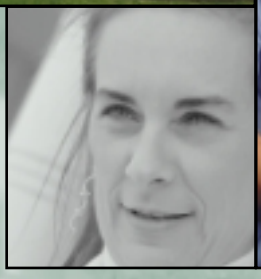
strong neighbors
strong hospitals
strong communities



LIFEPOINT HOSPITALS, INC.

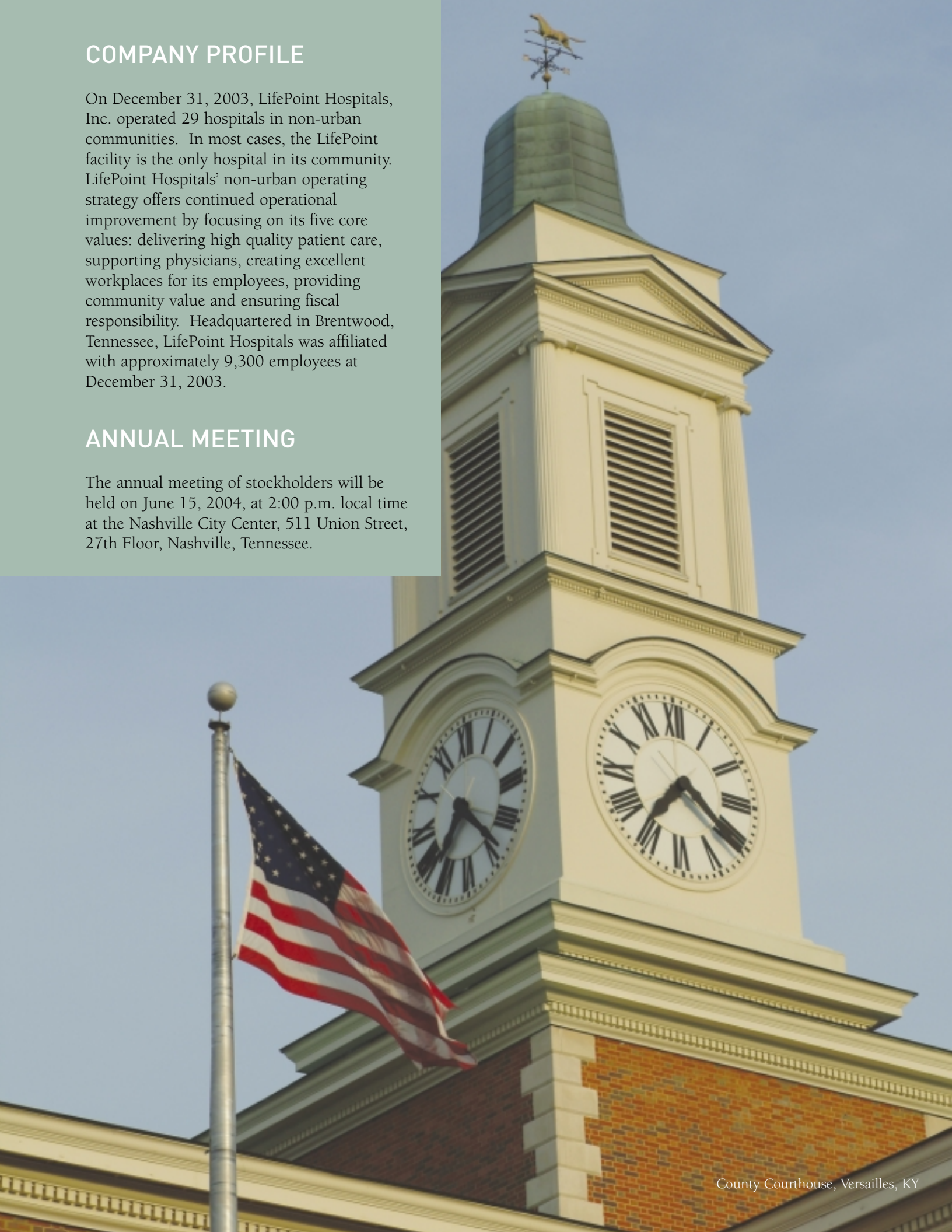
Annual Report 2003

COMPANY PROFILE

On December 31, 2003, LifePoint Hospitals, Inc. operated 29 hospitals in non-urban communities. In most cases, the LifePoint facility is the only hospital in its community. LifePoint Hospitals' non-urban operating strategy offers continued operational improvement by focusing on its five core values: delivering high quality patient care, supporting physicians, creating excellent workplaces for its employees, providing community value and ensuring fiscal responsibility. Headquartered in Brentwood, Tennessee, LifePoint Hospitals was affiliated with approximately 9,300 employees at December 31, 2003.

ANNUAL MEETING

The annual meeting of stockholders will be held on June 15, 2004, at 2:00 p.m. local time at the Nashville City Center, 511 Union Street, 27th Floor, Nashville, Tennessee.



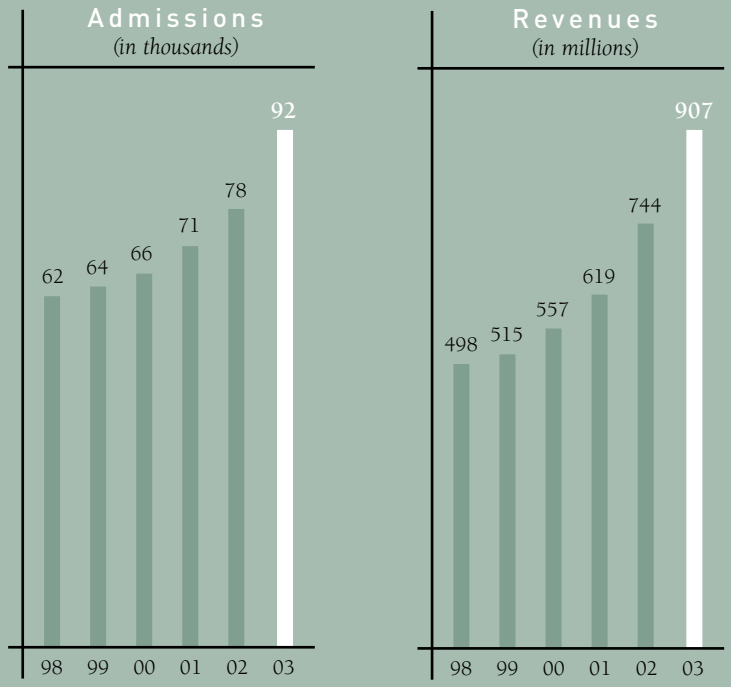
County Courthouse, Versailles, KY

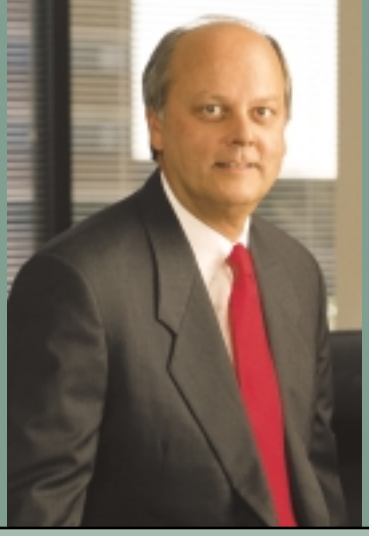
FINANCIAL HIGHLIGHTS

(Dollars in millions, except per share amounts)	Years Ended December 31, 2003	2002	Percent Change
Operating Results:			
Revenues [1]	$ 907.1	$ 743.6	22.0%
Net income	$ 68.5	$ 41.5	65.1%
Diluted earnings per share [2]	$ 1.76	$ 1.07	64.5%
Weighted average number of shares and equivalents – diluted	43,288	38,627	12.1%
Statistics:			
Number of hospitals at end of period	29	28	3.6%
Weighted average licensed beds	2,651	2,248	17.9%
Admissions	92,184	77,927	18.3%
Equivalent admissions	181,879	149,152	21.9%

(1) Prior-year contractual adjustments increased revenues by $6.0 million, or $0.08 per diluted share, for the year ended December 31, 2003, and by $13.0 million, or $0.17 per diluted share, including related costs of $0.9 million, for the year ended December 31, 2002.

(2) The impact of 3.3 million potential weighted average shares of common stock, if converted, and interest expense related to the convertible notes was not included in the computation of diluted earnings per share for the year ended December 31, 2002, because the effect would have been anti-dilutive.





Kenneth C. Donahey
Chairman, President and Chief Executive Officer

strong neighbors
strong hospitals
strong communities

To Our Shareholders:

Some people use the term "community hospital" as a synonym for "small-town" or "rural" facility. To all of us at LifePoint Hospitals, it means so much more. A community hospital is a place of shared experiences, a source of the community's pride and a reflection of a community's vitality. By making strong hospitals, LifePoint is helping to create stronger, more closely connected communities.

Community hospitals are the lifeblood of a small town. As critical as its fundamental mission is, providing care to patients is not the hospital's only key function in the community. Typically, the hospital is one of the community's largest employers, providing livelihoods for hundreds of people. It serves as a focal point where community meetings and other functions often are held. It brings new people, especially physicians, nurses, skilled technicians and their families, who help sustain and enlarge the community. It regularly adds new services and medical technologies to the community; thereby improving convenience for residents who can obtain these medical services without traveling many miles to larger urban facilities. These expanded capabilities help keep jobs and revenues within the community. The hospital is also one of the community's most important citizens, providing tax revenues that help sustain many other local services and institutions that serve everyone.

We feel a great sense of responsibility to the communities where we operate hospitals. In each of our communities, we seek to deliver high-quality, cost-effective care. We work to equip physicians with technologies they need to treat their patients. We strive to promote excellent working environments for hospital employees. We rigorously work to ensure fiscal responsibility. And we make every effort to see that our hospitals remain strong, vital resources for the people in their communities. Experience has taught us that, by pursuing these goals in each of our communities, we also enhance shareholder value.

Bringing Big-City Resources to Smaller Communities.

While our hospitals play key roles in their communities that enhance the quality of life there, our presence in our communities reflects, first and foremost, our belief that smaller towns offer compelling, long-term business opportunities. It's not an accident. We chose to focus on this segment of the healthcare marketplace. Each succeeding year continues to validate that choice.

In 2003, hospitals across the country faced several negative trends. The hospital industry, which traditionally has been virtually immune to the effects of recessions, was affected by a weakened economy through the middle of the year. Faced with higher co-payments and deductibles, or because they were reluctant to miss work during uncertain economic times, many workers seemed to postpone elective procedures or otherwise use the healthcare system more selectively. Others who lost their jobs in recent years saw their COBRA benefits expire. As a result, hospital admissions nationwide remained static or declined in 2003, while collection of receivables slowed for many facilities and bad debt increased.

These short-term obstacles add to the longer-term challenges that many community hospitals face. As hospitals continue to evolve into institutions of sophisticated (and expensive) medical technology, many smaller, non-profit facilities are struggling to remain competitive with large, urban hospitals that can afford to invest in each new generation of equipment. Likewise, many non-urban hospitals lack the reach and resources to recruit new physicians who will enable them to expand their services to local patients. Meanwhile, these hospitals also are dealing with pressure from payors to contain costs, while maintaining their quality of care.

In this difficult environment, LifePoint continued to invest in its communities by recruiting new physicians and expanding the services offered in our hospitals. By helping patients in our communities to enjoy healthier, better lives, we also help our shareholders by adding value to their investment. We believe that there is a direct correlation between the quality of care we deliver and the value we earn in the financial marketplace. In our view, it's a perfect alignment of interests.

A Place with a Future.

Our operating results last year gave us renewed confidence in the validity of LifePoint's operating strategy. We continue to recognize the opportunity for our company to use its resources to make a difference in our communities.

The fundamentals remain strong. As the baby boom generation ages and new or improved healthcare technologies continue to emerge, analysts project that inpatient hospital admissions will enjoy a long pattern of steady growth. According to a 2003 projection by the Office of the Actuary of the Centers of Medicare and Medicaid Services, national health expenditures will reach $3.1 trillion per year by 2012—reflecting a compounded annual growth rate of 7.3% and accounting for more than one of every six dollars spent within the U.S. economy.

Competition remains low. LifePoint is the only hospital operator in all but one of the 28 communities we serve. It's no coincidence. In part, the absence of direct competition results from our selectivity in making acquisitions. Even more, it results from the nature of our environment, where the size of the marketplace itself creates a barrier to entry. In most cases, the biggest competitive threat to our hospitals comes from urban facilities that are generally located in excess of 25 miles from our hospitals. Local residents, however, generally prefer to receive care in the convenience of their own communities, provided the hospital offers services, physicians and quality of care that compare favorably with hospitals in large cities. By equalizing all of these factors, we create a real advantage for our hospitals.

Medicare changes help rural hospitals. In addition to its widely publicized prescription drug benefit, the Medicare reform bill that was signed into law last year included a number of provisions that will provide additional funding to rural hospitals. These changes to Medicare's reimbursement formula are designed to correct historical imbalances that have placed rural facilities at a disadvantage and will mean more than $18 billion in additional payments to community hospitals over a 10-year period.

MAYOR FRED SIEGELMAN

"Versailles is such a tight-knit community, and our hospital is an important community member. The administration and staff are involved in everything we do to keep our community beautiful and vibrant. They not only provide convenient quality healthcare, but also have sponsored events like our 'Paint the Town Pink' for breast cancer awareness and been a significant contributor to our one-of-a kind community water tower – where the artist's 33-foot tall horses proudly say 'Welcome to Versailles' for all who pass by. Bluegrass Community Hospital has had a major hand in helping our community grow yet keeping it a very special place."

We have abundant room to grow. More than 40% of the nation's hospitals are in rural areas. Yet the market is almost entirely fragmented. Of all community hospitals, approximately 92% are owned by government entities or not-for-profit groups. The increasing financial and administrative pressures that accompany operating a rural hospital have led growing numbers of these facilities to look to outside ownership for the resources that will enable them to continue their missions. LifePoint is extremely well positioned to capitalize on that trend, while enjoying the flexibility to remain selective about the acquisitions we pursue. In 2003, we completed another strategic acquisition when we purchased Spring View Hospital in Lebanon, KY.

Higher Efficiency, Lower Costs, Stronger Hospitals.

In addition to the challenges posed by their size, non-urban hospitals often lack the in-house management expertise that would enable them to achieve the operating efficiencies that large, urban hospitals attain. Here, particularly, LifePoint's long operating experience serves as a competitive leveler. Through our focus on improving cost-effectiveness, for example, our hospitals have scored real gains in productivity, while holding steady or even reducing overall labor costs. Through our equity participation in the HealthTrust Purchasing Group, we negotiate volume discounts that are among the most aggressive in the industry. Drawing on our extensive business office expertise, our hospitals have maximized collection opportunities and minimized bad-debt writeoffs as much as possible. Meanwhile, we have negotiated agreements with managed care payors that have increased net revenues to our facilities. In all of these ways and more, LifePoint has improved the vitality of its hospitals.

New Physicians, New Specialties, Big Additions.

Just as a community's strength is often reflected by the strength of its hospital, building a strong hospital ultimately depends upon the quality of its medical staff. For many non-urban hospitals, recruiting and retaining outstanding physicians has long proved to be a formidable challenge. Frequently, smaller, rural hospitals lack the resources to mount large-scale physician recruiting efforts, or they may not have invested in the sophisticated medical equipment needed to support particular physician specialties.

LifePoint, on the other hand, is committed to making significant investments each year in the recruitment of new physicians. It is an investment that only a company with considerable resources and opportunities can make. Practicing in a community hospital and living in a small town are not for every physician. Yet many doctors are attracted by a small-town lifestyle and the chance to make a meaningful difference in a community. Drawing upon our experience and strength, we have been effective, not only in identifying such physicians, but in matching their geographical preferences to the needs of our hospitals across the country.

In 2003, we had our most successful physician recruitment results in our company's history, with the addition of 125 new doctors representing a variety of clinical specialties. As these physicians begin practicing in LifePoint hospitals from Wyoming to

MICHELE WELLING, MD

"My patients love Bluegrass Community Hospital. It's a friendly, nurturing place, and they feel comfortable there. I send them to our community hospital knowing they will have a good experience and get quality care. It's a place where everyone has the patient's best interest at heart. As chairman of the hospital's board, I also know that LifePoint's integrity and honesty are evident in the day-to-day workings of the hospital. Hospital administrators welcome physicians' suggestions, and they are completely committed to our community and taking care of the people who live here."

JOHN SOPER, *President, Citizen's Commerce National Bank*
"It's critical for us to have quality medical care in Woodford County. A well-run community hospital can be an economic engine – near the top of the list with schools and safety when new businesses are considering relocating here. And it helps to keep our current factories and businesses here by meeting their employees' healthcare needs. LifePoint's Bluegrass Community Hospital is also a valuable resource to local management, offering training and counsel in a variety of areas. And as an employer, I appreciate the fact that our bank's employees have a local hospital where they might get a needed test or x-ray during lunch without the need to take the day off or leave our community."

Florida, our efforts should bear even greater fruit in the years to come in the form of increased patient volume and revenues. Alongside these tangible, bottom-line measures, the new physicians and their families are enriching their new communities through their energies, their talents, their purchasing power, their tax contributions and, certainly, their medical expertise.

More Services, More Convenience, More Revenues.

Just as we invest in bringing new medical staff to our communities, we also continually work to enhance the hospital services and physical facilities upon which our neighbors depend. Still, because no two communities or hospitals are totally alike, we tailor our capital investments to meet the particular needs in each location.

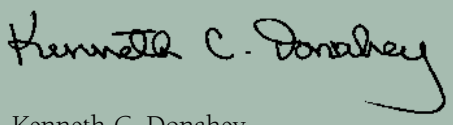
In the past four years, for example, our company has invested in new or updated operating rooms for 12 hospitals. During that time, we added MRI or CT technologies at another 26 facilities. We added rehab units in seven communities; four others now have state-of-the-art emergency facilities. In still others, we added capacity for more licensed beds to meet the growing demand for our healthcare services. Altogether, we have invested more than $190 million in capital expenditures since the beginning of 2000. These, too, are investments not just in buildings or equipment, but in our communities. Often, they provide access to specialty services that residents would otherwise have to travel to larger cities to obtain. And, they add revenues for the hospital that can be reinvested in ways that further benefit the community.

Making a Qualitative Difference.

Out of more than 5,600 acute-care facilities nationwide, four of our 29 LifePoint hospitals last year ranked among the nation's 100 best: Meadowview Regional Medical Center in Maysville, KY; Georgetown Community Hospital in Georgetown, KY; Crockett Hospital in Lawrenceburg, TN; and Ashley Valley in Vernal, UT. Meadowview has received this honor four other times since 1993, and Georgetown has been named twice before. This list of top-performing hospitals, compiled by Solucient, Inc., uses eight objective statistical measures, including successful patient outcomes and levels of financial performance.

We are extremely proud that our hospitals have achieved this recognition. It affirms both the standard of quality we seek to obtain at all LifePoint hospitals and our long-held belief that we can simultaneously meet the expectations of our shareholders while serving the needs of our home communities. In all these ways and more, in non-urban hospitals like Bluegrass Community Hospital in Versailles, KY, serving our neighbors is entwined with serving our company and you, our stockholders. We are grateful for your continued confidence and belief in our mission.

Sincerely,



Kenneth C. Donahey
Chairman, President and Chief Executive Officer

SELECTED FINANCIAL DATA

The following table contains selected financial data of our company or a division of HCA, prior to the May 11, 1999 spin-off from HCA, for, or as the end of, each of the five years ended December 31, 2003. The selected financial data are derived from our audited financial statements. Financial data for the period from January 1, 1999 through May 11, 1999 are derived from HCA. The timing of acquisitions and divestitures completed during the years presented affect the comparability of the selected financial data. You should read this table in conjunction with the consolidated financial statements and related notes included elsewhere in this report and "Management's Discussion and Analysis of Financial Condition and Results of Operations."

(Dollars in millions, except revenues per equivalent admission and per share amounts)	Years Ended December 31, 1999	2000	2001	2002	2003
Summary of Operations:					
Revenues	$ 515.2	$ 557.1	$ 619.4	$ 743.6	$ 907.1
Salaries and benefits	217.4	224.2	243.2	291.4	365.0
Supplies	64.2	67.0	78.2	92.2	118.1
Other operating expenses	117.3	118.1	120.8	137.1	162.8
Provision for doubtful accounts	38.2	42.0	45.8	55.2	81.5
Depreciation and amortization	31.4	34.1	34.7	37.9	45.7
Interest expense, net	23.4	30.7	18.1	13.3	12.8
Management fees	3.2	–	–	–	–
Debt retirement costs	–	–	2.6	31.0	–
ESOP expense	2.9	7.1	10.4	9.7	6.9
Impairment of long-lived assets	25.4	(1.4)	(0.5)	–	–
	523.4	521.8	553.3	667.8	792.8
Income (loss) before minority interests and income taxes	(8.2)	35.3	66.1	75.8	114.3
Minority interests in earnings of consolidated entities	1.9	2.2	2.7	2.2	0.7
Income (loss) before income taxes	(10.1)	33.1	63.4	73.6	113.6
Provision (benefit) for income taxes	(2.7)	15.2	30.1	32.1	45.1
Net income (loss) [(a) (b)]	$ (7.4)	$ 17.9	$ 33.3	$ 41.5	$ 68.5
Basic earnings (loss) per share [(a) (b)]	$ (0.24)	$ 0.57	$ 0.93	$ 1.11	$ 1.84
Shares used in computing basic earnings (loss) per share (in millions)	30.5	31.6	35.7	37.5	37.2
Diluted earnings (loss) per share [(a) (b)]	$ (0.24)	$ 0.54	$ 0.90	$ 1.07	$ 1.76
Shares used in computing diluted earnings (loss) per share (in millions)	30.5	32.9	37.1	38.6	43.3
Cash dividends declared per common share	–	–	–	–	–

SELECTED FINANCIAL DATA

(Dollars in millions, except revenues per equivalent admission and per share amounts)	Years Ended December 31, 1999	2000	2001	2002	2003
Financial Position (as of End of Year):					
Total assets	$ 421.6	$ 496.3	$ 554.3	$ 733.5	$ 799.0
Long-term debt, including amounts due within one year	260.2	289.4	150.0	250.0	270.0
Working capital	42.2	65.4	82.7	67.9	102.4
Other Operating Data:					
Capital expenditures	$ 64.8	$ 31.4	$ 35.8	$ 60.7	$ 70.2
Number of hospitals at end of year	23	20	23	28	29
Number of licensed beds at end of year [(c)]	2,169	1,963	2,197	2,617	2,737
Weighted average licensed beds [(d)]	2,169	2,056	2,011	2,248	2,651
Admissions [(e)]	64,081	66,085	70,891	77,927	92,184
Equivalent admissions [(f)]	114,321	119,812	129,163	149,152	181,879
Revenues per equivalent admission	$ 4,507	$ 4,650	$ 4,796	$ 4,986	$ 4,988
Average length of stay (days) [(g)]	4.2	4.1	4.0	4.1	4.0
Emergency room visits [(h)]	278,250	294,952	313,110	355,891	434,424
Inpatient surgeries	17,081	18,301	20,042	23,030	27,201
Outpatient surgeries [(i)]	46,773	49,711	57,423	65,545	77,119
Total surgeries	63,854	68,012	77,465	88,575	104,320
Outpatient revenues as a percentage of total revenues	47.2%	48.1%	47.8%	49.8%	49.7%
Medicare case mix index [(j)]	1.17	1.15	1.15	1.15	1.17

(a) Includes charges related to debt retirement costs of $2.6 million ($1.6 million after tax) and $31.0 million ($19.1 million after tax) for the years ended December 31, 2001 and 2002, respectively.

(b) Includes charges related to impairment of long-lived assets of $25.4 million ($16.2 million after tax) for the year ended December 31, 1999, and gain on impairment of long-lived assets of $1.4 million ($0.8 million after tax), and $0.5 million ($0.3 million after tax) for the years ended December 31, 2000 and 2001, respectively.

(c) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(d) Represents the average number of licensed beds weighted based on periods operated.

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

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

(g) Represents the average number of days admitted patients stay in our hospitals.

(h) Represents the total number of hospital-based emergency room visits.

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

(j) Refers to the acuity or severity of illness of an average Medicare patient at our hospitals.

You should read this discussion together with our consolidated financial statements and related notes included elsewhere in this report.

Executive Overview

This was a challenging year for both the healthcare services industry and our company. We believe that our results were solid after considering all of the factors affecting our industry. This year was negatively impacted by lower patient volumes experienced by most healthcare providers and higher co-payments and deductibles for patients resulting in increased collection pressures on providers. We believe that our financial results for 2003 reflect our disciplined operating strategy that addressed these industry challenges. We are guardedly optimistic regarding our outlook for 2004 as a result of the improved reimbursement environment and patient volumes more in line with historical trends. During 2004, we will continue to focus on physician recruiting and retention, investing capital in our hospitals and seeking additional hospital acquisitions that fit our non-urban strategy. The following table reflects our summarized operating results:

	Years Ended December 31,		
	2001	2002	2003
Number of hospitals at end of period	23	28	29
Revenues (in millions)	$ 619.4	$ 743.6	$ 907.1
Net income (in millions)	$ 33.3	$ 41.5	$ 68.5
Diluted earnings per share	$ 0.90	$ 1.07	$ 1.76

Revenue Sources

The revenues that our hospitals generate are a result of providing healthcare services to our patients. We are paid for these healthcare services from a number of different sources, depending upon the patient's medical insurance coverage. Primarily, we are paid by governmental Medicare and Medicaid programs, by commercial insurance, including managed care organizations, and directly by the patient. The amounts we are paid for providing healthcare services to our patients vary depending upon the payor. Governmental payors generally pay significantly less than the hospital's customary charges for the services provided. Please refer to the "Sources of Revenue" section in Part I, Item 1. Business in our 2003 Form 10K for a detailed discussion of our revenue sources.

Revenues from governmental payors, such as Medicare and Medicaid, are controlled by complex rules and regulations that stipulate the amount a hospital is paid for providing healthcare services. These rules and regulations require an extensive amount of effort to ensure our compliance with the requirements to participate in these governmental programs. In addition, these rules and regulations are subject to frequent changes as a result of legislative and administrative action on both the federal and state level. For these reasons, revenues from governmental payors change frequently and require us to regularly monitor the environment in which these governmental programs operate. For example, MMA will increase the payments received by non-urban healthcare providers beginning in April 2004.

Revenues from HMOs, PPOs and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services. These discounted arrangements often limit our ability to increase charges in response to increasing costs. We actively negotiate with these payors to ensure we are appropriately pricing our healthcare services. Insured patients are generally not responsible for any difference between customary hospital charges and the amounts received from commercial insurance payors. However, the patient is responsible for payments related to amounts not covered by insurance, such as exclusions, deductibles and co-payments.

Self-pay revenues are generated through the treatment of uninsured patients. Our hospitals experienced an increase in self-pay revenues during 2003.

Revenues/Volume Trends

The key metrics we use internally to evaluate our revenues are equivalent admissions, which equate to volume, and revenue per equivalent admission, which relates to pricing and acuity. We anticipate our patient volumes and related revenues will continue to increase as a result of the following factors:

- *Physician Recruitment and Retention.* Recruiting and retaining both primary care physicians and specialists for our non-urban communities is a key to increasing revenues and patient volumes. Continuing to add specialists should

help our hospitals increase volumes by offering new services. We signed 125 physicians during 2003, which was significantly more than our original goal of 85. Of these 125 physicians signed, 96 started in 2003 and 29 are scheduled to start in 2004. Of the 96 physicians that started in 2003, 77 are admitting physicians. During 2004, we anticipate to recruit an additional 63 admitting physicians to start in 2004.

- *Capital Expenditures.* Increases in capital expenditures in our hospitals should increase our local market share and help persuade patients to obtain healthcare services within their communities. The following table reflects our capital expenditures:

	Capital Expenditures			
(in millions)	2001	2002	2003	Estimated 2004
Capital projects	$ 19.5	$ 41.9	$ 47.3	$ 63.0
Routine	16.3	18.8	22.9	27.0
Total	$ 35.8	$ 60.7	$ 70.2	$ 90.0

- *Medicare Rate Increases.* MMA provides a prescription drug benefit for Medicare beneficiaries and also provides numerous provisions that provide incremental funding to hospitals. The earliest provisions of MMA are effective in April 2004. Please refer to the "Sources of Revenue" section in Part I, Item 1. Business in our 2003 Form 10K for a discussion of MMA's provisions that affect our reimbursement.

- *Acquisitions.* We seek to identify and acquire additional hospitals in non-urban areas. We pursue a disciplined acquisition strategy that is focused on attempting to acquire one to three additional hospitals each year. We seek to acquire hospitals that are the sole or significant market provider of healthcare services in their community. In evaluating a hospital for acquisition, we focus on a variety of factors. One factor we consider is the number of patients that are traveling outside of the community for healthcare services. Another factor we consider is the hospital's prior operating history and our ability to implement new healthcare services. Upon acquiring a facility, we work to quickly integrate the hospital into our operating practices. Our goodwill and fixed asset balances have increased significantly in 2003 while our unallocated purchase price balance decreased significantly in 2003 as a result of the allocation of the purchase prices related to our hospitals acquired in 2002. Please refer to Note 2 of our consolidated financial statements included in our 2003 Form 10K for further discussion of acquisitions that we made in 2001, 2002 and 2003.

  Our acquisition activity during the last three years is as follows:

Acquisition	State	Licensed Beds	Acquisition Date	Consideration [(a)] (in millions)
Acquired during 2003:				
Spring View Hospital	Kentucky	113	10/1/2003	$ 15.8
Acquired during 2002:				
Remaining 30% interest in Dodge City Healthcare Group, L.P.	Kansas	110	10/1/2002	25.0
Russellville Hospital	Alabama	100	10/3/2002	19.8
Logan Regional Medical Center and Guyan Valley Hospital	West Virginia	151	12/1/2002	89.4
Northwest Medical Center and Lakeland Community Hospital	Alabama	170	12/1/2002	29.5
Acquired during 2001:				
Bluegrass Community Hospital	Kentucky	25	1/2/2001	Lease
Athens Regional Medical Center	Tennessee	118	10/1/2001	19.8
Ville Platte Medical Center	Louisiana	116	12/1/2001	15.1

(a) Includes cash paid and liabilities assumed, but excludes other direct transaction costs, such as legal fees.

Although we anticipate that our patient volumes will increase, the resulting revenues will likely be partially offset by the following factors:

- *Growth in Outpatient Services.* We anticipate that the long-term growth trend in outpatient services will continue. A number of procedures once performed only on an inpatient basis have been, and will continue to be, converted to outpatient procedures. This conversion has occurred through continuing advances in pharmaceutical and medical technologies and as a result of efforts made by payors to control costs. Generally, the payments we receive for outpatient procedures are less than those for similar procedures performed in an inpatient setting. The following table shows net outpatient, inpatient and other revenues as a percentage of our total revenues:

	Revenues		
	2001	2002	2003
Outpatient	47.8%	49.8%	**49.7%**
Inpatient	50.7	48.6	**49.1**
Other	1.5	1.6	**1.2**
Total	100.0%	100.0%	**100.0%**

- *Efforts to Reduce Payments.* Revenues from HMOs, PPOs and other private insurance programs are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services. These discounted arrangements often limit our ability to increase charges in response to increasing costs during the term of the contracts.

- *States Implementing Medicaid Cost Containment Measures.* A number of states have incurred budget deficits within recent years. To close these budget gaps, certain states have reduced spending and increased taxes. State cost containment activity continues to focus on reducing provider payments and limiting eligible enrollees under the state Medicaid programs.

Other Trends

- *Increases in Provision for Doubtful Accounts.* We experienced an increase in our provision for doubtful accounts during the second half of 2003. The increase was the result of a combination of broad economic factors, including an increased number of uninsured patients, employers shifting costs to employees through higher co-payments and deductibles and higher unemployment rates. The following table reflects our quarterly self-pay revenue activity which exhibits these trends (in millions):

	Self-Pay Revenues		
	2001	2002	2003
First Quarter	$ 10.9	$ 15.3	**$ 18.8**
Second Quarter	11.6	16.7	**18.1**
Third Quarter	14.4	14.5	**23.0**
Fourth Quarter	12.8	16.9	**21.6**
Total	$ 49.7	$ 63.4	**$ 81.5**

We anticipate that our provision for doubtful accounts will increase for the next several quarters to approximately 9% - 10% of revenues from approximately 7.4% - 8% of revenues for recent years. We are implementing a number of operating strategies that should increase our cash collections of self-pay revenues. If this trend of increasing self-pay revenues continues, then it could have a material adverse effect on our results of operations and financial position.

- *Increased Purchase Prices for Acquisitions.* As previously discussed, we attempt to make acquisitions in a highly competitive environment. We have seen higher prices being paid for hospital acquisitions in the past two years. In some cases, the cost of an acquisition could result in a dilutive effect on our results of operations for up to two years depending on various factors, including the acquired hospital's results of operations, allocations of tangible and intangible assets, effects of subsequent legislation changes and limitations on rate increases. In addition, our acquisition activity requires transitions from, and the integration of, various information systems that are used by hospitals we acquire. We rely heavily on HCA for information systems integration as part of our contractual arrangement for information technology services.

- *Shortage of Clinical Personnel and Increased Contract Labor Usage.* In recent years, many hospitals, including the hospitals we own, have encountered difficulty in recruiting and retaining nursing and other clinical personnel. When we are unable to staff our nursing and clinical positions, we are required to use contract labor to ensure adequate patient care. Contract labor generally costs more per hour than employed labor. We have adopted a number of human resources strategies in an attempt to improve our ability to recruit and retain nursing and other clinical personnel. We expect that the staffing issues related to nurses and other clinical personnel will continue in the near term.

- *Increases in Supply Costs.* During 2003, we experienced an increase in supply costs as a percentage of revenues, especially in the areas of pharmaceutical and orthopedic supplies. We participate in a group purchasing organization in an attempt to achieve optimum supply costs from our vendors. Because of the fixed reimbursement nature of most governmental and commercial payor arrangements, we may not be able to recover supply cost increases through increased revenues.

Outlook

We expect to continue increasing our revenues and net income by continuing to acquire additional hospitals and increasing the operating results of the hospitals we currently own. We plan to adhere to our disciplined acquisition strategy as we seek to acquire additional hospitals. We intend to continue to invest in additional healthcare services in our facilities and implement our operating strategies.

In order for us to increase revenues and profitability of our hospitals, there are a number of on-going challenges that we must effectively manage, such as:

- competition from other healthcare providers, including physicians in our communities;
- recruiting and retaining quality physicians;
- increasing the volume of patients in our facilities;
- staffing issues related to the shortage of clinical personnel and the use of contract labor;
- identifying and acquiring hospitals at appropriate prices;
- the integration of new acquisitions into our operating systems and practices;
- pricing pressures from government and commercial payors; and
- increased bad debt risk as a result of the increased number of uninsured patients and increased co-payments and deductibles due from insured patients.

By successfully focusing on each of these challenges, we anticipate increasing our revenues and profitability on both a short-term and long-term basis. These challenges are intensified by our inability to control related trends and the associated risks. Therefore, our actual results may differ from our expectations. To maintain or improve operating margins in the future, we must, among other things, increase patient volumes through physician recruiting while controlling the costs of providing services.

Critical Accounting Estimates

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

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

The table 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:

Balance Sheet or Income Statement Caption / Nature of Critical Estimate Item	Assumptions / Approach Used	Sensitivity Analysis
Allowance for doubtful accounts and provision for doubtful accounts Accounts receivable primarily consist of amounts due from third-party payors and patients. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. The primary uncertainty lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients. Our allowance for doubtful accounts, included in our balance sheets as of December 31 was as follows (in millions): • 2003 - $111.7; and • 2002 - $109.1. Our provision for doubtful accounts, included in our results of operations, was as follows (in millions): • 2003 - $81.5; • 2002 - $55.2; and • 2001 - $45.8.	We have an established process to determine the adequacy of this allowance that relies on a number of analytical tools and benchmarks to arrive at a reasonable allowance. No single statistic or measurement determines the adequacy of the allowance. One analytical tool that we use is the hindsight analysis, which is performed by us on an annual basis. The hindsight analysis reviews write-offs and recoveries that occur over a one-year period that relate to accounts receivable of the prior year. These write-offs, net of recoveries, roughly estimate what the allowance should have been in the prior year. This allowance is then used to calculate a day metric by applying the allowance estimate to the accounts receivable aging. This analysis is a key historical analytical tool, especially when the composition of accounts receivable is static. However, the composition of our accounts receivable is not static, due to payor shifts, rate increases and acuity changes. In addition, the results of the hindsight analysis are over 12 months old by the time the data gathering is complete and the ultimate evaluation is performed. Given the necessary time delay in performing a hindsight analysis and the dynamic environment, we take additional steps and review additional data. As it relates to our recently-acquired hospitals, we perform hindsight analyses based on their historical collection information, when available. In addition, we monitor trends in revenues and collections on a monthly basis for 18 to 24 months subsequent to the acquisition on a facility-by-facility basis. As it relates to our core hospitals, which we refer to as "same-hospital", we monitor the revenue trends by payor classification on a month-by-month basis along with the composition of our accounts receivable agings. This review is focused primarily on trends in self-pay revenues, accounts receivable and co-payment receivables. In addition, we analyze other factors such as revenue days in accounts receivable and reviewing admissions and charges by physicians, primarily focusing on recently recruited physicians.	If self-pay revenues during 2003 were changed by 1%, our 2003 after-tax net income would change by approximately $0.5 million. This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate uncollectible patient accounts that are highly uncertain and requires a high degree of judgment. It is impacted by changes in regional economic conditions, business office operations, payor mix and trends in federal or state governmental healthcare coverage. A significant increase in our provision for doubtful accounts (as a percentage of revenues) would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Balance Sheet or Income Statement Caption / Nature of Critical Estimate Item	Assumptions / Approach Used	Sensitivity Analysis
Revenue recognition / Allowance for contractual discounts We recognize revenues in the period in which services are performed. Accounts receivable primarily consist of amounts due from third-party payors and patients. Amounts we receive for treatment of patients covered by governmental programs, such as Medicare and Medicaid, and other third-party payors such as HMOs, PPOs and other private insurers, Managed Care, are generally less than our established billing rates. Accordingly, our gross revenues and accounts receivable are reduced to net realizable value through an allowance for contractual discounts. Approximately 88% of our revenues during 2003 relate to discounted charges. The sources of these revenues were as follows (as a percentage of total revenues): • Medicare – 36%; • Medicaid – 11%; and • Managed Care – 41%.	***Governmental payors*** 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 revenues. Under a prospective reimbursement system, 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, which were more prevalent in periods before 2000, 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. **Managed Care** For most managed care plans, estimated contractual allowances are adjusted to actual contractual allowances as cash is received and claims are reconciled. We evaluate the following criteria in developing the estimated contractual allowance percentages each month: historical contractual allowance trends based on actual claims paid by managed care payors; impact of rate increases on contractual allowances; review of contractual allowance information reflecting current contract terms; consideration and analysis of changes in payor mix reimbursement levels; and other issues that may impact contractual allowances.	***Governmental payors*** Because the laws and regulations governing the Medicare and Medicaid programs are complex and subject to change, the estimates recorded by us could change by material amounts. Adjustments related to final settlements increased our revenues by the following amounts (in millions): • 2003 - $6.0; • 2002 - $13.0; and • 2001 - $2.0. **Managed Care** If our overall estimated contractual discount percentage on all of our managed care revenues were changed by 1%, our 2003 after-tax net income would change by approximately $4.1 million. This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate the amount expected to be received 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 would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Balance Sheet or Income Statement Caption / Nature of Critical Estimate Item	Assumptions / Approach Used	Sensitivity Analysis
Professional and general liability claims We are subject to potential medical malpractice lawsuits and other claims as part of providing healthcare services. To mitigate a portion of this risk, we maintained insurance for individual malpractice claims exceeding $1.0 million for 2001. For 2002, we increased our self-insured retention level to $10.0 million on individual malpractice claims. For 2003, we lowered our self-insured retention level to $5.0 million on individual malpractice claims and for 2004, we increased our self-insured retention level back to $10.0 million. Each year, we obtain quotes from various malpractice insurers with respect to the cost of obtaining medical malpractice insurance coverage. We compare these quotes to our most recent actuarially determined estimates of losses at various self-insured retention levels. Accordingly, changes in insurance costs affect the self-insurance retention level we choose each year. As insurance costs have increased in recent years, we have accepted a higher level of risk in self-insured retention levels. The reserve for professional and general liability claims, included in our balance sheets as of December 31 was as follows (in millions): • 2003 - $27.5; and • 2002 - $25.1. The reserve for professional and general liability claims as of the balance sheet dates reflect the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The total cost of professional and general liability coverage included in our results of operations, was as follows (in millions): • 2003 - $9.8; • 2002 - $12.9; and • 2001 - $11.4. Our cost for professional and general liability coverage each year includes the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of our self-insured retention levels; the administrative costs of the insurance program and interest expense related to the discounted portion of the liability.	Our reserves for professional and general liability claims are based upon independent actuarial calculations, which consider historical claims data, demographic considerations, severity factors and other actuarial assumptions in the determination of reserve estimates. Reserve estimates are discounted to present value using a 5.0% discount rate. We revise our reserve estimates twice each year based upon the calculations performed by our independent actuaries. Our estimated reserve for professional and general liability claims will be significantly affected if current and future claims differ from historical trends. While we monitor reported claims closely and consider potential outcomes as estimated by our independent actuaries when determining our professional and general liability reserves, the complexity of the claims, the extended period of time to settle the claims and the wide range of potential outcomes complicates the estimation process. In addition, certain states have passed varying forms of tort reform limiting the amount of medical malpractice losses. If such laws are passed in the states where our hospitals are located, our loss estimates could decrease. We implemented enhanced risk management processes for monitoring professional and general liability claims and managing losses in high-risk areas during 2002 and 2003 to attempt to reduce loss levels and appropriately manage risk. We improved our estimation process for determining our reserves for professional and general liability claims during 2003 by expanding from using one actuary to using multiple actuaries. We use the calculations of each actuary and average their results in determining our recorded reserve levels. This averaging process results in a refined estimation approach that we believe produces a more reliable estimate of ultimate losses.	Based upon multiple actuarial valuations performed using recent loss information, the change in the estimation process during 2003 decreased our reserves for professional and general liability claims and our cost for professional and general liability claims by approximately $7.4 million on a pre-tax basis, or $0.10 per diluted share. Of the $7.4 million reduction, $4.8 million relates to estimates for losses prior to 2003 and $2.6 million relates to losses for 2003. Additionally, actuarial calculations include a large number of variables that may significantly impact the estimate of ultimate losses that are recorded during a reporting period. Professional judgment is used by each actuary in determining their loss estimates by selecting factors that are considered appropriate by the actuary for our specific circumstances. Changes in assumptions used by our independent actuaries with respect to demographics, industry trends and judgmental selection of factors may impact our recorded reserve levels and our results of operations. We derive our estimates for financial reporting purposes by using a mathematical average of our actuarial results. Changes in our estimates of professional and general liability claims are non-cash charges and accordingly, there would be no material impact on our liquidity or capital resources.

Balance Sheet or Income Statement Caption / Nature of Critical Estimate Item	Assumptions / Approach Used	Sensitivity Analysis
Accounting for income taxes Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our income statement. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or increase this allowance, we must include an expense as part of the income tax provision in our results of operations. Our deferred tax asset balances in our balance sheets as of December 31 were as follows (in millions): • 2003 - $36.3; and • 2002 - $34.5. Our valuation allowances for deferred tax assets in our balance sheets as of December 31 were as follows (in millions): • 2003 - $4.0; and • 2002 - $3.5. In addition, significant judgment is required in determining and assessing the impact of certain tax-related contingencies. We establish accruals when, despite our belief that our tax return positions are fully supportable, it is probable that we have incurred a loss related to tax contingencies and the loss or range of loss can be reasonably estimated. We adjust the accruals related to tax contingencies as part of our provision for income taxes in our results of operations based upon changing facts and circumstances, such as progress of a tax audit, development of industry related examination issues, as well as legislative, regulatory or judicial developments. A number of years may elapse before a particular matter, for which we have established an accrual, is audited and resolved.	The first step in determining the deferred tax asset valuation allowance is identifying reporting jurisdictions where we have a history of tax and operating losses or are projected to have losses in future periods as a result of changes in operational performance. We then determine if a valuation allowance should be established against the deferred tax assets for that reporting jurisdiction. The second step is to determine the amount of the valuation allowance. We will generally establish a valuation allowance equal to the net deferred tax asset (deferred tax assets less deferred tax liabilities) related to the jurisdiction identified in step one of the analysis. In certain cases, we may not reduce the valuation allowance by the amount of the deferred tax liabilities depending on the nature and timing of future taxable income attributable to deferred tax liabilities. In assessing tax contingencies, we identify tax issues that we believe are probable to be challenged upon examination by the taxing authorities. We compute the tax and related interest on each contingency. We then determine the probable amount of loss and reflect such amount as a component of the provision for income taxes in the reporting period. During each reporting period, we assess the facts and circumstances related to recorded tax contingencies. If tax contingencies are no longer deemed probable based upon new facts and circumstances, the contingency is reflected as a reduction of the provision for income taxes in the current period.	Our deferred tax liabilities exceeded our deferred tax assets by $21.5 million as of December 31, 2003, excluding the impact of valuation allowances. Historically, we have produced federal taxable income. Therefore, the likelihood of us not realizing the federal tax benefit of our deferred tax assets is remote. However, we do have subsidiaries with a history of tax losses in certain state jurisdictions. If our assertion regarding the future profitability of those subsidiaries were incorrect, then our deferred tax assets would be understated by the amount of the valuation allowance of $4 million at December 31, 2003. The IRS may propose adjustments for items we have failed to identify as tax contingencies. If the IRS were to propose and sustain assessments equal to 10% of our taxable income for 2003, we would incur $3.6 million of additional tax payments plus applicable penalties and interest.

Our management has discussed the development and selection of these critical accounting estimates with the audit committee of our Board of Directors and the audit committee has reviewed the disclosure presented above relating to our critical accounting estimates.

The above table of critical accounting estimates is not intended to be a comprehensive list of all of our accounting policies that require estimates. We believe that of our significant accounting policies, as discussed in Note 1 of our consolidated financial statements, the estimates discussed above 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.

Results of Operations

Operating Results Summary

The following tables present summaries of results of operations for the three months ended December 31, 2002 and 2003 and for the years ended December 31, 2001, 2002 and 2003 (dollars in millions, except revenues per equivalent admission):

	Three Months Ended December 31,			
	2002		2003	
	Amount	% of Revenues	Amount	% of Revenues
Revenues	$ 201.9	100.0%	$ 237.3	100.0%
Salaries and benefits [a]	78.8	39.0	93.4	39.3
Supplies [b]	24.8	12.3	31.9	13.4
Other operating expenses [c]	36.0	17.9	40.8	17.2
Provision for doubtful accounts	16.4	8.1	22.9	9.7
Depreciation and amortization	9.9	4.9	12.3	5.3
Interest expense, net	3.4	1.7	2.9	1.2
Debt retirement costs	0.5	0.3	–	–
ESOP expense	2.3	1.1	2.0	0.8
Income before minority interest and income taxes	29.8	14.7	31.1	13.1
Minority interest in earnings of consolidated entity	–	–	0.2	0.1
Income before income taxes	29.8	14.7	30.9	13.0
Provision for income taxes	12.2	6.0	11.6	4.9
Net income	$ 17.6	8.7%	$ 19.3	8.1%

	Three Months Ended December 31,			
	2002		2003	
	Amount	% Change from Prior Year	Amount	% Change from Prior Year
Consolidated:				
Number of hospitals at end of period	28	21.7%	29	3.6%
Admissions [d]	20,531	14.1	24,689	20.3
Equivalent admissions [e]	39,353	17.6	47,969	21.9
Revenues per equivalent admission	$ 5,131	4.5	$ 4,948	(3.6)
Outpatient factor [e]	1.92	3.1	1.95	1.5
Emergency room visits [f]	92,960	15.9	117,835	26.8
Inpatient surgeries	6,133	15.5	6,951	13.3
Outpatient surgeries [g]	17,067	12.1	18,201	6.6
Total surgeries	23,200	13.0	25,152	8.4
Outpatient revenues as a percentage of total revenues	48.9%	N/M	46.6%	N/M
Medicare case mix index [i]	1.15	(0.9)%	1.16	0.9%
Same-hospital [h]:				
Revenues	$ 188.5	N/M	$ 194.7	3.3%
Number of hospitals at end of period	23	N/M	23	–
Admissions [d]	18,763	N/M	19,562	4.3
Equivalent admissions [e]	35,893	N/M	37,540	4.6
Revenues per equivalent admission	$ 5,251	N/M	$ 5,186	(1.2)
Outpatient factor [e]	1.92	N/M	1.92	–
Emergency room visits [f]	84,337	N/M	93,683	11.1
Inpatient surgeries	5,706	N/M	5,655	(0.9)
Outpatient surgeries [g]	15,939	N/M	16,361	2.6
Total surgeries	21,645	N/M	22,016	1.7
Outpatient revenues as a percentage of total revenues	49.3%	N/M	48.2%	N/M
Medicare case mix index [i]	1.17	N/M	1.17	–%

	Years Ended December 31,					
	2001		2002		2003	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Revenues	$ 619.4	100.0 %	$ 743.6	100.0 %	$ 907.1	100.0 %
Salaries and benefits [a]	243.2	39.3	291.4	39.2	365.0	40.2
Supplies [b]	78.2	12.6	92.2	12.4	118.1	13.0
Other operating expenses [c]	120.8	19.5	137.1	18.4	162.8	18.0
Provision for doubtful accounts	45.8	7.4	55.2	7.4	81.5	9.0
Depreciation and amortization	34.7	5.6	37.9	5.1	45.7	5.0
Interest expense, net	18.1	2.9	13.3	1.8	12.8	1.4
Debt retirement costs	2.6	0.3	31.0	4.2	–	–
ESOP expense	10.4	1.7	9.7	1.3	6.9	0.8
Gain on previously impaired assets	(0.5)	(0.1)	–	–	–	–
Income before minority interests and income taxes	66.1	10.8	75.8	10.2	114.3	12.6
Minority interests in earnings of consolidated entities	2.7	0.4	2.2	0.3	0.7	0.1
Income before income taxes	63.4	10.4	73.6	9.9	113.6	12.5
Provision for income taxes	30.1	5.0	32.1	4.3	45.1	4.9
Net income	$ 33.3	5.4 %	$ 41.5	5.6 %	$ 68.5	7.6 %

	Years Ended December 31,					
	2001		2002		2003	
	Amount	% Change from Prior Year	Amount	% Change from Prior Year	Amount	% Change from Prior Year
Consolidated:						
Number of hospitals at end of period	23	15.0 %	28	21.7 %	29	3.6 %
Admissions [d]	70,891	7.3	77,927	9.9	92,184	18.3
Equivalent admissions [e]	129,163	7.8	149,152	15.5	181,879	21.9
Revenues per equivalent admission	$ 4,796	3.1	$ 4,986	4.0	$ 4,988	–
Outpatient factor [e]	1.82	0.5	1.91	5.0	1.97	3.1
Emergency room visits [f]	313,110	6.2	355,891	13.7	434,424	22.1
Inpatient surgeries	20,042	9.5	23,030	14.9	27,201	18.1
Outpatient surgeries [g]	57,423	15.5	65,545	14.1	77,119	17.7
Total surgeries	77,465	13.9	88,575	14.3	104,320	17.8
Outpatient revenues as a percentage of total revenues	47.8 %	N/M	49.8 %	N/M	49.7 %	N/M
Medicare case mix index [i]	1.15	– %	1.15	– %	1.17	1.7 %
Same-hospital [h]:						
Revenues	N/M	N/M	$ 730.2	N/M	$ 760.6	4.2 %
Number of hospitals at end of period	N/M	N/M	23	N/M	23	–
Admissions [d]	N/M	N/M	76,159	N/M	75,795	(0.5)
Equivalent admissions [e]	N/M	N/M	145,692	N/M	147,194	1.0
Revenues per equivalent admission	N/M	N/M	$ 5,012	N/M	$ 5,167	3.1
Outpatient factor [e]	N/M	N/M	1.91	N/M	1.94	1.4
Emergency room visits [f]	N/M	N/M	347,268	N/M	353,415	1.8
Inpatient surgeries	N/M	N/M	22,603	N/M	22,887	1.3
Outpatient surgeries [g]	N/M	N/M	64,417	N/M	65,359	1.5
Total surgeries	N/M	N/M	87,020	N/M	88,246	1.4
Outpatient revenues as a percentage of total revenues	N/M	N/M	49.9 %	N/M	49.7 %	N/M
Medicare case mix index [i]	N/M	N/M	1.16	N/M	1.18	1.7 %

N/M – not meaningful.

(a) Represents our cost of salaries and benefits, including employee health benefits and workers compensation insurance, for all hospital and corporate employees and contract labor.
(b) Includes our hospitals' costs for pharmaceuticals, blood, surgical instruments and all general supply items, including the cost of freight.
(c) Consists primarily of contract services, physician recruitment, professional fees, repairs and maintenance, rents and leases, utilities, insurance, marketing and non-income taxes.
(d) Represents the total number of patients admitted (in the facility for a period in excess of 23 hours) to our hospitals and used by management and investors as a general measure of inpatient volume.
(e) Management and investors use equivalent admissions as a general measure of combined inpatient and outpatient volume. We compute equivalent admissions by multiplying admissions (inpatient volume) by the outpatient factor (the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue). The equivalent admissions computation "equates" outpatient revenue to the volume measure (admissions) used to measure inpatient volume resulting in a general measure of combined inpatient and outpatient volume.
(f) Represents the total number of hospital-based emergency room visits.
(g) Outpatient surgeries are those surgeries that do not require admission to our hospitals.
(h) Same-hospital information excludes the operations of hospitals which we acquired during the periods presented. The costs of corporate overhead are included in same-hospital information, which ranges from approximately 2.5% to 3% of revenues.
(i) Refers to the acuity or severity of illness of an average Medicare patient at our hospitals.

For the Quarters Ended December 31, 2003 and 2002

Revenues

Our revenues for the quarter ended December 31, 2003 increased by $35.4 million, or 17.5%, to $237.3 million compared to the quarter ended December 31, 2002. This increase is attributable to a number of factors, including:

- $11.7 million from our same-hospital revenues, excluding net adjustments to estimated third-party payor settlements and including a $0.7 million decrease in non-patient revenues;
- $22.6 million increase from our 2002 acquisitions;
- $6.4 million from our 2003 acquisition of Spring View Hospital; and
- $5.3 million net decrease in our net adjustments to estimated third-party payor settlements. Net adjustments to estimated third-party payor settlements resulted in a decrease to revenues of $0.2 million in the quarter ended December 31, 2003 compared to an increase to revenues of $5.1 million in the quarter ended December 31, 2002. The $5.1 million of adjustments in the quarter ended December 31, 2002 related primarily to cost reports that were delayed by outpatient PPS and had an effect of increasing after-tax diluted earnings per share by approximately $0.07.

Our same-hospital inpatient revenues, excluding net adjustments to estimated third-party payor settlements, for the quarter ended December 31, 2003 increased by $7.4 million, or 8.3%, to $96.2 million compared to the quarter ended December 31, 2002. A primary driver was an increase in flu-related admissions late in the quarter.

Our same-hospital outpatient revenues, excluding net adjustments to estimated third-party payor settlements, for the quarter ended December 31, 2003 increased by $5.0 million, or 5.5%, to $96.5 million compared to the quarter ended December 31, 2002. This outpatient growth was largely driven by a 2.6% increase in same-hospital outpatient surgeries and an 11.1% increase in same-hospital emergency room visits.

After factoring all of the above, our equivalent admissions increased by 4.6% on a same-hospital basis for the quarter ended December 31, 2003 compared to the same period in 2002. As it relates to pricing and acuity, our same-hospital revenues per equivalent admission for the quarter ended December 31, 2003 were down 1.2%, or $65 per equivalent admission, over the same period in 2002. However, our same-hospital revenues per equivalent admission for the quarter ended December 31, 2003, excluding net adjustments to estimated third-party payor settlements, increased by 1.7% over the same period in 2002.

The table below shows the sources of our revenues for the quarters ended December 31, expressed as percentages of total revenues, including net adjustments to estimated third-party payor settlements:

	Consolidated		Same-hospital	
	2002	2003	2002	2003
Medicare	38.4%	36.2%	39.0%	35.4%
Medicaid	11.5	10.9	11.9	11.1
HMOs, PPOs and other private insurers	39.9	39.9	39.7	42.9
Self Pay	8.4	9.1	7.7	8.8
Other	1.8	3.9	1.7	1.8
Total	100.0%	100.0%	100.0%	100.0%

Our historical sources of revenues table in prior Form 10-K and Form 10-Q reports required certain reclassifications. Specifically, contractual discounts relating to certain Medicaid state managed care programs were historically classified incorrectly against the HMOs, PPOs and other private insurers revenue line as opposed to the Medicaid revenue line. This change produced no impact on our historical results of operations. Generally, these reclassifications reduced Medicaid as a percentage of total revenues and increased HMOs, PPOs and other private insurers as a percentage of total revenues.

Expenses

Salaries and benefits increased as a percentage of revenues to 39.3% for the quarter ended December 31, 2003 from 39.0% for the quarter ended December 31, 2002, primarily as a result of our 2002 acquisitions, which had higher than average salaries and benefits as a percentage of our revenues. Salaries and benefits in the quarter ended December 31, 2003 were approximately 41.4% as a percentage of revenues for our 2002 acquisitions. On a same-hospital basis, salaries and benefits increased as a percentage of revenues to 38.6% in the quarter ended December 31, 2003 compared to 37.9% in the quarter ended December 31, 2002. This was primarily due to a 4.4% increase in same-hospital salaries and benefits per man-hour in the fourth quarter of 2003 compared to the same period in 2002. However, our productivity improved in the quarter ended December 31, 2003 with a 3.7% decrease in our man-hours per equivalent admission compared to the same period in 2002. In addition, our same-hospital contract labor increased by 10.8% to $3.9 million in the quarter ended December 31, 2003, compared to $3.5 million in the quarter ended December 31, 2002, as a result of continuing clinical labor shortages in some of our communities.

Supply costs as a percentage of revenues increased to 13.4% in the quarter ended December 31, 2003 from 12.3% in the quarter ended December 31, 2002. On a same-hospital basis, supply costs increased as a percentage of revenues to 13.5% in the quarter ended December 31, 2003 from 11.9% in the quarter ended December 31, 2002. On a same-hospital basis, our cost of supplies per equivalent admission increased 11.2% in the quarter ended December 31, 2003 as a result of rising supply costs compared to the same period in 2002, particularly in the pharmaceutical, cardiac and spine and joint implant areas.

Other operating expenses decreased as a percentage of revenues to 17.2% in the quarter ended December 31, 2003 from 17.9% in the quarter ended December 31, 2002. On a same-hospital basis, other operating expenses decreased as a percentage of revenues to 16.7% in the quarter ended December 31, 2003 from 17.6% in the quarter ended December 31, 2002, primarily as a result of lower professional and general liability insurance expense. Our professional and general liability insurance expense was $0.9 million during the quarter ended December 31, 2003 compared to $3.2 million in the quarter ended December 31, 2002. This decrease relates to favorable loss experience as reflected in our external actuarial reports and our 2003 change to using multiple actuaries to estimate projected losses under the self-insured portion of our insurance program, as further discussed previously in the "Critical Accounting Estimates." Our physician recruiting costs increased from $2.0 million in the quarter ended December 31, 2002 to $3.6 million in the quarter ended December 31, 2003 as a result of our increased number of recruited physicians.

Provision for doubtful accounts increased as a percentage of revenues to 9.7% in the quarter ended December 31, 2003 from 8.1% in the quarter ended December 31, 2002. The provision for doubtful accounts related primarily to self-pay amounts due from patients. Our self-pay revenues for the quarter ended December 31, 2003 increased by 28.0% to $21.6 million compared to the same period in 2002. The factors influencing this increase are a combination of broad economic factors, including the increased number of uninsured patients, employers shifting costs to employees through higher co-payments and higher unemployment rates. In addition, our 2002 acquisitions had a higher than average provision for doubtful accounts as a percentage of revenues. Provision for doubtful accounts as a percentage of revenues for our 2002 acquisitions was 16.4% for the quarter ended December 31, 2003. On a same-hospital basis, the provision for doubtful accounts increased as a percentage of revenues to 8.4% in the quarter ended December 31, 2003 from 7.4% in the quarter ended December 31, 2002.

Depreciation and amortization expense increased to $12.3 million in the quarter ended December 31, 2003 from $9.9 million in the quarter ended December 31, 2002, primarily as a result of our 2002 and 2003 acquisitions and depreciation associated with capital improvements at our facilities. Depreciation expense associated with our 2002 and 2003 acquisitions was $1.8 million for the quarter ended December 31, 2003. Same-hospital depreciation and amortization expense was $10.5 million in the quarter ended December 31, 2003 compared to $9.5 million in the quarter ended December 31, 2002.

The provision for income taxes decreased to $11.6 million in the quarter ended December 31, 2003 from $12.2 million in the quarter ended December 31, 2002. The income tax provisions reflected an effective income tax rate of 37.5% for the quarter ended December 31, 2003 compared to 40.6% for the quarter ended December 31, 2002. The

effective tax rate decrease in 2003 was attributable to a decrease in the ESOP permanent difference and a reduction in tax contingencies relating to adjustments to IRS examination issues as a result of the IRS issuing its findings during the quarter ended December 31, 2003. Please refer to Note 4 our consolidated financial statements in our 2003 Form 10K for more information related to the IRS findings.

For the Years Ended December 31, 2003 and 2002

Revenues

Our revenues for 2003 increased by $163.5 million, or 22.0%, to $907.1 million compared to 2002. This increase is attributable to a number of factors, including:

- $37.6 million from our same-hospital revenues, excluding net adjustments to estimated third-party payor settlements and including a $2.6 million decrease in non-patient revenues;
- $126.5 million increase from our 2002 acquisitions (our 2002 acquisitions had revenues of $140.1 million and $13.6 million in 2003 and 2002, respectively);
- $6.4 million from our 2003 acquisition of Spring View Hospital; and
- $7.0 million net decrease in our net adjustments to estimated third-party payor settlements. Net adjustments to estimated third-party payor settlements resulted in an increase to net revenues of $6.0 million in 2003 compared to $13.0 million in 2002. Net adjustments of $5.0 million of the $13.0 million in 2002 related to the favorable settlement of a Kentucky inpatient Medicaid rate appeal that covered the period January 1, 1996 through June 30, 2002. The remaining $8.0 million of adjustments related primarily to cost reports that were delayed by outpatient PPS. The net adjustments to estimated third party-payor settlements had a favorable diluted earnings per share effect of $0.08 for 2003 and $0.17 for 2002.

Our same-hospital inpatient revenues, excluding net adjustments to estimated third-party payor settlements, in 2003 increased by $20.9 million, or 6.1%, to $366.3 million compared to 2002. Our same-hospital Medicare case mix increased from 1.16 in 2002 to 1.18 in 2003. A primary driver in the case mix increase was our open-heart program at Lake Cumberland Regional Hospital that opened in the fourth quarter of 2002. In addition, we had a 1.3% increase in our inpatient surgeries in 2003 compared to 2002, on a same-hospital basis.

Our same-hospital outpatient revenues for 2003 increased by $19.3 million, or 5.4%, to $378.8 million compared to 2002. This outpatient growth was largely driven by a 1.5% increase in same-hospital outpatient surgeries and a 1.8% increase in same-hospital emergency room visits.

After factoring all of the above, our equivalent admissions increased by 1.0% on a same-hospital basis in 2003 compared to 2002. As it relates to pricing and acuity, our same-hospital revenues per equivalent admission for 2003 were up 3.1%, or $155 per equivalent admission, over 2002. Revenues per equivalent admission on our 2002 acquisitions were approximately $1,000 less than our same-hospital revenues per equivalent admission during 2003 because our 2002 acquisitions are located in states with lower reimbursement levels. Our same-hospital revenues per equivalent admission in 2003, excluding the net adjustments to estimated third-party payor settlements, increased by 4.2% as compared to 2002.

The table below shows the sources of our revenues for the years ended December 31, expressed as percentages of total revenues, including net adjustments to estimated third-party payor settlements:

	Consolidated		Same-hospital	
	2002	2003	2002	2003
Medicare	35.2%	35.7%	35.3%	36.0%
Medicaid	11.4	10.7	11.5	10.9
HMOs, PPOs and other private insurers	42.9	40.6	42.9	42.5
Self Pay	8.5	9.0	8.4	8.5
Other	2.0	4.0	1.9	2.1
Total	100.0%	100.0%	100.0%	100.0%

Our historical sources of revenues table in prior Form 10-K and Form 10-Q reports required certain reclassifications. Specifically, contractual discounts relating to certain Medicaid state managed care programs were historically classified incorrectly against the HMOs, PPOs and other private insurers revenue line as opposed to the Medicaid revenue line. This change produced no impact on our historical results of operations. Generally, these reclassifications reduced Medicaid as a percentage of total revenues and increased HMOs, PPOs and other private insurers as a percentage of total revenues.

Expenses

Salaries and benefits increased as a percentage of revenues to 40.2% in 2003 from 39.2% in 2002, primarily as a result of our 2002 acquisitions, which had higher than average salaries and benefits as a percentage of our revenues. Salaries and benefits in 2003 were approximately 45.3% as a percentage of revenues for our 2002 acquisitions. On a same-hospital basis, salaries and benefits increased as a percentage of revenues to 39.2% in 2003 compared to 38.9% in 2002. This was primarily due to a 4.9% increase in same-hospital salaries and benefits per man-hour in 2003 compared to 2002. However, our productivity improved with a 0.9% decrease in our man-hours per equivalent admission. In addition, our same-hospital contract labor increased by 15.4% to $13.5 million in 2003 compared to $11.7 million in 2002 as a result of continuing clinical labor shortages in some of our communities.

Supply costs as a percentage of revenues increased to 13.0% in 2003 from 12.4% in 2002. On a same-hospital basis, supply costs increased as a percentage of revenues to 12.8% in 2003 from 12.3% in 2002. On a same-hospital basis, our cost of supplies per equivalent admission increased 7.5% as a result of rising supply costs, particularly in the pharmaceutical and cardiac areas. In addition, we opened our new open-heart unit at Lake Cumberland Regional Hospital during the fourth quarter of 2002, which also contributed to the increase in our supply costs per equivalent admission. We utilize the group-purchasing and supplies management services of HealthTrust Purchasing Group, which makes certain national supply and equipment contracts available to our facilities.

Other operating expenses decreased as a percentage of revenues to 18.0% in 2003 from 18.4% in 2002. On a same-hospital basis, other operating expenses decreased as a percentage of revenues to 17.8% in 2003 from 18.4% in 2002 primarily as a result of lower professional and general liability insurance expense. Our professional and general liability insurance expense was $9.8 million during 2003 compared to $12.9 million in 2002. This decrease relates to favorable loss experience as reflected in our external actuarial reports and our 2003 change to using multiple actuaries to estimate projected losses under the self-insured portion of our insurance program, as discussed previously in the "Critical Accounting Estimates." Our physician recruiting costs increased from $6.5 million in 2002 to $13.0 million in 2003 as a result of our increased number of recruited physicians.

Provision for doubtful accounts increased as a percentage of revenues to 9.0% in 2003 from 7.4% in 2002. The provision for doubtful accounts related primarily to self-pay amounts due from patients. Our self-pay revenues for 2003 increased by 28.6% to $81.5 million compared to 2002. The factors influencing this increase are a combination of broad economic factors, including increased uninsured patients, employers shifting costs to employees through higher co-payments and higher unemployment rates. In addition, our 2002 acquisitions had a higher than average provision for doubtful accounts as a percentage of our revenues. Provision for doubtful accounts as a percentage of revenues for our 2002 acquisitions was 14.8% for 2003. On a same-hospital basis, the provision for doubtful accounts also increased as a percentage of revenues to 7.9% in 2003 from 7.2% in 2002 as a result of the same factors described above.

Depreciation and amortization expense increased to $45.7 million in 2003 from $37.9 million in 2002, primarily as a result of our 2002 and 2003 acquisitions and depreciation associated with capital improvements at our facilities. Depreciation expense associated with our 2002 and 2003 acquisitions was $6.6 million for 2003. Same-hospital depreciation and amortization expense was $39.1 million in 2003 compared to $37.4 million in 2002.

We repurchased all of our $150.0 million 10 3/4% Senior Subordinated Notes during 2002. In connection with these repurchases, we incurred debt retirement costs of $31.0 million which consisted of $26.5 million in premiums, commissions and fees paid for the repurchases and $4.5 million in non-cash net deferred loan cost write-offs.

The provision for income taxes increased to $45.1 million in 2003 compared to $32.1 million in 2002. The income tax provisions reflected an effective income tax rate of 39.7% for 2003 compared to 43.5% for 2002. The effective tax rate decrease was attributable to a decrease in the ESOP permanent difference and a reduction in tax contingencies relating to adjustments to IRS examination issues as a result of the IRS issuing its findings during 2003. Please refer to Note 4 of our consolidated financial statements in our 2003 Form 10K for more information related to the IRS findings.

For the Years Ended December 31, 2002 and 2001

Revenues

For the comparison of 2002 to 2001, our same-hospital information includes the twenty-one hospitals that we operated in January 2001.

Our revenues for 2002 increased by $124.2 million, or 20.0%, to $743.6 million compared to 2001. This increase is attributable to a number of factors, including:

- $52.5 million from our same-hospital revenues, net of adjustments to estimated third-party payor settlements. Our same-hospital outpatient revenues for 2002 increased by $35.2 million, or 12.2%, to $324.3 million. This outpatient growth was largely driven by a 7.2% increase in same-hospital outpatient surgeries and a 2.3% increase

in same-hospital emergency room visits. Our same-hospital inpatient revenues for 2002 increased by $14.3 million, or 4.6%, to $324.2 million, compared to 2001 primarily as a result of a 5.7% growth in our same-hospital inpatient surgeries, as same-hospital admissions were flat in 2002 compared to 2001;

- $47.1 million from our 2001 acquisitions;
- $13.6 million from our 2002 acquisitions; and
- $11.0 million from net adjustments to estimated third-party payor settlements. Net adjustments to estimated third-party payor settlements resulted in an increase to revenues of $13.0 million in 2002 compared to $2.0 million in 2001. Net adjustments of $5.0 million of the $13.0 million in 2002 related to the favorable settlement of a Kentucky inpatient Medicaid rate appeal that covered the period January 1, 1996 through June 30, 2002. The remaining $8.0 million of adjustments related primarily to the cost reports that were delayed by outpatient PPS. The net adjustments to estimated third-party payor settlements had a favorable diluted earnings per share effect of $0.17 for 2002.

The table below shows the sources of our revenues for the years ended December 31, expressed as percentages of total revenues, including net adjustments to estimated third-party payor settlements:

	Consolidated		Same-hospital	
	2001	2002	2001	2002
Medicare	35.4%	35.2%	35.4%	35.3%
Medicaid	10.7	11.4	10.7	11.6
HMOs, PPOs and other private insurers	42.5	42.9	43.2	42.8
Self Pay	8.0	8.5	8.0	8.5
Other	3.4	2.0	2.7	1.8
Total	100.0%	100.0%	100.0%	100.0%

Our historical sources of revenues table in prior Form 10-K and Form 10-Q reports required certain reclassifications. Specifically, contractual discounts relating to certain Medicaid state managed care programs were historically classified incorrectly against the HMOs, PPOs and other private insurers revenue line as opposed to the Medicaid revenue line. This change produced no impact on our historical results of operations. Generally, these reclassifications reduced Medicaid as a percentage of total revenues and increased HMOs, PPOs and other private insurers as a percentage of total revenues.

Expenses

Our salaries and benefits decreased as a percentage of revenues to 39.2% for 2002 from 39.3% for 2001. We had a 2.4% decrease in man-hours per equivalent admission in 2002 compared to 2001. However, we had a 6.4% increase in salaries and benefits per man-hour. Our largest area of increase was employee benefits, primarily self-insured health claims, which increased by $11.7 million over 2001. On a same-hospital basis, salaries and benefits decreased as a percentage of revenues to 38.2% in 2002 from 39.1% in 2001. On a same-hospital basis, our salaries and benefits per equivalent admission grew 6.8%. In addition, our same-hospital contract labor increased by $1.7 million, or 19.7%, in 2002 over 2001 as a result of clinical labor shortages in some of our communities.

Supply costs decreased as a percentage of revenues to 12.4% in 2002 from 12.6% in 2001. This decrease is primarily the result of the savings utilizing the group-purchasing and supplies management services of HealthTrust Purchasing Group, which makes certain national supply and equipment contracts available to our facilities.

Other operating expenses decreased as a percentage of revenues to 18.4% in 2002 from 19.5% in 2001. The decrease was primarily the result of a decrease in physician recruiting expense as a percentage of revenues. However, the amount of physician recruiting expense increased to $6.5 million in 2002 from $6.4 million in 2001.

Provision for doubtful accounts remained the same as a percentage of revenues at 7.4% in 2002 and 2001. On a same-hospital basis, our provision for doubtful accounts decreased as a percentage of revenues to 7.1% for 2002 from 7.5% for 2001 primarily as a result of an improvement in same-hospital collections from all payor sources.

Depreciation and amortization expense increased to $37.9 million in 2002 from $34.7 million in 2001, primarily as a result of our 2001 and 2002 acquisitions and our increase in capital expenditures during 2002. This was partially offset by the cessation of goodwill amortization required by Statement of Financial Accounting Standards ("SFAS") No. 142, which was effective January 1, 2002. Goodwill amortization during 2001 was $1.6 million.

We repurchased all of our $150.0 million 10 3/4% Senior Subordinated Notes during 2002. In connection with these repurchases, we incurred debt retirement costs of $31.0 million which consisted of $26.5 million in premiums, commissions and fees paid for the repurchases and $4.5 million in non-cash net deferred loan cost write-offs.

The provision for income taxes for 2002 increased to $32.1 million compared to $30.1 million for 2001. The provisions reflect effective income tax rates of 43.5% for 2002 compared to 47.5% for 2001. The effective tax rate decreased primarily due to the decline in the permanent differences between book and taxable income as a percentage of pre-tax income.

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash flows provided by our operations and our revolving credit facility. Our liquidity for 2003 and 2002 was derived primarily from net cash provided by operating activities.
Cash flows for the years ended December 31 were as follows (in millions):

Source (use) of cash flows	2001	2002	2003
Operating activities	$ 114.1	$ 114.8	$ 104.6
Investing activities	(68.3)	(224.7)	(86.0)
Financing activities	(28.3)	75.7	(21.0)
Net increase (decrease) in cash	$ 17.5	$ (34.2)	$ (2.4)
Interest payments	$ 20.8	$ 16.3	$ 12.4
Income taxes paid	$ 18.4	$ 21.0	$ 41.4
Working capital as of December 31	$ 82.7	$ 67.9	$ 102.4

2003

Operating activities

The decrease in cash flows from operating activities in 2003 compared to 2002 primarily reflects:

- Higher tax payments of approximately $20.4 million in 2003, primarily as a result of the tax benefit associated with our debt retirement costs during 2002, which reduced income tax payments in 2002, and approximately $6.6 million of prepaid tax payments related to our pending IRS examination settlement;
- Higher revenues in December 2003 compared to December 2002 as a result of higher admissions in December 2003. In addition, some of our Medicare intermediaries experienced some technical difficulties complying with HIPAA as we electronically submitted our bills, thereby slowing our collections. These factors led to a $16.4 million increase, in our consolidated accounts receivable balance as of December 31, 2003 compared to December 31, 2002; and
- An increase in our working capital by $34.5 million from December 31, 2002 to December 31, 2003. This increase was primarily the result of the increases in accounts receivable and income taxes receivable, as discussed above. The increase in accounts receivable increased our net revenue days in accounts receivable at December 31, 2003, exclusive of our 2002 and 2003 acquisitions, to 37.5 days compared to 35.4 days at December 31, 2002.

Investing activities

Cash used in investing activities primarily consisted of net purchases of equipment of $70.2 million and the purchase of Spring View Hospital for $15.8 million, including direct transaction costs and working capital. We used our available cash to finance the cost of this acquisition. Our routine capital expenditures increased from $18.8 million in 2002 to $22.9 million in 2003 as a result of an increased base of fixed assets.

Financing activities

Cash used in financing activities consisted primarily of $45.7 million in repurchases of common stock, partially offset by $20.0 million borrowed under our revolving credit facility.

2002

Operating activities

There was a slight increase in cash flows from operating activities in 2002 compared to 2001. The primary factors that led to this slight increase in spite of our improved results of operations are as follows: Our consolidated accounts receivable increased $28.3 million during 2002.

- Our net revenue days in accounts receivable at December 31, 2002, exclusive of the recent acquisitions, were 35.4 days compared to 31.7 days at December 31, 2001. The difference in days is primarily due to the filing of our cost reports during 2002.

- There was $8.0 million in non-cash net adjustments to estimated third-party settlements during 2002 that were classified as credit balances in accounts receivable at December 31, 2001. This equates to 4.5 revenue days. The estimated third-party payor settlements account balance of $8.2 million includes $7.9 million payable to Kentucky Medicaid. We paid a total of $6.7 million in cash in the fourth quarter of 2002 on all settlements, $5.8 million of which was paid to Kentucky Medicaid.

Investing activities

Cash used in investing activities consisted of net purchases of equipment of $60.7 million, the purchase of five facilities for approximately $137.1 million, including direct acquisition costs and working capital, and the purchase of the outstanding 30% limited partnership interest in Dodge City Healthcare Group, L.P., the entity that owns and operates 110-bed Western Plains Regional Hospital and affiliated surgery center in Dodge City, Kansas, for $25.0 million. We used our available cash to finance the cost of these transactions.

Financing activities

Cash provided by financing activities primarily consisted of the $242.5 million net proceeds from our offering of $4\frac{1}{2}$% Convertible Subordinated Notes due 2009. This was partially offset by our repurchase of $150.0 million of our $10\frac{3}{4}$% senior subordinated notes and related debt retirement costs of $26.5 million in premiums, commissions and fees.

Capital Resources

Our revolving credit facility provides for borrowings up to $200.0 million, expires in June 2006, is guaranteed by substantially all of our current and future subsidiaries and is secured by substantially all of our assets. The revolving credit facility requires that we comply with certain financial covenants, including:

	Requirement	Level at December 31, 2003
Maximum permitted consolidated leverage ratio	<3.50 to 1.00	1.57 to 1.00
Maximum permitted consolidated senior leverage ratio	<2.50 to 1.00	0.19 to 1.00
Minimum permitted consolidated interest coverage ratio	>3.50 to 1.00	12.62 to 1.00
Minimum permitted consolidated net worth	>$269.9 million	$394.3 million
Maximum capital expenditures – last twelve months	<$136.1 million	$70.2 million

The revolving credit facility also requires that we comply with various other covenants, including, but not limited to, restrictions on new indebtedness, the ability to merge or consolidate, asset sales, capital expenditures, acquisitions and dividends, with which we were in compliance as of December 31, 2003. As of December 31, 2003, we had outstanding indebtedness of $20.0 million under our revolving credit facility and letters of credit in the aggregate amount of $13.6 million outstanding, leaving $166.4 million available under our revolving credit facility. We repaid the $20.0 million of indebtedness outstanding under our revolving credit facility in February 2004 with our available cash.

The applicable interest rate under the revolving credit facility is based on a rate, at our option, equal to either (i) LIBOR plus a margin ranging from 1.25% to 2.25% or (ii) prime plus a margin ranging from 0% to 0.5%, both depending on our consolidated total debt to consolidated EBITDA ratio, as defined, for the most recent four quarters.

Our revolving credit facility does not contain provisions that would accelerate the maturity date of our debt upon a downgrade in our credit rating. However, a downgrade in our credit rating could adversely affect our ability to renew our existing credit facility or obtain access to new credit facilities or other capital sources in the future and could increase the cost of such facilities and other capital sources. In 2003, Standard & Poor's upgraded its credit rating on our senior secured debt obligations to BB+. Our Standard & Poor's corporate rating is a BB as of January 31, 2004. We do not have any relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance, special purpose or variable interest entities, established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. Accordingly, we are not materially exposed to any financing, liquidity, market or credit risk that could arise if we had engaged in such relationships.

On May 22, 2002, we sold $4\frac{1}{2}$% Convertible Subordinated Notes due 2009 in the aggregate principal amount of $250 million (the "Convertible Notes"). The net proceeds of approximately $242.5 million were used for acquisitions, capital improvements at our existing facilities, repurchase of our $10\frac{3}{4}$% Senior Subordinated Notes, working capital and general corporate purposes. The Convertible Notes bear interest at the rate of $4\frac{1}{2}$% per year, payable semi-annually on June 1 and December 1. The Convertible Notes are convertible at the option of the holder at any time on

or prior to maturity into shares of our common stock at a conversion price of $47.36 per share. The conversion price is subject to adjustment in certain circumstances. We may redeem all or a portion of the Convertible Notes on or after June 3, 2005, at the then current redemption prices, plus accrued and unpaid interest. Holders of the Convertible Notes may require us to repurchase all of the holder's Convertible Notes at 100% of their principal amount plus accrued and unpaid interest in some circumstances involving a change of control. The Convertible Notes are unsecured and subordinated to our existing and future senior indebtedness and senior subordinated indebtedness. The Convertible Notes rank junior to our other liabilities. The indenture governing the Convertible Notes does not contain any financial covenants. A total of 5,278,825 shares of common stock have been reserved for issuance upon conversion of the Convertible Notes.

Liquidity and Capital Resources Outlook

We expect the level of capital expenditures in 2004 to be approximately $90.0 million. We have large projects in process at a number of our facilities. We are reconfiguring some of our hospitals to more effectively accommodate patient services and restructuring existing surgical capacity in some of our hospitals to permit additional patient volume and a greater variety of services. At December 31, 2003, we had projects under construction with an estimated additional cost to complete and equip of approximately $88.2 million. We anticipate that these projects will be completed over the next three years. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings under our revolving credit facility.

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

We have never declared or paid dividends on our common stock. We intend to retain future earnings to finance the growth and development of our business and, accordingly, do not currently intend to declare or pay any dividends on our common stock. Our Board of Directors will evaluate our future earnings, results of operations, financial condition and capital requirements in determining whether to declare or pay cash dividends. Delaware law prohibits us from paying any dividends unless we have capital surplus or net profits available for this purpose. In addition, our credit facilities impose restrictions on our ability to pay dividends. We repurchased approximately 2.1 million shares of our common stock for an aggregate price of approximately $45.7 million during 2003. Please refer to Part II, Item 5. *Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities* in our 2003 Form 10K for a discussion of our share repurchase program.

We believe that cash flows from operations, amounts available under our revolving credit facility and our anticipated access to capital markets are sufficient to meet expected liquidity needs, planned capital expenditures, potential acquisitions and other expected operating needs over the next three years.

Contractual Obligations

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

The following table summarizes our significant contractual obligations as of December 31, 2003 and the future periods in which such obligations are expected to be settled in cash (in millions):

	Payments Due by Period				
Contractual Obligations	Total	Less Than 1 Year	1-3 Years	4-5 Years	After 5 Years
Long-term debt obligations [a]	$ 331.0	$ 31.3	$ 22.5	$ 22.5	$ 254.7
Capital lease obligations [b]	0.5	0.3	0.2	-	-
Operating lease obligations [c]	21.2	6.0	7.3	3.7	4.2
Purchase obligations [d]	107.0	55.7	31.4	1.5	18.4
Other long-term liabilities [b]	-	-	-	-	-
Total	$ 459.7	$ 93.3	$ 61.4	$ 27.7	$ 277.3

(a) Included in long-term debt obligations are principal and interest owed on our Convertible Notes and on our revolving credit facility. In addition, "Less than 1 Year" in the above table includes the $20.0 million of outstanding indebtedness under our revolving credit facility, which we repaid during the first quarter of 2004 even though we were not contractually obligated to make this payment until 2006. These obligations are explained further in Note 5 of our consolidated financial statements in our 2003 Form 10K.

(b) We had a $28.6 million other long-term liability balance on our consolidated balance sheet as of December 31, 2003. This balance reflected a $27.5 million reserve for professional and general liability claims, $0.2 million related to capital leases and $0.9 million related to other liabilities. We excluded the $27.5 million reserve for professional and general liability claims and $0.9 million of other liabilities from this table due to the uncertainty of the dollar amounts to be ultimately paid as well as the timing of such amounts. Please refer to the "Critical Accounting Estimates – Professional and General Liability Reserves" in the section above for more information.

(c) We enter into operating leases in the normal course of business. Substantially all of our lease agreements have fixed payment terms based on the passage of time. Some lease agreements provide us with the option to renew the lease. Our future operating lease obligations would change if we exercised these renewal options and if we entered into additional operating lease agreements. The above table reflects our future minimum operating lease payments. Please refer to Note 7 of our consolidated financial statements in our 2003 Form 10K for more information regarding our operating leases.

(d) The following table summarizes our significant purchase obligations as of December 31, 2003 and the future periods in which such obligations are expected to be settled in cash (in millions):

	Payments Due by Period				
Purchase Obligations	Total	Less Than 1 Year	1-3 Years	4-5 Years	After 5 Years
HCA-IT services [e]	$ 34.6	$ 12.3	$ 22.3	$ -	$ -
Capital expenditure obligations [f], [g]	32.6	14.2	-	-	18.4
Physician commitments [h]	11.1	9.4	1.7	-	-
GEMS obligations [i]	13.8	11.0	2.8	-	-
Other purchase obligations [j]	14.9	8.8	4.6	1.5	-
Total	$ 107.0	$ 55.7	$ 31.4	$ 1.5	$ 18.4

(e) HCA-IT provides various information systems services, including, but not limited to, financial, clinical, patient accounting and network information services to us under a seven-year contract that expires in May 2006. Please refer to the "Arrangements Relating to the Distribution" section in Part I, *Business* in our 2003 Form 10K for more information. The amounts in the above table are based on estimated fees that will be charged to our 29 hospitals as of December 31, 2003. These fees will increase if we acquire a hospital and use HCA-IT for information system conversion services at the acquired hospital.

(f) Capital expenditure obligations include $7.5 million in purchase orders for medical equipment and $25.1 million in committed capital improvements remaining under two asset purchase agreements. Please refer to Note 7 of our consolidated financial statements in our 2003 Form 10K for more information on our committed capital improvements.

(g) We had projects under construction with an estimated additional cost to complete and equip of approximately $88.2 million as of December 31, 2003. Since we can terminate substantially all of the related construction contracts at any time without paying a termination fee, such cost is excluded from the above table except for the amounts disclosed in footnote (f) above.

(h) In consideration for a physician relocating to one of our communities and agreeing to engage in private practice for the benefit of the respective community, we may loan certain amounts to a physician, normally over a period of one year, to assist in establishing his or her practice. We have committed to advance a maximum amount of approximately $27.8 million as of December 31, 2003. The actual amount of such commitments to be advanced often depends upon the financial results of a physician's private practice during the loan period. The physician commitment amounts reflected in the above table were estimated based on our historical amounts actually paid to physicians.

(i) General Electric Medical Services ("GEMS") provides diagnostic imaging equipment maintenance and bio-medical services to us pursuant to a contract that expires in the first quarter of 2005. The amounts in the above table reflect our obligation based on the equipment we owned as of December 31, 2003.

(j) Reflects our minimum commitments to purchase goods or services under non-cancelable contracts as of December 31, 2003.

Off-Balance Sheet Arrangements

We had standby letters of credit outstanding of approximately $13.6 million as of December 31, 2003. Of this amount, $13.4 million was related to the self-insured retention levels of our professional and general liability insurance programs as security for the payment of claims and $0.2 million was related to obligations to certain utility companies.

Recently Issued Accounting Pronouncements

We adopted SFAS No. 145 effective January 1, 2003, which required a reclassification of debt retirement costs from an extraordinary loss to a component of income before income taxes. The Financial Accounting Standards Board ("FASB") issued SFAS No. 145 "Rescission of FASB Statements Nos. 4, 44 and 64, Amendment of FASB No. 13, and Technical Corrections" ("SFAS No. 145") in April 2002. Under certain provisions of SFAS No. 145, gains and losses related to the extinguishment of debt are no longer segregated on the income statement as extraordinary items net of the effect of income taxes. Instead, these gains and losses are included as a component of income before income taxes. The provisions of SFAS No. 145 were effective for fiscal years beginning after May 15, 2002. Any gain or loss on early extinguishment of debt that was classified as an extraordinary item in prior periods presented that did not meet the criteria in APB Opinion No. 30 for classification as an extraordinary item was reclassified upon adoption.

In January 2003, the FASB issued Interpretation No. 46, "Consolidation of Variable Interest Entities" ("FIN 46") which requires the consolidation of variable interest entities. FIN 46, as revised, is applicable to financial statements of companies that have interests in "special purpose entities," during 2003. Effective as of the first quarter of 2004, FIN 46 is applicable to financial statements of companies that have interests in all other types of entities. However, disclosures are required currently if we expect to consolidate any variable interest entities. We do not currently believe that any material entities will be consolidated with us as a result of FIN 46.

In May 2003, the FASB issued SFAS No. 149, "Amendment of Statement 133 on Derivative Instruments and Hedging Activities" ("SFAS No. 149"). SFAS No. 149 amends and clarifies financial accounting and reporting for derivative instruments and hedging activities. SFAS No. 149 was effective for contracts entered into or modified after June 30, 2003. We do not expect SFAS No. 149 to have a material impact on our future results of operations or financial position.

We adopted SFAS No. 150 "Accounting for Certain Financial Instruments with Characteristics of both Liabilities and Equity" ("SFAS No. 150") on July 1, 2003. SFAS No. 150 establishes standards for classifying and measuring as liabilities certain financial instruments that embody obligations of the issuer and have characteristics of both liabilities and equity, such as redeemable preferred stock and certain equity derivatives that frequently are used in connection with share repurchase programs. On October 29, 2003, the FASB voted to defer for an indefinite period the application of SFAS No. 150 to classification of noncontrolling interests of limited-life subsidiaries. Neither the adoption of SFAS No. 150 nor the deferral had a material impact on our results of operations or financial position.

Seasonality

We typically experience higher patient volumes and revenues in the first and fourth quarters of each year. We typically experience such seasonal volume and revenue peaks because more people generally become ill during the winter months, which in turn results in significant increases in the number of patients we treat during those months.

Inflation

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

Factors That May Affect Future Results

We make forward-looking statements in our 2003 Form 10K and in other reports and proxy statements we file with the SEC. In addition, our senior management makes forward-looking statements orally to analysts, investors, the media and others. Broadly speaking, forward-looking statements include:

- projections of our revenues, net income, earnings per share, capital expenditures or other financial items;
- descriptions of plans or objectives of our management for future operations or services, including pending acquisitions;
- forecasts of our future economic performance; and
- descriptions of assumptions underlying or relating to any of the foregoing.

In our 2003 Form 10K, for example, we make forward-looking statements discussing our expectations about:

- future financial performance;
- future liquidity;
- industry trends;
- reimbursement changes;
- future capital expenditures;
- the impact of new accounting standards; and
- physician recruiting.

Forward-looking statements discuss matters that are not historical facts. Because they discuss future events or conditions, forward-looking statements often include words such as "can," "could," "may," "should," "believe," "will," "would," "expect," "project," "estimate," "anticipate," "plan," "intend," "target," "continue" or similar expressions. Do not unduly rely on forward-looking statements. They give our expectations about the future and are not guarantees. Forward-looking statements speak only as of the date they are made, and we might not update them to reflect changes that occur after the date they are made.

There are several factors, many beyond our control, that could cause results to differ significantly from our expectations. Some of these factors are described under "Risk Factors" in the Company's filings with the SEC. Other factors, such as market, operational, liquidity, interest rate and other risks, are described elsewhere in our 2003 Form 10K (see, for example, "Liquidity and Capital Resources" and "Quantitative and Qualitative Disclosures About Market Risk"). Any factor described in our 2003 Form 10K could by itself, or together with one or more factors, adversely affect our business, results of operations and/or financial condition. There may be factors not described in our 2003 Form 10K that could cause results to differ from our expectations.

Quantitative and Qualitative Disclosures about Market Risk

Interest Rates

The following discusses our exposure to market risk related to changes in interest rates.

Outstanding debt – As of December 31, 2003, we had outstanding debt of $270.0 million, $250.0 million of which was our Convertible Notes and $20.0 million of which was indebtedness under our revolving credit facility. Our Convertible Notes bear interest at the annual fixed rate of $4^1/_2$%. As of December 31, 2003, the fair value of our Convertible Notes was $251.9 million, based on the quoted market price at December 31, 2003. Indebtedness under our revolving credit facility bears interest at a rate, at our option, equal to either (i) LIBOR plus a margin ranging from 1.25% to 2.25% or (ii) prime plus a margin ranging from 0% to 0.5%, both depending on our consolidated total debt to consolidated EBITDA ratio, as defined, for the most recent four quarters. Our borrowing rate under the revolving credit facility as of December 31, 2003 was 4.0%. At December 31, 2003, the fair value of our indebtedness under our revolving credit facility approximates the carrying value. If the prime rate were to increase 100 basis points, the estimated impact on our consolidated financial statements for the year ended December 31, 2003, would be to reduce net income by approximately $0.1 million after taxes based on the $20.0 million outstanding at December 31, 2003. In the event we increase the amount outstanding under the revolving credit facility and interest rates increase significantly, we expect to take actions to mitigate our exposure to such interest rate increases. We do not currently use derivatives to alter the interest rate characteristics of our debt instruments.

Cash balances – Certain of our outstanding cash balances are invested overnight with high credit quality financial institutions. We do not have significant exposure to changing interest rates on invested cash at December 31, 2003. As a result, the interest rate market risk implicit in these investments at December 31, 2003, if any, is low.

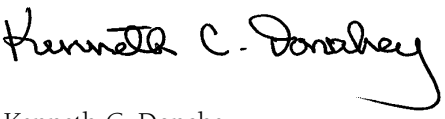
MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The consolidated financial statements included in this Annual Report have been prepared by management, which is responsible for the integrity and fair presentation of the financial data and related disclosures. The consolidated financial statements are presented in accordance with accounting principles generally accepted in the United States and include amounts that are based on management's estimates and assumptions. Management believes that the consolidated financial statements fairly reflect the Company's financial position and results of operations.

To gather and control financial data, the Company maintains accounting systems supported by internal controls that provide reasonable assurance over the preparation of reliable financial statements. Management believes that a high level of internal control is maintained by the selection and training of qualified personnel, by the establishment and communication of accounting and business policies, and by internal audits.

Ernst & Young LLP, the Company's independent auditors, are engaged to audit and to render an opinion as to whether the Company's financial statements, considered in their entirety, present the Company's financial condition and operating results fairly. Their audit is conducted in accordance with auditing standards generally accepted in the United States.

The Audit and Compliance Committee of the Board of Directors, composed of six outside directors, reviews the Company's accounting and auditing policies and meets regularly with the Company's Senior Vice President, Audit and Compliance, and the independent auditors.



Kenneth C. Donahey
Chairman, President and Chief Executive Officer

Michael J. Culotta
Chief Financial Officer

REPORT OF ERNST & YOUNG LLP, INDEPENDENT AUDITORS

To the Board of Directors and Stockholders
LifePoint Hospitals, Inc.

We have audited the accompanying consolidated balance sheets of LifePoint Hospitals, Inc. (the "Company") as of December 31, 2002 and 2003, and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2003. These financial statements are the responsibility of the management of the Company. Our responsibility is to express an opinion on these financial statements based on our audits.

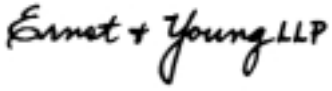
We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a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

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of LifePoint Hospitals, Inc. at December 31, 2002 and 2003, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2003, in conformity with accounting principles generally accepted in the United States.

As discussed in Note 1 to the consolidated financial statements, in 2002, the Company changed its method of accounting for certain intangible assets.

As discussed in Note 1 to the consolidated financial statements, the Company adopted Statement of Financial Accounting Standards No. 145, "Rescission of FASB Statements Nos. 4, 44 and 64, Amendment of FASB No. 13, and Technical Corrections," effective January 1, 2003 resulting in a reclassification of debt retirement costs from an extraordinary loss to a component of income before income taxes.

Nashville, Tennessee
February 13, 2004



LIFEPOINT HOSPITALS, INC.
CONSOLIDATED STATEMENTS OF INCOME

(Dollars in millions, except per share amounts)	Years Ended December 31, 2001	2002	2003
Revenues	$ 619.4	$ 743.6	$ 907.1
Salaries and benefits	243.2	291.4	365.0
Supplies	78.2	92.2	118.1
Other operating expenses	120.8	137.1	162.8
Provision for doubtful accounts	45.8	55.2	81.5
Depreciation and amortization	34.7	37.9	45.7
Interest expense, net	18.1	13.3	12.8
Debt retirement costs	2.6	31.0	–
ESOP expense	10.4	9.7	6.9
Gain on previously impaired assets	(0.5)	–	–
	553.3	667.8	792.8
Income before minority interests and income taxes	66.1	75.8	114.3
Minority interests in earnings of consolidated entities	2.7	2.2	0.7
Income before income taxes	63.4	73.6	113.6
Provision for income taxes	30.1	32.1	45.1
Net income	$ 33.3	$ 41.5	$ 68.5
Basic earnings per share	$ 0.93	$ 1.11	$ 1.84
Diluted earnings per share	$ 0.90	$ 1.07	$ 1.76

The accompanying notes are an integral part of the consolidated financial statements.

LIFEPOINT HOSPITALS, INC.
CONSOLIDATED BALANCE SHEETS

(Dollars in millions, except per share amounts)	December 31, 2002	2003
Assets		
Current assets:		
Cash and cash equivalents	$ 23.0	$ 20.6
Accounts receivable, less allowances for doubtful accounts of $109.1 and $111.7 at December 31, 2002 and 2003, respectively	85.0	101.4
Inventories	20.5	22.3
Income taxes receivable	–	7.4
Deferred income taxes and other current assets	14.8	19.5
	143.3	171.2
Property and equipment:		
Land	11.3	19.0
Buildings and improvements	285.3	357.1
Equipment	295.5	337.2
Construction in progress (estimated cost to complete and equip after December 31, 2003 — $88.2)	18.1	28.3
	610.2	741.6
Accumulated depreciation	(238.0)	(277.4)
	372.2	464.2
Deferred loan costs, net	8.6	7.0
Unallocated purchase price	136.1	16.4
Intangible assets, net	3.8	3.6
Goodwill	69.2	136.6
Other	0.3	–
	$ 733.5	$ 799.0
Liabilities and Equity		
Current liabilities:		
Accounts payable	$ 28.5	$ 30.9
Accrued salaries	24.4	25.7
Other current liabilities	14.3	9.7
Estimated third-party payor settlements	8.2	2.5
	75.4	68.8
Long-term debt	250.0	270.0
Deferred income taxes	24.9	35.9
Professional and general liability claims and other liabilities	25.6	28.6
Minority interest in equity of consolidated entity	–	1.4
Stockholders' equity:		
Preferred stock, $.01 par value; 10,000,000 shares authorized; no shares issued	–	–
Common stock, $.01 par value; 90,000,000 shares authorized; 39,550,540 shares and 39,084,396 shares issued at December 31, 2002 and 2003, respectively	0.4	0.4
Capital in excess of par value	297.2	301.7
Unearned ESOP compensation	(19.3)	(16.1)
Retained earnings	79.3	137.2
Less common stock in treasury, at cost, 1,198,800 shares at December 31, 2003	–	(28.9)
	357.6	394.3
	$ 733.5	$ 799.0

The accompanying notes are an integral part of the consolidated financial statements.

LIFEPOINT HOSPITALS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

(Dollars in millions)	Years Ended December 31, 2001	2002	2003
Cash flows from operating activities:			
Net income	$ 33.3	$ 41.5	$ 68.5
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	34.7	37.9	45.7
ESOP expense	10.4	9.7	6.9
Minority interests in earnings of consolidated entities	2.7	2.2	0.7
Deferred income taxes	6.9	3.0	8.9
Reserve for professional and general liability claims, net	7.0	9.2	2.4
Debt retirement costs	2.6	31.0	–
Tax benefit from stock option exercises	8.1	1.7	2.3
Increase (decrease) in cash from operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable	(1.0)	(16.9)	(15.9)
Inventories and other current assets	(0.6)	(3.2)	(4.8)
Accounts payable and accrued expenses	2.8	1.7	1.3
Income taxes payable	(3.5)	6.9	(7.5)
Estimated third-party payor settlements	9.6	(10.1)	(5.7)
Other	1.1	0.2	1.8
Net cash provided by operating activities	114.1	114.8	104.6
Cash flows from investing activities:			
Purchase of property and equipment, net	(35.8)	(60.7)	(70.2)
Purchase of facilities, net of cash acquired	(36.5)	(137.1)	(16.5)
Purchase of minority interest in joint venture	–	(25.0)	–
Other	4.0	(1.9)	0.7
Net cash used in investing activities	(68.3)	(224.7)	(86.0)
Cash flows from financing activities:			
Repurchases of common stock	–	–	(45.7)
Proceeds from issuance of convertible notes, net	–	242.5	–
Repurchase of senior subordinated notes	–	(176.5)	–
Proceeds from stock offering, net	100.4	–	–
Repayments of bank debt	(139.3)	–	–
Borrowings from bank credit facility	–	–	20.0
Proceeds from exercise of stock options	12.2	3.0	3.7
Proceeds from employee loan repayments	1.5	5.7	–
Other	(3.1)	1.0	1.0
Net cash (used in) provided by financing activities	(28.3)	75.7	(21.0)
Change in cash and cash equivalents	17.5	(34.2)	(2.4)
Cash and cash equivalents at beginning of year	39.7	57.2	23.0
Cash and cash equivalents at end of year	$ 57.2	$ 23.0	$ 20.6
Supplemental disclosure of cash flow information:			
Interest payments	$ 20.8	$ 16.3	$ 12.4
Capitalized interest	$ 0.7	$ 0.8	$ 0.8
Income taxes paid, net	$ 18.4	$ 21.0	$ 41.4

The accompanying notes are an integral part of the consolidated financial statements.

LIFEPOINT HOSPITALS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

(Amounts in millions)	Common Shares	Stock Amount	Capital In Excess of Par Value	Unearned ESOP Compensation	Notes Receivable for Shares Sold to Employees	Retained Earnings	Treasury Stock	Total
Balance at December 31, 2000	34.7	$ 0.3	$ 156.5	$ (25.7)	$ (7.2)	$ 4.5	$ –	$ 128.4
Net income	–	–	–	–	–	33.3	–	33.3
ESOP compensation earned	–	–	7.2	3.2	–	–	–	10.4
Exercise of stock options, including tax benefits and other	0.9	–	20.5	–	–	–	–	20.5
Stock issued in connection with employee stock purchase plans	–	–	0.5	–	–	–	–	0.5
Proceeds from employee loan repayments	–	–	–	–	1.5	–	–	1.5
Issuance of common stock from offering	3.7	0.1	100.3	–	–	–	–	100.4
Balance at December 31, 2001	39.3	0.4	285.0	(22.5)	(5.7)	37.8	–	295.0
Net income	–	–	–	–	–	41.5	–	41.5
ESOP compensation earned	–	–	6.5	3.2	–	–	–	9.7
Exercise of stock options, including tax benefits and other	0.3	–	4.7	–	–	–	–	4.7
Stock issued in connection with employee stock purchase plans	–	–	1.0	–	–	–	–	1.0
Proceeds from employee loan repayments	–	–	–	–	5.7	–	–	5.7
Balance at December 31, 2002	39.6	0.4	297.2	(19.3)	–	79.3	–	357.6
Net income	–	–	–	–	–	68.5	–	68.5
ESOP compensation earned	–	–	3.7	3.2	–	–	–	6.9
Exercise of stock options, including tax benefits and other	0.3	–	6.0	–	–	–	–	6.0
Stock activity in connection with employee stock purchase plans	0.1	–	1.3	–	–	(0.3)	–	1.0
Repurchases and retirement of common stock	(0.9)	–	(6.5)	–	–	(10.3)	–	(16.8)
Purchases of treasury stock at cost	(1.2)	–	–	–	–	–	(28.9)	(28.9)
Balance at December 31, 2003	37.9	$ 0.4	$ 301.7	$ (16.1)	$ –	$137.2	$ (28.9)	$394.3

The accompanying notes are an integral part of the consolidated financial statements.

1. Organization and Summary of Significant Accounting Policies

Organization

As of December 31, 2003, LifePoint Hospitals, Inc. (the "Company") operated 29 general, acute care hospitals with an aggregate of 2,737 licensed beds in non-urban communities. The Company's hospitals are located in the states of Alabama, Florida, Kansas, Kentucky, Louisiana, Tennessee, Utah, West Virginia and Wyoming.

The Company became independent and publicly traded on May 11, 1999 when HCA Inc. ("HCA") distributed all outstanding shares of the Company's common stock to its stockholders in a spin-off transaction.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through the Company's direct or indirect ownership of a majority interest and exclusive rights granted to the Company as the sole general partner of such entities. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation.

Fair Value of Financial Instruments

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

As of December 31, 2003, the Company had outstanding debt of $270.0 million, comprised of the $250.0 million of the Company's $4\frac{1}{2}\%$ Convertible Subordinated Notes due June 1, 2009 (the "Convertible Notes") and $20.0 million of indebtedness under the Company's revolving credit facility. As of December 31, 2003, the fair value of the Company's Convertible Notes was $251.9 million, based on the quoted market price at December 31, 2003. At December 31, 2003, the fair value of the indebtedness under the Company's revolving credit facility approximated the carrying value.

Revenue Recognition and Allowance for Contractual Discounts

The Company recognizes revenues in the period in which services are performed. Accounts receivable primarily consist of amounts due from third-party payors and patients. Amounts the Company receives for treatment of patients covered by governmental programs such as Medicare and Medicaid and other third-party payors such as health maintenance organizations, preferred provider organizations and other private insurers are generally less than the Company's established billing rates. Accordingly, the revenues and accounts receivable reported in the Company's consolidated financial statements are recorded at the amount expected to be received.

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

Settlements under reimbursement agreements with third-party payors are estimated and recorded in the period the related services are rendered and are adjusted in future periods as final settlements are determined. There is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The net adjustments to estimated third-party payor settlements resulted in increases to revenues of $2.0 million, $13.0 million and $6.0 million for the years ended December 31, 2001, 2002 and 2003, respectively. Management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs.

During the years ended December 31, 2001, 2002 and 2003, approximately 46.1%, 46.6% and 46.4%, respectively, of the Company's revenues related to patients participating in the Medicare and Medicaid programs. 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.

Management does not believe that there are any other significant concentrations of revenues from any particular payor that would subject the Company to any significant credit risks in the collection of its accounts receivable.

Laws and regulations governing Medicare and Medicaid programs are complex and subject to interpretation. The Company believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Company's financial statements. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

The Company's revenue is particularly sensitive to regulatory and economic changes in Kentucky and Tennessee. As of December 31, 2003, the Company operated 29 hospitals with eight located in the commonwealth of Kentucky and seven located in the state of Tennessee. The Company generated 39.2%, 38.0% and 33.3% of its revenue from its Kentucky hospitals (including 4.3%, 4.8% and 3.6% from state-sponsored Medicaid programs) and 22.3%, 23.6% and 19.8% from its Tennessee hospitals (including 2.9%, 3.1% and 2.7% from the state-sponsored TennCare program) for the years ended December 31, 2001, 2002 and 2003, respectively.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash on hand and marketable securities with original maturities of three months or less. The Company places its cash in financial institutions that are federally insured.

Accounts Receivable and Allowance for Doubtful Accounts

Accounts receivable primarily consist of amounts due from third-party payors and patients. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. To provide for accounts receivable that could become uncollectible in the future, the Company establishes an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. The primary uncertainty of such allowances lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients.

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

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

	Balances at Beginning of Period	Additions Charged to Costs and Expenses	Accounts Written off, Net of Recoveries	Acquisitions	Balances at End of Period
Allowance for doubtful accounts:					
Year ended December 31, 2001	$ 52.3	$ 45.8	$ (43.7)	$ 4.6	$ 59.0
Year ended December 31, 2002	59.0	55.2	(48.6)	43.5	109.1
Year ended December 31, 2003	109.1	81.5	(78.9)	–	111.7

Inventories

Inventories are stated at the lower of cost (first-in, first-out) or market.

Long-Lived Assets

(a) Property and Equipment. Property and equipment are stated at cost less accumulated depreciation. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase capacities or extend useful lives are capitalized. Depreciation is computed by applying the straight-line method over the estimated useful lives of buildings and improvements (10 to 40 years) and equipment (3 to 10 years). Interest on funds used to pay for the

construction of major capital additions is included in the cost of each capital addition. Depreciation expense was $33.0 million, $37.6 million and $45.0 million for the years ended December 31, 2001, 2002 and 2003, respectively.

The Company evaluates its long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows, in accordance with Statement of Financial Accounting Standards ("SFAS") No. 144. Fair value estimates are derived from independent appraisals, established market values of comparable assets, or internal calculations of estimated future net cash flows. The Company's estimates of future cash flows are based on assumptions and projections it believes to be reasonable and supportable. The Company's assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix, and changes in legislation and other payor payment patterns. These assumptions vary by type of facility.

(b) Goodwill and Intangible Assets. Under SFAS No. 142, Goodwill and Other Intangible Assets ("SFAS No. 142"), goodwill and intangible assets with indefinite lives are no longer amortized but are reviewed at least annually for impairment. The amortization provisions of SFAS No. 142 applied to goodwill and intangible assets acquired after June 30, 2001. With respect to goodwill and intangible assets acquired prior to July 1, 2001, the Company adopted SFAS No. 142, effective January 1, 2002. Pursuant to SFAS No. 142, the Company completed its transition impairment tests of goodwill during the second quarter of 2002 and did not incur an impairment charge. The Company also performed its annual impairment tests as of October 1, 2002 and 2003 and did not incur an impairment charge.

The Company's intangible assets relate to non-competition agreements and certificates of need. Non-competition agreements are amortized over the terms of the agreements. The certificates of need were determined to have indefinite lives by an independent appraiser and, accordingly, are not amortized. See Note 3 for a summary of goodwill and intangible assets and the effects of adopting SFAS No. 142.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income. To the extent the Company believes that recovery is not likely, a valuation allowance is established. To the extent the Company establishes a valuation allowance or increases this allowance, the Company must include an expense within the provision for income taxes in the consolidated statements of income.

Professional and General Liability Claims

Given the nature of the Company's operating environment, the Company is subject to potential medical malpractice lawsuits and other claims. To mitigate a portion of this risk, the Company maintained insurance for individual malpractice claims exceeding $1.0 million for 2001. For 2002, the Company increased its self-insured retention level to $10.0 million on individual malpractice claims. For 2003, the Company lowered its self-insured retention level to $5.0 million on individual malpractice claims and for 2004, the Company increased its self-insured retention level back up to $10.0 million. The Company's reserves for professional and general liability claims are based upon independent actuarial calculations, which consider historical claims data, demographic considerations, severity factors, industry trends and other actuarial assumptions in the determination of reserve estimates. This estimate is discounted to its present value using a 5.0% rate.

The Company implemented enhanced risk management processes in monitoring claims and managing losses in high-risk areas during 2002 and 2003 to attempt to reduce loss levels and appropriately manage risk. During 2003, the Company improved its estimation process for determining its reserves for professional and general liability claims by expanding from using one actuary to using multiple actuaries. The Company uses the calculations of each actuary by averaging each actuary's results into the determination of its recorded reserve levels. This averaging process results in a refined estimation approach that the Company believes produces a more reliable estimate of ultimate losses. Based

upon using multiple actuarial valuations performed using recent loss information, the change in the estimation process during 2003 decreased the Company's reserves for professional and general liability claims and the Company's cost for professional and general liability claims by approximately $7.4 million on a pre-tax basis, or $0.10 per diluted share. Of the $7.4 million reduction, $4.8 million relates to estimates for losses prior to 2003 and $2.6 million relates to losses for 2003.

Actuarial calculations include a large number of variables that may significantly impact the estimate of ultimate losses that are recorded during a reporting period. Professional judgment is used by each actuary in determining the loss estimates by selecting factors that are considered appropriate by the actuary for the Company's specific circumstances. Changes in assumptions used by the Company's actuaries with respect to demographics, industry trends and judgmental selection of factors may impact the Company's recorded reserve levels.

The reserve for professional and general liability claims as of the balance sheet date reflects the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The reserve for professional and general liability claims was $25.1 million and $27.5 million at December 31, 2002 and 2003, respectively.

The Company's cost for professional and general liability claims 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 level; the administrative costs of the insurance program; and interest expense related to the discounted portion of the liability. The total cost of professional and general liability claims for the years ended December 31, 2001, 2002 and 2003 was approximately $11.4 million, $12.9 million and $9.8 million, respectively.

Physician Recruiting Costs

Physician recruiting costs are expensed when incurred and are included in other operating expenses in the accompanying consolidated statements of income. Physician recruiting expenses were $6.4 million, $6.5 million and $13.0 million for the years ended December 31, 2001, 2002 and 2003, respectively. See Note 7 for a discussion on the Company's commitments to advance amounts to recruited physicians.

Comprehensive Income

SFAS No. 130, Reporting Comprehensive Income, requires that changes in certain amounts that are recorded directly to stockholders' equity be shown in the financial statements as a component of comprehensive income. For the years ended December 31, 2001, 2002 and 2003, the Company had no items of comprehensive income recorded directly to stockholders' equity. Therefore, comprehensive income is equivalent to net income.

Segment Reporting

The Company's business of providing healthcare services to patients comprises a single reportable operating segment under SFAS No. 131, Disclosures About Segments of an Enterprise and Related Information.

Stock-Based Compensation

In January 2003, the Financial Accounting Standards Board ("FASB") issued SFAS No. 148, Accounting for Stock-Based Compensation – Transition and Disclosure, an Amendment of FASB Statement No. 123. SFAS No. 148 amends SFAS No. 123, Accounting for Stock-Based Compensation, to provide alternative methods of transition for a voluntary change to the fair-value based method of accounting for stock-based employee compensation. In addition, SFAS No. 148 amends the disclosure requirements of SFAS No. 123 to require prominent disclosures in both annual and interim financial statements about the method of accounting for stock-based employee compensation and the effect of the method used on reported results. SFAS No. 148 has no material impact on the Company, because the Company does not plan to adopt the fair-value method of accounting for stock options at the current time. The Company has included the required disclosures below and in Note 6.

The Company issues stock options and other stock-based awards to key employees and directors as more fully described in Note 6. SFAS No. 123, Accounting for Stock-Based Compensation, encourages, but does not require,

companies to record compensation cost for stock-based employee compensation plans at fair value. The Company has chosen to continue to account for employee stock-based compensation using the intrinsic value method as prescribed in Accounting Principles Board ("APB") Opinion No. 25, Accounting for Stock Issued to Employees, and related FASB Interpretations, under which no compensation cost related to stock plans has been recognized in net income for the years ended December 31, 2001, 2002 and 2003.

The following table illustrates the effect on net income and earnings per share if the Company had applied the fair value recognition provisions of SFAS No. 123 to stock-based compensation for the years ended December 31, 2001, 2002 and 2003 (dollars in millions, except per share amounts):

	2001	2002 [a]	2003
Net income, as reported	$ 33.3	$ 41.5	$ 68.5
Less stock-based compensation expense determined under fair value based method for all awards, net of related tax effects	(4.5)	(8.2)	(9.0)
Pro forma net income	28.8	33.3	59.5
Interest on Convertible Notes, net of taxes	–	–	7.8
Diluted pro forma net income	$ 28.8	$ 33.3	$ 67.3
Denominator for basic earnings per share – weighted average shares	35.7	37.5	37.2
Effect of dilutive securities:			
Employee stock options	1.3	1.0	0.7
Convertible Notes	–	–	5.3
Other	0.1	0.1	0.1
Denominator for diluted earnings per share – adjusted weighted average shares	37.1	38.6	43.3
Earnings per share:			
Basic – as reported	$ 0.93	$ 1.11	$ 1.84
Basic – pro forma	$ 0.81	$ 0.89	$ 1.60
Diluted – as reported	$ 0.90	$ 1.07	$ 1.76
Diluted – pro forma	$ 0.78	$ 0.86	$ 1.56

(a) The impact of 3.3 million potential weighted average shares of common stock, if converted, and interest expense related to the Convertible Notes was not included in the computation of diluted earnings per share and pro forma diluted earnings per share because the effect would have been anti-dilutive.

The per share weighted-average fair value of stock options granted during 2001, 2002 and 2003 was $15.25, $13.99 and $8.02, respectively, on the date of grant using a Black-Scholes option pricing model, assuming no expected dividends and the following weighted average assumptions:

	2001	2002	2003
Risk free interest rate	4.51%	3.51%	1.90%
Expected life, in years	4.0	3.0	3.0
Expected volatility	45.0%	53.0%	53.0%

Earnings Per Share

Earnings per share ("EPS") is based on the weighted average number of common shares outstanding and dilutive stock options, convertible notes and restricted shares, adjusted for the shares issued to the LifePoint Employee Stock Ownership Plan (the "ESOP"). As the ESOP shares are committed to be released, the shares become outstanding for EPS calculations. In addition, the numerator, net income, is adjusted for interest expense related to the Convertible Notes.

Use of Estimates

The preparation of the accompanying consolidated financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation.

Recently Issued Accounting Pronouncements

The Company adopted SFAS No. 145 effective January 1, 2003, which required a reclassification of debt retirement costs from an extraordinary loss to a component of income before income taxes. In April 2002, the FASB issued SFAS No. 145, "Rescission of FASB Statement Nos. 4, 44 and 64, Amendment of FASB Statement No. 13, and Technical Corrections" ("SFAS No. 145"). Under certain provisions of SFAS No. 145, gains and losses related to the early extinguishment of debt are no longer segregated on the income statement as extraordinary items net of the effect of income taxes. Instead, these gains and losses are included as a component of income before income taxes. The provisions of SFAS No. 145 were effective for fiscal years beginning after May 15, 2002. Any gain or loss on early extinguishment of debt that was classified as an extraordinary item in prior periods presented that did not meet the criteria in APB Opinion No. 30 for classification as an extraordinary item was reclassified upon adoption.

In January 2003, the FASB issued Interpretation No. 46, "Consolidation of Variable Interest Entities" ("FIN 46"), which requires the consolidation of variable interest entities. FIN 46, as revised, is applicable to financial statements of companies that have interests in "special purpose entities," during 2003. Effective as of the first quarter of 2004, FIN 46 is applicable to financial statements of companies that have interests in all other types of entities. However, disclosures are required currently if the Company expects to consolidate any variable interest entities. The Company does not currently believe that any material entities will be consolidated as a result of FIN 46.

In May 2003, the FASB issued SFAS No 149, "Amendment of Statement 133 on Derivative Instruments and Hedging Activities" ("SFAS No. 149"). SFAS No. 149 amends and clarifies financial accounting and reporting for derivative instruments and hedging activities. SFAS No. 149 was effective for contracts entered into or modified after June 30, 2003. The Company does not expect SFAS No. 149 to have a material impact on its future results of operations or financial position.

The Company adopted SFAS No. 150, "Accounting for Certain Financial Instruments with Characteristics of both Liabilities and Equity" ("SFAS No. 150"), on July 1, 2003. SFAS No. 150 establishes standards for classifying and measuring as liabilities certain financial instruments that embody obligations of the issuer and have characteristics of both liabilities and equity, such as redeemable preferred stock and certain equity derivatives that frequently are used in connection with share repurchase programs. The Company's adoption of SFAS No. 150 did not have a material impact on its results of operation or financial position. On October 29, 2003, the FASB voted to defer for an indefinite period the application of SFAS No. 150 to classification of noncontrolling interests of limited-life subsidiaries. Neither the adoption of SFAS No. 150 nor the deferral had a material impact on the Company's results of operations or financial position.

2. Acquisitions

Acquisition – 2003. Effective October 1, 2003, the Company acquired Spring View Hospital, a 75-bed acute care hospital located in Lebanon, Kentucky. The acquisition also included 38-bed Spring View Nursing Home and Spring View Pediatrics. The consideration for this acquisition was $15.8 million, which consisted of $15.5 million in cash paid at the closing and a $0.3 million net working capital payable. The net working capital payable was accrued as of December 31, 2003 on the accompanying consolidated balance sheet in other current liabilities. The Company used its available cash to pay for this acquisition. Unallocated purchase price of approximately $16.4 million is included in the accompanying balance sheet as of December 31, 2003, pending a final appraisal from an independent third party. In addition, the allocation of the purchase price is subject to settling amounts related to purchased working capital.

Acquisitions – 2002. Effective December 1, 2002, the Company acquired Northwest Medical Center, a 71-bed acute care hospital located in Winfield, Alabama, and Burdick-West Medical Center (now known as Lakeland Community Hospital), a 99-bed acute care hospital located in Haleyville, Alabama. The consideration for both hospitals totaled

$29.5 million, including $6.5 million for net working capital. The consideration consisted of $28.7 million in cash and $0.8 million in assumed liabilities. The Company used its available cash to fund this acquisition. Goodwill totaled approximately $4.2 million, all of which is expected to be deductible for tax purposes.

Effective December 1, 2002, the Company acquired Logan General Hospital (now known as Logan Regional Medical Center), a 132-bed acute care hospital and Guyan Valley Hospital, a 19-bed critical access hospital both located in Logan, West Virginia. The consideration for both hospitals totaled $89.4 million, which consisted of $87.5 million in cash and $1.9 million related to the net working capital payable. The Company accrued $1.9 million as of December 31, 2003 for the net working capital settlement payable to the seller on the accompanying consolidated balance sheet in accounts payable. The Company anticipates a final net working capital settlement during 2004. The Company used its available cash to fund this acquisition. Goodwill totaled approximately $56.2 million, all of which is expected to be deductible for tax purposes.

Effective October 3, 2002, the Company acquired Russellville Hospital, a 100-bed acute care hospital located in Russellville, Alabama. The consideration for this hospital was $19.8 million in cash. The Company used its available cash to fund this acquisition. Goodwill totaled approximately $7.0 million, all of which is expected to be deductible for tax purposes.

The Company's motivation to acquire Northwest Medical Center, Lakeland Community Hospital and Russellville Hospital was to expand the Company's presence in Alabama. It was also expected that a combined strategy for recruitment of various physician specialties could be achieved. In addition, some managerial positions have been combined for purposes of enhanced operational efficiencies. The Company acquired Logan Regional Medical Center and Guyan Valley Hospital to enter the West Virginia market. The Company's strategy is to expand healthcare services in Logan and southern West Virginia.

In October 2002, the Company purchased the outstanding 30% limited partner interest in Dodge City Healthcare Group, L.P., the entity that owns and operates 110-bed Western Plains Regional Hospital in Dodge City, Kansas, for $25.0 million in cash. The Company used its available cash to fund this acquisition. Under the terms of the purchase agreement, the Company's former limited partners have agreed not to compete with the hospital for five years. The non-competition agreements have been valued by an independent third party at $4.0 million and are being amortized over the life of the agreements. Goodwill totaled approximately $16.3 million, all of which is expected to be deductible for tax purposes.

Intangible assets in the aggregate for acquisitions in 2002 totaled $0.5 million and relate to certificates of need issued by the states where we acquired hospitals. See Note 3 for a discussion of these intangible assets.

Acquisitions – 2001. Effective December 1, 2001, the Company acquired Ville Platte Medical Center, a 116-bed acute care hospital located in Ville Platte, Louisiana. The consideration for this hospital was $15.1 million. The consideration consisted of $11.1 million in cash and $4.0 million in assumed liabilities. The Company used its available cash to fund this acquisition. Goodwill totaled approximately $4.1 million and of that amount, $2.3 million is expected to be deductible for tax purposes.

Effective October 1, 2001, the Company acquired Athens Regional Medical Center in Athens, Tennessee. The consideration for this hospital was $19.8 million in cash, including $2.8 million for net working capital. The Company used its available cash to fund this acquisition. Goodwill totaled approximately $0.5 million and $0.2 million is expected to be deductible for tax purposes.

Effective April 1, 2001, the Company purchased a diagnostic imaging center in Palatka, Florida. The consideration for this facility was $5.7 million in cash. The Company used its available cash to fund this acquisition. Goodwill totaled $1.8 million and of that amount, $1.7 million is expected to be deductible for tax purposes.

Effective January 2, 2001, the Company entered into a lease to operate Bluegrass Community Hospital, a 25-bed critical access hospital located in Versailles, Kentucky, which the parties mutually agreed to extend until December 31, 2004.

Allocations of Purchase Price

The above acquisitions were accounted for using the purchase method of accounting. The purchase prices of these transactions were allocated to the assets acquired and liabilities assumed based upon their respective fair values and are subject to change during the twelve month period subsequent to the acquisition date. The operating results of the above facilities have been included in the accompanying consolidated statements of income from the date of each

respective facility's acquisition. The following table summarizes the allocations of the aggregate purchase price of the acquisitions, including assumed liabilities and direct transaction costs, excluding the purchase of the remaining 30% interest in Dodge City Healthcare Group, L.P., for the years ended December 31, 2001, 2002 and 2003 (in millions):

	2001	2002	2003
Fair value of assets acquired, excluding cash:			
Accounts receivable, net	$ 5.5	$ 11.9	$ –
Other current assets	1.5	2.3	0.5
Property and equipment	28.4	68.4	–
Intangible assets	–	0.5	–
Goodwill	6.4	67.4	–
Unallocated purchase price	–	–	16.4
	$ 41.8	$ 150.5	$ 16.9

Pro forma Results of Operations

The following unaudited pro forma results of operations give effect to the operations of the hospitals acquired during the years ended December 31, 2001 and 2002 as if the respective transactions had occurred as of the first day of the year immediately preceding the year of the acquisitions (in millions, except per share data):

	2001	2002
Revenues	$ 796.7	$ 864.4
Net income	$ 33.3	$ 40.9
Basic earnings per share	$ 0.93	$ 1.09
Diluted earnings per share	$ 0.90	$ 1.06

The pro forma results of operations do not purport to represent what the Company's results of operations would have been had such transactions occurred at the beginning of the periods presented or to project the Company's results of operations in any future period. The pro forma results of operations for the 2003 acquisition of Spring View Hospital were not included in the above table because it was not material.

3. Goodwill and Intangible Assets

As of January 1, 2002, the Company adopted SFAS No. 142. The table below shows the Company's net income for the year ended December 31, 2001, adjusted for the cessation of goodwill amortization required by SFAS No. 142 as if it had occurred as of January 1, 2001 (dollars in millions except per share amounts):

	2001
Net income, as reported	$ 33.3
Goodwill amortization, net of applicable income tax benefits	1.3
Adjusted net income	$ 34.6
Basic earnings per share, as reported	$ 0.93
Goodwill amortization, net of applicable income tax benefits	0.03
Adjusted basic earnings per share	$ 0.96
Diluted earnings per share, as reported	$ 0.90
Goodwill amortization, net of applicable income tax benefits	0.03
Adjusted diluted earnings per share	$ 0.93

Amortization expense related to goodwill for the year ended December 31, 2001 was $1.6 million.

Pursuant to SFAS No. 142, the Company completed its transition impairment tests of goodwill during the second quarter of 2002 and did not incur an impairment charge. The Company also performed its annual impairment tests as of October 1, 2002 and 2003 and did not incur an impairment charge.

The following table presents the changes in the carrying amount of goodwill for the years ended December 31, 2002 and 2003 (in millions):

Balance at December 31, 2001	$ 47.1
Finalization of purchase price allocations for certain acquisitions completed in 2001	22.1
Balance at December 31, 2002	69.2
Consideration adjustments and finalization of purchase price allocations for acquisitions completed in 2002	67.4
Balance at December 31, 2003	$ 136.6

The following table provides information regarding the Company's intangible assets, which are included in the accompanying consolidated balance sheets at December 31 (in millions):

	Gross Carrying Amount		Accumulated Amortization	
Class of Intangible Asset	2002	2003	2002	2003
Non-competition agreements	$ 4.2	$ 4.2	$ 0.4	$ 1.1
Certificates of need	–	0.5	–	–
Total	$ 4.2	$ 4.7	$ 0.4	$ 1.1

In connection with the Company's finalization of purchase price allocations for acquisitions completed prior to 2003, an aggregate of $0.5 million was allocated to intangible assets. These intangible assets represent the certificates of need issued by state governments to the hospitals acquired by the Company. An independent appraiser valued each certificate of need. In addition, these intangible assets were determined to have indefinite lives and accordingly, are not amortized.

Approximately $4.0 million of the gross carrying amount of the non-competition agreements is related to the Company's purchase of the outstanding 30% limited partnership interest in Dodge City Healthcare Group, L.P., as discussed in Note 2. Amortization expense related to the non-competition agreements for the years ended December 31, 2001, 2002 and 2003 was $0.1 million, $0.3 million and $0.7 million, respectively. The Company estimates amortization expense for these intangible assets to approximate $0.8 million for each of the years ending December 31, 2004, 2005 and 2006, and $0.7 million for the year ending December 31, 2007. The non-competition agreements are amortized on a straight-line basis over the five-year length of the agreements.

4. Income Taxes

The provision for income taxes for the years ended December 31, 2001, 2002 and 2003 consists of the following (in millions):

	2001	2002	2003
Current:			
Federal	$ 21.8	$ 26.7	$ 33.4
State	1.4	2.4	2.8
	23.2	29.1	36.2
Deferred:			
Federal	5.6	1.0	9.7
State	(0.1)	1.2	(1.3)
	5.5	2.2	8.4
Increase in valuation allowance	1.4	0.8	0.5
Total	$ 30.1	$ 32.1	$ 45.1

The increases in the valuation allowance are primarily the result of state net operating loss carryforwards that management believes may not be fully utilized because of the uncertainty regarding the Company's ability to generate taxable income in certain states. Various subsidiaries have state net operating loss carryforwards in the aggregate of approximately $85.9 million (primarily in the states of Florida, Tennessee and West Virginia) with expiration dates through the year 2023.

The Company generated a federal net operating loss of approximately $8.4 million for the year ended December 31, 2000, which was fully utilized in 2001.

A reconciliation of the statutory federal income tax rate to the Company's effective income tax rate on income before income taxes for the years ended December 31, 2001, 2002 and 2003 follows:

	2001	2002	2003
Federal statutory rate	35.0%	35.0%	35.0%
State income taxes, net of federal income tax benefit	3.7	3.3	2.4
ESOP expense	4.8	3.2	1.2
Non-deductible intangible assets	0.5	–	–
Valuation allowance	0.3	1.1	0.5
Other items, net	3.2	0.9	0.6
Effective income tax rate	47.5%	43.5%	39.7%

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

	2002	2003
Deferred tax liabilities:		
Depreciation and amortization	$ (41.2)	$ (46.2)
Prepaid expenses	(2.7)	(3.7)
Other	(3.7)	(7.9)
Total deferred tax liabilities	(47.6)	(57.8)
Deferred tax assets:		
Provision for doubtful accounts	14.0	13.3
Employee compensation	3.3	3.6
Professional liability	12.5	14.1
Other	4.7	5.3
Total deferred tax assets	34.5	36.3
Valuation allowance	(3.5)	(4.0)
Net deferred tax assets	31.0	32.3
Net deferred tax liabilities	$ (16.6)	$ (25.5)

The balance sheet classification of deferred income tax assets (liabilities) at December 31 is as follows (in millions):

	2002	2003
Current	$ 8.3	$ 10.4
Long-term	(24.9)	(35.9)
Total	$ (16.6)	$ (25.5)

The Company had a net income tax payable of $0.1 million as of December 31, 2002, which is included in other current liabilities in the accompanying consolidated balance sheet. At December 31, 2003, the Company's income

taxes receivable balance was $7.4 million. The tax benefits associated with the exercise of stock options were $8.1 million, $1.7 million and $2.3 million for the years ended December 31, 2001, 2002 and 2003, respectively. These tax benefits reduced current taxes payable and increased capital in excess of par value.

During 2003, the Internal Revenue Service ("IRS") notified the Company regarding its findings related to the examination of the Company's tax returns for the years ended December 31, 1999, 2000 and 2001. The Company reached a partial settlement with the IRS on all issues except for the Company's method of determining its bad debt deduction for which the IRS has proposed an additional assessment of $7.4 million. All of the adjustments proposed by the IRS are temporary differences. The IRS has delayed final settlement of this assessment until resolution of certain pending court proceedings related to the use of this bad debt deduction method by another hospital company. The Company applied its 2002 federal income tax refund in the amount of $6.6 million as a deposit against any potential settlement to forestall the tolling of interest on such settlement beyond the March 15, 2003 deposit date. Management believes that adequate provisions have been reflected in the consolidated financial statements to satisfy final resolution of the remaining disputed issue based upon current facts and circumstances.

HCA and the Company entered into a tax sharing and indemnification agreement as part of the 1999 spin-off transaction. Under the agreement, HCA maintains full control and absolute discretion with regard to any combined or consolidated tax filings for periods prior to the 1999 spin-off transaction. In addition, the agreement provides that HCA will generally be responsible for all taxes that are allocable to periods prior to the 1999 spin-off transaction and HCA and the Company will each be responsible for its own tax liabilities for periods after the 1999 spin-off transaction.

The tax sharing and indemnification agreement does not have an impact on the realization of deferred tax assets or the payment of deferred tax liabilities of the Company, except to the extent that the temporary differences give rise to such deferred tax assets and liabilities after the 1999 spin-off transaction and are adjusted as a result of final tax settlements after the 1999 spin-off transaction. In the event of such adjustments, the tax sharing and indemnification agreement provides for certain payments between HCA and the Company, as appropriate.

5. Long-Term Debt

Long-term debt consists of the following at December 31 (in millions):

	2002	2003
Bank Credit Agreement	$ –	$ 20.0
Convertible Notes	250.0	250.0
	250.0	270.0
Less current maturities	–	–
	$ 250.0	$ 270.0

Maturities of the Company's long-term debt at December 31, 2003 were as follows (in millions):

2004, 2005	$ —
2006	20.0
2007, 2008	—
Thereafter	250.0
	$ 270.0

Bank Credit Agreement

In June 2001, the Company completed a $200 million, five-year amended and restated credit agreement (the "2001 Agreement") with a syndicate of lenders, which increased the available credit under the revolving credit agreement from $65 million to $200 million and expires in June 2006. As of December 31, 2003, the Company had indebtedness of $20.0 million under the 2001 Agreement and $13.6 million in letters of credit outstanding, leaving $166.4 million available under the 2001 Agreement. Of the $13.6 million in letters of credit outstanding as of December 31, 2003, $13.4 million was related to the self-insured retention levels of the Company's professional and general liability insurance program as security for the payment of claims and $0.2 million was related to certain utility

companies. The Company repaid its $20.0 million of indebtedness under the 2001 Agreement in February 2004 with its available cash.

The applicable interest rate under the 2001 Agreement is based on a rate, at the Company's option, equal to either (i) LIBOR plus a margin ranging from 1.25% to 2.25% or (ii) prime plus a margin ranging from 0% to 0.5%, both depending on the Company's consolidated total debt to consolidated EBITDA ratio, as defined in the 2001 Agreement, for the most recent four quarters. The Company also pays a commitment fee ranging from 0.3% to 0.5% of the average daily unused balance. The applicable commitment fee rate is based on the Company's consolidated total debt to consolidated EBITDA ratio, as defined, for the most recent four quarters. The interest rate under the 2001 Agreement was 4.0% at December 31, 2003.

Obligations under the 2001 Agreement are guaranteed by substantially all of the Company's current and future subsidiaries and are secured by substantially all of the assets of the Company and its subsidiaries and the stock of the Company's subsidiaries. The 2001 Agreement requires that the Company comply with various financial ratios and tests and contains covenants, including, but not limited to, restrictions on new indebtedness, the ability to merge or consolidate, asset sales, capital expenditures and dividends, for which the Company is in compliance as of December 31, 2003.

Convertible Notes

Effective May 22, 2002, the Company sold $250 million of Convertible Subordinated Notes due June 1, 2009 (the "Convertible Notes"). The net proceeds were approximately $242.5 million and were used for acquisitions, capital improvements at the Company's existing facilities, repurchases of the Company's $10^{3}/_{4}$% Senior Subordinated Notes discussed below, working capital and general corporate purposes. The Convertible Notes bear interest at the rate of $4^{1}/_{2}$% per year, payable semi-annually on June 1 and December 1. The Convertible Notes are convertible at the option of the holder at any time on or prior to maturity into shares of the Company's common stock at a conversion price of $47.36 per share. The conversion price is subject to adjustment in certain circumstances. The Company may redeem all or a portion of the Convertible Notes on or after June 3, 2005, at the then current redemption prices, plus accrued and unpaid interest. Holders of the Convertible Notes may require the Company to repurchase all of the holder's Convertible Notes at 100% of their principal amount plus accrued and unpaid interest in some circumstances involving a change of control. The Convertible Notes are unsecured and subordinated to the Company's existing and future senior indebtedness and senior subordinated indebtedness. The Convertible Notes rank junior to the Company's liabilities. The indenture does not contain any financial covenants. A total of 5,278,825 shares of common stock have been reserved for issuance upon conversion of the Convertible Notes.

Senior Subordinated Notes

During 2002, the Company repurchased its $150.0 million $10^{3}/_{4}$% Senior Subordinated Notes and paid $26.5 million in premiums, commissions and fees on these repurchases. In connection with these repurchases, the Company recorded debt retirement costs in the year ended December 31, 2002 of $31.0 million.

Deferred Loan Costs

The Company incurred loan costs of approximately $1.9 million and $7.5 million during 2001 and 2002, respectively. The Company capitalized such costs and is amortizing these costs to interest expense over the terms of the related debt (five years for the 2001 Agreement and seven years for the Convertible Notes). The interest expense related to deferred loan cost amortization was approximately $1.2 million, $1.4 million and $1.6 million during 2001, 2002, and 2003, respectively. During 2002, as a result of the repurchase of the $10^{3}/_{4}$% Senior Subordinated Notes, the Company expensed the remaining deferred loan costs of $4.5 million attributable to the $10^{3}/_{4}$% Senior Subordinated Notes as part of the debt retirement costs in the consolidated income statements. Upon consummation of the 2001 Agreement, the Company wrote off $2.6 million of net deferred loan costs related to its original credit agreement, which resulted in a $2.6 million charge to debt retirement costs in 2001.

6. Stockholders' Equity

Preferred Stock

The Company's certificate of incorporation provides up to 10,000,000 shares of preferred stock may be issued, of which 90,000 shares have been designated as Series A Junior Participating Preferred Stock, par value $.01 per share. The board of directors has the authority to issue preferred stock in one or more series and to fix for each series the voting powers (full, limited or none), and the designations, preferences and relative, participating, optional or other special rights and qualifications, limitations or restrictions on the stock and the number of shares constituting any series and the designations of this series, without any further vote or action by the stockholders. Because the terms of the preferred stock may be fixed by the board of directors without stockholder action, the preferred stock could be issued quickly with terms calculated to defeat a proposed takeover or to make the removal of the Company's management more difficult.

Preferred Stock Purchase Rights

Pursuant to the Company's stockholders' rights plan, each outstanding share of common stock is accompanied by one preferred stock purchase right. Each right entitles the registered holder to purchase one one-thousandth of a share of Series A preferred stock at a price of $35 per one one-thousandth of a share, subject to adjustment.

Each share of Series A preferred stock will be entitled, when, as and if declared, to a preferential quarterly dividend payment in an amount equal to the greater of $10 or 1,000 times the aggregate of all dividends declared per share of common stock. In the event of liquidation, dissolution or winding up, the holders of Series A preferred stock will be entitled to a minimum preferential liquidation payment equal to $1,000 per share, plus an amount equal to accrued and unpaid dividends and distributions on the stock, whether or not declared, to the date of such payment, but will be entitled to an aggregate payment of 1,000 times the payment made per share of common stock. The rights are not exercisable until the rights distribution date as defined in the stockholders' rights plan. The rights will expire on May 7, 2009, unless the expiration date is extended or unless the rights are earlier redeemed or exchanged.

The rights have certain anti-takeover effects. The rights will cause substantial dilution to a person or group that attempts to acquire the Company on terms not determined by the board of directors to be in the best interests of all stockholders. The rights should not interfere with any merger or other business combination approved by the board of directors.

Common Stock

Holders of the Company's common stock are entitled to one vote for each share held of record on all matters on which stockholders may vote. There are no preemptive, conversion, redemption or sinking fund provisions applicable to our common stock. In the event of liquidation, dissolution or winding up, holders of common stock are entitled to share ratably in the assets available for distribution, subject to any prior rights of any holders of preferred stock then outstanding.

Share Repurchase Program

In April 2003, the Company's Board of Directors authorized the repurchase of up to $100 million of outstanding shares of the Company's common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other factors, to enable it to take advantage of opportunistic market conditions. This stock repurchase program was publicly announced on April 28, 2003. The Company is not obligated to repurchase any specific number of shares under the program. The expiration date under the program is October 28, 2004. As of December 31, 2003, the Company repurchased 2,062,400 shares for an aggregate of approximately $45.7 million. Certain of these shares are designated by the Company as treasury stock. The Company retired 863,600 of its 2,062,400 treasury shares during 2003 at a cost of $16.8 million, leaving 1,198,800 shares in treasury at a cost of $28.9 million as of December 31, 2003.

The Company may continue to execute share repurchases from time to time in order to take advantage of attractive share price levels, as determined by its management. The timing and terms of the transactions depend on market conditions, its liquidity and other considerations. The following table summarizes the Company's share repurchase activity by month:

Period	Total Number of Shares Purchased	Average Price Paid Per Share	Total Number of Shares Purchased as Part of a Publicly Announced Program	Approximate Dollar Value of Shares That May Yet Be Purchased Under the Program (in millions)
May 2003	863,600	$ 19.43	863,600	$ 83.2
June 2003	10,200	19.70	10,200	83.0
September 2003	450,000	24.31	450,000	72.1
October 2003	738,600	23.92	738,600	54.3
Total	2,062,400	$ 22.10	2,062,400	$ 54.3

2001 Secondary Offering

In March 2001, the Company completed its public offering of 3,680,000 shares of common stock at an offering price of $29.00 per share. The net proceeds from the offering of approximately $100.4 million were used to reduce debt.

ESOP Compensation

In connection with the 1999 spin-off transaction, the Company established the ESOP, a defined contribution retirement plan, which covers substantially all employees. The ESOP purchased from the Company approximately 8.3% of the Company's common stock at fair market value (approximately 2.8 million shares at $11.50 per share). The purchase was primarily financed by the ESOP issuing a promissory note to the Company, which will be repaid annually in equal installments over a 10-year period beginning December 31, 1999. The Company makes contributions to the ESOP which the ESOP uses to repay the loan. The Company's stock acquired by the ESOP is held in a suspense account and will be allocated to participants at book value from the suspense account as the loan is repaid over a 10-year period.

The loan to the ESOP is recorded as unearned ESOP compensation in the accompanying consolidated balance sheets. Reductions are made to unearned ESOP compensation as shares are committed to be released to participants at cost. Shares are deemed to be committed to be released ratably during each period as the employees perform services. Shares are allocated ratably to employee accounts over a period of 10 years (1999 through 2008). ESOP expense is recognized using the average market price of shares committed to be released to participants during the accounting period with any difference between the average market price and the cost being charged or credited to capital in excess of par value. As the shares are committed to be released, the shares become outstanding for earnings per share calculations. The non-cash ESOP expense was $10.4 million, $9.7 million and $6.9 million for the years ended December 31, 2001, 2002 and 2003, respectively. The ESOP expense tax deduction is fixed at $3.2 million per year. The fair value of unreleased shares was $41.2 million at December 31, 2003.

The ESOP shares as of December 31, 2003 were as follows:

Allocated shares	1,264,008
Shares committed to be released	134,352
Unreleased shares	1,398,359
Total ESOP shares	2,796,719

Executive Stock Purchase Plan

The Company adopted the Executive Stock Purchase Plan in 1999, in which 1,000,000 shares of the Company's common stock were reserved and issued in 1999. The Executive Stock Purchase Plan granted a right to specified executives of the Company to purchase shares of common stock from the Company. The Company loaned each participant in the plan 100% of the purchase price of the Company's common stock at the fair value based on the date of purchase (approximately $10.2 million), on a full recourse basis at interest rates ranging from 5.2% to 5.3%. The loans are reflected as notes receivable for shares sold to employees in the accompanying consolidated statements of stockholders' equity. During the years ended December 31, 2001 and 2002, the Company's executives repaid $1.5 million and $5.7 million of such loans, respectively, which were fully repaid as of December 31, 2002.

Management Stock Purchase Plan

The Company has a Management Stock Purchase Plan which provides to certain designated employees an opportunity to purchase restricted shares of the Company's common stock at a discount through payroll deductions over six month intervals. Shares of the Company's common stock reserved for this plan were 250,000 at December 31, 2003. Approximately 21,000, 19,000 and 32,000 restricted shares were issued to employees during the years ended December 31, 2001, 2002 and 2003, respectively, under this plan. Such shares are subject to a three-year cliff-vesting period.

Employee Stock Purchase Plan

Effective January 1, 2002, the Company began an Employee Stock Purchase Plan which provides an opportunity for substantially all employees to purchase shares of the Company's common stock at a purchase price equal to 85% of the lower of the closing price on the first day or last day of a six month interval. The Company's stockholders approved an amendment to the Employee Stock Purchase Plan to increase the number of shares of common stock available for issuance from 100,000 to 300,000 in May 2003. Approximately 40,000 and 71,000 shares of common stock were issued to employees through this plan during the years ended December 31, 2002 and 2003, respectively.

Stock Options

1998 Long-Term Incentive Plan

The Company's 1998 Long-Term Incentive Plan, as amended, authorizes 9,625,000 shares of the Company's common stock for issuance as of December 31, 2003. In May 2002, the Company's stockholders approved an amendment to the 1998 Long-Term Incentive Plan to increase the number of shares of common stock available for issuance from 7,125,000 to 9,625,000. The 1998 Long-Term Incentive Plan authorizes the grant of stock options, stock appreciation rights and other stock based awards to officers and employees of the Company. Options to purchase 1,133,300, 914,900 and 1,036,800 shares were granted to the Company's employees during the years ended December 31, 2001, 2002 and 2003, respectively, under this plan with an exercise price equal to the fair market value on the date of grant. These options become exercisable beginning one year from the date of grant to five years after the date of grant. All options granted under this plan expire 10 years from the date of grant.

Outside Directors Stock and Incentive Plan

The Company also adopted an Outside Directors Stock and Incentive Plan for which 175,000 shares of the Company's common stock have been reserved for issuance. Approximately 12,500, 26,000 and 30,000 options were granted under such plan to non-employee directors during the years ended December 31, 2001, 2002 and 2003, respectively. These options become exercisable beginning in part from the date of grant to three years after the date of grant and expire 10 years after grant.

Summary

Presented below is a summary of stock option activity for 2001, 2002 and 2003:

	Stock Options	Option Price Per Share	Weighted Average Exercise Price
Balances, December 31, 2000	3,339,700	$ 0.07 - 39.69	$ 11.73
Granted	1,145,800	31.39 - 46.19	37.58
Exercised	(873,800)	0.18 - 37.13	13.96
Cancelled	(172,600)	0.18 - 39.69	20.62
Balances, December 31, 2001	3,439,100	0.07 - 46.19	19.33
Granted	940,900	31.05 - 38.17	36.11
Exercised	(265,000)	0.18 - 37.13	11.18
Cancelled	(98,600)	0.18 - 37.13	19.04
Balances, December 31, 2002	4,016,400	0.07 - 46.19	23.81
Granted	1,066,800	20.32 - 27.97	21.60
Exercised	(333,000)	0.18 - 18.38	11.20
Cancelled	(356,800)	8.29 - 46.19	27.75
Balances, December 31, 2003	**4,393,400**	**$ 0.07 - 46.19**	**$ 23.91**

At December 31, 2003, there were approximately 2,656,700 options available for grant.

The following table summarizes information regarding the options outstanding at December 31, 2003:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Outstanding	Weighted Average Remaining Contractual Life	Weight Average Exercise Price	Exercisable	Weighted Average Exercise Price
$ 0.07 to $ 11.87	46,600	1	$ 8.53	46,600	$ 8.53
12.22 to 12.90	40,500	2	12.47	40,500	12.47
14.16 to 17.47	52,600	3	16.35	52,600	16.35
17.44 to 18.38	16,700	4	18.37	16,700	18.37
15.64	800	5	15.64	800	15.64
7.63 to 10.81	1,395,500	6	10.53	1,212,500	10.59
17.25 to 39.69	124,700	7	22.32	99,800	22.85
31.39 to 46.19	916,700	8	37.77	624,500	37.72
31.05 to 38.17	827,300	9	36.07	291,200	36.17
20.32 to 27.97	972,000	10	21.60	10,000	20.51
	4,393,400			2,395,200	

7. Commitments and Contingencies

Americans with Disabilities Act Claim

On January 12, 2001, Access Now, Inc., a disability rights organization, filed a class action lawsuit against each of the Company's hospitals alleging non-compliance with the accessibility guidelines under the Americans with Disabilities Act (the "ADA"). The lawsuit, filed in the United States District Court for the Eastern District of Tennessee, seeks injunctive relief requiring facility modification, where necessary, to meet the Americans with Disabilities Act guidelines, along with attorneys fees and costs. In January 2002, the District Court certified the class action and issued a scheduling order that requires the parties to complete discovery and inspection for approximately six facilities per year. The Company intends to vigorously defend the lawsuit, recognizing the Company's obligation to correct any deficiencies in order to comply with the ADA. As of December 31, 2003, the Company has conducted inspections at 17 of its hospitals.

HCA Investigations, Litigation and Indemnification Rights

HCA has been the subject of various federal and state investigations, qui tam actions, shareholder derivative and class action suits, patient/payor actions and general liability claims. These investigations, actions and claims relate to HCA and its subsidiaries, including subsidiaries that, before the Company's formation as an independent company, owned many of the facilities that the Company now owns.

In June 2003, HCA announced agreements with the Department of Justice that settled all federal criminal and civil litigation brought by the Department of Justice against HCA with respect to cost reports, physician relations and wound care issues. The settlement of these issues does not affect qui tam actions in which the Department of Justice has not intervened. Additionally, HCA has announced that it made payments to CMS in accordance with an agreement to resolve all Medicare cost report, home office cost statement and appeal issues.

HCA has agreed to indemnify the Company for any losses, other than consequential damages, arising from the governmental investigations of HCA's business practices prior to the date of the distribution of the outstanding shares of the Company's common stock to the stockholders of HCA and losses arising from legal proceedings, present or future, related to the investigation or actions engaged in before the distribution that relate to the investigation. However, the Company could be held responsible for any claims that are not covered by the agreements reached with the federal government or for which HCA is not required to, or fails to, indemnify the Company.

Corporate Integrity Agreement

In December 2000, the Company entered into a corporate integrity agreement with the Office of Inspector General and agreed to maintain its compliance program in accordance with the corporate integrity agreement. This agreement was amended in April 2002. Complying with the compliance measures and reporting and auditing requirements of the corporate integrity agreement requires additional efforts and costs. Failure to comply with the terms of the corporate integrity agreement could subject the Company to significant monetary penalties.

Legal Proceedings and General Liability Claims

The Company is, 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 management contracts, wrongful restriction of or interference with physicians' staff privileges and employment related claims. In certain of these actions, plaintiffs request punitive or other damages against the Company which may not be covered by insurance. The Company is currently not a party to any proceeding which, in management's opinion, would have a material adverse effect on the Company's business, financial condition or results of operations.

Physician Commitments

The Company has committed to provide certain financial assistance pursuant to recruiting agreements with various physicians practicing in the communities it serves. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may loan certain amounts of money to a physician, normally over a period of one year, to assist in establishing his or her practice. The Company has committed to advance a maximum amount of approximately $27.8 million at December 31, 2003. The actual amount of such commitments to be subsequently advanced to physicians often depends upon the financial results of a physician's private practice during the guaranteed period. Generally, amounts advanced under the recruiting agreements may be forgiven prorata over a period of 48 months contingent upon the physician continuing to practice in the respective community.

Capital Expenditure Commitments

The Company is reconfiguring some of its facilities to accommodate more effectively patient services and restructuring existing surgical capacity in some of its hospitals to permit additional patient volume and a greater variety of services. The Company has incurred approximately $28.3 million in uncompleted projects as of December 31, 2003, which is included in construction in progress in its accompanying consolidated balance sheet. At December 31, 2003, the Company had projects under construction with an estimated additional cost to complete and equip of approximately $88.2 million.

Pursuant to the asset purchase agreement for Ville Platte Medical Center, the Company has agreed to make certain capital improvements, the cost of which, together with the initial cash payment, defeasement of certain bonds and liabilities assumed, is not required to exceed $25.0 million. The capital improvements must be completed by

December 1, 2004. The initial cash payment and liabilities assumed totaled $15.1 million, which leaves $9.9 million required for capital improvements. The Company has incurred approximately $3.2 million of the required capital improvements as of December 31, 2003.

Pursuant to the asset purchase agreement for Logan Regional Medical Center, the Company has agreed to expend, regardless of the results of the hospital's operations, at least $20.0 million in the aggregate for capital expenditures and improvements during the ten-year period following the date of acquisition of December 1, 2002. The Company had incurred approximately $1.6 million of the required capital improvements as of December 31, 2003.

Acquisitions

The Company has acquired and will continue to acquire businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with health care laws and regulations, such as billing and reimbursement, fraud and abuse and similar anti-referral laws. Although the Company institutes policies designed to conform practices to its standards following completion of acquisitions, there can be no assurance that the Company will not become liable for past activities that may later be asserted to be improper by private plaintiffs or government agencies. Although the Company generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

Leases

The Company leases real estate properties, buildings, vehicles and equipment under cancelable and non-cancelable leases. Rental expense for the years ended December 31, 2001, 2002 and 2003 was $6.9 million, $7.8 million and $8.7 million, respectively.

Future minimum operating lease payments are as follows at December 31, 2003 (in millions):

2004	$ 6.0
2005	4.2
2006	3.1
2007	2.5
2008	1.2
Thereafter	4.2
Total minimum payments	$ 21.2

8. Earnings Per Share

The following table sets forth the computation of basic and diluted earnings per share for the years ended December 31, 2001, 2002 and 2003 (dollars and shares in millions, except per share amounts):

	2001	2002 [(a)]	2003
Numerator:			
Numerator for basic earnings per share – net income	$ 33.3	$ 41.5	$ 68.5
Interest on Convertible Notes, net of taxes	–	–	7.8
Numerator for diluted earnings per share	$ 33.3	$ 41.5	$ 76.3
Denominator:			
Denominator for basic earnings per share – weighted average shares	35.7	37.5	37.2
Effect of dilutive securities:			
Employee stock options	1.3	1.0	0.7
Convertible Notes	–	–	5.3
Other	0.1	0.1	0.1
Denominator for diluted earnings per share – adjusted weighted average shares	37.1	38.6	43.3
Basic earnings per share	$ 0.93	$ 1.11	$ 1.84
Diluted earnings per share	$ 0.90	$ 1.07	$ 1.76

(a) The impact of 3.3 million potential weighted average shares of common stock, if converted, and interest expense related to the Convertible Notes was not included in the computation of diluted earnings per share because the effect would have been anti–dilutive.

9. Unaudited Quarterly Financial Information

The quarterly interim financial information shown below has been prepared by the Company's management and is unaudited. It should be read in conjunction with the audited consolidated financial statements appearing herein (dollars in millions, except per share amounts).

	2002			
	First	Second	Third	Fourth
Revenues [a]	$ 181.6	$ 177.9	$ 182.2	$ 201.9
Net income (loss)	13.7	(2.5)	12.7	17.6
Earnings (loss) per share:				
Basic	$ 0.37	$ (0.07)	$ 0.34	$ 0.47
Diluted	$ 0.36	$ (0.07)	$ 0.33	$ 0.44

	2003			
	First	Second	Third	Fourth
Revenues [b]	$ 220.9	$ 221.6	$ 227.3	$ 237.3
Net income	17.7	15.3	16.2	19.3
Earnings per share:				
Basic	$ 0.47	$ 0.41	$ 0.43	$ 0.53
Diluted	$ 0.45	$ 0.40	$ 0.42	$ 0.50

(a) The net adjustments to estimated third-party payor settlements increased revenues by $2.1 million, $5.8 million and $5.1 million during the second, third and fourth quarters, respectively.

(b) The net adjustments to estimated third-party payor settlements increased (decreased) revenues by $2.9 million, $1.4 million, $1.9 million and $(0.2) million during the first, second, third and fourth quarters, respectively.

10. Related Party Transactions

As part of an officer's relocation package, the Company purchased a house for approximately $0.6 million in the second quarter of 2002 and subsequently sold it in the fourth quarter of 2002.

The Company loaned certain Company executives 100% of the purchase price of the Company's common stock at the fair market value based on the date of purchase during 1999. The loans are reflected as notes receivable for shares sold to employees in the Company's consolidated statements of stockholders' equity. During the years ended December 31, 2001 and 2002, Company executives repaid $1.5 million and $5.7 million of such loans, respectively, which were fully repaid as of December 31, 2002.

BOARD OF DIRECTORS

Kenneth C. Donahey
Chairman of the Board,
President and Chief Executive Officer
LifePoint Hospitals, Inc.

Richard H. Evans
Chairman
Evans Holdings, LLC

DeWitt Ezell, Jr.
Former State President
BellSouth Corporation

Ricki Tigert Helfer
Independent Consultant
Financial Regulation and Reform International

William V. Lapham
Retired Partner
Ernst & Young LLP

John E. Maupin, Jr., D.D.S.
President
Meharry Medical College

Owen G. Shell, Jr.
Retired President
Bank of America, Asset Management Group

OFFICERS

Kenneth C. Donahey
Chairman of the Board,
President and Chief Executive Officer

William F. Carpenter III
Executive Vice President, General Counsel,
Secretary and Corporate Governance Officer

Michael J. Culotta
Chief Financial Officer

William M. Gracey
Chief Operating Officer

Neil D. Hemphill
Senior Vice President, Human Resources
and Administration

Todd J. Kerr
Senior Vice President, Audit
and Compliance

Joné L. Koford
President, American Division

R. Scott Raplee
Senior Vice President,
Operations Chief Financial Officer

Thomas N. Weiss
President, Continental Division

Michael A. Wiechart
President, National Division

Gary D. Willis
Vice President and Controller

TRANSFER AGENT AND REGISTRAR

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Cleveland, Ohio 44193-0900
216-476-8663/800-622-6757

INDEPENDENT AUDITORS

Ernst & Young LLP
Nashville, Tennessee

CORPORATE HEADQUARTERS

103 Powell Court, Suite 200
Brentwood, Tennessee 37027
615-372-8500

FORM 10-K

The Company has filed an annual report on Form 10-K for the year ended December 31, 2003, with the Securities and Exchange Commission. Stockholders may obtain a copy of this report, without charge, by writing: Investor Relations, LifePoint Hospitals, Inc., 103 Powell court, Suite 200, Brentwood, Tennessee 37027, or by visiting the Company's Website at www.lifepointhospitals.com.

COMMON STOCK AND DIVIDEND INFORMATION

The Common Stock of LifePoint Hospitals, Inc. is traded on the Nasdaq National Market under the symbol "LPNT." At April 16, 2004, the Company had approximately 39,896 stockholders, including 5,196 stockholders of record and approximately 34,700 persons or entities holding common stock, in nominee name. No dividends have been paid on the common stock and the Company does not currently intend to declare or pay any dividends.

The following table shows, for periods indicated, the high and low sales prices per share of the Common Stock as reported by the Nasdaq National Market.

	High	Low
2002		
First Quarter	$ 38.42	$ 29.67
Second Quarter	42.77	34.97
Third Quarter	36.54	28.59
Fourth Quarter	38.05	28.75
2003		
First Quarter	$ 30.65	$ 19.60
Second Quarter	25.72	16.55
Third Quarter	29.44	20.55
Fourth Quarter	31.05	22.51
2004		
First Quarter	$ 37.35	$ 29.48

FACILITY LOCATIONS

LifePoint Hospitals, Inc. (NASDAQ: LPNT) operates 29 hospitals in non-urban communities of Alabama, Florida, Kansas, Kentucky, Louisiana, Tennessee, Utah, West Virginia and Wyoming. In most cases, the LifePoint facility is the only hospital in its community. The Company was formed on May 11, 1999, as a tax-free spin-off to the shareholders of HCA.

Facility	City	State	Licensed Beds
Andalusia Regional Hospital	Andalusia	AL	101
Lakeland Community Hospital	Haleyville	AL	99
Russellville Hospital	Russellville	AL	100
Northwest Medical Center	Winfield	AL	71
Bartow Memorial Hospital	Bartow	FL	56
Putnam Community Medical Center	Palatka	FL	141
Western Plains Regional Hospital	Dodge City	KS	110
Georgetown Community Hospital	Georgetown	KY	75
Spring View Hospital	Lebanon	KY	113
Jackson Purchase Medical Center	Mayfield	KY	107
Meadowview Regional Medical Center	Maysville	KY	111
Bourbon Community Hospital	Paris	KY	58
Logan Memorial Hospital	Russellville	KY	92
Lake Cumberland Regional Hospital	Somerset	KY	234
Bluegrass Community Hospital	Versailles	KY	25
Ville Platte Medical Center	Ville Platte	LA	116
Athens Regional Medical Center	Athens	TN	118
Smith County Memorial Hospital	Carthage	TN	63
Crockett Hospital	Lawrenceburg	TN	107
Livingston Regional Hospital	Livingston	TN	114
Hillside Hospital	Pulaski	TN	95
Emerald Hodgson Hospital	Sewanee	TN	41
Southern Tennessee Medical Center	Winchester	TN	157
Castleview Hospital	Price	UT	84
Ashley Valley Medical Center	Vernal	UT	39
Guyan Valley Hospital	Logan	WV	19
Logan Regional Medical Center	Logan	WV	132
Lander Valley Medical Center	Lander	WY	89
Riverton Memorial Hospital	Riverton	WY	70

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