements***

In February 2013, the Financial Accounting Standards Board issued Accounting Standards Update (''ASU'') No. 2013-2, ''Comprehensive Income — Reporting of Amounts Reclassified Out of Accumulated Other Comprehensive Income'' (''ASU 2013-2''). ASU 2013-2 requires entities to report the effect of significant reclassifications out of accumulated other comprehensive income on the respective line items in net income if the amount being reclassified is required under GAAP to be reclassified in its entirety to net income. For other amounts that are not required under GAAP to be reclassified in their entirety to net income

**Note 1. Organization and Summary of Significant Accounting Policies – (continued)**

in the same reporting period, an entity is required to cross-reference other disclosures required under GAAP that provide additional detail about those amounts. At December 31, 2012, the Company's only component of accumulated other comprehensive income relates to the unrealized gains on changes in the funded status of its pension benefit obligation. ASU 2013-2 is effective for the Company's three month period ending March 31, 2013. The Company does not expect the adoption of ASU 2013-2 to impact its financial position, results of operations or cash flows.

**Note 2. Acquisitions**

***2012 Acquisitions***

*Marquette General*

Effective September 1, 2012, the Company, through its joint venture with Duke, acquired Marquette General for cash consideration of approximately $132.7 million, including net working capital. The Company committed to invest in Marquette General $350.0 million in capital expenditures and improvements as well as for the continuation of existing or initiation of new physician recruiting activities over the next ten years, subject to certain offsets. The aggregate remaining capital and physician recruitment commitment as of December 31, 2012 was $318.6 million. The results of operations of Marquette General are included in the Company's results of operations beginning on September 1, 2012.

The fair values assigned to Marquette General's assets acquired and liabilities assumed at the date of acquisition were as follows (in millions):

| | |
|---|---|
| Current assets | $ 50.4 |
| Property and equipment | 114.7 |
| Other assets | 16.6 |
| Goodwill | 27.1 |
| Total assets acquired, excluding cash | 208.8 |
| Current liabilities | 37.0 |
| Other long-term liabilities | 39.1 |
| Total liabilities assumed | 76.1 |
| Net assets acquired | $132.7 |

In connection with the acquisition of Marquette General, the Company agreed, pursuant to the asset purchase agreement that Marquette General Hospital, Inc. (the ''Marquette Seller'') would receive initial net proceeds of $23.0 million at the closing of the transaction. To the extent that the Marquette Seller's satisfaction of its retained liabilities causes its net proceeds to be reduced to less than $15.0 million, the Company has agreed to pay additional purchase consideration to the Marquette Seller.

As a result of the $15.0 million net proceeds requirement, the Company believes it will pay to the Marquette Seller additional purchase consideration. As such, based on facts that existed as of the acquisition date, the Company's management made reasonable estimates and recorded an aggregate of $31.3 million representing the preliminary fair values of its potential obligations to the Marquette Seller. This $31.3 million of contingent obligations (''Marquette Contingent Obligations'') consists primarily of pre-acquisition healthcare contingent liabilities. The Company will continue to analyze and refine its estimate as changes in facts and circumstances warrant. The Company's management does not control and cannot predict with certainty the progress or final outcome of any discussions with third parties, such as government agencies. Therefore, the final amounts paid in settlement of the pre-acquisition healthcare and other retained liabilities, if any, could materially differ from amounts currently recorded. Any such changes in estimate will impact the Company's future results of operations and cash flows.

**Note 2. Acquisitions – (continued)**

To the extent the Company is required to pay additional purchase consideration pursuant to the information described above, the amounts paid will reduce, on a dollar-for-dollar basis, the remaining $318.6 million of the initial $350.0 million capital improvements and physician recruitment commitment at Marquette General.

*Woods Memorial Hospital ("Woods Memorial")*

Effective July 1, 2012, the Company acquired Woods Memorial, a 72 bed hospital and an 88 bed long-term care facility located in Etowah, Tennessee for approximately $17.7 million, including net working capital. The results of operations of Woods Memorial are included in the Company's results of operations beginning on July 1, 2012.

*Twin County Regional Hospital ("Twin County")*

Effective April 1, 2012, the Company, through its joint venture with Duke, acquired an 80% interest in Twin County, a 141 bed hospital located in Galax, Virginia for approximately $20.5 million, including 80% of the net working capital. The Company has committed to invest in Twin County an additional $20.0 million in capital expenditures and improvements over the next ten years as well as an additional $3.0 million for the continuation of existing or initiation of new physician recruiting activities over the next five years. The results of operations of Twin County are included in the Company's results of operations beginning April 1, 2012.

In connection with the acquisition of Twin County, the Company entered into an agreement to provide management and administrative support for the operations of the hospital. The Company has concluded that the hospital qualifies as a variable interest entity in accordance with ASC 810-10 ''Consolidations'', (''ASC 810-10''), and, due to its economic interest in Twin County combined with its agreement to provide management and administrative support, it is the primary beneficiary. Accordingly, the Company has consolidated the operations of Twin County.

***2011 Acquisitions***

*Maria Parham Medical Center ("Maria Parham")*

Effective November 1, 2011, the Company, through its joint venture with Duke, acquired an 80% interest in Maria Parham, a 102 bed hospital located in Henderson, North Carolina for approximately $57.9 million. The results of operations of Maria Parham are included in the Company's results of operations beginning November 1, 2011.

In connection with the acquisition of Maria Parham, the Company entered into an agreement to provide management and administrative support for the operations of the hospital. The Company has concluded that the hospital qualifies as a variable interest entity in accordance with ASC 810-10, and, due to its economic interest in Maria Parham combined with its agreement to provide management and administrative support, it is the primary beneficiary. Accordingly, the Company has consolidated the operations of Maria Parham.

*Person Memorial Hospital ("Person Memorial")*

Effective October 1, 2011, the Company, through its joint venture with Duke, acquired Person Memorial, a 110 bed hospital located in Roxboro, North Carolina for approximately $22.7 million. The results of operations of Person Memorial are included in the Company's results of operations beginning October 1, 2011.

***2010 Acquisitions***

*HighPoint Health Systems ("HighPoint")*

Effective September 1, 2010, the Company acquired Sumner Regional Health Systems, subsequently renamed HighPoint Health Systems, for approximately $145.0 million plus net working capital. HighPoint includes Sumner Regional Medical Center a 155 bed hospital located in Gallatin, Tennessee, Trousdale

**Note 2. Acquisitions – (continued)**

Medical Center, a 25 bed hospital located in Hartsville, Tennessee and Riverview Regional Medical Center, a 35 bed hospital located in Carthage, Tennessee. The results of operations of HighPoint are included in the Company's results of operations beginning September 1, 2010.

*Clark Regional Medical Center ("Clark")*

Effective May 1, 2010, the Company acquired the operations, working capital and equipment of Clark, a 100 bed hospital located in Winchester, Kentucky for approximately $10.1 million. In connection with this transaction, the Company committed to build and equip a new hospital to replace the previous hospital facility which was completed and opened in March 2012. The results of operations of Clark are included in the Company's results of operations beginning May 1, 2010.

***Ancillary Service-Line Acquisitions***

The Company completed certain ancillary service-line acquisitions, including physician practices, totaling $19.3 million, $40.4 million and $17.2 million during the years ended December 31, 2012, 2011, and 2010, respectively.

**Note 3. Goodwill and Intangible Assets**

The following table presents the changes in the carrying amount of goodwill during the years ended December 31, 2012 and 2011 (in millions):

| | |
|---|---|
| Balance at January 1, 2011 | $1,550.7 |
| Acquisitions of ancillary service-lines | 18.0 |
| Balance at December 31, 2011 | 1,568.7 |
| Acquisition of Twin County | 0.6 |
| Acquisition of Woods | 3.7 |
| Acquisition of Marquette | 27.1 |
| Acquisitions of ancillary service-lines | 11.7 |
| Balance at December 31, 2012 | $1,611.8 |

The following table provides information regarding the Company's intangible assets, which are included in the accompanying consolidated balance sheets at December 31, 2012 and 2011 (in millions):

| | 2012 | 2011 |
|---|---|---|
| Amortized intangible assets: | | |
| Contract-based physician minimum revenue guarantees | | |
| Gross carrying amount | $ 90.2 | $ 92.5 |
| Accumulated amortization | (49.2) | (48.7) |
| Net total | 41.0 | 43.8 |
| Non-competition agreements | | |
| Gross carrying amount | 34.7 | 32.8 |
| Accumulated amortization | (19.9) | (15.2) |
| Net total | 14.8 | 17.6 |
| Other amortized intangible assets | | |
| Gross carrying amount | 2.4 | 2.4 |
| Accumulated amortization | (1.5) | (0.3) |
| Net total | 0.9 | 2.1 |
| Total amortized intangible assets | | |
| Gross carrying amount | 127.3 | 127.7 |
| Accumulated amortization | (70.6) | (64.2) |
| Net total | 56.7 | 63.5 |

**Note 3. Goodwill and Intangible Assets – (continued)**

| | 2012 | 2011 |
|---|---|---|
| Indefinite-lived intangible assets: | | |
| Certificates of need and certificates of need exemptions | 24.8 | 23.9 |
| Licenses, provider numbers, accreditations and other | 3.0 | 2.1 |
| Net total | 27.8 | 26.0 |
| Total intangible assets: | | |
| Gross carrying amount | 155.1 | 153.7 |
| Accumulated amortization | (70.6) | (64.2) |
| Net total | $ 84.5 | $ 89.5 |

***Contract-Based Physician Minimum Revenue Guarantees***

The Company has committed to provide certain financial assistance pursuant to recruiting agreements, or ''physician minimum revenue guarantees,'' with various physicians practicing in the communities it serves. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician to assist in establishing his or her practice.

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460-10, ''Guarantees'' (''ASC 460-10''). In accordance with ASC 460-10, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized as a component of other operating expenses, in the accompanying consolidated statements of operations, over the period of the physician contract, which typically ranges from four to five years. As of December 31, 2012 and 2011, the Company's liability for contract-based physician minimum revenue guarantees was $15.2 million and $13.6 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 operates hospitals in twelve 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 determined that these intangible assets have an indefinite useful life.

***Amortization Expense***

Amortization expense for the Company's intangible assets, including physician minimum revenue guarantee expense in accordance with ASC 460-10, during the years ended December 31, 2012, 2011 and 2010 was $25.6 million, $23.4 million and $19.7 million, respectively.

**Note 3. Goodwill and Intangible Assets – (continued)**

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

| | |
|---|---|
| 2013 | $22.9 |
| 2014 | 14.7 |
| 2015 | 9.4 |
| 2016 | 5.2 |
| 2017 | 1.3 |
| Thereafter | 3.2 |
| | $56.7 |

**Note 4. Long-Term Debt**

The Company's long-term debt consists of the following at December 31, 2012 and 2011 (in millions):

| | 2012 | 2011 |
|---|---|---|
| Senior Borrowings: | | |
| Term Facility | $ 444.4 | $ — |
| Revolving Facility | 85.0 | — |
| Term B Loans | — | 443.7 |
| 6.625% Senior Notes | 400.0 | 400.0 |
| | 929.4 | 843.7 |
| Subordinated Borrowings: | | |
| 3½% Notes | 575.0 | 575.0 |
| 3¼% Debentures | 225.0 | 225.0 |
| Unamortized discounts on 3½% Notes and 3¼% Debentures | (29.5) | (55.5) |
| | 770.5 | 744.5 |
| Capital leases | 9.9 | 9.1 |
| Total long-term debt | 1,709.8 | 1,597.3 |
| Less: current portion | 13.3 | 1.9 |
| | $1,696.5 | $1,595.4 |

Maturities of the Company's long-term debt at December 31, 2012, excluding unamortized discounts on 3½% Notes and 3¼% Debentures are as follows for the years indicated (in millions):

| | |
|---|---|
| 2013 | $ 13.3 |
| 2014 | 587.4 |
| 2015 | 18.0 |
| 2016 | 23.7 |
| 2017 | 692.9 |
| Thereafter | 404.0 |
| | $1,739.3 |

**Note 4. Long-Term Debt – (continued)**

***Senior Credit Agreement***

*Terms*

Effective July 24, 2012, the Company replaced the Prior Credit Agreement with the Senior Credit Agreement maturing on July 24, 2017. The Senior Credit Agreement provides for the $450.0 million Term Facility and the $350.0 million Revolving Facility. The proceeds from the Term Facility were used to repay the $443.7 million outstanding Term B Loans under the Prior Credit Agreement and to pay fees and expenses related to the Senior Credit Agreement. The Term Facility requires scheduled quarterly repayments in an amount equal to 2.5% per annum for each of the first, second and third years and 5.0% per annum for the fourth year and first three quarters of the fifth year, with the balance due at maturity. Additionally, the Term Facility is subject to mandatory prepayments based on excess cash flow, as well as upon the occurrence of certain other events, as specifically described in the Senior Credit Agreement.

On February 6, 2013, the Company amended its Senior Credit Agreement pursuant to which it issued $325.0 million of incremental term loans (the ''Incremental Term Loans''). The proceeds of the Incremental Term Loans were used to repurchase $223.0 million of the Company's 3¼% Debentures, plus accrued and unpaid interest, following the exercise by the holders thereof of their right to require us to repurchase the 3¼% Debentures on February 15, 2013, as well as to pay fees and expenses related to the issuance of the Incremental Term Loans. The Company currently intends, subject to market conditions, to redeem the remaining $2.0 million of the outstanding 3¼% Debentures with the proceeds of the Incremental Term Loans on or after February 20, 2013. The Company intends to use the remaining proceeds of the Incremental Term Loan for general corporate purposes.

*Letters of Credit and Availability*

The Revolving Facility may be utilized for letters of credit and swingline loans up to a maximum of $75.0 million and $25.0 million, respectively. Issued letters of credit and outstanding swingline loans reduce the amounts available under the Revolving Facility. As of December 31, 2012, the Company had $29.8 million in letters of credit outstanding that were related to the self-insured retention level of its general and professional liability insurance and workers' compensation programs as security for payment of claims.

As of December 31, 2012, the Company had outstanding borrowings of $85.0 million under the Revolving Facility for general purposes. Under the terms of the Senior Credit Agreement, amounts available for borrowing under the Revolving Facility were $235.2 million as of December 31, 2012.

The Senior Credit Agreement may, subject to certain conditions and to receipt of commitments from new or existing lenders, be increased up to a total of (i) $800.0 million and (ii) an amount such that, after giving pro forma effect to such increase and to the use of proceeds therefrom, the Company's secured leverage ratio does not exceed 3.50:1.00; provided that no lender is obligated to participate in any such increase. The Senior Credit Agreement is guaranteed on a senior basis by the Company's subsidiaries with certain limited exceptions.

*Interest Rates*

Interest on the outstanding borrowings under the Senior Credit Agreement is payable at the Company's option at either an adjusted London Interbank Offer Rate (''LIBOR'') or an adjusted base rate plus an applicable margin. The applicable margin under the Senior Credit Agreement ranges from 1.50% to 2.50% for LIBOR loans and from 0.50% to 1.50% for adjusted base rate loans based on the Company's total leverage ratio, calculated in accordance with the Senior Credit Agreement.

**Note 4. Long-Term Debt – (continued)**

As of December 31, 2012, the applicable annual interest rate was 1.97% under the Senior Credit Agreement which was based on the 30-day adjusted LIBOR plus the applicable margin. The 30-day adjusted LIBOR was 0.22% for the Senior Credit Agreement as of December 31, 2012. The weighted-average applicable annual interest rate for the year ended December 31, 2012 under the Term Facility was 1.99%.

***Covenants***

The Senior Credit Agreement requires the Company to satisfy a maximum total leverage ratio not to exceed 5.00:1.00 through June 30, 2014 with a step-down to 4.75:1.00 through June 30, 2015, 4.50:1.00 through June 30, 2016 and 4.25:1.00 through the remaining term and as determined on a trailing four quarter basis. The Company was in compliance with this covenant as of December 31, 2012.

In addition, the Senior Credit Agreement contains certain customary affirmative and negative covenants, which among other things, limit the Company's ability to incur additional debt, create liens, merge, consolidate, enter into acquisitions, sell assets, effect sale leaseback transactions, pay dividends, pay subordinated debt and effect transactions with its affiliates. It does not contain provisions that would accelerate the maturity dates upon a downgrade in the Company's credit rating. However, a downgrade in the Company's credit rating could adversely affect its ability to obtain other capital sources in the future and could increase the Company's cost of borrowings.

***6.625% Senior Notes***

Effective September 23, 2010, the Company issued in a private placement $400.0 million of 6.625% unsecured senior notes due October 1, 2020 with The Bank of New York Mellon Trust Company, N.A., as trustee. The net proceeds from this issuance were used to repay a portion of the Company's outstanding borrowings under its Term B Loans and for general corporate purposes. The 6.625% Senior Notes bear interest at the rate of 6.625% per year, payable semi-annually on April 1 and October 1, commencing April 1, 2011. The 6.625% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by substantially all of the Company's existing and future subsidiaries that guarantee the Senior Credit Agreement.

The Company may redeem up to 35% of the aggregate principal amount of its 6.625% Senior Notes, at any time before October 1, 2013, with the net cash proceeds of one or more qualified equity offerings at a redemption price equal to 106.625% of the principal amount to be redeemed, plus accrued and unpaid interest, provided that at least 65% of the aggregate principal amount of its 6.625% Senior Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of any such qualified equity offering.

The Company may redeem its 6.625% Senior Notes, in whole or in part, at any time prior to October 1, 2015 at a price equal to 100% of the principal amount of the notes redeemed plus an applicable makewhole premium, plus accrued and unpaid interest, if any, to the date of redemption. The Company may redeem its 6.625% Senior Notes, in whole or in part, at any time on or after October 1, 2015, plus accrued and unpaid interest, if any, to the date of redemption plus a redemption price equal to a percentage of the principal amount of the notes redeemed based on the following redemption schedule:

| | |
|---|---|
| October 1, 2015 to September 30, 2016 | 103.313% |
| October 1, 2016 to September 30, 2017 | 102.208% |
| October 1, 2017 to September 30, 2018 | 101.104% |
| October 1, 2018 and thereafter | 100.000% |

**Note 4. Long-Term Debt – (continued)**

If the Company experiences a change of control under certain circumstances, it must offer to repurchase all of the notes at a price equal to 101.000% of their principal amount, plus accrued and unpaid interest, if any, to the repurchase date.

The 6.625% Senior Notes contain customary affirmative and negative covenants, which among other things, limit the Company's ability to incur additional debt, create liens, pay dividends, effect transactions with its affiliates, sell assets, pay subordinated debt, merge, consolidate, enter into acquisitions and effect sale leaseback transactions.

***3½% Notes***

The Company's 3½% Notes bear interest at the rate of 3½% per year, payable semi-annually on May 15 and November 15. The 3½% Notes are convertible prior to March 15, 2014 under the following circumstances: (1) if the price of the Company's common stock reaches a specified threshold during specified periods; (2) if the trading price of the 3½% Notes is below a specified threshold; or (3) upon the occurrence of specified corporate transactions or other events. On or after March 15, 2014, holders may convert their 3½% Notes at any time prior to the close of business on the scheduled trading day immediately preceding May 15, 2014, regardless of whether any of the foregoing circumstances has occurred.

Subject to certain exceptions, the Company will deliver cash and shares of our common stock upon conversion of each $1,000 principal amount of its 3½% Notes as follows: (i) an amount in cash, which the Company refers to as the ''principal return'', equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, the lesser of the daily conversion value for such volume-weighted average price trading day and $50; and (ii) a number of shares in an amount equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, any excess of the daily conversion value above $50. The Company's ability to pay the principal return in cash is subject to important limitations imposed by the Senior Credit Agreement and the agreements or indentures governing any additional indebtedness that the Company incurs in the future. If the Company does not make any payments it is obligated to make under the terms of the 3½% Notes, holders may declare an event of default.

The initial conversion rate is 19.3095 shares of the Company's common stock per $1,000 principal amount of the 3½% Notes (subject to certain events). This represents an initial conversion price of approximately $51.79 per share of the Company's common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, the Company will increase the conversion rate in certain circumstances.

Upon the occurrence of a fundamental change (as specified in the indenture), each holder of the 3½% Notes may require the Company to purchase some or all of the 3½% Notes at a purchase price in cash equal to 100% of the principal amount of the 3½% Notes surrendered, plus any accrued and unpaid interest.

The indenture for the 3½% Notes does not contain any financial covenants or any restrictions on the payment of dividends, the incurrence of senior or secured debt or other indebtedness, or the issuance or repurchase of securities by the Company. The indenture contains no covenants or other provisions to protect holders of the 3½% Notes in the event of a highly leveraged transaction or other events that do not constitute a fundamental change.

***3¼% Debentures***

The Company's 3¼% Debentures bear interest at the rate of 3¼% per year, payable semi-annually on February 15 and August 15. The 3¼% Debentures are convertible (subject to certain limitations imposed by the Senior Credit Agreement) under the following circumstances: (1) if the price of the Company's common stock reaches a specified threshold during the specified periods; (2) if the trading price of the 3¼%

**Note 4. Long-Term Debt – (continued)**

Debentures is below a specified threshold; (3) if the 3¼% Debentures have been called for redemption; or (4) if specified corporate transactions or other specified events occur. Subject to certain exceptions, the Company will deliver cash and shares of its common stock, as follows: (i) an amount in cash, which the Company refers to as the ''principal return'', equal to the lesser of (a) the principal amount of the 3¼% Debentures surrendered for conversion and (b) the product of the conversion rate and the average price of the Company's common stock, as set forth in the indenture governing the securities, which the Company refers to as the ''conversion value''; and (ii) if the conversion value is greater than the principal return, an amount in shares of the Company's common stock. The Company's ability to pay the principal return in cash is subject to important limitations imposed by the Senior Credit Agreement and the agreements or indentures governing any additional indebtedness that the Company incurs in the future. Based on the terms of the Senior Credit Agreement, in certain circumstances, even if any of the foregoing conditions to conversion have occurred, the 3¼% Debentures will not be convertible, and holders of the 3¼% Debentures will not be able to declare an event of default under the 3¼% Debentures.

The initial conversion rate for the 3¼% Debentures is 16.3345 shares of the Company's common stock per $1,000 principal amount of 3¼% Debentures (subject to adjustment in certain events). This is equivalent to a conversion price of $61.22 per share of common stock. In addition, if certain corporate transactions that constitute a change of control occur on or prior to February 20, 2013, the Company will increase the conversion rate in certain circumstances, unless such transaction constitutes a public acquirer change of control and the Company elects to modify the conversion rate into public acquirer common stock.

Holders may require the Company to purchase for cash some or all of the 3¼% Debentures on February 15, 2013, February 15, 2015 and February 15, 2020 or upon the occurrence of a fundamental change, at 100% of the principal amount of the 3¼% Debentures to be purchased, plus any accrued and unpaid interest. On February 15, 2013, as more fully discussed in Note 13, the Company repaid $223.0 million of outstanding 3¼% Debentures, plus accrued and unpaid interest, following the exercise by the holders thereof of their right to require us to repurchase the 3¼% Debentures on February 15, 2013 with the proceeds from its issuance of $325.0 million in Incremental Term Loans available for issuance under its Senior Credit Agreement. The Company currently intends to redeem the remaining $2.0 million of the outstanding 3¼% Debentures with the proceeds of the Incremental Term Loans on or after February 20, 2013.

The indenture for the 3¼% Debentures does not contain any financial covenants or any restrictions on the payment of dividends, the incurrence of senior or secured debt or other indebtedness, or the issuance or repurchase of securities by the Company. The indenture contains no covenants or other provisions to protect holders of the 3¼% Debentures in the event of a highly leveraged transaction or fundamental change.

***Debt Extinguishment Costs***

In connection with the Company's replacement of the Prior Credit Agreement with the Senior Credit Agreement during the year ended December 31, 2012, the Company recorded $4.4 million of debt extinguishment costs. The debt extinguishment costs include $2.4 million of previously capitalized loan costs and $2.0 million of loan costs related to the issuance of the Senior Credit Agreement.

In connection with the Company's issuance of its 6.625% Senior Notes and its partial repayment of the Term B Loans during the year ended December 31, 2010, the Company recorded $2.4 million of debt extinguishment costs. The debt extinguishment costs include $1.2 million of previously capitalized loan costs and $1.2 million of loan costs related to the issuance of the 6.625% Senior Notes.

***Unamortized Discounts on Convertible Debt***

In accordance with ASC 470-20, ''Debt with Conversion and Other Options'' (''ASC 470-20''), the Company separately accounts for the liability and equity components of its convertible debt instruments in a manner that reflects the Company's nonconvertible debt borrowing rates for its 3½% Notes and its 3¼%

**Note 4. Long-Term Debt – (continued)**

Debentures at their fair values at their date of issuance. The resulting discounts are amortized as a component of interest expense over the expected lives of similar liabilities that do not have associated equity components. Specifically, the Company is amortizing the discount for its 3½% Notes through May 2014, which is the maturity date of these notes, and for its 3¼% Debentures through February 2013, which is the first date that the holders of the 3¼% Debentures can redeem their debentures.

The following table provides information regarding the principal balance, unamortized discount and net carrying balance of the Company's convertible debt instruments as of December 31, 2012 and 2011 (in millions):

| | 2012 | 2011 |
|---|---|---|
| 3½% Notes: | | |
| Principal balance | $575.0 | $575.0 |
| Unamortized discount | (28.6) | (47.7) |
| Net carrying balance | $546.4 | $527.3 |
| 3¼% Debentures: | | |
| Principal balance | $225.0 | $225.0 |
| Unamortized discount | (0.9) | (7.8) |
| Net carrying balance | $224.1 | $217.2 |

For the years ended December 31, 2012, 2011, and 2010, the contractual cash interest expense and non-cash interest expense (discount amortization) for the Company's convertible debt instruments were as follows (in millions):

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| 3½% Notes: | | | |
| Contractual cash interest expense | $20.1 | $20.1 | $20.1 |
| Non-cash interest expense (discount amortization) | 19.1 | 17.8 | 16.5 |
| Total interest expense | $39.2 | $37.9 | $36.6 |
| 3¼% Debentures: | | | |
| Contractual cash interest expense | $ 7.3 | $ 7.3 | $ 7.3 |
| Non-cash interest expense (discount amortization) | 6.9 | 6.5 | 6.1 |
| Total interest expense | $14.2 | $13.8 | $13.4 |

Considering both the contractual cash interest expense and the non-cash amortization of the discounts for the 3½% Notes and 3¼% Debentures, the effective interest rates for the years ended December 31, 2012, 2011 and 2010 were 6.82%, 6.59% and 6.38%, respectively, for the 3½% Notes and 6.31%, 6.13% and 5.95%, respectively, for the 3¼% Debentures.

***Interest Rate Swap***

Through May 30, 2011, the Company had an interest rate swap agreement in effect with Citibank as counterparty. Effective May 30, 2011, the Company's interest rate swap agreement matured. Prior to its maturity, the interest rate swap agreement required the Company to make quarterly fixed rate payments to Citibank calculated on a notional amount as set forth in the table below at an annual fixed rate of 5.585% while Citibank was obligated to make quarterly floating payments to the Company based on the three-month LIBOR on the same referenced notional amount.

**Note 4. Long-Term Debt – (continued)**

The following table provides information regarding the notional amounts in effect for the indicated date ranges for the Company's interest rate swap agreement:

| Date Range | Notional Amount (In millions) |
|---|---|
| November 30, 2009 to November 30, 2010 | $450.0 |
| November 30, 2010 to May 30, 2011 | 300.0 |

The Company entered into the interest rate swap agreement to mitigate the floating interest rate risk on a portion of its outstanding borrowings under the Prior Credit Agreement. In accordance with ASC 815-10, ''Derivatives and Hedging (''ASC 815-10''), the Company designated its interest rate swap as a cash flow hedge. For derivative instruments that are designated and qualify as cash flow hedges, the effective portion of the gain or loss on the derivative is reported as a component of other comprehensive income (''OCI'') and reclassified into earnings in the same period or periods during which the hedged transactions affect earnings. Gains and losses on the derivative representing either hedge ineffectiveness or hedge components excluded from the assessment of effectiveness are recognized in current earnings.

Through May 30, 2011, the Company assessed the effectiveness of its interest rate swap and determined the hedge to be effective. In connection with the Company's quarterly effective assessments for the year ended December 31, 2010, the Company determined the hedge to be partially ineffective because the notional amount of the interest rate swap in effect at certain quarterly assessment points exceeded the Company's outstanding variable rate borrowings under the Prior Credit Agreement. The Company recognized an increase in interest expense of approximately $0.1 million related to the ineffective portion of the Company's cash flow hedge for the year ended December 31, 2010. During the year ended December 31, 2011, the Company reclassed $1.1 million in previously recognized and cumulative ineffective losses to OCI in connection with the maturity of the Company's interest rate swap agreement.

The following table shows the effect of the Company's interest rate swap derivative instrument qualifying and designated as a hedging instrument in cash flow hedges for the years ended December 31, 2012, 2011 and 2010 (in millions):

| | Amount of gain (loss) recognized in OCI on Derivative (Effective Portion) | | | Location of gain (loss) recognized in Income on Derivative (Ineffective Portion and Amount Excluded from Effectiveness Testing) | Amount of gain (loss) recognized in Income on Derivative (Ineffective Portion and Amount Excluded from Effectiveness Testing) | | |
|---|---|---|---|---|---|---|---|
| | 2012 | 2011 | 2010 | | 2012 | 2011 | 2010 |
| **Derivative in ASC 815-10 cash flow hedging relationships:** | | | | | | | |
| Interest rate swap | $— | $6.8 | $20.4 | Interest expense, net | $— | $1.1 | $(0.1) |

Since the Company's interest rate swap was not traded on a market exchange, the fair value was determined using a valuation model that involved a discounted cash flow analysis on the expected cash flows. This cash flow analysis reflected the contractual terms of the interest rate swap agreement, including the period to maturity, and used observable market-based inputs, including the three-month LIBOR forward interest rate curve. The fair value of the Company's interest rate swap agreement was determined by netting the discounted future fixed cash payments and the discounted expected variable cash receipts. The variable cash receipts were based on the expectation of future interest rates based on the observable market three-month LIBOR forward interest rate curve and the notional amount being hedged. In addition, the Company incorporated credit valuation adjustments to appropriately reflect both its own and Citibank's non-performance or credit risk in the fair value measurements. The interest rate swap agreement exposed the

**Note 4. Long-Term Debt – (continued)**

Company to credit risk in the event of non-performance by Citibank. The majority of the inputs used to value its interest rate swap agreement, including the three-month LIBOR forward interest rate curve and market perceptions of the Company's credit risk used in the credit valuation adjustments, were observable inputs available to a market participant. As a result, the Company made the determination that the interest rate swap valuation was categorized as Level 2 in the fair value hierarchy, in accordance with ASC 820-10.

**Note 5. Accounting for Income Taxes**

The provision for income taxes for the years ended December 31, 2012, 2011, and 2010 consists of the following (in millions):

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Current: | | | |
| Federal | $101.2 | $72.8 | $37.6 |
| State | 13.9 | 8.3 | 4.5 |
| | 115.1 | 81.1 | 42.1 |
| Deferred: | | | |
| Federal | (20.7) | 20.3 | 38.9 |
| State | (7.0) | (4.8) | (2.5) |
| | (27.7) | 15.5 | 36.4 |
| Increase in valuation allowance | 1.1 | 1.2 | 3.9 |
| Total | $ 88.5 | $97.8 | $82.4 |

The increases in the valuation allowance during the years ended December 31, 2012, 2011 and 2010 were primarily the result of state net operating loss carry forwards that management believes may not be fully utilized because of the uncertainty regarding the Company's ability to generate taxable income in certain states. Various subsidiaries have state net operating loss carry forwards in the aggregate of approximately $803.6 million (primarily in Alabama, Florida, Indiana, Louisiana, Pennsylvania, Tennessee, Virginia and West Virginia) with expiration dates through the year 2031.

The following is a reconciliation of the statutory federal income tax rate to the Company's effective income tax rate for income from continuing operations before income taxes and including net income from non-controlling interests for the years ended December 31, 2012, 2011 and 2010:

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Federal statutory rate | 35.0% | 35.0% | 35.0% |
| State income taxes, net of federal income tax benefits | 1.8 | 2.1 | 1.6 |
| Valuation allowances | 0.6 | 0.5 | 1.6 |
| Income tax liability reversals | (0.1) | — | (2.5) |
| Other items, net | (0.5) | — | (1.1) |
| Effective income tax rate | 36.8% | 37.6% | 34.6% |

**Note 5. Accounting for Income Taxes – (continued)**

Deferred income taxes result from temporary differences in the recognition of assets, liabilities, revenues and expenses for financial accounting and tax purposes. Sources of these differences and the related tax effects are as follows as of December 31, 2012 and 2011 (in millions):

| | 2012 | 2011 |
|---|---|---|
| Deferred income tax liabilities: | | |
| Depreciation and amortization | $(310.2) | $(290.7) |
| Amortization of convertible debt discounts | (11.9) | (22.5) |
| Prepaid expenses | (1.6) | (1.3) |
| Other | (5.1) | (14.3) |
| Total deferred income tax liabilities | (328.8) | (328.8) |
| Deferred income tax assets: | | |
| Provision for doubtful accounts | 89.9 | 85.7 |
| Employee compensation | 70.5 | 59.5 |
| Professional liability claims | 45.4 | 45.2 |
| Other | 77.7 | 64.9 |
| Total deferred income tax assets | 283.5 | 255.3 |
| Valuation allowance | (61.4) | (59.8) |
| Net deferred income tax assets | 222.1 | 195.5 |
| Net deferred income tax liabilities | $(106.7) | $(133.3) |

The balance sheet classification of deferred income tax assets (liabilities) at December 31, 2012 and 2011 is as follows (in millions):

| | 2012 | 2011 |
|---|---|---|
| Current | $ 142.5 | $ 125.7 |
| Long-term | (249.2) | (259.0) |
| Total | $(106.7) | $(133.3) |

A reconciliation of the beginning and ending liability for gross unrecognized tax benefits at December 31, 2012 and 2011 is as follows (in millions):

| | 2012 | 2011 |
|---|---|---|
| Balance at beginning of year | $15.7 | $16.1 |
| Additions for tax positions of prior years | 0.1 | 5.2 |
| Reductions for tax positions of prior years | (0.8) | (5.5) |
| Reductions for lapse of statutes of limitations | (0.2) | (0.1) |
| Balance at end of year | $14.8 | $15.7 |

The components of the long-term income tax liability at December 31, 2012 and 2011 are as follows (in millions):

| | 2012 | 2011 |
|---|---|---|
| Unrecognized tax benefits | $14.8 | $15.7 |
| Accrued interest and penalties | 2.1 | 2.3 |
| | $16.9 | $18.0 |

**Note 5. Accounting for Income Taxes – (continued)**

Of the $14.8 million of unrecognized tax benefits at December 31, 2012, $1.1 million, if recognized, would affect the Company's effective tax rate. Included in the balance of unrecognized tax benefits at December 31, 2012 are tax positions of $13.7 million for which the ultimate deductibility is highly certain but for which there is uncertainty about the timing of such deductibility. Because of the impact of deferred income tax accounting, other than for interest and penalties, the disallowance of the shorter deductibility period would not affect the effective income tax rate but would accelerate the payment of cash to the taxing authority to an earlier period.

The Company includes interest and penalties as a component of its income tax expense. During the year ended December 31, 2012, the Company recorded a net $0.1 million reduction of interest expense related to unrecognized tax benefits in income tax expense, which is comprised of an interest benefit of $0.5 million from the expiration of federal and state statutes of limitation, settlements with taxing authorities and interest expense of $0.4 million on unrecognized tax benefits from prior years.

The Company's U.S. Federal income tax returns for tax years 2009 and beyond remain subject to examination by the Internal Revenue Service. The expiration of the statutes of limitation related to the various state income tax returns that the Company and its subsidiaries file, varies by state. Generally, the Company's various state income tax returns for tax years 2006 and beyond remain subject to examination by various state taxing authorities. As a result of the expiration of the statutes of limitation for specific taxing jurisdictions, the Company's unrecognized tax positions could change within the next twelve months by a range of zero to $1.0 million.

**Note 6. 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, 2012 and 2011 (in millions):

| | 2012 | 2011 |
|---|---|---|
| Current portion of reserves for self-insurance claims | $ 27.2 | $ 41.6 |
| Medical benefits liability | 20.9 | 21.9 |
| Physician minimum revenue guarantee liability | 15.2 | 13.6 |
| Current portion of Marquette Contingent Obligations | 13.3 | — |
| EHR deferred income | 12.6 | — |
| Other deferred revenues | 15.6 | 13.0 |
| Accrued interest | 12.4 | 14.0 |
| Accrued property taxes | 8.8 | 7.6 |
| Estimated third party cost report settlements | 7.2 | 4.1 |
| Other | 52.8 | 52.4 |
| | $186.0 | $168.2 |

**Note 7. Stockholders' Equity**

***Preferred Stock***

The Company's Amended and Restated Certificate of Incorporation provides that up to 10,000,000 shares of preferred stock may be issued, of which 90,000 shares have been designated as Series A Junior Participating Preferred Stock, par value $0.01 per share (''Series A Preferred Stock''). The Board of Directors has the authority to issue preferred stock in one or more series and to fix for each series the voting powers (full, limited or none), and the designations, preferences and relative participating, optional or other special rights and qualifications, limitations or restrictions on the stock and the number of shares constituting any series and the designations of this series, without any further vote or action by the stockholders. Because the

**Note 7. Stockholders' Equity – (continued)**

terms of the preferred stock may be fixed by the Board of Directors without stockholder action, the preferred stock could be issued quickly with terms calculated to defeat a proposed takeover or to make the removal of the Company's management more difficult.

***Preferred Stock Purchase Rights***

Pursuant to the Company's stockholders' rights plan, which was amended and restated on February 25, 2009, each outstanding share of common stock is accompanied by one preferred stock purchase right. Each right entitles the registered holder to purchase from the Company one one-thousandth of a share of Series A Preferred Stock of the Company at a price of $125 per one one-thousandth of a share, subject to adjustment. As of December 31, 2012, and 2011 there was no Series A Preferred Stock outstanding.

Each share of Series A Preferred Stock will be entitled, when, as and if declared, to a preferential quarterly dividend payment in an amount equal to the greater of $10 or 1,000 times the aggregate of all dividends declared per share of common stock. In the event of liquidation, dissolution or winding up, the holders of Series A Preferred Stock will be entitled to a minimum preferential liquidation payment equal to $1,000 per share, plus an amount equal to accrued and unpaid dividends and distributions on the stock, whether or not declared, to the date of such payment, but will be entitled to an aggregate payment of 1,000 times the payment made per share of common stock. The rights are not exercisable until the rights distribution date as defined in the stockholders' rights plan. The rights will expire on February 25, 2019, unless the expiration date is extended or unless the rights are earlier redeemed or exchanged.

The rights are designed to deter coercive takeover tactics and to prevent an acquirer from gaining control of the Company without offering a fair price to all of our stockholders. The Rights will not prevent a takeover, but are designed to encourage anyone seeking to acquire the Company to negotiate with its Board of Directors prior to attempting a takeover.

***Common Stock***

Holders of the Company's common stock are entitled to one vote for each share held of record on all matters on which stockholders may vote. There are no preemptive, conversion, redemption or sinking fund provisions applicable to shares of the Company's common stock. In the event of liquidation, dissolution or winding up, holders of the Company's common stock are entitled to share ratably in the assets available for distribution, subject to any prior rights of any holders of preferred stock then outstanding. Delaware law prohibits the Company from paying any dividends unless it has capital surplus or net profits available for this purpose. In addition, the Senior Credit Agreement imposes restrictions on the Company's ability to pay dividends.

***Common Stock in Treasury and Repurchases of Common Stock***

The Company's Board of Directors has authorized the repurchase of outstanding shares of its common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other customary factors in accordance with repurchase plans adopted in 2009, 2010 and 2011. The 2009 plan provided for the repurchase of up to $100.0 million shares of the Company's common stock and expired in February 2011. The 2010 plan provided for the repurchase of up to $150.0 million shares of the Company's common stock and expired in March 2012. The 2011 plan provides for the repurchase of up to $250.0 million in shares of the Company's common stock through March 2013, although it does not obligate the Company to repurchase any specific number of shares. Through December 31, 2012, the Company had repurchased approximately 4.3 million shares for an aggregate purchase price, including commissions, of approximately $154.6 million in accordance with the 2011 repurchase plan. As of December 31, 2012, the Company had remaining authority to repurchase up to an additional $95.4 million in shares in accordance with the 2011 repurchase plan. The Company has designated repurchased shares as treasury stock.

**Note 7. Stockholders' Equity – (continued)**

In connection with the 2011 repurchase plan, the Company has entered into a trading plan in accordance with U.S. Securities and Exchange Commission (''SEC'') Rule 10b5-1 of the Exchange Act to facilitate the repurchase of its common stock during its current black out period (the ''10b5-1 Trading Plan''). The 10b5-1 Trading Plan became effective on December 17, 2012 and will expire on February 19, 2013.

The following tables summarize the Company's share repurchases in accordance with stock repurchase plans for the years ended December 31, 2012, 2011 and 2010:

| | Year Ended December 31, 2012 | | |
|---|---|---|---|
| | Amount (In millions) | Total Number of Shares Repurchased (In millions) | Weighted Average Price Paid per Share |
| 2011 repurchase plan | $89.5 | 2.5 | $36.28 |
| Total | $89.5 | 2.5 | |

| | Year Ended December 31, 2011 | | |
|---|---|---|---|
| | Amount (In millions) | Total Number of Shares Repurchased (In millions) | Weighted Average Price Paid per Share |
| 2010 repurchase plan | $103.6 | 3.0 | $35.24 |
| 2011 repurchase plan | 65.1 | 1.8 | $35.41 |
| Total | $168.7 | 4.8 | |

| | Year Ended December 31, 2010 | | |
|---|---|---|---|
| | Amount (In millions) | Total Number of Shares Repurchased (In millions) | Weighted Average Price Paid per Share |
| 2009 repurchase plan | $100.0 | 3.0 | $33.21 |
| 2010 repurchase plan | 46.4 | 1.3 | $34.90 |
| Total | $146.4 | 4.3 | |

Additionally, the Company redeems shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to the Company's Amended and Restated 1998 Long-Term Incentive Plan (''LTIP'') and Amended and Restated Management Stock Purchase Plan (''MSPP''). The Company redeemed approximately 0.1 million, 0.1 million and 0.2 million shares of certain vested LTIP and MSPP shares during the years ended December 31, 2012, 2011 and 2010 for an aggregate price of approximately $6.0 million, $5.9 million and $5.7 million, respectively. The Company has designated these shares as treasury stock.

***Comprehensive Income (Loss)***

Comprehensive income (loss) consists of two components: net income and other comprehensive income (loss). Other comprehensive income (loss) refers to revenues, expenses, gains and losses that in accordance with ASC 220-10 ''Comprehensive Income,'' are recorded as an element of stockholders' equity but are excluded from net income.

Changes in the funded status of the Company's pension benefit obligations resulted in pretax comprehensive gains of $0.2 million for the year ended December 31, 2012. The Company's defined benefit pension plan is further discussed in Note 9. Additionally, changes in the fair value of the Company's interest rate swap resulted in pretax comprehensive gains of $6.8 million and $20.5 million, or comprehensive gains net of taxes of $4.0 million and $13.4 million for the years ended December 31, 2011 and 2010, respectively. The Company's interest rate swap agreement matured effective May 30, 2011, as further discussed in Note 4.

## Note 8. Stock-Based Compensation

***Stock-Based Compensation Plan Overview***

The Company issues stock-based awards, including stock options and other stock-based awards (nonvested stock, restricted stock, restricted stock units, performance shares and deferred stock units) to certain officers, employees and non-employee directors in accordance with the Company's various stockholder-approved stock-based compensation plans. The Company accounts for its stock-based awards in accordance with the provisions of ASC 718-10 and accordingly recognizes compensation expense over each of the stock-based award's requisite service period based on the estimated grant date fair value.

Effective June 5, 2012, upon stockholders' approval, the Company increased the shares available for grant under its LTIP and Amended and Restated Outside Directors Stock and Incentive Compensation Plan (the ''Outside Directors Plan'') by an additional approximate 0.5 million and 0.1 million shares, respectively. All of the approximate 0.5 million increase in shares available for grant in accordance with the LTIP are available for issuance as nonvested stock, restricted stock and performance shares.

***Description of Stock-Based Compensation Plans***

*1998 Long-Term Incentive Plan*

As of December 31, 2012, the Company is authorized to issue to its officers and employees approximately 18.6 million shares of the Company's common stock in the form of stock options, nonvested stock, restricted stock and performance shares in accordance with the LTIP.

The Company granted stock options to purchase 789,800, 882,990 and 1,279,688 shares of the Company's common stock to certain officers and employees in accordance with the LTIP during the years ended December 31, 2012, 2011 and 2010, respectively. Options to purchase shares granted to the Company's officers and employees in accordance with the LTIP were granted with an exercise price equal to the fair market value of the Company's common stock on the day prior to the grant date. The options granted during the years ended December 31, 2012, 2011 and 2010 become ratably exercisable beginning one year from the date of grant to three years after the date of grant and expire ten years from the date of grant.

The Company granted 436,722, 422,470 and 427,250 shares of nonvested stock awards to certain officers and employees in accordance with the LTIP during the years ended December 31, 2012, 2011 and 2010, respectively. The nonvested stock awards granted during the years ended December 31, 2012, 2011 and 2010 have cliff-vesting periods from the grant date of three years or ratable vesting periods beginning one year from the date of grant to three years after the date of grant.

Of the nonvested stock awards granted during the years ended December 31, 2012, 2011 and 2010, 320,000, 297,000 and 317,000 were performance-based. In addition to requiring continuing service of an employee, the vesting of these nonvested stock awards is contingent upon the satisfaction of certain financial goals, specifically related to the achievement of targeted annual revenues or earnings goals within a three-year period. In accordance with the LTIP, if these goals are achieved, the nonvested stock awards will cliff-vest three years after the grant date. The performance criteria for performance-based nonvested stock awards granted during the years ended December 31, 2011 and 2010 have been certified as met by the Compensation Committee of the Company's Board of Directors, however, these awards are still subject to continuing service requirements and the three year cliff-vesting provisions. For purposes of estimating compensation expense for the performance-based nonvested stock awards granted during the year ended December 31, 2012, the Company has assumed that the performance goals will be achieved. If the performance goals are not met, no compensation expense will be recognized, and any previously recognized compensation expense will be reversed.

Notwithstanding the specific grant vesting requirements, nonvested stock awards and performance-based awards granted under the LTIP become fully vested upon the death or disability of the participant.

**Note 8. Stock-Based Compensation – (continued)**

Additionally, in the event of termination without cause of a participant, the nonvested stock awards and performance-based awards otherwise subject to cliff-vesting become vested in a percentage equal to the number of full months of continuous employment following the date of grant through the date of termination divided by the total number of months in the vesting period, and in the case of performance-based awards, only in the event that the performance goals are attained.

*Outside Directors Stock and Incentive Compensation Plan*

As of December 31, 2012, the Company is authorized to issue to its non-employee directors approximately 0.5 million shares of the Company's common stock in the form of stock options, deferred stock units and restricted stock units in accordance with the Outside Directors Plan.

The Outside Directors Plan provides the Company's non-employee directors an opportunity to receive, in lieu of any portion of their annual retainer (in multiples of 25%), a deferred stock unit award. A deferred stock unit represents the right to receive a specified number of shares of the Company's common stock. The shares are paid, subject to the election of the non-employee director, either three years following the date of the award or at the end of the director's service on the Board of Directors. The number of shares of the Company's common stock to be paid as a deferred stock unit award is equal to the value of the cash retainer that the non-employee director has elected to forego, divided by the fair market value of the Company's common stock on the date of the award.

The Company granted 32,599, 24,143 and 27,475 restricted stock units to its non-employee directors in accordance with the Outside Directors Plan during the years ended December 31, 2012, 2011 and 2010, respectively. All of the restricted stock units granted during the years ended December 31, 2012, 2011 and 2010 are fully vested and are no longer subject to forfeiture. The non-employee director's receipt of shares of the Company's common stock pursuant to the restricted stock unit award is deferred until the first business day following the earliest to occur of (i) the third anniversary of the date of grant, or (ii) the date the non-employee director ceases to be a member of the Company's Board of Directors.

*Management Stock Purchase Plan*

As of December 31, 2012, the Company is authorized to issue to its officers and employees approximately 0.4 million shares of the Company's common stock in the form of restricted stock in accordance with the MSPP.

The MSPP provides the Company's officers and employees an opportunity to purchase shares of the Company's common stock at a 25% discount through payroll deductions over six-month intervals. The Company granted 51,690, 47,081 and 52,048 shares of restricted stock to certain of its officers and employees in accordance with the MSPP during the years ended December 31, 2012, 2011 and 2010, respectively. The restricted stock awards granted during the years ended December 31, 2012, 2011 and 2010 cliff-vest three years from the grant date.

***Stock Options***

*Valuation*

The Company estimated the fair value of stock options granted using the Hull-White II (''HW-II'') lattice option valuation model and a single option award approach. The Company uses the HW-II because it considers characteristics of fair value option pricing, such as an option's contractual term and the probability of exercise before the end of the contractual term. In addition, the complications surrounding the expected term of an option are material, as indicated in ASC 718-10. Given the Company's relatively large pool of unexercised options, the Company believes a lattice model that specifically addresses this fact and models a full term of exercises is the most appropriate and reliable means of valuing its stock options. The Company is

**Note 8. Stock-Based Compensation – (continued)**

amortizing the fair value on a straight-line basis over the requisite service period of the awards, which is the vesting period of three years. The stock options vest 33.3% on each grant anniversary date over three years of continued employment.

The following table shows the weighted average assumptions the Company used to develop the fair value estimates under its HW-II option valuation model and the resulting estimates of weighted-average fair value per share of stock options granted during the years ended December 31, 2012, 2011 and 2010:

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Expected volatility | 36.0% | 36.0% | 39.9% |
| Risk free interest rate (range) | 0.03% – 1.97% | 0.01% – 3.58% | 0.06% – 3.69% |
| Expected dividends | — | — | — |
| Average expected term (years) | 5.3 | 5.4 | 5.4 |
| Fair value per share of stock options granted | $12.18 | $11.73 | $11.22 |

*Population Stratification*

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

*Expected Volatility*

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

*Risk-Free Interest Rate*

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

*Expected Dividends*

The Company has never paid any cash dividends on its common stock and does not anticipate paying any cash dividends in the foreseeable future. Accordingly, the Company uses an expected dividend yield of zero.

**Note 8. Stock-Based Compensation – (continued)**

*Pre-Vesting Forfeitures*

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

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

*Post-Vesting Cancellations*

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

*Expected Term*

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

*Stock Option Activity*

A summary of stock option activity during the year ended December 31, 2012 is as follows:

| Stock Options | Number Shares | Weighted Average Exercise Price | Weighted Average Fair Value | Total Fair Value | Aggregate Intrinsic Value[(a)] | Weighted Average Remaining Contractual Term |
|---|---|---|---|---|---|---|
| | | | | (In millions) | (In millions) | (In years) |
| Outstanding at December 31, 2011 | 3,719,265 | $31.97 | $11.16 | $41.5 | $20.9 | 6.95 |
| Exercisable at December 31, 2011 | 1,818,952 | $31.74 | $11.34 | $20.6 | $11.4 | 5.29 |
| Unvested at December 31, 2011 | 1,900,313 | $32.18 | $10.98 | $20.9 | $ 9.4 | 8.54 |
| Granted | 789,800 | $39.97 | $12.18 | $ 9.6 | N/A | N/A |
| Forfeited (pre-vest cancellation) | (51,395) | $33.42 | $11.42 | $ (0.6) | N/A | N/A |
| Exercised | (745,474) | $29.34 | $10.06 | $ (7.5) | $ 8.3 | N/A |
| Expired (post-vest cancellation) | (45,151) | $36.95 | $16.58 | $ (0.7) | N/A | N/A |
| Vested | 946,579 | $30.15 | $10.43 | $ 9.9 | N/A | N/A |
| Outstanding at December 31, 2012 | 3,667,045 | $34.12 | $11.53 | $42.3 | $16.2 | 6.84 |
| Exercisable at December 31, 2012 | 1,974,906 | $31.72 | $11.26 | $22.3 | $13.1 | 5.45 |
| Unvested at December 31, 2012 | 1,692,139 | $36.92 | $11.84 | $20.0 | $ 3.1 | 8.46 |

(a) The aggregate intrinsic value represents the difference between the underlying stock's market price and the stock option's exercise price.

The total intrinsic value of stock options exercised during the years ended December 31, 2012, 2011 and 2010 was $8.3 million, $13.4 million and $5.4 million, respectively. The Company received $21.8 million, $39.0 million and $20.4 million in cash from stock option exercises for the years ended December 31, 2012,

**Note 8. Stock-Based Compensation – (continued)**

2011 and 2010, respectively. The actual tax benefit realized for the tax deductions from stock option exercises totaled $0.7 million, $1.6 million and $0.6 million for the years ended December 31, 2012, 2011 and 2010, respectively.

As of December 31, 2012, there was $11.2 million of total estimated unrecognized compensation cost related to stock option compensation arrangements. Total estimated unrecognized compensation cost will be adjusted for future changes in estimated forfeitures. The Company expects to recognize this cost over a weighted average period of 1.3 years.

***Other Stock-Based Awards***

The fair value of other stock-based awards is determined based on the closing price of the Company's common stock on the day prior to the grant date. Stock-based compensation expense for the Company's other stock-based awards is recorded equally over the vesting periods of such awards generally ranging from six months to three years.

A summary of other stock-based award activity in accordance with the LTIP, the Outside Directors Plan and MSPP during the year ended December 31, 2012 is as follows:

| Other Stock-Based Awards | Number Shares | Weighted Average Fair Value | Total Fair Value | Aggregate Intrinsic Value[(a)] |
|---|---|---|---|---|
| | | | (In millions) | (In millions) |
| Outstanding at December 31, 2011 | 1,523,534 | $27.46 | $ 41.8 | $56.6 |
| Granted | 521,011 | $36.87 | $ 19.2 | N/A |
| Vested | (551,511) | $22.36 | $(12.3) | $21.6 |
| Forfeited (pre-vest cancellation) | (26,873) | $27.62 | $ (0.7) | N/A |
| Outstanding at December 31, 2012 | 1,466,161 | $32.72 | $ 48.0 | $55.3 |
| Unvested at December 31, 2012 | 1,381,945 | $32.49 | $ 44.9 | $52.2 |

The Company received $1.2 million, $1.2 million and $1.0 million for the issuance of restricted stock in accordance with the MSPP during the years ended December 31, 2012, 2011, and 2010, respectively.

As of December 31, 2012, there was $17.8 million of total estimated unrecognized compensation cost related to other stock-based awards granted in accordance with the LTIP, the Outside Directors Plan and MSPP. Total estimated unrecognized compensation cost will be adjusted for future changes in estimated forfeitures. The Company expects to recognize this cost over a weighted average period of 1.6 years.

**Note 8. Stock-Based Compensation – (continued)**

***Summary of Stock-Based Compensation***

The following table summarizes the activity in accordance with all of the Company's stock-based compensation plans for the years ended December 31, 2012, 2011 and 2010:

| | | Stock Options Outstanding | | Other Stock-Based Awards Outstanding | | Deferred Stock Units Outstanding |
|---|---|---|---|---|---|---|
| | Shares Available For Grant | Number of Shares | Weighted Average Grant Date Price | Number of Shares | Weighted Average Grant Date Price | Number of Shares |
| January 1, 2010 | 2,813,205 | 4,223,676 | $30.47 | 1,753,271 | $25.87 | 11,046 |
| Increase in shares available for grant | 2,455,000 | — | — | — | — | — |
| Stock option grants | (1,279,688) | 1,279,688 | 31.59 | — | — | — |
| Other stock-based awards grants | (506,773) | — | — | 506,773 | 29.41 | — |
| Deferred stock unit grants | (700) | — | — | — | — | 700 |
| Stock option exercises | — | (737,923) | 27.67 | — | — | — |
| Other stock-based awards vested | — | — | — | (561,629) | 33.34 | — |
| Stock option cancellations | 294,953 | (294,953) | 32.77 | — | — | — |
| Other stock-based awards cancellations | 91,758 | — | — | (91,758) | 23.11 | — |
| December 31, 2010 | 3,867,755 | 4,470,488 | 31.10 | 1,606,657 | 24.57 | 11,746 |
| Stock option grants | (882,990) | 882,990 | 35.87 | — | — | — |
| Other stock-based awards grants | (493,694) | — | — | 493,694 | 33.63 | — |
| Deferred stock unit grants | (798) | — | — | — | — | 798 |
| Stock option exercises | — | (1,316,301) | 29.65 | — | — | — |
| Other stock-based awards vested | — | — | — | (548,348) | 25.05 | — |
| Deferred stock units vested | — | — | — | — | — | (1,465) |
| Stock option cancellations | 317,912 | (317,912) | 39.21 | — | — | — |
| Other stock-based awards cancellations | 28,469 | — | — | (28,469) | 20.82 | — |
| December 31, 2011 | 2,836,654 | 3,719,265 | $31.97 | 1,523,534 | $27.46 | 11,079 |
| Increase in shares available for grant | 555,000 | — | — | — | — | — |
| Stock option grants | (789,800) | 789,800 | 39.97 | — | — | — |
| Other stock-based awards grants | (521,011) | — | — | 521,011 | 36.87 | — |
| Stock option exercises | — | (745,474) | 29.34 | — | — | — |
| Other stock-based awards vested | — | — | — | (551,511) | 22.36 | — |
| Stock option cancellations | 96,546 | (96,546) | 35.07 | — | — | — |
| Other stock-based awards cancellations | 26,873 | — | — | (26,873) | 27.62 | — |
| December 31, 2012 | 2,204,262[(a)] | 3,667,045 | $34.12 | 1,466,161 | $32.72 | 11,079 |

(a) Of the 2,204,262 shares available for grant as of December 31, 2012, 1,413,819 are available for grant as stock options in accordance with the LTIP; 727,727 are available for grant as other stock-based awards in accordance with the LTIP; 58,333 are available for grant in accordance with the Outside Directors Plan; and 4,383 are available for grant in accordance with the MSPP.

**Note 8. Stock-Based Compensation – (continued)**

The following table summarizes the Company's total stock-based compensation expense as well as the total recognized tax benefits related thereto for the years ended December 31, 2012, 2011 and 2010 (in millions):

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Other stock-based awards | $16.9 | $14.7 | $13.9 |
| Stock options | 10.5 | 9.3 | 8.5 |
| Total stock-based compensation expense | $27.4 | $24.0 | $22.4 |
| Tax benefit on stock-based compensation expense | $10.9 | $ 9.7 | $ 9.0 |

The Company did not capitalize any stock-based compensation cost during the years ended December 31, 2012, 2011 or 2010. As of December 31, 2012, there was $29.0 million of total estimated unrecognized compensation cost related to all of the Company's stock compensation arrangements. Total estimated unrecognized compensation cost may be adjusted for future changes in estimated forfeitures. The Company expects to recognize this cost over a weighted-average period of 1.5 years.

**Note 9. Defined Benefit Pension Plan**

In connection with its acquisition of Marquette General, the Company acquired certain assets and assumed certain liabilities associated with the benefits in the seller's defined benefit pension plan of certain employees covered by a collective bargaining agreement. The Company has established a separate defined benefit pension plan, the Pension Plan, pursuant to its assumption of a spin-off of a portion of the seller's defined benefit pension plan. Participation in the Pension Plan is closed to any new or future participants, and participants are required to make contributions totaling 6% of annual compensation in order to continue to accrue benefits. The Company makes contributions to the Pension Plan sufficient to meet its minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended.

The following table presents the changes in the Company's Pension Plan benefit obligation and assets from September 1, 2012, the effective date of the Marquette General acquisition, to December 31, 2012 and the unfunded status of the Company's Pension Plan at December 31, 2012 (in millions):

| | |
|---|---|
| Benefit obligation at September 1, 2012 | $34.9 |
| Service costs | 0.2 |
| Interest costs | 0.5 |
| Participant contributions | 0.2 |
| Actuarial loss | (0.5) |
| Benefit obligation at December 31, 2012 | 35.3 |
| Fair value of plan assets at September 1, 2012 | 14.4 |
| Actual return on plan assets | 0.1 |
| Employer contributions | 0.2 |
| Participant contributions | 0.2 |
| Fair value of plan assets at December 31, 2012 | 14.9 |
| Unfunded status included in other long-term liabilities in the Company's accompanying consolidated balance sheet at December 31, 2012 | $20.4 |

The Company recognizes changes in the funded status of the Pension Plan as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income (loss). As of December 31, 2012, the Company recognized a change in the funded status of the Pension Plan as an increase in stockholders' equity through accumulated other comprehensive income (loss) of $0.2 million based primarily

**Note 9. Defined Benefit Pension Plan – (continued)**

on year-end adjustments related to a decrease in its unfunded pension liability due to an increase in the discount rate 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 Company's Pension Plan as of December 31, 2012 (in millions):

| | |
|---|---|
| Projected benefit obligation | $35.3 |
| Accumulated benefit obligation | $29.3 |
| Fair value of plan assets | $14.9 |

The following table summarizes the weighted-average assumptions used by the Company to determine its benefit obligation at December 31, 2012 (in millions):

| | |
|---|---|
| Discount rate | 4.0% |
| Rate of compensation increases | 3.0% |
| Expected long-term return on plan assets | 7.0% |

The following table summarizes the components of net periodic costs from September 1, 2012 to December 31, 2012 (in millions):

| | |
|---|---|
| Net periodic benefit cost: | |
| Service cost | $ 0.2 |
| Interest cost | 0.5 |
| Expected return on plan assets | (0.4) |
| Total net periodic benefit cost | $ 0.3 |

The following table summarizes the weighted-average assumptions used by the Company to determine its net periodic benefit costs from September 1, 2012 to December 31, 2012 (in millions):

| | |
|---|---|
| Discount rate | 3.8% |
| Rate of compensation increases | 3.0% |
| Expected long-term return on plan assets | 7.0% |

The Company's Pension Plan investment policy 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. Cash and cash equivalents are comprised of money market funds and a receivable due to the Pension Plan from the previous sponsor as a result of the final asset allocations as a result of the Marquette acquisition. Fixed income investments include corporate and U.S. government bonds as well as asset and mortgage-backed securities that employ liability directed approaches to minimize changes in the funded status of the plan.

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 of the Pension Plan. The Pension Plan 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.

As of December 31, 2012, the Company was still in the process of developing and implementing its investment policies and strategies for the allocation of plan assets within different asset categories and funds. Prospectively, the Company's target allocation for plan assets is approximately 50% fixed income and 50% equity securities.

**Note 9. Defined Benefit Pension Plan – (continued)**

The Company measures the fair value of the Pension Plan assets in accordance with ASC 820-10. ASC 820-10 establishes a framework for measuring fair value and establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. The tiers are as follows:

Level 1 — defined as observable inputs such as quoted prices in active markets;

Level 2 — defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and

Level 3 — defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

The Pension Plan's investments in corporate and U.S. government bonds are generally valued at the closing price reported in the active market in which the related instrument is traded. In certain limited circumstances, other corporate debt instruments are valued based on yields currently available on comparable securities of issuers with similar credit ratings. The Pension Plan's investments in asset and mortgage-backed securities are valued based on external prices or on the basis of their future principal and interest payments that have been discounted to prevailing interest rates for similar investments, using market spread data and other current market assumptions on prepayments and defaults.

Because all of the inputs used to value corporate and U.S. government bonds as well as asset and mortgage-backed securities are either directly or indirectly observable but other than quoted prices in active markets, the Company has classified these assets as Level 2 investments. Although quoted prices are generally available for the Pension Plan's investments in corporate and U.S. government bonds, in certain limited circumstances, the markets in which the securities are distributed or traded may be limited to one or only a few brokers and vendors. Additionally, in certain other circumstances information regarding the trading volume of these investments is not always available or verifiable.

The following table summarizes the plan assets measured at fair value as of December 31, 2012, 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) |
|---|---|---|---|---|
| Cash and cash equivalents | $ 3.9 | $3.9 | $ — | $— |
| U.S. government bonds | 2.2 | — | 2.2 | — |
| Corporate bonds | 7.4 | — | 7.4 | — |
| Asset and mortgage-backed securities | 1.4 | — | 1.4 | — |
| Total | $14.9 | $3.9 | $11.0 | $— |

**Note 9. Defined Benefit Pension Plan – (continued)**

The Company expects to contribute approximately $1.2 million to the Pension Plan during the year ended December 31, 2013. Additionally, the Company expects to make future benefit payments from the Pension Plan as follows for the years indicated (in millions):

| | |
|---|---|
| 2013 | $ 0.3 |
| 2014 | 0.4 |
| 2015 | 0.6 |
| 2016 | 0.8 |
| 2017 | 0.9 |
| Five years thereafter | 7.7 |
| | $10.7 |

**Note 10. Commitments and Contingencies**

***Legal Proceedings and General Liability Claims***

Hospitals are subject to the regulation and oversight of various state and federal governmental agencies. Further, under the federal False Claims Act, private parties have the right to bring qui tam, or ''whistleblower,'' suits against hospitals that submit false claims for payments to, or improperly retain overpayments from, governmental payors. Some states have adopted similar state whistleblower and false claims provisions. The healthcare industry has seen a number of ongoing investigations related to patient referrals, physician recruiting practices, cost reporting and billing practices, laboratory and home healthcare services, physician ownership of hospitals and other healthcare providers, and joint ventures involving hospitals and physicians. Hospitals continue to be one of the primary focal areas of the Office of the Inspector General (''OIG''), the Department of Justice (''DOJ'') and other governmental fraud and abuse programs. Certain of the Company's individual facilities have received, and from time to time, other facilities may receive, government inquiries from federal and state agencies. 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.

In May 2009, the Company's hospital in Andalusia, Alabama (''Andalusia Regional Hospital'') produced documents responsive to a request received from the U.S. Attorney's Office for the Western District of New York (''AUSA-NY'') regarding an investigation they are conducting with respect to the billing of kyphoplasty (spine-related) procedures. Based on a review of the number of the kyphoplasty procedures performed at all of the Company's other hospitals, as part of an effort to cooperate with the U.S. Attorney's Office, by letter dated January 20, 2010 the Company identified to the U.S. Attorney's Office four additional facilities at which the number of inpatient kyphoplasty procedures approximated those performed at Andalusia Regional Hospital. The Company has completed its review of the relevant medical records and is continuing to cooperate with the government's investigation. In January 2013, the Company reached a settlement in principle with the AUSA-NY that will, if effectuated, settle this matter for approximately $2.6 million, which was included in the Company's reserves for uninsured litigation at December 31, 2012.

In January 2013, Jackson Purchase Medical Center (''Jackson Purchase'') entered into a voluntary settlement agreement with the DOJ and the OIG for a cash payment of approximately $0.9 million, which was included in the Company's reserves for uninsured litigation at December 31, 2012. The settlement relates to the relationship between the hospital and a physician on its medical staff and that physician's use of a hospital-employed advanced nurse practitioner, as well as lease arrangements between the hospital and physician. Jackson Purchase is currently subject to a five-year Corporate Integrity Agreement with the OIG, which became effective June 26, 2011.

**Note 10. Commitments and Contingencies – (continued)**

In addition to legal proceedings initiated by government agencies and third parties, all hospitals have an obligation to report and refund promptly any overpayments received once identified. ''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 become obligations in violation of the False Claims Act if not reported and refunded within 60 days of identification. Hospitals can meet the obligation to report and refund in three ways: (1) refunding overpayments directly to the program, (2) self-disclosing the overpayment to the OIG via its voluntary self-disclosure protocol (with respect to False Claims Act and other violations not related to the Stark law), and (3) self-disclosing to CMS via the self-referral disclosure protocol (with respect to overpayments caused by potential violations of the Stark law only) for which CMS has the authority to reduce the amounts otherwise owed.

In connection with the Company's acquisition of Marquette General, Marquette General self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. This self-disclosure is pending with CMS. To the extent that the Marquette Seller's satisfaction of the Marquette Contingent Obligations, which include the CMS voluntary self-disclosure as well as other obligations, causes its net proceeds to be reduced to less than $15.0 million, the Company would pay additional purchase consideration to the Marquette Seller. The Company made reasonable estimates of these potential liabilities and recorded an aggregate of $31.3 million (a portion of which relates to Marquette General's CMS voluntary self-disclosure) representing the preliminary fair values of its potential obligation to the Marquette Seller related to the Marquette Contingent Obligations. The Company's management does not control and cannot predict with certainty the amount the Marquette Seller will owe any agency or creditor. Therefore, the final amounts paid in settlement, if any, could materially differ from amounts currently recorded. To the extent the Company is required to pay additional purchase consideration pursuant to the Marquette Contingent Obligations, the amounts paid will reduce on a dollar-for-dollar basis, the remaining $318.6 million of the initial $350.0 million in capital improvements and physician recruitment commitment at Marquette General. The Marquette Contingent Obligations are further described in Note 2.

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

***Physician Commitments***

The Company has committed to provide certain financial assistance pursuant to recruiting agreements with various physicians practicing in the communities it serves. In consideration for a physician's relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician, normally over a period of one year, to assist in establishing the physician's practice. The Company has committed to advance a maximum amount of approximately $33.0 million at December 31, 2012. The actual amount of such commitments to be subsequently advanced to physicians is estimated at $15.2 million and often depends upon the financial results of a physician's private practice during the guarantee period. Generally, amounts advanced under the recruiting agreements may be forgiven pro rata over a period of 36 to 48 months contingent upon the physician continuing to practice in the respective community. Pursuant to the Company's standard physician recruiting agreement, any breach or non-fulfillment by a physician under the physician recruiting agreement gives the Company the right to recover any payments made to the physician under the agreement. Additionally, the Company is subject to annual commitments for certain physician recruiting activities, including the continuation of existing or initiation of new activities with several of its facilities, including its recent acquisitions of Marquette General and Twin County.

**Note 10. Commitments and Contingencies – (continued)**

***Capital Expenditure Commitments***

The Company is reconfiguring some of its hospitals to more effectively accommodate patient services and to provide for a greater variety of services, as well as implementing various information system initiatives in its efforts to comply with the Health Information Technology for Economic and Clinical Health Act. The Company has incurred approximately $81.0 million in costs related to uncompleted projects as of December 31, 2012, which is included under the caption ''Construction in progress'' in the Company's accompanying consolidated balance sheet. At December 31, 2012, these uncompleted projects had an estimated cost to complete and equip of approximately $68.8 million. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities, including its recent acquisitions of Marquette General and Twin County.

***Shared Centralized Resource Model Arrangements***

In June 2012, the Company entered into agreements with a third party to provide certain nonclinical business functions to the Company, including supply chain management and revenue cycle functions under a shared centralized resource model for periods ranging from six to ten years. These agreements are in addition to the Company's existing agreement with this third party to provide payroll processing services.

The Company's management believes this model of sharing centralized resources to support common business functions across multi-facility enterprises provides it efficiencies and is the most cost effective approach to managing these nonclinical business functions. The Company expects to implement the supply chain management and revenue cycle functions over the next 18 to 24 months. Primarily in connection with the implementation process, the Company incurred severance and retention costs for its affected workforce of $3.8 million for the year ended December 31, 2012. The Company estimates it will recognize approximately $4.6 million of additional severance and retention costs over the remaining implementation periods.

***Acquisitions***

The Company has historically acquired businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, medical and general professional liabilities, workers compensation liabilities, previous tax liabilities and unacceptable business practices. Although the Company institutes policies designed to conform practices to its standards following completion of acquisitions, there can be no assurance that the Company will not become liable for past activities that may later be asserted to be improper by private plaintiffs or government agencies. Although the Company generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

***Development Agreement with the City of Ennis***

The Company entered into an agreement with the City of Ennis, Texas during 2005 to construct and equip a new hospital to replace the existing Ennis Regional Medical Center. During 2007, the Company completed the construction of the new facility for approximately $35.0 million, all of which was paid for by the Company. Pursuant to the terms of the agreement, the City of Ennis paid $14.7 million of the construction cost to the Company, and the Company entered into a 40-year lease agreement as lessee of the facility from the City of Ennis. The Company recorded the $14.7 million payment from the City of Ennis as a deferred income liability which the Company is amortizing on a straight-line basis over the term of the lease. As of December 31, 2012, the unamortized deferred income liability was $12.4 million.

**Note 10. Commitments and Contingencies – (continued)**

***Leases***

The Company leases real estate properties, buildings, vehicles and equipment under cancelable and non-cancelable leases. The leases expire at various times and have various renewal options. Certain leases that meet the lease capitalization criteria in accordance with ASC 840-10, ''Leases'', have been recorded as an asset and liability at the lower of the net present value of the minimum lease payments at the inception of the lease or the fair value of the asset at the inception date. Interest rates used in computing the net present value of the lease payments are based on the Company's incremental borrowing rate at the inception of the lease. Rental expense of operating leases for the years ended December 31, 2012, 2011 and 2010 was $34.3 million, $30.0 million and $27.0 million, respectively.

Future minimum lease payments at December 31, 2012, for those leases having an initial or remaining non-cancelable lease term in excess of one year are as follows for the years indicated (in millions):

| | Operating Leases | Capital Lease Obligations | Total |
|---|---|---|---|
| 2013 | $23.4 | $ 3.6 | $ 27.0 |
| 2014 | 12.7 | 2.6 | 15.3 |
| 2015 | 8.8 | 2.4 | 11.2 |
| 2016 | 6.6 | 2.2 | 8.8 |
| 2017 | 4.9 | 1.2 | 6.1 |
| Thereafter | 24.1 | 9.4 | 33.5 |
| | $80.5 | $ 21.4 | $101.9 |
| Less: interest portion | | (11.5) | |
| Long-term obligations under capital leases | | $ 9.9 | |

***Hospital Support Center Lease***

The Company has entered into an agreement with an unrelated third party to lease a new hospital support center with a targeted occupancy date in the fourth quarter of 2013. Under the terms of the lease agreement, the Company will lease from the third party the newly constructed hospital support center for a period of just over 15 years following construction completion. The Company's management has determined that it has substantially all of the risks of ownership of the new hospital support center during the construction period and in accordance with ASC 840-40, ''Leases — Sale-Leaseback Transactions'' (''ASC 840-40'') has recorded an asset under the caption ''Construction in progress'' and related financing obligation under the caption ''Other long-term liabilities'' in the accompanying consolidated balance sheet of $15.8 million as of December 31, 2012. This asset and related liability represents the cumulative costs incurred to date and funded by the unrelated third party to construct the new hospital support center. Once construction is complete, the Company will consider the applicable requirements of ASC 840-40 for sale-leaseback treatment, including the transfer back of all risks of ownership to the unrelated third party and whether the Company has any continuing involvement in the leased property. Currently, the Company anticipates that its lease agreement will qualify as a financing lease in accordance with ASC 840-40 and accordingly, the Company will depreciate the completed hospital support center and amortize the related financing obligation over the expected lease agreement term.

***Tax Matters***

See Note 5 for a discussion of the Company's contingent tax matters.

**Note 11. Earnings Per Share**

The following table sets forth the computation of basic and diluted earnings per share for the years ended December 31, 2012, 2011 and 2010 (dollars and shares in millions, except per share amounts):

| | 2012 | 2011 | 2010 |
|---|---|---|---|
| Numerator for basic and diluted earnings per share attributable to LifePoint Hospitals, Inc.: | | | |
| Income from continuing operations | $155.6 | $165.5 | $158.7 |
| Less: Net income attributable to noncontrolling interests | (3.7) | (2.8) | (3.1) |
| Income from continuing operations attributable to LifePoint Hospitals, Inc. stockholders | 151.9 | 162.7 | 155.6 |
| Income (loss) from discontinued operations, net of income taxes | — | 0.2 | (0.1) |
| Net income attributable to LifePoint Hospitals, Inc. | $151.9 | $162.9 | $155.5 |
| Denominator: | | | |
| Weighted average shares outstanding – basic | 47.2 | 49.3 | 52.2 |
| Effect of dilutive securities: stock options and other stock-based awards | 1.2 | 1.2 | 1.3 |
| Weighted average shares outstanding – diluted | 48.4 | 50.5 | 53.5 |
| Earnings per share attributable to LifePoint Hospitals, Inc. stockholders: | | | |
| Basic | $ 3.22 | $ 3.30 | $ 2.98 |
| Diluted | $ 3.14 | $ 3.22 | $ 2.91 |

The Company's 3½% Notes and 3¼% Debentures are included in the calculation of diluted earnings per share whether or not the contingent requirements have been met for conversion using the treasury stock method if the conversion price of $51.79 and $61.22, respectively, is less than the average market price of the Company's common stock for the period. Upon conversion, the par value is settled in cash, and only the conversion premium is settled in shares of the Company's common stock. The impact of the 3½% Notes and 3¼% Debentures have been excluded because the effects would have been anti-dilutive for the years ended December 31, 2012, 2011 and 2010.

## Note 12. Unaudited Quarterly Financial Information

The quarterly interim financial information shown below has been prepared by the Company's management and is unaudited. It should be read in conjunction with the audited consolidated financial statements appearing herein (in millions, except per share amounts):

| | 2012 | | | |
|---|---|---|---|---|
| | First | Second | Third | Fourth |
| Revenues | $851.0 | $827.3 | $820.2 | $893.3 |
| Income from continuing operations | $ 56.9 | $ 41.9 | $ 19.3 | $ 37.5 |
| Income (loss) from discontinued operations, net of income taxes | 0.1 | 0.1 | — | (0.2) |
| Net income | 57.0 | 42.0 | 19.3 | 37.3 |
| Less: Net income attributable to noncontrolling interests | (0.9) | (1.7) | (0.1) | (1.0) |
| Net income attributable to LifePoint Hospitals, Inc. | $ 56.1 | $ 40.3 | $ 19.2 | $ 36.3 |
| Basic earnings (loss) per share attributable to LifePoint Hospitals, Inc. stockholders: | | | | |
| Continuing operations | $ 1.19 | $ 0.85 | $ 0.40 | $ 0.78 |
| Discontinued operations | — | — | — | (0.01) |
| Net income | $ 1.19 | $ 0.85 | $ 0.40 | $ 0.77 |
| Diluted earnings (loss) per share attributable to LifePoint Hospitals, Inc. stockholders: | | | | |
| Continuing operations | $ 1.16 | $ 0.83 | $ 0.39 | $ 0.76 |
| Discontinued operations | — | — | — | (0.01) |
| Net income | $ 1.16 | $ 0.83 | $ 0.39 | $ 0.75 |

| | 2011 | | | |
|---|---|---|---|---|
| | First | Second | Third | Fourth |
| Revenues | $758.5 | $747.1 | $739.2 | $781.3 |
| Income from continuing operations | $ 46.5 | $ 41.1 | $ 39.6 | $ 38.3 |
| Income (loss) from discontinued operations, net of income taxes | 0.3 | — | (0.1) | — |
| Net income | 46.8 | 41.1 | 39.5 | 38.3 |
| Less: Net income attributable to noncontrolling interests | (0.7) | (0.8) | (0.7) | (0.6) |
| Net income attributable to LifePoint Hospitals, Inc. | $ 46.1 | $ 40.3 | $ 38.8 | $ 37.7 |
| Basic earnings per share attributable to LifePoint Hospitals, Inc. stockholders: | | | | |
| Continuing operations | $ 0.91 | $ 0.79 | $ 0.79 | $ 0.80 |
| Discontinued operations | 0.01 | — | — | — |
| Net income | $ 0.92 | $ 0.79 | $ 0.79 | $ 0.80 |
| Diluted earnings per share attributable to LifePoint Hospitals, Inc. stockholders: | | | | |
| Continuing operations | $ 0.89 | $ 0.77 | $ 0.77 | $ 0.78 |
| Discontinued operations | — | — | — | — |
| Net income | $ 0.89 | $ 0.77 | $ 0.77 | $ 0.78 |

**Note 13. Subsequent Events**

In May 2012, the Company entered into a joint venture agreement with Norton Healthcare, Inc. to form the Regional Healthcare Network of Kentucky and Southern Indiana (''RHN''), the purpose of which is to own and operate hospitals in non-urban communities in the Kentucky and Southern Indiana region. Effective January 1, 2013, RHN acquired Scott Memorial Hospital (''Scott Memorial''), a 25 bed hospital located in Scottsburg, Indiana for approximately $9.5 million, including net working capital. The purchase price of Scott Memorial, which was paid on December 31, 2012, is reflected as a deposit and is included under the caption ''Other assets'' in the accompanying consolidated balance sheet at December 31, 2012. The Company has committed to invest in Scott Memorial an additional $3.0 million in capital expenditures and improvements over the next five years.

On February 6, 2013, the Company amended its Senior Credit Agreement pursuant to which it issued $325.0 million of Incremental Term Loans. The proceeds of the Incremental Term Loans were used to repurchase $223.0 million of the Company's 3¼% Debentures, plus accrued and unpaid interest, following the exercise by the holders thereof of their right to require us to repurchase the 3¼% Debentures on February 15, 2013, as well as to pay fees and expenses related to the issuance of the Incremental Term Loans. The Company currently intends, subject to certain market conditions, to redeem the remaining $2.0 million of the outstanding 3¼% Debentures with the proceeds of the Incremental Term Loans on or after February 20, 2013. The Company intends to use the remaining proceeds of the Incremental Term Loan for general corporate purposes.

The Incremental Term Loans mature on July 24, 2017 and require quarterly repayments, commencing on March 31, 2013, in an amount equal to 0.25% of the aggregate principal amount of all Incremental Term Loans, with the remaining outstanding balance paid at maturity. The Incremental Term Loans bear interest at a rate equal to either the ABR or LIBOR from time to time in effect, at the Company's option, plus an applicable margin above the specified index as follows: (i) in the case of borrowings accruing interest at a rate based on ABR, ABR plus an applicable margin of 1.50% per annum, and (ii) in the case of borrowings accruing interest at a rate based on LIBOR, LIBOR plus an applicable margin of 2.50% per annum. The Incremental Term Loans will initially bear interest at a rate based on 30-day adjusted LIBOR.

The Company may prepay the Incremental Term Loans at any time prior to the six-month anniversary of their issuance, subject to a 1.0% prepayment premium if such prepayment is made from proceeds of long-term bank debt financing having an effective interest rate or weighted average yield that is less than the interest rate for or weighted average yield of such Incremental Term Loans. The Company may prepay the Incremental Term Loans at any time after the six-month anniversary of their issuance without any prepayment premium.

The Incremental Term Loans are guaranteed, on a senior basis, by the subsidiaries of the Company that guarantee the Senior Credit Agreement. The Incremental Term Loans are secured by the collateral that secures the Senior Credit Agreement, consisting of a perfected first priority lien on, and pledge of, all of the capital stock and intercompany notes owned by the Company and each guarantor. The Incremental Term Loans will rank *pari passu* with the term loans outstanding immediately prior to the effective date of their issuance.

**Note 14. Guarantor and Non-Guarantor Supplementary Information**

The Company's 6.625% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by substantially all of the Company's existing subsidiaries that guarantee the Company's Senior Credit Agreement. The following presents the condensed consolidating financial information for the parent issuer, guarantor subsidiaries, non-guarantor subsidiaries, certain eliminations and the Company for the years ended December 31, 2012, 2011 and 2010 and as of December 31, 2012 and 2011:

**LIFEPOINT HOSPITALS, INC.**
**Condensed Consolidating Statements of Operations**
**For the Year Ended December 31, 2012**
*(In millions)*

| | Parent Issuer | Guarantors | Non-Guarantors | Eliminations | Consolidated |
|---|---|---|---|---|---|
| Revenues before provision for doubtful accounts | $ — | $3,427.1 | $589.1 | $ — | $4,016.2 |
| Provision for doubtful accounts | — | 538.9 | 85.5 | — | 624.4 |
| Revenues | — | 2,888.2 | 503.6 | — | 3,391.8 |
| Salaries and benefits | 27.4 | 1,303.4 | 223.7 | — | 1,554.5 |
| Supplies | — | 430.0 | 94.6 | — | 524.6 |
| Other operating expenses | 0.2 | 696.1 | 102.8 | — | 799.1 |
| Other income | — | (27.5) | (4.5) | — | (32.0) |
| Equity in earnings of affiliates | (200.2) | — | — | 200.2 | — |
| Depreciation and amortization | — | 162.2 | 30.9 | — | 193.1 |
| Interest expense, net | 22.4 | 70.9 | 6.7 | — | 100.0 |
| Debt extinguishment costs | 4.4 | — | — | — | 4.4 |
| Impairment charges | — | 4.0 | — | — | 4.0 |
| Management (income) fees | — | (8.4) | 8.4 | — | — |
| | (145.8) | 2,630.7 | 462.6 | 200.2 | 3,147.7 |
| Income from continuing operations before taxes | 145.8 | 257.5 | 41.0 | (200.2) | 244.1 |
| (Benefit) provision for income taxes | (6.1) | 94.6 | — | — | 88.5 |
| Net income | 151.9 | 162.9 | 41.0 | (200.2) | 155.6 |
| Less: Net income attributable to noncontrolling interests | — | (0.7) | (3.0) | — | (3.7) |
| Net income attributable to LifePoint Hospitals, Inc. | $ 151.9 | $ 162.2 | $ 38.0 | $(200.2) | $ 151.9 |

**Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)**

**LIFEPOINT HOSPITALS, INC.**
**Condensed Consolidating Statements of Operations**
**For the Year Ended December 31, 2011**
*(In millions)*

| | Parent Issuer | Guarantors | Non-Guarantors | Eliminations | Consolidated |
|---|---|---|---|---|---|
| Revenues before provision for doubtful accounts | $ — | $3,207.0 | $337.6 | $ — | $3,544.6 |
| Provision for doubtful accounts | — | 470.5 | 48.0 | — | 518.5 |
| Revenues | — | 2,736.5 | 289.6 | — | 3,026.1 |
| Salaries and benefits | 24.0 | 1,232.8 | 107.9 | — | 1,364.7 |
| Supplies | — | 414.8 | 54.7 | — | 469.5 |
| Other operating expenses | 0.2 | 630.2 | 52.0 | — | 682.4 |
| Other income | — | (24.6) | (2.1) | — | (26.7) |
| Equity in earnings of affiliates | (216.5) | — | — | 216.5 | — |
| Depreciation and amortization | — | 148.1 | 17.7 | — | 165.8 |
| Interest expense, net | 34.2 | 70.8 | 2.1 | — | 107.1 |
| Management (income) fees | — | (9.6) | 9.6 | — | — |
| | (158.1) | 2,462.5 | 241.9 | 216.5 | 2,762.8 |
| Income from continuing operations before taxes | 158.1 | 274.0 | 47.7 | (216.5) | 263.3 |
| (Benefit) provision for income taxes | (4.8) | 102.6 | — | — | 97.8 |
| Income from continuing operations | 162.9 | 171.4 | 47.7 | (216.5) | 165.5 |
| Income from discontinued operations, net of taxes | — | 0.2 | — | — | 0.2 |
| Net income | 162.9 | 171.6 | 47.7 | (216.5) | 165.7 |
| Less: Net income attributable to noncontrolling interests | — | (0.8) | (2.0) | — | (2.8) |
| Net income attributable to LifePoint Hospitals, Inc. | $ 162.9 | $ 170.8 | $ 45.7 | $(216.5) | $ 162.9 |

**Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)**

**LIFEPOINT HOSPITALS, INC.**
**Condensed Consolidating Statements of Operations**
**For the Year Ended December 31, 2010**
*(In millions)*

| | Parent Issuer | Guarantors | Non-Guarantors | Eliminations | Consolidated |
|---|---|---|---|---|---|
| Revenues before provision for doubtful accounts | $ — | $2,961.9 | $300.5 | $ — | $3,262.4 |
| Provision for doubtful accounts | — | 405.2 | 38.6 | — | 443.8 |
| Revenues | — | 2,556.7 | 261.9 | — | 2,818.6 |
| Salaries and benefits | 22.4 | 1,153.6 | 94.3 | — | 1,270.3 |
| Supplies | — | 392.7 | 50.3 | — | 443.0 |
| Other operating expenses | 0.4 | 557.8 | 47.0 | — | 605.2 |
| Equity in earnings of affiliates | (215.4) | — | — | 215.4 | — |
| Depreciation and amortization | — | 134.1 | 14.4 | — | 148.5 |
| Interest expense, net | 41.2 | 66.4 | 0.5 | — | 108.1 |
| Debt extinguishment costs | 2.3 | 0.1 | — | — | 2.4 |
| Management (income) fees | — | (8.6) | 8.6 | — | — |
| | (149.1) | 2,296.1 | 215.1 | 215.4 | 2,577.5 |
| Income from continuing operations before taxes | 149.1 | 260.6 | 46.8 | (215.4) | 241.1 |
| (Benefit) provision for income taxes | (6.4) | 88.8 | — | — | 82.4 |
| Income from continuing operations | 155.5 | 171.8 | 46.8 | (215.4) | 158.7 |
| Loss from discontinued operations, net of taxes | — | (0.1) | — | — | (0.1) |
| Net income | 155.5 | 171.7 | 46.8 | (215.4) | 158.6 |
| Less: Net income attributable to noncontrolling interests | — | (0.8) | (2.3) | — | (3.1) |
| Net income attributable to LifePoint Hospitals, Inc. | $ 155.5 | $ 170.9 | $ 44.5 | $(215.4) | $ 155.5 |

**Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)**

**LIFEPOINT HOSPITALS, INC.**
**Condensed Consolidating Statements of Comprehensive Income**
**For the Year Ended December 31, 2012**
*(In millions)*

| | Parent Issuer | Guarantors | Non-Guarantors | Eliminations | Consolidated |
|---|---|---|---|---|---|
| Net income | $151.9 | $162.9 | $41.0 | $(200.2) | $155.6 |
| Other comprehensive income, net of income taxes: | | | | | |
| Unrealized gains on changes in funded status of pension benefit obligation | 0.2 | | 0.2 | (0.2) | 0.2 |
| Other comprehensive income | 0.2 | — | 0.2 | (0.2) | 0.2 |
| Comprehensive income | 152.1 | 162.9 | 41.2 | (200.4) | 155.8 |
| Less: Net income attributable to noncontrolling interests | — | (0.7) | (3.0) | — | (3.7) |
| Comprehensive income attributable to LifePoint Hospitals, Inc. | $152.1 | $162.2 | $38.2 | $(200.4) | $152.1 |

**LIFEPOINT HOSPITALS, INC.**
**Condensed Consolidating Statements of Comprehensive Income**
**For the Year Ended December 31, 2011**
*(In millions)*

| | Parent Issuer | Guarantors | Non-Guarantors | Eliminations | Consolidated |
|---|---|---|---|---|---|
| Net income | $162.9 | $171.6 | $47.7 | $(216.5) | $165.7 |
| Other comprehensive income, net of income taxes: | | | | | |
| Unrealized gains on changes in fair value of interest rate swap | 4.0 | — | — | — | 4.0 |
| Other comprehensive income | 4.0 | — | — | — | 4.0 |
| Comprehensive income | 166.9 | 171.6 | 47.7 | (216.5) | 169.7 |
| Less: Net income attributable to noncontrolling interests | — | (0.8) | (2.0) | — | (2.8) |
| Comprehensive income attributable to LifePoint Hospitals, Inc. | $166.9 | $170.8 | $45.7 | $(216.5) | $166.9 |

**Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)**

**LIFEPOINT HOSPITALS, INC.**
**Condensed Consolidating Statements of Comprehensive Income**
**For the Year Ended December 31, 2010**
*(In millions)*

| | Parent Issuer | Guarantors | Non-Guarantors | Eliminations | Consolidated |
|---|---|---|---|---|---|
| Net income | $155.5 | $171.7 | $46.8 | $(215.4) | $158.6 |
| Other comprehensive income, net of income taxes: | | | | | |
| Unrealized gains on changes in fair value of interest rate swap | 13.4 | — | — | — | 13.4 |
| Other comprehensive income | 13.4 | — | — | — | 13.4 |
| Comprehensive income | 168.9 | 171.7 | 46.8 | (215.4) | 172.0 |
| Less: Net income attributable to noncontrolling interests | — | (0.8) | (2.3) | — | (3.1) |
| Comprehensive income attributable to LifePoint Hospitals, Inc. | $168.9 | $170.9 | $44.5 | $(215.4) | $168.9 |

**Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)**

**LIFEPOINT HOSPITALS, INC.**
**Condensed Consolidating Balance Sheets**
**December 31, 2012**
*(In millions)*

| | Parent Issuer | Guarantors | Non-Guarantors | Eliminations | Consolidated |
|---|---|---|---|---|---|
| **ASSETS** | | | | | |
| Current assets: | | | | | |
| Cash and cash equivalents | $ — | $ 26.8 | $ 58.2 | $ — | $ 85.0 |
| Accounts receivable, net | — | 410.1 | 108.7 | — | 518.8 |
| Inventories | — | 76.9 | 20.1 | — | 97.0 |
| Prepaid expenses | 0.1 | 28.0 | 3.7 | — | 31.8 |
| Deferred tax assets | 142.5 | — | — | — | 142.5 |
| Other current assets | — | 37.9 | 12.3 | — | 50.2 |
| | 142.6 | 579.7 | 203.0 | — | 925.3 |
| Property and equipment: | | | | | |
| Land | — | 74.7 | 27.2 | — | 101.9 |
| Buildings and improvements | — | 1,524.2 | 291.0 | — | 1,815.2 |
| Equipment | — | 1,172.2 | 117.5 | — | 1,289.7 |
| Construction in progress | — | 76.2 | 4.8 | — | 81.0 |
| | — | 2,847.3 | 440.5 | — | 3,287.8 |
| Accumulated depreciation | — | (1,175.5) | (81.4) | — | (1,256.9) |
| | — | 1,671.8 | 359.1 | — | 2,030.9 |
| Deferred loan costs, net | 21.9 | — | — | — | 21.9 |
| Intangible assets, net | — | 48.0 | 36.5 | — | 84.5 |
| Investments in subsidiaries | 1,663.1 | — | — | (1,663.1) | — |
| Other | 1.5 | 27.3 | 19.0 | — | 47.8 |
| Goodwill | — | 1,440.4 | 171.4 | — | 1,611.8 |
| Total assets | $ 1,829.1 | $ 3,767.2 | $789.0 | $(1,663.1) | $ 4,722.2 |
| **LIABILITIES AND EQUITY** | | | | | |
| Current liabilities: | | | | | |
| Accounts payable | $ — | $ 92.9 | $ 24.5 | $ — | $ 117.4 |
| Accrued salaries | — | 105.0 | 23.2 | — | 128.2 |
| Other current liabilities | 13.1 | 137.4 | 35.5 | — | 186.0 |
| Current maturities of long-term debt | 11.3 | 1.3 | 0.7 | — | 13.3 |
| | 24.4 | 336.6 | 83.9 | — | 444.9 |
| Long-term debt | 1,688.6 | 5.8 | 2.1 | — | 1,696.5 |
| Intercompany | (2,200.5) | 1,963.1 | 237.4 | — | — |
| Deferred income tax liabilities | 249.2 | — | — | — | 249.2 |
| Long-term portion of reserves for self-insurance claims | — | 106.7 | 26.3 | — | 133.0 |
| Other long-term liabilities | — | 39.5 | 39.7 | — | 79.2 |
| Long-term income tax liability | 16.9 | — | — | — | 16.9 |
| Total liabilities | (221.4) | 2,451.7 | 389.4 | — | 2,619.7 |
| Redeemable noncontrolling interests | — | — | 29.4 | — | 29.4 |
| Total LifePoint Hospitals, Inc. stockholders' equity | 2,050.5 | 1,314.1 | 349.0 | (1,663.1) | 2,050.5 |
| Noncontrolling interests | — | 1.4 | 21.2 | — | 22.6 |
| Total equity | 2,050.5 | 1,315.5 | 370.2 | (1,663.1) | 2,073.1 |
| Total liabilities and equity | $ 1,829.1 | $ 3,767.2 | $789.0 | $(1,663.1) | $ 4,722.2 |

**Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)**

**LIFEPOINT HOSPITALS, INC.**
**Condensed Consolidating Balance Sheets**
**December 31, 2011**
*(In millions)*

| | Parent Issuer | Guarantors | Non-Guarantors | Eliminations | Consolidated |
|---|---|---|---|---|---|
| **ASSETS** | | | | | |
| Current assets: | | | | | |
| Cash and cash equivalents | $ — | $ 106.2 | $ 20.0 | $ — | $ 126.2 |
| Accounts receivable, net | — | 373.6 | 57.0 | — | 430.6 |
| Inventories | — | 75.4 | 11.8 | — | 87.2 |
| Prepaid expenses | 0.1 | 24.7 | 1.6 | — | 26.4 |
| Deferred tax assets | 125.7 | — | — | — | 125.7 |
| Other current assets | 1.6 | 42.3 | — | — | 43.9 |
| | 127.4 | 622.2 | 90.4 | — | 840.0 |
| Property and equipment: | | | | | |
| Land | — | 74.1 | 19.4 | — | 93.5 |
| Buildings and improvements | — | 1,427.5 | 204.1 | — | 1,631.6 |
| Equipment | — | 991.3 | 92.7 | — | 1,084.0 |
| Construction in progress | — | 102.6 | 3.1 | — | 105.7 |
| | — | 2,595.5 | 319.3 | — | 2,914.8 |
| Accumulated depreciation | — | (1,001.2) | (83.2) | — | (1,084.4) |
| | — | 1,594.3 | 236.1 | — | 1,830.4 |
| Deferred loan costs, net | 21.7 | — | — | — | 21.7 |
| Intangible assets, net | — | 46.7 | 42.8 | — | 89.5 |
| Investments in subsidiaries | 1,467.9 | — | — | (1,467.9) | — |
| Other | 1.0 | 16.7 | 2.1 | — | 19.8 |
| Goodwill | — | 1,413.1 | 155.6 | — | 1,568.7 |
| Total assets | $ 1,618.0 | $ 3,693.0 | $527.0 | $(1,467.9) | $ 4,370.1 |
| **LIABILITIES AND EQUITY** | | | | | |
| Current liabilities: | | | | | |
| Accounts payable | $ — | $ 88.5 | $ 11.1 | $ — | $ 99.6 |
| Accrued salaries | — | 94.3 | 8.8 | — | 103.1 |
| Other current liabilities | 14.0 | 141.1 | 13.1 | — | 168.2 |
| Current maturities of long-term debt | — | 1.5 | 0.4 | — | 1.9 |
| | 14.0 | 325.4 | 33.4 | — | 372.8 |
| Long-term debt | 1,588.2 | 6.0 | 1.2 | — | 1,595.4 |
| Intercompany | (2,206.4) | 2,151.4 | 55.0 | — | — |
| Deferred income tax liabilities | 259.0 | — | — | — | 259.0 |
| Long-term portion of reserves for self-insurance claims | — | 94.8 | 23.5 | — | 118.3 |
| Other long-term liabilities | — | 18.4 | 2.4 | — | 20.8 |
| Long-term income tax liability | 18.0 | — | — | — | 18.0 |
| Total liabilities | (327.2) | 2,596.0 | 115.5 | — | 2,384.3 |
| Redeemable noncontrolling interests | — | — | 26.2 | — | 26.2 |
| Total LifePoint Hospitals, Inc. stockholders' equity | 1,945.2 | 1,095.5 | 372.4 | (1,467.9) | 1,945.2 |
| Noncontrolling interests | — | 1.5 | 12.9 | — | 14.4 |
| Total equity | 1,945.2 | 1,097.0 | 385.3 | (1,467.9) | 1,959.6 |
| Total liabilities and equity | $ 1,618.0 | $ 3,693.0 | $527.0 | $(1,467.9) | $ 4,370.1 |

**Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)**

**LIFEPOINT HOSPITALS, INC.**
**Condensed Consolidating Statements of Cash Flows**
**For the Year Ended December 31, 2012**
*(In millions)*

| | Parent Issuer | Guarantors | Non-Guarantors | Eliminations | Consolidated |
|---|---|---|---|---|---|
| Cash flows from operating activities: | | | | | |
| Net income | $ 151.9 | $ 162.9 | $ 41.0 | $(200.2) | $ 155.6 |
| Adjustments to reconcile net income to net cash provided by operating activities: | | | | | |
| Equity in earnings of affiliates | (200.2) | — | — | 200.2 | — |
| Stock-based compensation | 27.4 | — | — | — | 27.4 |
| Depreciation and amortization | — | 162.2 | 30.9 | — | 193.1 |
| Amortization of physician minimum revenue guarantees | — | 17.9 | 1.7 | — | 19.6 |
| Amortization of convertible debt discounts | 26.0 | — | — | — | 26.0 |
| Amortization of deferred loan costs | 5.4 | — | — | — | 5.4 |
| Debt extinguishment costs | 4.4 | — | — | — | 4.4 |
| Impairment charges | — | 4.0 | — | — | 4.0 |
| Deferred income tax benefit | (24.2) | — | — | — | (24.2) |
| Reserve for self-insurance claims, net of payments | — | (1.2) | 2.8 | — | 1.6 |
| Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures: | | | | | |
| Accounts receivable | — | (25.3) | (18.0) | — | (43.3) |
| Inventories and other current assets | — | (4.2) | (5.5) | — | (9.7) |
| Accounts payable and accrued expenses | (1.6) | 16.2 | 4.9 | — | 19.5 |
| Income taxes payable/receivable | 2.3 | — | — | — | 2.3 |
| Other | — | 2.1 | (0.9) | — | 1.2 |
| Net cash (used in) provided by operating activities – continuing operations | (8.6) | 334.6 | 56.9 | — | 382.9 |
| Net cash used in operating activities – discontinued operations | — | (0.7) | — | — | (0.7) |
| Net cash (used in) provided by operating activities | (8.6) | 333.9 | 56.9 | — | 382.2 |
| Cash flows from investing activities: | | | | | |
| Purchases of property and equipment | — | (201.3) | (20.1) | — | (221.4) |
| Acquisitions, net of cash acquired | — | (40.3) | (159.4) | — | (199.7) |
| Other | (0.5) | (0.5) | — | — | (1.0) |
| Net cash used in investing activities | (0.5) | (242.1) | (179.5) | — | (422.1) |
| Cash flows from financing activities: | | | | | |
| Proceeds from borrowings | 555.0 | — | — | — | 555.0 |
| Payments of borrowings | (469.3) | — | — | — | (469.3) |
| Repurchases of common stock | (95.5) | — | — | — | (95.5) |
| Payment of debt financing costs | (10.0) | — | — | — | (10.0) |
| Proceeds from exercise of stock options | 21.8 | — | — | — | 21.8 |
| Proceeds from employee stock purchase plans | 1.2 | — | — | — | 1.2 |
| Proceeds from (distributions to) noncontrolling interests | — | 1.2 | (5.0) | — | (3.8) |
| Sales of redeemable noncontrolling interests | — | — | 1.6 | — | 1.6 |
| Change in intercompany balances with affiliates, net | 5.9 | (170.8) | 164.9 | — | — |
| Capital lease payments and other | — | (1.6) | (0.7) | — | (2.3) |
| Net cash provided by (used in) financing activities | 9.1 | (171.2) | 160.8 | — | (1.3) |
| Change in cash and cash equivalents | — | (79.4) | 38.2 | — | (41.2) |
| Cash and cash equivalents at beginning of period | — | 106.2 | 20.0 | — | 126.2 |
| Cash and cash equivalents at end of period | $ — | $ 26.8 | $ 58.2 | $ — | $ 85.0 |

**Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)**

**LIFEPOINT HOSPITALS, INC.**
**Condensed Consolidating Statements of Cash Flows**
**For the Year Ended December 31, 2011**
*(In millions)*

| | Parent Issuer | Guarantors | Non-Guarantors | Eliminations | Consolidated |
|---|---|---|---|---|---|
| Cash flows from operating activities: | | | | | |
| Net income | $ 162.9 | $ 171.6 | $ 47.7 | $(216.5) | $ 165.7 |
| Adjustments to reconcile net income to net cash provided by operating activities: | | | | | |
| Income from discontinued operations | — | (0.2) | — | — | (0.2) |
| Equity in earnings of affiliates | (216.5) | — | — | 216.5 | — |
| Stock-based compensation | 24.0 | — | — | — | 24.0 |
| Depreciation and amortization | — | 148.1 | 17.7 | — | 165.8 |
| Amortization of physician minimum revenue guarantees | — | 17.8 | 2.0 | — | 19.8 |
| Amortization of convertible debt discounts | 24.3 | — | — | — | 24.3 |
| Amortization of deferred loan costs | 5.9 | — | — | — | 5.9 |
| Deferred income taxes | 23.1 | — | — | — | 23.1 |
| Reserve for self-insurance claims, net of payments | — | 17.4 | 0.6 | — | 18.0 |
| Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures: | | | | | |
| Accounts receivable | — | (13.3) | (16.2) | — | (29.5) |
| Inventories and other current assets | (0.1) | (19.8) | (0.2) | — | (20.1) |
| Accounts payable and accrued expenses | (2.0) | 9.1 | (4.2) | — | 2.9 |
| Income taxes payable/receivable | 3.9 | — | — | — | 3.9 |
| Other | — | (2.5) | 0.1 | — | (2.4) |
| Net cash provided by operating activities – continuing operations | 25.5 | 328.2 | 47.5 | — | 401.2 |
| Net cash provided by operating activities – discontinued operations | — | 0.3 | — | — | 0.3 |
| Net cash provided by operating activities | 25.5 | 328.5 | 47.5 | — | 401.5 |
| Cash flows from investing activities: | | | | | |
| Purchases of property and equipment | — | (205.3) | (14.6) | — | (219.9) |
| Acquisitions, net of cash acquired | — | (2.0) | (119.0) | — | (121.0) |
| Other | (1.0) | (0.2) | — | | (1.2) |
| Net cash used in investing activities | (1.0) | (207.5) | (133.6) | — | (342.1) |
| Cash flows from financing activities: | | | | | |
| Payments of borrowings | — | (0.1) | — | — | (0.1) |
| Repurchases of common stock | (174.6) | — | — | — | (174.6) |
| Payment of debt financing costs | (0.4) | — | — | — | (0.4) |
| Proceeds from exercise of stock options | 39.0 | — | — | — | 39.0 |
| Proceeds from employee stock purchase plans | 1.2 | — | — | — | 1.2 |
| Proceeds from (distributions to) noncontrolling interests | — | 1.5 | (3.3) | — | (1.8) |
| Repurchases of redeemable noncontrolling interests | — | — | (2.3) | — | (2.3) |
| Change in intercompany balances with affiliates, net | 110.3 | (211.9) | 101.6 | — | — |
| Capital lease payments and other | — | (1.4) | (0.2) | — | (1.6) |
| Net cash (used in) provided by financing activities | (24.5) | (211.9) | 95.8 | — | (140.6) |
| Change in cash and cash equivalents | — | (90.9) | 9.7 | — | (81.2) |
| Cash and cash equivalents at beginning of period | — | 197.1 | 10.3 | — | 207.4 |
| Cash and cash equivalents at end of period | $ — | $ 106.2 | $ 20.0 | $ — | $ 126.2 |

**Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)**

**LIFEPOINT HOSPITALS, INC.**
**Condensed Consolidating Statements of Cash Flows**
**For the Year Ended December 31, 2010**
*(In millions)*

| | Parent Issuer | Guarantors | Non-Guarantors | Eliminations | Consolidated |
|---|---|---|---|---|---|
| Cash flows from operating activities: | | | | | |
| Net income | $ 155.5 | $ 171.7 | $ 46.8 | $(215.4) | $ 158.6 |
| Adjustments to reconcile net income to net cash provided by operating activities: | | | | | |
| Loss from discontinued operations | — | 0.1 | — | — | 0.1 |
| Equity in earnings of affiliates | (215.4) | — | — | 215.4 | — |
| Stock-based compensation | 22.4 | — | — | — | 22.4 |
| Depreciation and amortization | — | 134.1 | 14.4 | — | 148.5 |
| Amortization of physician minimum revenue guarantees | — | 15.6 | 1.5 | — | 17.1 |
| Amortization of convertible debt discounts | 22.6 | — | — | — | 22.6 |
| Amortization of deferred loan costs | 7.1 | — | — | — | 7.1 |
| Debt extinguishment costs | 2.3 | 0.1 | — | — | 2.4 |
| Deferred income tax benefit | (29.0) | — | — | — | (29.0) |
| Reserve for self-insurance claims, net of payments | — | 10.8 | (0.5) | — | 10.3 |
| Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures: | | | | | |
| Accounts receivable | — | (39.9) | 0.8 | — | (39.1) |
| Inventories and other current assets | — | (4.7) | (0.7) | — | (5.4) |
| Accounts payable and accrued expenses | 7.1 | 7.5 | (1.4) | — | 13.2 |
| Income taxes payable/receivable | 48.8 | — | — | — | 48.8 |
| Other | (0.2) | (1.6) | (0.1) | — | (1.9) |
| Net cash provided by operating activities – continuing operations | 21.2 | 293.7 | 60.8 | — | 375.7 |
| Net cash used in operating activities – discontinued operations | — | (1.6) | — | — | (1.6) |
| Net cash provided by operating activities | 21.2 | 292.1 | 60.8 | — | 374.1 |
| Cash flows from investing activities: | | | | | |
| Purchases of property and equipment | — | (160.6) | (8.1) | — | (168.7) |
| Acquisitions, net of cash acquired | — | (172.1) | (12.8) | — | (184.9) |
| Net cash used in investing activities | — | (332.7) | (20.9) | — | (353.6) |
| Cash flows from financing activities: | | | | | |
| Proceeds from borrowings | 400.0 | — | — | — | 400.0 |
| Payments of borrowings | (249.2) | (6.0) | — | — | (255.2) |
| Repurchases of common stock | (152.1) | — | — | — | (152.1) |
| Payment of debt financing costs | (13.7) | — | — | — | (13.7) |
| Proceeds from exercise of stock options | 20.4 | — | — | — | 20.4 |
| Proceeds from employee stock purchase plans | 1.0 | — | — | — | 1.0 |
| Proceeds from (distributions to) noncontrolling interests | — | 1.0 | (3.4) | — | (2.4) |
| Sales of redeemable noncontrolling interests | — | — | 3.1 | — | 3.1 |
| Change in intercompany balances with affiliates, net | (27.6) | 65.5 | (37.9) | — | — |
| Capital lease payments and other | — | (1.2) | (0.2) | — | (1.4) |
| Net cash (used in) provided by financing activities | (21.2) | 59.3 | (38.4) | — | (0.3) |
| Change in cash and cash equivalents | — | 18.7 | 1.5 | — | 20.2 |
| Cash and cash equivalents at beginning of period | — | 178.4 | 8.8 | — | 187.2 |
| Cash and cash equivalents at end of period | $ — | $ 197.1 | $ 10.3 | $ — | $ 207.4 |

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## SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, in the City of Brentwood, State of Tennessee, on February 15, 2013.

LIFEPOINT HOSPITALS, INC.

By: /s/ WILLIAM F. CARPENTER III
William F. Carpenter III
*Chief Executive Officer and*
*Chairman of the Board of Directors*

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant in the capacities and on the date indicated.

| Name | Title | Date |
|---|---|---|
| /s/ WILLIAM F. CARPENTER III<br>William F. Carpenter III | Chief Executive Officer and Chairman of the Board of Directors (Principal Executive Officer) | February 15, 2013 |
| /s/ JEFFREY S. SHERMAN<br>Jeffrey S. Sherman | Chief Financial Officer (Principal Financial Officer) | February 15, 2013 |
| /s/ MICHAEL S. COGGIN<br>Michael S. Coggin | Chief Accounting Officer (Principal Accounting Officer) | February 15, 2013 |
| /s/ GREGORY T. BIER<br>Gregory T. Bier | Director | February 15, 2013 |
| /s/ RICHARD H. EVANS<br>Richard H. Evans | Director | February 15, 2013 |
| /s/ DEWITT EZELL, JR.<br>DeWitt Ezell, Jr. | Director | February 15, 2013 |
| /s/ MICHAEL P. HALEY<br>Michael P. Haley | Director | February 15, 2013 |
| /s/ MARGUERITE W. KONDRACKE<br>Marguerite W. Kondracke | Director | February 15, 2013 |
| /s/ JOHN E. MAUPIN, JR., D.D.S.<br>John E. Maupin, Jr., D.D.S. | Director | February 15, 2013 |
| /s/ OWEN G. SHELL, JR.<br>Owen G. Shell, Jr. | Lead Director | February 15, 2013 |

**EXHIBIT 31.1**

**LIFEPOINT HOSPITALS, INC.**
**CERTIFICATION**

I, William F. Carpenter III, certify that:

1. I have reviewed this annual report on Form 10-K of LifePoint Hospitals, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report, based on such evaluation; and

d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ William F. Carpenter III

William F. Carpenter III
Chief Executive Officer and
Chairman of the Board of Directors

Date: February 15, 2013

**EXHIBIT 31.2**

**LIFEPOINT HOSPITALS, INC.**
**CERTIFICATION**

I, Jeffrey S. Sherman, certify that:

1. I have reviewed this annual report on Form 10-K of LifePoint Hospitals, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report, based on such evaluation; and

d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Jeffrey S. Sherman

Jeffrey S. Sherman
Executive Vice President and
Chief Financial Officer

Date: February 15, 2013

**EXHIBIT 32.1**

**LIFEPOINT HOSPITALS, INC.**

**CERTIFICATION PURSUANT TO**
**18 U.S.C. SECTION 1350,**
**AS ADOPTED PURSUANT TO**
**SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Report of LifePoint Hospitals, Inc. (the ''Company'') on Form 10-K for the year ended December 31, 2012, as filed with the Securities and Exchange Commission on the date hereof (the ''Report''), I, William F. Carpenter III, Chief Executive Officer and Chairman of the Board of Directors of the Company, certify, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) To the best of my knowledge information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ William F. Carpenter III

William F. Carpenter III
Chief Executive Officer and
Chairman of the Board of Directors

Date February 15, 2013

**EXHIBIT 32.2**

**LIFEPOINT HOSPITALS, INC.**

**CERTIFICATION PURSUANT TO**
**18 U.S.C. SECTION 1350,**
**AS ADOPTED PURSUANT TO**
**SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Report of LifePoint Hospitals, Inc. (the ''Company'') on Form 10-K for the year ended December 31, 2012, as filed with the Securities and Exchange Commission on the date hereof (the ''Report''), I, Jeffrey S. Sherman, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) To the best of my knowledge information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Jeffrey S. Sherman

Jeffrey S. Sherman
Executive Vice President and
Chief Financial Officer

Date: February 15, 2013

## Directors and Executive Officers

### Board of Directors

**William F. Carpenter III**
Chairman and
Chief Executive Officer
*LifePoint Hospitals, Inc.*

**Owen G. Shell Jr.**
Lead Director
*LifePoint Hospitals, Inc.*
Retired President
*Asset Management Group*
*Bank of America Corporation*

**Gregory T. Bier**
Retired Partner
*Deloitte & Touche LLP*

**Richard H. Evans**
Chairman
*Evans Holdings, LLC*

**DeWitt Ezell Jr.**
Former State President of
Tennessee
*BellSouth Corporation*

**Michael P. Haley**
Managing Director-Fenway
Resources and Advisor
*Fenway Partners, LLC*

**Marguerite W. Kondracke**
Senior Advisor
*America's Promise –*
*The Alliance for Youth*

**John E. Maupin Jr.**
President
*Morehouse School of Medicine*

### Executive Officers

**William F. Carpenter III**
Chief Executive Officer

**David M. Dill**
President and
Chief Operating Officer

**Jeffrey S. Sherman**
Executive Vice President and
Chief Financial Officer

**Paul D. Gilbert**
Executive Vice President,
Chief Legal Officer and
Corporate Governance Officer

**John P. Bumpus**
Executive Vice President and
Chief Administrative Officer

**Leif M. Murphy**
Executive Vice President and
Chief Development Officer

**Lanny R. Copeland, M.D.**
Chief Medical Officer Emeritus

**Russell L. Holman, M.D.**
Chief Medical Officer

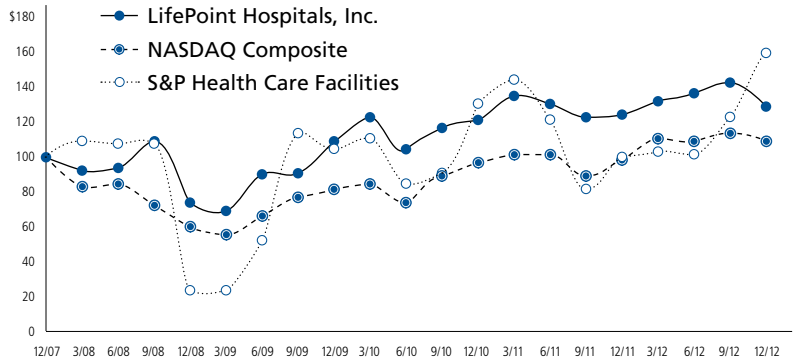
**Michael S. Coggin**
Senior Vice President and
Chief Accounting Officer

## Comparative Performance

The graph below compares the yearly percentage change of cumulative total stockholder return on our common stock with (a) the cumulative total return of a broad equity market index, the NASDAQ Composite Index (the "Broad Index") and (b) the cumulative total return of a published industry index, the S&P Health Care Facilities (Hospital Management) Index (the "Industry Index"). The graph begins on December 31, 2007, and the comparison assumes the investment of $100 on such date in each of our common stock, the Broad Index and the Industry Index and assumes the reinvestment of all dividends, if any. The table following the graph presents the corresponding data for December 31, 2007, and each subsequent fiscal year end.

### Comparison of 5 Year Cumulative Total Return

Among LifePoint Hospitals, Inc, The NASDAQ Composite Index and The S&P Health Care Facilities Index




| | 12/07 | 12/08 | 12/09 | 12/10 | 12/11 | 12/12 |
|---|---|---|---|---|---|---|
| LifePoint Hospitals, Inc | 100.00 | 76.80 | 109.38 | 123.57 | 124.92 | 126.93 |
| NASDAQ Composite | 100.00 | 59.03 | 82.25 | 97.32 | 98.63 | 110.78 |
| S&P Health Care Facilities | 100.00 | 22.64 | 106.11 | 131.70 | 100.99 | 159.80 |

*$100 invested on 12/31/07 in stock or index, including reinvestment of dividends. Fiscal year ending December 31.

## Corporate Information

### Transfer Agent and Registrar
American Stock Transfer & Trust Co., LLC
Operations Center
6201 15th Avenue
Brooklyn, NY 11219
800-937-5449 or 718-921-8124
www.amstock.com

### Independent Registered Public Accounting Firm
Ernst & Young LLP
Nashville, TN

### LifePoint Hospital Support Center
103 Powell Court
Brentwood, TN 37027
615-372-8500

### Form 10-K
The Company has filed an annual report on Form 10-K for the year ended December 31, 2012, with the United States Securities and Exchange Commission. Stockholders may obtain a copy of this report, without charge, by writing: Investor Relations, LifePoint Hospitals, Inc., 103 Powell Court, Brentwood, Tennessee 37027, or by visiting the Company's Website at www.lifepointhospitals.com.

### Common Stock and Dividend Information
The Common Stock of LifePoint Hospitals, Inc. is listed on the NASDAQ Global Select Market under the symbol "LPNT."

### Annual Meeting of Stockholders:
The annual meeting of stockholders will be held on June 4, 2013, at 3:00 p.m. local time at the Nashville City Center, 511 Union Street, 27th Floor, Nashville, Tennessee. Stockholders of record as of April 12, 2013, are invited to attend.

At April 5, 2013, the Company had a total of approximately 45,981 stockholders, including 10,230 stockholders of record and approximately 35,751 persons or entities holding Common Stock in nominee name. No dividends have been paid on the Common Stock, and the Company does not currently intend to declare or pay any dividends.

The following table shows, for periods indicated, the high and low sales prices per share of the Company's Common Stock as reported by the NASDAQ Global Select Market:

| 2011 | High | Low |
|---|---|---|
| First Quarter | $ 40.48 | $ 39.65 |
| Second Quarter | 43.45 | 37.19 |
| Third Quarter | 40.59 | 28.95 |
| Fourth Quarter | 41.97 | 32.61 |

| 2012 | High | Low |
|---|---|---|
| First Quarter | $ 42.19 | $ 34.91 |
| Second Quarter | 41.80 | 34.82 |
| Third Quarter | 43.87 | 36.62 |
| Fourth Quarter | 43.86 | 34.37 |

| 2013 | High | Low |
|---|---|---|
| First Quarter | $ 48.79 | $ 38.08 |

LIFEPOINT
HOSPITALS®

103 Powell Court | Brentwood, Tennessee 37027 | 615.372.8500

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