ANNUAL REPORT

OF

LIFEPOINT HEALTH, INC.

FOR THE

FISCAL YEAR ENDED DECEMBER 31, 2020

PREPARED IN ACCORDANCE WITH

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

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

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

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

LifePoint Health, Inc.

Annual Report

For the Fiscal Year Ended December 31, 2020

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DISCLOSURE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report for the fiscal year ended December 31, 2020 (this "***Report***") contains forward-looking statements that involve risks and uncertainties. Forward-looking statements include any statements that address future results or occurrences. In some cases, you can identify forward-looking statements by terminology such as: "may," "might," "will," "would," "should," "could" or the negatives thereof. Generally, the words "anticipate," "believe," "continue," "expect," "intend," "estimate," "project," "plan" and similar expressions identify forward-looking statements. In particular, statements about our expectations, beliefs, plans, objectives, assumptions or future events or performance contained elsewhere in this Report are forward-looking statements. These forward-looking statements include statements that are not historical facts, including statements concerning our possible or assumed future actions and business strategies. We have based these forward-looking statements on our current expectations, assumptions, estimates and projections. While we believe these expectations, assumptions, estimates and projections are reasonable, such forward-looking statements are only predictions and involve known and unknown risks, uncertainties and other factors, many of which are outside of our control, which could cause our actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. Such factors include, among others, the following:

- the length and severity of the novel coronavirus ("***COVID-19***") pandemic, the measures we are taking to respond to the pandemic and the potential availability of a vaccine on a widespread basis;
- significantly reduced patient volumes and operating revenues for elective procedures and services provided to non-COVID-19 patients and the uncertainty of future patient volumes and related revenues, including shifts from in-person patient services to telehealth services;
- the impact of increases in the volume of COVID-19 patients cared for across our facilities;
- the impact of existing or future COVID-19 related government and administrative regulation and stimulus, including the Families First Coronavirus Response Act, the Coronavirus Aid, Relief, and Economic Security Act (the "***CARES Act***") and other COVID-19 relief or stimulus legislation, and uncertainty in how these programs may be administered, monitored and modified in the future;
- supply shortages, workforce disruptions or shortages, and increased costs of providing care to our patients, including increased equipment, staffing and supply expenses resulting from the COVID-19 pandemic;
- the emergence of and effects related to other pandemics, epidemics and highly contagious infectious diseases;
- payment changes, including policy considerations and changes resulting from federal and state budgetary restrictions;
- impact from or likelihood of the repeal of, or material modification to, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "***Affordable Care Act***"), as a result of court or legislative action;
- potential impact from the repeal of the penalties associated with the "***individual mandate***" to purchase health insurance under the Affordable Care Act, included in the Tax Cuts and Jobs Act of 2017 (the "***Tax Act***");
- impact from changes to Medicaid supplemental payment programs;
- our compliance with new and existing laws and regulations, including laws and regulations adopted in connection with the COVID-19 pandemic, as well as costs and benefits associated with compliance;
- any potential action brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the "qui tam" or "whistleblower" provisions of the federal False Claims Act (the "***False Claims Act***");
- impact from the changes in payer mix marked by a shift of patients from private insurance to Medicare and Medicaid programs;
- our acquisition strategy, including integration risks relating to future acquisitions;
- the potential for material obligations if we acquire facilities with unknown or contingent liabilities;
- claims and legal actions relating to professional liabilities and other litigation risks;
- delayed payments and repayments resulting from reviews of claims to Medicare and Medicaid for our services;
- impact of controls imposed by payers designed to reduce inpatient services;
- risks associated with outsourcing functions to third-parties;
- our relationships with our joint venture partners;
- changes in physician employment regulations;
- increases in the amount and risk of collectability of patient accounts receivable, particularly as the unemployment rate and number of underinsured and uninsured patients increases as a result of the COVID-19 pandemic;
- our need to make investments continually in our processes and information systems to protect the privacy of patients, employees and other persons and reduce the risk of successful cybersecurity attacks;
- damage to our reputation, regulatory penalties, legal claims and liability under state and federal laws that we could suffer upon any cybersecurity or privacy breaches;
- anticipated capital expenditures, including routine projects, investments in information systems and capital projects related to acquisitions, construction of new facilities and construction projects and the expectation that capital commitments could be a component of future acquisitions;
- effects of competition in a facility's market;
- changes in industry and general economic trends, including macroeconomic conditions negatively impacted by the COVID-19 pandemic;
- recruitment and retention of senior executives, providers and other healthcare employees;

- our ability to acquire facilities on favorable terms and successfully complete asset sales and divestitures;
- effects of union organizing activities;
- potential recoupment of previously recognized income from electronic health record ("***EHR***") incentive programs;
- timeframes for completion of capital projects;
- changes in depreciation and amortization expenses;
- costs of providing care to our patients, including increased equipment, staffing and supply expenses resulting from the COVID-19 pandemic;
- accounting estimates and the impact of accounting methodologies and new accounting pronouncements;
- changes in interpretations, assumptions and expectations regarding tax legislation, including provisions of the CARES Act, and additional guidance that may be issued by federal and state taxing authorities;
- consolidation of commercial insurance companies and patient shifts to lower cost healthcare plans, including association health plans and short-term limited duration health insurance plans, which generally provide lower payment for services provided;
- participation in the healthcare exchanges (the "***Exchanges***") and the impact of increasing enrollment by patients in insurance plans with narrow networks, tiered networks, high deductibles or high co-payments;
- governmental or third-party investigations, legal actions and voluntary self-disclosures relating to overpayments or other regulatory compliance matters;
- the ability of our local management teams to identify and meet the needs of our patients, medical staffs and their communities;
- the efforts of insurers, healthcare providers and others to contain healthcare costs;
- our ability to obtain adequate levels of general and professional liability insurance;
- our ability to implement initiatives promoting cost reductions and operational efficiencies;
- possible future indebtedness that may be incurred; and
- other factors referenced under the caption "Risk Factors" in this Report.

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

Statements in this Report are made as of the date hereof unless stated otherwise. New factors emerge from time to time, and it is not possible to predict all such factors.

EXPLANATORY INFORMATION REGARDING THIS REPORT

This Report has been prepared in accordance with the obligations of the Company under (i) Section 4.02 of the Indenture, dated as of December 4, 2020 (the "***5.375% Unsecured Notes Indenture***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 5.375% Senior Notes due 2029 (the "***5.375% Unsecured Notes***"), (ii) Section 4.02 of the Indenture, dated as of April 13, 2020 (as amended or supplemented from time to time, the "***6.75% Secured Notes Indenture***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee and notes collateral agent, relating to the Company's 6.750% Senior Secured Notes due 2025 (the "***6.75% Secured Notes***"), (iii) Section 4.02 of the Indenture, dated as of February 13, 2020 (as amended or supplemented from time to time, the "***4.375% Secured Notes Indenture***") among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee and notes collateral agent, relating to the Company's 4.375% Senior Secured Notes due 2027 (the "***4.375% Secured Notes***") and (iv) Section 4.02 of the Indenture, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***9.75% Unsecured Notes Indenture***" and, together with the 5.375% Unsecured Notes Indenture, the 6.75% Secured Notes Indenture and the 4.375% Secured Notes Indenture , the "***Indentures***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 9.750% Senior Notes due 2026 (the "***9.75% Unsecured Notes***" and, together with the 5.375% Unsecured Notes, 6.75% Secured Notes and the 4.375% Secured Notes, the "***Notes***"), (v) Section 5.04 of the Asset-Based Revolving Credit Agreement, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***ABL Agreement***"), among the Company, as Lead Borrower, DSB Acquisition, LLC, a Delaware limited liability company ("***Holdings***"), the lenders party thereto from time to time and Citibank, N.A., as administrative agent and collateral agent, and (vi) Section 5.04 of the First Lien Credit Agreement, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***Term Loan Agreement***" and, together with the ABL Agreement, the "***Credit Agreements***"), among the Company, as Lead Borrower, Holdings, the lenders party thereto and Citibank, N.A., as administrative agent and collateral agent. This Report has been prepared in all material respects in accordance with the rules and regulations of the Securities and Exchange Commission (the "***SEC***") applicable to an Annual Report on Form 10-K for the fiscal year ended December 31, 2020, except to the extent permitted to be excluded by the Indentures and the Credit Agreements.

USE OF NON-GAAP FINANCIAL INFORMATION

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

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

DOCUMENT SUMMARIES AND REQUESTS

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

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

FISCAL YEAR

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

OTHER ITEMS

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

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

References in this Report to the "***RegionalCare/Capella Merger***" refer to the merger, effective for accounting purposes on May 1, 2016, of a wholly-owned subsidiary of RegionalCare Hospital Partners Inc. ("***Regional Care***"), with and into Capella Health Holdings, LLC ("***Capella***"), with Capella surviving the RegionalCare/Capella Merger as a wholly-owned subsidiary of RegionalCare, which began to do business as RCCH HealthCare Partners.

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

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

PART I

Item 1. *Business.*

Our Company

We own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities through our subsidiaries. As of December 31, 2020, we operated 88 hospital campuses in 29 states throughout the U.S., having a total of 11,512 licensed beds. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a network of hospitals and outpatient facilities.

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

Our Business Strategy

The key elements of our business strategy include:

- *Commitment to the Delivery of Exceptional Quality Patient Care*. Providing high quality patient care is essential to our mission and will always be our top priority. We believe our quality efforts are central to creating places where people choose to come for care, physicians want to practice and employees want to work. Our National Quality Program provides a structured, evidence approach to enhancing quality and patient safety and is nationally renowned. Several factors contribute to providing high quality patient care, including leadership and accountability at all levels of our organization, aligning ourselves with talented physicians and medical staff who share our commitment to quality, and providing a clinical environment that is satisfactory to our patients, physicians and employees. We continually strive to improve physician and employee satisfaction, which we believe is critical to delivering quality patient care. We also partner with academic medical centers and regional health systems to better serve the needs of our communities. In addition, providing high quality patient care is increasingly vital to achieving our operating and financial success, including with governmental and commercial payers.

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

- *Develop Digital Health Capabilities to Engage our Communities with Seamless, Personalized, Quality Experiences Across the Healthcare Continuum*. We are committed to providing high quality care close to home and identifying innovative ways to make it easier for patients to access the care they need when and where they need it. We are working to optimize the patient health journey by partnering with digital health technology providers and connecting our patients and physicians with enhanced digital capabilities that increase access, improve engagement and satisfaction, and result in a more complete and seamless patient experience. Some of our digital health initiatives include on-demand telehealth services, artificial intelligence functionality, online scheduling for in-person and telehealth visits, virtual check-in and waiting room options, remote patient monitoring, next best action campaigns, and computational linguistics designed to identify at-risk patients.

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

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

- *Continue to Engage in Strategic Relationships with Local Partners.* We partner with several academic medical centers and regionally significant health systems to better serve our communities. We have established partnerships with Duke University Health System ("***Duke***"), Norton Healthcare, Inc. ("***Norton***"), LHC Group, Inc. ("***LHC***"), University of Washington Health, Billings Clinic and Emory Healthcare ("***Emory***").

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

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

Our Background

LifePoint/RCCH Merger

Summary

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

Equity Contribution

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

Financing Transactions

Concurrently with the closing of the LifePoint/RCCH Merger, we (1) issued the 9.75% Unsecured Notes, (2) entered into the ABL Agreement, which provides a senior secured asset-based revolving credit facility (the "***ABL Facility***") in an aggregate principal amount of $800.0 million with a maturity of five years, (3) terminated our existing senior secured asset-based revolving credit facility, which we entered into on April 29, 2016 (the "***Prior ABL Facility***"), (4) entered into the Term Loan Agreement, which provides a senior secured term loan credit facility (the "***Term Loan Facility***") in an aggregate principal amount of $3,550.0 million with a maturity of seven years, and (5) repaid in full our $150.0 million term loan facility, which we entered into on April 25, 2018 (the "***Prior Term Facility***").

Our Operations

Services

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

Impact of COVID-19

During March 2020, the global COVID-19 pandemic began to significantly affect our facilities, employees, patients, communities, business operations and financial performance, as well as the U.S. economy and financial markets, as a whole. Approximately one year into the pandemic, we continue to be deeply committed to protecting the health of our communities and are continuing to respond to the evolving COVID-19 situation across the country. Importantly, we are taking every precaution to ensure we can continue providing quality care and safeguard the health and well-being of patients, employees, providers, volunteers and visitors in each community we serve. The national footprint of our health system, along with our HSC, has enabled us to support our communities during this challenging time.

We established an internal COVID-19 taskforce during the early stages of the pandemic which continues to meet regularly today. Additionally, in November 2020, we established a COVID-19 vaccine team to help facilitate the successful distribution and administration of vaccines across our markets.

Our top priority continues to be ensuring the safety, health and well-being of those in our facilities and communities. We have put in place a number of protocols to protect our patients, providers, employees, volunteers and visitors, including:

- mandatory masking for all providers, employees, volunteers and visitors across our facilities;
- required eye protection for providers and employees during all clinical encounters across our facilities;
- required COVID-19 testing for all admissions in communities with the highest rates of COVID-19 spread;
- performing pre-operative COVID-19 testing for patients undergoing certain elective procedures; and
- social distancing practices and other protective measures throughout our facilities, including visitor restrictions, closing common areas, limiting entry points and screening providers, employees and visitors who enter our facilities based on criteria established by the Centers for Disease Control and Prevention (the "***CDC***").

Restrictive measures, such as travel bans, social distancing and quarantine guidelines, significantly reduced the volume of procedures performed at our facilities during 2020, as well as the volume of emergency room and physician office visits unrelated to COVID-19. Furthermore, broad economic factors resulting from the current COVID-19 pandemic, including increasing unemployment rates and reduced consumer spending, could negatively affect our payer mix, increase the relative proportion of lower margin services we provide and reduce patient volumes, as well as diminish our ability to collect outstanding receivables.

Our evaluation of the measures taken across our health system in response to COVID-19 is ongoing and additional updates to our policies, procedures and operations could occur as best practices continue to evolve. Furthermore, our facilities are located across a wide geographic range of communities, which may require us to modify measures we take at specific facilities based on local conditions, including the severity of COVID-19 in the community served by the facility and changes in state and local restrictive measures.

As a result of the adverse impact of the COVID-19 pandemic on our business, we have undertaken several additional measures intended to enhance our financial flexibility, including among other things:

- increasing our liquidity with proceeds from the offering of the 6.75% Secured Notes;
- instituting net working capital optimization initiatives along with the curtailment of non-critical capital expenditures;
- receiving Medicare accelerated payments under the Centers for Medicare and Medicaid Services *("**CMS**")* expanded Accelerated and Advance Payment Program;
- receiving direct grant aid payments from the Emergency Fund established under the CARES Act; and
- anticipating current year cash tax savings related to various tax provisions of the CARES Act.

Additionally, although we have received funds that are available to us and our facilities under the CARES Act and other stimulus legislation and may seek additional funds that may become available under existing or future stimulus legislation, we cannot predict the manner in which such funds will be allocated or administered and we cannot assure you that we will be able to access such funds in a timely manner or at all. Most of these programs require healthcare providers to meet certain requirements and/or otherwise agree to certain terms and conditions in order to receive payment. In many cases, only limited guidance has been provided on those requirements and terms and conditions, and we already have seen changes in the substance and interpretation of that guidance.

For additional information about the risks presented by the COVID-19 pandemic, our responses to the pandemic, and the resources available to healthcare providers, refer to "—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" below and "Part I, Item 1A. Risk Factors" and "Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Developments, Trends and Operating Environment—Impact of COVID-19" included in this Report.

Management and Oversight

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

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

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

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

Cost Management

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

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

Attracting Patients

We believe that the most important factors influencing a patient's choice in where to receive healthcare services are the quality of care delivered by the facility, the overall reputation of the facility, the availability and expertise of physicians and nurses, and the location and convenience of the facility. Other factors that affect utilization include local demographics and population growth, local economic conditions and the facility's success in contracting with a wide range of local payers.

Outpatient Services

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

Sources of Revenues

General

Our facilities generate revenues by providing healthcare services to our patients. Depending upon the patient's medical insurance coverage, we are paid for these services by governmental Medicare and Medicaid programs, commercial insurance, including health maintenance organizations ("***HMOs***"), preferred provider organizations ("***PPOs***") and plans offered through the Exchanges, private insurers, and directly by the patient. The amounts we are paid for providing healthcare services to our patients vary depending upon the payer. Governmental payers generally pay significantly less than the hospital's customary charges for the services provided. Insured patients are generally not responsible for any difference between customary hospital charges and the amounts received from commercial insurance payers. However, insured patients are responsible for payments not covered by insurance, such as exclusions, deductibles and co-payments.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the years ended December 31, 2020, 2019 and 2018 (dollars in millions):

	2020		2019		2018	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,134.0	38.6 %	$ 3,338.1	38.1 %	$ 1,105.3	39.8 %
Medicaid	1,392.4	17.1	1,495.3	17.1	486.3	17.5
HMOs, PPOs and other private insurers	3,381.9	41.6	3,698.6	42.3	1,113.8	40.1
Self-pay	54.5	0.7	59.2	0.7	17.2	0.6
Other	142.7	1.8	143.6	1.6	49.4	1.8
Revenue from contracts with customers	8,105.5	99.8	8,734.8	99.8	2,772.0	99.8
Rental income	16.4	0.2	18.0	0.2	6.1	0.2
Revenues	$ 8,121.9	100.0 %	$ 8,752.8	100.0 %	$ 2,778.1	100.0 %

Medicare

For the year ended December 31, 2020, approximately 38.6% of our revenues related to patients participating in Medicare programs. Medicare provides hospital and medical insurance benefits, regardless of income, to persons age 65 and over, some disabled persons and persons with end-stage renal or Lou Gehrig's disease. All of our hospitals are currently certified as providers of Medicare services.

Over the years, Congress and CMS have made several sweeping changes to the Medicare program and its reimbursement methodologies, including the numerous changes contained in the Affordable Care Act. Many of these changes have resulted in decreased reimbursement to healthcare providers. In addition, the Budget Control Act of 2011 ("***BCA***"), which is intended to reduce the federal deficit, imposed a 2% reduction in Medicare spending which began on April 1, 2013. Congress has extended the 2% reduction in Medicare spending on numerous occasions. Most recently, Congress adopted the CARES Act and the Consolidated Appropriations Act, 2021 (the "***CCA***"), which temporarily suspend Medicare sequestration from May 1, 2020 until March 31, 2021, but also extend the 2% reduction in Medicare spending through 2030. Additional reductions in Medicare reimbursement could result from changes to, or the repeal of, the Affordable Care Act, or as a result of the enactment of Medicare reform, deficit reduction or other legislation.

Medicare Inpatient Prospective Payment System

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

The base MS-DRG operating expense payment rate that is used by the Medicare program in the IPPS is adjusted by an update factor each federal fiscal year ("***FFY***"), which begin on October 1 (for example, FFY 2021 began on October 1, 2020). The index used to adjust the base MS-DRG payment rate, which is known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. For FFYs 2021, 2020, and 2019, the hospital market basket index increased 2.4%, 3.0%, and 2.9%, respectively. Generally, however, the percentage increase in the MS-DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the hospital market basket increase for FFY 2019 was reduced by CMS by 0.75%. As also mandated by the Affordable Care Act, the market basket increase is reduced by a productivity adjustment equal to the Bureau of Labor Statistics' 10-year moving average of changes in annual economy-wide productivity. For FFYs 2021, 2020, and 2019, the productivity adjustment equated to a 0.0%, 0.4%, and 0.8% reduction in the market basket increase, respectively. As a result of these reductions and other changes implemented by CMS, the MS-DRG-rate increased by 2.9% for FFY 2021.

On October 1, 2007, CMS replaced the previously existing 538 diagnosis related groups with 745 MS-DRGs. The MS-DRGs are intended to more accurately reflect the cost of providing inpatient services and eliminate any incentives that hospitals may have to only treat the healthiest and most profitable patients. The American Taxpayer Relief Act of 2012 ("***ATRA***") required CMS to recoup $11 billion from IPPS payments in FFYs 2014 through 2017 to offset an additional increase in aggregate payments to hospitals that Congress believes occurred from FFYs 2008 through 2013 solely as the result of the transition to the MS-DRG system. In FFYs 2014, 2015 and 2016, CMS applied negative 0.8% adjustments as part of the recovery process required by ATRA, and it applied a negative 1.5% adjustment in FFY 2017 to recover the remaining outstanding amount. CMS had previously indicated that the reductions required by ATRA would be fully restored in FFY 2018. However, under the Medicare Access and CHIP Reauthorization Act of 2015 ("***MACRA***"), those reductions were to be restored in 0.5% increments over a six-year period from FFYs 2018 through 2023, which would result in a cumulative 3.0% increase in rates, which would be less than the 3.9% reduction that was imposed by CMS in FFYs 2014 through 2017. In addition, some of that restoration has been subject to further limits, such as under the 21st Century Cures Act (the "***Cures Act***") which further reduced the restoration for FFY 2018 from 0.5% to 0.4588%.

CMS has implemented a number of programs and requirements that are intended to promote value-based purchasing and to link payments to quality and efficiency. For example, all acute care hospitals are required to participate in CMS' Hospital Inpatient Quality Reporting Program (the "***IQR Program***") in order to receive the full hospital market basket update. Hospitals that do not participate in the IQR Program receive a 25% reduction in their IPPS annual payment update for the applicable FFY. Our hospitals reported all quality measures required by CMS related to the IQR Program and nearly all will receive the full market basket update through FFY 2021. In addition, hospitals that are not meaningful EHR users are also subject to an additional 75% reduction of the hospital market basket increase.

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

Medicare also does not allow an inpatient hospital discharge to be assigned to a higher paying MS-DRG if certain designated hospital acquired conditions ("***HACs***") were not present on admission and the identified HAC is the only condition resulting in the assignment of the higher paying MS-DRG. In those situations, the case is paid as though the secondary diagnosis was not present. In addition, hospitals that fall into the top 25.0% of national risk-adjusted HAC rates for all hospitals in the previous year receive a 1.0% reduction in their total Medicare payments.

Furthermore, inpatient payments are reduced pursuant to the Affordable Care Act if a hospital experiences "excessive readmissions" within a 30-day period of discharge for certain conditions designated by CMS including heart attack, chronic obstructive pulmonary disease, heart failure, pneumonia, coronary artery bypass, and total hip arthroplasty. Hospitals with what HHS defines as "excessive readmissions" for these conditions will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Each hospital's performance is publicly reported by HHS. HHS has the discretion to determine what "excessive readmissions" means, the amount of the payment reduction and other terms and conditions of this program. The basic maximum payment reduction amount is 3.0%. The Cures Act does, however, allow for an adjustment factor that would reduce the penalties imposed on hospitals, based on the portion of beneficiaries the hospitals serve that are eligible for both Medicare and Medicaid.

Medicare Hospital Outpatient Prospective Payment System and Other Outpatient Services

CMS reimburses hospital outpatient services under the Medicare hospital outpatient prospective payment system ("***OPPS***"), and generally uses fee schedules to pay for durable medical equipment and physical, occupational and speech therapy, clinical diagnostic laboratory and independent diagnostic testing facility services. Under the OPPS, hospital outpatient services are classified into groups called ambulatory payment classifications ("***APCs***"). Services in each APC are clinically similar and are similar in terms of the resources they require. Depending on the services provided, a hospital may be paid for more than one APC for an encounter. CMS establishes a payment rate for each APC by multiplying the scaled relative weight for the APC by a conversion factor. The payment rate is further adjusted to reflect geographic wage differences. The APC conversion factors for calendar years ("***CYs***") 2021, 2020, and 2019 were $82.797, $80.793, and $79.490, respectively, after the inclusion of the productivity adjustments and other reductions that were required by the Affordable Care Act. APC classifications and payment rates are reviewed and adjusted on an annual basis, and, historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services. To receive the full increase, hospitals must satisfy the reporting requirements of the Hospital Outpatient Quality Reporting Program (the "***OQR Program***"). Hospitals that do not satisfy the reporting requirements of the OQR Program are subject to a reduction of 2.0% in their annual payment update under the OPPS. Our hospitals reported all quality measures required by CMS related to the OQR Program and will receive the full market basket update through CY 2021.

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

In December 2018, a lawsuit was filed challenging the portion of CMS' final rule that reduced reimbursement for clinic visit services provided at grandfathered PBDs to the lower Medicare PFS-equivalent payment rate. On September 17, 2019, the U.S. District Court for the District of Columbia ruled that the reduction in reimbursement for clinic services provided at grandfathered PBDs exceeded CMS' statutory authority. As a result of the ruling, CMS paid claims for clinic visit services provided at grandfathered PBDs in CY 2019 at the full OPPS payment rate. However, in the OPPS final rule for CY 2020, CMS noted that the court's ruling only applied to clinic visit services provided in CY 2019, and, as a result, CMS moved forward with the planning phase-in of the second year of the clinic visit service payment reduction in CY 2020 while it appealed the court's decision. A new lawsuit was filed on January 13, 2020, challenging the continued phase-in of the reduction for CY 2020. On July 17, 2020, the U.S. Court of Appeals for the District of Columbia reversed the lower court's ruling regarding the CY 2019 reductions and upheld CMS' reimbursement reductions for clinic visit services provided at grandfathered PBDs. The ruling of the U.S. Court of Appeals for the District of Columbia has been appealed to the U.S. Supreme Court. However, we cannot predict whether the U.S. Supreme Court will agree to hear the appeal and, if so, whether the appeal will be successful. CMS has stated that it will reprocess claims for outpatient clinic visit services that were provided at grandfathered PBDs in CY 2019 at the lower Medicare PFS-equivalent payment rate. CMS has indicated that it expects the reprocessing of the affected claims to be completed by July 1, 2021.

In addition to those reimbursement reductions and in furtherance of its efforts to increase site neutrality in Medicare payments, CMS announced in the OPPS final rule for CY 2021 that it would eliminate the Medicare program's inpatient only procedure list over a three-year period, beginning with the removal of approximately 300 primarily musculoskeletal-related procedures, with the list being completely phased out by CY 2024. The elimination of the inpatient only procedure list will make those procedures eligible to be paid by Medicare in the hospital outpatient setting when outpatient care is appropriate, as well as maintain the ability of Medicare to pay for these services in the hospital inpatient setting when inpatient care is appropriate, as determined by the patient's physician.

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

In September 2018, a lawsuit was filed challenging the authority of CMS to make the 340B Program payment reductions set forth in the OPPS final rule for CY 2018. On December 27, 2018, the U.S. District Court for the District of Columbia held that the payment reductions exceeded CMS' statutory authority and entered a permanent injunction against the reductions. However, because the 340B Program payment reductions were made in a budget-neutral manner and the savings derived from the reductions were used to increase reimbursement for all of the other items and services provided under the OPPS, the court ordered the parties to submit briefs as to how the issue should be remedied. The lawsuit was subsequently expanded to include the 340B Program payment reductions that were made in CY 2019, and an additional lawsuit has been filed against the 340B Program payment reductions being made by CMS in CY 2020. CMS appealed the District Court's rulings, and, on July 31, 2020, the U.S. Court of Appeals for the District of Columbia reversed the lower court's ruling and upheld CMS' 340B Program payment reductions. The ruling of the U.S. Court of Appeals for the District of Columbia has been appealed to the U.S. Supreme Court, and we cannot predict whether the appeal will be successful or whether CMS will continue the 340B Program payment reductions under the new Presidential administration. If OPPS payments to hospitals are reduced (either retroactively or prospectively) in connection with the 340B Program, we would be materially adversely affected.

Medicare Disproportionate Share Hospital Payments

Hospitals may also qualify for Medicare disproportionate share hospital ("***DSH***") payments, if they treat a high percentage of low-income patients (as determined by a ratio involving Medicare and Medicaid patients eligible to receive Supplemental Security Income). DSH payments are determined annually based on certain statistical information specified by HHS and are paid as an addition to MS-DRG payments. The Affordable Care Act requires Medicare DSH payments to providers to be reduced by 75% beginning in FFY 2014, subject to adjustment if the Affordable Care Act does not decrease uncompensated care to the extent anticipated. The amount that is withheld is reduced by the percentage change in uninsured individuals under the age of 65, and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period. The IPPS final rule for FFY 2021 established the uncompensated care amount which will be distributed to qualifying hospitals in FFY 2021 at approximately $8.3 billion, a decrease of approximately $60 million from FFY 2020.

Medicare Dependent and Low Volume Hospital Programs

On April 16, 2015, MACRA was enacted. Among other things, MACRA extended the Medicare dependent hospital program, which provides enhanced payment support for rural hospitals that have no more than 100 beds and at least 60% of their inpatient days or discharges covered by Medicare, and the Medicare low volume hospital program, which provides additional Medicare reimbursement for general acute care hospitals that are located a certain distance from another general acute care hospital and have less than a certain number of Medicare discharges each fiscal year, through September 30, 2017. The Bipartisan Budget Act of 2018 extended both of these programs through FFY 2022.

Cost Reports

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

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

Medicare Bad Debt Reimbursement

Under Medicare, the costs attributable to the deductible and coinsurance amounts that remain unpaid by Medicare beneficiaries after reasonable collection efforts can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by the Medicare administrative contractor ("***MAC***") from prior cost report filings.

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

Medicare Physician Fee Schedule

Professional medical services provided to Medicare beneficiaries by physicians and certain other healthcare practitioners, including physician assistants and nurse practitioners, are reimbursed under the PFS. Under the PFS, CMS has assigned a national relative value unit ("***RVU***") to most medical procedures and services that reflects the various resources required by a physician or practitioner 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 and the practice overhead and malpractice insurance expenses that are attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs and are then aggregated. The aggregated amount is multiplied by a conversion factor to determine the payment rate for the service. The conversion factor is updated by CMS on an annual basis.

MACRA, which was adopted in 2015, significantly changed how CMS determines the annual updates to the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased annually by an additional 0.5% for CYs 2016, 2017 and 2018 and, after the adoption of the Bipartisan Budget Act of 2018, were increased by 0.25% for CY 2019. PFS payment rates are scheduled to remain at their CY 2019 levels through CY 2025. To account for changes that have been made to the RVUs associated with certain procedures and services, particularly those associated with evaluation and management visits, the final PFS rule for CY 2021 reduced the PFS conversion factor to $32.41, an approximate reduction of 10.2%, in order to maintain budget neutrality as required by law. However, the CCA temporarily increases PFS payment rates by 3.75% (approximately $3 billion) for CY 2021 and partially offsets the reduction.

In addition to revising the methodology that is used to update payments that are made under the PFS, MACRA also established a Quality Payment Program ("***QPP***") for incentivizing physician and practitioner care that meets certain value, quality, cost, and performance criteria. Beginning in CY 2019, amounts paid to physicians and practitioners under the PFS are subject to adjustment through the QPP and participation in either the Merit-Based Incentive Payment System ("***MIPS***") or an Advanced Alternative Payment Model ("***APM***") program. Physicians and practitioners who participate in the MIPS program, which essentially consolidated the prior Physician Quality Reporting System, the Value-Based Modifier, and the Meaningful Use of EHR incentive programs, are subject to positive, zero, or negative performance adjustments depending on how the physician's or practitioner's performance compared to a performance threshold. The payment adjustments are based on the physician's or practitioner's performance in the year that is two years prior to the current payment period. As a result, PFS payments in CY 2021 will be based on CY 2019 performance scores, and so on for the following years. HHS and CMS revise the MIPS reporting measures on an annual basis and have indicated that they intend to routinely increase the performance thresholds in connection with those revisions. In addition, from CY 2019 through CY 2024, MACRA provides $500 million per year for an additional performance adjustment for physicians and practitioners who participate in MIPS and achieve exceptional performance. Physicians and practitioners who participate in a specified APM program, which, among other things, requires the physician or practitioner to receive a substantial amount of their revenue from an APM, will receive, from CYs 2019 through 2024, a lump-sum payment equal to 5% of their Medicare payments in the prior year for services paid under the PFS. Beginning in CY 2026, PFS payment rates for physicians and practitioners participating in an APM program would be increased by 0.75% a year. Payments for other physicians and practitioners would be increased by 0.25% per year.

Medicaid

For the year ended December 31, 2020, approximately 17.1% of our revenues related to patients participating in the various state Medicaid programs. Included in these payments are DSH and other supplemental payments received under various state Medicaid programs. Medicaid programs are funded by both the federal government and states to provide healthcare benefits to limited categories of low-income individuals under 65 years of age. These programs and the reimbursement methodologies are administered by the states under approved plans and vary from state to state and from year to year. Amounts received under the Medicaid programs are often significantly less than the hospital's customary charges for the services provided. Most state Medicaid payments are made under a prospective payment system, fee schedule, cost reimbursement program, or some combination of these three methods. All of our hospitals are currently certified to participate in their respective state Medicaid programs.

As enacted, the Affordable Care Act essentially required states to expand Medicaid coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level ("***FPL***"). However, that portion of the Affordable Care Act was held to be unconstitutional by the U.S. Supreme Court, and, as a result, states may opt out of the expansion without losing their existing Medicaid funding. Therefore, the income level required for individuals to qualify for Medicaid varies widely from state to state. To offset the cost of the Medicaid program's expansion, the Affordable Care Act authorized the federal government to provide states with "matching funds" (referred to as "***Enhanced FMAP***") to cover the costs of covering the newly eligible individuals. The Enhanced FMAP was 100% for CYs 2014 through 2016; 95% in CY 2017; 94% in CY 2018; 93% in CY 2019; and will be 90% in CYs 2020 and thereafter.

In recent years, we have benefited from the expansion of Medicaid under the Affordable Care Act, and effective as of January 1, 2020, Idaho and Utah, two additional states in which we operate, expanded their Medicaid programs. In addition, Oklahoma, an additional state in which we operate, is expected to expand its Medicaid program in 2021. However, a number of states in which we operate have not expanded their Medicaid programs or are seeking waivers that could reduce their Medicaid-eligible populations. Several states have adopted or are considering legislation designed to reduce or control their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs, and imposing additional taxes on hospitals to help finance such states' Medicaid systems. Given the reductions in the Enhanced FMAP and in light of the ongoing litigation regarding the constitutionality of, and potential further modification to, the Affordable Care Act, we are unable to predict how many, if any, additional states in which we operate will expand their Medicaid programs or how many, if any, of the states in which we operate that have expanded their Medicaid programs will keep their expansions in place in the future.

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

Work Requirements

In addition to implementing value-based purchasing and quality-driven reimbursement requirements, CMS has also issued new guidance permitting states to impose work and/or community engagement requirements on certain Medicaid beneficiaries. In response to the guidance, a number of states, including several in which the Company has facilities, have requested demonstration waivers from CMS that would allow those states to impose work requirements on their Medicaid beneficiaries. CMS has approved the requests that have been made by Arizona, Arkansas, Georgia, Indiana, Michigan, Ohio, South Carolina, Utah and Wisconsin, and the remaining requests are still pending. However, a number of lawsuits have been filed challenging the authority of CMS to allow state Medicaid programs to impose work and/or community engagement requirements on their respective beneficiaries and, as a result, most of the demonstration waivers that have been approved by CMS have not yet been implemented. We cannot predict whether CMS will grant additional waivers that allow for the imposition of work and community engagement requirements on Medicaid beneficiaries or the impact that any such waivers will have on coverage for patients seeking care at our facilities. We also cannot predict whether the legal challenges that have been initiated against the demonstration waivers that have been approved by CMS will be successful or whether any legal challenges will be initiated against any other similar demonstration waivers that have been or may be granted by CMS in the future.

Medicaid Block Grants and Capped Federal Funding

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

On November 11, 2019, Tennessee, one of the states in which we operate, submitted an amendment to CMS for its Medicaid demonstration waiver that would convert federal funding for the Tennessee Medicaid program to a modified block grant program. CMS approved the amendment on January 8, 2021, and as required by state law, the Tennessee General Assembly approved the implementation of the amendment on January 15, 2021. Under the amendment, the Tennessee Medicaid program would receive federal matching funds for expenditures up to an aggregate annual cap. The aggregate cap would be based on the Tennessee Medicaid program's historical expenditures and would be increased to reflect a reasonable growth rate over time and for unexpected increases in enrollment. In exchange, the Tennessee Medicaid program would be given increased flexibility in how it operates and would be entitled to 55% of any savings that are achieved if spending is below the aggregate cap and the state meets certain quality targets. Any savings would generally be required to be re-invested in the Tennessee Medicaid or other health related programs. Despite being granted increased administrative flexibility, the Tennessee Medicaid program would be required to maintain the coverage and benefit levels that were in place as of December 31, 2020. We cannot predict whether the new Presidential administration will attempt to rescind CMS' approval of the amendment to the Tennessee Medicaid program, whether litigation will be filed against the conversion of federal funding for the Tennessee Medicaid program to a modified block grant program, whether the changes authorized by the amendment to the Tennessee Medicaid program will ever become effective, and, if so, the impact those changes will have on our operations and revenues.

Medicaid Supplemental Payments

Medicaid supplemental payments ("***MSPs***") are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and Upper Payment Limit ("***UPL***") payments.

Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating those patients. 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. However, the total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law.

Pursuant to the Affordable Care Act, as amended by subsequent legislation, funding for Medicaid DSH programs was to be reduced by $4 billion in FFY 2020 and $8 billion per year from FFY 2021 through FFY 2025. Congress has delayed the reduction in funding for Medicaid DSH programs on a number of occasions, most recently through the CCA, which eliminates the scheduled Medicaid DSH reductions for FFYs 2021 through 2023 but adds additional Medicaid DSH reductions for FFYs 2026 and 2027. We cannot predict whether Congress will further delay or otherwise modify the reductions in the future. Because many of the states in which we operate have not expanded Medicaid programs as intended under the Affordable Care Act, the reduction in Medicaid DSH payments may take place without a coupled increase in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars. UPL programs have expanded in recent years, and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs.

On November 18, 2019, CMS released a proposed rule, the Medicaid Fiscal Accountability Rule, that was intended to increase federal oversight of MSPs and state Medicaid financing policies. Among other things, the proposed rule would have added new reporting requirements on UPL payment arrangements, imposed limitations on UPL payments that are made to physicians and certain other practitioners, and imposed limits on the use of healthcare provider taxes, intergovernmental transfers and certified public expenditures. CMS withdrew the proposed rule in 2020. However, some of the reporting requirements contained in the Medicaid Fiscal Accountability Rule were included in the CCA, and, beginning in FFY 2022, each state will be required to provide CMS with, among other things, (i) a description of the stated purpose and intended effects of the state's MSPs, (ii) an explanation of how the state's MSPs will result in payments that are consistent with the requirements of the Medicaid program, including the program's standards with respect to efficiency, economy, quality of care, and access, (iii) the criteria used to determine provider eligibility for the state's MSPs, (iv) a comprehensive description of the methodology used to calculate the amount of, and distribute, MSPs to each eligible provider, and (v) an assurance that the total Medicaid payments made by the state to inpatient hospital providers, including any MSPs, will not exceed the UPL. The CCA also further clarifies how third-party payments are to be considered when determining Medicaid DSH hospital-specific limits. We cannot predict the impact, if any, that the reporting requirements and other Medicaid provisions in the CCA will have on MSPs and UPL payments that are made by state Medicaid programs or whether Congress or CMS will adopt any additional legislation or regulations that will eliminate or otherwise limit MSPs and/or UPL payments. In addition, we cannot predict whether MSP programs will continue (and, if continued, whether we will qualify for such programs) or guarantee that revenues recognized from these programs will not decrease.

Budget cuts, federal or state legislation, or other changes in the administration or interpretation of government health programs by government agencies or contracted managed care organizations could have a material adverse effect on our financial position and results of operations.

Recovery Audit and Other Review Contractors

Recovery audit contractors ("***RACs***") are used by CMS and state agencies to detect Medicare and Medicaid overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare and Medicaid claims filed by healthcare providers. RACs perform post-discharge audits of medical records to identify overpayments resulting from incorrect payment amounts, non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services and are paid on a contingency basis. Any claims identified as overpayments are subject to a RAC program appeals process. In 2016, in connection with the procurement of the new recovery audit contracts, CMS made a number of enhancements to the RAC program, including the establishment of a RAC program Provider Relations Coordinator, requiring RACs to maintain an overturn rate of less than 10% at the first level of appeal, requiring RACs to maintain an accuracy rate of at least 95%, and establishing additional documentation request limits based on a provider's compliance with Medicare rules, that are intended to address provider and other stakeholder concerns. CMS has also limited the number of claims that RACs may audit by limiting the number of records that RACs may request from hospitals based on each hospital's claim denial rate for the previous year.

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

Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs are accurate, many of our hospitals have had Medicare claims audited by the RAC program. While our hospitals have successfully appealed many of the adverse determinations raised by Medicare RAC audits, we cannot predict if this trend will continue or the results of any future audits. We cannot predict the volume or outcome of any future audits conducted by the various RACs and other review programs to which our hospitals will be subject.

Utilization and Claim Review

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

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

HMOs, PPOs and Other Private Insurers

In addition to government programs, our facilities are reimbursed by differing types of private payers including HMOs, PPOs and other private insurers. Also included in this category are the patient responsibility portions for co-payment and deductible obligations under these programs. Our revenues from HMOs, PPOs and other private insurers were approximately 41.6% of our revenues for the year ended December 31, 2020. Revenues from HMOs, PPOs and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services or accept fixed, pre-determined fees for our services. These discounted contractual arrangements often limit our ability to increase charges or revenues in response to increasing costs. We actively negotiate with these payers in an effort to maintain or increase the pricing of our healthcare services. However, we have no control over patients switching their healthcare coverage to a payer with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. Additionally, plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices. If we provide services when we are not a participating provider in the network, it can result in higher patient responsibility amounts that a patient may not have the ability to pay or may choose not to pay. We expect these trends to continue in the coming years.

Self-Pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Our revenues from self-pay patients were approximately 0.7% of our revenues for the year ended December 31, 2020. Beginning in 2014, our self-pay revenues began to decrease as a percentage of overall revenues due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities experienced in prior years, which included increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. We cannot predict how administrative or judicial interpretations, legislative actions or any other modifications to the Affordable Care Act that may be implemented or adopted, such as the cessation of cost sharing reduction payments or the repeal of the individual mandate, may impact our self-pay revenues. We also cannot predict whether the business closures and layoffs that are occurring as a result of the COVID-19 pandemic will increase the number of underinsured and uninsured patients that seek treatment at our facilities.

In addition, effective January 1, 2022, the No Surprises Act requires health care providers, including hospitals and other health care facilities, to provide uninsured patients with a good faith estimate of the provider's total expected charges for scheduled items or services, including any expected ancillary services, before providing the items or services to the patient. Uninsured patients will be able to utilize a patient-provider dispute resolution process to challenge the provider's charges if they receive a bill that is substantially higher than the good faith estimate that was provided by the health care provider. We cannot predict how the uninsured patient good faith estimate and dispute resolution provisions of the No Surprises Act will impact the amounts collected by the Company's facilities for self-pay patients.

Surprise Medical Billing

On December 21, 2020, Congress adopted legislation that is intended to limit the "surprise" medical bills that are often received by individuals receiving emergency and certain other services (such as anesthesia services) from out-of-network providers. Effective as of January 1, 2022, the No Surprises Act prohibits out-of-network providers from balance billing patients for (i) emergency care services that are provided by out-of-network facilities or at in-network facilities by out-of-network providers and (ii) transportation and related services that are provided by out-of-network air ambulance providers. The No Surprises Act also generally prohibits out-of-network providers from billing patients for non-emergency medical treatment unless the provider first notifies the patient of the provider's network status and estimated charges and the patient agrees to be financially liable for the additional amounts. Violations of the No Surprises Act are punishable by civil monetary penalties of up to $10,000, and the No Surprises Act may be enforced by both the state and federal governments.

When the prohibitions of the No Surprises Act apply, a patient's financial liability will generally be limited to his or her in-network amount, which will be determined in accordance with a process that will be set forth in regulations that are required to be promulgated by the Secretary of HHS prior to the effective date of the legislation. In addition, the patient's third-party payer must either pay the out-of-network provider an initial payment amount or issue a notice of denial to the provider for the services that were rendered within 30 days of the payer's receipt of the provider's claim. If the provider is not satisfied with the payer's initial payment amount, the provider and the payer will begin a 30-day negotiation period. If the provider and the payer cannot agree on a payment amount during the negotiation period, the parties may elect to initiate an independent dispute resolution ("***IDR***") process. The IDR process will be conducted by a neutral arbitrator that has been approved by the federal government. As part of the IDR process, the provider and the payer will each submit a final payment offer for consideration by the arbitrator. The arbitrator may consider any relevant information regarding the claim, including the acuity of the patient and the training and experience of the provider. However, the arbitrator may not consider the provider's billed charges or the reimbursement rates paid by Medicare, Medicaid or any other government healthcare program. The arbitrator will be required to pick one of the two offers (i.e., the arbitrator will not be allowed to split the difference between the amounts that have been proposed by the payer and the provider or otherwise determine a different payment amount), and the losing party will be responsible for the costs of the arbitration.

We cannot predict how the No Surprises Act will be implemented by HHS or how it will ultimately be enforced by the federal and various state governments. We also cannot predict the amounts that will be received by our facilities and our employed providers for out-of-network services, whether the No Surprises Act will impact the in-network payment rates that are offered by third-party payers and the willingness of those payers to enter into participation agreements with us and our facilities in the future, or the costs we will incur in complying with the requirements of the No Surprises Act. In addition, a number of states are considering or have already adopted legislation to eliminate surprise medical billing. We cannot predict how state legislative actions to modify or pass these proposals may be implemented or adopted, or what impact, if any, those actions may have on our operations and revenues.

Price Transparency

Transparency in healthcare pricing has become a focal point for CMS, Congress, and many state legislatures. For example, effective as of January 1, 2021, hospitals generally are required to post their standard charges prominently on a publicly available website. Under CMS regulations, each hospital's standard charges must be posted in two ways: (1) a single machine-readable digital file containing the gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for all items and services provided by the hospital and (2) a public display in a consumer-friendly manner of cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for at least 300 "shoppable" services (70 CMS-specified and 230 hospital-selected). CMS has stated that it intends to audit and monitor hospital compliance with its reporting requirements and to take actions to address hospital noncompliance, including issuing a warning notice, requesting a corrective action plan, and imposing civil monetary penalties. In addition to the CMS hospital price transparency regulations, HHS and the Departments of the Treasury and Labor have issued regulations that require most private health plans, including group health plans and individual health insurance market plans, to disclose pricing and cost-sharing information to their beneficiaries. A number of states have also adopted their own healthcare price transparency and/or disclosure statutes.

In addition to addressing surprise billing, the No Surprises Act contains a number of provisions that are intended to promote provider and health plan price transparency. Among other things, effective as of January 1, 2022, under the No Surprises Act, healthcare providers will be required to provide "good faith estimates" of their total expected charges for scheduled items and services to the patient's health plan if the patient is insured prior to the item and/or service being provided. Health plans will be required to provide patients with an "advanced explanation of benefits" that includes: (1) information regarding the network status of the provider, (2) a copy of the provider's "good faith estimate," (3) an estimate of the amount that the patient will be expected to pay for the item or service, and (4) information on any applicable pre-authorization requirements. The Secretary of HHS is required to adopt regulations to implement the price transparency provisions of the No Surprises Act.

Although we continue to evaluate, and are taking proactive steps in response to, the legislative and regulatory developments regarding price transparency, we cannot predict how existing regulations will be implemented or interpreted or whether any other requirements will be imposed on providers and health plans. We also cannot predict what affect the public disclosure of hospitals' or insurance providers' negotiated rates will have on our future negotiations with payers or the effect that the disclosure of pricing information by healthcare providers and health plans will have on our patient volumes and revenues.

Healthcare Reform

The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare by, among other things, requiring most Americans to obtain health insurance, also referred to as the "individual mandate," providing additional funding for Medicaid in states that choose to expand their programs, reducing IPPS, OPPS and Medicare and Medicaid DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and instituting certain private health insurance reforms. The Affordable Care Act has, however, been subject to a number of legislative and regulatory changes and court challenges, and its future is uncertain.

For example, during his term, President Trump issued various executive orders that were designed to delay or alter the implementation of various provisions of the Affordable Care Act. While President Biden has stated that he will take executive actions to increase the number of individuals covered under the Affordable Care Act, such as by opening a special enrollment period, we cannot predict the impact that the change in Presidential administrations may have on how the Affordable Care Act is interpreted and/or implemented in the future. In addition, a number of bills have been introduced in Congress that would repeal the Affordable Care Act and would replace it with varying health coverage plans, including plans that would allow insurers to sell health insurance across state lines, allow the use of health savings accounts ("***HSAs***") without a high-deductible plan, or give states the option to either keep the coverage framework created by the Affordable Care Act (e.g., expanded Medicaid, individual subsidies, and insurance exchanges) or utilize the increased federal funding that was intended for Medicaid expansion to be provided by the federal government under the Affordable Care Act to create HSAs that can be used by low-income individuals to purchase health insurance.

In addition to the administrative actions and legislative efforts to repeal, replace or modify the Affordable Care Act, there have been and may continue to be a number of legal challenges to various provisions of the Affordable Care Act and the regulations that have been promulgated thereunder. For example, in 2018, a number of states filed a lawsuit against the federal government alleging that, in light of the repeal of the penalties associated with the individual mandate, the entire Affordable Care Act was unconstitutional. On December 14, 2018, the U.S. District Court for the Northern District of Texas ruled in favor of those states and held that the Affordable Care Act was unconstitutional. The Court did not, however, issue an injunction against the continued enforcement of the Affordable Care Act. On appeal, the U.S. Fifth Circuit Court of Appeals held that the individual mandate was unconstitutional, but it remanded the case back to the U.S. District Court for the Northern District of Texas for further analysis as to whether the entire Affordable Care Act should be held to be unlawful. The case was appealed to the U.S. Supreme Court, which heard oral arguments on the matter in November 2020 and is expected to issue its ruling on the case in the spring or summer of 2021.

We cannot predict the outcome or impact of any legislative efforts to repeal, replace, or materially modify the Affordable Care Act or the litigation that has been filed in relation to the Affordable Care Act, including its constitutionality. Additionally, we also cannot predict the impact that the new Presidential administration and Congressional leadership will have on the implementation and enforcement of the provisions of the Affordable Care Act, on any current, pending or potential regulations adopted to implement the law, or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

Expanded Coverage

Based on original Congressional Budget Office ("***CBO***") and CMS estimates, by 2020, the Affordable Care Act was originally expected to expand coverage to 32 to 34 million people, resulting in coverage of an estimated 95% of the legal U.S. population and an uninsured population of approximately 27 million individuals. This increased coverage was expected to occur through a combination of public program expansion and private sector health insurance and other reforms. However, in September 2020, the CBO estimated that, due to a number of factors, between 31 and 32 million people were uninsured in 2020 and that the number of uninsured individuals would remain relatively consistent through 2030.

Public program expansion has been driven primarily by expanding the categories of individuals who are eligible for Medicaid coverage and allowing individuals with relatively higher incomes to qualify for Medicaid coverage. When the Affordable Care Act was adopted, it essentially made the expansion of the Medicaid program mandatory. However, in 2012, the U.S. Supreme Court held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that chose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. Based on the U.S. Supreme Court's ruling, a number of states, including several in which the Company has facilities, have opted not to expand their Medicaid programs. Additional public program expansion has occurred through provisions of the Affordable Care Act that authorize the federal government to subsidize states that create non-Medicaid plans for residents whose incomes are greater than 133% of the FPL but do not exceed 200% of the FPL and allow Medicaid participating hospitals to make presumptive determinations of Medicaid eligibility for certain categories of individuals, such as pregnant women, infants, children, and parents and other caretaker relatives and their spouses. If an individual is found to be presumptively eligible for Medicaid benefits, the hospital will get paid for the services it provides during the temporary presumptive eligibility period, just as though the patient were already enrolled in the Medicaid program.

The expansion of health coverage through the private sector as a result of the Affordable Care Act has occurred through new requirements on health insurers, employers and individuals. For example, commencing January 1, 2014, health insurance companies were prohibited from imposing annual coverage limits, excluding persons based upon pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. In addition, since January 1, 2011, each health plan has been required to keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual markets or rebate its enrollees the amount spent in excess of the percentage. Also, since September 23, 2010, health insurers have not been permitted to deny coverage to children based upon a pre-existing condition and must allow dependent care coverage for children up to 26 years old. Larger employers are subject to new requirements and incentives to provide health insurance benefits to their full-time employees, and, effective January 1, 2016, all employers subject to the requirement were required to offer health insurance coverage to 95% of their full-time employees and their dependents in order to avoid penalties.

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

Public Program Spending

The Affordable Care Act provides for a number of Medicare, Medicaid and other federal healthcare program spending reductions. The CBO previously estimated that between 2013 and 2023, these program spending reductions would include $415 billion in Medicare fee-for-service market basket and productivity reimbursement reductions for all providers, the majority of which ($260 billion) would come from hospitals. The CBO's estimate also included an additional $56 billion in reductions of Medicare and Medicaid DSH funding. CMS had originally estimated that the Affordable Care Act would result in $64 billion in reductions of Medicare and Medicaid DSH funding, with $50 billion of the reductions coming from Medicare. Some of those reductions, most notably the Medicaid DSH funding reductions, have been delayed by subsequent legislation, and we cannot predict whether the public program spending reductions required by the Affordable Care Act will be further delayed or modified in the future.

Accountable Care Organizations

The Affordable Care Act requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("***ACOs***"). ACOs are groups of hospitals, physicians and other designated professionals and suppliers who come together voluntarily to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS are eligible to share in a portion of the amounts saved by the Medicare program. There are several types of ACO programs, and as of January 1, 2021, 477 ACOs had been established to participate in the Medicare Shared Savings Program, and additional ACOs are being established by private payers. A few of our facilities currently participate in ACOs.

Bundled Payment Pilot Programs

The Affordable Care Act created the Center for Medicare & Medicaid Innovation ("***CMMI***") and made it responsible for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for healthcare that create savings under the Medicare and Medicaid programs while improving quality of care. Under these projects and initiatives, participating providers agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care and accept accountability for costs and the quality of care that is provided. By financially rewarding providers for quality, cost-effective care and penalizing providers when costs exceed a certain amount, these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. In connection with these programs, CMMI has developed a voluntary Bundled Payment for Care Improvement Advanced Model ("***BPCI Advanced***") to test innovative payment and service delivery models that have the potential to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care for beneficiaries. Participation in bundled payments programs is generally voluntary, but CMS does currently require hospitals in certain geographic areas to participate in the Comprehensive Care for Joint Replacement model, which covers certain extremity joint replacement procedures and is scheduled to end in 2021. CMS has developed a radiation oncology bundled payment program that could become effective as soon as January 1, 2022, and CMS has indicated that it expects to develop additional voluntary and mandatory bundled payment models in the future. Several of our facilities currently participate in bundled payment programs.

Specialty Hospital Limitations

Over the last decade, we have faced competition from hospitals that have physician ownership. The Affordable Care Act prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. While the Affordable Care Act grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand. As of December 31, 2020, we operated four hospitals through joint ventures with physicians in which we own a controlling interest.

Impact of the Affordable Care Act on the Company

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

- the elimination of the penalties associated with the individual mandate;
- the cessation of cost sharing reduction payments to insurers;
- the outcome of continuing litigation relating to the constitutionality of the Affordable Care Act or the possibility that the Affordable Care Act will be further modified by Congress;
- how many previously uninsured individuals will ultimately obtain coverage as a result of the Affordable Care Act;
- what percentage of the future newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states impose work and community engagement and/or premium requirements on their Medicaid beneficiaries;
- the number of states that ultimately elect to expand their Medicaid programs and when that expansion occurs;
- whether any states that have expanded their Medicaid programs will scale back such expansion through the imposition of work or premium requirements or otherwise as the Enhanced FMAP is reduced;
- the extent to which states will enroll any new Medicaid participants in managed care programs;
- the rates charged by private payers for insurance purchased on the Exchanges;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the future rates paid to hospitals by private payers for newly covered individuals under different plans, including those covered through the Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- increasing self-pay amounts as a result of individuals in the Exchanges who select high deductible plans and risks presented by their ability to pay such deductibles;
- whether or not private insurers will participate in the Exchanges, and whether such participation is through the use of narrow networks that restrict the number of participating providers or tiered networks that impose significantly higher cost sharing obligations on patients that obtain services from providers in a disfavored tier; and
- whether the net effect of the Affordable Care Act, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business.

Additionally, since approximately 55.7% of our revenues in 2020 were related to patients participating in Medicare and Medicaid programs, collectively, the reductions in Medicare and Medicaid reimbursement and in the growth of spending by the Medicare and Medicaid programs that are contemplated by the Affordable Care Act will significantly impact us and could offset any positive effects of the Affordable Care Act. It is difficult to predict with great precision the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

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

Because of the many variables involved, we are unable to predict the future effect on the Company of the expected increases or decreases in insured individuals using our facilities, the reductions in Medicare spending and reductions in Medicare and Medicaid DSH funding, and numerous other provisions in the Affordable Care Act that may affect us. Additionally, it is unclear how many states will ultimately implement the Medicaid expansion, whether the Medicaid program will be reformed, or whether the Affordable Care Act will be further modified or found to be unconstitutional. Due to these factors, we are unable to predict with any reasonable certainty or otherwise quantify the future impact of the Affordable Care Act on our business model, financial condition or result of operations.

Competition for Patients

Our hospitals and other healthcare businesses operate in extremely competitive environments. Competition among healthcare providers occurs primarily at the local level. Accordingly, each facility develops its own strategies to address competition locally. A hospital's position within the geographic area in which it operates is affected by a number of competitive factors, including, but not limited to:

- the scope, breadth and quality of services a hospital offers to its patients and physicians;
- whether new, competitive services are subject to certificate of need or other restrictions;
- the number, quality and specialties of the physicians who admit and refer patients to the hospital;
- the nurses and other healthcare professionals employed by the hospital or on the hospital's staff;
- the hospital's reputation;
- its managed care contracting relationships;
- its location and the location and number of competitive facilities and other healthcare alternatives;
- the physical condition of its buildings and improvements;
- the quality, age and state-of-the-art of its medical equipment;
- its parking or proximity to public transportation;
- the length of time it has been a part of the community;
- the relative convenience of the manner in which care is provided (for example, whether services are available on an outpatient basis and whether services can be obtained quickly);
- the choices made by the physicians on the medical staff of the hospital; and
- the charges for its services.

In addition, tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, exemptions from sales, property and income taxes, and participation in the 340B Program. In certain states, some not-for-profit hospitals are permitted by law to directly employ physicians while for-profit hospitals are prohibited from doing so.

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

Human Capital Resources

Overview

At December 31, 2020, our subsidiaries collectively had approximately 52,000 employees, including approximately 12,000 part-time employees. The majority of these employees are hospital-based, including nursing staff, physical and occupational therapists, laboratory and radiology technicians, pharmacy staff, facility maintenance workers and the administrative staffs of our facilities. We understand that, to fulfill our mission of Making Communities Healthier®, we must create places where people choose to come for healthcare, physicians want to practice, and employees want to work. To support this mission, talent development has been a longstanding strategic pillar for the organization.

Diversity, Equity and Inclusion

We are committed to creating an inclusive, community-based healthcare delivery system that provides equitable opportunities for all people, starting with our employees. We appointed a Chief Diversity and Patient Experience officer in early 2021 who is leading an enterprise-wide strategy focused on training and education of our workforce, targeted efforts to address health equity in our communities, and the recruitment and development of diverse talent. This includes the creation of new formal partnerships to recruit more diverse talent and match new recruits with carefully selected mentors and sponsors within our organization.

Recruitment and Retention

We believe that healthcare is best delivered close to home, and our facilities strive to recruit and retain qualified management and staff personnel. Our frontline caregivers, including nurses, are the heartbeat of our organization, and we have a robust strategy to enhance the recruitment and retention of clinical staff into the future. This strategy includes meaningful education and career advancement opportunities, and competitive compensation. The scarce availability of nurses and other medical support personnel in some markets has required us to enhance wages and benefits and/or hire more expensive temporary personnel in certain situations.

Our facilities also employ and have affiliations with physicians. Many physicians today prefer to be employed, rather than operating their own practices or joining existing medical groups. Our hospitals and affiliated entities employed more physicians during 2020 than 2019. When employing office-based physicians, we also often employ office employees and other personnel necessary to support these physicians and incur additional expenses as a result. We expect this trend to continue.

We seek to attract both employed and affiliated physicians by maintaining a sharp focus on quality, driven by our National Quality Program; employing high performing talent; equipping our facilities with technologically advanced equipment and an attractive, up-to-date physical plant; and otherwise creating an environment within which physicians choose to practice. While physicians may terminate their association with our facilities at any time, we believe that by striving to maintain and improve the quality of care at our facilities and by maintaining ethical and professional standards, our facilities will be better positioned to attract and retain qualified physicians with a variety of specialties.

When recruiting new physicians to our communities, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the federal physician self-referral law (commonly referred to as the "***Stark law***"), the federal Anti-kickback Statute (the "***Anti-kickback Statute***"), state anti-kickback and physician self-referral statutes, and related regulations. The Stark law requires, among other things, that recruitment assistance can only be provided to physicians who meet certain geographic and practice requirements, that the amount of assistance cannot be changed during the term of the recruitment agreement, and that the recruitment payments cannot generally benefit physicians currently in practice in the community beyond recruitment costs actually incurred. In addition to these legal requirements, there is competition from other communities and facilities for these physicians, and this competition continues after the physician begins practicing in one of our communities.

Labor Costs and Union Activity

Approximately 3,000 of our employees across certain of our facilities are unionized. While some of our non-unionized facilities experience union organizing activity from time to time, currently we do not expect these efforts to affect our future operations materially. Our facilities, like most facilities, have experienced rising labor costs. Our labor costs also may increase at higher rates among unionized employees. Unionized employees also may have rights under their collective bargaining agreements that restrict the ability of a facility to take certain actions with respect to these employees.

Government Regulation

Overview

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

Acute care hospitals are subject to periodic inspection by federal, state and local authorities to determine their compliance with applicable regulations and requirements necessary for licensing, certification and accreditation. All of our hospitals are currently licensed under appropriate state laws and are qualified to participate in the Medicare and Medicaid programs. In addition, as of December 31, 2020, with the exception of Bluegrass Community Hospital and Saline Memorial Hospital, all of our hospitals were accredited by the Joint Commission.

Legislative and Regulatory Developments in Response to COVID-19

Numerous recent legislative and regulatory actions have been taken in an attempt to provide businesses, including healthcare providers, with relief from the negative impacts of the COVID-19 pandemic. The legislative and regulatory responses to COVID-19 generally impact many of the statutes, regulations and policies summarized or discussed throughout this Report. Unless otherwise noted, such summaries or discussions have not been updated to reflect the impact of the COVID-19 legislative and regulatory developments.

CARES Act and Related Stimulus Legislation

On March 27, 2020, the CARES Act was signed into law. The CARES Act is intended to provide over $2 trillion in stimulus funding for the U.S. economy. Among other things, the CARES Act contains a number of provisions that are intended to assist healthcare providers as they combat the effects of the COVID-19 pandemic. Those provisions include, among others:

- the temporary suspension of Medicare sequestration from March 1, 2020, to December 31, 2020;
- the delay of the planned reductions to the Medicaid DSH payments program until December 11, 2020;
- an appropriation of $180 million to Health Resources and Services Administration's Federal Office of Rural Health Policy that will be awarded to small rural hospitals by the states through the Small Rural Hospital Improvement Program;
- an appropriation of $250 million to the Hospital Preparedness Program; and
- an appropriation of $100 billion to the Emergency Fund for a new program to reimburse, through grants or other mechanisms, hospitals, healthcare providers and other approved entities for COVID-19-related expenses or lost revenues, represented as a negative change in year-over-year net patient care operating income.

The Paycheck Protection Program and Health Care Enhancement Act was enacted on April 24, 2020, which, among other things, provides an additional allocation of $75 billion to the Emergency Fund and an allocation of $25 billion for COVID-19 testing.

On December 21, 2020, Congress adopted the CCA, which provides an additional $900 billion in COVID-19 relief, including an additional $3 billion allocation to the Emergency Fund. The CCA also, among other things, further extends the temporary suspension of Medicare sequestration through March 31, 2021, delays the planned reductions to the Medicaid DSH payments program through FFY 2023, adds additional reductions to the Medicaid DSH payments program in FFYs 2026 and 2027, provides for a 3.75% increase in PFS rates in CY 2021 and allocates $30 billion for the purchase and administration of COVID-19 vaccines and related therapeutics.

Direct Grant Aid Payments

With respect to payments being made to providers from the Emergency Fund, beginning April 10, 2020, the Emergency Fund distributed $50 billion to hospitals based on their 2018 net patient revenue. Since that time, the Emergency Fund has distributed an additional $56 billion to a number of different types of healthcare providers, including participants in state Medicaid/CHIP programs, providers in areas particularly impacted by the COVID-19 outbreak, rural providers (including hospitals and rural health clinics), skilled nursing facilities, dentists, providers of services with lower shares of Medicare reimbursement or who predominantly serve Medicaid beneficiaries, and providers requesting reimbursement for the treatment of uninsured patients. In addition, on October 1, 2020, HHS announced that an additional $24.5 billion in relief payments would be made from the Emergency Fund, on an application basis, to certain healthcare providers. HHS has stated that these additional relief payments will be allocated in a way that is intended to achieve an equitable payment of two percent of annual revenue from patient care for all applicants and may also take into account a provider's change in operating revenues from patient care, minus their operating expenses from patient care. We recognized $646.3 million of direct grant aid payments as other income under the caption "Government stimulus income" in our accompanying consolidated statement of operations for the year ended December 31, 2020 included elsewhere in this Report.

Payments made by the Emergency Fund to healthcare providers are not loans, and, as a result, they do not need to be repaid. However, healthcare providers are required to file attestations acknowledging receipt of the payments and must agree to and meet the terms and conditions that are associated with the payments, which include, among other things, accepting in-network amounts for presumptive or actual out-of-network COVID-19 patients and not using the payments received from the Emergency Fund to reimburse expenses or losses that other sources are obligated to reimburse. HHS has indicated that it will be closely monitoring the payments that are made to providers through the Emergency Fund, and that HHS, along with the OIG, will be auditing providers to ensure that recipients comply with the terms and conditions that are associated with the Emergency Fund and other COVID-19 relief programs.

Medicare Accelerated and Advance Payment Program

Using existing authority and certain expanded authority under the CARES Act, HHS temporarily expanded the CMS Accelerated and Advance Payment Program to a broad group of Medicare Part A and Part B providers. Under the expanded Accelerated and Advance Payment Program, inpatient acute care hospitals could request up to 100% of their Medicare payment amount for a six-month period (critical access hospitals could request up to 125% of their payment amount for such period), and other providers and suppliers could request up to 100% of their Medicare payment amount for a three-month period. The repayment of these accelerated/advance payments does not begin until one year after the date of the provider's or supplier's receipt of the payment, which means repayment of these amounts will not commence until the second quarter of 2021. Once the repayment period starts, the amounts previously advanced to the provider or supplier will automatically be recouped from the provider's or supplier's new Medicare claims at a rate of 25% for a period of 11 months. After the end of that 11-month period, the amounts previously advanced to the provider or supplier will be automatically recouped from the provider's or supplier's new Medicare claims at a rate of 50% for a period of six months. At the end of the 17-month recoupment period, a letter requesting repayment of any remaining balance will be issued, and the provider or supplier will have 30 days from the date of the letter to repay the balance in full. If the remaining balance is not repaid after 30 days, the unpaid balance will accrue interest at a rate of 4% from the date of the demand letter until the balance has been repaid in full. Through December 31, 2020, we received a total of $991.0 million of Medicare advance payments under the Accelerated and Advance Payment Program, of which $369.8 million and $621.2 million are included under the captions "Current portion of Medicare advance payments" and "Long-term portion of Medicare advance payments", respectively, in our accompanying consolidated balance sheet at December 31, 2020 included elsewhere in this Report. We do not anticipate receiving any additional funds from the CMS Accelerated and Advance Payment Program.

COVID-19 Waivers and Temporary Suspension of Certain Regulatory Requirements

In addition to the financial relief that has been provided by the federal government under the CARES Act and other legislation that has been passed by Congress, CMS and many state governments have also issued a number of waivers or temporarily suspended a number of healthcare facility licensure and reimbursement requirements in order to provide hospitals, skilled nursing facilities, and other types of healthcare providers with increased flexibility to meet the challenges that are being presented by the COVID-19 pandemic. For example, CMS has temporarily waived the enforcement of certain requirements of the Medicare hospital conditions of participation and the Stark law to enable hospitals to treat patients in temporary locations and to obtain services from physicians in a more efficient and timely manner. Likewise, many states have also suspended the enforcement of certain certificate of need and licensure requirements to ensure that hospitals and other healthcare providers have sufficient capacity to treat COVID-19 patients. Our facilities have utilized the waivers and regulatory flexibility that is being provided to the extent necessary to appropriately respond to the COVID-19 pandemic.

CARES Act Tax Provisions

The CARES Act also provides for certain federal income tax changes, including an increase in the interest expense tax deduction limitation, the deferral of the employer portion of Social Security payroll taxes, refundable payroll tax credits, employee retention tax credits, net operating loss carryback periods, alternative minimum tax credit refunds and bonus depreciation of qualified improvement property. The federal income tax changes brought about by the CARES Act are complex and further guidance is expected. For the year ended December 31, 2020, we have deferred cash payments of approximately $84 million related to Social Security payroll tax payments into 2021 and 2022. Additionally, we have generated 2020 cash tax savings of approximately $57 million related to corporate tax law changes which increased the limitation in the tax deductibility of interest expense from 30% to 50% of adjusted taxable income as well as the ability to carry back net operating losses to each of the five tax years preceding the tax year of such loss. However, we may change our provision for income taxes and our deferred income taxes as our understanding of the CARES Act tax provisions evolves due to additional U.S. Department of Treasury guidance. Any such adjustments could materially impact our provision for income taxes and, as a result, our financial results in the relevant periods.

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, among other things:

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

Anti-kickback Statute

The Anti-kickback Statute prohibits the payment, receipt, offer or solicitation of anything of value, whether in cash or in kind, with the intent of generating referrals or orders, or recommending or arranging for services or items covered by a federal or state healthcare program. Violations of the Anti-kickback Statute are punishable by, among other things, imprisonment, criminal fines, substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation, damages equal to three times the total remuneration associated with the unlawful referrals or services, and/or possible exclusion from participating in Medicare, Medicaid or other governmental healthcare programs. Violations of the Anti-kickback Statute can also result in liability under the False Claims Act.

The OIG is responsible for identifying fraud and abuse activities in government healthcare programs. In order to fulfill its duties, the OIG performs audits, investigations and inspections. In addition, it provides guidance to healthcare providers by identifying types of activities that could violate the Anti-kickback Statute. The OIG has identified the following hospital/physician incentive arrangements, among other things, as potential violations:

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

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

Stark Law

The Stark law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship if those entities provide certain "designated health services" unless an exception applies. The Stark law also prohibits entities that provide designated health services reimbursable by Medicare and Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires entities to refund amounts received for items and services provided pursuant to a prohibited referral on a timely basis. "Designated health services" include, among other things, inpatient and outpatient hospital services, laboratory services and radiology services. A violation of the Stark law may result in (i) a denial of payment, (ii) substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation or circumvention scheme and (iii) exclusion from participation in the Medicare and Medicaid programs and other governmental healthcare programs. In addition, violations of the Stark law could also result in penalties under the False Claims Act.

There are ownership and compensation arrangement exceptions to the self-referral prohibition. There are also exceptions for many of the customary financial arrangements between physicians and facilities, including employment contracts, leases and recruitment agreements, and there is a "whole hospital exception," which allows a physician to make a referral to a hospital if, among other things, the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. The Affordable Care Act significantly modified the requirements of the whole hospital exception and placed a number of restrictions on the ownership structure, operations, and expansion of physician owned hospitals. Four of our facilities are subject to those requirements. We intend for our financial arrangements with physicians to comply with the exceptions included in the Stark law and regulations.

In recent years, CMS has issued a number of proposed and final rules modifying and/or clarifying the Stark law exceptions. For example, on November 20, 2020, HHS published two final rules related to the Anti-kickback Statute and the Stark law that are intended to reduce regulatory barriers to care coordination and ease unnecessary compliance burdens for physicians and other healthcare providers. Among other things, the rules create new Anti-kickback Statute safe harbors and Stark law exceptions for value-based and cyber-technology arrangements and provide new guidance and clarification as to how the Anti-kickback Statute and Stark law will be interpreted and enforced by the OIG and CMS, respectively. We cannot predict the impact that the final rules will have on our facilities and our operations or whether the recent trend toward reducing provider compliance burdens will continue in the future. We also anticipate that there will be further changes to the regulations that implement the Anti-kickback Statute and/or the Stark law, and those changes may require us to modify our activities.

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

False Claims Act

The False Claims Act prohibits providers from, among other things, knowingly submitting false or fraudulent claims for payment to the federal government and failing to refund identified overpayments received from the government. The False Claims Act defines the term "knowingly" broadly, and while simple negligence generally will not give rise to liability, submitting a claim with reckless disregard to its truth or falsity can constitute the "knowing" submission of a false or fraudulent claim for the purposes of the False Claims Act. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are generally entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. When a private party brings a qui tam action under the False Claims Act, because such cases are filed under seal, the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation. If found liable under the False Claims Act, a provider may be required to pay up to three times the actual damages sustained by the government plus substantial civil monetary penalties that are subject to annual adjustments for inflation for each separate false claim. The government and whistleblowers have used the False Claims Act to prosecute Medicare, Medicaid 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. Violations of the Stark law can result in False Claims Act liability, as well.

Changes in the Regulatory Environment

The Fraud Enforcement and Recovery Act of 2009 ("***FERA***") expanded the scope of the False Claims Act by, among other things, creating liability for knowingly and improperly avoiding or decreasing an obligation to pay money to the federal government and broadening protections for whistleblowers. In addition, the Affordable Care Act made several significant changes to healthcare fraud and abuse laws, including providing additional enforcement tools to the government, increasing cooperation between agencies by establishing mechanisms for the sharing of information and enhancing criminal and administrative penalties for non-compliance. For example, the Affordable Care Act: (1) expands the scope of the RAC program to include Medicaid, (2) 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," (3) provides Medicare contractors with additional flexibility to conduct random prepayment reviews, and (4) requires providers to adopt compliance programs that meet certain specified requirements as a condition of their Medicare enrollment. The Affordable Care Act also expanded the scope of the False Claims Act to cover payments in connection with the Exchanges if those payments include any federal funds and provides that claims submitted in connection with patient referrals that result from violations of the Anti-kickback Statute constitute false claims for the purposes of the False Claims Act.

In addition to the changes mentioned above, the Affordable Care Act created False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later. On February 11, 2016, CMS published a final rule that provides clarification around the meaning of overpayment identification and generally establishes a six-year lookback period for Medicare Part A and Part B providers and suppliers. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments, accurately prepare cost reports and timely resolve credit balances. In light of the provisions of FERA and the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law, including technical violations of certain fraud and abuse laws, and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law.

State Laws

Many of the states in which we operate have adopted laws similar to the Anti-kickback Statute and the Stark law. These state laws are generally very broad in scope and typically apply to patients whose treatment is covered by the Medicaid program and, in some cases, to all patients regardless of payment source. In addition, many of the states in which we operate have false claims statutes that impose civil and/or criminal liability for the types of acts prohibited by the False Claims Act or that otherwise prohibit the submission of false or fraudulent claims to the state government or Medicaid program. Violations of these laws are punishable by substantial civil and/or criminal penalties and, in many cases, the loss of the facility's license. Although we believe that our operations and arrangements with physicians and other referral sources comply with the applicable state fraud and abuse laws, most of these laws have not been interpreted by any court or governmental agency, and there can be no assurance that the regulatory authorities responsible for enforcing these laws will determine that our arrangements comply with the applicable requirements.

Emergency Medical Treatment and Active Labor Act

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

Administrative Simplification Provisions and Privacy and Security Requirements

We are subject to the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("***HIPAA***") which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. Additionally, we are subject to the privacy, security and breach notification regulations promulgated under HIPAA and the Health Information Technology for Economic and Clinical Health Act (the "***HITECH Act***"), which are designed to protect the confidentiality, availability and integrity of protected health information ("***PHI***") and establish an array of patient rights with respect to such information. The HIPAA privacy, security and breach notification regulations apply to covered entities, which include health plans, healthcare clearinghouses, and healthcare providers that conduct certain standard transactions (such as billing insurance) electronically. In addition, certain provisions of the privacy, security and breach notification regulations apply to business associates, which are entities that perform certain functions or activities on behalf of covered entities that require access to or the use or disclosure of protected health information. In certain circumstances, a covered entity may be held liable for the actions of its business associate if HHS determines an agency relationship exists between the covered entity and the business associate under federal agency law.

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

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

Our facilities continue to remain subject to other applicable federal or state laws that are more restrictive than the HIPAA privacy and security regulations, which could impose additional penalties on us. For example, the Federal Trade Commission uses its consumer protection authority to initiate enforcement actions against companies whose inadequate data security programs may expose consumers to fraud, identity theft and privacy intrusions, including the security programs of entities subject to the HIPAA regulations.

Corporate Practice of Medicine and Fee-Splitting

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

Certificates of Need

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

Not-for-Profit Hospital Conversion Legislation

Many states have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In states that do not have such legislation, the attorneys general have demonstrated an interest in reviewing these transactions under their general obligations to protect charitable assets. These legislative and administrative efforts primarily focus on the appropriate valuation of the assets divested and the use of the proceeds of the sale by the not-for-profit seller. Reviews and approval processes adopted by state authorities can add additional time to the closing of a not-for-profit hospital acquisition, and can also impose on buyers ongoing requirements to provide certain levels of charity care, or limit buyers' ability to discontinue particular service lines or to sell or otherwise dispose of a converted hospital. Future actions by state legislators or attorneys general may seriously delay or even prevent our ability to acquire certain hospitals.

Environmental Regulation

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

Compliance Program

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

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

Risk Management and Insurance

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("***SIR***") and deductible levels. At December 31, 2020, our SIR for professional liability claims is $15.0 million per claim at the majority of our facilities. Additionally, we participate in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2020, our deductible for workers' compensation claims was $1.0 million per claim in all states in which we operate except for Montana, Ohio, Oklahoma, Washington and Wyoming. We participate in state-specific programs for our workers' compensation claims arising in these states. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

We also maintain directors' and officers', property, some professional liability and other types of insurance coverage with unrelated commercial carriers. Our directors' and officers' liability insurance coverage for current officers and directors is a program that protects us as well as the individual director or officer. We maintain property insurance through unrelated commercial insurance companies.

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

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

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

Risk Factor Summary

The following is a summary of the principal risks that could adversely affect our business, operations and financial results.

COVID-19 and Other Potential Pandemic Risks

- The COVID-19 global pandemic continues to affect our operations, business and financial condition, and our liquidity could be negatively impacted, particularly if the U.S. economy remains unstable for a significant amount of time.
- There is a high degree of uncertainty regarding the implementation and impact of the CARES Act and other stimulus legislation, as well as future stimulus legislation, if any, and lack of guidance regarding accounting treatment of funds received under such acts.
- The emergence and effects related to a pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations and financial condition.

Business and Operational Risks

- Our revenues will decline if federal or state programs reduce our Medicare or Medicaid payments.
- Uncertainty regarding the Affordable Care Act or future healthcare reform may adversely affect our business, financial condition and results of operations.
- Changes to Medicaid supplemental payment programs may materially and adversely affect our revenues and results of operations.
- Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may limit our revenues and profitability.
- We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. Also, if we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations, or it could diminish the anticipated value of the acquired facility.
- If our fair value declines or if our estimated future cash flows decrease, a material non-cash charge to earnings from impairment of our goodwill or our long-lived assets could result.
- We are subject to risks associated with outsourcing functions to third parties.
- We conduct a significant portion of our operations through joint ventures.
- Deterioration in the collectability of "patient due" accounts could adversely affect our revenues and results of operations.
- Other hospitals and outpatient facilities provide services similar to those which we offer. In addition, healthcare providers provide services in their offices that could be provided in our facilities.
- We may have difficulty acquiring or divesting facilities on favorable terms.
- If we are unable to implement successfully standardized processes, policies and systems throughout our facilities, our operating results could be negatively impacted.
- Under the A&R Capella Master Lease (as defined below) and the 2019 Master Lease, each of which separately governs certain of our facilities, a default with respect to one facility under either such lease, or in the case of the A&R Capella Master Lease, certain related separate leases, could cause a default under all of the facilities subject to the A&R Capella Master Lease or the 2019 Master Lease, as applicable, which would have a material adverse effect on our business, results of operations and financial condition.
- Because many of the facilities we operate are subject to long-term leases, failure to comply with the terms of such leases or failure to renew such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises.
- Many of the non-urban communities in which we operate continue to face challenging economic conditions and demographic trends, which may materially and adversely impede our business strategies intended to generate organic growth and improve operating results at our facilities.

Credit and Liquidity Risks

- Our substantial indebtedness could materially and adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry and prevent us from making debt service payments.
- We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness that may not be successful.
- We may not be able to generate sufficient cash flow through operations or successfully access other capital resources to fund all of our capital expenditure programs and commitments.
- Our debt agreements contain restrictions that will limit our flexibility in operating our business.
- Repayment of our debt is dependent on cash flow generated by our subsidiaries.
- Despite our substantial indebtedness, we may still be able to incur significantly more debt, which could intensify the risks described above.
- Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.
- Our ability to utilize our net operating loss carryforwards ("***NOLs***") may be limited, and we may not be able to utilize our NOLs as a result of recent U.S. federal tax reform legislation.

Human Capital Risks

- Factors related to our employment of physicians could affect our financial performance.
- If we do not effectively attract, recruit and retain qualified physicians and other healthcare providers, our ability to deliver healthcare services efficiently will be adversely affected.
- Our facilities face competition for management and other non-physician staffing, which may increase labor costs and reduce profitability.
- Labor union activity could raise costs and interfere with our operations. Certain of our employees are union members and are subject to the terms of collective bargaining agreements.
- We are dependent on our executive management team and the loss of the services of one or more of our executive management team could have a material adverse effect on our business.

Regulatory and Legal Risks

- We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may reduce our revenues and profitability.
- 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 will be subject to liabilities because of malpractice and related legal claims brought against our facilities or healthcare providers associated with, or employed by, our facilities or affiliated entities. If we become subject to these claims, we could be required to pay significant damages, which may not be covered by insurance.
- As a result of reviews of claims to Medicare and Medicaid for our services, we may experience delayed payments or incur additional costs and may be required to repay amounts already paid to us.
- Controls designed to reduce inpatient services may reduce our revenues.
- Certificate of need laws and regulations regarding licenses, ownership and operation may impair our future expansion in some states. In states without certificate of need laws, competing providers of healthcare services are able to expand and construct facilities without the need for significant regulatory approval.
- If we fail to implement and maintain certified electronic health record systems and other health information technology in an effective and timely manner, our operations could be adversely affected.
- The industry emphasis on value-based purchasing and bundled payment arrangements may negatively affect our revenues.

Data Security and Privacy Risks

- A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.
- If access to our information systems or those provided by our third-party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.

COVID-19 and Other Potential Pandemic Risks

The COVID-19 global pandemic continues to affect our operations, business and financial condition, and our liquidity could be negatively impacted, particularly if the U.S. economy remains unstable for a significant amount of time.

The COVID-19 global pandemic continues to affect our facilities, employees, patients, communities, business operations and financial performance, as well as the U.S. economy and financial markets. Although vaccines have been developed and are being distributed in the U.S., the length and severity of the COVID-19 pandemic continues to evolve and much of its impact remains unknown and difficult to predict because many of the driving factors are beyond our control, including the timing and effectiveness of the distribution of the vaccines.

We are taking every precaution to ensure we can continue providing quality care and safeguard the health and well-being of patients, employees, providers, volunteers and visitors in each community we serve. For example, during 2020, we cancelled or postponed a substantial number of elective procedures scheduled at our hospitals and closed or reduced operating hours at certain of our physician clinics, ambulatory surgery centers and other outpatient centers that specialize in elective procedures, resulting in significantly reduced patient volumes and operating revenues. We cannot predict how quickly elective procedure volumes will return or if they will be further restricted in the future. In addition, we instituted social distancing practices and protective measures throughout our facilities, including visitor restrictions, closing common areas, limiting entry points and screening staff and visitors who enter our facilities based on the CDC's criteria.

Even with such steps, exposure to COVID-19 patients has led to increased risks to doctors and nurses, which has reduced and may further reduce our operating capacity and/or staffing levels, and may require us to continue utilizing temporary healthcare practitioners. If our hospitals were to continue to treat an increasing number of COVID-19 patients, they could experience staffing shortages or become overwhelmed by excessive demand, potentially preventing them from treating all patients who seek care. We also experienced supply chain disruptions during 2020, including shortages and delays, as well as price increases, in equipment, pharmaceuticals and medical supplies, particularly personal protective equipment (or PPE). Any staffing, equipment, and pharmaceutical and medical supplies shortages may impact our ability to see, admit and treat patients.

The willingness and ability of patients to seek healthcare services also has been impacted by restrictive measures, like travel bans, social distancing and quarantine guidelines, which have further reduced the volume of procedures performed at our facilities more generally, as well as the volume of emergency room and physician office visits unrelated to COVID-19. Furthermore, in response to the COVID-19 pandemic, regulatory barriers to telehealth services have been reduced to expand the availability of remote care. As patients become more comfortable with remote care, which generally receives a lower reimbursement for services, our revenues may be adversely impacted.

Broad economic factors resulting from the current COVID-19 pandemic, including increased unemployment rates and reduced consumer spending, could also negatively affect our payer mix, increase the relative proportion of lower margin services we provide and reduce patient volumes, as well as diminish our ability to collect outstanding receivables. See "—Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may limit our revenues and profitability." Business closings and layoffs in the areas in which we operate may lead to increases in the uninsured, underinsured and Medicaid populations and adversely affect demand for our services, as well as the ability of patients and other payers to pay for services as rendered. Any increase in the amount or deterioration in the collectability of patient accounts receivable will adversely affect our cash flows and results of operations, requiring an increased level of working capital. If general economic conditions continue to deteriorate or remain uncertain for an extended period of time, our liquidity and ability to repay our outstanding debt may be harmed.

In addition, our results and financial condition may be further adversely affected by future federal or state laws, regulations, orders, or other governmental or regulatory actions addressing the current COVID-19 pandemic or the U.S. healthcare system, which, if adopted, could result in direct or indirect restrictions to our business, financial condition, results of operations and cash flow. We may also be subject to lawsuits from patients, employees and others exposed to COVID-19 at our facilities, or from other third-parties or family members who are exposed due to contact with patients, employees, or others exposed at our facilities. Such actions may involve large demands, as well as substantial defense costs. Our professional and general liability insurance may not cover all claims against us.

The foregoing and other continued disruptions to our business as a result of the COVID-19 pandemic have had and are likely to continue to have a material adverse effect on our business and could have a material adverse effect on our results of operations, financial condition, cash flows and our ability to service our debt. Furthermore, the COVID-19 pandemic (including governmental responses, broad economic impacts and market disruptions) has heightened the materiality of certain other risk factors described herein.

There is a high degree of uncertainty regarding the implementation and impact of the CARES Act and other stimulus legislation, as well as future stimulus legislation, if any, and lack of guidance regarding accounting treatment of funds received under such acts. There can be no assurance as to the total amount of financial assistance or types of assistance we will receive, or that the terms of provider relief funding or other programs will not change in ways that affect our funding or eligibility to participate.

We received and may seek other funds that are made available to us and our facilities under the CARES Act and other existing or future stimulus legislation, if any; however, there is still a high degree of uncertainty surrounding the interpretation and implementation of the terms and conditions of these acts. There can be no assurance that the terms of provider relief funding or other programs under the CARES Act, and other existing stimulus legislation or future stimulus legislation, if any, will not change in ways that affect our funding or eligibility to participate, or that changes to the terms of such programs will not result in government recoupment of funds that were initially released to us as grants. Additionally, although the federal government may consider additional stimulus and relief efforts, such efforts may be drafted or implemented in ways that restrict, limit or otherwise negatively impact our ability to access these funds. As a result, we cannot predict the manner in which existing or future stimulus funds will be allocated or administered and we cannot assure you that we will be able to access future stimulus funds in a timely manner or at all. For additional information regarding the CARES Act, and related stimulus legislation and our participation in programs under the CARES Act and related stimulus legislation, if any, see "Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19."

In addition, there currently is limited and sometimes changing guidance available regarding the accounting treatment of funds that have been received by us and our facilities under the CARES Act and other COVID-19 stimulus legislation. This lack of guidance requires us to apply professional judgement and make certain estimates and assumptions with respect to the presentation, amount and timing of our recognition of direct grant aid received under the CARES Act. For additional information regarding the CARES Act and related financial impact, refer to Note 2 to the consolidated financial statements included elsewhere in this Report.

The emergence and effects related to a pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations and financial condition.

As evidenced by the COVID-19 pandemic, the occurrence of a pandemic, epidemic, outbreak of an infectious disease or other public health crisis in an area in which we operate could adversely affect our operations and financial condition. In reaction to such a crisis or the fear of exposure to infection, patients might cancel elective procedures or fail to seek needed care at our facilities, which could result in reduced patient volumes and operating revenues, potentially over an extended period of time. Furthermore, a pandemic, epidemic or outbreak might adversely affect our operations by causing a temporary shutdown or diversion of patients, by disrupting or delaying production and delivery of materials and products in the supply chain or by causing staffing shortages in our facilities. Additionally, such a crisis could diminish the public trust in healthcare facilities, especially hospitals that fail to accurately or timely diagnose, or are treating (or have treated) patients affected by infectious diseases, and negatively affect the reputation at our facilities.

Although we have disaster plans in place and operate pursuant to infectious disease protocols, the extent to which the potential emergence of a pandemic, epidemic or outbreak would impact our business and operations is difficult to predict and would depend on many factors beyond our control, including the speed of the contagion, the development and implementation of effective preventative measures and possible treatments, the scope of governmental and other restrictions on travel and other activities, and public reactions to these factors.

Business and Operational Risks

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

For the years ended December 31, 2020, 2019 and 2018, approximately 55.7%, 55.2% and 57.3% of our revenues, respectively, related to patients participating in Medicare and Medicaid programs, collectively. Numerous factors could materially decrease, or delay timing of, Medicare and Medicaid payments to our facilities. These factors include statutory and regulatory changes, administrative rulings and determinations concerning patient and provider eligibility and requirements for utilization review. Furthermore, the Affordable Care Act and related federal laws provide for material scheduled reductions in the growth rate of Medicare and Medicaid program spending, including reductions in market basket updates and Medicare and Medicaid DSH funding. Additionally, a number of states have adopted or are considering legislation designed to reduce their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs. States may also impose additional taxes on hospitals to help finance the state's Medicaid programs. Some states have also taken steps to implement work and/or community engagement requirements for Medicaid beneficiaries, which could have the effect of reducing the number of individuals eligible for Medicaid in those states.

Uncertainty regarding the Affordable Care Act or future healthcare reform may adversely affect our business, financial condition and results of operations.

The Affordable Care Act dramatically altered the U.S. healthcare system, and we have expended substantial cost and effort to prepare for and comply with the Affordable Care Act. The net effect of the Affordable Care Act on our business continues to be subject to a number of variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. Additionally, the Affordable Care Act has been challenged before the U.S. Supreme Court and several bills have been introduced in Congress to delay, defund or repeal implementation of or amend significant provisions of the Affordable Care Act.

For example, in 2017, the U.S. Department of Justice ("***DOJ***") announced that HHS was immediately ceasing its cost sharing reduction payments to insurance companies based on a determination that those payments had not been appropriated by Congress, and Congress enacted the Tax Act that, in addition to overhauling the federal tax system, repealed the penalties associated with the individual mandate effective as of January 1, 2019. In addition, in December 2019, the U.S. Fifth Circuit Court of Appeals found that the individual mandate set forth in the Affordable Care Act was unconstitutional and ordered the U.S. District Court for the Northern District of Texas to conduct further analysis as to whether the entire Affordable Care Act should be held to be unlawful. The U.S. Supreme Court heard the case during the fourth quarter of 2020, but it likely will not issue an opinion until 2021. We cannot predict the outcome of litigation challenging the constitutionality of the Affordable Care Act or whether the Affordable Care Act will be repealed, replaced, or modified. If the Affordable Care Act is found to be unconstitutional or if it is repealed, replaced or modified, we cannot predict what, if any, the replacement plan or modifications would be, when any such replacement plan or modifications would become effective, or whether any of the existing provisions of the Affordable Care Act would remain in place.

We also cannot predict the impact that the new Presidential administration and Congressional leadership will have on the implementation and enforcement of the provisions of the Affordable Care Act, on any current, pending or potential regulations adopted to implement the law, or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

Changes to Medicaid supplemental payment programs may materially and adversely affect our revenues and results of operations.

MSPs are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and UPL payments. Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating these patients. The total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law. Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars.

The Affordable Care Act called for significant reductions in Medicaid DSH funding to account for decreases in uncompensated care anticipated under the health insurance coverage expansion. Subsequent changes in the law have delayed the implementation of these reductions, but they are scheduled to take effect in FFY 2021. Reductions in Medicaid DSH payments may take place without increases in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

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

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

The amounts we receive for services provided to patients are determined by a number of factors, including the payer mix of our patients and the reimbursement methodologies and rates utilized by our payers. We have seen shifts of patients from commercial and private insurance to Medicare and Medicaid programs and from "traditional" fee-for-service Medicare and Medicaid programs to "managed" Medicare and Medicaid programs. Additionally, we cannot predict whether the new Presidential administration or Congressional leadership will propose measures that would expand government-sponsored coverage, including "Medicare-for-all" or other single-payer proposals. Reimbursement rates generally are lower for (i) Medicare and Medicaid beneficiaries than they are for patients whose care is covered by commercial and private insurance and (ii) managed Medicare and Medicaid beneficiaries than they are for traditional Medicare and Medicaid beneficiaries. We also experience demographic pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs. Our revenues and results of operations may be adversely affected by these shifts.

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

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

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

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

We may be unable to timely and effectively integrate facilities that we acquire with our ongoing operations. Many of the facilities we have acquired had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced delays in improving the operating margins or effectively integrating the operations of our acquired facilities, and we may experience such delays in implementing operating procedures and systems in newly or future acquired facilities. Integrating an acquired facility could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel. Additionally, we may experience delays in reimbursement from governmental and third-party payers as a result of the change of ownership of our acquired facilities.

We must integrate complex information, accounting and operational systems, compliance programs and internal controls over financial reporting of acquired facilities into our existing systems and internal controls. While we devote a significant amount of employee and management resources on these integrations, we also rely heavily on third parties for systems integration. Our efforts to integrate new facilities, including causing those third parties to convert our newly acquired facilities' systems, may fail or be significantly delayed. Failure to timely and effectively integrate or convert any of these systems could cause business interruption, affect provider and staff morale and our ability to accurately manage accounting, clinical, compliance and operational functions. As future acquisitions may involve large operations, any such failure could cause a material adverse effect on our results of operations.

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

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

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

As of December 31, 2020, we had approximately $2,976.8 million of goodwill and other intangible assets and approximately $3,523.0 million of long-lived assets, net of accumulated depreciation. We expect to recover the carrying values of both our goodwill as well as our long-lived assets through our future cash flows. We evaluate the carrying value of our goodwill at least annually, based on our fair value, to determine whether it is impaired. We evaluate our long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows. If the carrying value of our goodwill or our long-lived assets is impaired, we may incur a material non-cash charge to earnings.

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

We outsource selected business functions to third parties, including revenue cycle management, patient access, billing, cash collections, payment compliance and support services, project implementation, supply chain management, payroll system services and parts of cybersecurity. We take steps to monitor and regulate the performance of the independent third parties to whom we delegate selected functions. Arrangements with third-party service providers may make our operations vulnerable if vendors fail to satisfy their obligations to us as a result of their performance, changes in their own operations, financial condition, or other matters outside of our control. We may also face legal, financial or reputational harm for the actions or omissions of such providers, including for violations of HIPAA and other privacy and security laws applicable to healthcare providers, and we may not have effective recourse against the providers for those harms. The expanding role of third-party providers may also require changes to our existing operations and the adoption of new procedures and processes for retaining and managing these providers, as well as redistributing responsibilities as needed. Effective management, development and implementation of our outsourcing strategies are important to our business and strategy. If there are delays or difficulties in enhancing business processes or our third-party providers do not perform as anticipated, we may not fully realize on a timely basis the anticipated economic and other benefits of the outsourcing projects or other relationships we enter into with key vendors, which could result in substantial costs, divert management's attention from other strategic activities, negatively affect employee morale or create other operational or financial problems for us. Terminating, transitioning or renegotiating arrangements with key vendors or failure to renegotiate on favorable terms could result in additional costs and a risk of operational delays, potential errors and possible control issues as a result of the termination or during the transition or renegotiation phase.

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

We have completed a number of joint ventures, affiliations and other strategic alliances as part of our business strategy. We expect to enter into similar transactions in the future, including joint ventures where we may have a noncontrolling interest. Any changes in our relationships with our joint venture partners could disrupt ongoing business, negatively affect cash flow and distract management and other key personnel. In the event of a material disagreement with any of our joint venture partners or the breach of any of our joint venture agreements, a joint venture may be subject to dissolution, unwinding or purchase of either party's interest, which could have a material adverse effect on our revenues and results of operations or result in reputational harm.

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

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

Deterioration in the collectability of "patient due" accounts could adversely affect our revenues and results of operations.

The primary collection risks associated with our accounts receivable relate to uninsured patient accounts and patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (exclusions, deductibles and co-payments) remain outstanding. The provision for doubtful accounts relates primarily to amounts due directly from patients. The amount of our provision for doubtful accounts is based on management's assessment of historical collection trends, business and economic conditions, trends in federal and state governmental and private employer health coverage, the rate of growth in uninsured patient admissions and other collection indicators.

If we experience growth in self-pay volume and revenue, including increased acuity levels for uninsured patients and increases in co-payments and deductibles for insured patients, our revenues and results of operations could be adversely affected. Although we have experienced a reduction in uninsured patients since 2014 as a result of the Affordable Care Act and the expansion of state Medicaid programs, we are unable to predict whether that trend will continue in light of the repeal of the penalties associated with the individual mandate, the cessation of the cost sharing reduction payments to insurers, the decision by some states not to expand their Medicaid programs, and the business closings and layoffs that have and may continue to occur as a result of the COVID-19 pandemic. In addition, the risk of collection from insured patients (and the amounts due) has increased, and will likely continue to increase, as a result of more individuals being enrolled in insurance plans with high deductibles and high co-payments, including those purchased on the Exchanges. Furthermore, our ability to improve co-insurance collections and collections from self-pay patients may be limited by legislative developments, such as federal and state legislation designed to reduce "surprise billing," or by other regulatory or investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

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

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

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

Quality of care and value-based purchasing have also become significant trends and competitive factors in the healthcare industry. CMS makes public the performance data relating to multiple quality measures that facilities submit in connection with their Medicare payment. CMS also requires every Medicare participating hospital to establish and update annually a public online listing of the hospital's standard charges for items and services and recently issued new regulations that would significantly increase hospital charge reporting requirements. If the publicly-available performance and charge data become a primary factor in where patients choose to receive care, and if competing facilities have lower charges or better results than our facilities on those measures, our revenues and/or patient volumes could decline.

We also face significant and increasing competition from services offered by providers (including providers on our medical staffs) in their offices and from other specialized care providers, including freestanding emergency departments and outpatient surgery, oncology, physical therapy, diagnostic and urgent care centers (including many in which providers may have an ownership interest). We also compete with specialty facilities that focus on one or a small number of lucrative service lines, some of which are not required to operate emergency departments. Some of our facilities have and will seek to develop outpatient facilities where necessary to compete effectively. However, to the extent that other providers are successful in developing outpatient facilities or providers are able to offer additional, advanced services in their offices, our market share for these services will likely decrease in the future. In addition, the phasing out and eventual elimination of the Medicare program's inpatient only procedure list may also reduce our inpatient volumes.

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

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

The cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired facility's results of operations, allocation of purchase price, effects of subsequent legislation and limitations on rate increases. As part of our acquisition strategy, we may commit to making significant capital improvements at acquired facilities. Such improvements may be difficult to achieve in the anticipated timeframe, if at all, due to a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions.

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

Even if we are able to identify an attractive target, we may need to obtain financing for acquisitions, joint ventures or required capital improvements. Such financing may not be available, or we may incur or assume additional indebtedness as a result. Any financing arrangements we enter into may not be on terms favorable to us, and this could have a material adverse effect on our results of operations.

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

We regularly evaluate the potential disposition of assets and facilities that may no longer help us attain our objectives. When we decide to sell assets or facilities, we may encounter difficulties in finding buyers or alternative exit strategies on acceptable terms or in a timely manner, which could delay the achievement of our strategic objectives. Additionally, the terms of our Master Leases (as defined below) entered into pursuant to sale leaseback transactions may make it more difficult to dispose of certain facilities. We may also dispose of assets or a facility at a price, or on terms, less desirable than we anticipated. In addition, we may experience greater dis-synergies than expected. After reaching an agreement with a buyer for the disposition of assets or a facility, we will be subject to satisfaction of pre-closing conditions as well as to necessary regulatory and governmental approvals on acceptable terms, which, if not satisfied or obtained, may prevent us from completing the transaction. Dispositions may also involve continued financial involvement in the divested facilities, such as through continuing equity ownership, guarantees, indemnities, transition service agreements or other financial and commercial obligations, and inability to avoid retention of certain regulatory and compliance risks. There can be no assurance that the anticipated benefits of our future divestiture strategies will be realized. Furthermore, we may be exposed to contingent liabilities in connection with completed divestitures. Finally, certain acquisition agreements and joint venture arrangements contain covenants that restrict our ability to dispose of certain facilities without first seeking consent of a joint venture partner or other third parties, which may affect our ability to take advantage of business opportunities that may be in our interest. If we do not realize the anticipated benefits of such divestitures, if contingent liabilities related to such divestitures materialize or if we are unable to divest certain properties on favorable terms or at all, this could have a material adverse effect on our results of operations.

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

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

In addition, as new information systems are developed in the future, we will need to integrate them into our existing systems. Evolving industry and regulatory standards may require changes to our systems in the future. System conversions are costly, time consuming and disruptive for providers, staff and, in some cases, patients. Some of our facilities have recently converted or are currently converting from their existing system to another third-party information system. If such conversions occurred on a large scale or if conversions at our larger facilities experience difficulties, the costs and disruptions could have a material adverse effect on our revenues or results of operations.

Under the A&R Capella Master Lease (as defined below) and the 2019 Master Lease, each of which separately governs certain of our facilities, a default with respect to one facility under either such lease, or in the case of the A&R Capella Master Lease, certain related separate leases, could cause a default under all of the facilities subject to the A&R Capella Master Lease or the 2019 Master Lease, as applicable, which would have a material adverse effect on our business, results of operations and financial condition.

If there is a default under that certain Amended and Restated Master Lease Agreement (the "***A&R Capella Master Lease***") with subsidiaries of MPT Camaro OpCo, LLC, a Delaware limited liability company and wholly-owned subsidiary of MPT, dated as of March 21, 2016, or the 2019 Master Lease (together with the A&R Capella Master Lease, the "***Master Leases***" and each a "***Master Lease***"), even if such default relates to one facility, the lessor(s) may terminate the applicable Master Lease in its entirety with respect to all of the facilities governed by such Master Lease. Additionally, we have entered into amended and restated separate leases with affiliates of MPT with respect to our joint ventures Capital Medical Center located in Olympia, Washington on October 31, 2016 (the "***Olympia Lease***") and National Park Medical Center in Hot Springs, Arkansas on March 21, 2016 (the "***Hot Springs Lease***").

Under each Master Lease, the Olympia Lease and the Hot Springs Lease, we are subject to financial covenants based on certain fixed charges. The failure to meet or obtain a waiver of such covenants or otherwise cure such non-compliance in each Master Lease, the Olympia Lease or the Hot Springs Lease in the future would result in an event of default under the applicable lease. We have received a waiver of compliance with respect to the Olympia Lease financial covenants through March 31, 2022. There can be no assurance that we will be able to obtain a similar waiver in the future if we are unable to meet such financial covenants. Additionally, on December 23, 2020, we entered into a definitive agreement with an unrelated third-party to sell our ownership interest in Capital Medical Center.

Other events that could trigger a default under each Master Lease, the Olympia Lease or the Hot Springs Lease if not cured within the time periods required by such lease include, without limitation, (i) failure to pay rent or other amounts due under the lease, (ii) failure to comply with the non-financial covenants under the lease, (iii) the bankruptcy of any facility lessee under such lease or the guarantor of the facility lessees under the applicable lease, (iv) termination of any licenses necessary for operation of a facility or required for certification under Medicare or Medicaid, (v) a change of control (as defined in the applicable lease) in violation of such lease and (vi) a default under any material documents between any lessee of the facilities and any lessor of any facility. Each Master Lease contains cross-default provisions so that certain defaults with respect to one of the facilities subject to such Master Lease may cause a default under the entire Master Lease. Accordingly, a default under a Master Lease that results in a termination of such Master Lease would cause us to lose the ability to operate all of the facilities subject to such Master Lease and to incur substantial costs in restoring the premises, which would have a material adverse effect on our business, results of operations and financial condition. Although the A&R Capella Master Lease and the 2019 Master Lease are not cross defaulted to one another, a default under the Olympia Lease or the Hot Springs Lease may trigger a cross default of the A&R Capella Master Lease.

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

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

The rights to use many of our facilities are based upon long-term leases, including the Master Leases. Pursuant to the terms of these leases, we are required to pay all rent due and comply with all other lessee obligations. As of December 31, 2020, the remaining term of these leases (including renewal options) generally ranged from less than one year up to 76 years. A pledge of our interest in some of these leases may also require the consent of the respective lessor and its lenders. As a result, we may not be able to sell, assign, transfer or convey our interest in certain facilities subject to such leases in the future absent consent of such third parties even if such transactions may be in our best interest. Most of the leases require that, upon the expiration or termination of the leases, we must surrender any improvements to the land to lessor. In addition, some of our leases include early termination provisions. We are typically responsible for all taxes, insurance, assessments and maintenance obligations under the leases. The leases also generally require the lessee to either reconstruct or restore the premises to its original condition following a casualty and to apply in a specified manner any proceeds received in connection therewith. In some leases the lessor has the option to purchase some or all of the assets owned by us and used in connection with the operation of the applicable facility. Accordingly, failure to comply with the terms of such leases, the invalidity of or default or termination under such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises, which could have a material adverse effect on our business, results of operations and financial condition.

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

Many of the non-urban communities in which we operate continue to face challenging economic conditions, including high levels of unemployment and demographic trends. These challenging economic conditions have been further exacerbated by the impact of the COVID-19 pandemic. The economies in the non-urban communities in which our facilities primarily operate are often dependent on a small number of large employers, especially manufacturing or similar facilities. These employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our facilities for care. The failure of one or more large employers, or the closure or substantial reduction in the number of individuals employed at manufacturing or similar facilities located in or near many of the non-urban communities in which our facilities primarily operate, could cause affected employees to move elsewhere for employment or lose insurance coverage that was otherwise available to them.

When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to:

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

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

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

Credit and Liquidity Risks

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

We are a highly leveraged company. As of December 31, 2020, we had total outstanding debt of approximately $6,339.5 million, excluding finance leases and unamortized debt issuance costs and premium. Our substantial indebtedness could have important consequences for the Lenders and Holders of our indebtedness. For example, it could:

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

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

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

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

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

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

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

If we cannot make scheduled payments on our indebtedness, we will be in default, and the Lenders under the Term Loan Facility and the Holders of the Notes could declare all outstanding principal and interest to be due and payable, the Lenders under the ABL Facility could terminate their commitments to loan money, our secured lenders (including the Lenders under the ABL Facility and the holders of the Notes) could foreclose against the assets securing their loans and the Notes and we could be forced into bankruptcy or liquidation.

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

We require substantial capital resources to fund our growth strategy and ongoing capital expenditure programs, including capital expenditure programs for renovation, expansion and construction at our facilities and the addition of equipment and technology at our facilities. We often commit to significant capital expenditures well in advance of the time these expenditures will be made. Our cash flows and available capital resources may be insufficient to fund our capital expenditure programs and commitments, and we may be forced to reduce or delay planned and required capital expenditures. Additionally, we may experience delays or impediments in satisfying the schedule for capital expenditure commitments because of a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions, adverse weather conditions, shortages of labor or materials or other unforeseen problems or delays. The failure to satisfy our capital expenditure commitment obligations could also damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities, lessors or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions.

At December 31, 2020, we estimated our total remaining capital expenditure commitments to be approximately $1,174.7 million, which generally have remaining terms of two to six years. Of this amount, more than one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time. The failure to satisfy our capital expenditure commitment obligations could damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities, lessors or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions. As a result, if our cash flows and available capital resources are not sufficient to fund all of our anticipated capital expenditures, it may be necessary for us to give priority to contractual capital expenditure commitment obligations over other elective capital expenditure programs.

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

The Indentures and the Credit Agreements contain a number of covenants that will impose significant operating and financial restrictions on us, including restrictions on our and our subsidiaries ability to, among other things:

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

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

In addition, the ABL Facility requires us to maintain a minimum fixed charge coverage ratio at any time when the average availability is less than the greater of $65.0 million and 10% of the lesser of the aggregate amount of revolving facility commitments and the borrowing base at such time. In that event, we must satisfy a minimum fixed charge ratio of 1.0 to 1.0. At December 31, 2020, we were in compliance with this financial maintenance covenant.

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

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

Such actions by the Lenders could cause cross defaults under our other indebtedness. If we were unable to repay those amounts, the Lenders and Holders under the ABL Facility, the Term Loan Facility, the 6.75% Secured Notes and the 4.375% Secured Notes could proceed against the collateral granted to them to secure the ABL Facility, the Term Loan Facility, the 6.75% Secured Notes and the 4.375% Secured Notes, respectively. If any of our outstanding indebtedness under the ABL Facility, the Term Loan Facility, the Notes or any of our other existing or future indebtedness were to be accelerated, there can be no assurance that our assets would be sufficient to repay such indebtedness in full.

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

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

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

We and our subsidiaries may be able to incur substantial indebtedness in the future. Although the terms of the Credit Agreements and the Indentures contain restrictions on our and our subsidiaries' ability to incur additional indebtedness, these restrictions are subject to a number of important qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. As of December 31, 2020, we had $538.8 million available for additional borrowing under the ABL Facility, after giving effect to any letters of credit issued thereunder, which were approximately $45.3 million as of December 31, 2020, all of which would be secured. In addition to the Notes and our borrowings under the Credit Agreements, the covenants under any other existing or future debt instruments could allow us to incur a significant amount of additional indebtedness and, subject to certain limitations, such additional indebtedness could be secured. The more leveraged we become, the more we, and in turn our security holders, will be exposed to certain risks described above under "—Our debt agreements contain restrictions that will limit our flexibility in operating our business."

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

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. Assuming the revolving credit facility is fully drawn, each 1% change in assumed blended interest rates would result in an approximately $40 million change in aggregate annual interest expense on indebtedness under the ABL Facility and the Term Loan Facility. To manage this risk, we entered into an interest rate swap agreement on December 21, 2018 with Citibank, N.A. as counterparty (the "***Interest Rate Swap***"). The terms of the Interest Rate Swap require us to pay a fixed rate of 2.63% on a notional amount of $1,100.0 million and, in exchange, we receive one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. We have not designated our Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging" ("***ASC 815***"). Therefore, all changes in the fair value of our Interest Rate Swap will be recognized through interest expense in our results of operations. Changes in the fair value of our Interest Rate Swap could result in a material effect on our consolidated results of operations and financial position; however, we do not anticipate that changes in the fair value of our Interest Rate Swap will have any impact on our cash flows.

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

As of December 31, 2020, we had approximately $1.9 billion in state and local NOLs that expire at various dates between 2021 and 2039. To the extent available and not otherwise utilized, we intend to use any NOLs to reduce the applicable state corporate income tax liability associated with our operations. However, our ability to utilize our NOLs is based on the extent to which we generate future taxable income and on prevailing corporate income tax rates, and we cannot provide any assurance as to when and to what extent we will generate sufficient future taxable income to realize our deferred tax assets, whether in whole or in part. Furthermore, the utilization of our NOLs may become subject to an annual limitation under Section 382 of the Code (and similar state provisions) in the event of certain cumulative changes in the ownership interest of significant shareholders in excess of 50 percent over a three-year period. This could limit the amount of NOLs that can be utilized annually to offset taxable income. The amount of the annual limitation is determined based on the value of a company immediately prior to the ownership change. Subsequent ownership changes may further affect the limitation in future years. For these reasons, our ability to utilize our NOLs may be limited.

Human Capital Risks

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

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

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

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

Additionally, our ability to recruit and employ providers is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the federal physician self-referral law (commonly referred to as the Stark law), the Anti-kickback Statute, state anti-kickback and self-referral statutes, and related regulations. The Stark law requires, among other things, that recruitment assistance can only be provided to physicians who meet certain geographic and practice requirements, that the amount of assistance cannot be changed during the term of the recruitment agreement, and that the recruitment payments cannot generally benefit physicians currently in practice in the community beyond recruitment costs actually incurred by them. All arrangements with physicians must also be fair market value and commercially reasonable.

In addition to these legal requirements, there is competition from other communities and facilities for these providers, and this competition continues after the provider is practicing in one of our communities. For example, integrated ACOs and other kinds of "narrow" provider networks or organizations may exclude our providers from their plans' networks of healthcare providers. These contracting networks often organize hospitals, providers and ancillary healthcare providers into exclusive networks involving fewer healthcare providers. If our affiliated providers are excluded from such networks, we may have difficulty recruiting new providers or retaining existing providers.

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

Generally, a small number of attending physicians within each of our facilities represent a large share of our inpatient revenues and admissions. The loss of one or more of these physicians—even if temporary—could cause a material reduction in our revenues, which could take significant time to replace given the difficulty and cost associated with recruiting and retaining physicians.

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

In addition to depending on our physicians and other providers, the operations of our facilities are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians. We compete with other healthcare facilities in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our facilities, including physician assistants, nurses and other non-physician healthcare professionals. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue and the competition for experienced and talented hospital management personnel is intense. This may result in employee turnover, require us to enhance wages and benefits to recruit and retain management, nurses and other medical support personnel, recruit personnel from foreign countries (which may be limited by changes in immigration law, regulation and policy), and hire more expensive temporary or contract personnel. In addition, the states in which we operate could adopt mandatory nurse staffing ratios or could increase mandatory nurse-to-patient staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. Some of the employees at some of our facilities are represented by a union, and others may be in the future, which can also increase the cost of labor. If our labor costs increase, we may not be able to raise rates to offset these increased costs. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs could have a material adverse effect on our revenues or results of operations.

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

Increased or ongoing labor union activity could adversely affect our labor costs or otherwise adversely impact us. Several of our facilities have unionized employees. When a new collective bargaining agreement with a union must be negotiated, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur, and our operations could be disrupted or our labor costs increased as a result of these disruptions. Our labor costs also could increase significantly if a substantial number of other employees at our facilities unionize. If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained.

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

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

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

Regulatory and Legal Risks

We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may reduce our revenues and profitability.

All participants in the healthcare industry are required to comply with numerous overlapping laws and regulations at the federal, state and local government levels. These laws and regulations require that hospitals meet various requirements, including those relating to relationships with providers and other referral sources, the adequacy and quality of medical care, inpatient admission criteria, privacy and security of health information, standards for equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, compliance with building codes and environmental protection, among other matters. Many of the laws and regulations applicable to the healthcare industry are complex and may be violated inadvertently, and there are numerous enforcement authorities, including CMS, the Office of Inspector General (the "***OIG***"), the DOJ, state attorneys general, and contracted auditors, as well as private plaintiffs.

There are also heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment, which has led to a number of investigations, prosecutions, convictions and settlements in the healthcare industry. Recent enforcement actions have focused on, among other things, financial arrangements between hospitals and providers, billing for services without adequately documenting the medical necessity for such services and billing for services outside the coverage guidelines for such services. Hospitals continue to be one of the primary focal areas of the OIG and other governmental fraud and abuse programs, as described in the OIG Work Plan. Dealing with investigations can be time and resource consuming and can divert management's attention from the business. Any such investigation or settlement could increase our costs or otherwise have an adverse effect on our business. In addition, because of the potential for large monetary exposure under the False Claims Act, which provides for treble damages and substantial civil monetary penalties for each separate false claim or statement, healthcare providers often resolve allegations without admissions of liability for significant and material amounts to avoid the uncertainty of damages and penalties that may be awarded in litigation proceedings. Such settlements often contain additional compliance and reporting requirements as part of a consent decree, settlement agreement or corporate integrity agreement. These additional requirements can result in significant additional and ongoing expenditures. Given the significant size of actual and potential settlements, it is expected that the government will continue to devote substantial resources to investigating healthcare providers' compliance with the healthcare payment rules and fraud and abuse laws. Certain of our facilities have received inquiries and subpoenas from various governmental agencies regarding these matters, and we are also subject to various claims and lawsuits relating to these and other matters.

The laws and regulations with which we must comply continually change. In the future, different interpretations or enforcement of these laws and regulations could subject our business practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws and regulations, many of these laws and regulations are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable laws and regulations. If we fail to comply with applicable laws and regulations, we could suffer substantial civil or criminal penalties, including the loss of our licenses to operate our facilities or loss of our ability to participate in the Medicare, Medicaid and other governmental programs.

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

We are also subject to various federal, state and local statutes and ordinances regulating the discharge of materials into the environment. For example, our healthcare operations generate medical waste, such as pharmaceuticals, biological materials and disposable medical instruments that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Environmental regulations also may apply when we build new facilities or renovate existing facilities, particularly older facilities. If we fail to comply with environmental regulations, we may be liable for substantial investigation and clean-up costs or we may be subject to lawsuits by governmental authorities or private plaintiffs.

Finally, we send short message service ("***SMS***") text messages to patients. While we obtain consent from these individuals to send text messages, federal or state regulatory authorities or private litigants may claim that the notices and disclosures we provide, form of consents we obtain, or our SMS texting practices are not adequate or violate applicable law. In addition, we must ensure that our SMS texting practices comply with regulations and agency guidance under the Telephone Consumer Protection Act (the "***TCPA***"), a federal statute that protects consumers from unwanted telephone calls, faxes and text messages. While we strive to adhere to strict policies and procedures that comply with the TCPA, the Federal Communications Commission, as the agency that implements and enforces the TCPA, may disagree with our interpretation of the TCPA and impose penalties and other consequences for noncompliance. Determination by a court or regulatory agency that our SMS texting practices violate the TCPA could subject us to civil penalties and could require us to change some portions of our business. Even an unsuccessful challenge by patients or regulatory authorities of our activities could result in adverse publicity and could require a costly response from and defense by us.

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

The False Claims Act prohibits healthcare facilities and providers, as well as other entities or individuals from, among other things, knowingly submitting false claims for payment to the federal government, or knowingly causing the submission of such claims. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are generally entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. We are required to provide information to our employees and certain contractors about state and federal false claims laws and whistleblower provisions and protections. Defendants found to be liable under the False Claims Act may be required to pay up to three times the actual damages sustained by the government, plus substantial civil monetary penalties, that are subject to annual inflation adjustments, for each separate false claim.

There are many potential bases for liability under the False Claims Act, including reckless or intentional acts or omissions. The government has used the False Claims Act to prosecute Medicare and other government healthcare program violations such as coding errors, billing for services not provided, submitting false cost reports, falsely certifying meaningful use of certified health information technology, and providing care that is not medically necessary or that is substandard in quality. The Affordable Care Act also (i) created potential False Claims Act liability for failing to report and repay identified overpayments within sixty (60) days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later, and (ii) provided that claims submitted in connection with patient referrals that result from violations of the Anti-kickback Statute constitute false claims for the purposes of the False Claims Act. Violations of the Stark law can result in False Claims Act liability, as well. In addition, a number of states have adopted their own false claims and whistleblower provisions whereby a private party may file a civil lawsuit in state court.

Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws, many of these laws are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable fraud and abuse laws.

We will be subject to liabilities because of malpractice and related legal claims brought against our facilities or healthcare providers associated with, or employed by, our facilities or affiliated entities. If we become subject to these claims, we could be required to pay significant damages, which may not be covered by insurance.

We will be subject to medical malpractice lawsuits and other legal actions arising out of the operations of our facilities and the activities of our employed or affiliated providers. As a matter of policy, we typically notify patients of any potential harms they may have suffered at our facilities, regardless of whether such notifications are required by law and notwithstanding our uncertainty as to the severity of such harms or whether they even took place. This may lead to class actions or other multi-plaintiff lawsuits or whistleblower reports. These actions may involve large claims and significant defense costs and, if we or our facilities are found liable, any judgments against us may be material. Furthermore, some states in which we operate do not impose caps on non-economic malpractice damages and, even in the states that have imposed caps on such damages, litigants may seek recoveries under alternative theories of liability that might not be subject to such caps. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement whether or not we believe we are liable. Amounts we pay to settle any of these matters also may be material.

Although we maintain professional and general liability insurance with unrelated commercial insurance carriers, each individual plaintiff's claim is generally subject to an SIR insurance program administered in-house by our risk department with assistance from our insurance brokers. Any successful claim against us that is within our SIR amounts could have an adverse effect on our results of operations or liquidity. Some of these claims could exceed the scope of the excess coverage in effect, or coverage of particular claims could be denied, and any amounts not covered by insurance could be material.

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

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

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare and Medicaid for payment for our services. These post-payment reviews may increase as a result of government cost-containment initiatives, including enhanced medical necessity reviews for patients admitted as inpatients to general acute care hospitals for certain procedures and audits of claims under the RAC programs to detect overpayments not identified through existing claims review mechanisms. RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those claims most likely to contain overpayments, such as incorrectly coded services, short stays, incorrect payment amounts, non-covered services and duplicate payments. The claims review strategies used by the RACs generally include a review of high dollar claims, including inpatient hospital claims. As a result, a large majority of the total amounts recovered by RACs has come from hospitals.

In addition, CMS and the states use UPICs to perform post-payment audits of claims and identify Medicare and Medicaid overpayments. Third-party audits or investigations of Medicare or Medicaid claims could result in increases or decreases in operating revenues to be recognized in periods subsequent to when the related services were performed, which may have a material adverse effect on our results of operations.

Controls designed to reduce inpatient services may reduce our revenues.

Over the last several years, payers have instituted policies and procedures to reduce or limit the use of inpatient services. Controls imposed by Medicare, Medicaid, and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for payment are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by QIO, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of the MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. QIOs may deny payment for services or assess fines and also have the authority to recommend to HHS that a provider that is in substantial noncompliance with quality standards be excluded from participation in the Medicare program.

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

Certificate of need laws and regulations regarding licenses, ownership and operation may impair our future expansion in some states. In states without certificate of need laws, competing providers of healthcare services are able to expand and construct facilities without the need for significant regulatory approval.

Some states require prior approval for the purchase, construction and expansion of healthcare facilities, based on the state's determination of need for additional or expanded healthcare facilities or services. Certain states in which we operate facilities require a certificate of need for the purchase, construction or expansion of hospital facilities, capital expenditures exceeding a prescribed amount, changes in bed capacity or services, or for other hospital-related activities. We may not be able to obtain certificates of need required for expansion activities or to effectively compete with competing healthcare providers in the future. In addition, all of the states in which we operate facilities require hospitals, other healthcare facilities, and most healthcare providers to maintain one or more licenses. If we fail to obtain any required certificate of need or license, our ability to operate or expand operations in those states could be impaired.

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

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

The federal government has adopted laws and regulations intended to promote the adoption of health information technology, advance the interoperability of medical record systems, and support the access, exchange, and use of electronic health information. For example, under the Medicare Promoting Interoperability Programs (formerly the Medicare EHR Incentive Program), eligible hospitals, critical access hospitals and eligible professionals that do not successfully demonstrate meaningful use of certified electronic health record technologies every year (absent a hardship exception) are subject to a downward payment adjustment under Medicare. In addition, the 21st Century Cures Act and its implementing regulations impose new Medicare conditions of participation on hospitals and critical access hospitals related to the exchange of electronic health information and prohibit information blocking, which includes any practice that is unreasonable and likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information, by health care providers and certain other entities, unless required by law or otherwise permitted by an exception in the applicable regulations. Failure to comply with these requirements could subject us to financial penalties or other disincentives or reputational damage. In addition, complying with these and future initiatives related to health care technology and interoperability may require us to change our operations or incur additional costs related to investments in information technology and EHR system software upgrades, and our payers may not adequately reimburse us for these costs and investments.

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

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

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

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

Physicians participate in MIPS unless they are participants of specific forms of APM, are newly enrolled in Medicare, or see a low volume of Medicare patients (i.e., no more than 200 patients in a calendar year, 200 covered professional services, or $90,000 in charges for professional services). Groups or eligible clinicians who choose not to participate and fall within specified circumstances may request an exception through a hardship application and incur no MIPS impact on Medicare payments. CMS permitted hardship applications in 2020 based on circumstances arising from COVID related operational issues. MIPS eligible clinicians or Group Practices were subject to a negative payment adjustment of up to minus 5% in CY 2020, or positive adjustment on a sliding scale (based on CY 2018 performance) and are subject to a negative payment adjustment of up to minus 7% in CY 2021, or positive adjustment on a sliding scale (based on CY 2019 performance) with the payment adjustment increasing each year until it reaches minus 9% in CY 2023 and up to beyond. In addition, MIPS eligible clinicians with exceptional performance may receive up to 10% bonus payment from $500 million that has been specifically allocated for this purpose. For CY 2020 reporting, CMS offered reporting flexibilities, including expanded hardship exceptions, in response to pandemic challenges. For CY 2021 payment adjustments, which are based on CY 2019 reporting, CMS reported that more than 97% of eligible clinicians participated, and projects that in light of the large number of hardship exceptions, negative adjustments were negligible and positive payment adjustments were much lower than expected. However, for the 84% of participating MIPS eligible clinicians whose score was exceptional (above 75 points), an additional positive adjustment of 1.79% will be received. MACRA requires MIPS to be operated in a budget neutral manner, and the number of providers receiving hardship exceptions and neutral treatment reduced the funding from negative adjustments which would have been available for positive adjustment payments. The impact of COVID-19 expanded hardship exceptions in 2020 was reported by CMS to have resulted in 29,136 providers receiving neutral scores in 2020. Providers participating in an APM may be eligible for more advantageous adjustments under MIPS (or avoid any negative adjustment) and receive a 5% bonus. At this time, we have limited participation in APMs.

If an eligible clinician has not been satisfactorily participating in MIPS (and is not qualified to participate in an APM), his or her claims for Medicare Part B services are likely to be subject to negative payment adjustments in CY 2021 (which will be based on CY 2019 performance) and CY 2022 (which will be based on CY 2020 performance). For participating eligible clinicians that meet or exceed the MIPS threshold or APM requirements, claims for payment are likely to be subject to positive adjustments as well as a share of an additional pool of bonus payments. At this time, and as CMS continues to modify MIPS payment policies, it is unclear how MIPS will impact our overall physician payments under the Medicare program. If we have not timely and effectively implemented policies and procedures, quality programs and appropriate clinician contracting to ensure compliance with MACRA and other QPP requirements, we would experience a negative effect on future revenues related to Medicare Part B claims.

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

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

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

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

Data Security and Privacy Risks

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

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

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

The secure processing, maintenance and transmission of this information is critical to our operations and business strategy. If, in spite of our security and compliance efforts we or any of our business associates were to experience a breach, loss, or other compromise of PHI or PII, such event could disrupt our operations, result in increased data protection costs, damage our reputation, or result in regulatory penalties, legal claims and civil or criminal liability under HIPAA and other state and federal laws, which could have a material adverse effect on our results of operations.

If access to our information systems or those provided by our third-party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.

Our business depends heavily on effective information systems to process clinical, operational and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and to develop new systems in order to keep pace with continuing changes in information processing technology. In addition to our own systems, we rely on multiple third-party providers of financial, clinical, supply chain, patient accounting and network information services and, as a result, we face operational challenges in maintaining multiple provider platforms and facilitating the interface of such systems with one another. The third-party providers may not have appropriate controls to protect confidential information. We do not control the information systems of third-party providers, and in some cases we may have difficulty accessing information archived on third-party systems, which could subject us to liability for failure to respond to legal, regulatory or payer obligations or information requests. Our networks and technology systems are also subject to disruption due to events such as a major earthquake, fire, flood, hurricane, telecommunications failure, terrorist attack or other catastrophic event. If these systems fail or are interrupted, if our access to these systems is limited in the future or if providers develop systems more appropriate for more urban healthcare markets and not suited for our facilities, our operations could suffer.

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

Item 2. ***Properties.***

The table below presents certain information with respect to our hospital campuses as of December 31, 2020:

Facility Name	City	Licensed Beds	Ownership and Real Property Status
Alabama			
Andalusia Regional Hospital	Andalusia	88	Own
North Alabama Medical Center	Florence	263	Own
Shoals Hospital	Muscle Shoals	198	Own
Vaughan Regional Medical Center (a)	Selma	175	JV/Own
Arizona			
Canyon Vista Medical Center	Sierra Vista	100	Lease
Havasu Regional Medical Center (b)	Lake Havasu City	171	JV/Own
Valley View Medical Center	Fort Mohave	84	Own
Arkansas			
National Park Medical Center (c) (d)	Hot Springs	163	JV/Lease
Saline Memorial Hospital (a)	Benton	177	JV/Lease
St. Mary's Regional Medical Center	Russellville	170	Own
Colorado			
Colorado Plains Medical Center	Fort Morgan	50	Lease
Georgia			
St. Francis Hospital (e)	Columbus	376	Own
Idaho			
St. Joseph Regional Medical Center (d)	Lewiston	145	Lease
Indiana			
Clark Memorial Hospital (f)	Jeffersonville	236	JV/Own
Scott Memorial Hospital (f)	Scottsburg	25	JV/Own
Iowa			
Ottumwa Regional Health Center (d)	Ottumwa	217	Lease
Kansas			
Western Plains Medical Complex (d)	Dodge City	99	Lease
Kentucky			
Bluegrass Community Hospital	Versailles	25	Own
Bourbon Community Hospital	Paris	58	Own
Clark Regional Medical Center	Winchester	79	Own
Fleming County Hospital	Flemingsburg	25	Own
Georgetown Community Hospital	Georgetown	75	Own
Jackson Purchase Medical Center	Mayfield	107	Own
Lake Cumberland Regional Hospital	Somerset	295	Own
Logan Memorial Hospital	Russellville	75	Own
Meadowview Regional Medical Center	Maysville	100	Own
Spring View Hospital	Lebanon	75	Own
Michigan			
UP Health System - Bell	Ishpeming	25	Own
UP Health System - Marquette (g)	Marquette	222	JV/Own
UP Health System - Portage (a)	Hancock	96	JV/Own
Mississippi			
Bolivar Medical Center	Cleveland	199	Lease
Montana			
Community Medical Center (a)	Missoula	151	JV/Own
Nevada			
Northeastern Nevada Regional Hospital	Elko	75	Own
New Mexico			
Los Alamos Medical Center	Los Alamos	47	Own
Memorial Medical Center of Las Cruces	Las Cruces	199	Lease

Facility Name	City	Licensed Beds	Ownership and Real Property Status
North Carolina			
Central Carolina Hospital (g)	Sanford	137	JV/Own
Frye Regional Medical Center (g)	Hickory	355	JV/Lease
Harris Regional Hospital (g)	Sylva	86	JV/Own
Haywood Regional Medical Center (g)	Clyde	154	JV/Own
Maria Parham Medical Center (h)	Henderson	205	JV/Own
Person Memorial Hospital (g)	Roxboro	98	JV/Own
Rutherford Regional Medical Center (g)	Rutherfordton	143	JV/Own
Swain County Hospital (g)	Bryson City	48	JV/Own
Wilson Medical Center (h)	Wilson	384	JV/Own
Ohio			
Clinton Memorial Hospital	Wilmington	141	Own
Oklahoma			
Southwestern Medical Center (d)	Lawton	107	Lease
Southwestern Behavioral Health Center (d)	Lawton	92	Lease
Oregon			
Willamette Valley Medical Center (d)	McMinnville	60	Lease
Pennsylvania			
Conemaugh Memorial Medical Center (d) (g)	Johnstown	537	JV/Lease
Meyersdale Medical Center (d) (g)	Meyersdale	20	JV/Lease
Miners Medical Center (d) (g)	Hastings	25	JV/Lease
Nason Medical Center (d)	Roaring Spring	45	Lease
South Carolina			
Carolina Pines Regional Medical Center (c) (d)	Hartsville	116	JV/Lease
KershawHealth (d)	Camden	119	Lease
Providence Hospital - Downtown	Columbia	258	Own
Providence Hospital - Northeast	Columbia	74	Own
Tennessee			
Livingston Regional Hospital	Livingston	114	Own
Riverview Regional Medical Center	Carthage	35	Own
Southern Tennessee Regional Health System - Lawrenceburg	Lawrenceburg	99	Own
Southern Tennessee Regional Health System - Pulaski	Pulaski	95	Own
Southern Tennessee Regional Health System - Sewanee	Sewanee	41	Lease
Southern Tennessee Regional Health System - Winchester	Winchester	157	Own
Starr Regional Medical Center - Athens	Athens	118	Own
Starr Regional Medical Center - Etowah	Etowah	160	Own
Sumner Regional Medical Center	Gallatin	167	Own
Trousdale Medical Center	Hartsville	25	Own
Texas			
Ennis Regional Medical Center	Ennis	60	Lease
Palestine Regional Medical Center (d)	Palestine	160	Lease
Paris Regional Medical Center	Paris	154	Own
Parkview Regional Hospital	Mexia	58	Lease
Utah			
Ashley Regional Medical Center	Vernal	39	Own
Castleview Hospital	Price	39	Own
Virginia			
Clinch Valley Medical Center	Richlands	175	Own
Fauquier Health	Warrenton	210	Own
Sovah Health - Danville	Danville	250	Own
Sovah Health - Martinsville	Martinsville	220	Own
Twin County Regional Hospital (h)	Galax	141	JV/Own
Wythe County Community Hospital	Wytheville	100	Lease

Facility Name	City	Licensed Beds	Ownership and Real Property Status
Washington			
Capital Medical Center (d) (i)	Olympia	107	JV/Lease
Lourdes Health - Medical Center (d)	Pasco	95	Lease
Lourdes Health - Counseling Center (d)	Pasco	32	Lease
Trios Health - Southridge Hospital (j)	Kennewick	74	JV/Lease
Trios Health - Women's and Children's Hospital (j)	Kennewick	37	JV/Lease
West Virginia			
Logan Regional Medical Center	Logan	140	Own
Raleigh General Hospital	Beckley	300	Own
Wisconsin			
Watertown Regional Medical Center (a)	Watertown	95	JV/Own
Wyoming			
SageWest Healthcare - Lander (d)	Lander	76	Lease
SageWest Healthcare - Riverton (d)	Riverton	70	Lease
		11,512	

(a) This facility is owned and operated by a joint venture between us and an unrelated third-party. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(b) This facility is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest. The real property on which this facility is located is owned by the LifePoint member and leased to the joint venture.
(c) This facility is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest.
(d) This facility is subject to a sale-leaseback arrangement with affiliates of MPT.
(e) This facility is owned and operated by St. Francis Holding Company, LLC ("***SFHC***"), a joint venture between us and Emory. A wholly-owned LifePoint affiliate owns the real property of this facility and leases the real property to SFHC.
(f) This facility is owned and operated by the Regional Health Network of Kentucky and Southern Indiana ("***RHN***"), a joint venture between us and Norton. A wholly-owned LifePoint affiliate owns a controlling interest in RHN.
(g) This facility is owned and operated by Duke LifePoint Healthcare (or a joint venture between affiliates of the members of Duke LifePoint Healthcare). A wholly-owned LifePoint affiliate owns a controlling interest in Duke LifePoint Healthcare and such other joint venture.
(h) This facility is owned and operated by a joint venture between a local not-for-profit entity and Duke LifePoint Healthcare.
(i) This facility is owned and operated by a joint venture among us, physicians and a joint venture between us and University of Washington. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture. On December 23, 2020, certain LifePoint affiliates entered into an agreement with an unrelated third-party to sell LifePoint's majority ownership interest in this facility.
(j) This facility is owned and operated by a joint venture between us and University of Washington. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.

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

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

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

Except as discussed under "Legal Proceedings and General Liability Claims" in Note 14 to our accompanying consolidated financial statements included elsewhere in this Report, we are currently not a party to any pending proceedings, which, in management's opinion would have a material adverse effect on our business, financial condition or results of operations.

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

Not applicable.

PART II

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

All of our equity securities are held by Holdings, whose indirect parent is DSB Parent. As of December 31, 2020, our Sponsor beneficially owned approximately 98.6% of the capital units of LifePoint with the remaining approximate 1.4% owned by our current or former directors, members of management, employees and consultants. Because our equity securities are privately held, there is no established public trading market for our equity securities.

Equity Compensation Plan Information

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

Recent Sales of Unregistered Securities

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

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

Not applicable.

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

The following is management's discussion and analysis of our financial condition and results of operations for the three months and years ended December 31, 2020 and December 31, 2019. We recommend that you read this discussion together with our accompanying consolidated financial statements and related notes included elsewhere in this Report.

Management's discussion and analysis of our financial condition and results of operations as of and for the year ended December 31, 2018 has been omitted as permitted by Instruction 1 to Item 303(a) of Regulation S-K. Refer to "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations for the Years Ended December 31, 2019 and 2018" in our Annual Report for the year ended December 31, 2019 for management's discussion and analysis of changes in financial condition and results of operations as of and for the year ended December 31, 2018.

Overview

We, acting through our subsidiaries, own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. As of December 31, 2020, we operated 88 hospital campuses in 29 states throughout the U.S., having a total of 11,512 licensed beds. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a network of hospitals and outpatient facilities.

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

We generated revenues of $2,191.9 million and $2,218.6 million during the three months ended December 31, 2020 and 2019, respectively, and $8,121.9 million and $8,752.8 million for the years ended December 31, 2020 and 2019, respectively. For the years ended December 31, 2020 and 2019, approximately 55.7% and 55.2% of our revenues, respectively, related to patients participating in Medicare and Medicaid programs, collectively. Payments made to our facilities pursuant to the Medicare and Medicaid programs for services rendered rarely exceed our costs for such services. As a result, we rely largely on payments made by private or commercial payers, together with certain limited services provided to Medicare recipients, to generate an operating profit. The healthcare industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial payers. This places a premium on efficient operation, the ability to reduce or control costs and the need to leverage the benefits of our organization across all of our facilities.

Developments, Trends and Operating Environment

Entry into Agreement to Sell Capital Medical Center

On December 23, 2020, we entered into a definitive agreement with an unrelated third-party to sell our majority ownership interest in Capital Medical Center. We expect the transaction to close during the first half of 2021. We have excluded Capital Medical Center from the classification of "same-hospital" in the forthcoming discussion and analysis of our results of operations for the three months and years ended December 31, 2020 and 2019. For additional information regarding our planned and historical divestitures, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

Entry into Services Agreement for Revenue Cycle Management

On October 28, 2020, we announced entry, through our subsidiary, LifePoint Corporate Services, into a services agreement with R1 RCM Inc. ("***R1***"), pursuant to which, commencing January 1, 2021, R1 began to manage revenue cycle operations in our hospitals that currently utilize independent revenue cycle management systems and those supported by our Business Services Center in Johnstown, Pennsylvania.

Impact of COVID-19

During March 2020, the global COVID-19 pandemic began to significantly affect our facilities, employees, patients, communities, business operations and financial performance, as well as the U.S. economy and financial markets, as a whole. Approximately one year into the pandemic, we continue to be deeply committed to protecting the health of our communities and are continuing to respond to the evolving COVID-19 situation across the country. Importantly, we are taking every precaution to ensure we can continue providing quality care and safeguard the health and well-being of patients, employees, providers, volunteers and visitors in each community we serve. The national footprint of our health system, along with our HSC, has enabled us to support our communities during this challenging time.

We established an internal COVID-19 taskforce during the early stages of the pandemic which continues to meet regularly today. Additionally, in November 2020, we established a COVID-19 vaccine team to help facilitate the successful distribution and administration of vaccines across our markets.

Our top priority continues to be ensuring the safety, health and well-being of those in our facilities and communities. We have put in place a number of protocols to protect our patients, providers, employees, volunteers and visitors, including:

- mandatory masking for all providers, employees, volunteers and visitors across our facilities;
- required eye protection for providers and employees during all clinical encounters across our facilities;
- required COVID-19 testing for all admissions in communities with the highest rates of COVID-19 spread;
- performing pre-operative COVID-19 testing for patients undergoing certain elective procedures; and
- social distancing practices and other protective measures throughout our facilities, including visitor restrictions, closing common areas, limiting entry points and screening providers, employees and visitors who enter our facilities based on criteria established by the CDC.

Restrictive measures, such as travel bans, social distancing and quarantine guidelines, significantly reduced the volume of procedures performed at our facilities during 2020, as well as the volume of emergency room and physician office visits unrelated to COVID-19. Furthermore, broad economic factors resulting from the current COVID-19 pandemic, including increasing unemployment rates and reduced consumer spending, could negatively affect our payer mix, increase the relative proportion of lower margin services we provide and reduce patient volumes, as well as diminish our ability to collect outstanding receivables.

Our evaluation of the measures taken across our health system in response to COVID-19 is ongoing and additional updates to our policies, procedures and operations could occur as best practices continue to evolve. Furthermore, our facilities are located across a wide geographic range of communities, which may require us to modify measures we take at specific facilities based on local conditions, including the severity of COVID-19 in the community served by the facility and changes in state and local restrictive measures.

As a result of the adverse impact of the COVID-19 pandemic on our business, we have undertaken several additional measures intended to enhance our financial flexibility, including among other things:

- increasing our liquidity with proceeds from the offering of the 6.75% Secured Notes;
- instituting net working capital optimization initiatives along with the curtailment of non-critical capital expenditures;
- receiving Medicare accelerated payments under the expanded Accelerated and Advance Payment Program (described in more detail below);
- receiving direct grant aid payments from the Emergency Fund established under the CARES Act (described in more detail below); and
- anticipating current year cash tax savings related to various tax provisions of the CARES Act (described in more detail below).

Additionally, although we have received funds that are available to us and our facilities under the CARES Act and related stimulus legislation and may seek additional funds that may become available under existing or future COVID-19 stimulus legislation, we cannot predict the manner in which such funds will be allocated or administered and we cannot assure you that we will be able to access such funds in a timely manner or at all. Most of these programs require healthcare providers to meet certain requirements and/or otherwise agree to certain terms and conditions in order to receive payment. In many cases, only limited guidance has been provided on those requirements and terms and conditions, and we already have seen changes in the substance and interpretation of that guidance.

For additional information about the risks presented by the COVID-19 pandemic, our responses to the pandemic and the resources available to healthcare providers, refer to "Part I, Item 1A. Risk Factors" included in this Report.

Legislative and Regulatory Developments in Response to COVID-19

CARES Act, Other Stimulus Legislation and Regulatory Developments

Numerous recent legislative and regulatory actions have been taken in an attempt to provide businesses, including healthcare providers, with relief from the negative impacts of the COVID-19 pandemic. For additional information about the CARES Act and other stimulus legislation and regulatory development related to the COVID-19 pandemic, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" included in this Report.

Direct Grant Aid Payments

With respect to payments being made to providers from the Emergency Fund, beginning April 10, 2020, the Emergency Fund distributed $50 billion to hospitals based on their 2018 net patient revenue. Since that time, the Emergency Fund has distributed an additional $74 billion to a number of different types of healthcare providers, including participants in state Medicaid/CHIP programs, providers in areas particularly impacted by the COVID-19 outbreak, rural providers (including hospitals and rural health clinics), skilled nursing facilities, dentists, providers of services with lower shares of Medicare reimbursement or who predominantly serve Medicaid beneficiaries, and providers requesting reimbursement for the treatment of uninsured patients. In addition, on October 1, 2020, HHS announced that an additional $24.5 billion in relief payments would be made from the Emergency Fund, on an application basis, to certain healthcare providers. HHS has stated that these additional relief payments will be allocated in a way that is intended to achieve an equitable payment of two percent of annual revenue from patient care for all applicants and may also take into account a provider's change in operating revenues from patient care, minus their operating expenses from patient care. For the year ended December 31, 2020, we recognized $646.3 million of direct grant aid payments as other income under the caption "Government stimulus income" in our accompanying consolidated statement of operations included elsewhere in this Report.

For additional information about direct grant aid payments, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" included in this Report.

Medicare Accelerated and Advance Payment Program

Using existing authority and certain expanded authority under the CARES Act, HHS had also expanded the CMS Accelerated and Advance Payment Program to a broader group of Medicare Part A and Part B providers. Under the expanded Accelerated and Advance Payment Program, inpatient acute care hospitals could request up to 100% of their Medicare payment amount for a six-month period (critical access hospitals could request up to 125% of their payment amount for such period), and other providers and suppliers could request up to 100% of their Medicare payment amount for a three-month period. Through December 31, 2020, we received a total of $991.0 million of Medicare advance payments under the Accelerated and Advance Payment Program, of which $369.8 million and $621.2 million are included under the captions "Current portion of Medicare advance payments" and "Long-term portion of Medicare advance payments", respectively, in our accompanying consolidated balance sheet at December 31, 2020 included elsewhere in this Report. We do not anticipate receiving any additional funds from the CMS Accelerated and Advance Payment Program.

For additional information about the repayment of these accelerated/advance payments refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" included in this Report.

CARES Act Tax Provisions

The CARES Act also provides for certain federal income tax changes, including an increase in the interest expense tax deduction limitation, the deferral of the employer portion of Social Security payroll taxes, refundable payroll tax credits, employee retention tax credits, net operating loss carryback periods, alternative minimum tax credit refunds and bonus depreciation of qualified improvement property. The federal income tax changes brought about by the CARES Act are complex and further guidance is expected. For the year ended December 31, 2020, we have deferred cash payments of approximately $84 million related to Social Security payroll tax payments into 2021 and 2022. Additionally, we have generated 2020 cash tax savings of approximately $57 million related to corporate tax law changes which increased the limitation in the tax deductibility of interest expense from 30% to 50% of adjusted taxable income as well as the ability to carry back net operating losses to each of the five tax years preceding the tax year of such loss. However, we may change our provision for income taxes and our deferred income taxes as our understanding of the CARES Act tax provisions evolves due to additional U.S. Department of Treasury guidance. Any such adjustments could materially impact our provision for income taxes and, as a result, our financial results in the relevant periods.

Healthcare Reform Efforts

The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare by, among other things, requiring most Americans to obtain health insurance, also referred to as the "individual mandate," providing additional funding for Medicaid in states that choose to expand their programs, reducing Medicare inpatient prospective payment system, Medicare outpatient prospective payment system, and Medicare and Medicaid disproportionate share hospital payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and instituting certain private health insurance reforms. The Affordable Care Act has, however, been subject to a number of legislative and regulatory changes and court challenges, and its future is uncertain.

The net effect of the Affordable Care Act, as currently adopted, on our business continues to be subject to a number of variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. Additionally, the Affordable Care Act has been challenged before the U.S. Supreme Court. We cannot predict the outcome of litigation challenging the constitutionality of the Affordable Care Act or whether the Affordable Care Act will be repealed, replaced or modified. If the Affordable Care Act is found to be unconstitutional, we cannot predict what, if any, the replacement plan or modifications would be, when any such replacement plan or modifications would become effective, or whether any of the existing provisions of the Affordable Care Act would remain in place. We also cannot predict the impact that the new Presidential administration and Congressional leadership will have on the implementation and enforcement of the provisions of the Affordable Care Act, on any current, pending or potential regulations adopted to implement the law, or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

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

Competitive and Structural Environment

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

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

We believe other key factors in our competition for patients is the quality of our patient care and the perception of that quality in the communities where our facilities are located, which may be influenced by, among other things, the technology, service lines and capital improvements made at our facilities and by the skills and experience of our non-physician employees involved in patient care.

In addition to competitive concerns, many of our communities are experiencing slow growth, and in some cases, population losses. We believe this trend has occurred mainly as a result of recent challenging economic conditions because the economies in the non-urban communities in which our facilities primarily operate are often dependent on a small number of larger employers, especially manufacturing or other facilities. This causes the economies of our communities to be more sensitive to economic downturns and slower to rebound when the overall U.S. economy improves. In addition, other economic factors, including, potentially, self-rationing of healthcare services, have made it more difficult to increase the number of patients who seek care at many of our facilities.

Regulatory Environment

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

Not only are our facilities heavily regulated, but the rules, regulations and laws to which they are subject often change, with little or no notice, and are often interpreted and applied differently by various regulatory agencies with authority to enforce such requirements. Each change or conflicting interpretation may require our facilities to make changes in space usage, equipment, personnel or services, and may also require that standard operating policies and procedures be re-written and re-implemented. The cost of complying with such laws and regulations is a significant component of our overall expenses. Further, this expense has grown in recent periods because of new regulatory requirements and the severity of the penalties associated with non-compliance. Management anticipates that compliance expenses will continue to grow in the foreseeable future. The healthcare industry has seen a number of ongoing investigations related to patient referrals, physician recruiting and employment practices, cost reporting and billing practices, medical necessity of inpatient admissions, physician office leasing, laboratory and home healthcare services, physician ownership of hospitals and other healthcare providers, and joint ventures involving hospitals and physicians. Hospitals continue to be one of the primary focal areas of the OIG, the DOJ and other governmental fraud and abuse programs.

The Affordable Care Act imposed an affirmative obligation on healthcare providers to report and refund any overpayments received. "Overpayments" in this context include any amount received from a government program by a provider to which it is not entitled, regardless of the cause. Such overpayments are deemed to be fraudulent and become violations of the False Claims Act if not reported and refunded within the later of 60 days of identification or the date any corresponding cost report is due (if applicable). Hospitals can meet the obligation to report and refund in three ways: (1) refunding overpayments directly to the program; (2) self-disclosing the overpayment to the OIG via its voluntary self-disclosure protocol (with respect to False Claims Act and other violations not related to the Stark law); and (3) self-disclosing to CMS via the self-referral disclosure protocol (with respect to overpayments caused by potential violations of the Stark law only) for which CMS has the authority to reduce the amounts otherwise owed.

In light of the provisions of the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law.

Revenue Sources

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

Medicare and Medicaid Reimbursement

Revenues from governmental payers, such as Medicare and Medicaid, are controlled by complex rules and regulations that stipulate the amount a hospital is paid for providing healthcare services. We must comply with these rules and regulations to continue to be eligible to participate in the Medicare and Medicaid programs. These rules and regulations are subject to frequent changes as a result of legislative and administrative action and annual payment adjustments on both the federal and the state levels. In addition, Medicare payment methodologies have been, and are expected to continue to be, revised significantly based on cost containment and policy considerations.

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

Physician & Non-Physician Practitioner Services

We employ an increasing number of physicians and non-physician practitioners, such as physician assistants and nurse practitioners, in our hospital markets. Medicare pays us for services provided by our employed physicians and non-physician practitioners under the PFS system. MACRA, which was adopted in 2015, significantly changed how CMS determines the annual updates to the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased annually by an additional 0.5% for CYs 2016, 2017 and 2018 and, after the adoption of the Bipartisan Budget Act of 2018, were increased by 0.25% for CY 2019. PFS payment rates are scheduled to remain at their CY 2019 levels through CY 2025. In addition, MACRA also established the QPP for incentivizing physician and practitioner care that meets certain value, quality, cost, and performance criteria, and, beginning in CY 2019, amounts paid to physicians and practitioners under the PFS are subject to adjustment through the QPP and participation in either MIPS or an APM. For more information, refer to "Part I, Item 1. Business—Sources of Revenue—Medicare Physician Fee Schedule" included in this Report.

HMOs, PPOs and Other Private Insurers

In addition to government programs, our facilities are reimbursed by differing types of private payers, including HMOs, PPOs and other private insurers. Revenues from HMOs, PPOs and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services or accept fixed, pre-determined fees for our services. These contractual discounted arrangements often limit our ability to increase charges or revenues in response to increasing costs. We actively negotiate with these payers in an effort to maintain or increase the pricing of our healthcare services; however, we have no control over patients switching their healthcare coverage to a payer with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower-cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. Additionally, plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices. If we provide services when we are not a participating provider in the network, it can result in higher patient responsibility amounts that a patient may not have the ability to pay or may choose not to pay. We expect these trends to continue in the coming years.

Self-pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Beginning in 2014, our self-pay revenues began to decrease as a percentage of overall revenues due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities have experienced in prior years, which included increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. We cannot predict how administrative or judicial interpretations, legislative actions or any other modifications to the Affordable Care Act that may be implemented or adopted, such as the cessation of cost sharing reduction payments or the repeal of the individual mandate, may impact our self-pay revenues.

Surprise Medical Billing

On December 21, 2020, Congress adopted legislation that is intended to limit the "surprise" medical bills that are often received by individuals receiving emergency and certain other services (such as anesthesia services) from out-of-network providers. Effective as of January 1, 2022, the No Surprises Act prohibits out-of-network providers from balance billing patients for (i) emergency care services that are provided by out-of-network facilities or at in-network facilities by out-of-network providers and (ii) transportation and related services that are provided by out-of-network air ambulance providers. The No Surprises Act also generally prohibits out-of-network providers from billing patients for non-emergency medical treatment unless the provider first notifies the patient of the provider's network status and estimated charges and the patient agrees to be financially liable for the additional amounts. Violations of the No Surprises Act are punishable by civil monetary penalties of up to $10,000, and the No Surprises Act may be enforced by both the state and federal governments.

We cannot predict how the No Surprises Act will be implemented by HHS or how it will ultimately be enforced by the federal and various state governments. We also cannot predict the amounts that will be received by our facilities and our employed providers for out-of-network services, whether the No Surprises Act will impact the in-network payment rates that are offered by third-party payers and the willingness of those payers to enter into participation agreements with us and our facilities in the future, or the costs we will incur in complying with the requirements of the No Surprises Act. In addition, a number of states are considering or have already adopted legislation to eliminate surprise medical billing. We cannot predict how state legislative actions to modify or pass these proposals may be implemented or adopted, or what impact, if any, those actions may have on our operations and revenues.

Price Transparency

Transparency in healthcare pricing has become a focal point for CMS, Congress, and many state legislatures. For example, effective as of January 1, 2021, hospitals generally are required to post their standard charges prominently on a publicly available website. CMS has stated that it intends to audit and monitor hospital compliance with its reporting requirements and to take actions to address hospital noncompliance, including issuing a warning notice, requesting a corrective action plan, and imposing civil monetary penalties. In addition to the CMS hospital price transparency regulations, HHS and the Departments of the Treasury and Labor have issued regulations that require most private health plans, including group health plans and individual health insurance market plans, to disclose pricing and cost-sharing information to their beneficiaries. A number of states have also adopted their own healthcare price transparency and/or disclosure statutes.

In addition to addressing surprise billing, the No Surprises Act also contains a number of provisions that are intended to promote provider and health plan price transparency. Among other things, effective as of January 1, 2022, under the No Surprises Act, healthcare providers will be required to provide "good faith estimates" of their total expected charges for scheduled items and services to the patient's health plan if the patient is insured prior to the item and/or service being provided. Health plans will be required to provide patients with an "advanced explanation of benefits" that includes (1) information regarding the network status of the provider, (2) a copy of the provider's "good faith estimate," (3) an estimate of the amount that the patient will be expected to pay for the item or service, and (4) information on any applicable pre-authorization requirements. The Secretary of HHS is required to adopt regulations to implement the price transparency provisions of the No Surprises Act.

Although we continue to evaluate, and are taking proactive steps in response to, the legislative and regulatory developments regarding price transparency, we cannot predict how existing regulations will be implemented or interpreted or whether any other requirements will be imposed on providers and health plans. We also cannot predict what affect the public disclosure of hospitals' or insurance providers' negotiated rates will have on our future negotiations with payers or the effect that the disclosure of pricing information by healthcare providers and health plans will have on our patient volumes and revenues.

Results of Operations

Certain Definitions

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

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

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

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

Consolidated. Consolidated information includes the results of all hospital operations and corporate overhead costs, including the results of our recent acquisitions and divestitures.

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

Equivalent admissions. Management and investors use equivalent admissions as a general measure of combined inpatient and outpatient volume. We compute equivalent admissions by multiplying admissions (inpatient volume) by the Outpatient factor. The equivalent admissions computation "equates" outpatient revenue to the volume measure (admissions) used to measure inpatient volume resulting in a general measure of combined inpatient and outpatient volume.

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

Same-hospital. Same-hospital information includes the results of the same 87 hospital campuses operated during both the three and twelve months ended December 31, 2020 and 2019. Same-hospital information excludes the results of our previously divested hospitals, as well as Capital Medical Center, which is classified as held-for-sale as of December 31, 2020.

For the Three Months Ended December 31, 2020 and 2019

Summary

The following table summarizes our results of operations for the three months ended December 31, 2020 and 2019 (dollars in millions):

	Three Months Ended December 31,			
	2020		2019 [a]	
	Amount	% of Revenues	Amount	% of Revenues
Revenues	$ 2,191.9	100.0 %	$ 2,218.6	100.0 %
Salaries and benefits	1,018.0	46.4	1,023.4	46.1
Supplies	399.7	18.2	374.1	16.9
Other operating expenses, net	574.5	26.3	545.1	24.6
Government stimulus income	(232.2)	(10.6)	-	-
Depreciation and amortization	90.7	4.1	100.9	4.5
Interest expense, net	119.5	5.5	132.5	6.0
Debt transaction costs	13.4	0.6	-	-
Merger, integration and other transaction-related costs	-	-	39.1	1.8
Impairments of goodwill and long-lived assets	-	-	3.3	0.1
Other non-operating losses, net	6.3	0.3	1.8	0.1
	1,989.9	90.8	2,220.2	100.1
Income (loss) before income taxes	202.0	9.2	(1.6)	(0.1)
(Benefit from) provision for income taxes	(15.3)	(0.7)	74.9	3.3
Net income (loss)	217.3	9.9	(76.5)	(3.4)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(8.3)	(0.4)	(3.7)	(0.2)
Net income (loss) attributable to LifePoint Health, Inc.	$ 209.0	9.5 %	$ (80.2)	(3.6) %

(a) Our results of operations for the three months ended December 31, 2019 have been restated in accordance with the adoption of Accounting Standards Update ("***ASU***") 2016-02, "Leases" ("***ASU 2016-02***"). For additional information regarding the impact of the adoption of ASU 2016-02, refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report.

Revenues

The following table summarizes our key revenue metrics for the three months ended December 31, 2020 and 2019:

	Three Months Ended December 31,		Increase	% Increase
	2020	2019	(Decrease)	(Decrease)
Consolidated:				
Number of hospital campuses at end of period	88	88	-	- %
Revenues (in millions)	$ 2,191.9	$ 2,218.6	$ (26.7)	(1.2)%
Admissions	75,895	83,129	(7,234)	(8.7)%
Equivalent admissions	184,740	219,228	(34,488)	(15.7)%
Revenues per equivalent admission	$ 11,864	$ 10,120	$ 1,744	17.2 %
Case mix index	1.51	1.38	0.13	9.4 %
Inpatient surgeries	19,448	22,550	(3,102)	(13.8)%
Outpatient surgeries	75,763	86,271	(10,508)	(12.2)%
Total surgeries	95,211	108,821	(13,610)	(12.5)%
Emergency department visits	382,249	481,491	(99,242)	(20.6)%
Same-hospital:				
Number of hospital campuses at end of period	87	87	-	- %
Revenues (in millions)	$ 2,170.4	$ 2,185.8	$ (15.4)	(0.7)%
Admissions	75,192	81,912	(6,720)	(8.2)%
Equivalent admissions	182,641	216,737	(34,096)	(15.7)%
Revenues per equivalent admission	$ 11,884	$ 10,085	$ 1,799	17.8 %
Case mix index	1.51	1.38	0.13	9.4 %
Inpatient surgeries	19,280	21,975	(2,695)	(12.3)%
Outpatient surgeries	75,356	85,453	(10,097)	(11.8)%
Total surgeries	94,636	107,428	(12,792)	(11.9)%
Emergency department visits	378,700	476,408	(97,708)	(20.5)%

For the three months ended December 31, 2020, our consolidated revenues decreased $26.7 million, or 1.2%, to $2,191.9 million compared to $2,218.6 million for the same period last year. The decrease in our revenues was a direct result of declines in patient volumes across the majority of our markets and service lines, which we believe is related to the deferral of non-urgent and elective procedures in connection with the COVID-19 pandemic and the response of federal, state, and local governments to the pandemic. This decrease was partially offset by an increase in the overall acuity of services provided and improvements in both commercial and government pricing during the three months ended December 31, 2020 compared to the same period last year.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the three months ended December 31, 2020 and 2019 (dollars in millions):

	Three Months Ended December 31,			
	2020		2019	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 867.9	39.6 %	$ 844.2	38.1 %
Medicaid	358.5	16.4	374.2	16.9
HMOs, PPOs and other private insurers	908.5	41.4	944.1	42.6
Self-pay	13.7	0.6	14.2	0.6
Other	39.4	1.8	37.5	1.6
Revenue from contracts with customers	2,188.0	99.8	2,214.2	99.8
Rental income	3.9	0.2	4.4	0.2
Revenues	$ 2,191.9	100.0 %	$ 2,218.6	100.0 %

Salaries and Benefits

For the three months ended December 31, 2020, our consolidated salaries and benefits expense was $1,018.0 million, or 46.4% of revenues, compared to $1,023.4 million, or 46.1% of revenues, for the same period last year. The increase in our salaries and benefits expense as a percentage of revenues for the three months ended December 31, 2020 compared to the same period last year was primarily a result of the decrease in revenue associated with the COVID-19 pandemic.

Supplies

For the three months ended December 31, 2020, our consolidated supplies expense was $399.7 million, or 18.2% of revenues, compared to $374.1 million, or 16.9% of revenues, for the same period last year. The increase in our supplies expense was partially attributable to an increase in the overall level of acuity of services provided during the three months ended December 31, 2020 compared to the same period last year, in addition to higher costs and an increase in the utilization of supplies related to pharmaceuticals, laboratory supplies and personal protective equipment, primarily associated with the COVID-19 pandemic.

Other Operating Expenses, Net

Other operating expenses include, among other things, contract services, professional fees, rents and leases, repairs and maintenance, utilities, insurance, non-income taxes, other income and other expenses. For the three months ended December 31, 2020, our consolidated other operating expenses were $574.5 million, or 26.3% of revenues, compared to $545.1 million, or 24.6% of revenues, for the same period last year. The increase in our other operating expenses as a percentage of revenues for the three months ended December 31, 2020 compared to the same period last year was primarily related to increases in physician subsidies and an increase in the utilization of outsourced contracted services for laboratory testing associated with the COVID-19 pandemic.

Government Stimulus Income

As a result of the adverse impact of the COVID-19 pandemic on our business, we received direct grant aid payments from the Emergency Fund established under the CARES Act. For the three months ended December 31, 2020, we recognized $232.2 million of direct grant aid payments as other income. For a further discussion of the CARES Act and related financial impact, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" and Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Depreciation and Amortization

For the three months ended December 31, 2020, our consolidated depreciation and amortization expense was $90.7 million, or 4.1% of revenues, compared to $100.9 million, or 4.5% of revenues, for the same period last year. Our depreciation expense was higher during the three months ended December 31, 2019 due to the impact of the finalization of certain significant construction projects which resulted in additional depreciation expense.

Interest Expense, Net

For the three months ended December 31, 2020, our consolidated interest expense was $119.5 million, or 5.5% of revenues, compared to $132.5 million, or 6.0% of revenues, for the same period last year. The decrease in our interest expense was primarily attributable to the various debt financing activities completed during 2020, which resulted in a lower weighted average borrowing rate for the three months ended December 31, 2020 compared to the same period last year. Additionally, we recognized non-cash changes in the estimated fair value of our Interest Rate Swap through interest expense during the three months ended December 31, 2020 and 2019. For a further discussion of our debt and corresponding interest expense, refer to Notes 4 and 11 to our accompanying consolidated financial statements included elsewhere in this Report.

Debt Transaction Costs

For the three months ended December 31, 2020, we recognized $13.4 million of debt transaction costs associated with the offering of the 5.375% Unsecured Notes and the $500.0 million prepayment of the Term Loan Facility. For a further discussion of our debt transactions, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Merger, Integration and Other Transaction-Related Costs

For the three months ended December 31, 2019, we recognized merger, integration and other transaction-related costs of $39.1 million, primarily related to expenses associated with our sale-leaseback transaction with Medical Properties Trust, which became effective December 17, 2019 (the "***2019 Sale Leaseback Transaction***") and other integration-related expenses in connection with the LifePoint/RCCH Merger.

Other Non-Operating Losses, Net

For the three months ended December 31, 2020 and 2019, we recognized net other non-operating losses of $6.3 million and $1.8 million, respectively, primarily related to non-cash changes in the estimated fair value of certain contingent liabilities and miscellaneous disposals of property and equipment.

Income Taxes

For the three months ended December 31, 2020, we recognized a benefit from income taxes of $15.3 million, primarily related to differences in the current tax liabilities between the 2019 filed tax returns and amounts recorded in the 2019 tax provision that resulted from the significant revisions to the U.S. corporate tax laws due to the enactment of the CARES Act. For the three months ended December 31, 2019, we recognized a provision for income taxes of $74.9 million, primarily related to a gain, recognized for tax purposes only, resulting from the 2019 Sale Leaseback Transaction. For a further discussion of our income taxes, refer to Note 6 to our accompanying consolidated financial statements included elsewhere in this Report.

For the Years Ended December 31, 2020 and 2019

Summary

The following table summarizes our results of operations for the years ended December 31, 2020 and 2019 (dollars in millions):

	Years Ended December 31,			
	2020		2019 [a]	
	Amount	% of Revenues	Amount	% of Revenues
Revenues	$ 8,121.9	100.0 %	$ 8,752.8	100.0 %
Salaries and benefits	3,877.5	47.7	4,044.0	46.2
Supplies	1,417.6	17.5	1,471.7	16.8
Other operating expenses, net	2,207.2	27.3	2,150.3	24.6
Government stimulus income	(646.3)	(8.0)	-	-
Depreciation and amortization	377.4	4.6	376.5	4.3
Interest expense, net	528.1	6.5	568.6	6.5
Debt transaction costs	115.4	1.4	-	-
Merger, integration and other transaction-related costs	-	-	76.9	0.9
Impairments of goodwill and long-lived assets	-	-	3.3	-
Other non-operating losses, net	4.0	-	5.5	0.1
	7,880.9	97.0	8,696.8	99.4
Income (loss) before income taxes	241.0	3.0	56.0	0.6
(Benefit from) provision for income taxes	(63.7)	(0.8)	77.9	0.9
Net income (loss)	304.7	3.8	(21.9)	(0.3)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(21.5)	(0.3)	(19.3)	(0.2)
Net income (loss) attributable to LifePoint Health, Inc.	$ 283.2	3.5 %	$ (41.2)	(0.5) %

(a) Our results of operations for the year ended December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. For additional information regarding the impact of the adoption of ASU 2016-02, refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report.

Revenues

The following table summarizes our key revenue metrics on a consolidated basis for the years ended December 31, 2020 and 2019:

	Years Ended December 31,		Increase	% Increase
	2020	2019	(Decrease)	(Decrease)
Consolidated:				
Number of hospital campuses at end of period	88	88	-	- %
Revenues (in millions)	$ 8,121.9	$ 8,752.8	$ (630.9)	(7.2)%
Admissions	299,254	339,571	(40,317)	(11.9)%
Equivalent admissions	744,917	888,331	(143,414)	(16.1)%
Revenues per equivalent admission	$ 10,903	$ 9,853	$ 1,050	10.7 %
Case mix index	1.45	1.37	0.08	5.8 %
Inpatient surgeries	79,612	92,908	(13,296)	(14.3)%
Outpatient surgeries	277,777	344,919	(67,142)	(19.5)%
Total surgeries	357,389	437,827	(80,438)	(18.4)%
Emergency department visits	1,570,558	1,961,459	(390,901)	(19.9)%
Same-hospital:				
Number of hospital campuses at end of period	87	87	-	- %
Revenues (in millions)	$ 8,025.4	$ 8,589.5	$ (564.1)	(6.6)%
Admissions	295,790	333,106	(37,316)	(11.2)%
Equivalent admissions	735,833	874,480	(138,647)	(15.9)%
Revenues per equivalent admission	$ 10,907	$ 9,822	$ 1,085	11.0 %
Case mix index	1.45	1.37	0.08	5.8 %
Inpatient surgeries	78,335	90,262	(11,927)	(13.2)%
Outpatient surgeries	275,522	340,602	(65,080)	(19.1)%
Total surgeries	353,857	430,864	(77,007)	(17.9)%
Emergency department visits	1,555,257	1,920,176	(364,919)	(19.0)%

For the year ended December 31, 2020, our consolidated revenues decreased $630.9 million, or 7.2%, to $8,121.9 million compared to $8,752.8 million for the prior year. The decrease in our revenues was a direct result of declines in patient volumes across the majority of our markets and service lines, which we believe is related to the deferral of non-urgent and elective procedures in connection with the COVID-19 pandemic and the response of federal, state, and local governments to the pandemic. This decrease was partially offset by an increase in the overall acuity of services provided and improvements in both commercial and government pricing during the year ended December 31, 2020 compared to the prior year.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the years ended December 31, 2020 and 2019 (dollars in millions):

	Years Ended December 31,			
	2020		2019	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,134.0	38.6 %	$ 3,338.1	38.1 %
Medicaid	1,392.4	17.1	1,495.3	17.1
HMOs, PPOs and other private insurers	3,381.9	41.6	3,698.6	42.3
Self-pay	54.5	0.7	59.2	0.7
Other	142.7	1.8	143.6	1.6
Revenue from contracts with customers	8,105.5	99.8	8,734.8	99.8
Rental income	16.4	0.2	18.0	0.2
Revenues	$ 8,121.9	100.0 %	$ 8,752.8	100.0 %

Salaries and Benefits

For the year ended December 31, 2020, our consolidated salaries and benefits expense was $3,877.5 million, or 47.7% of revenues, compared to $4,044.0 million, or 46.2% of revenues, for the prior year. The increase in our salaries and benefits expense as a percentage of revenues for the year ended December 31, 2020 compared to the prior year was primarily a result of the decrease in revenues associated with the COVID-19 pandemic.

Supplies

For the year ended December 31, 2020, our consolidated supplies expense was $1,417.6 million, or 17.5% of revenues, compared to $1,471.7 million, or 16.8% of revenues, for the prior year. The increase in our supplies expense was partially attributable to an increase in the overall level of acuity of services provided during the year ended December 31, 2020 compared to the same period last year, in addition to higher costs and an increase in the utilization of supplies related to pharmaceuticals, laboratory supplies and personal protective equipment, primarily associated with the COVID-19 pandemic.

Other Operating Expenses, Net

Other operating expenses include, among other things, contract services, professional fees, rents and leases, repairs and maintenance, utilities, insurance, non-income taxes, other income and other expenses. For the year ended December 31, 2020, our consolidated other operating expenses were $2,207.2 million, or 27.3% of revenues, compared to $2,150.3 million, or 24.6% of revenues, for the prior year. The increase in our other operating expenses was primarily related to increases in physician subsidies and an increase in the utilization of outsourced contracted services for laboratory testing associated with the COVID-19 pandemic.

Government Stimulus Income

As a result of the adverse impact of the COVID-19 pandemic on our business, we received direct grant aid payments from the Emergency Fund established under the CARES Act. For the year ended December 31, 2020, we recognized $646.3 million of direct grant aid payments as other income. For a further discussion of the CARES Act and related financial impact, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" and Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Depreciation and Amortization

For the year ended December 31, 2020, our consolidated depreciation and amortization expense was $377.4 million, or 4.6% of revenues, which was comparable to $376.5 million, or 4.3% of revenues, for the prior year.

Interest Expense, Net

For the year ended December 31, 2020, our consolidated interest expense was $528.1 million, or 6.5% of revenues, compared to $568.6 million, or 6.5% of revenues, for the prior year. The decrease in our interest expense was primarily attributable to the various debt financing activities completed during 2020, which resulted in a lower weighted average borrowing rate for the year ended December 31, 2020 compared to last year. Additionally, we recognized non-cash changes in the estimated fair value of our Interest Rate Swap through interest expense during the year ended December 31, 2020 and 2019. For a further discussion of our debt and corresponding interest expense, refer to Notes 4 and 11 to our accompanying consolidated financial statements included elsewhere in this Report.

Debt Transaction Costs

For the year ended December 31, 2020, we recognized $115.4 million of debt transaction costs associated with the various debt financing activities completed during 2020. For a further discussion of our debt transactions, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Merger, Acquisition and Other Transaction-Related Costs

For the year ended December 31, 2019, we recognized costs of $76.9 million, primarily related to employee severance and retention costs and other integration-related expenses in connection with the LifePoint/RCCH Merger, as well as costs related to the 2019 Sale Leaseback Transaction.

Impairments of Goodwill and Long-lived Assets

For the year ended December 31, 2019, we recognized a goodwill impairment charge of $3.3 million related to one of our facilities. For a further discussion of impairments of goodwill and other long-lived assets, refer to Notes 1 and 5 to our accompanying consolidated financial statements included elsewhere in this Report.

Other Non-Operating Losses, Net

For the years ended December 31, 2020 and 2019, we recognized net other non-operating losses of $4.0 million and $5.5 million, respectively, primarily related to non-cash changes in the estimated fair value of certain contingent liabilities and miscellaneous disposals of property and equipment.

Income Taxes

For the year ended December 31, 2020, we recognized a benefit from income taxes of $63.7 million, primarily as a result of significant revisions to the U.S. corporate tax laws due to the enactment of the CARES Act. We were most notably impacted by an increase in the limitation in the tax deductibility of interest expense from 30% to 50% of adjusted taxable income for the years ended December 31, 2020 and 2019, as well as the ability to carry back net operating losses to each of the five tax years preceding the tax year of such loss. For the year ended December 31, 2019, we recorded a provision for income taxes of $77.9 million, primarily related to a gain recognized for tax purposes only resulting from the 2019 Sale Leaseback Transaction. For a further discussion of our income taxes, refer to Note 6 to our accompanying consolidated financial statements included elsewhere in this Report.

Non-GAAP Measures

Adjusted EBITDA

Included in net income for the three months and year ended December 31, 2020 is $232.2 million and $646.3 million, respectively, of CARES Act direct grant aid payments recognized as other income.

The following table presents a reconciliation of net income (loss) to EBITDA and Adjusted EBITDA on a consolidated basis for the three months and years ended December 31, 2020 and December 31, 2019 (in millions):

	Three Months Ended December 31,		Years Ended December 31,	
	2020	2019 [a]	2020	2019 [a]
Net income (loss)	$ 217.3	$ (76.5)	$ 304.7	$ (21.9)
Interest expense, net	119.5	132.5	528.1	568.6
Income taxes	(15.3)	74.9	(63.7)	77.9
Depreciation and amortization	90.7	100.9	377.4	376.5
EBITDA	412.2	231.8	1,146.5	1,001.1
(1) Debt transaction costs	13.4	-	115.4	-
(2) Merger, integration and other transaction-related costs	-	39.1	-	76.9
(3) Facility lease expense	(19.9)	(9.5)	(79.8)	(31.8)
(4) One-time costs, non-cash charges and non-recurring items	22.1	17.6	74.7	62.9
Subtotal	427.8	279.0	1,256.8	1,109.1
(5) Pro forma run rate adjustments	19.4	(6.4)	76.3	(4.5)
Adjusted EBITDA	$ 447.2	$ 272.6	$ 1,333.1	$ 1,104.6

(a) Our results of operations for the three months and year ended December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. The adoption of ASU 2016-02 had no impact on Adjusted EBITDA. For additional information regarding the impact of the adoption of ASU 2016-02, refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report.

* *Footnote references regarding EBITDA adjustments are included on the following page.*

(1) Represents costs associated with the various debt financing activities completed during 2020, including payments of early termination premiums and write-offs of previously capitalized debt issuance costs.

(2) Represents costs associated with the LifePoint/RCCH Merger, the 2019 Sale Leaseback Transaction and certain other transactions, including legal, financing and transaction advisory services, employee severance and retention costs and other integration-related expenses associated with such transactions.

(3) Represents cash interest expense in connection with certain finance leases. Pursuant to the terms of our financial covenants contained in our debt agreements, we are required to consider cash interest expense on hospital-related finance leases within the definition of Adjusted EBITDA.

(4) Represents the exclusion of certain one-time costs, non-cash charges and non-recurring items, including the elimination of EBITDA associated with facilities that have been divested, differences between cash payments and reported rent expense for facility operating leases, and certain accounting changes resulting from our adoption of ASU 2016-02.

(5) Represents the estimated pro forma EBITDA impact attributable to various strategic initiatives in accordance with our debt agreements. For the year ended December 31, 2020, such items primarily consist of (i) unrealized cost savings related to conversions of the revenue cycle management function in certain of our hospitals; (ii) new or expanded service lines, newly constructed facilities and other strategic investments; and (iii) the pro forma impact of our pending divestiture of Capital Medical Center. For the year ended December 31, 2019, such items primarily consist of (i) unrealized incremental lease expense associated with the 2019 Sale Leaseback Transaction; (ii) new acquisitions, new or expanded service lines, newly constructed facilities and other strategic investments; and (iii) unrealized cost savings related to synergies anticipated from the LifePoint/RCCH Merger.

Leverage

The following table illustrates our indebtedness and certain leverage ratios prepared in accordance with the calculations set forth in the Indentures and the Credit Agreements as of and for the years ended December 31, 2020 and 2019 (dollars in millions):

	December 31, 2020	December 31, 2019
Cash and cash equivalents [a]	$ 2,652.6	$ 748.1
ABL Facility	$ -	$ -
Term Loan Facility	3,214.5	3,523.4
6.75% Secured Notes	600.0	-
4.375% Secured Notes	600.0	-
8.25% Secured Notes	-	800.0
Total Secured Debt [b]	$ 4,414.5	$ 4,323.4
Net Secured Debt [a][b]	$ 1,761.9	$ 3,575.3
9.75% Unsecured Notes	$ 1,425.0	$ 1,425.0
5.375% Unsecured Notes	500.0	-
11.5% Unsecured Notes	-	350.0
Total Debt [b]	$ 6,339.5	$ 6,098.4
Net Debt [a][b]	$ 3,686.9	$ 5,350.3
Adjusted EBITDA	$ 1,333.1	$ 1,104.6
Total Secured Debt [b] / Adjusted EBITDA	3.31x	3.91x
Net Secured Debt [a][b] / Adjusted EBITDA	1.32x	3.24x
Total Debt [b] / Adjusted EBITDA	4.76x	5.52x
Net Debt [a][b] / Adjusted EBITDA	2.77x	4.84x

(a) Included in cash and cash equivalents at December 31, 2020 is $991.0 million of Medicare advance payments. For additional information regarding Medicare advance payments, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

(b) Excludes finance leases, which are not considered indebtedness for purposes of calculating the ratios set forth in the Indentures and the Credit Agreements, as well as unamortized debt issuance costs and premium.

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash generated by operations and borrowings under the ABL Facility. Our primary uses of cash are working capital requirements, debt service requirements and capital expenditures. Based on our current level of operations and available cash, we believe our cash flows from operations, combined with availability under the ABL Facility, will provide sufficient liquidity to fund our current obligations, projected working capital requirements, debt service requirements and capital spending requirements over the next twelve months. We cannot assure you, however, that our business will generate sufficient cash flows from operations or that future borrowings will be available to us under the ABL Facility, which is subject to a borrowing base, in an amount sufficient to enable us to pay principal and interest on the ABL Facility, the Term Loan Facility and the Notes, or to fund other liquidity needs. Our ability to do so depends on prevailing economic conditions, many of which are beyond our control. In addition, upon the occurrence of certain events, such as a change of control, we could be required to repay or refinance our indebtedness. We cannot assure you that we will be able to refinance any of our indebtedness on commercially reasonable terms or at all. Any future acquisitions, joint ventures or other similar transactions will likely require additional capital, and there can be no assurance that any such capital will be available to us on acceptable terms or at all. Any refinancing of our indebtedness could be at higher interest rates and may require us to comply with more onerous covenants that could further restrict our business operations. See "Item 1A, Risk Factors—Credit and Liquidity Risks" included elsewhere in this Report.

The following table presents summarized cash flow information for the years ended December 31, 2020 and 2019 (in millions):

	2020	2019
Net cash provided by operating activities	$ 1,920.3	$ 413.6
Net cash used in investing activities	(120.6)	(310.1)
Net cash provided by financing activities	104.8	585.7
Change in cash and cash equivalents	$ 1,904.5	$ 689.2

Operating Activities

For the year ended December 31, 2020, our net cash provided by operating activities were $1,920.3 million, including the receipt of $991.0 million of Medicare advance payments in connection with the CARES Act. Additionally, our net cash provided by operating activities for the year ended December 31, 2020 was positively impacted by our receipt and recognition of CARES Act direct grant aid payments, as well as changes in net working capital, including the deferral of payroll taxes, lower cash interest payments and improvements in the amount and timing of collections of outstanding patient and other receivables. These positive operating cash flows were partially offset by differences in the amount and timing of income tax payments made during the year ended December 31, 2020, compared to the receipt of net income tax refunds in the prior year.

For the year ended December 31, 2019, our cash flows from operating activities were $413.6 million, primarily driven by our strong operating performance, in addition to the collection of income tax refunds.

Investing Activities

For the year ended December 31, 2020, our net cash used in investing activities primarily consisted of purchases of property and equipment. We invested $170.4 million and $336.7 million in purchases of property and equipment for the years ended December 31, 2020 and 2019, respectively. Refer to "—Capital Expenditures" below for further information.

Financing Activities

Our net cash provided by financing activities for the year ended December 31, 2020 consisted of proceeds from the offering of our 6.75% Secured Notes, 4.375% Secured Notes, and 5.375% Unsecured Notes, in addition to the issuances of the Incremental Term Loan, partially offset by payments made in connection with the redemption and discharge of our 8.25% Secured Notes and 11.5% Unsecured Notes, and prepayments of our Term Loan Facility. Refer to "—Capital Resources" below for further information regarding our recent debt transactions.

For the year ended December 31, 2019, our net cash provided by financing activities primarily consisted of proceeds from the 2019 Sale Leaseback Transaction, net repayments of loans outstanding on our ABL Facility and installment payments on our Term Loan Facility.

Capital Expenditures

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

The following table summarizes our capital expenditures as a percentage of revenues and as a percentage of depreciation expense for the years ended December 31, 2020 and 2019 (dollars in millions):

	2020		2019	
	Amount	% of Revenues	Amount	% of Revenues
Capital expenditures	$ 170.4	2.1 %	$ 336.7	3.8 %
Depreciation expense	$ 376.1		$ 374.7	
Ratio of capital expenditures to depreciation expense	45.3 %		89.9 %	

We have a formal and intensive review procedure for the authorization of capital expenditures that exceed an established threshold. One of the most important financial measures of acceptability for a discretionary capital project is whether its projected discounted cash flow return on investment exceeds our projected cost of capital for that project. We expect to continue to invest in information systems, modern technologies, emergency room and operating room expansions, the construction of medical office buildings for physician expansion and the reconfiguration of the flow of patient care. Additionally, we may from time to time replace existing hospital buildings with new buildings as we evaluate ongoing repair and maintenance costs and other factors that impact the future operations of the existing buildings. For the year ended December 31, 2020, we intentionally decreased our capital expenditures by pausing on many of the growth and expansion projects during the early stages of the pandemic. Refer to "—Liquidity and Capital Resources Outlook" below for further information regarding our long-term capital expenditure commitments.

Capital Resources

ABL Facility

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

Term Loan Facility

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we entered into the Term Loan Facility with an original aggregate principal amount of $3,550.0 million with a maturity of seven years and we repaid in full our Prior Term Facility. The Term Loan Facility was amended in connection with a refinancing transaction during the first quarter of 2020. For further information regarding the Term Loan Facility, including certain restrictive covenants and the refinancing transactions, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

6.75% Secured Notes

On April 13, 2020, we issued the 6.75% Secured Notes in an aggregate principal amount of $600.0 million with a maturity of five years. For further information regarding the 6.75% Secured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

4.375% Secured Notes

On February 13, 2020, we issued the 4.375% Secured Notes in an aggregate principal amount of $600.0 million with a maturity of seven years. For further information regarding the 4.375% Secured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

9.75% Unsecured Notes

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

5.375% Unsecured Notes

On December 4, 2020, we issued the 5.375% Unsecured Notes in an aggregate principal amount of $500.0 million with a maturity of eight years. For further information regarding the 5.375% Unsecured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

A roll-forward of our long-term debt, including current portions, during 2020 is as follows (in millions):

	December 31, 2019 [a]	Proceeds from Borrowings	Payments of Borrowings	Debt Issuance Costs [b]	Finance Lease Obligations [c]	December 31, 2020
Senior borrowings:						
ABL Facility	$ -	$ -	$ -	$ -	$ -	$ -
ABL FILO Term Loan	-	80.0	(80.0)			-
Term Loan Facility	3,523.4	600.0	(908.9)	-	-	3,214.5
6.75% Secured Notes	-	600.0	-	-	-	600.0
4.375% Secured Notes	-	600.0	-	-	-	600.0
8.25% Secured Notes	800.0	-	(800.0)	-	-	-
9.75% Unsecured Notes	1,425.0	-	-	-	-	1,425.0
5.375% Unsecured Notes	-	500.0	-	-	-	500.0
11.5% Unsecured Notes	350.0	-	(350.0)	-	-	-
Finance lease obligations	1,128.3	-	-	-	(80.1)	1,048.2
Unamortized debt issuance costs and premium	(191.8)	1.5	-	38.5	-	(151.8)
Subordinated borrowings, net	1.6	-	(1.7)	0.1	-	-
	$ 7,036.5	$ 2,381.5	$ (2,140.6)	$ 38.6	$ (80.1)	$ 7,235.9

(a) Our finance lease obligations as of December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. For additional information regarding the impact of the adoption of ASU 2016-02, refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report.

(b) Represents non-cash write-offs of $47.4 million and amortization of $26.0 million, partially offset by the capitalization of new debt issuance costs of $34.8 million.

(c) Represents finance lease obligations reclassified to liabilities held for sale of $111.3 million and amortization of $11.4 million, partially offset by new finance leases entered into during 2020 of $42.6 million.

We monitor the capital markets and our capital structure and make changes from time to time, with the goal of maintaining financial flexibility, preserving or improving liquidity and/or achieving cost efficiency. From time to time, we may elect to repurchase amounts of our outstanding debt for cash through open market repurchases or privately negotiated transactions with certain of our debt holders, although there is no assurance we will do so.

Liquidity and Capital Resources Outlook

We continue to have ongoing capital commitments in connection with several of our acquired facilities. At December 31, 2020, we estimated our total remaining capital expenditure commitments to be approximately $1,174.7 million, which generally have remaining terms of two to six years. Of this amount, more than one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the ABL Facility.

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

Inflation

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

Contractual Obligations and Material Cash Requirements

We have certain material contractual obligations which are recorded as liabilities in our consolidated financial statements, primarily including:

- long-term debt obligations (refer to "—Capital Resources" above and to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report); and
- finance and operating lease obligations (refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report).

Additionally, we have certain other material cash requirements related to items that are not recognized as liabilities in our consolidated financial statements, primarily including:

- capital expenditure commitments (refer to "—Capital Expenditures" above and to Note 14 to our accompanying consolidated financial statements included elsewhere in this Report);
- shared centralized resource model arrangements with various third-parties to provide certain nonclinical business functions to us, including payroll, supply chain management and revenue cycle management;
- information technology services, including, but not limited to, financial, clinical, patient accounting and other information services;
- diagnostic imaging equipment maintenance and bio-medical services; and
- other minimum commitments to purchase miscellaneous goods or services under non-cancelable contracts.

Off-Balance Sheet Arrangements

We had letters of credit outstanding of approximately $45.3 million as of December 31, 2020, primarily related to the self-insured retention level of our general and professional liability insurance and workers' compensation programs as security for payment of claims and as security for certain lease agreements.

Adoption of Recently Issued Accounting Standards

Refer to Note 1 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of our adoption of recently issued accounting standards.

Critical Accounting Estimates

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

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

Our critical accounting estimates include the following areas:

- Accounting for CARES Act direct grant aid payments;
- Revenue recognition and accounts receivable;
- Goodwill impairment analysis;
- Accounting for income taxes; and
- Reserves for self-insurance claims.

The following discussion of critical accounting estimates is not intended to be a comprehensive list of all of our accounting policies that require estimates, but the estimates discussed below involve a higher degree of judgment and complexity. We believe the current assumptions and other considerations used to estimate amounts reflected in our consolidated financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in our consolidated financial statements, the resulting changes could have a material adverse effect on our consolidated results of operations and our financial condition. The discussion that follows presents information about our critical accounting estimates, as well as the effects of hypothetical changes in the material assumptions used to develop each estimate.

Accounting for CARES Act Direct Grant Aid Payments

For the year ended December 31, 2020, we recognized $646.3 million of direct grant aid payments as other income under the caption "Government stimulus income" in our accompanying consolidated statement of operations included elsewhere in this Report. Payments made by the Emergency Fund to healthcare providers are not loans, and, as a result, they do not need to be repaid. However, healthcare providers are required to file attestations acknowledging receipt of the payments and must agree to and meet the terms and conditions that are associated with the payments, which include, among other things, accepting in-network amounts for presumptive or actual out-of-network COVID-19 patients and not using the payments received from the Emergency Fund to reimburse expenses or losses that other sources are obligated to reimburse. HHS has indicated that it will be closely monitoring the payments that are made to providers through the Emergency Fund, and that HHS, along with the OIG, will be auditing providers to ensure that recipients comply with the terms and conditions that are associated with the Emergency Fund and other COVID-19 relief programs.

We have accounted for the direct grant aid payments received as a government grant related to income in a manner consistent with International Accounting Standards 20, "Accounting for Government Grants and Disclosure of Government Assistance" ("***IAS 20***"). In accordance with IAS 20, government grants are recognized either as other income or a reduction to a related expense when there is reasonable assurance that the grant will be received, and the entity will comply with any conditions attached to the grant. There is currently limited, and sometimes changing, guidance available regarding the accounting treatment of funds that have been received by us and our facilities under the CARES Act and the related stimulus legislation. This lack of guidance requires us to apply professional judgement and make certain estimates and assumptions with respect to the presentation, amount and timing of our recognition of direct grant aid received under the CARES Act. For additional information regarding the CARES Act and related financial impact, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" and Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Revenue Recognition and Accounts Receivable

We recognize revenues in the period in which performance obligations are satisfied. Generally, we bill patients and third-party payers several days after the services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payers and patients. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. Amounts we receive for treatment of patients covered by governmental programs and third-party payers such as Medicare, Medicaid, HMOs, PPOs and private insurers as well as directly from patients are subject to contractual adjustments, discounts and implicit price concessions. Accordingly, the revenue and accounts receivable reported in our financial statements are recorded at the net consideration to which we expect to be entitled to receive in exchange for providing patient care.

Approximately 98.0%, 98.2% and 98.0% of our patient revenues recognized during the years ended December 31, 2020, 2019 and 2018, respectively, related to discounted charges, which were comprised of the following sources (as a percentage of our revenues):

	2020	2019	2018
Medicare	38.6 %	38.1 %	39.8 %
Medicaid	17.1 %	17.1 %	17.5 %
HMOs, PPOs and other private insurers	41.6 %	42.3 %	40.1 %
Self-pay	0.7 %	0.7 %	0.6 %

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

We monitor our processes for calculating contractual allowances through:

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

Medicare and Medicaid

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

Discounts for retrospectively cost-based revenues are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under these programs are subject to adjustment based on administrative review and audit by third-party intermediaries, which can take several years to resolve completely.

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

HMOs, PPOs and Other Private Insurers

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

The process of determining the allowance requires us to estimate the amount expected to be received based on payer contract provisions, historical collection data as well as other factors and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts for managed care plans would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Self-Pay Revenues

Self-pay revenues are derived from patients who do not have any form of healthcare coverage as well as from patients with third-party healthcare coverage related to the patient responsibility portion, including deductibles and co-payments. We evaluate these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs. We estimate the transaction price for self-pay patients and the patient responsibility portion using a number of analytical tools, benchmarks and market conditions. No single statistic or measurement determines the transaction price for these patients. Some of the analytical tools that we utilize include, but are not limited to, historical cash collection experience, revenue trends by payer classification and revenue days in accounts receivable.

The revenues associated with self-pay patients are reported at the net amount that we expect to collect. Because we provide care to patients regardless of their ability to pay, we have determined that the differences between the amounts we bill based on gross or discounted charges and the amounts we expect to collect represent implicit price concessions. The final amount that will be received from the patient is not known at the date of service, and we account for this variable consideration in accordance with the provisions of ASC 606. Self-pay accounts receivable are written off after collection efforts have been followed in accordance with our policies.

Goodwill Impairment Analysis

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired businesses. Our goodwill included in our consolidated balance sheet as of December 31, 2020 was $2,918.5 million. Refer to Note 5 to our accompanying consolidated financial statements included elsewhere in this Report for a detailed rollforward of changes in our goodwill during the years ended December 31, 2020 and 2019.

In accordance with ASC 350, "Intangibles — Goodwill and Other" ("***ASC 350***") goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. Prior to the LifePoint/RCCH Merger, we historically determined that each of our hospitals represented a reporting unit in accordance with ASC 280, "Segment Reporting" ("***ASC 280***") and ASC 350. Due to the significance of the LifePoint/RCCH Merger and its impact on our management team and business operations, we re-evaluated our reporting units in accordance with ASC 280 and ASC 350 during 2019 and determined that our consolidated business comprises a single reporting unit for goodwill impairment testing purposes. For the annual impairment evaluation, we determine fair value using a discounted cash flow ("***DCF***") analysis and consideration of certain market inputs including those of guideline public companies. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing our assumptions. The cash flows employed in the DCF analysis are based on our most recent financial budgets and business plans and, when applicable, various growth rates for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the respective reporting unit.

If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. Refer to Note 5 to our accompanying consolidated financial statements included elsewhere in this Report for further discussion of the results of our annual goodwill impairment evaluation procedures.

Accounting for Income Taxes

Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our income statement. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or subsequently increase or decrease this allowance, we must include an adjustment as part of the income tax provision in our results of operations. Our deferred tax asset balances in our consolidated balance sheets were $537.3 million and $636.9 million as of December 31, 2020 and 2019, respectively. Our valuation allowances for deferred tax assets in our consolidated balance sheets were $360.1 million and $493.6 million as of December 31, 2020 and 2019, respectively.

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

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

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

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

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

Our deferred tax assets exceeded our deferred tax labilities by $341.7 million as of December 31, 2020, excluding the impact of valuation allowances. Historically, we have not produced federal taxable income, and in connection with the LifePoint/RCCH Merger, we became highly leveraged. As such, we believe it is likely that the majority of our deferred tax assets will not be realized and thus have established a valuation allowance against these deferred tax assets as of December 31, 2020. In addition, we have subsidiaries with a history of tax losses in certain state jurisdictions, and, based upon those historical tax losses, we have assumed that the subsidiaries would not be profitable in the future for those states' tax purposes. If our assertion regarding the future profitability of those subsidiaries would have been different, then our deferred tax assets would be understated by the amount of the state valuation allowance of $164.2 million at December 31, 2020. Furthermore, the valuation allowance decreased $133.5 million during the year ended December 31, 2020, primarily as a result of the projected utilization of all federal NOLs, as well as the significant revisions to the U.S. corporate tax laws due to the enactment of the CARES Act, specifically relating to the increase in the interest expense limitation from 30 percent to 50 percent for tax years 2019 and 2020. The interest expense limitation percentage decreases to 30 percent for tax years 2021 and forward, which may result in our inability to deduct all of the annual interest expense currently.

Reserves for Self-Insurance Claims

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding SIR and deductible levels. At December 31, 2020, our SIR for professional liability claims is $15.0 million per claim at the majority of our facilities. Additionally, we participate in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2020, our deductible for workers' compensation claims was $1.0 million per claim in all states in which we operate except for Montana, Ohio, Oklahoma, Washington and Wyoming. We participate in state-specific programs for our workers' compensation claims arising in these states. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

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

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

Our reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. Our reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. We have discounted our reserves for self-insured claims to their present value using a discount rate of 1.7% at December 31, 2020, 1.9% at December 31, 2019, and 1.8% at December 31, 2018. We select a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

The following table provides information regarding our reserves for self-insured claims at December 31, 2020 and 2019 (in millions):

	2020	2019
Undiscounted	$ 300.6	$ 275.8
Discounted (as reported)	$ 287.3	$ 261.0

As of December 31, 2020 and 2019, we estimated less than 1% of our reserves for self-insured claims represent reserves for settled and unpaid claims. Our average lag time between the settlement and payment of a self-insured claim ranges from 1 to 2 weeks.

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

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

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

Ultimately, from an actuarial standpoint, the sensitivity in the estimates of reserves for self-insured claims is reflected in the various actuarial confidence levels. Our best estimate of our reserves for self-insured claims utilizes an actuarial central estimate, which employs a statistical confidence level that approximates 50%. Higher statistical confidence levels, while not representative of our best estimate, reflect reasonably likely outcomes upon the ultimate resolution of related claims. Using a higher statistical confidence level would increase the estimated reserves for self-insured claims. At a 75% statistical confidence level, our estimated reserve would increase by $33.4 million. Changes in our estimates of reserves for self-insured claims are non-cash charges and accordingly, do not impact our liquidity or capital resources.

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of our quarterly and semi-annual actuarial calculations resulted in changes to our reserves for self-insured claims for prior years. As a result, for the years ended December 31, 2020 and 2018 our related self-insured claims expense decreased by $4.4 million and $3.9 million, respectively. For the year ended December 31, 2019, our related self-insured claims expense increased by $6.7 million.

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

Market Risk

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

Credit Risk

We define credit risk as the risk that amounts payable by uninsured patients and remaining patient responsibility amounts (deductibles and co-payments) for patient accounts where the primary insurance carrier has paid the amounts covered by the applicable agreements will not be paid. The provision for doubtful accounts relates primarily to amounts due directly from patients. While we have experienced a reduction in uninsured patients, the risk of collection from insured patients and the amounts due, may increase as more individuals are enrolled in insurance plans with larger deductibles and/or co-payments, including those purchased on insurance exchanges. Additionally, the counterparty to our Interest Rate Swap exposes us to credit risk in the event of nonperformance. However, we do not anticipate nonperformance by our counterparty. We do not hold or issue derivative financial instruments for trading purposes.

Liquidity Risk

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

Interest Rate Risk

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

As of December 31, 2020, we had total outstanding debt of $6,339.5 million, excluding finance leases and unamortized debt issuance costs and premium, of which $2,114.5 million, or 33.3%, was subject to variable rates of interest after giving effect to our Interest Rate Swap. If the interest rate on our variable rate long-term debt outstanding as of December 31, 2020, not subject to our Interest Rate Swap, were to increase by 100 basis points during any annual period, our cash flows would be negatively impacted by approximately $21.1 million.

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

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

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

None.

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

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

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

None.

PART III

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

The following table provides information regarding our executive officers and the members of our Board of Directors (ages as of March 5, 2021):

Name	Age	Position(s)
David M. Dill	52	President and Chief Executive Officer
Michael S. Coggin	51	Executive Vice President and Chief Financial Officer
Victor E. Giovanetti	57	Executive Vice President, Hospital Operations
Robert F. Jay	53	Executive Vice President, Integrated Operations
Jennifer C. Peters	49	Executive Vice President, General Counsel and Corporate Secretary
Terry W. Terrill, Jr.	54	Executive Vice President, Administration
J. Michael Grooms	42	Senior Vice President and Chief Accounting Officer
Matthew H. Nord	41	Director and Chairman
Norman Brownstein	77	Director
Christopher J. Christie	58	Director
Maxwell David	30	Director
Michael P. Haley	70	Director
Steve Levin	55	Director
Holly McMullan	44	Director
Daniel Morissette	55	Director
Eric L. Press	55	Director
Martin S. Rash	66	Director
James H. Simmons III	54	Director
Olivia Wassenaar	41	Director
G. Rodney Wolford	74	Director

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

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

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

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

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

Terry W. "Sonny" Terrill, Jr. joined the Company in April 2019 as Executive Vice President, Human Resources. Mr. Terrill is responsible for providing leadership in developing and executing human resources strategies in support of the overall business plan and strategic direction of the organization. Mr. Terrill has three decades of HR experience, including executive coaching, full-cycle talent management and management of large-scale system and organizational integration. Before joining the Company, he served in a number of leadership roles, most recently as executive vice president, chief human resources officer for BrightSpring Health from August 2017 to March 2019 and human resources officer for CIGNA- HealthSpring from May 2005 to August 2017. He is also a Six Sigma Black Belt.

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

Matthew H. Nord has been our Director since consummation of the Apollo/RegionalCare Acquisition in December 2015 and became Chairman of the Board in December 2018. Mr. Nord is the Co-Lead Partner of Apollo Private Equity, having joined in 2003. Prior to that time, he was a member of the Investment Banking division of Salomon Smith Barney Inc. Mr. Nord serves on the board of directors of Tech Data Corporation, ADT, Intrado, and Lifepoint Health. Mr. Nord also serves on the board of trustees of Montefiore Health System and on the Board of Advisors of the University of Pennsylvania's Stuart Weitzman School of Design. He graduated summa cum laude with a BS in economics from the University of Pennsylvania's Wharton School of Business.

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

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

Maxwell David became our Director in December 2018. Mr. David is a Principal in Apollo Global Management's Private Equity business, having joined in 2014. Prior to that time, Mr. David was a member of the Investment Banking division of Bank of America Merrill Lynch. Mr. David serves on the board of directors of Camaro Parent, LLC (parent of CareerBuilder) and Aris Mortgage Holding Company, LLC (parent of Amerihome). Mr. David graduated cum laude from Dartmouth College with a B.A. in Economics.

Michael P. Haley became our Director in December 2018. Prior to that time, Mr. Haley served as a director of Legacy LifePoint since 2005 and as chair of its Audit Committee since 2016. Mr. Haley is also a member of the board of directors of American National Bankshares, Inc., a bank holding company. From 2005 until April 2018, Mr. Haley served as a director of Ply Gem Holdings, Inc., a producer of window, door and siding products for the residential construction industry. Mr. Haley served as an advisor to Fenway Partners, LLC, a private equity investment firm, from April 2006 to June 2015, and was a managing director of its affiliate, Fenway Resources, from 2008 to June 2015. Mr. Haley's previous executive leadership experience includes service as executive chairman of Coach America, a transportation services operator, and as chairman, president and chief executive officer of MW Manufacturers, Inc., a subsidiary of Ply Gem Industries, Inc. In addition, Mr. Haley has served on the Board of Trustees of Roanoke College (Virginia) since 2010 and previously served on the board of the Martinsville-Henry County United Way and as chairman of the board of trustees of Memorial Hospital of Martinsville and of the Martinsville-Henry County Economic Development Corporation.

Steven Levin became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Levin is the Chief Executive Officer of Quest Analytics, a payer network analytic company focused on improve access to quality healthcare in America. Previous, Mr. Levin was the chief strategy officer of Waystar, a healthcare revenue cycle technology platform. In 2018, Waystar acquired Connance, an analytics company that delivers workflow optimization technology for healthcare providers, which Mr. Levin founded in collaboration with Tenet Healthcare, FICO and Northbridge Venture Partners. Prior to Connance, Mr. Levin was a Partner at Monitor Company (now Monitor Deloitte) working with hospitals, HCIT companies and health insurers. Mr. Levin holds a B.A. from Dartmouth College and an M.B.A. from Harvard Business School.

Holly McMullan became our Director in December 2018. Ms. McMullan is a Partner in Apollo Global Management's Client and Product Solutions group, where she is responsible for fundraising efforts for Apollo's private equity and capital markets businesses, having joined in 2008. Prior to that time, Ms. McMullan was a Senior Vice President at Pequot Capital Management and was previously a member of Guggenheim Advisors, Bear Stearns, and Robertson Opportunity Capital. She currently serves on the following advisory boards: 30 % Coalition, McCombs Advisory Council, New York for McCombs (Chair) and the Hicks Muse Private Equity Research Center at the University of Texas at Austin. Ms. McMullan holds an M.B.A. with a concentration in Finance from the McCombs School of Business at the University of Texas at Austin and a B.A. (honors) in International Business from Sheffield Hallam University, Sheffield, UK.

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

Eric L. Press has been our Director since consummation of the Apollo/RegionalCare Acquisition in December 2015. Mr. Press is a Senior Partner at Apollo, having joined in 1998. In his time with Apollo, he has been involved in many of the firm's investments in basic industrials, metals, lodging/gaming/leisure and financial services. Prior to joining Apollo, Mr. Press worked at the law firm of Wachtell, Lipton, Rosen & Katz, specializing in mergers, acquisitions, restructurings and related financing transactions. Prior thereto, Mr. Press was a consultant with The Boston Consulting Group, a management consulting firm focused on corporate strategy. Mr. Press serves on the board of directors of ADT Inc., Gamenet Group S.p.A., Apollo Commercial Real Estate Finance, Inc., and Eagle LM5 Holdings Inc. He previously served on the board of directors of Caesars Entertainment Corporation, Princimar Chemical Holdings, LLC, PlayAGS, Inc., and Verso Corporation. He graduated magna cum laude from Harvard College, with an A.B. in economics, and Yale Law School, where he was a Senior Editor of the Yale Law Journal.

Martin S. Rash has been our director since October 2015 following the Apollo/RegionalCare Acquisition and served as Executive Chairman following the consummation of the RegionalCare/Capella Merger in April 2016 until October 2016. Additionally, Mr. Rash served as Chief Executive Officer and Chairman of RegionalCare from October 2016 until the consummation of the LifePoint/RCCH Merger. Mr. Rash served as the Executive Chairman at RegionalCare Hospital Partners, Inc. from March 2013 to January 2014 and served as its Chief Executive Officer from 2009 until March 2013. From December 1996 to 2005, Mr. Rash was Chairman and Chief Executive Officer of Province Healthcare, a $1 billion NYSE company that owned 21 hospitals and managed more than 50 facilities. Prior to his tenure at Province Healthcare, Mr. Rash served as Executive Vice President and Chief Operating Officer for Community Health Systems where he led the growth of the company from 10 to 41 hospitals in 17 states. Earlier in his 40-year healthcare career, he worked at numerous community hospitals in various administrative and financial roles. Mr. Rash's experience and leadership includes Board of Directorships in the past at Healthspring, a NYSE company, and Odyssey Healthcare, a Nasdaq company, serving as the chair of the compensation committee for both organizations. He is a past Chairman of the Federation of American Hospitals and of the Nashville Health Care Council. He holds both a B.A. and M.B.A. from Middle Tennessee State University. He currently serves as Chairman of American Pathology Partners; ReVIDA Recovery; and Unifeye Vison Partners.

James H. Simmons III has been our director since September 2020. Mr. Simmons is Chief Executive Officer and Founding Partner of Asland Capital Partners, serving as head of its investment committee with oversight over the day-to-day operations of the firm. Mr. Simmons has over two decades of real estate investment experience across the public and private sectors. Prior to founding Asland Capital Partners, Mr. Simmons was a Partner at Ares Management, where he led the Ares Domestic Emerging Markets Fund, and was previously a Partner at Apollo Real Estate Advisors. Mr. Simmons was also previously President and Chief Executive Officer of the Upper Manhattan Empowerment Zone Development Corporation and held prior roles at Bankers Trust and Salomon Smith Barney. Mr. Simmons currently serves on the Board of Directors of the Real Estate Executive Council (Vice Chair), The Dalton School and the Greater Jamaica Development Corporation. Mr. Simmons received a BS degree from Princeton University, an M.S. from the Virginia Polytechnic Institute and State University and an M.M. from Northwestern University's J.L. Kellogg Graduate School of Management.

Olivia Wassenaar became our Director in December 2018. Ms. Wassenaar is a Senior Partner at Apollo Global Management and is Co-Lead of Natural Resources, having joined in 2018. Prior to that time, Ms. Wassenaar was a Managing Director at Riverstone Holdings and was previously a member of the Investment Banking division of Goldman Sachs. Ms. Wassenaar also serves on the boards of directors of Talos Energy Inc., Jupiter Resources Ltd., Pegasus Optimization Partners, LLC, and High Road Resources, LLC (f/k/a American Petroleum Partners, LLC). During the past five years, Ms. Wassenaar also served as a director of Northern Blizzard Resources Inc. (from June 2011 to May 2017), USA Compression Partners, LP (from June 2011 to April 2018), Admiral Permian Resources, LLC (from March 2017 to May 2018), Hammerhead Resources Inc. (from June 2017 to May 2018), Canadian Non-Operated Resources GP Inc. (from August 2014 to May 2018), Eagle Energy Exploration LLC (from December 2013 to May 2018), Vesta Energy Corp. (from May 2017 to May 2018), Canera III (from 2015 to 2017), Niska Gas Storage Partners LLC (from July 2014 to June 2016) and Apex Energy, LLC (from September 2019 to December 2019). She received her A.B., magna cum laude, from Harvard College and an M.B.A. from the Wharton School at the University of Pennsylvania.

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

Code of Ethics

Our Board expects its members, as well as our officers and employees, to act ethically at all times and to acknowledge in writing their adherence to the policies comprising our Code of Conduct, which is known as "Common Ground," and, as applicable, our Code of Ethics for Senior Financial Officers and Chief Executive Officer.

Board Structure

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

Committees of our Board of Directors

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

Audit Committee

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

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

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

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

Compensation Committee

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

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

Nominating and Governance Committee

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

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

Compliance Committee

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

Quality Committee

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

Executive Committee

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

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

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

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

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

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

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

For a discussion of certain relationships and related party transactions, refer to the Offering Memorandum dated December 4, 2020 for the 5.375% Unsecured Notes.

Equity Repurchases

Since the closing of the LifePoint/RCCH Merger, through December 31, 2020, DSB Parent has repurchased 3,807,682 profits units and 385,319 capital units from various former employees of LifePoint. Repurchases are anticipated to continue to occur from time to time.

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

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

Audit Fees. The aggregate audit fees billed by Ernst & Young LLP for professional services rendered for the audit of our annual consolidated financial statements and services that are normally provided by the independent registered public accounting firm in connection with statutory and regulatory filings totaled approximately $3.8 million for 2020 and approximately $4.3 million for 2019.

Audit-Related Fees.. The aggregate fees billed by Ernst & Young LLP for assurance and related services other than those described under "Audit Fees" were approximately $0.8 million for 2020 and $2.4 million for 2019.

Tax Fees. The aggregate fees billed by Ernst & Young LLP for professional services rendered for tax compliance, tax advice and tax planning were approximately $0.3 million for both 2020 and 2019.

All Other Fees. There were no fees billed by Ernst & Young LLP for products or services other than those described above in 2020 or 2019.

PART IV

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

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

1. *Consolidated Financial Statements*:

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

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

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Building a better working world

Report of Independent Auditors

Board of Directors and Shareholders of
LifePoint Health, Inc.

We have audited the accompanying consolidated financial statements of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.), which comprise the consolidated balance sheets as of December 31, 2020 and 2019, and the related consolidated statements of operations, comprehensive income (loss), equity and cash flows for each of the three years in the period ended December 31, 2020, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.) at December 31, 2020 and 2019, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2020 in conformity with U.S. generally accepted accounting principles.

Change in Accounting Principle

As discussed in Note 8 to the consolidated financial statements, LifePoint Health, Inc. has changed its method of accounting for leases due to the adoption of Financial Accounting Standards Board Accounting Standards Update No. 2016-02, Leases, effective January 1, 2019. Our opinion is not modified with respect to this matter.

Ernst + Young LLP

March 4, 2021

LifePoint Health, Inc.

Consolidated Statements of Operations
For the Years Ended December 31, 2020, 2019 and 2018
(In millions)

	2020	2019 [a]	2018
Revenues	$ 8,121.9	$ 8,752.8	$ 2,778.1
Salaries and benefits	3,877.5	4,044.0	1,329.4
Supplies	1,417.6	1,471.7	484.5
Other operating expenses, net	2,207.2	2,150.3	709.2
Government stimulus income	(646.3)	-	-
Depreciation and amortization	377.4	376.5	129.0
Interest expense, net	528.1	568.6	186.1
Debt transaction costs	115.4	-	8.2
Merger, integration and other transaction-related costs	-	76.9	141.5
Impairments of goodwill and long-lived assets	-	3.3	78.4
Other non-operating losses (gains), net	4.0	5.5	(0.4)
	7,880.9	8,696.8	3,065.9
Income (loss) before income taxes	241.0	56.0	(287.8)
(Benefit from) provision for income taxes	(63.7)	77.9	0.2
Net income (loss)	304.7	(21.9)	(288.0)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(21.5)	(19.3)	(5.7)
Net income (loss) attributable to LifePoint Health, Inc.	$ 283.2	$ (41.2)	$ (293.7)

(a) The consolidated statement of operations for the year ended December 31, 2019 has been restated in accordance with the adoption of Accounting Standards Update ("ASU") 2016-02, "Leases" ("ASU 2016-02"). Refer to Note 8 for additional information.

LifePoint Health, Inc.

Consolidated Statements of Comprehensive Income (Loss)
For the Years Ended December 31, 2020, 2019 and 2018
(In millions)

	2020	2019 [(a)]	2018
Net income (loss)	$ 304.7	$ (21.9)	$ (288.0)
Other comprehensive loss:			
Unrealized losses on changes in funded status of pension benefit obligations	(1.3)	(4.4)	(3.1)
Other comprehensive loss	(1.3)	(4.4)	(3.1)
Comprehensive income (loss)	303.4	(26.3)	(291.1)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(21.5)	(19.3)	(5.7)
Comprehensive income (loss) attributable to LifePoint Health, Inc.	$ 281.9	$ (45.6)	$ (296.8)

(a) The consolidated statement of comprehensive loss for the year ended December 31, 2019 has been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

LifePoint Health, Inc.

Consolidated Balance Sheets
As of December 31, 2020 and 2019
(In millions, except for share and per share amounts)

	2020	2019 [a]
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,652.6	$ 748.1
Accounts receivable	1,041.6	1,167.9
Inventories	238.6	225.9
Prepaid expenses	103.4	92.7
Other current assets	332.2	172.2
	4,368.4	2,406.8
Property and equipment:		
Land	226.5	232.4
Buildings and improvements	2,612.1	2,626.9
Equipment	1,552.3	1,383.6
Construction in progress	84.9	148.6
	4,475.8	4,391.5
Accumulated depreciation	(952.8)	(616.5)
	3,523.0	3,775.0
Intangible assets, net	58.3	65.4
Other long-term assets	731.0	772.9
Goodwill	2,918.5	2,961.2
Total assets	$ 11,599.2	$ 9,981.3
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 357.9	$ 340.6
Accrued salaries	295.4	319.3
Current portion of Medicare advance payments	369.8	-
Other current liabilities	591.3	489.0
Current maturities of long-term debt	30.0	69.7
	1,644.4	1,218.6
Long-term debt, net	7,205.9	6,966.8
Long-term portion of Medicare advance payments	621.2	-
Other long-term liabilities	759.7	719.6
Total liabilities	10,231.2	8,905.0
Redeemable noncontrolling interests	180.4	147.8
Equity:		
LifePoint Health, Inc. stockholders' equity:		
Common stock, $0.01 par value; 30,000 shares authorized; 100 shares issued and outstanding at December 31, 2020 and 2019	-	-
Capital in excess of par value	1,266.9	1,295.8
Accumulated other comprehensive loss	(8.8)	(7.5)
Accumulated deficit	(102.5)	(385.7)
Total LifePoint Health, Inc. equity	1,155.6	902.6
Noncontrolling interests	32.0	25.9
Total equity	1,187.6	928.5
Total liabilities and equity	$ 11,599.2	$ 9,981.3

(a) The consolidated balance sheet as of December 31, 2019 has been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

LifePoint Health, Inc.

Consolidated Statements of Cash Flows
For the Years Ended December 31, 2020, 2019 and 2018
(In millions)

	2020	2019 [a]	2018
Cash flows from operating activities:			
Net income (loss)	$ 304.7	$ (21.9)	$ (288.0)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:			
Depreciation and amortization	377.4	376.5	129.0
Other non-cash amortization	34.8	39.5	9.9
Non-cash interest expense	15.2	19.1	5.8
Debt transaction costs	115.4	-	8.2
Impairments of goodwill and long-lived assets	-	3.3	78.4
Other non-operating losses (gains), net	4.0	5.5	(0.4)
Deferred income taxes	1.1	2.2	(0.6)
Reserve for self-insurance claims, net of payments	30.3	(5.4)	2.3
Changes in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:			
Accounts receivable	110.0	(57.4)	(48.1)
Inventories, prepaid expenses and other current assets	(20.4)	(36.7)	(0.2)
Accounts payable, accrued salaries and other current liabilities	48.5	(53.6)	(9.6)
Medicare advance payments	991.0	-	-
Income taxes payable/receivable	(102.8)	134.2	53.0
Other	11.1	8.3	(12.7)
Net cash provided by (used in) operating activities	1,920.3	413.6	(73.0)
Cash flows from investing activities:			
Purchases of property and equipment	(170.4)	(336.7)	(319.7)
Acquisitions, net of cash acquired	(0.6)	(4.4)	(5,345.9)
Proceeds from sales of equity method investments and other ancillary businesses	23.8	6.4	-
Other	26.6	24.6	19.9
Net cash used in investing activities	(120.6)	(310.1)	(5,645.7)
Cash flows from financing activities:			
Proceeds from borrowings	2,381.5	-	5,125.0
Payments of borrowings	(2,140.6)	(28.3)	(189.3)
Net change in ABL Facility and Prior ABL Facility	-	(20.0)	10.0
Proceeds from lease financing	-	700.0	38.0
Payments of debt financing costs	(102.8)	(18.1)	(207.0)
Cash (distributed to) contributed by parent	-	(10.9)	1,000.0
Distributions and other cash transactions associated with noncontrolling interests and redeemable noncontrolling interests	(13.2)	(18.0)	(6.0)
Finance lease payments and other	(20.1)	(19.0)	(10.0)
Net cash provided by financing activities	104.8	585.7	5,760.7
Change in cash and cash equivalents	1,904.5	689.2	42.0
Cash and cash equivalents at beginning of period	748.1	58.9	16.9
Cash and cash equivalents at end of period	$ 2,652.6	$ 748.1	$ 58.9
Supplemental disclosure of cash flow information:			
Interest payments	$ 423.5	$ 515.8	$ 138.1
Capitalized interest	$ 1.7	$ 11.1	$ 17.4
Property and equipment acquired under finance leases	$ 42.6	$ 22.4	$ 3.1
Income tax payment (refunds), net	$ 38.0	$ (58.5)	$ (53.7)

(a) Certain items included within the reconciliation of net loss to net cash provided by operating activities for the year ended December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

LifePoint Health, Inc.

Consolidated Statements of Equity
For the Years Ended December 31, 2020, 2019 and 2018
(Dollars in millions)

	Common Stock		Capital in Excess of	Accumulated Other Comprehensive	Accumulated	Noncontrolling	
	Shares	Amount	Par Value	Loss	Deficit	Interests	Total
Balance at January 1, 2018	100	$ -	$ 308.1	$ -	$ (88.1)	$ -	$ 220.0
Comprehensive (loss) income	-	-	-	(3.1)	(293.7)	0.2	(296.6)
Stock-based compensation	-	-	7.0	-	-	-	7.0
Reclassification of vested stock-based compensation units to a liability	-	-	(6.8)	-	-	-	(6.8)
Capital contribution from parent	-	-	1,000.0	-	-	-	1,000.0
Noncontrolling interests assumed in LifePoint/RCCH Merger	-	-	-	-	-	29.9	29.9
Distributions to noncontrolling interests	-	-	-	-	-	(0.2)	(0.2)
Balance at December 31, 2018	100	-	1,308.3	(3.1)	(381.8)	29.9	953.3
Adoption of ASU 2016-02 [(a)]	-	-	-	-	37.3	-	37.3
Comprehensive (loss) income [(a)]	-	-	-	(4.4)	(41.2)	4.4	(41.2)
Stock-based compensation	-	-	4.8	-	-	-	4.8
Reclassification of vested stock-based compensation units to a liability	-	-	(2.9)	-	-	-	(2.9)
Distributions to parent	-	-	(3.2)	-	-	-	(3.2)
Fair value adjustments related to noncontrolling interests and redeemable noncontrolling interests	-	-	(11.2)	-	-	(0.2)	(11.4)
Distributions to noncontrolling interests	-	-	-	-	-	(8.2)	(8.2)
Balance at December 31, 2019 [(a)]	100	-	1,295.8	(7.5)	(385.7)	25.9	928.5
Comprehensive (loss) income	-	-	-	(1.3)	283.2	7.5	289.4
Stock-based compensation	-	-	2.4	-	-	-	2.4
Reclassification of vested stock-based compensation units to a liability	-	-	(0.2)	-	-	-	(0.2)
Reclassification of equity to redeemable noncontrolling interests related to Emory joint venture	-	-	(26.1)	-	-	-	(26.1)
Fair value adjustments related to redeemable noncontrolling interests	-	-	(5.0)	-	-	-	(5.0)
Distributions to noncontrolling interests	-	-	-	-	-	(1.4)	(1.4)
Balance at December 31, 2020	100	$ -	$ 1,266.9	$ (8.8)	$ (102.5)	$ 32.0	$ 1,187.6

(a) The consolidated statement of equity for the year ended December 31, 2019 has been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

Note 1. Organization and Summary of Significant Accounting Policies

Organization

LifePoint Health, Inc., a Delaware corporation, acting through its subsidiaries, owns or leases and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. At December 31, 2020, on a consolidated basis, LifePoint Health, Inc. operated 88 hospital campuses in 29 states throughout the United States ("U.S.").

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

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

Principles of Consolidation

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

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

Use of Estimates

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

Revenue Recognition and Accounts Receivable

Overview

The Company recognizes revenues in the period in which performance obligations are satisfied. Generally, the Company bills patients and third-party payers several days after the services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payers and patients. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. Amounts the Company receives for treatment of patients covered by governmental programs and third-party payers such as Medicare, Medicaid, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and private insurers as well as directly from patients are subject to contractual adjustments, discounts and implicit price concessions. Accordingly, the revenue and accounts receivable reported in the Company's financial statements are recorded at the net consideration to which the Company expects to be entitled to receive in exchange for providing patient care.

The majority of the Company's performance obligations are satisfied over time for the delivery of patient care in both outpatient and inpatient settings. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected charges for services anticipated to be provided. The Company believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the remaining services needed to satisfy the obligation. Generally, unsatisfied or partially unsatisfied performance obligations at the end of the reporting period are related to patients admitted to the Company's hospitals that have not yet been discharged. The performance obligations for these patients are typically satisfied when the patients are discharged, which generally occurs within a matter of days of admission. Patients are generally billed when discharged, though they may be billed on an interim basis for longer stays. Accordingly, because all of the Company's performance obligations are part of a contract that is expected to have a duration of one year or less, the Company has elected to apply the exemption provided by ASC 606, "Revenue from Contracts with Customers" ("ASC 606") to not disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied as of period end.

Subsequent adjustments that are determined to be the result of an adverse change in the patient's or the payer's ability to pay are recognized as bad debt expense. With the adoption of ASC 606, bad debt expense is included under the caption "Other operating expenses, net" in the accompanying consolidated statements of operations, instead of separately as a deduction to arrive at revenue. Bad debt expense for the years ended December 31, 2020, 2019 and 2018 was not material for the Company.

Change in Accounting Estimate

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

Contractual Discounts

The Company derives a significant portion of its revenues from Medicare, Medicaid and other payers that receive discounts from the Company's established billing rates. The Company must estimate the total amount of these discounts to prepare its financial statements. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex and are subject to interpretation and adjustment. The Company estimates contractual discounts on a payer-specific basis given its interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the Company's estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management. Subsequent changes in estimates for contractual discounts are reflected as an adjustment to revenues in the period of the change. Medicare, Medicaid and other discounted payer accounts receivables are written off after they have been final settled with the payer.

Cost Report Settlements

Cost report settlements under reimbursement agreements with Medicare, Medicaid and certain other payers for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the payment terms of the reimbursement agreement with the payer, correspondence from the payer, and the Company's historical experience. Estimated settlements are adjusted in future periods as final settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. For the years ended December 31, 2020, 2019 and 2018, the net adjustments to estimated cost report settlements and other reimbursement adjustments resulted in an increase to revenues of $33.5 million, an increase to revenues of $17.2 million, and a decrease to revenues of $4.0 million, respectively.

The net cost report settlements due from the Company at December 31, 2020 and 2019 were $2.0 million and $6.6 million, respectively, and are included under the caption "Other current liabilities" on the accompanying consolidated balance sheets. The Company's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs consistent with the constraints that are required by ASC 606.

Self-Pay Revenues

Self-pay revenues are derived from patients who do not have any form of healthcare coverage as well as from patients with third-party healthcare coverage related to the patient responsibility portion, including deductibles and co-payments. The Company evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs. The Company estimates the transaction price for self-pay patients and the patient responsibility portion using a number of analytical tools, benchmarks and market conditions. No single statistic or measurement determines the transaction price for these patients. Some of the analytical tools that the Company utilizes include, but are not limited to, historical cash collection experience, revenue trends by payer classification and revenue days in accounts receivable.

The revenues associated with self-pay patients are reported at the net amount that the Company expects to collect. Because the Company provides care to patients regardless of their ability to pay, the Company has determined that the differences between the amounts it bills based on gross or discounted charges and the amounts the Company expects to collect represent implicit price concessions. The final amount that will be received from the patient is not known at the date of service, and the Company accounts for this variable consideration in accordance with the provisions of ASC 606. Self-pay accounts receivable are written off after collection efforts have been followed in accordance with the Company's policies.

Charity Care

The Company provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the years ended December 31, 2020, 2019 and 2018, the Company estimates that its costs of care provided under its charity care programs approximated $26.8 million, $34.1 million and $16.8 million, respectively. The Company does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Company's policy not to pursue collection of amounts related to these patients, and therefore contracts with these patients do not exist.

The Company's management estimates its costs of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Company's gross charity care charges provided. The Company's gross charity care charges include only services provided to patients who are unable to pay and qualify under the Company's local charity care policies. To the extent the Company receives reimbursement through the various governmental assistance programs in which it participates to subsidize its care of indigent patients, the Company does not include these patients' charges in its cost of care provided under its charity care program.

Financing Component

The Company has elected to apply the practical expedient permitted under ASC 606 and does not adjust the estimated amount of consideration from patients and third-party payers for the effects of a significant financing component due to the Company's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payer pays for that service will be one year or less.

Rental Income

The Company leases certain real estate assets it owns to unrelated third parties, primarily medical office buildings to non-employed physicians. The Company recognizes rental income for these operating lease arrangements in which the Company is the lessor on a straight-line basis over the lease term in accordance with ASC 842, "Leases" ("ASC 842").

Concentration of Revenues

The Company's revenues by payer and approximate percentages of revenues were as follows for the years ended December 31, 2020, 2019 and 2018 (dollars in millions):

	2020		2019		2018	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,134.0	38.6 %	$ 3,338.1	38.1 %	$ 1,105.3	39.8 %
Medicaid	1,392.4	17.1	1,495.3	17.1	486.3	17.5
HMOs, PPOs and other private insurers	3,381.9	41.6	3,698.6	42.3	1,113.8	40.1
Self-pay	54.5	0.7	59.2	0.7	17.2	0.6
Other	142.7	1.8	143.6	1.6	49.4	1.8
Revenue from contracts with customers	8,105.5	99.8	8,734.8	99.8	2,772.0	99.8
Rental income	16.4	0.2	18.0	0.2	6.1	0.2
Revenues	$ 8,121.9	100.0 %	$ 8,752.8	100.0 %	$ 2,778.1	100.0 %

During the years ended December 31, 2020, 2019 and 2018, approximately 55.7%, 55.2% and 57.3%, respectively, of the Company's revenues related to patients participating in the Medicare and Medicaid programs, collectively. The Company's management recognizes that revenues and receivables from government agencies are significant to the Company's operations, but it does not believe that there are significant credit risks associated with these government agencies.

Any changes in the current demographic, economic, competitive or regulatory conditions, or to Medicaid programs could have an adverse effect on the Company's revenues or results of operations. The Company's management does not believe that there are any other significant concentrations of revenues from any particular payer or geographic area that would subject the Company to any significant credit risks in the collection of its accounts receivable.

The Company's revenues by primary service type and approximate percentages of revenues were as follows for the years ended December 31, 2020, 2019 and 2018 (dollars in millions):

	2020		2019		2018	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Inpatient services	$ 3,379.0	41.6 %	$ 3,524.0	40.3 %	$ 1,188.3	42.8 %
Outpatient services	4,583.8	56.4	5,067.2	57.9	1,534.3	55.2
Non-patient (a)	159.1	2.0	161.6	1.8	55.5	2.0
Revenues	$ 8,121.9	100.0 %	$ 8,752.8	100.0 %	$ 2,778.1	100.0 %

(a) Represents revenues from ancillary goods, services and rental income.

General and Administrative Costs

The majority of the Company's operating expenses are "cost of revenue" items. Operating costs that could be classified as "general and administrative" by the Company would include its corporate overhead costs, excluding depreciation and amortization, debt transaction costs and merger, integration and other transaction-related costs, which were $175.9 million, $179.5 million and $72.4 million for the years ended December 31, 2020, 2019 and 2018, respectively.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash on hand and short-term investments with original maturities of three months or less. The Company places its cash in financial institutions that are federally insured in limited amounts.

Inventories

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

Investments

The Company accounts for its investments in entities in which the Company exhibits significant influence, but not control, under the equity method of accounting in accordance with ASC 323, "Investments – Equity Method and Joint Ventures" ("ASC 323"). The Company does not consolidate its equity method investments but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period. Refer to Note 9 for further discussion of the Company's equity method investments.

Property and Equipment

Purchases of property and equipment are recorded at cost. Property and equipment acquired in connection with business combinations are recorded at estimated fair value in accordance with the acquisition method of accounting as prescribed in ASC 805, "Business Combinations" ("ASC 805"). Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase capacities or extend useful lives are capitalized. Fully depreciated assets are retained in property and equipment accounts until they are disposed. The Company capitalizes interest on funds used to pay for the construction of major capital additions and such interest is included in the cost of each capital addition.

Depreciation is computed by applying the straight-line method over the estimated useful lives of buildings, improvements and equipment. Assets under capital and finance leases are generally amortized using the straight-line method over the shorter of the estimated useful life of the assets or life of the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured. Capitalized internal-use software costs are amortized over their expected useful life, which is generally four years. Useful lives are as follows:

	Years		
Buildings and improvements (including those under finance leases)	3	-	40
Equipment	2	-	15
Equipment under finance leases	3	-	6

Depreciation expense (including amortization of finance lease obligations) totaled $376.1 million, $374.7 million and $128.5 million for the years ended December 31, 2020, 2019 and 2018, respectively.

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

There were no long-lived asset impairments recorded for the years ended December 31, 2020 and 2019. For the year ended December 31, 2018, the Company recognized an impairment charge of $24.5 million to reduce the carrying amounts of certain long-lived assets at one of its facilities to their estimated fair values, which is included under the caption "Impairments of goodwill and long-lived assets" in the accompanying consolidated statements of operations for the year ended December 31, 2018.

Goodwill and Intangible Assets

The Company accounts for its acquisitions in accordance with ASC 805 using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350, Intangibles – Goodwill and Other ("ASC 350"), goodwill and intangible assets with indefinite lives are reviewed by the Company annually for impairment on October 1. Prior to the LifePoint/RCCH Merger, the Company historically determined that each of its hospitals represented a reporting unit in accordance with ASC 280, "Segment Reporting" ("ASC 280") and ASC 350. Due to the significance of the LifePoint/RCCH Merger and its impact on the Company's management team and business operations, the Company re-evaluated its reporting units in accordance with ASC 280 and ASC 350 during 2019 and determined that the consolidated business comprises a single reporting unit for goodwill impairment testing purposes. For the annual impairment evaluation, the Company determines fair value using a discounted cash flow ("DCF") analysis and consideration of certain market inputs including those of guideline public companies. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates, profitability and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing the Company's assumptions. The cash flows employed in the DCF analysis are based on the Company's most recent financial budgets and business plans and, when applicable, various growth rates and profitability for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the reporting unit.

The Company's intangible assets primarily relate to contract-based physician minimum revenue guarantees; certificates of need and certificates of need exemptions; and licenses, provider numbers, accreditations and other. Contract-based physician minimum revenue guarantees are amortized over the terms of the agreements. The certificates of need, certificates of need exemptions, licenses, provider numbers, accreditations and other have been determined to have indefinite lives and, accordingly, are not amortized. Refer to Note 5 for further discussion of the Company's goodwill and intangible assets.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the income tax provision in the period that includes the enactment date. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income. To the extent the Company believes that recovery is not likely, a valuation allowance is established. The establishment or increase in a valuation allowance is included as an expense within the provision for income taxes in the consolidated statements of operations. The Company classifies interest and penalties related to its tax positions as a component of income tax expense. Refer to Note 6 for further discussion of the Company's accounting for income taxes.

Reserves for Self-Insurance Claims

Given the nature of the Company's operating environment, the Company is subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("SIR") and deductible levels. At December 31, 2020, the Company's SIR for professional liability claims is $15.0 million per claim at the majority of its facilities. Additionally, the Company participates in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2020, the Company's deductible for workers' compensation claims was $1.0 million per claim in all states in which it operates except for Montana, Ohio, Oklahoma, Washington and Wyoming. The Company participates in state-specific programs for its workers' compensation claims arising in these states. The Company's SIR and deductible levels are evaluated annually as a part of the Company's insurance program's renewal process.

The Company's reserves for self-insurance and deductible claims reflect the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The Company's expense for self-insurance and deductible claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of the Company's self-insured retention and deductible levels; and interest expense related to the discounted portion of the liability. The Company's expense for self-insurance and deductible claims was approximately $85.0 million, $75.6 million and $20.7 million for the years ended December 31, 2020, 2019 and 2018, respectively.

The Company's reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. These reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. The Company's reserves for self-insured claims have been discounted to their present value using a discount rate of 1.7% at December 31, 2020, 1.9% at December 31, 2019, and 1.8% at December 31, 2018. The Company's management selects a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

Professional and general liability claims are typically resolved over an extended period of time, often as long as five years or more, while workers' compensation claims are typically resolved in one to two years. Accordingly, the Company's reserves for self-insured claims, comprised of estimated indemnity and expense payments related to reported events and incurred but not reported events as of the end of the period, include both a current and long-term component. The current portion of the Company's reserves for self-insured claims is included under the caption "Other current liabilities" and the long-term portion is included under the caption "Other long-term liabilities" in the accompanying consolidated balance sheets.

The following table provides information regarding the classification of the Company's reserves for self-insured claims at December 31, 2020 and 2019 (in millions):

	2020	2019
Current portion	$ 82.3	$ 64.5
Long-term portion	205.0	196.5
	$ 287.3	$ 261.0

The following table presents the changes in our reserves for self-insured claims for the years ended December 31, 2020 and 2019 (in millions):

	2020	2019
Reserve at the beginning of the period	$ 261.0	$ 264.7
Increase for the provision of current year claims	88.3	69.2
Increase (decrease) for the provision of prior year claims	(4.4)	6.7
Payments related to current year claims	(5.9)	(5.2)
Payments related to prior year claims	(48.8)	(75.8)
Provision for the change in discount rate	1.1	(0.3)
Non-cash change in reserve for claims in excess of SIR levels	(4.0)	1.7
Reserve at the end of the period	$ 287.3	$ 261.0

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of the Company's quarterly and semi-annual actuarial calculations resulted in changes to its reserves for self-insured claims for prior years. As a result, the Company's related self-insured claims expense decreased by $4.4 million for the year ended December 31, 2020, increased by $6.7 million for the year ended December 31, 2019 and decreased by $3.9 million for the year ended December 31, 2018.

Point of Life Indemnity, Ltd.

The Company operates, with approval from the Cayman Islands Monetary Authority, a captive insurance company under the name Point of Life Indemnity, Ltd. Through this wholly-owned subsidiary of the Company, the captive insurance company issues malpractice indemnity policies to certain subsidiaries employing physicians and advanced practice providers and contracting with physicians. Fees charged to these subsidiaries are eliminated in consolidation. Reserves for the Company's estimate of the related outstanding claims, including incurred but not reported losses, are actuarially determined and are included as a component of the Company's reserves for professional liability self-insurance claims.

Self-Insured Medical Benefits

The Company is self-insured for substantially all of the medical expenses and benefits of its employees. The reserve for medical benefits primarily reflects the current estimate of incurred but not reported losses based upon an annual actuarial calculation as of the balance sheet date. The undiscounted reserve for self-insured medical benefits was $37.7 million and $53.8 million at December 31, 2020 and 2019, respectively, and is included in the Company's accompanying consolidated balance sheets under the caption "Other current liabilities".

Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to the Company. The Company's accompanying consolidated financial statements include all assets, liabilities, revenues, and expenses at their consolidated amounts, which include the amounts attributable to the Company and the noncontrolling interest. The Company recognizes as a separate component of earnings that portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by the Company. Refer to Note 10 for further discussion of the Company's noncontrolling interests and redeemable noncontrolling interests.

Variable Interest Entities

The Company's consolidated financial statements at December 31, 2020 include eight facilities that qualify as a variable interest entity in which the Company is the primary beneficiary under the provisions of ASC 810, "Consolidation," and in which the Company owns a controlling economic interest.

Stock-Based Compensation

The Company's indirect parent, DSB Parent L.P., a Delaware limited partnership ("DSB Parent"), has issued profits units (the "Units") to certain employees, directors and consultants under the terms and conditions of the Amended and Restated Limited Partnership Agreement of DSB Parent dated of December 3, 2015 (the "DSB Parent Partnership Agreement") and forms of award agreements. The Company accounted for these stock-based awards in accordance with the provisions of ASC 718, "Compensation – Stock Compensation" ("ASC 718"). In accordance with ASC 718, the Company recognized compensation expense based on the estimated grant date fair value of each stock-based award. The Company recognizes forfeitures of Units as they occur. Refer to Note 13 for further discussion of the Company's accounting for the Units.

Defined Benefit Pension Plans

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

Defined Contribution Plans

The Company maintains two separate defined contribution retirement plans covering a majority of the Company's employees. These defined contribution retirement plans contain discretionary matching contribution formulas and definite non-elective contribution formulas for employees at certain facilities. Refer to Note 12 for further discussion of the Company's defined contribution plans.

Reclassifications

Certain reclassifications have been made to the prior years to conform to current year presentation. These reclassifications had no effect on results of operations, financial position or cash flows as previously reported.

Adoption of Recently Issued Accounting Standards

Accounting Standards Update ("ASU") 2016-02, "Leases"

In February 2016, the FASB issued ASU 2016-02, "Leases" (Topic 842) along with subsequent amendments, updates and an extension of the effective date (collectively, "ASU 2016-02"). ASU 2016-02 requires the rights and obligations arising from lease contracts, including existing and new arrangements, to be recognized as assets and liabilities on the balance sheet. As permitted, the Company adopted ASU 2016-02 early, during the fourth quarter of 2020, with an effective transition date of January 1, 2019 and retrospective application. As a result, the accompanying consolidated financial statements as of and for the year ended December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. The Company applied certain available practical expedients to facilitate the adoption of ASU 2016-02, including the package of practical expedients to not reassess whether a contract is or contains a lease, the lease classification and the initial direct costs. In conjunction with the adoption of ASU 2016-02, the Company has implemented a new information technology application as well as new processes, policies, procedures and controls. Refer to Note 8 for additional information regarding the impact of the adoption of ASU 2016-02.

Note 2. CARES Act

Overview

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was signed into law. The CARES Act is intended to provide over $2 trillion in stimulus funding for the U.S. economy. Among other things, the CARES Act contains a number of provisions that are intended to assist healthcare providers as they combat the effects of the COVID-19 pandemic. Those provisions include, among others:

- the temporary suspension of Medicare sequestration from March 1, 2020, to December 31, 2020;
- the delay of the planned reductions to the Medicaid disproportionate share hospital ("DSH") payments program until December 1, 2020;
- an appropriation of $180 million to Health Resources and Services Administration's Federal Office of Rural Health Policy that will be awarded to small rural hospitals by the states through the Small Rural Hospital Improvement Program;
- an appropriation of $250 million to the Hospital Preparedness Program; and
- an appropriation of $100 billion to the Public Health and Social Services Emergency Fund (the "Emergency Fund") for a new program to reimburse, through grants or other mechanisms, hospitals, healthcare providers and other approved entities for COVID-19-related expenses or lost revenues.

The Paycheck Protection Program and Health Care Enhancement Act was enacted on April 24, 2020, which, among other things, provides an additional allocation of $75 billion to the Emergency Fund and an allocation of $25 billion for COVID-19 testing.

On December 21, 2020, Congress adopted the Consolidated Appropriations Act, 2021 ("CCA"), which provides an additional $900 billion in COVID-19 relief, including an additional $3 billion allocation to the Emergency Fund. In addition, the CCA also, among other things, further extends the temporary suspension of Medicare sequestration through March 31, 2021, delays the planned reductions to the Medicaid DSH payments program through FFY 2023, adds additional reductions to the Medicaid DSH payments program in FFYs 2026 and 2027, provides for a 3.75% increase in PFS rates in CY 2021 and allocates $30 billion for the purchase and administration of COVID-19 vaccines and related therapeutics.

Direct Grant Aid Payments

With respect to payments being made to providers from the Emergency Fund, beginning April 10, 2020, the Emergency Fund distributed $50 billion to hospitals based on their 2018 net patient revenue. The remaining $50 billion originally appropriated to the Emergency Fund is being distributed to providers in areas particularly impacted by the COVID-19 outbreak, rural providers (including hospitals and rural health clinics), skilled nursing facilities, providers of services with lower shares of Medicare reimbursement or who predominantly serve Medicaid beneficiaries, and providers requesting reimbursement for the treatment of uninsured patients.

Payments made by the Emergency Fund to healthcare providers are not loans, and, as a result, they do not need to be repaid. However, healthcare providers are required to file attestations acknowledging receipt of the payments and must agree to and meet the terms and conditions that are associated with the payments, which include, among other things, accepting in-network amounts for presumptive or actual out-of-network COVID-19 patients and not using the payments received from the Emergency Fund to reimburse expenses or losses that other sources are obligated to reimburse. The Department of Health and Human Services ("HHS") has indicated that it will be closely monitoring the payments that are made to providers through the Emergency Fund, and that HHS, along with the Office of Inspector General ("OIG"), will be auditing providers to ensure that recipients comply with the terms and conditions that are associated with the Emergency Fund and other COVID-19 relief programs.

The Company has accounted for the direct grant aid payments received as a government grant related to income in a manner consistent with International Accounting Standards 20, "Accounting for Government Grants and Disclosure of Government Assistance" ("IAS 20"). In accordance with IAS 20, government grants are recognized either as other income or a reduction to a related expense when there is reasonable assurance that the grant will be received, and the entity will comply with any conditions attached to the grant. For the year ended December 31, 2020, the Company recognized $646.3 million of direct grant aid payments as other income under the caption "Government stimulus income" in the accompanying consolidated statement of operations.

Medicare Accelerated and Advance Payment Program

Using existing authority and certain expanded authority under the CARES Act, HHS temporarily expanded the Centers for Medicare and Medicaid Services ("CMS") Accelerated and Advance Payment Program to a broad group of Medicare Part A and Part B providers. Under the expanded Accelerated and Advance Payment Program, inpatient acute care hospitals could request up to 100% of their Medicare payment amount for a six-month period (critical access hospitals could request up to 125% of their payment amount for such period), and other providers and suppliers could request up to 100% of their Medicare payment amount for a three-month period. The repayment of these accelerated/advance payments does not begin until one year after the date of the provider's or supplier's receipt of the payment, which means repayment of these amounts will not commence until the second quarter of 2021. Once the repayment period starts, the amounts previously advanced to the provider or supplier will automatically be recouped from the provider's or supplier's new Medicare claims at a rate of 25% for a period of 11 months. After the end of that 11-month period, the amounts previously advanced to the provider or supplier will be automatically recouped from the provider's or supplier's new Medicare claims at a rate of 50% for a period of six months. At the end of the 17-month recoupment period, a letter requesting repayment of any remaining balance will be issued, and the provider or supplier will have 30 days from the date of the letter to repay the balance in full. If the remaining balance is not repaid after 30 days, the unpaid balance will accrue interest at a rate of 4% from the date of the demand letter until the balance has been repaid in full.

Through December 31, 2020, the Company received a total of $991.0 million of Medicare advance payments under the Accelerated and Advance Payment Program, of which $369.8 million and $621.2 million are included under the captions "Current portion of Medicare advance payments" and "Long-term portion of Medicare advance payments", respectively, in the accompanying consolidated balance sheet at December 31, 2020. The Company does not anticipate receiving any additional funds from the CMS Accelerated and Advance Payment Program.

Note 3. Merger, Acquisitions, Divestitures and Joint Ventures

LifePoint/RCCH Merger

Summary

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

The Company accounted for the LifePoint/RCCH Merger in accordance with ASC 805 under the acquisition method of accounting. The results of operations of Legacy LifePoint are included in the Company's results of operations beginning on November 17, 2018. Revenues from the operations acquired in the LifePoint/RCCH Merger included in the Company's consolidated statements of operations were $754.9 million for the year ended December 31, 2018. Income before income taxes from the operations acquired in the LifePoint/RCCH Merger was $50.9 million for the year ended December 31, 2018.

For the years ended December 31, 2019 and 2018, the Company recognized merger and integration-related costs of $47.1 and $134.7 million, respectively, primarily related to legal and transaction advisory services as well as employee severance and retention and other integration-related expenses in connection with the LifePoint/RCCH Merger. Included in the 2018 merger-related costs is a $55.0 million transaction fee paid by the Company to an affiliate of its Sponsor upon the closing of the LifePoint/RCCH Merger.

Equity Contribution

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

Financing Transactions

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

Acquisitions

Lourdes Health ("Lourdes")

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

Trios Health ("Trios")

At the close of business on August 3, 2018, the Company acquired Trios for $18.0 million. Trios is comprised of two hospital campuses with a total of 111 beds each located in Kennewick, Washington. In connection with the Trios acquisition, the Company entered into a sale-leaseback arrangement for a hospital building whose rent is contingent on the financial performance of the hospital and a sale-leaseback arrangement for a medical office building. The results of operations of Trios are included in the Company's results of operations beginning on August 4, 2018.

Pacific Medical Data Solutions ("PMDS")

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

Divestitures

Capital Medical Center

On December 23, 2020, the Company entered into a definitive agreement with an unrelated third-party to sell its majority ownership interest in Capital Medical Center, located in Olympia, Washington. Upon entry into the definitive agreement, the Company received a deposit of $5.0 million from the purchaser, which is included under the caption "Other current liabilities" in the Company's accompanying consolidated balance sheet at December 31, 2020. The Company anticipates receiving additional cash proceeds of approximately $35.0 million upon the close of the transaction in exchange for its majority ownership interest, subject to the finalization of net working capital, in addition to the purchaser's assumption of certain finance lease obligations. The Company expects the transaction to close during the first half of 2021.

In connection with the entry into a definitive agreement to sell the Company's majority ownership interest in Capital Medical Center, the Company reclassified $142.9 million in total assets, comprised of property and equipment, allocated goodwill and working capital assets, and $129.4 million in total liabilities, comprised of finance lease obligations and working capital liabilities, to assets and liabilities held for sale, which are included under the captions "Other current assets" and "Other current liabilities", respectively, in the Company's accompanying consolidated balance sheet at December 31, 2020.

Teche Regional Medical Center ("Teche")

Effective October 1, 2019, the Company terminated its lease of Teche, located in Morgan City, Louisiana, and transferred the owned assets and operations of Teche to a new operator. Included in the Company's consolidated results of operations for the years ended December 31, 2019 and 2018 are net operating losses before income taxes attributable to Teche of $1.4 million and $0.6 million, respectively.

Joint Ventures

Emory Healthcare

Effective January 1, 2020, the Company formed a new joint venture with Emory Healthcare, Inc. ("Emory") to operate St. Francis Hospital ("St. Francis") located in Columbus, Georgia. Upon formation of the joint venture, the Company reclassified $26.1 million of its equity in St. Francis to redeemable noncontrolling interests representing the estimated fair value of Emory's ownership interest in St. Francis. The Company maintains a controlling interest in St. Francis such that it will continue to be included in the Company's consolidated financial statements. Additionally, the Company retained 100% ownership of the real and personal property of St. Francis through a wholly-owned subsidiary of the Company and leases such real and personal property to the joint venture.

In-Home Healthcare Partnership

The Company maintains a joint venture with a wholly-owned subsidiary of LHC Group, Inc. ("LHC"), In-Home Healthcare Partnership ("IHHP"), the purpose of which is to own and operate the Company's home health agencies and hospices and certain of LHC's home health agencies and hospices. The Company accounts for its ownership interest in IHHP as an equity method investment in accordance with ASC 323, "Investments." Effective January 1, 2020, the Company sold a portion of its ownership interest in IHHP to LHC for cash proceeds of $23.6 million.

Note 4. Long-Term Debt

The Company's long-term debt, including current portions and finance leases, consists of the following at December 31, 2020 and 2019 (in millions):

	2020	2019 [a]
Senior borrowings:		
ABL Facility	$ -	$ -
Term Loan Facility	3,214.5	3,523.4
6.75% Secured Notes	600.0	-
4.375% Secured Notes	600.0	-
8.25% Secured Notes	-	800.0
9.75% Unsecured Notes	1,425.0	1,425.0
5.375% Unsecured Notes	500.0	-
11.5% Unsecured Notes	-	350.0
Finance lease obligations	1,048.2	1,128.3
Unamortized debt issuance costs and premium	(151.8)	(191.8)
	7,235.9	7,034.9
Subordinated borrowings, net	-	1.6
Total debt	$ 7,235.9	$ 7,036.5

(a) The Company's finance lease obligations as of December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

Maturities of the Company's long-term debt outstanding at December 31, 2020, excluding finance lease obligations and unamortized debt issuance costs and premium, are as follows for the years indicated (in millions):

2021	$	-
2022		-
2023		-
2024		-
2025		3,814.5
Thereafter		2,525.0
	$	6,339.5

ABL Facility

General

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Company and Legend Merger Sub (together, prior to the effective time of the LifePoint/RCCH Merger, the "Co-Borrowers") entered into the ABL Facility in an aggregate principal amount of $800.0 million with a maturity of five years. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint assumed all of the rights and obligations of Legend Merger Sub under the ABL Facility. The ABL Facility also includes both a letter of credit sub-facility and a swingline loan sub-facility (including in its capacity as co-borrower under the Term Loan Facility) entered into between the Co-Borrowers on November 16, 2018. In addition, the Company may request one or more incremental revolving commitments in an aggregate principal amount up to the greater of (x) the greater of (i) $255.0 million and (ii) 0.23 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, and (y) the amount by which the borrowing base exceeds the aggregate commitments under the ABL Facility, subject to certain conditions and receipt of commitments by existing or additional lenders.

As of December 31, 2020, the Company had no borrowings outstanding under the ABL Facility and approximately $45.3 million in letters of credit outstanding primarily related to the self-insured retention level of its general and professional liability insurance and workers' compensation programs as security for payment of claims and as security for certain lease agreements. Amounts available for borrowing under the ABL Facility were approximately $538.8 million as of December 31, 2020.

Collateral and Guarantors

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

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

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

Interest Rates and Fees

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

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

Restrictive Covenants and Other Matters

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

The ABL Facility requires that the Co-Borrowers and its restricted subsidiaries maintain a minimum fixed charge coverage ratio of not less than 1.00 to 1.00 at any time when availability is less than an agreed amount.

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

ABL FILO Term Loan

On April 13, 2020, the Company executed the ABL Facility Amendment that provided for an $80.0 million last-out term loan (the "ABL FILO Term Loan") with a maturity of 364 days, which was incremental to the existing $800.0 million of revolving commitments under the ABL Facility. The ABL FILO Term Loan was fully drawn at closing of the ABL Facility Amendment and then subsequently repaid in full on December 14, 2020, which effectively terminated the ABL FILO Term Loan.

Term Loan Facility

General

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Co-Borrowers entered into the Term Loan Facility, which is a senior secured term loan credit facility in an aggregate principal amount of $3,550.0 million with a maturity of seven years. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint assumed all of the rights and obligations of Legend Merger Sub under the Term Loan Facility (including in its capacity as a Co-Borrower under the Term Loan Facility). In addition, the Company may request one or more incremental commitments in an aggregate principal amount up to the sum of (x) the greater of (i) $800.0 million and (ii) 0.75 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, plus additional amounts subject to certain agreed leverage requirements, certain other conditions and receipt of commitments by existing or additional lenders.

On January 21, 2020, the Company amended its Term Loan Facility to, among other things, reduce the applicable interest rate margin for the term loans by 0.75% to 3.75% with respect to LIBOR-based loans and 2.75% with respect to base rate loans.

On January 23, 2020, the Company made a prepayment of $400.0 million of term loans outstanding under the Term Loan Facility with a portion of the net proceeds from the sale-leaseback transaction with Medical Properties Trust completed effective December 17, 2019 (the "2019 Sale Leaseback Transaction"), which is discussed further in Note 8. After giving effect to the prepayment, the Company had prepaid all remaining quarterly amortization payments in respect of the Term Loan Facility.

On February 24, 2020, the Company closed the issuance of $600.0 million of incremental term loans (the "Incremental Term Loan") under the Term Loan Facility. The Incremental Term Loan bears interest at a rate equal to, at its option, (a) a LIBOR rate plus an applicable margin of 3.75% or (b) a base rate plus an applicable margin of 2.75%. There are no scheduled amortization payments required on the Incremental Term Loan prior to maturity. The net proceeds from the Incremental Term Loan, together with the net proceeds from the 4.375% Secured Notes and cash on hand, was used to fund the settlement of the tender offer, the redemption of the Company's 8.25% Senior Secured Notes due 2023 (the "8.25% Secured Notes") and the redemption of the Company's 11.5% Senior Notes due 2024 (the "11.5% Unsecured Notes") and to pay certain fees in connection with the refinancing transactions described herein.

On December 4, 2020, the Company made an optional prepayment of $500.0 million of term loans outstanding under the Term Loan Facility with the net proceeds from the offering of $500.0 million in aggregate principal amount of 5.375% Senior Notes due 2029 (the "5.375% Unsecured Notes"), together with cash on hand.

Collateral and Guarantors

All obligations under the Term Loan Facility are unconditionally guaranteed by Holdings on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the Co-Borrowers, subject to certain exceptions. The obligations under the Term Loan Facility are secured by a pledge of the capital stock of the Company and substantially all of its assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company (including Legacy LifePoint) and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the Non-ABL Priority Collateral and a second-priority lien with respect to the ABL Priority Collateral.

Interest Rates

Borrowings under the Term Loan Facility bear interest at a rate equal to, at the Company's option, either (a) a LIBOR rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an applicable margin of 3.75% for LIBOR loans and 2.75% for base rate loans.

Restrictive Covenants and Other Matters

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

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

6.75% Secured Notes

On April 13, 2020, the Company completed the offering of $600.0 million in aggregate principal amount 6.750% Senior Secured Notes due 2025 (the "6.75% Secured Notes"). The 6.75% Secured Notes will mature on April 15, 2025. Interest on the 6.75% Secured Notes will accrue at 6.75% per annum and will be paid semi-annually, in arrears, on April 15 and October 15 of each year, beginning October 15, 2020. The net proceeds from the offering were used for general corporate purposes.

The Company's obligations under the 6.75% Secured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantee the Term Loan Facility and the 4.375% Senior Secured Notes due 2027 (the "4.375% Secured Notes"). The 6.75% Secured Notes and the related guarantees are secured obligations of the Company and each subsidiary guarantor. The 6.75% Secured Notes and related guarantees are secured by, subject to permitted liens, (i) first-priority security interests in the Company's Non-ABL Priority Collateral and (ii) second-priority security interests in the Company's ABL Priority Collateral.

Prior to April 15, 2022, the Company may redeem the 6.75% Secured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 6.75% Secured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to April 15, 2022, the Company may also redeem up to 40% of the original aggregate principal amount of the 6.75% Secured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 106.750%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 6.75% Secured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption. On or after April 15, 2022, the Company may redeem the 6.75% Secured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of April 13, 2020 (as amended or supplemented from time to time, the "6.75% Secured Notes Indenture").

The 6.75% Secured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions as described in the 6.75% Secured Notes Indenture. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 6.75% Secured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 6.75% Secured Notes Indenture also provides for customary events of default.

4.375% Secured Notes

On February 13, 2020, the Company completed the offering of $600.0 million in aggregate principal amount of its 4.375% Secured Notes. The 4.375% Secured Notes will mature on February 15, 2027. Interest on the 4.375% Secured Notes will accrue at 4.375% per annum and will be paid semi-annually, in arrears, on February 15 and August 15 of each year, beginning August 15, 2020. The net proceeds from the offering, together with the net proceeds from the Incremental Term Loan and cash on hand, were used to fund the settlement of the tender offer, the 8.25% Notes Redemption (as defined herein) and the 11.5% Notes Redemption (as defined herein) and to pay certain fees in connection with the refinancing transactions described herein.

The Company's obligations under the 4.375% Secured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantee the Term Loan Facility. The 4.375% Secured Notes and the related guarantees are secured obligations of the Company and each subsidiary guarantor. The 4.375% Secured Notes and related guarantees are secured by, subject to permitted liens, (i) first-priority security interests in the Company's Non-ABL Priority Collateral and (ii) second-priority security interests in the Company's ABL Priority Collateral.

Prior to February 15, 2022, the Company may redeem the 4.375% Secured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 4.375% Secured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to February 15, 2022, the Company may also redeem up to 40% of the original aggregate principal amount of the 4.375% Secured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 104.375%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 4.375% Secured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption. On or after February 15, 2022, the Company may redeem the 4.375% Secured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of February 13, 2020 (as amended or supplemented from time to time, the "4.375% Secured Notes Indenture").

The 4.375% Secured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions as described in the 4.375% Secured Notes Indenture. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 4.375% Secured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 4.375% Secured Notes Indenture also provides for customary events of default.

9.75% Unsecured Notes

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

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

Prior to December 1, 2021, the Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 9.75% Unsecured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. Additionally, prior to December 1, 2021, the Company may redeem in the aggregate up to 40% of the aggregate principal amount of the 9.75% Unsecured Notes in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 109.750%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 9.75% Unsecured Notes must remain outstanding after each such redemption. On or after December 1, 2021, the Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of November 16, 2018 (as amended or supplemented from time to time, the "9.75% Unsecured Notes Indenture").

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

5.375% Unsecured Notes

On December 4, 2020, the Company completed the offering of $500.0 million in aggregate principal amount of its 5.375% Unsecured Notes. The 5.375% Unsecured Notes will mature on January 15, 2029. Interest on the 5.375% Unsecured Notes will accrue at 5.375% per annum and will be paid semi-annually, in arrears, on January 15 and July 15 of each year, beginning July 15, 2021. The net proceeds of the offering, together with cash on hand, were used to prepay $500.0 million of the total aggregate principal amount outstanding under the Term Loan Facility and to pay related fees and expenses in connection with the offering.

The Company's obligations under the 5.375% Unsecured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantees the Term Loan Facility. The 5.375% Unsecured Notes and the related guarantees are unsecured obligations of the Company and the subsidiary guarantors.

Prior to January 15, 2024, the Company may redeem the 5.375% Unsecured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 5.375% Unsecured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to December 4, 2023, the Company may also redeem up to 40% of the original aggregate principal amount of the 5.375% Unsecured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 105.375%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 5.375% Unsecured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption. On or after January 15, 2024, the Company may redeem the 5.375% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of December 4, 2020 (the "5.375% Unsecured Notes Indenture").

The 5.375% Unsecured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 5.375% Unsecured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 5.375% Unsecured Notes Indenture also provides for customary events of default.

Tender Offer, Redemption and Discharge of 8.25% Secured Notes and 11.5% Unsecured Notes

On February 7, 2020, the Company commenced a tender offer and consent solicitation (the "tender offer") to purchase any and all of its outstanding (i) 8.25% Secured Notes issued pursuant to the indenture, dated as of April 29, 2016, among the Company, the guarantors party thereto and Wilmington Trust, National Association, as trustee (as amended, supplemented or otherwise modified, the "8.25% Secured Notes Indenture") and (ii) 11.5% Unsecured Notes issued pursuant to the indenture, dated as of April 29, 2016, among the Company, the guarantors party thereto and Wilmington Trust, National Association, as trustee (as amended, supplemented or otherwise modified, the "11.5% Unsecured Notes Indenture"). The early tender deadline for the tender offer was February 21, 2020, and the expiration date for the tender offer was March 6, 2020.

Upon expiration of the early tender deadline, on February 24, 2020, the Company accepted and purchased (i) $622.5 million of the aggregate principal amount of the 8.25% Secured Notes that were validly tendered for total consideration of $1,052.50 per $1,000 principal amount, plus accrued and unpaid interest thereon, and (ii) $84.1 million of the aggregate principal amount of the 11.5% Unsecured Notes that were validly tendered for a total consideration of $1,072.50 per $1,000 principal amount, plus accrued and unpaid interest thereon. Following the expiration of the tender offer, on March 9, 2020, the Company accepted and purchased an additional $0.2 million of the aggregate principal amount of the 8.25% Secured Notes that were validly tendered after the early tender deadline for a tender consideration of $1,022.50 per $1,000 principal amount, plus accrued and unpaid interest thereon. No additional 11.5% Unsecured Notes were tendered after the early tender deadline.

On March 9, 2020, (i) pursuant to the 8.25% Secured Notes Indenture, the Company provided notice to the holders that it had elected to redeem any and all of the 8.25% Secured Notes that remain outstanding after giving effect to the tender offer at a redemption price of 104.125%, plus accrued and unpaid interest thereon, on May 1, 2020 (the "8.25% Notes Redemption") and (ii) pursuant to the 11.5% Unsecured Notes Indenture, the Company provided notice to the holders that it had elected to redeem any and all of the 11.5% Unsecured Notes that remain outstanding after giving effect to the tender offer at a redemption price of 105.750%, plus accrued and unpaid interest thereon, on May 1, 2020 (the "11.5% Notes Redemption"). Concurrently with the delivery of the notices of redemption, on March 9, 2020, the Company (i) irrevocably deposited with the trustee for the 8.25% Secured Notes approximately $191.9 million, which was the amount sufficient to fund the 8.25% Notes Redemption and to satisfy and discharge the Company's obligations under the 8.25% Secured Notes and the 8.25% Secured Notes Indenture, and (ii) irrevocably deposited with the trustee for the 11.5% Unsecured Notes approximately $296.5 million, which was the amount sufficient to fund the 11.5% Notes Redemption and to satisfy and discharge the Company's obligations under the 11.5% Unsecured Notes and the 11.5% Unsecured Notes Indenture.

Debt Transaction Costs

During the year ended December 31, 2020, the Company recognized $115.4 million of debt transaction costs associated with the various debt financing activities completed during 2020. These debt transaction costs were comprised of $61.4 million of early termination premiums associated with the tender offer, 8.25% Notes Redemption and 11.5% Notes Redemption, the write-off of $47.4 million of previously capitalized debt issuance costs associated with the Term Loan Facility, the 8.25% Secured Notes and the 11.5% Unsecured Notes and $6.6 million of other miscellaneous legal and financing costs.

During the year ended December 31, 2018, the Company recognized $8.2 million of debt transaction costs associated with the extinguishment of the Prior ABL Facility and the Prior Term Facility.

Additionally, in connection with the offering of the 5.375% Unsecured Notes, the 6.75% Secured Notes, the 4.375% Secured Notes, the issuance of the Incremental Term Loan and the ABL FILO Term Loan, the Company capitalized $34.8 million of new debt issuance costs during the year ended December 31, 2020, which are included as a reduction to "Long-term debt, net" on the Company's accompanying consolidated balance sheet.

Finance Lease Obligations

Refer to Note 8 for discussion of the Company's finance lease obligations.

Interest Rate Swap Agreement

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

Note 5. Goodwill and Intangible Assets

Goodwill

The following table presents the changes in the carrying amount of goodwill for the years ended December 31, 2020 and 2019 (in millions):

Balance at January 1, 2019	$	2,567.6
Finalization of purchase price allocations for the LifePoint/RCCH Merger		381.1
Adjustments related to acquisitions		17.0
Impairments		(3.3)
Write-off allocation related to IHHP transactions		(1.2)
Balance at December 31, 2019		2,961.2
Acquisitions of ancillary businesses		0.6
Allocation to assets held for sale related to Capital Medical Center		(41.2)
Write-off allocation related to IHHP transaction		(2.1)
Balance at December 31, 2020	$	2,918.5

Prior to the LifePoint/RCCH Merger, the Company historically determined that each of its hospitals represented a reporting unit in accordance with ASC 280 and ASC 350. Due to the significance of the LifePoint/RCCH Merger and its impact on the Company's management team and business operations, the Company re-evaluated its reporting units in accordance with ASC 280 and ASC 350 during 2019 and determined that the consolidated business comprises a single reporting unit for goodwill impairment testing purposes. There have been no changes in the Company's determination of reporting units for the year ended December 31, 2020.

Under the current methodology, for which the consolidated Company comprises a single reporting unit, the Company performed goodwill impairment tests as of October 1, 2020 and 2019 and did not incur any impairment charges. Under the prior reporting unit methodology, for which each of the Company's hospitals represented a reporting unit, the Company performed a goodwill impairment test as of October 1, 2019 and recorded a non-cash impairment charge of $3.3 million for the year ended December 31, 2019 related to one of its facilities. Additionally, for the year ended December 31, 2018, the Company recorded non-cash impairment charges in the aggregate of $53.9 million related to three of its facilities.

Intangible Assets

The following table provides information regarding the Company's intangible assets included in the accompanying consolidated balance sheets as of December 31, 2020 and 2019 (in millions):

	2020	2019 [a]
Amortizable intangible assets:		
Contract-based physician minimum revenue guarantees		
Gross carrying amount	$ 28.3	$ 34.7
Accumulated amortization	(12.1)	(12.7)
Net total	16.2	22.0
Other amortizable intangible assets		
Gross carrying amount	3.2	4.4
Accumulated amortization	(2.4)	(2.3)
Net total	0.8	2.1
Total amortizable intangible assets		
Gross carrying amount	31.5	39.1
Accumulated amortization	(14.5)	(15.0)
Net total	17.0	24.1
Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	29.3	29.3
Licenses, provider numbers, accreditations and other	12.0	12.0
Net total	41.3	41.3
Total intangible assets:		
Gross carrying amount	72.8	80.4
Accumulated amortization	(14.5)	(15.0)
Net total	$ 58.3	$ 65.4

(a) Certain of the Company's other amortizable intangible assets as of December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

Contract-Based Physician Minimum Revenue Guarantees

The Company has committed to provide certain financial assistance pursuant to recruiting agreements, or "physician minimum revenue guarantees," with various physicians practicing in the communities it serves. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician to assist in establishing his or her practice.

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460, "Guarantees" ("ASC 460"). In accordance with ASC 460, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized as a component of other operating expenses, in the accompanying consolidated statements of operations, over the period of the physician contract, which typically ranges from four to five years. As of December 31, 2020 and 2019, the Company's liability for contract-based physician minimum revenue guarantees was $8.3 million and $9.3 million, respectively. These amounts are included as a current liability under the caption "Other current liabilities" in the Company's accompanying consolidated balance sheets.

Other Amortizable Intangible Assets

The Company has various other amortizable intangible assets that are amortized on a straight-line basis over the respective terms.

Certificates of Need and Certificates of Need Exemptions

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and certain equipment at the Company's facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. The Company has acquired facilities in certain states that have adopted certificate of need laws. The Company has determined that these intangible assets have an indefinite useful life.

Licenses, Provider Numbers, Accreditations and Other

To operate hospitals, the Company must obtain certain licenses, provider numbers and accreditations from federal, state and other accrediting agencies. The Company has acquired facilities in certain jurisdictions that require licenses, provider numbers and accreditations. The Company has determined that these intangible assets have an indefinite useful life.

Amortization Expense

Amortization expense for the Company's intangible assets during the years ended December 31, 2020, 2019 and 2018 was $8.6 million, $14.1 million and $4.7 million, respectively.

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

2021	$ 8.1
2022	5.0
2023	2.5
2024	1.2
2025	0.2
Thereafter	-
	$ 17.0

Note 6. Income Taxes

For the year ended December 31, 2020, the Company recognized a benefit from income taxes of $63.7 million, compared to a provision for income taxes of $77.9 million and $0.2 million for the years ended December 31, 2019 and 2018, respectively. The benefit from income taxes recognized for the year ended December 31, 2020 was primarily a result of significant revisions to the U.S. corporate tax laws due to the enactment of the CARES Act. The Company was most notably impacted by an increase in the limitation in the tax deductibility of interest expense from 30% to 50% of adjusted taxable income for the years ended December 31, 2020 and 2019, as well as the ability to carry back net operating losses to each of the five tax years preceding the tax year of such loss.

The (benefit from) provision for income taxes for the years ended December 31, 2020, 2019 and 2018 consisted of the following (in millions):

	2020	2019	2018
Current:			
Federal	$ (72.5)	$ 67.5	$ -
State	7.8	8.2	1.3
	(64.7)	75.7	1.3
Deferred:			
Federal	98.7	(80.6)	(27.1)
State	38.4	(19.9)	(10.0)
	137.1	(100.5)	(37.1)
Change in valuation allowance	(136.1)	102.7	36.0
Total	$ (63.7)	$ 77.9	$ 0.2

The following table reconciles the differences between the statutory federal income tax rate to the Company's effective tax rate on net income (loss) before income taxes and including net income attributable to noncontrolling interests and redeemable noncontrolling interests for the years ended December 31, 2020, 2019 and 2018 (in millions):

	2020	2019	2018
Federal statutory rate	21.0 %	21.0 %	21.0 %
State income taxes, net of federal income tax benefits	3.8	(26.3)	2.2
Change in valuation allowance	(56.5)	171.0	(12.5)
Tax effect of goodwill write-offs and impairments	0.2	1.8	(2.3)
Noncontrolling interests and redeemable noncontrolling interests	(1.9)	(7.4)	0.4
State net operating loss carryforward expirations, refunds and rate change	10.4	-	-
Rate benefit from federal net operating loss carryback to 35% year	(3.8)	-	-
Nondeductible acquisition and merger-related costs	-	(24.2)	(8.2)
Other nondeductible expenses and other items	0.4	7.1	(0.7)
Effective income tax rate	(26.4) %	143.0 %	(0.1) %

Deferred income taxes result from temporary differences in the recognition of assets, liabilities, revenues and expenses for financial accounting and tax purposes. Sources of these differences and the related tax effects were as follows as of December 31, 2020 and 2019 (in millions):

	2020	2019 [(a)]
Deferred income tax liabilities:		
Depreciation and amortization	$ (61.2)	$ (37.6)
Right-of-use operating lease assets	(99.0)	(98.4)
Tax deductible goodwill	(29.2)	(18.3)
Other	(6.2)	(6.3)
Total deferred income tax liabilities	(195.6)	(160.6)
Deferred income tax assets:		
Provision for doubtful accounts	63.8	48.1
Employee compensation	64.0	45.9
Acquisition and start-up costs	3.7	15.6
Net operating loss carryforwards	98.8	220.6
Insurance reserves	72.5	67.5
Prepaid rent	17.6	16.4
Section 163(j) interest expense carryforward	14.1	81.8
Investments in partnerships	60.3	14.3
Right-of-use operating lease obligations	99.9	99.6
Other	42.6	27.1
Total deferred income tax assets	537.3	636.9
Valuation allowance	(360.1)	(493.6)
Net deferred income tax assets	177.2	143.3
Deferred income taxes	$ (18.4)	$ (17.3)

(a) The Company's deferred income taxes as of December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

Noncurrent deferred income tax liabilities totaled $18.4 million and $17.3 million at December 31, 2020 and 2019, respectively. As of December 31, 2020, the Company had no federal net operating loss carryforwards ("NOLs") and state and local NOLs of approximately $1.9 billion that expire at various dates between 2021 and 2039. The Company has established a valuation allowance for deferred tax assets at December 31, 2020 and 2019, due to the uncertainty of realizing these assets in the future. The valuation allowance decreased $133.5 million during the year ended December 31, 2020, primarily as a result of the projected utilization of all federal NOLs, as well as the significant revisions to the U.S. corporate tax laws due to the enactment of the CARES Act.

The Company made federal income tax payments of $33.0 million for the year ended December 31, 2020. No federal income tax payments were made during the years ended December 31, 2019 or 2018. Net refunds of federal income taxes paid by Legacy LifePoint for tax years ended December 31, 2017 and November 16, 2018 in the amount of $59.5 million and $54.1 million were received during the years ended December 31, 2019 and 2018, respectively. The tax year 2017 refund resulted from an automatic accounting method change, for tax purposes, relating to income recognition made by Legacy LifePoint. The November 16, 2018 tax year-end refund resulted from estimated tax payments made by Legacy LifePoint prior to the announced LifePoint/RCCH Merger that were not needed due to the taxable loss generated for the year. The Company made net state and local income tax payments in the amount of $5.0 million, $1.0 million, and $0.4 million for the years ended December 31, 2020, 2019 and 2018, respectively.

The Company's policy is to accrue interest and penalties related to potential underpayment of income taxes within the provision for income taxes. Interest is computed on the difference between the Company's uncertain tax benefit positions and the amount deducted or expected to be deducted in our income tax returns.

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

Note 7. Other Current Liabilities

The following table provides information regarding the Company's other current liabilities, which are included in the accompanying consolidated balance sheets at December 31, 2020 and 2019 (in millions):

	2020	2019 [a]
Accrued interest	$ 33.4	$ 49.6
Current portion of self-insurance reserves	82.3	64.5
Self-insured medical benefits liabilities	37.7	53.8
Income taxes payable	-	71.8
Current portion of right-of-use operating lease obligations	44.2	43.9
Accrued property taxes	19.8	18.6
Liabilities held for sale	129.4	-
Accrued expenses and other	244.5	186.8
	$ 591.3	$ 489.0

(a) Certain of the Company's other current liabilities as of December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

Note 8. Leases

Adoption of ASU 2016-02

The Company adopted ASU 2016-02 early, during the fourth quarter of 2020, with an effective transition date of January 1, 2019 and retrospective application. As a result, the accompanying consolidated financial statements as of and for the year ended December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. The Company applied certain available practical expedients to facilitate the adoption of ASU 2016-02, including the package of practical expedients to not reassess whether a contract is or contains a lease, the lease classification and the initial direct costs.

The following is a summary of the line items impacted by the adoption of ASU 2016-02 in the Company's consolidated statement of operations for the year ended December 31, 2019 (in millions):

	As Originally Reported	Adoption of ASU 2016-02	As Currently Reported
Other operating expenses, net	$ 2,140.6	$ 9.7	$ 2,150.3
Depreciation and amortization	$ 378.7	$ (2.2)	$ 376.5
Interest expense, net	$ 577.6	$ (9.0)	$ 568.6
Total expenses	$ 8,698.3	$ (1.5)	$ 8,696.8
Income before income taxes	$ 54.5	$ 1.5	$ 56.0
Net loss	$ (23.4)	$ 1.5	$ (21.9)
Net loss attributable to LifePoint Health, Inc.	$ (42.7)	$ 1.5	$ (41.2)

The adoption of ASU 2016-02 primarily impacted the Company's other operating expenses and interest expense as a result changes in the accounting classification of certain leases from finance to operating, in addition to the derecognition of interest expense associated with a variable lease agreement that was previously accounted for as a finance lease.

The following is a summary of the line items impacted by the adoption of ASU 2016-02 in the Company's consolidated balance sheet as of December 31, 2019 (in millions):

	As Originally Reported	Adoption of ASU 2016-02	As Currently Reported
Land	$ 236.1	$ (3.7)	$ 232.4
Buildings and improvements	$ 2,709.9	$ (83.0)	$ 2,626.9
Property and equipment	$ 4,478.2	$ (86.7)	$ 4,391.5
Accumulated depreciation	$ (618.8)	$ 2.3	$ (616.5)
Property and equipment, net of accumulated depreciation	$ 3,859.4	$ (84.4)	$ 3,775.0
Intangible assets, net	$ 73.5	$ (8.1)	$ 65.4
Other long-term assets	$ 380.0	$ 392.9	$ 772.9
Total assets	$ 9,680.9	$ 300.4	$ 9,981.3
Other current liabilities	$ 446.0	$ 43.0	$ 489.0
Current maturities of long-term debt	$ 69.9	$ (0.2)	$ 69.7
Total current liabilities	$ 1,175.8	$ 42.8	$ 1,218.6
Long-term debt, net	$ 7,106.2	$ (139.4)	$ 6,966.8
Other long-term liabilities	$ 361.4	$ 358.2	$ 719.6
Total liabilities	$ 8,643.4	$ 261.6	$ 8,905.0
Accumulated deficit	$ (424.5)	$ 38.8	$ (385.7)
Total LifePoint Health, Inc. equity	$ 863.8	$ 38.8	$ 902.6
Total equity	$ 889.7	$ 38.8	$ 928.5
Total liabilities and equity	$ 9,680.9	$ 300.4	$ 9,981.3

The adoption of ASU 2016-02 primarily impacted other long-term assets and other long-term liabilities as a result of the recognition of right-of-use operating lease assets and obligations, respectively, on the Company's balance sheet. Additionally, the Company derecognized real property assets and finance lease obligations associated with a variable lease agreement, as well as changes in the accounting classification of certain leases from finance to operating. Lastly, the Company recorded a one-time transition adjustment through equity as a result of the derecognition of real property assets and finance lease obligations associated with a variable lease agreement, as well as changes in the Company's deferred income taxes.

Summary

The Company leases real property and equipment under finance and operating leases. The leases expire at various times and have various renewal options. For leases with terms greater than 12 months, the Company records the related assets and obligations at the present value of lease payments over the term. Interest rates used in computing the present value of the lease payments are based on the Company's incremental borrowing rate at the inception of the lease. The Company's lease agreements generally require the Company to pay maintenance, repairs, taxes and insurance costs.

The following table presents certain information related to the Company's lease assets and liabilities at December 31, 2020 and 2019 (dollars in millions):

	Balance Sheet Classification	2020	2019
Assets:			
Finance leases	Property and equipment	$ 678.3	$ 742.2
Operating leases	Other long-term assets	367.5	392.8
Total lease assets		$ 1,045.8	$ 1,135.0
Liabilities:			
Current:			
Finance leases	Current maturities of long-term debt	$ 30.0	$ 23.6
Operating leases	Other current liabilities	44.2	43.9
Long-term:			
Finance leases	Long-term debt, net	1,018.2	1,104.7
Operating leases	Other long-term liabilities	334.8	355.2
Total lease liabilities		$ 1,427.2	$ 1,527.4
Weighted-average remaining term (in years):			
Finance leases		22.6	24.5
Operating leases		12.9	13.5
Weighted-average discount rate:			
Finance leases		7.9 %	8.0 %
Operating leases		8.9 %	8.9 %

The following table presents certain information related to finance and operating lease expense for the years ended December 31, 2020 and 2019 (in millions):

	Statement of Operations Classification	2020	2019
Finance lease expense:			
Amortization related to lease assets	Depreciation and amortization	$ 46.8	$ 27.8
Interest related to lease liabilities	Interest expense, net	90.5	36.3
Operating lease expense	Other operating expenses, net	85.6	80.5
Short-term, variable and other lease expense	Other operating expenses, net	47.4	47.8
Total lease expense		$ 270.3	$ 192.4

The following table presents supplemental cash flow information related to finance and operating leases for the years ended December 31, 2020 and 2019 (in millions):

	2020	2019
Operating cash flows related to operating leases	$ 128.0	$ 122.9
Operating cash flows related to finance leases	$ 82.0	$ 33.1
Financing cash flows related to finance leases	$ 20.1	$ 19.0

The following table reconciles the undiscounted cash flows to the finance and operating lease obligations included in the consolidated balance sheet at December 31, 2020 (in millions):

	Finance Leases	Operating Leases
2021	$ 102.5	$ 74.8
2022	162.1	67.9
2023	91.0	52.1
2024	91.1	44.9
2025	92.8	39.4
Thereafter	2,013.2	390.9
Total minimum lease payments	2,552.7	670.0
Less: amounts attributable to interest	(1,557.5)	(291.0)
Present value of minimum lease payments	995.2	379.0
Non-cash residual value of finance lease obligations	53.0	-
Less: current portion of lease obligations	(30.0)	(44.2)
Long-term portion of lease obligations	$ 1,018.2	$ 334.8

2019 Sale Leaseback Transaction

Effective December 17, 2019, certain subsidiaries of the Company (collectively, the "LifePoint Entities") entered into a Real Property Asset Purchase Agreement (the "Real Property APA") with certain subsidiaries of MPT (the "2019 Sale Leaseback Transaction"). Pursuant to the Real Property APA, the LifePoint Entities sold the real estate of eleven medical facilities (the "2019 Master Lease Facilities") to certain affiliates of MPT, and immediately thereafter certain LifePoint Entities and certain affiliates of MPT entered into an agreed upon Master Lease Agreement (the "2019 Master Lease") pursuant to which such LifePoint Entities now lease or sublease the land and the buildings associated with the 2019 Master Lease Facilities from certain affiliates of MPT. The 2019 Master Lease has an initial term of 20 years (the "Initial Term"). However, the LifePoint Entities who are parties to the 2019 Master Lease have the option to extend the Initial Term for two additional five-year periods.

In connection with the 2019 Sale Leaseback Transaction, the Company received an aggregate amount of sale proceeds of $700.0 million and incurred $18.1 million of transaction-related expenses, which is included under the caption "Merger, acquisition and other transaction-related expenses" in the accompanying consolidated statement of operations for the year ended December 31, 2019.

Lease Covenants

Certain of the Company's lease agreements contain financial covenants based on certain fixed charges. The failure to meet or obtain a waiver of such covenants or otherwise cure such non-compliance could result in an event of default under the applicable lease. The Company has received a waiver of compliance with respect to the financial covenants associated with its amended and restated lease agreement with affiliates of MPT related to Capital Medical Center through March 31, 2022. Additionally, as more fully discussed in Note 3, on December 23, 2020, the Company entered into a definitive agreement with an unrelated third-party to sell its ownership interest in Capital Medical Center.

Note 9. Investments

The Company accounts for its investments in entities in which the Company exhibits significant influence, but not control, under the equity method of accounting in accordance with ASC 323. The Company does not consolidate its equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period. The Company's equity method investments totaled $255.6 million and $274.3 million at December 31, 2020 and 2019, respectively, and are included under the caption "Other long-term assets" in the accompanying consolidated balance sheets.

Note 10. Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to a parent. The Company's accompanying consolidated financial statements include all assets, liabilities, revenues and expenses at their consolidated amounts, which include the amounts attributable to the Company and the noncontrolling interest. The Company recognizes as a separate component of equity and earnings on the portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by the Company.

The following table presents the changes in the Company's noncontrolling interests during the years ended December 31, 2020 and 2019 (in millions):

Balance at January 1, 2019	$	29.9
Finalization of purchase price allocations for the LifePoint/RCCH Merger		(0.2)
Net income attributable to noncontrolling interests		4.4
Distributions		(8.2)
Balance at December 31, 2019		25.9
Net income attributable to noncontrolling interests		7.5
Distributions		(1.4)
Balance at December 31, 2020	$	32.0

Redeemable Noncontrolling Interests

Certain of the Company's noncontrolling interests include redemption features that cause these interests not to meet the requirements for classification as equity in accordance with ASC 480-10-S99-3, "Distinguishing Liabilities from Equity." Redemption features related to these interests could require the Company to deliver cash, if exercised. Accordingly, these redeemable noncontrolling interests are classified in the mezzanine section of the Company's accompanying consolidated balance sheets under the caption "Redeemable noncontrolling interests." Changes in the fair value of the Company's redeemable noncontrolling interests are recognized as adjustments to consolidated stockholders' equity.

The following table presents the changes in the Company's redeemable noncontrolling interests during the years ended December 31, 2020 and 2019 (in millions):

Balance at January 1, 2019	$	136.1
Finalization of purchase price allocations for the LifePoint/RCCH Merger		(4.6)
Net income attributable to redeemable noncontrolling interests		14.9
Fair value adjustments		11.2
Distributions and repurchases		(9.8)
Balance at December 31, 2019		147.8
Reclassification of equity to redeemable noncontrolling interests related to Emory joint venture		26.1
Net income attributable to redeemable noncontrolling interests		14.0
Fair value adjustments		5.0
Distributions and repurchases		(11.8)
Reclassification of redeemable noncontrolling interests related to Capital Medical Center to liabilities held for sale		(0.7)
Balance at December 31, 2020	$	180.4

Note 11. Fair Value of Financial Instruments

Fair Value Hierarchy

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

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

Level 1: Quoted market prices in active markets for identical assets or liabilities.
Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.
Level 3: Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions.

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

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

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

Long-Term Debt

The carrying amounts and fair values of the Company's ABL Facility, Term Loan Facility, 6.75% Secured Notes, 4.375% Secured Notes, 8.25% Secured Notes, 9.75% Unsecured Notes, 5.375% Unsecured Notes and 11.5% Unsecured Notes, excluding unamortized debt issuance costs and premium, as of December 31, 2020 and December 31, 2019 were as follows (in millions):

	Carrying Amount		Fair Value	
	December 31, 2020	December 31, 2019	December 31, 2020	December 31, 2019
ABL Facility	$ -	$ -	$ -	$ -
Term Loan Facility	$ 3,214.5	$ 3,523.4	$ 3,210.5	$ 3,549.8
6.75% Secured Notes	$ 600.0	$ -	$ 640.5	$ -
4.375% Secured Notes	$ 600.0	$ -	$ 600.0	$ -
8.25% Secured Notes	$ -	$ 800.0	$ -	$ 849.0
9.75% Unsecured Notes	$ 1,425.0	$ 1,425.0	$ 1,556.8	$ 1,610.3
5.375% Unsecured Notes	$ 500.0	$ -	$ 496.3	$ -
11.5% Unsecured Notes	$ -	$ 350.0	$ -	$ 376.3

The fair values of the Company's long-term debt instruments were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820.

Interest Rate Swap

The Company measures its Interest Rate Swap at fair value on a recurring basis. The fair value of the Company's Interest Rate Swap is based on quotes from its counterparty. The Company considers those inputs to be Level 2 in the fair value hierarchy. At December 31, 2020 and 2019, the fair value of the Company's Interest Rate Swap was a total liability of $31.2 million and $24.6 million, respectively, of which $26.5 million and $10.7 million, respectively, is included under the caption "Other current liabilities" and $4.7 million and $13.9 million, respectively, is included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheets.

The Company has not designated its Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging." Accordingly, all changes in the fair value of the Company's Interest Rate Swap are recognized through interest expense in its statement of operations. For the years ended December 31, 2020, 2019 and 2018, the Company recognized non-cash interest expense of $6.6 million, $18.8 million and $5.8 million, respectively, related to changes in the fair value of its Interest Rate Swap.

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

Financial Liabilities

The Company has a contingent consideration liability payable to the former owners of Canyon Vista Medical Center ("Canyon Vista") that represents the Level 3 estimated fair value of the contingent consideration using unobservable inputs and assumptions available to the Company. The key assumptions used in estimating the fair value of the Canyon Vista contingent consideration liability are the range of probabilities that the payments will be earned by the seller and a discount rate adjusted for the Company's credit risk.

At December 31, 2020 and 2019, the Canyon Vista contingent consideration liability was recorded at an estimated fair value of $18.8 million and $13.6 million, respectively, of which $2.0 million is included under the caption "Other current liabilities" at December 31, 2020, and $16.8 million and $13.6 million, respectively, is included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheets. For the year ended December 31, 2020, the Company recognized a non-cash charge of $5.2 million related to the change in the estimated fair value of the Canyon Vista contingent consideration liability, which is included under the caption "Other non-operating losses (gains), net" on the accompanying consolidated statement of operations.

Note 12. Employee Benefit Plans

Defined Benefit Pension Plans

In connection with the LifePoint/RCCH Merger, the Company acquired certain assets and assumed certain liabilities associated with two separate defined benefit pension plans (i) associated with certain employees of Marquette General Hospital covered by a collective bargaining agreement (the "Marquette Pension Plan") and (ii) associated with certain non-union employees of Bell Hospital (the "Bell Pension Plan" and, collectively with the Marquette Pension Plan, the "Pension Plans"). Both Pension Plans are closed to new participants. Participants in the Marquette Pension Plan are required to make annual contributions totaling 6% of annual compensation to the Marquette Pension Plan to continue accruing benefits. Participants in the Bell Pension Plan no longer accrue benefits. The Company makes contributions to the Pension Plans sufficient to meet its minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended.

Status and Expense

The following table presents the changes in the benefit obligations and plan assets of the Pension Plans during the years ended December 31, 2020 and 2019 and the unfunded liability of the Pension Plans at December 31, 2020 and 2019 (in millions):

	2020	2019
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 70.1	$ 58.6
Service costs	0.6	0.5
Interest costs	2.1	2.4
Participant contributions	0.3	0.3
Actuarial loss	5.6	10.2
Benefits paid	(2.1)	(1.9)
Benefit obligation at end of year	76.6	70.1
Change in plan assets:		
Fair value of plan assets at beginning of year	47.1	38.5
Actual return on plan assets	6.9	8.1
Employer contributions	2.1	2.1
Participant contributions	0.3	0.3
Benefits and expenses paid	(2.1)	(1.9)
Fair value of plan assets at end of year	54.3	47.1
Unfunded liability included in other long-term liabilities in the Company's accompanying consolidated balance sheet	$ 22.3	$ 23.0

The Company recognizes changes in the funded status of the Pension Plans as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income (loss). For the years ended December 31, 2020 and 2019, the Company recognized comprehensive losses of $1.3 million and $4.4 million, respectively, as decreases in stockholders' equity through accumulated other comprehensive loss. The adjustments were primarily related to changes in the Company's unfunded pension liability due to changes in the discount rates and mortality assumptions used to measure the projected benefit obligation.

The following table summarizes the projected benefit obligation, accumulated benefit obligation and fair value of plan assets related to the Pension Plans as of December 31, 2020 and 2019 (in millions):

	2020	2019
Projected benefit obligation	$ 76.6	$ 70.1
Accumulated benefit obligation	$ 71.7	$ 65.4
Fair value of plan assets	$ 54.3	$ 47.1

The following table summarizes the weighted-average assumptions used by the Company to determine its benefit obligation as of December 31, 2020 and 2019 (in millions):

	2020	2019
Discount rate	2.5 %	3.1 %
Rate of compensation increases, when applicable	3.0 %	3.0 %

Plan Assets

The investment policy for the Pension Plans has been formulated to achieve a risk adjusted return that balances the need for asset growth against the risk of significant fluctuations in asset prices and the need for significant contributions from the Company. On a quarterly basis, or more frequently as necessary, the current risk levels, asset performance and expected return on assets are reviewed and evaluated against goals and targets by a committee appointed to oversee investment of the Pension Plans' assets (the "Investment Committee"). The Investment Committee strives to maintain a balance between risk and return through the use of modern portfolio theory methods, in conjunction with Monte Carlo modeling to evaluate the behavior of the portfolio under different scenarios. At December 31, 2020, the Pension Plans' investments include a balance of mutual funds and money market funds in order to achieve an overall rate of return that minimizes the need for additional employer contributions. The Company measures the fair value of its

Pension Plans' assets in accordance with ASC 820.

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

The following table summarizes the assets of the Pension Plans, measured at fair value as of December 31, 2020 and 2019, by major asset category and aggregated by level within the fair value hierarchy (in millions):

	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
December 31, 2020:				
Mutual funds	$ 52.6	$ 52.6	$ -	$ -
Money market funds	1.7	-	1.7	-
Total	$ 54.3	$ 52.6	$ 1.7	$ -
December 31, 2019:				
Mutual funds	$ 44.5	$ 44.5	$ -	$ -
Money market funds	2.6	-	2.6	-
Total	$ 47.1	$ 44.5	$ 2.6	$ -

The Company expects to contribute approximately $1.7 million to the Pension Plans during the year ended December 31, 2021. Additionally, the Company expects to make future benefit payments from the Pension Plans as follows for the years indicated (in millions):

2021	$ 2.5
2022	2.6
2023	2.9
2024	3.0
2025	3.2
Five years thereafter	18.0
	$ 32.2

Multiemployer Pension Plan

In connection with the LifePoint/RCCH Merger, the Company assumed the obligation to contribute to a multiemployer pension plan on behalf of certain employees covered by collective bargaining agreements, in accordance with the terms of such collective bargaining agreements. The Company's contributions to the multiemployer pension plan are determined based on the terms of the applicable collective bargaining agreements. Multiemployer plans are different from single-employer plans because assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers. Also, if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers. If the Company stops participating in the multiemployer plan, the Company may be required to pay a withdrawal liability based on its portion of the unfunded status of the plan. Currently, the Company does not anticipate ending its participation in this plan.

Defined Contribution Plans

The Company maintains two separate defined contribution retirement plans covering a majority of the Company's employees. These defined contribution plans contain discretionary matching contribution formulas and definite non-elective contribution formulas for employees at certain facilities. The Company's expense related to its defined contribution plans was $31.4 million, $31.2 million and $5.6 million for the years ended December 31, 2020, 2019 and 2018, respectively.

Deferred Compensation Plans

The Company maintains supplemental deferred compensation plans with respect to certain of its employees and affiliated physicians. As of December 31, 2020 and 2019, the assets associated with these deferred compensation plans were $56.1 million and $46.2 million, respectively, and the liabilities were $60.4 million and $48.1 million, respectively. These amounts are included under the captions "Other long-term assets" and "Other long-term liabilities", respectively, on the accompanying consolidated balance sheets at December 31, 2020 and 2019.

Note 13. Stock-Based Compensation

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

There are 35,270,000 aggregate number of Units authorized for issuance. Service Units and Performance Units have been issued under the DSB Parent Partnership Agreement and forms of award agreements. The following table summarizes the activity with regards to units available for grant under the Company's stock-based compensation plan for the years ended December 31, 2020, 2019 and 2018:

	Units Available for Grant
January 1, 2018	5,407,989
Granted	(3,073,000)
Forfeited	1,653,720
December 31, 2018	3,988,709
Authorized for grant	16,400,000
Granted	(17,749,956)
Repurchased	3,750,184
Forfeited	735,704
December 31, 2019	7,124,641
Granted	(5,352,467)
Repurchased	57,498
Forfeited	240,100
December 31, 2020	2,069,772

Service Units

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

Service Units are accounted for as equity awards and related compensation expense is recognized ratably over the vesting period. For employees and executives granted Service Units prior to November 16, 2018 who are severed during the 18-month period following the LifePoint/RCCH Merger under certain circumstances, Tranche A Units vest in full upon the eligible employee's termination date. On November 16, 2018, Service Units originally issued to approximately 40 employees and executives were modified in connection with the LifePoint/RCCH Merger. The Company calculated the fair value of the service units before and after the modification and recorded expense of $1.2 million and $2.4 million for the years ended December 31, 2020 and 2019, respectively, related to the modification and acceleration of service units. As of December 31, 2020, Service Units had unrecognized compensation expense of $7.9 million. The expense is expected to be recognized over a weighted-average period of 1.9 years from December 31, 2020.

Performance Units

Performance Units, which have been granted as Tranche B Units and Tranche C Units, will vest based upon equity holders of DSB Parent realizing certain targeted multiples of invested capital ("MOIC thresholds"). Performance Units are accounted for as equity awards with expense recognition occurring upon the realization of the stated MOIC thresholds due to a liquidity event. For employees and executives granted Performance Units prior to November 16, 2018 who were severed in connection with the LifePoint/RCCH Merger, Tranche B units vest in full upon the eligible employee's termination date and Tranche C units are forfeited in accordance with the original terms and conditions of the applicable Profits Units award agreement. On November 16, 2018, Tranche B Units previously issued to approximately 40 employees and executives were modified in connection with the LifePoint/RCCH Merger. The Company calculated the fair value of the Tranche B Units before and after the modification and recorded expense of $1.2 million and $2.7 million for the years ended December 31, 2020 and 2019, respectively, related to the modification and acceleration of Tranche B Units. For Performance Units not modified in connection with the LifePoint/RCCH Merger, the Company determined that a liquidity event was not probable, therefore no compensation expense has been recognized related to the unmodified Performance Units. Unvested Units that do not vest on termination are forfeited upon such termination, subject to certain conditions.

The following table summarizes the Company's total stock-based compensation expense for the years ended December 31, 2020, 2019 and 2018 (in millions):

	2020	2019	2018
Service Units	$ 2.4	$ 3.5	$ 3.4
Performance Units	-	1.3	3.6
	2.4	4.8	7.0
Modification expense for awards classified as a liability	2.5	2.8	-
Total stock-based compensation expense	$ 4.9	$ 7.6	$ 7.0

Valuation Assumptions

The fair value of all Units was determined using a Monte Carlo simulation framework. The following table shows the weighted average assumptions used by the Company to develop the fair value estimates and the resulting estimates of weighted-average fair value per Unit granted during the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
Common equity value of the Company (in millions)	$ 1,999.0	$ 1,671.9	$ 624.1
Expected volatility	48.0 %	38.0 %	24.0 %
Risk-free interest rate	0.60 %	2.90 %	1.60 %
Expected dividends	-	-	-
Average expected term (years)	3.7	5.0	3.2

Units Activity

The following represents the activity of the Units for the years ended December 31, 2020, 2019 and 2018:

	Service Units		Performance Units			
	Tranche A and Units to the Board	Weighted Average Grant Date Fair Value per Unit	Tranche B	Weighted Average Grant Date Fair Value per Unit	Tranche C	Weighted Average Grant Date Fair Value per Unit
Unvested at January 1, 2018	3,801,029	$ 0.71	5,262,169	$ 0.41	2,631,085	$ 0.30
Granted	1,229,200	1.43	1,229,200	0.68	614,600	0.37
Vested	(2,054,331)	0.82	(1,636,959)	0.46	-	-
Forfeited	(266,140)	0.70	(379,400)	0.41	(1,008,180)	0.31
Unvested at December 31, 2018	2,709,758	0.97	4,475,010	0.47	2,237,505	0.31
Granted	6,996,576	1.23	6,868,920	0.80	3,884,460	0.63
Vested	(2,893,910)	1.07	(891,400)	0.54	-	-
Forfeited	(85,044)	1.18	(136,640)	0.60	(514,020)	0.38
Unvested at December 31, 2019	6,727,380	1.19	10,315,890	0.68	5,607,945	0.53
Granted	2,197,487	1.08	2,103,320	1.08	1,051,660	1.08
Vested	(2,217,947)	1.10	-	-	-	-
Forfeited	(75,100)	1.19	(110,000)	0.74	(55,000)	0.60
Unvested at December 31, 2020	6,631,820	$ 1.19	12,309,210	$ 0.75	6,604,605	$ 0.61

Note 14. Commitments and Contingencies

Capital Expenditure Commitments

The Company is reconfiguring some of its facilities to more effectively accommodate patient services and to provide for a greater variety of services. The Company has incurred approximately $84.9 million in costs related to uncompleted projects as of December 31, 2020, which is included under the caption "Construction in progress" in the Company's accompanying consolidated balance sheet. At December 31, 2020, these uncompleted projects had an estimated cost to complete of approximately $124.0 million. The estimated timeframe for completion of these projects generally ranges from less than one year up to two years. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities. At December 31, 2020, the Company estimated its total remaining capital expenditure commitments to be approximately $1,174.7 million, which generally have remaining terms of two to six years. Of this amount, more than one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time.

Legal Proceedings and General Liability Claims

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

In addition, the Company is subject to the regulation and oversight of various state and federal governmental agencies. Further, under the False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against healthcare facilities that submit false claims for payments to, or improperly retain identified overpayments from, governmental payers. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without the Company's knowledge. If a provider is found to be liable under the False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus substantial civil monetary penalties that are subject to annual adjustment for inflation for each separate false claim.

Although the healthcare industry has seen numerous ongoing investigations related to compliance and billing practices, hospitals, in particular, continue to be a primary enforcement target for the Office of Inspector General ("OIG"), the Department of Justice ("DOJ") and other governmental agencies and fraud and abuse programs. Certain of the Company's individual facilities have received, and from time to time, other facilities may receive, inquiries or subpoenas from Medicare Administrative Contractors, and federal and state agencies. Any proceedings against the Company may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on the Company's financial position, results of operations and liquidity.

The Company does not control and cannot predict with certainty the progress or final outcome of discussions with government agencies, investigations and legal proceedings against the Company. Therefore, the final amounts paid to resolve such matters, claims and obligations could be material and could materially differ from amounts currently recorded, if any. Any such changes in the Company's estimates or any adverse judgments could materially adversely impact the Company's future results of operations and cash flows.

On November 6, 2019, following an internal review conducted by the Company with the assistance of outside counsel, the Company and one of its hospitals and a related physician practice initiated a voluntary self-disclosure to the DOJ related to concerns regarding the medical necessity of certain interventional cardiology procedures performed at the hospital by a physician employed at the related physician practice and the appropriateness of that physician's coding for evaluation and management services. The related physician practice has terminated the employment of the physician who was the subject of the internal review and that physician no longer practices at the hospital. On October 28, 2020, the hospital and the related physician practice entered into a settlement agreement, the terms of which require the hospital and the related physician practice to pay approximately $14.7 million in exchange for a release of claims by the U.S. and provide that the agreement itself is not an admission of liability by the hospital or the related physician practice. The settlement was consistent with the amount previously accrued for loss contingencies related to this matter. It is reasonably possible that the Company could incur additional losses related to this matter, but the Company is not able to predict or estimate such amounts at this time.

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

Note 15. Subsequent Events

In accordance with the provisions of ASC 855, "Subsequent Events," the Company evaluated all material events subsequent to the balance sheet date through March 4, 2021, the date of issuance, for events requiring disclosure or recognition in the Company's consolidated financial statements. There were no subsequent events requiring disclosure or recognition in the Company's consolidated financial statements.

SIGNATURES

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

LIFEPOINT HEALTH, INC.

Date: March 4, 2021

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