LIFEPOINT HOSPITALS, INC.
Form 10-K
February 18, 2011

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

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2010

or

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

For the transition period from to

Commission file number: 000-51251

LifePoint Hospitals, Inc.

(Exact Name of Registrant as Specified in its Charter)

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

(615) 372-8500

(Registrant s Telephone Number, Including Area Code)

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

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

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

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

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 o No x

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 x No o

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 x No o

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. o

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 x Accelerated filer o Non-accelerated filer o Smaller reporting company o
(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 o No x

The aggregate market value of the shares of registrant s Common Stock held by non-affiliates as of June 30, 2010, was approximately $1.3 billion.

As of February 11, 2011, the number of outstanding shares of the registrant s Common Stock was 51,490,182.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the definitive proxy statement for our 2011 annual meeting of stockholders are incorporated by reference into Part III of this report.

TABLE OF CONTENTS

LifePoint Hospitals, Inc.

TABLE OF CONTENTS

PART I
Item 1. Business 1
Item 1A. Risk Factors 26
Item 1B. Unresolved Staff Comments 39
Item 2. Properties 40
Item 3. Legal Proceedings 41
PART II
Item 5. Market for Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities 43
Item 6. Selected Financial Data 46
Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations 47
Item 7A. Quantitative and Qualitative Disclosures About Market Risk 88
Item 8. Financial Statements and Supplementary Data 89
Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure 89
Item 9A. Controls and Procedures 89
Item 9B. 90

Other Information
PART III
Item 10.
91
Directors, Executive Officers and Corporate Governance
Item 11.
91
Executive Compensation
Item 12.
91
Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters
Item 13.
92
Certain Relationships and Related Transactions, and Director Independence
Item 14.
92
Principal Accountant Fees and Services
PART IV
Item 15.
93
Exhibits, Financial Statement Schedules
SIGNATURES 98
Exhibit Index 99

TABLE OF CONTENTS

PART I

Item 1. *Business.*

Overview of Our Company

LifePoint Hospitals, Inc., a Delaware corporation, acting through its subsidiaries, operates general acute care hospitals in non-urban communities in the United States. Unless the context otherwise requires, LifePoint and its subsidiaries are referred to herein as LifePoint, the Company, we, our or us. At December 31, 2010, we operated 52 hosp campuses in 17 states, having a total of 5,915 licensed beds. We generate revenue primarily through hospital services offered at our facilities. We generated $3,262.4 million, $2,962.7 million and $2,700.8 million in revenues from continuing operations during 2010, 2009 and 2008, 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 and to better tailor our communications to the physicians who want to practice in non-urban communities.

Additionally, we believe that growth can be achieved by demonstrating 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 is 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 all of 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, when necessary, awareness campaigns and hospital specific action plans.

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 fact 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.

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 correctly 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.

TABLE OF CONTENTS

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 on 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. We also believe that our position as the sole acute care hospital in virtually all of our communities has allowed us, and will continue to allow us, in many cases to negotiate preferred reimbursement rates with commercial insurance payors.

Acquisitions

Our intention is to acquire well-positioned hospitals in growing areas of the United States that we believe are fairly priced and that could benefit from our management and strategic initiatives. We believe that strategic acquisitions can supplement the growth we believe we can generate organically in our existing markets. We believe that our acquisition of Sumner Regional Health Systems, subsequently renamed HighPoint Health Systems (HighPoint), effective September 1, 2010 and our acquisition of Clark Regional Medical Center (Clark) effective May 1, 2010, along with our commitment to build and equip a replacement hospital facility for Clark, are consistent with our acquisition strategy. Additionally, on January 31, 2011, we announced the formation of DLP Healthcare, LLC (DLP), a joint venture between the Company and Duke University Health System, with a mission to own and operate community hospitals in North Carolina and the surrounding area. Also on January 31, 2011, we announced that DLP had signed a memorandum of understanding with Maria Parham Medical Center, a private, non-profit, hospital located in Henderson, North Carolina, to make it the first hospital in DLP s network.

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 strive to: (1) expand the breadth of services offered at our hospitals by adding equipment and seeking to attract specialty and primary care physicians 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 located; (3) recruit, retain and develop hospital executives interested in working and living in the non-urban communities where our hospitals are located; (4) negotiate favorable, facility-specific contracts with managed care and other private-pay 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. Like most hospitals located in non-urban markets, our hospitals do not engage in extensive medical research and medical education programs. However, three 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.

TABLE OF CONTENTS

With the exception of Bluegrass Community Hospital, which is designated by CMS as a critical access hospital, all of our hospitals are accredited by the Joint Commission or the Healthcare Facilities Accreditation Program (HFAP). 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.

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 order for our hospitals to be successful, we must recruit and retain a sufficient number of active, engaged and successful physicians.

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 4.1% equity interest in this group purchasing organization at December 31, 2010.

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 United States Securities and Exchange Commission (SEC).

TABLE OF CONTENTS

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). The approximate percentages of total revenues from continuing operations from these sources during the years specified below were as follows:

	2010	2009	2008
Medicare	30.2 %	30.1 %	31.7 %
Medicaid	11.8	10.6	9.7
HMOs, PPOs and other private insurers	42.4	45.1	45.3
Self-pay	14.6	13.2	12.1
Other	1.0	1.0	1.2
	100.0 %	100.0 %	100.0 %

Certain changes have been made to our historical sources of revenues table above. Specifically, we previously classified our revenues related to our owned physician practices as other revenue. In 2010 and for all previously reported periods, we changed the classification of our revenues for our owned physician practices from other to the respective payor classifications, as appropriate. This change had no impact on our historical results of operations. These reclassifications reduced other revenue as a percentage of total revenues and increased Medicare, Medicaid, HMOs, PPOs and other private insurers and self-pay as a percentage of total revenues. We have determined that it is more appropriate to classify our owned physician practices revenue by their respective payor classification.

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 bad debt expense at many of our hospitals in the past few years.

Medicare

Our revenues from Medicare were approximately $983.7 million, or 30.2% of total revenues for the year ended December 31, 2010. 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 a number of additional changes will be required in the future 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) are implemented.

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 diagnosis related group, commonly known as a DRG, which groups patients that have similar clinical conditions and that are expected to require a similar amount of hospital resources. Each 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

TABLE OF CONTENTS

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 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 DRG payment rate does not consider the actual costs incurred by an individual hospital in providing a particular inpatient service.

The base 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 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) 2011, 2010, and 2009, the hospital market basket index increased 2.6%, 2.1%, and 3.6%, 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 increase for FFY 2010 was reduced by CMS on June 2, 2010, by 25 basis points (bps) (from 2.1% to 1.85%) for discharges occurring on or after April 1, 2010, and the hospital market basket increase for FFY 2011, which began on October 1, 2010, was reduced by 25 bps (from 2.6% to 2.35%).

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%. For FFY 2011, our hospitals reported all quality measures required by CMS and received the full market basket update.

Prior to October 1, 2007, CMS had established 538 DRG classifications. However, on October 1, 2007, CMS replaced the existing 538 DRGs with 745 new severity-adjusted diagnosis related groups (Medicare Severity DRGs or MS-DRGs). The new 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. CMS anticipates that the conversion to MS-DRGs will result in an increase in payments to hospitals that serve more severely ill patients and a decrease to hospitals that serve patients who are less severely ill.

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 Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007 (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 requires 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 adjustment. The remaining (2.9%) reduction will be implemented in FFY 2012. However, the (2.9%) reduction that was made in FFY 2011 will be restored in FFY 2012, which essentially means that the adjustments in FFY 2012 will cancel each other out. The (2.9%) reduction made in FFY 2012 will be restored in FFY 2013. The TMA Act also requires CMS to make an additional cumulative adjustment to future payments, which CMS believes will be a reduction of 3.9%, but it does not specify when or how CMS must

apply the adjustment. The cumulative adjustment will further reduce IPPS payments to hospitals and could adversely impact our Medicare revenues.

TABLE OF CONTENTS

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
2010	$ 481.4	$ 40.5
2009	460.6	38.9
2008	453.7	39.6

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 2010, 2009 and 2008, were approximately $65.0 million and $58.3 million and $55.3 million, respectively. However, the Affordable Care Act does generally require 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) 2011, 2010, and 2009 were $68.876, $67.241 and $66.059, respectively, after the inclusion of the 25 bps reduction for CYs 2011 and 2010 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, which in CY 2011, would result in a conversion factor of $67.530. For CY 2011 our hospitals reported all quality measures required by CMS and received the full market basket update.

In addition to establishing the OPPS, BBRA eliminated the anticipated average reduction of 5.7% for various Medicare outpatient payments under the Balanced Budget Act of 1997. Under BBRA, outpatient payment reductions for non-urban hospitals with 100 beds or less were postponed until December 31, 2003. Several of our hospitals qualified for this hold harmless relief. Payment reductions under Medicare OPPS for non-urban hospitals with greater than 100 beds and urban hospitals were mitigated through a corridor reimbursement approach, pursuant to which a

percentage of such reductions were reimbursed through December 31, 2003. Substantially all of our remaining hospitals qualified for relief under this provision. MMA extended the hold harmless provision for non-urban hospitals with 100 beds or less and expanded the provision to include sole community hospitals for cost reporting periods beginning in 2004 until December 31, 2005. DRA extended these payments for three years but at a reduced amount. Payments for 2007 and 2008 were 90% and 85%, respectively, of the hold harmless amount. On July 15, 2008, Congress enacted the Medicare Improvement for Patients and Providers Act (MIPPA), which included a provision extending hold

TABLE OF CONTENTS

harmless payments through 2009 at the 85% rate for both small rural hospitals and sole community hospitals. The Affordable Care Act and the Medicare and Medicaid Extenders Act of 2010 (the MME Act) extended these payments through December 31, 2011.The following table lists our historical Medicare outpatient payments for the years presented (in millions):

	Medicare Outpatient Payments
2010	$ 248.6
2009	216.6
2008	190.5

Medicare Bad Debt Reimbursement

Under Medicare, the costs attributable to the deductible and coinsurance amounts that 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.

Bad debts must meet the following criteria to be allowable:

the debt must be related to covered services and derived from deductible and coinsurance amounts;
the provider must be able to establish that reasonable collection efforts were made;
the debt was actually uncollectible when claimed as worthless; and
sound business judgment established that there was no likelihood of recovery at any time in the future.

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 30%. Under this program, our hospitals received an aggregate of approximately $17.5 million, $17.0 million and $16.4 million for 2010, 2009 and 2008, 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, such that total payments made under the PFS may not differ by more than $20 million from what payments would have been if adjustments were not made.

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, the U.S. Congress has passed multiple legislative acts delaying application of the SGR to the PFS. For CY 2011, CMS issued a final rule that would have applied the SGR and resulted in an aggregate reduction of 24.9% to all physician payments under the PFS for FFY 2011. The MME Act delayed application of the SGR until January 1, 2012. We cannot predict whether Congress will intervene to prevent this reduction to payments in the future.

TABLE OF CONTENTS

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 $386.3 million, or 11.8% of total revenues for the year ended December 31, 2010. These payments are typically based on fixed rates determined by the individual states. Included in these payments are DSH payments received under various state Medicaid programs. For 2010, 2009 and 2008, our revenue attributable to DSH payments and other supplemental payments was approximately $61.1 million, $25.1 million, $19.8 million, respectively. The increase in revenue from DSH payments 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 that pose a threat to Medicaid funding levels to hospitals and other providers. We expect these challenges to continue and, perhaps, to intensify. Many states have adopted, or are considering, legislation designed to reduce coverage, provider reimbursements and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states Medicaid systems. Such budget cuts, federal or state legislation, or other changes in the administration or interpretation of government health programs could have a material adverse effect on our financial position and results of operations. Congress made an effort to address the financial challenges Medicaid is facing by increasing the amount of Medicaid funding available to states through the American Recovery and Reinvestment Act of 2009 (the ARRA) and the Education, Jobs, and Medicaid Assistance Act (the Assistance Act), which increased federal matching fund payments to state Medicaid programs through June 30, 2011.

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. CMS has given RACs the authority to look back at claims up to three years old, provided that the claim was paid on or after October 1, 2007. Any claims identified as overpayments will be 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 United States in 2008 and 2009 and is currently operating in all 50 states. The Affordable Care Act has further expanded the use of RACs and required each state to establish a Medicaid RAC program in 2011. Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs

TABLE OF CONTENTS

are accurate, many of our hospitals have had claims audited by the RAC program. While most of our hospitals have successfully appealed any adverse determinations raised by these audits, we cannot predict if this trend will continue or the results of any future audits.

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 $1,384.6 million, or 42.4% of total revenues for the year ended December 31, 2010. 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/Indigent 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 $475.1 million, or 14.6% of total revenues for the year ended December 31, 2010. 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/indigent care. 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. Over the past few years, we have seen an increase in the amount of self-pay revenues at our hospitals, which are the least collectible of all accounts.

We provide care to certain patients that qualify under the local charity/indigent care policy at each of our hospitals. We discount a charity/indigent care patient s charges against our revenues, therefore, we do not report such discounts in our provision for doubtful accounts as it is our policy not to pursue collection of amounts related to these patients.

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

	Self-Pay Revenues	Charity/Indigent Care Write-Offs	Combined Total
2010	$ 475.1	$ 62.3	$ 537.4
2009	390.1	58.5	448.6
2008	325.8	53.7	379.5

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 United States 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 payments, including 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, 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 or will be implemented in 2011 and 2012. In addition, there have been a number of challenges to the Affordable Care Act, and some courts have ruled that the requirement for individuals to carry health insurance or the Affordable Care Act in its entirety is unconstitutional. Several bills have been and will likely 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 due

TABLE OF CONTENTS

to its complexity, lack of implementing regulations and interpretive guidance, gradual and potentially delayed implementation, pending court challenges, and possible repeal and/or amendment, as well as our inability to foresee how individuals and businesses will respond to the choices afforded them by the Affordable Care Act. As a result, it is difficult to predict the full impact that the Affordable Care Act will have on our revenue and results of operations.

Expanded Coverage

Based on the Congressional Budget Office (CBO) and CMS estimates, by 2019, the Affordable Care Act will 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 will occur through a combination of public program expansion and private sector health insurance and other reforms.

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 changes the requirements for Medicaid eligibility. Commencing January 1, 2014, all state Medicaid programs are required to provide, and the federal government will subsidize, Medicaid coverage to virtually all adults under 65 years old with incomes at or under 133% of the federal poverty level (FPL). This expansion will create a minimum Medicaid eligibility threshold that is uniform across states. Further, the Affordable Care Act also requires states to apply a 5% income disregard to the Medicaid eligibility standard, so that Medicaid eligibility will effectively be extended to those with incomes up to 138% of the FPL. These new eligibility requirements will expand Medicaid and CHIP coverage by an estimated 16 to 18 million persons nationwide. A disproportionately large percentage of the new Medicaid coverage is likely to be in states that currently have relatively low income eligibility requirements.

As Medicaid is a joint federal and state program, the federal government provides states with matching funds in a defined percentage, known as the federal medical assistance percentage (FMAP). Beginning in 2014, states will receive an enhanced FMAP for the individuals enrolled in Medicaid pursuant to the Affordable Care Act. The 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.

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

TABLE OF CONTENTS

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) if 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 the Department of Health and Human Services (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 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. 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.

TABLE OF CONTENTS

The Affordable Care Act provides for three 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 will be implemented by HHS beginning in FFY 2012. The amount of that reduction will be the projected nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use 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. Based upon the latest available data, FFY 2012 market basket reductions resulting from this productivity adjustment are likely to range from 1% to 1.4%.

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.

If the aggregate of the three market basket reductions described above is more than the annual market basket adjustments made to account for inflation, there will be a reduction in the MS-DRG rates paid to hospitals. For example, for the FFY 2011 IPPS, the market basket increase to account for inflation is 2.6% and the aggregate reduction due to the Affordable Care Act and the documentation and coding adjustment is 3.15%. Thus, the rates paid to a hospital for inpatient services in FFY 2011 will be 55 bps less than rates paid for the same services in the prior year.

Quality-Based Payment Adjustments and Reductions for Inpatient Services

The Affordable Care Act establishes or expands three provisions to promote value-based purchasing and to link payments to quality and efficiency. First, in FFY 2013, HHS is directed to implement a value-based purchasing program for inpatient hospital services. This program will reward hospitals that meet certain quality performance standards established by HHS. The Affordable Care Act provides HHS considerable discretion over the value-based purchasing program. For example, HHS will have the authority to determine the quality performance measures, the standards hospitals must achieve in order to meet the quality performance measures, and the methodology for calculating payments to hospitals that meet the required quality threshold. HHS will also determine how much money each hospital will receive from the pool of dollars created by the reductions related to the value-based purchasing program as described above. Because the Affordable Care Act provides that the pool will be fully distributed, hospitals that meet or exceed the quality performance standards set by HHS will receive greater reimbursement under the value-based purchasing program than they would have otherwise. On the other hand, hospitals that do not achieve the necessary quality performance will receive reduced Medicare inpatient hospital payments.

Second, 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.

Third, reimbursement will be reduced based on a facility s hospital acquired condition (HAC) rates. A HAC is a condition that is acquired by a patient while admitted as an inpatient in a hospital, such as a surgical site infection. Beginning in FFY 2015, hospitals that rank in the top 25% nationally of HACs for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. In addition, effective July 1, 2011, the Affordable Care Act prohibits the use of federal funds under the Medicaid program to reimburse providers for medical services provided to treat HACs.

TABLE OF CONTENTS

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.

It is difficult to predict the full impact of the Medicare DSH reductions, and 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, the Affordable Care Act does not contain a definition of uncompensated care. As a result, it is unclear how a hospital s share of the Medicare DSH payment pool will be calculated. CMS could use the definition of uncompensated care used in connection with hospital cost reports. However, in July 2009, CMS proposed material revisions to the definition of uncompensated care used for cost report purposes. Those revisions would exclude certain significant costs that had historically been covered, such as unreimbursed costs of Medicaid services. CMS has not issued a final rule, and the Affordable Care Act does not require HHS to use this definition, even if finalized, for DSH purposes. 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.

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). 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). Beginning no later than January 1, 2012, the program will allow providers (including hospitals), physicians and other designated professionals and suppliers to form ACOs and 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. HHS has significant discretion to determine key elements of the program, including what steps providers must take to be considered an ACO, how to decide if Medicare program savings have occurred, and what portion of such savings will be paid to ACOs. In addition, HHS will determine to what degree hospitals, physicians and other eligible participants will be able to form and operate an ACO without violating certain existing laws, including the Civil Monetary Penalty Law, the anti-kickback provision of the Social Security Act (the Anti-kickback Statute) and the provision of the Social Security

TABLE OF CONTENTS

Act commonly known as Stark law . 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 ACOs, such as antitrust laws.

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. For example, HHS will determine what medical conditions will be included in the program and the amount of the payment for each condition. 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 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. As a result, the new law will effectively prevent the formation of physician-owned hospitals after December 31, 2010. While the new law 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.

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 (while the CBO estimates 32 million, CMS estimates almost 34 million; both agencies made a number of assumptions to derive that figure, including how many individuals will ignore substantial subsidies and decide to pay the penalty rather than obtain health insurance and what percentage of people in the future will meet the new Medicaid income eligibility requirements);

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 extent to which states will enroll 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;

TABLE OF CONTENTS

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 42.0% of our revenues in 2010 were 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 beginning in 2012 payment 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. Further, it is unclear how federal lawsuits challenging the constitutionality of the Affordable Care Act will be resolved or what the impact will be of any resulting changes to the law. For example, should the requirement that individuals maintain health insurance ultimately be deemed unconstitutional but the prohibition on health insurers excluding coverage due to pre-existing conditions be maintained, significant disruption to the health insurance industry could result, which could impact our revenues and operations.

TABLE OF CONTENTS

Competition for Patients

Our hospitals and other healthcare businesses operate in extremely competitive environments. Competition among healthcare providers occurs primarily at the local level. 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 require the receipt of a certificate of need or other similar authorization;
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.

Accordingly, each hospital develops its own strategies to address these competitive factors locally. 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 other 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. Some of our hospitals have developed specialized outpatient facilities where necessary to compete with these other providers. 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.

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.

TABLE OF CONTENTS

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, 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 employed substantially more physicians at the end of 2010 than at the end of 2009. When employing office-based physicians, we also often employ office employees and other personnel necessary to support these physicians. We expect this trend to continue.

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

Employees

At December 31, 2010, we had approximately 22,400 employees, including approximately 5,650 part-time employees. Nurses, therapists, lab and radiology technicians, facility maintenance workers and the administrative staffs of hospitals are the majority of our employees. 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 300 of our employees are subject to collective bargaining agreements. We consider our employee relations to be generally good. While some of our hospitals experience union organizing activity from time to time, we do not currently expect 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, 2010, all of our hospitals, with the exception of Bluegrass Community Hospital, were accredited by the Joint Commission or HFAP.

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

TABLE OF CONTENTS

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. Effective July 1, 2011, the Affordable Care Act will prohibit 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.

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.

TABLE OF CONTENTS

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 each time a physician refers a patient 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

19

TABLE OF CONTENTS

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. Two of our facilities are subject to those requirements. We intend for our financial arrangements with physicians to comply with the exceptions included in the Stark law and regulations. In recent years, CMS has issued a number of proposed and final rules modifying the Stark law exceptions. While some changes have been implemented, others remain in proposed form or have been delayed. Further, the Stark law and related regulations have been subject to little judicial interpretation to date. We anticipate that there will be further changes in the future 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. In light of the provisions of the Affordable Care Act that created potential False Claims Act liabilities for failing to report and repay known overpayments to the federal government in a timely manner, hospitals and other healthcare providers are encouraged to disclose potential violations of the Stark law to CMS. It is likely that self-disclosure of Stark law violations will continue in the future. We cannot predict how CMS will resolve the issues reported through the self-referral disclosure protocol or if the protocol will be modified in the future.

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.

Recent Changes in the Regulatory Environment

The Fraud Enforcement and Recovery Act of 2009 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

TABLE OF CONTENTS

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 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.

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 the next 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.

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.

Privacy and Security Requirements

We are subject to the privacy and security requirements of HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which was enacted as part of ARRA. Among other things, the HITECH Act strengthened the requirements and significantly increased the penalties

TABLE OF CONTENTS

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. On August 24, 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 has issued an interim final rule conforming HIPAA s enforcement

regulations to the HITECH Act s statutory revisions. This interim final rule also sets 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.

TABLE OF CONTENTS

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.

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 2011. 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.

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.

Patient Safety and Quality Improvement Act of 2005

On July 29, 2005, the President signed the Patient Safety and Quality Improvement Act of 2005, which has the goal of reducing medical errors and increasing patient safety. This legislation establishes a confidential reporting structure in which providers can voluntarily report Patient Safety Work Product (PSWP) to Patient Safety Organizations (PSOs Under the system, PSWP is made privileged, confidential and legally protected from disclosure. PSWP does not include medical, discharge or billing records or any other original patient or provider records but does include information gathered specifically in connection with the reporting of medical errors and improving patient safety. This legislation does not preempt state or federal mandatory disclosure laws concerning information that does not constitute PSWP. PSOs will be certified by the Secretary of the HHS for three-year periods after the Secretary develops applicable certification criteria. PSOs will analyze PSWP, provide feedback to providers and may report non-identifiable PSWP to a database. In addition, PSOs are expected to generate patient safety improvement strategies. We will monitor the progress of these voluntary reporting programs and we anticipate that we will participate in some form when the details are available. We anticipate that we will participate as they are formed.

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 ten states that have adopted certificate of need laws Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, Nevada, Tennessee, Virginia and West Virginia. If we fail

TABLE OF CONTENTS

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.

TABLE OF CONTENTS

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. In 2010, the Company created a new Quality Committee, which 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. For all claims made after April 1, 2009, our SIR is $5.0 million per claim. For claims made before April 1, 2009, our SIR ranges from $10.0 million per claim to $25.0 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 $2.0 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. The limits provided by the directors and officers policy are based on numerous factors, including the commercial insurance market. 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 the Company, issues malpractice insurance policies to our employed physicians.

TABLE OF CONTENTS

Item 1A. *Risk Factors.*

There are several factors, some beyond our control that could cause results to differ significantly from our expectations. Some of these factors are described below. Other factors, such as market, operational, liquidity, interest rate and other risks, are described elsewhere in this report (see, for example, Part II, Item 7. *Management s Discussion and Analysis of Financial Condition and Results of Operations*). Any factor described in this report could by itself, or together with one or more factors, 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 healthcare reform and other changes in government programs may have on our business, financial condition or results of operations.

The Affordable Care Act dramatically alters the United States healthcare system and is intended to decrease the number of uninsured Americans and reduce overall healthcare costs. 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 payments, including DSH payments to providers, expanding the Medicare program s use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and bundling payments to hospitals and other providers. The Affordable Care Act also contains a number of measures that are intended to reduce fraud and abuse in the Medicare and Medicaid programs, such as requiring the use of RACs in the Medicaid program expanding the scope of the federal False Claims Act and generally prohibiting physician-owned hospitals from adding new physician owners or increasing the number of beds and operating rooms for which they are licensed. Because a majority of the measures contained in the Affordable Care Act do not take effect until 2013, it is difficult to predict the impact the Affordable Care Act will have on our facilities. In addition, there have been a number of challenges to the Affordable Care Act, and some courts have ruled that the requirement for individuals to carry health insurance or the Affordable Health Care Act in its entirety is unconstitutional. Several bills have been and will likely 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 due to its complexity, lack of implementing regulations and interpretive guidance, gradual and potentially delayed implementation, pending court challenges, and possible repeal and/or amendment, as well as our inability to foresee how individuals and businesses will respond to the choices afforded them by the Affordable Care Act. Depending on further legislative developments, how the pending court challenges are resolved, and how the Affordable Care Act is ultimately interpreted and implemented, it could have an adverse effect on our business, financial condition and results of operations.

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 2010, we derived 42.0% 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, among other things; requirements for utilization review; 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 subsidiaries 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.

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 relating to paying for care provided, often in exchange for exclusive or preferred participation in their benefit

TABLE OF CONTENTS

plans. We expect efforts to impose greater discounts and more stringent cost controls by government and other payors to continue, thereby reducing the payments we receive for our services. In addition, these 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 provides for material reductions in the growth of Medicare program spending, including reductions in Medicare market basket updates, and Medicare DSH funding. Medicare payments in FFY 2011 for inpatient hospital services are expected to be slightly lower than payments for the same services in FFY 2010 because of reductions resulting from the Affordable Care Act and the MS-DRG implementation.

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 states Medicaid systems. The ARRA and the Assistance Act include increased federal funding for Medicaid through June 30, 2011. However, we are unable to predict at this time how this will impact states ability to provide Medicaid coverage in the future, particularly in light of the expanded Medicaid eligibility requirements that become effective in 2014 as part of the Affordable Care Act. It is possible that, despite Congress s actions, 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.

For example, one of our hospitals, Memorial Medical Center of Las Cruces, New Mexico (MMC), received approximately $38.5 million during 2010 under the New Mexico Sole Community Provider Program (the SCPP). While the funds made available to MMC (and other New Mexico hospitals that participate in the SCPP) are not tied directly to the cost of actual services provided, MMC is required to provide an annual report of its costs to Dona Ana County (the county primarily served by MMC). Once desired funding levels were established by Dona Ana County for 2009, the county submitted funds to the New Mexico Human Services Department (the NMHSD), which in turn were combined with funds sent by other New Mexico counties and then used by the NMHSD to request matching funds from the federal government. Once the federal matching dollars were made available to the state, the resulting sole community provider payment was made under the SCPP directly to MMC (and other hospitals participating in the SCPP) by the NMHSD. The payments made by the NMHSD to hospitals pursuant to the SCPP are based on formulas established with respect to each participating hospital. The SCPP was created in 1993 and has resulted in significant payments to MMC in prior years. Like many other states, 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 reconstituted. 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.

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, equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, privacy, compliance with building codes and environmental protection,

among other matters. Many of the laws and regulations applicable to the healthcare are complex, and, in public statements, governmental authorities have taken positions on issues for which little official interpretation was previously available. Some of these positions appear to be inconsistent with common practices within the industry but have not previously been challenged. In addition, the monitoring of compliance with and the enforcing of penalties for violations of these laws and regulations is changing and increasing. For example, in 2010, CMS issued a self-referral disclosure

TABLE OF CONTENTS

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. In light 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 the Stark law to CMS. It is likely that self-disclosure of Stark violations will continue in the future. Moreover, some government investigations that have in the past been conducted under the civil provisions of federal law are now being conducted as criminal investigations under the Medicare fraud and abuse laws.

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. Federal and state government agencies have announced heightened and coordinated civil and criminal enforcement efforts. In addition, the OIG (which is responsible for investigating fraud and abuse activities in government programs) and the U.S. Department of Justice periodically establish targeted enforcement initiatives that focus on specific billing practices or other areas that are highly susceptible to fraud and abuse. The OIG reported savings and expected recoveries for federal healthcare programs of more than $25.9 billion for FFY 2010 as a result of its enforcement activities.

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. In addition, the claims review strategies used by the RACs generally include a review of high dollar claims, including inpatient hospital claims. As a result, a large majority of the total amounts recovered by RACs has come from hospitals. The Affordable Care Act expands the RAC program s scope to include managed Medicare and to include Medicaid claims by requiring all states to establish programs to contract with RACs in 2011. 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.

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.

TABLE OF CONTENTS

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, 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, expand Medicaid 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, pending court challenges, and possible repeal and/or amendment, as well as our inability to foresee how individuals and businesses 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.

TABLE OF CONTENTS

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 will prohibit 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.

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 United States economy recently emerged 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 operate are often dependant 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

TABLE OF CONTENTS

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 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.

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 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.

The profitability of our employed physicians will be affected by changes in the Medicare and Medicaid payment rates.

In recent years, physician payment amounts have been determined on a year by year basis. If the SGR is applied to the physician fee schedule in January 2012 as required by current legislation, Medicare payments will decrease by 24.9%. 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. The combination of increased salary cuts and potential liabilities are significant and if this trend continues, could have an adverse effect on our results of operations.

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

TABLE OF CONTENTS

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.

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.

We are subject to the Anti-kickback Statute, which prohibits healthcare service providers from paying or receiving remuneration to induce or arrange for the referral of patients or purchase of items or services covered by a federal or state healthcare program. We are also subject to the Stark law, which prohibits a physician 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. If regulatory authorities determine that any of our hospitals arrangements violate the Anti-kickback Statute or Stark law, we could be subject to a number of significant liabilities such as criminal penalties (for violations of the Anti-kickback Statute), civil monetary penalties, and/or exclusion from participation in Medicare, Medicaid or other federal healthcare programs, any of which could impair our ability to operate one or more of our hospitals profitably.

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.

TABLE OF CONTENTS

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, 2017 (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.

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 is in the process of developing and implementing an incentive payment program for eligible hospitals and healthcare professionals that adopt and meaningfully use EHR technology. HHS intends to use 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 may have difficulty acquiring hospitals on favorable terms.

One element of our business strategy is expansion through the acquisition of acute care hospitals in non-urban markets. We face significant competition to acquire other attractive non-urban 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, including obligations to self-report violations of law or outstanding obligations to pay amounts under the voluntary self-referral protocol or other laws. 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.

TABLE OF CONTENTS

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 and integrating 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.

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 have historically obtained, and we intend 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.

TABLE OF CONTENTS

We also face very significant and increasing competitions 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.

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 the cost of 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.

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, New Mexico, Tennessee, West Virginia, Alabama, Arizona, Louisiana and Texas. The following table contains our revenues and revenues as a percentage of our total revenues by state for each of these states for the years presented (dollars in millions):

	Revenue Concentration by State					
	Amount			% of Total Revenues		
	2010	2009	2008	2010	2009	2008
Kentucky	$ 544.8	$ 485.5	$ 465.0	16.7 %	16.4 %	17.2 %
Virginia	404.7	384.1	381.6	12.4	13.0	14.1
New Mexico	295.4	288.0	245.7	9.1	9.7	9.1
Tennessee	293.9	225.5	223.2	9.0	7.6	8.3
West Virginia	273.7	250.7	243.4	8.4	8.5	9.0
Alabama	236.9	209.6	203.2	7.3	7.1	7.5
Arizona	216.7	195.2	173.8	6.6	6.6	6.4
Louisiana	212.3	204.2	194.6	6.5	6.9	7.2
Texas	148.2	139.9	142.3	4.5	4.7	5.3

Accordingly, any change in the current demographic, economic, competitive or regulatory conditions in the above-mentioned states 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.

TABLE OF CONTENTS

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, 2010, our consolidated debt, excluding the unamortized discount of convertible debt instruments, was approximately $1,651.7 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. As of December 31, 2010, revolving loans available for borrowing under our credit agreement were up to $318.9 million, net of outstanding letters of credit of $31.1 million. Additionally, our credit agreement contains uncommitted accordion features that permit us to borrow at a later date additional aggregate principal amounts of up to $650.0 million under the term A and the term B loan components and up to $300.0 million under the revolving loan component, subject to obtaining additional lender commitments and the satisfaction of other conditions. Our ability to repay or refinance our indebtedness will depend upon our ability to monetize our interests in our hospital assets and our operating performance, which may be affected by general economic, financial, competitive, regulatory, business and other factors beyond our control.

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

Under our 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, selling assets, reducing or delaying capital expenditures or seeking additional equity capital. There can be no assurances that any of these strategies could be effected on satisfactory terms, if at all, or that sufficient funds could be obtained to make these accelerated payments.

TABLE OF CONTENTS

Covenant restrictions under our senior secured credit facilities and our indenture will impose significant 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 credit agreement that governs our senior secured credit facilities and the indenture that will govern the notes 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;
pay dividends or make distributions on, or redeem or repurchase, our capital stock or certain other debt;
make other restricted payments, including investments;
dispose of assets;
engage in transactions with affiliates;
enter into agreements restricting our subsidiaries ability to pay dividends;
create liens on our assets or engage in sale/leaseback transactions; and
effect a consolidation or merger, or sell, transfer, lease all or substantially all of our assets.

The limitations in our credit agreement for our senior secured credit facilities, 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 2014 and the 3¼% convertible senior subordinated debentures due 2025 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% convertible senior subordinated notes due 2014 or 3¼% convertible senior subordinated debentures due 2025 upon maturity or upon conversion of the securities may result in a default.

Subject to certain conditions, the provisions of our indenture may also allow us to refinance indebtedness that is subordinated in right of payment to the notes with indebtedness that would rank pari passu with the notes.

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

TABLE OF CONTENTS

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.

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, 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, a material non-cash charge to earnings from impairment of our goodwill could result.

As of December 31, 2010, we had approximately $1,550.7 million of goodwill. We expect to recover the carrying value of this goodwill through our future cash flows. We evaluate annually, based on our fair value, whether the carrying value of our goodwill is impaired. If the carrying value of our goodwill 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. Ten 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.

TABLE OF CONTENTS

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.

TABLE OF CONTENTS

Item 2. *Properties.*

The following table presents certain information with respect to our hospitals as of December 31, 2010:

Hospital	City	Acquisition/Opening/ Lease Date	Licensed Beds	Real Property Status
Alabama				
Andalusia Regional Hospital	Andalusia	HCA Spin-Off [(a)]	100	Own
Lakeland Community Hospital	Haleyville	December 1, 2002	50	Own
Northwest Medical Center	Winfield	December 1, 2002	71	Own
Russellville Hospital	Russellville	October 3, 2002	100	Own
Vaughan Regional Medical Center	Selma	April 15, 2005	175	Own
Arizona				
Havasu Regional Medical Center	Lake Havasu City	April 15, 2005	181	Own [(b)]
Valley View Medical Center	Ft. Mohave	November 8, 2005	84	Own
Colorado				
Colorado Plains Medical Center	Fort Morgan	April 15, 2005	50	Lease
Florida				
Putnam Community Medical Center	Palatka	June 16, 2000	141	Own
Georgia				
Rockdale Medical Center	Conyers	February 1, 2009	146	Own
Kansas				
Western Plains Medical Complex	Dodge City	HCA Spin-Off [(a)]	99	Own [(b)]
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	100	Lease
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)]	275	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
Mississippi				

Bolivar Medical Center	Cleveland	April 15, 2005		200	Lease
Nevada					
Northeastern Nevada Regional Hospital	Elko	April 15, 2005		75	Own
New Mexico					
Los Alamos Medical Center	Los Alamos	April 15, 2005		47	Own
Memorial Medical Center of Las Cruces	Las Cruces	April 15, 2005		298	Lease
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 North	Carthage	September 1, 2010		63	Own
Riverview Regional Medical Center South	Carthage	September 1, 2010		25	Own

TABLE OF CONTENTS

Hospital	City	Acquisition/Opening/Lease Date	Licensed Beds	Real Property Status
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
Texas				
Ennis Regional Medical Center	Ennis	April 15, 2005	60	Lease
Palestine Regional Medical Center	Palestine	April 15, 2005	150	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]	84	Own
Virginia				
Clinch Valley Medical Center	Richlands	July 1, 2006	175	Own
Danville Regional Medical Center	Danville	July 1, 2005	290	Own
Memorial Hospital of Martinsville and Henry County	Martinsville	April 15, 2005	220	Own
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
			5,915	

(a) We were formerly a division of 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 with physicians in which a 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.

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 corporate headquarters are located in approximately 178,000 square feet of leased space in Brentwood, Tennessee. Our corporate headquarters, hospitals and other facilities are suitable for their respective uses and are generally adequate for our present needs.

Item 3. *Legal Proceedings.*

We are, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, medical malpractice, breach of contracts, wrongful restriction of or interference with physicians staff privileges and employment related claims. In certain of these actions, plaintiffs request payment for

damages, including punitive damages that may not be covered by insurance. We are currently not a party to any pending or threatened proceeding, which, in management s opinion, would have a material adverse effect on our business, financial condition or results of operations.

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 regarding an investigation they are conducting with respect to the billing of kyphoplasty procedures. Kyphoplasty is a surgical spine procedure that returns a compromised vertebrae (either from trauma or osteoporotic disease process) to its previous height, reducing or eliminating severe pain. It has been reported that other unaffiliated hospitals and hospital operators in multiple states have received similar requests for information. We believe that this investigation is related to the May 22, 2008 qui tam settlement between the same U.S. Attorney s Office and the manufacturer and distributor of the product used in performing the kyphoplasty procedure.

TABLE OF CONTENTS

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.

TABLE OF CONTENTS

PART II

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

Market Information for Common Stock

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

	High	Low
2011		
First Quarter (through February 17, 2011)	$ 37.87	$ 34.63
2010		
First Quarter	$ 37.95	$ 28.48
Second Quarter	39.61	31.32
Third Quarter	36.76	29.33
Fourth Quarter	38.77	32.88
2009		
First Quarter	$ 25.06	$ 17.74
Second Quarter	29.88	19.55
Third Quarter	29.37	23.94
Fourth Quarter	33.99	27.00

On February 17, 2011, the last reported sales price for our common stock on the NASDAQ Global Select Market was $37.03 per share.

Stockholders

As of February 11, 2011, there were 51,490,182 shares of our common stock held by 10,267 holders of record.

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, our credit agreement and certain other indebtedness 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

In August 2009, our Board of Directors authorized the repurchase of up to $100.0 million 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 factors (the 2009 Repurchase Plan). The 2009 Repurchase Plan expired in February 2011.

In connection with the 2009 Repurchase Plan, we repurchased approximately 0.4 million shares for an aggregate purchase price, including commissions, of approximately $12.4 million at an average purchase price of $34.54 per share for the three months ended December 31, 2010. We have designated the shares repurchased under the 2009 Repurchase Plan as treasury stock.

TABLE OF CONTENTS

In September 2010, our Board of Directors authorized the repurchase of up to an additional $150.0 million of outstanding shares of our common stock either in open market purchases, privately negotiated transactions, accelerated share repurchase programs or other transactions (the 2010 Repurchase Plan). The 2010 Repurchase Plan expires in March 2012. We are not obligated to repurchase any specific number of shares under the 2010 Repurchase Plan. In connection with the 2010 Repurchase Plan, we entered into a trading plan in accordance with the SEC Rule 10b5-1 to facilitate repurchases of our common stock (the 2010 10b5-1 Trading Plan). The 2010 10b5-1 Trading Plan became effective on September 22, 2010 and expired on November 2, 2010.

In connection with the 2010 Repurchase Plan, we repurchased approximately 1.2 million shares for an aggregate purchase price, including commissions, of approximately $42.2 million at an average purchase price of $34.99 per share for the three months ended December 31, 2010, 0.4 million shares of which was purchased in accordance with the 2010 10b5-1 Trading Plan. We have designated the shares repurchased under the 2010 Repurchase Plan as treasury stock.

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 (LTIP) and Amended and Restated Management Stock Purchase Plan (MSPP). We redeemed a nominal number of shares of certain vested LTIP and MSPP shares for an aggregate price of approximately $0.1 million during each of the three months ended December 31, 2010 and 2009. We have designated these shares as treasury stock.

Our repurchase activity under our 2009 Repurchase Plan, 2010 Repurchase Plan, 2010 10b5-1 Trading 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 LTIP and MSPP are more fully discussed in Note 8 to our consolidated financial statements included elsewhere in this report.

The following table summarizes our share repurchase activity by month for the three months ended December 31, 2010:

Period	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, 2010 to October 31, 2010	96,306 [(a)]	$ 33.96	96,170	$ 154.8
November 1, 2010 to November 30, 2010	1,026,756	$ 34.79	1,026,756	$ 119.1
December 1, 2010 to December 31, 2010	443,011 [(a)]	$ 35.34	439,600	$ 103.6
Total	1,566,073 [(a)]	$ 34.90	1,562,526	$ 103.6

(a) Includes shares redeemed for tax withholding purposes upon vesting of certain previously granted stock awards under the LTIP and MSPP plans.

TABLE OF CONTENTS

Equity Compensation Plan Information

The following table provides aggregate information as of December 31, 2010, with respect to shares of common stock that may be issued in accordance with our existing equity compensation plans, including our LTIP, our Outside Directors Stock and Incentive Compensation Plan (the ODSICP) and our MSPP:

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity Compensation Plans Approved by Security Holders	4,482,234 (1)	$ 31.10 (2)	3,867,755 (3)
Equity Compensation Plans not Approved by Security Holders	None	None	None
Total	4,482,234	$ 31.10	3,867,755

(1) Includes the following:

4,470,488 shares of common stock to be issued upon exercise of outstanding stock options granted in accordance with the LTIP; and

11,746 shares of common stock to be issued upon the vesting of deferred stock units outstanding in accordance with the ODSICP.

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

(3) Includes the following:

3,709,584 shares of common stock available for issuance in accordance with the LTIP;

68,873 shares of common stock available for issuance in accordance with the ODSICP; and

89,298 shares of common stock available for issuance in accordance with the MSPP.

TABLE OF CONTENTS

Item 6. *Selected Financial Data.*

The table below contains our selected financial data for, or as of the end of, the last five years ended December 31, 2010. The selected financial data is derived from our consolidated financial statements included elsewhere in this report. 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,				
	2010	2009	2008	2007	2006
	(In millions, except per share amounts)				
Statement of Operations Data:					
Revenues	$3,262.4	$2,962.7	$2,700.8	$2,568.4	$2,336.5
Income from continuing operations attributable to LifePoint Hospitals, Inc. stockholders	155.6	139.2	126.7	120.1	141.5
Income from continuing operations per share:					
Basic	$2.98	$2.64	$2.41	$2.13	$2.54
Diluted	$2.91	$2.59	$2.37	$2.09	$2.51
Weighted average shares outstanding:					
Basic	52.2	52.7	52.5	56.2	55.6
Diluted	53.5	53.8	53.5	57.2	56.3
Cash dividends declared per share					
Balance Sheet Data (as of end of year):					
Working capital	$498.8	$485.9	$376.2	$373.6	$377.7
Property and equipment, net	1,668.6	1,499.4	1,416.0	1,383.0	1,305.4
Total assets	4,152.4	3,873.3	3,680.3	3,635.9	3,638.3
Long-term debt, including amounts due within one year but excluding unamortized discounts of convertible debt instruments	1,651.7	1,502.2	1,516.7	1,517.1	1,668.5
Total LifePoint Hospitals, Inc. stockholders equity	1,887.5	1,827.7	1,652.0	1,629.1	1,471.5

TABLE OF CONTENTS

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

We recommend that you read this discussion together with our consolidated financial statements and related notes included elsewhere in this report. 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, including the use of proceeds from the Company s recent debt issuance; 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; the performance of counterparties to our agreements; effect of credit ratings; 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; future capital expenditures, including capital expenditures related to information systems, the replacement hospital for Clark and the aggregate capital commitment to HighPoint; claims and legal actions relating to professional liabilities, governmental investigations and other matters; 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, expect, project, estimate, seek, anticipate, intend, target, continue or similar expressions. You should n 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.

47

TABLE OF CONTENTS

Overview

We operate general acute care hospitals in non-urban communities in the United States. At December 31, 2010, on a consolidated basis and including our recent acquisition of HighPoint, effective September 1, 2010, we operated 52 hospital campuses in 17 states, having a total of 5,915 licensed beds. We generate revenues primarily through hospital services offered at our facilities. We generated $3,262.4 million, $2,962.7 and $2,700.8 million during 2010, 2009 and 2008, respectively, in revenues from continuing operations. In 2010, we derived 42.0% of our revenues from continuing operations 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. The hospital industry is also enduring a period where the costs of providing care are rising faster than reimbursement rates. 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. 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.

Our hospitals typically provide the range of medical and surgical services commonly available in hospitals in non-urban markets, although 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 might exist.

Competitive and Structural Environment

The environment in which our hospitals operate is extremely competitive. Many of our communities are experiencing slow growth, and in some cases, population losses. The economies of our communities are also more sensitive to economic downturns in the manufacturing sector than the United States, 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 United States has a shortage of physicians in certain practice areas, including 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 employ 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. The quality of care, and our communities perception of that quality, may also be influenced by the skills and experience of our non-physician employees involved in patient care.

TABLE OF CONTENTS

Business Strategy

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

Targeted recruiting of primary care physicians and physicians in key specialties;
Retention of physicians and efforts to improve physician satisfaction;
Retention and, where needed, recruitment of non-physician employees involved in patient care and efforts to improve employee satisfaction;
Measurement and improvement of quality of patient care and perceptions of such quality in communities where our hospitals are located;
Targeted investments in new technologies, new service lines and capital improvements at our facilities;
Improvements in management of expenses and revenue cycle; and
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.

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 believes compliance expenses will continue to grow in the foreseeable future.

Health Care Reform

The Affordable Care Act dramatically alters the United States healthcare system and is intended to decrease the number of uninsured Americans and reduce overall healthcare costs. 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 payments, including DSH payments, to providers, expanding the Medicare program s use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and bundling payments to hospitals and other providers. The Affordable Care Act also contains a number of measures that are intended to reduce fraud and abuse in the Medicare and Medicaid programs, such as

increased funding for fraud and abuse investigations and enforcement, requiring the use of RACs in the Medicaid program, and generally prohibiting physician-owned hospitals from adding new physician owners or increasing the number of beds and operating rooms for which they are licensed. Because a majority of the measures contained in the Affordable Care Act do not take effect until 2013, it is difficult to predict the impact the Affordable Care Act will have on our facilities. Additionally, some courts have ruled that the requirement for individuals to carry health insurance or the

TABLE OF CONTENTS

Affordable Health Care Act in its entirety is unconstitutional. Several bills have been and likely will 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 due to its complexity, lack of implementing regulations and interpretive guidance, gradual and potentially delayed implementation, pending court challenges, and possible repeal and/or amendment, as well as our inability to foresee how individuals and businesses will respond to the choices afforded them by the Affordable Care Act. However, depending on how it is ultimately interpreted and implemented, the Affordable Care Act could have an adverse effect on our business, financial condition and results of operations.

Medicare and Medicaid Reimbursement

Medicare payment methodologies have been, and can be expected to continue to be, significantly revised 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.

In addition, many of the states in which we operate are facing budgetary challenges and have adopted, or may be considering, legislation that is intended to reduce Medicaid coverage and program eligibility, enroll Medicaid recipients in managed care programs, and/or impose additional taxes on hospitals to help finance or expand their Medicaid programs. Such 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. Congress has made an effort to address the financial challenges Medicaid is facing by recently increasing the amount of Medicaid funding available to states through the ARRA and the Assistance Act, which increased FMAP payments through June 30, 2011. We cannot predict if the increased FMAP payments will be further extended or the impact that the phase-out of the increased FMAP payments will have on state Medicaid programs in the future.

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. We intend to comply with the EHR meaningful use requirements of the HITECH Act in time to qualify for the maximum available incentive payments. Our compliance will result in significant costs including 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 continue to refine our budgeted costs and the expected reimbursement improvements associated with our EHR initiatives. We currently estimate that at a minimum total costs incurred to comply will be recovered through improved reimbursement amounts over the projected lifecycle of this initiative.

Privacy and Security Regulations

We are subject to the privacy and security requirements of HIPAA and 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

TABLE OF CONTENTS

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. On August 24, 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 has issued an interim final rule conforming HIPAA s enforcement regulations to the HITECH Act s statutory revisions. This interim final rule also sets 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.

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 2011. 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.

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

TABLE OF CONTENTS

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 healthcare reform 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.

Self-pay revenues are primarily generated through the treatment of uninsured patients. Our hospitals have experienced an increase in self-pay revenues during recent years as well as throughout 2010 as a result of 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.

In recent periods, our business has experienced a shift in revenue from inpatient admissions to outpatient procedures. This trend has occurred due to a variety of factors including our strategic focus on improving our emergency departments and diagnostic lines of business. In addition, our hospitals, like those of other hospital companies, have experienced a shift from inpatient admissions to outpatient observations for a portion of our patient population. We believe the reasons for this shift, include, but are not limited to, the continuing competition from various providers and utilization pressure by both governmental programs and commercial insurance payors.

For additional information about our revenue sources, please also refer to the discussion above under the subheading Medicare and Medicaid Reimbursement.

Results of Operations

The following definitions apply throughout the remaining portion of *Management s Discussion and Analysis of Financial Condition and Results of 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 our same-hospital operations and our recent HighPoint and Clark acquisitions but excludes the results of our hospitals that have previously been disposed.

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.

TABLE OF CONTENTS

ESOP. Employee stock ownership plan. The ESOP was a defined contribution retirement plan that covered substantially all of our employees. On December 31, 2008. the ESOP loan was repaid in full and all remaining shares were released. Effective January 1, 2009, we began funding our defined contribution plan entirely with cash.

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

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 revenues, including revenues for held for sale / disposed of hospitals, by the number of calendar days in the quarter.

N/A. Not applicable.

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

Same-hospital. Same-hospital information includes the results of our corporate office and the same 47 hospitals operated during the years ended December 31, 2010 and 2009. Same-hospital information includes the results of Rockdale Medical Center, a 146 bed hospital located in Conyers, Georgia (Rockdale), which we acquired effective February 1, 2009. Same-hospital information excludes the results of HighPoint, which we acquired effective September 1, 2010, Clark, which we acquired effective May 1, 2010, and our hospitals that have previously been disposed.

Operating Results Summary

The following tables present summaries of results of operations for the three months ended December 31, 2010 and 2009 and for the years ended December 31, 2010, 2009 and 2008 (dollars in millions):

	Three Months Ended December 31,			
	2010		2009	
	Amount	% of Revenues	Amount	% of Revenues
Revenues	$853.3	100.0 %	$746.9	100.0 %
Salaries and benefits	335.2	39.3	295.9	39.6
Supplies	112.5	13.2	104.9	14.0
Other operating expenses	161.0	18.8	132.3	17.8
Provision for doubtful accounts	120.4	14.1	94.3	12.6
Depreciation and amortization	39.3	4.7	36.9	5.0
Interest expense, net	30.9	3.6	26.0	3.5
Impairment charge			1.1	0.1
	799.3	93.7	691.4	92.6
Income from continuing operations before income taxes	54.0	6.3	55.5	7.4
Provision for income taxes	16.9	2.0	16.1	2.1
Income from continuing operations	37.1	4.3	39.4	5.3
Less: Net income attributable to noncontrolling interests	(0.8)	(0.1)	(0.8)	(0.1)
Income from continuing operations attributable to	$36.3	4.2 %	$38.6	5.2 %

TABLE OF CONTENTS

	Years Ended December 31,					
	2010		2009		2008	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Revenues	$3,262.4	100.0%	$2,962.7	100.0%	$2,700.8	100.0%
Salaries and benefits	1,270.3	38.9	1,170.9	39.5	1,065.4	39.4
Supplies	443.0	13.6	409.1	13.8	372.6	13.8
Other operating expenses	605.2	18.6	538.0	18.2	499.8	18.5
Provision for doubtful accounts	443.8	13.6	375.4	12.7	313.2	11.6
Depreciation and amortization	148.5	4.5	143.0	4.8	132.1	5.0
Interest expense, net	108.1	3.3	103.2	3.5	107.7	4.0
Debt extinguishment costs	2.4	0.1				
Impairment charges			1.1		1.2	
	3,021.3	92.6	2,740.7	92.5	2,492.0	92.3
Income from continuing operations before income taxes	241.1	7.4	222.0	7.5	208.8	7.7
Provision for income taxes	82.4	2.5	80.3	2.7	79.9	2.9
Income from continuing operations	158.7	4.9	141.7	4.8	128.9	4.8
Less: Net income attributable to noncontrolling interests	(3.1)	(0.1)	(2.5)	(0.1)	(2.2)	(0.1)
Income from continuing operations attributable to LifePoint Hospitals, Inc.	$155.6	4.8%	$139.2	4.7%	$126.7	4.7%

For the Three Months Ended December 31, 2010 and 2009

Revenues

The following table shows our revenues and the key drivers of our revenues for the three months ended December 31, 2010 and 2009:

	Three Months Ended December 31,		Increase (Decrease)	% Increase (Decrease)
	2010	2009		
Continuing operations:				
Revenues (dollars in millions)	$853.3	$746.9	$106.4	14.3%
Admissions	47,701	46,560	1,141	2.5
Equivalent admissions	103,361	97,359	6,002	6.2
Revenues per equivalent admission	$8,255	$7,671	$584	7.6
Medicare case mix index	1.26	1.31	(0.05)	(3.8)
Average length of stay (days)	4.3	4.3		
Inpatient surgeries	13,375	13,354	21	0.2
Outpatient surgeries	39,893	37,799	2,094	5.5
Emergency room visits	244,014	232,702	11,312	4.9
Outpatient factor	2.17	2.09	0.08	3.8
Same-hospital:				

Revenues (dollars in millions)	$797.2	$746.9	$50.3	6.7 %
Admissions	44,718	46,560	(1,842)	(4.0)
Equivalent admissions	96,154	97,359	(1,205)	(1.2)
Revenues per equivalent admission	$8,292	$7,671	$621	8.1
Medicare case mix index	1.32	1.31	0.01	0.8
Average length of stay (days)	4.3	4.3		
Inpatient surgeries	12,696	13,354	(658)	(4.9)
Outpatient surgeries	37,749	37,799	(50)	(0.1)
Emergency room visits	227,417	232,702	(5,285)	(2.3)
Outpatient factor	2.15	2.09	0.06	2.9

TABLE OF CONTENTS

The following table shows the sources of our revenues by payor for the three months ended December 31, 2010 and 2009, expressed as a percentage of total revenues, including adjustments to estimated reimbursement amounts:

	Continuing Operations		Same-Hospital	
	2010	2009	2010	2009
Medicare	29.6 %	29.4 %	29.7 %	29.4 %
Medicaid	11.1	10.7	10.9	10.7
HMOs, PPOs and other private insurers	43.3	45.3	43.3	45.3
Self-Pay	15.0	13.7	15.1	13.7
Other	1.0	0.9	1.0	0.9
	100.0 %	100.0 %	100.0 %	100.0 %

For the three months ended December 31, 2010, our revenues increased by $50.3 million, or 6.7% to $797.2 million on a same-hospital basis as compared to $746.9 million for the same period last year. The increase was the result of the impact of favorable commercial pricing, inclusive of improvements in our third party payor contracting, an increase in our outpatient revenues, as evidenced by a 2.9% increase in our outpatient factor to 2.15 from 2.09 as compared to the same period last year, an increase in the average acuity of the service provided, as evidenced by a 0.8% increase in our Medicare case mix index to 1.32 as compared to 1.31 for the same period last year and an increase in our self-pay revenues as further discussed in our analysis of our provision for doubtful accounts for the three months ended December 31, 2010. As a result, our revenues per equivalent admission on a same-hospital basis increased by 8.1% to $8,292 during the three months ended December 31, 2010, as compared to $7,671 for the same period last year.

Certain changes have been made to our historical sources of revenues table above. Specifically, we previously classified our revenues related to our owned physician practices as other revenue. In 2010 and for all previously reported periods, we changed the classification of our revenues for our owned physician practices from other to the respective payor classifications, as appropriate. This change had no impact on our historical results of operations. These reclassifications reduced other revenue as a percentage of total revenues and increased Medicare, Medicaid, HMOs, PPOs and other private insurers and self-pay as a percentage of total revenues. We have determined that it is more appropriate to classify our owned physician practices revenue by their respective payor classification.

Expenses

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, 2010 and 2009:

	Three Months Ended December 31,					
	2010	% of Revenues	2009	% of Revenues	Increase	% Increase
Continuing operations:						
Salaries and benefits (dollars in millions)	$335.2	39.3 %	$295.9	39.6 %	$39.3	13.3 %
Man-hours per equivalent admission	100.3	N/A	96.0	N/A	4.3	4.4 %
Salaries and benefits per equivalent	$3,233	N/A	$3,055	N/A	$178.0	5.8 %

admission							
Same-hospital:							
Salaries and benefits (dollars in millions)	$310.0	38.9 %	$295.9	39.6 %	$14.1	4.8	%
Man-hours per equivalent admission	99.3	N/A	96.0	N/A	3.3	3.3	%
Salaries and benefits per equivalent admission	$3,214	N/A	$3,055	N/A	$159.0	5.2	%

TABLE OF CONTENTS

For the three months ended December 31, 2010, our salaries and benefits expense increased to $310.0 million, or 4.8%, on a same-hospital basis as compared to $295.9 million for the same period last year. This increase in our same-hospital salaries and benefits expense is primarily a result of the impact of an increasing number of employed physicians and their related support staff and the impact of compensation increases for our employees.

On a same-hospital basis, the number of our employed physicians, including hospitalists increased by 15 to 311 from 296 from the prior year and the number of employed physicians, including hospitalists, and their related support staff, increased by 48 to 974 from 926 from the same period last year. The increase in our employed physicians and their related support staff resulted in an increase of $3.2 million in our salaries and benefits expense for the three months ended December 31, 2010 as compared to the same period last year. As we continue to employ an increasing number of medical professionals, including physicians, we anticipate that salaries and benefits as a percentage of revenues will increase in future periods.

Supplies

The following table summarizes our supplies and supplies per equivalent admission for the three months ended December 31, 2010 and 2009:

	Three Months Ended December 31,					
	2010	% of Revenues	2009	% of Revenues	Increase	% Increase
Continuing operations:						
Supplies (dollars in millions)	$ 112.5	13.2 %	$ 104.9	14.0 %	$ 7.6	7.4 %
Supplies per equivalent admission	$ 1,089	N/A	$ 1,074	N/A	$ 15	1.4 %
Same-hospital:						
Supplies (dollars in millions)	$ 105.5	13.2 %	$ 104.9	14.0 %	$ 0.6	0.6 %
Supplies per equivalent admission	$ 1,097	N/A	$ 1,074	N/A	$ 23	2.2 %

For the three months ended December 31, 2010, our supplies expense increased to $105.5 million, or 0.6% on a same-hospital basis as compared to $104.9 million for the same period last year. This increase in our same-hospital supplies expense for the three months ended December 31, 2010 was primarily a result of an increase in our supplies expense per equivalent admission to $1,097, or 2.2%, as compared to $1,074 for the same period last year. Supplies per equivalent admission increased as a result of a higher utilization of more expensive supplies, predominantly cancer related supplies, as well as an increase in our pharmacy supplies expense. As a percentage of revenues, our same-hospital supplies expense decreased to 13.2% for the three months ended December 31, 2010 as compared to 14.0% for the same period last year, as a result of our continuing efforts to effectively manage our supply costs and increased synergies based on our participation in a group purchasing organization.

TABLE OF CONTENTS

Other Operating Expenses

The following table summarizes our other operating expenses for the three months ended December 31, 2010 and 2009 (dollars in millions):

	Three Months Ended December 31,					
	2010	% of Revenues	2009	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Continuing operations:						
Professional fees	$23.0	2.7 %	$18.8	2.5 %	$ 4.2	22.9 %
Utilities	13.7	1.6	12.1	1.6	1.6	11.9
Repairs and maintenance	19.5	2.3	15.8	2.1	3.7	23.4
Rents and leases	7.0	0.8	5.1	0.7	1.9	39.2
Insurance	9.5	1.1	11.4	1.5	(1.9)	(16.0)
Physician recruiting	6.5	0.8	6.2	0.8	0.3	5.8
Contract services	41.4	4.9	36.8	4.9	4.6	12.4
Non-income taxes	17.7	2.1	9.8	1.3	7.9	79.7
Other	22.7	2.5	16.3	2.4	6.4	38.6
	$161.0	18.8 %	$132.3	17.8 %	$ 28.7	21.6 %
Same-hospital:						
Professional fees	$20.8	2.6 %	$18.8	2.5 %	$ 2.0	11.1 %
Utilities	12.6	1.6	12.1	1.6	0.5	3.9
Repairs and maintenance	17.7	2.2	15.8	2.1	1.9	12.1
Rents and leases	6.4	0.8	5.1	0.7	1.3	27.3
Insurance	9.2	1.2	11.4	1.5	(2.2)	(18.9)
Physician recruiting	6.4	0.8	6.2	0.8	0.2	3.9
Contract services	39.4	4.9	36.8	4.9	2.6	6.9
Non-income taxes	16.1	2.0	9.8	1.3	6.3	63.1
Other	22.0	2.8	16.3	2.4	5.7	34.2
	$150.6	18.9 %	$132.3	17.8 %	$ 18.3	13.8 %

For the three months ended December 31, 2010, our other operating expenses increased to $150.6 million, or 13.8% on a same-hospital basis as compared to $132.3 million for the same period last year. This increase for the three months ended December 31, 2010 was primarily a result of increases in professional fees, contract services, non-income taxes and other expenses, 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 and hospitalists. We expect this trend to continue and that professional fees as a percentage of revenues will increase in future periods.

On a same-hospital basis, 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.

Our non-income taxes increased primarily as a result of increases in state provider taxes and property taxes experienced at certain hospitals in various states. Finally, our other expenses increased on a same-hospital basis as a result of additional legal expenses, training and implementation expenses from various information system initiatives in our efforts to comply with the HITECH Act as well as additional legal and consulting fees related to our recent

acquisitions, including HighPoint, Clark and certain ancillary service-line acquisitions.

These increases were partially offset by a decrease in our insurance expense. Our insurance expense decreased compared to the same period last year primarily because of favorable claim development for our workers compensation claims and professional and general liability claims experienced during the current period.

TABLE OF CONTENTS

Provision for Doubtful Accounts

The following table summarizes our provision for doubtful accounts and related key indicators for the three months ended December 31, 2010 and 2009 (dollars in millions):

	Three Months Ended December 31,					
	2010	% of Revenues	2009	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Continuing operations:						
Provision for doubtful accounts	$120.4	14.1 %	$94.3	12.6 %	$ 26.1	27.7 %
Related key indicators:						
Charity care write-offs	$18.0	2.1 %	$13.6	1.8 %	$ 4.4	31.2 %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$128.2	15.0 %	$102.5	13.7 %	$ 25.7	25.1 %
Net revenue days outstanding (at end of period)	41.8	N/A	40.1	N/A	1.7	4.2 %
Same-hospital:						
Provision for doubtful accounts	$111.7	14.0 %	$94.3	12.6 %	$ 17.4	18.4 %
Related key indicators:						
Charity care write-offs	$16.3	2.0 %	$13.6	1.8 %	$ 2.7	19.2 %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$120.3	15.1 %	$102.5	13.7 %	$ 17.8	17.4 %
Net revenue days outstanding (at end of period)	39.9	N/A	40.1	N/A	(0.2)	(0.5%)

For the three months ended December 31, 2010, our provision for doubtful accounts increased by $26.1 million, or 27.7%, to $120.4 million on a continuing operations basis and by $17.4 million, or 18.4%, to $111.7 million on a same-hospital basis as compared to the same period last year. This increase was primarily the result of increases in self-pay revenues during the three months ended December 31, 2010. Self-pay revenues on a continuing operations basis increased by $25.7 million over the same period last year and represented 15.0% of revenues, as compared to 13.7% 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 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 three months ended December 31, 2010, 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.

Certain changes have been made to our historical sources of revenues. Specifically, we previously classified our revenues related to our owned physician practices as other revenue. In 2010 and for all previously reported periods, we changed the classification of our revenues for our owned physician practices from other to the respective payor classifications, as appropriate. This change had no impact on our historical results of operations. These reclassifications increased self-pay revenue in the table above. We have determined that it is more appropriate to classify our owned physician practices revenue by their respective payor classification.

Depreciation and Amortization

For the three months ended December 31, 2010, our depreciation and amortization expense increased to $39.3 million, or 6.6%, on a continuing operations basis as compared to $36.9 million for the same period last year. Our depreciation and amortization expense increased primarily as a result of our recent acquisitions of HighPoint and Clark, capital improvement projects completed during 2010 as well as an increase in amortization expense for certain non-compete agreements as a result of ancillary service-line acquisitions

TABLE OF CONTENTS

completed during 2010. Throughout 2010, 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 increasing our spending related to information systems during 2011 as compared to 2010 and prior years. As a result, we anticipate that our depreciation and amortization expense as a percentage of revenues will increase in future periods.

Interest Expense

Our interest expense increased by $4.9 million, or 18.5%, to $30.9 million, for the three months ended December 31, 2010, as compared to $26.0 million for the same period last year. The increase in interest expense for the three months ended December 31, 2010, as compared to the same period last year, was largely attributable to an increase in our outstanding debt balance, excluding unamortized discounts of convertible debt instruments, at December 31, 2010 to $1,651.7 million as compared to $1,502.2 million at December 31, 2009 and increases in our applicable annual interest rates. Effective September 23, 2010, we issued $400.0 million of 6.625% Senior Notes in a private placement. The net proceeds from this issuance were used to repay $249.2 million of our outstanding borrowings under our Term B Loans and $6.0 million of our outstanding borrowings under our 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 three months ended December 31, 2010, on a weighted average basis, was 3.06%. These increases were partially offset by declines in interest expense attributable to our interest rate swap agreement. On November 30, 2010, the notional amount of our interest rate swap decreased from $450.0 million to $300.0 million. As the notional amount of our interest rate swap has continued to decline, a larger portion of our total outstanding debt has become subject to floating interest rates that were lower than our fixed rate under the agreement of 5.585% for the three months ended December 31, 2010 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 $16.9 million, or 2.0% of revenues, for the three months ended December 31, 2010, as compared to $16.1 million, or 2.1% of revenues, for the same period last year. The effective tax rate increased to 31.8% for the three months ended December 31, 2010, compared to 29.4% for the same period last year.

A reconciliation of the federal income tax and statutory federal income tax rate to our provision for income taxes and effective income tax rate, respectively, on income from continuing operations before income taxes and including net income from noncontrolling interests for the three months ended December 31, 2010 and 2009, giving effect to the net (reversal) accrual of interest on the long-term income tax liability and the expiration of the statutes of limitations on various income tax returns is as follows (dollars in millions):

	Three Months Ended December 31,		Increase (Decrease)	Three Months Ended December 31,		Increase (Decrease)
	2010	2009		2010	2009	
Federal income taxes	$18.7	$ 19.1	$ (0.4)	35.0%	35.0 %	bps
State income taxes, net of federal income tax benefits	0.8	0.7	0.1	1.7	1.2	50
Increase in valuation allowances for deferred tax assets	1.8	1.2	0.6	3.3	2.1	120
	(1.3)	(6.0)	4.7	(2.5)	(10.9)	840

Decrease in long-term income tax liabilities due to statute lapses and exam closures						
Decrease in deferred income tax liabilities due to exam closures	(2.6)		(2.6)	(4.9)		(490)
Other	(0.5)	1.1	(1.6)	(0.8)	2.0	(280)
	$16.9	$ 16.1	$ 0.8	31.8%	29.4 %	240 bps

59

TABLE OF CONTENTS

For the Years Ended December 31, 2010 and 2009

Revenues

The following table shows our revenues and the key drivers of our revenues for the years ended December 31, 2010 and 2009:

	Years Ended December 31,	Increase (Decrease)	% Increase (Decrease)