LIFEPOINT HOSPITALS, INC.
Form 10-Q
October 24, 2014

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

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Form 10-Q

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(Mark One)

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

For the quarterly period ended September 30, 2014

or

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

For the transition period from to

Commission file number: 000-51251

_____

LifePoint Hospitals, Inc.

(Exact Name of Registrant as Specified in its Charter)

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

(615) 920-7000

(Registrant's Telephone Number, Including Area Code)

Not Applicable

(Former name, former address and former fiscal year, if changed since last report)

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

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

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

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

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

As of October 17, 2014, the number of outstanding shares of the registrant’s Common Stock was 45,272,620.

LifePoint Hospitals, Inc.

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PART I – FINANCIAL INFORMATION

Item 1. Financial Statements.

LIFEPOINT HOSPITALS, INC.

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS

Unaudited

(In millions, except per share amounts)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Revenues before provision for doubtful accounts	$ 1,388.2	$ 1,092.9	$ 3,817.2	$ 3,268.8
Provision for doubtful accounts	222.2	193.2	597.0	543.1
Revenues	1,166.0	899.7	3,220.2	2,725.7
Salaries and benefits	558.8	422.2	1,522.1	1,277.5
Supplies	180.5	140.6	500.0	429.4
Other operating expenses	285.6	222.6	787.4	667.0
Other income	(14.6)	(20.0)	(49.5)	(36.7)
Depreciation and amortization	68.8	57.4	190.8	169.1
Interest expense, net	28.6	24.0	93.8	70.5
Gain on settlement of pre-acquisition contingent obligation	-	-	-	(5.6)
Debt transaction costs	-	0.3	-	4.7
Impairment charge	12.2	-	12.2	-
	1,119.9	847.1	3,056.8	2,575.9
Income from continuing operations before income taxes	46.1	52.6	163.4	149.8
Provision for income taxes	17.4	18.5	55.2	55.5
Income from continuing operations	28.7	34.1	108.2	94.3
Income from discontinued operations, net of income taxes	-	0.3	-	0.7
Net income	28.7	34.4	108.2	95.0
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(1.2)	(1.6)	(4.5)	(2.4)
Net income attributable to LifePoint Hospitals, Inc.	$ 27.5	$ 32.8	$ 103.7	$ 92.6

Basic earnings per share attributable to LifePoint Hospitals, Inc. stockholders:				
Continuing operations	$ 0.61	$ 0.70	$ 2.30	$ 1.99
Discontinued operations	-	-	-	0.01
Net income	$ 0.61	$ 0.70	$ 2.30	$ 2.00
Diluted earnings per share attributable to LifePoint Hospitals, Inc. stockholders:				
Continuing operations	$ 0.59	$ 0.68	$ 2.20	$ 1.93
Discontinued operations	-	-	-	0.01
Net income	$ 0.59	$ 0.68	$ 2.20	$ 1.94
Weighted average shares and dilutive securities outstanding:				
Basic	44.8	46.5	45.1	46.3
Diluted	46.7	47.8	47.1	47.6
Amounts attributable to LifePoint Hospitals, Inc. stockholders:				
Income from continuing operations, net of income taxes	$ 27.5	$ 32.5	$ 103.7	$ 91.9
Income from discontinued operations, net of income taxes	-	0.3	-	0.7
Net income	$ 27.5	$ 32.8	$ 103.7	$ 92.6

See accompanying notes

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LIFEPOINT HOSPITALS, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS

(Dollars in millions, except per share amounts)

	September 30, 2014 (Unaudited)	December 31, 2013(a)
ASSETS		
Current assets:		
Cash and cash equivalents	$ 263.0	$ 637.9
Accounts receivable, less allowances for doubtful accounts of $745.2 and $741.2 at September 30, 2014 and December 31, 2013, respectively	741.0	595.7
Inventories	115.1	102.0
Prepaid expenses	45.2	38.0
Income taxes receivable	43.4	-
Deferred tax assets	116.8	147.7
Other current assets	92.2	72.9
	1,416.7	1,594.2
Property and equipment:		
Land	135.4	112.3
Buildings and improvements	2,180.0	2,019.6
Equipment	1,576.4	1,469.9
Construction in progress (estimated costs to complete and equip after September 30, 2014 is $88.1)	74.8	58.7
	3,966.6	3,660.5
Accumulated depreciation	(1,615.4)	(1,463.3)
	2,351.2	2,197.2
Deferred loan costs, net	32.8	31.1
Intangible assets, net	69.1	72.6
Other	43.0	40.7
Goodwill	1,637.6	1,651.0
Total assets	$ 5,550.4	$ 5,586.8
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 164.8	$ 135.9
Accrued salaries	193.7	139.6
Other current liabilities	224.4	197.2
Current maturities of long-term debt	16.3	583.0
	599.2	1,055.7
Long-term debt	2,205.8	1,793.8

Deferred income tax liabilities	218.4	233.1
Long-term portion of reserves for self-insurance claims	128.5	139.8
Other long-term liabilities	86.1	55.4
Long-term income tax liability	19.2	16.6
Total liabilities	3,257.2	3,294.4
Redeemable noncontrolling interests	84.6	59.8
Equity:		
LifePoint Hospitals, Inc. stockholders' equity:		
Preferred stock, $0.01 par value; 10,000,000 shares authorized; no shares issued	-	-
Common stock, $0.01 par value; 90,000,000 shares authorized; 66,196,064 and 65,548,140 shares issued at September 30, 2014 and December 31, 2013, respectively	0.7	0.7
Capital in excess of par value	1,488.6	1,470.7
Accumulated other comprehensive income	3.4	3.4
Retained earnings	1,450.7	1,347.0
Common stock in treasury, at cost, 20,936,642 and 18,404,586 shares at September 30, 2014 and December 31, 2013, respectively	(761.0)	(611.7)
Total LifePoint Hospitals, Inc. stockholders' equity	2,182.4	2,210.1
Noncontrolling interests	26.2	22.5
Total equity	2,208.6	2,232.6
Total liabilities and equity	$ 5,550.4	$ 5,586.8

(a) Derived from audited consolidated financial statements.

See accompanying notes

LIFEPOINT HOSPITALS, INC.

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

Unaudited

(In Millions)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Cash flows from operating activities:				
Net income	$ 28.7	$ 34.4	$ 108.2	$ 95.0
Adjustments to reconcile net income to net cash provided by operating activities:				
Income from discontinued operations	-	(0.3)	-	(0.7)
Stock-based compensation	7.3	6.0	20.4	19.1
Depreciation and amortization	68.8	57.4	190.8	169.1
Amortization of physician minimum revenue guarantees	3.5	4.1	11.2	13.1
Amortization of debt discounts, premium and deferred loan costs	1.2	6.8	12.8	19.9
Gain on settlement of pre-acquisition contingent obligation	-	-	-	(5.6)
Debt transaction costs	-	0.3	-	4.7
Impairment charge	12.2	-	12.2	-
Deferred income tax (benefit)	28.2	(9.9)	23.1	(53.6)
Reserve for self-insurance claims, net of payments	1.0	0.8	5.7	7.5
Increase (decrease) in cash from operating assets and liabilities, net of effects from acquisitions and divestitures:				
Accounts receivable	(28.4)	(7.6)	(56.7)	(26.2)
Inventories and other current assets	6.7	(9.1)	27.1	(4.3)
Accounts payable and accrued expenses	28.7	6.6	(2.9)	(19.4)
Income taxes payable/receivable	(26.7)	14.7	(46.0)	34.2
Other	0.1	(0.1)	2.0	0.6
Net cash provided by operating activities - continuing operations	131.3	104.1	307.9	253.4
Net cash provided by operating activities - discontinued operations	-	0.2	-	-
Net cash provided by operating activities	131.3	104.3	307.9	253.4
Cash flows from investing activities:				
Purchases of property and equipment	(37.0)	(32.7)	(90.7)	(108.5)
Acquisitions, net of cash acquired	(172.1)	(12.2)	(259.9)	(18.4)

Other	(0.6)	(1.7)	(1.0)	(0.3)
Net cash used in investing activities	(209.7)	(46.6)	(351.6)	(127.2)
Cash flows from financing activities:				
Proceeds from borrowings	-	-	412.0	323.0
Payments of borrowings	(2.8)	(3.7)	(582.6)	(320.9)
Repurchases of common stock	(0.4)	(31.3)	(172.3)	(38.5)
Payment of debt financing costs	(0.8)	(7.3)	(6.7)	(8.3)
Proceeds from exercise of stock options	4.8	6.2	23.1	34.4
Other	(1.4)	(1.8)	(4.7)	(6.1)
Net cash used in financing activities	(0.6)	(37.9)	(331.2)	(16.4)
Change in cash and cash equivalents	(79.0)	19.8	(374.9)	109.8
Cash and cash equivalents at beginning of period	342.0	175.0	637.9	85.0
Cash and cash equivalents at end of period	$ 263.0	$ 194.8	$ 263.0	$ 194.8
Supplemental disclosure of cash flow information:				
Interest payments	$ 4.3	$ 5.3	$ 64.9	$ 40.7
Capitalized interest	$ 0.3	$ 0.4	$ 0.6	$ 1.1
Income tax payments, net	$ 15.7	$ 14.0	$ 78.0	$ 75.4

See accompanying notes

LIFEPOINT HOSPITALS, INC.

CONDENSED CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY

For the Nine Months Ended September 30, 2014

Unaudited

(In Millions)

	LifePoint Hospitals, Inc. Stockholders							
	Common Stock Shares	Common Stock Amount	Capital in Excess of Par Value	Accumulated Other Comprehensive Income	Retained Earnings	Treasury Stock	Noncontrolling Interests	Total
Balance at December 31, 2013 (a)	47.1	$ 0.7	$ 1,470.7	$ 3.4	$ 1,347.0	$ (611.7)	$ 22.5	$ 2,232.6
Net income	-	-	-	-	103.7	-	1.2	104.9
Exercise of stock options, tax benefits of stock-based awards and other	0.7	-	27.3	-	-	-	-	27.3
Stock-based compensation	-	-	20.4	-	-	-	-	20.4
Repurchases of common stock, at cost	(3.1)	-	-	-	-	(172.3)	-	(172.3)
Conversion of 3½% Notes	0.6	-	(22.1)	-	-	23.0	-	0.9
Noncash change in noncontrolling interests as a result of acquisition and other	-	-	(7.7)	-	-	-	4.0	(3.7)
Cash distributions to noncontrolling interests	-	-	-	-	-	-	(1.5)	(1.5)
Balance at September 30, 2014	45.3	$ 0.7	$ 1,488.6	$ 3.4	$ 1,450.7	$ (761.0)	$ 26.2	$ 2,208.6

(a) Derived from audited consolidated financial statements.

See accompanying notes

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

Note 1. Organization, Basis of Presentation and Recently Issued Accounting Pronouncements

Organization

LifePoint Hospitals, Inc., a Delaware corporation, acting through its subsidiaries, operates general acute care hospitals primarily in non-urban communities in the United States ("U.S."). Unless the context otherwise indicates, LifePoint Hospitals, Inc. and its subsidiaries are referred to herein as the "Company." At September 30, 2014, on a consolidated basis, the Company operated 68 hospital campuses in 21 states. Unless noted otherwise, discussions in these notes pertain to the Company's continuing operations, which exclude the results of those facilities that have previously been disposed prior to the adoption of Accounting Standards Update ("ASU") No. 2014-8, "Presentation of Financial Statements and Property, Plant, and Equipment - Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity" ("ASU 2014 8").

Basis of Presentation

The accompanying unaudited condensed consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP") for interim financial information and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, they do not include all of the information and notes required by GAAP for complete financial statements. In the opinion of management, all adjustments, consisting of normal recurring adjustments, and disclosures considered necessary for a fair presentation have been included. Operating results for the three and nine months ended September 30, 2014 are not necessarily indicative of the results that may be expected for the year ending December 31, 2014. For further information, refer to the consolidated financial statements and notes thereto included in the Company's Annual Report on Form 10-K for the year ended December 31, 2013.

Additionally, the accompanying unaudited condensed consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through its direct or indirect ownership of a majority interest and exclusive rights granted to the Company as the sole general partner or controlling member of such entities, including Duke LifePoint Healthcare, a joint venture between LifePoint and a wholly-controlled affiliate of Duke University Health System, Inc. Furthermore, the Company consolidates any entities for which it receives the majority of the entity's expected returns or is at risk for the majority of the entity's expected losses based upon its investment or financial interest in the entity. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation.

Recently Issued Accounting Pronouncements

ASU No. 2014-9, "Revenue from Contracts with Customers"

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU No. 2014-9, "Revenue from Contracts with Customers" ("ASU 2014-9"). ASU 2014-9 provides for a single comprehensive principles-based standard for the recognition of revenue across all industries through the application of the following five-step process:

Step 1: Identify the contract(s) with a customer.

Step 2: Identify the performance obligations in the contract.

Step 3: Determine the transaction price.

Step 4: Allocate the transaction price to the performance obligations in the contract.

Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

Among other provisions and in addition to expanded disclosure about the nature, amount, timing and uncertainty of revenue, as well as certain additional quantitative and qualitative disclosures, ASU 2014-9 changes the healthcare industry specific presentation guidance under ASU 2011-7, “Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities.” The provisions of ASU 2014-9 are effective for annual periods beginning after December 15, 2016, including interim periods within those years. Early adoption is not permitted. The Company is currently evaluating the impact that the adoption of ASU 2014-9 will have on its revenue recognition policies and procedures, financial position, result of operations, cash flows, financial disclosures and control framework.

ASU No. 2014-8, “Presentation of Financial Statements and Property, Plant, and Equipment - Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity”

In April 2014, the FASB issued ASU 2014-8. Among other provisions and in addition to expanded disclosures, ASU 2014-8 changes the definition of what components of an entity qualify for discontinued operations treatment and reporting from a reportable segment, operating segment, reporting unit, subsidiary or asset group to only those components of an entity that represent a strategic shift that has, or will have, a major effect on an entity’s operations and financial results. Additionally, ASU 2014-8 requires disclosure about a disposal of an individually significant component of an entity that does not qualify for discontinued operations presentation in the financial statements, including the pretax profit or loss, attributable to the component of an entity for the period in which it is disposed of or is classified as held for sale. The disclosure of this information is required for all of the same periods that are presented in the entity’s results of operations for the period.

As more fully discussed in Note 6, during the three months ended September 30, 2014, the Company entered into a definitive agreement to sell certain assets of River Parishes Hospital (“River Parishes”), located in LaPlace, Louisiana, and discontinue its operation. The Company has determined that the sale of River Parishes does not qualify for discontinued operations treatment in accordance with the provisions of ASU 2014-8. However, the Company has made the additional required disclosures.

Note 2. Revenue Recognition and Accounts Receivable

The Company recognizes revenues in the period in which services are performed. Accounts receivable primarily consist of amounts due from third-party payors and patients. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. Amounts the Company receives for treatment of patients covered by governmental programs such as Medicare and Medicaid and other third-party payors such as health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other private insurers are generally less than the Company's established billing rates. Additionally, to provide for accounts receivable that could become uncollectible in the future, the Company establishes an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. Accordingly, the revenues and accounts receivable reported in the Company's accompanying unaudited condensed consolidated financial statements are recorded at the net amount expected to be received.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

The Company's revenues before provision for doubtful accounts by payor and approximate percentages of revenues were as follows for the three and nine months ended September 30, 2014 and 2013 (in millions):

	Three Months Ended September 30,				Nine Months Ended September 30,			
	2014		2013		2014		2013	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 361.7	31.0 %	$ 296.0	32.9 %	$ 1,003.5	31.2 %	$ 903.6	33.2 %
Medicaid	161.7	13.9	133.9	14.9	451.7	14.0	385.1	14.1
HMOs, PPOs and other private insurers	631.0	54.1	446.0	49.6	1,745.2	54.2	1,370.2	50.3
Self-pay	207.9	17.8	200.8	22.3	547.4	17.0	558.7	20.5
Other	25.9	2.3	16.2	1.8	69.4	2.1	51.2	1.8
Revenues before provision for doubtful accounts	1,388.2	119.1	1,092.9	121.5	3,817.2	118.5	3,268.8	119.9
Provision for doubtful accounts	(222.2)	(19.1)	(193.2)	(21.5)	(597.0)	(18.5)	(543.1)	(19.9)
Revenues	$ 1,166.0	100.0 %	$ 899.7	100.0 %	$ 3,220.2	100.0 %	$ 2,725.7	100.0 %

The primary uncertainty of the Company's accounts receivable 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.

The following is a summary of the Company's activity in the allowance for doubtful accounts for the nine months ended September 30, 2014 (in millions):

Balance at January 1, 2014	$ 741.2
Additions recognized as a reduction to revenues	597.0
Accounts written off, net of recoveries	(593.0)

Balance at September 30, 2014	$ 745.2

The allowances for doubtful accounts as a percent of gross accounts receivable, net of contractual discounts were 50.1% and 55.4% as of September 30, 2014 and December 31, 2013, respectively. The decrease in the resulting ratio of the allowances for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts, at September 30, 2014 as compared to December 31, 2013 is primarily the result of our recent acquisitions. Additionally, as of September 30, 2014 and December 31, 2013, the allowances for doubtful accounts plus certain contractual allowances and discounts related to self-pay patients as a percentage of self-pay receivables were 87.5% and 86.5%, respectively.

Note 3. General and Administrative Costs

The majority of the Company’s expenses are “cost of revenue” items. Costs that could be classified as “general and administrative” by the Company would include its hospital support center overhead costs, which were $63.3 million and $42.5 million for the three months ended September 30, 2014 and 2013, respectively, and $169.4 million and $133.5 million for the nine months ended September 30, 2014 and 2013, respectively. Included in the Company’s hospital support center overhead costs are depreciation and amortization expense related to the Company’s information systems platforms as well as transactional expenses related to the Company’s recent acquisitions, including legal and consulting fees.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

Note 4. Fair Value of Financial Instruments

In accordance with Accounting Standards Codification ("ASC") 825-10, "Financial Instruments" and ASC 820-10, "Fair Value Measurements and Disclosures" ("ASC 820-10"), the fair value of the Company's financial instruments are further described as follows.

Cash and Cash Equivalents, Accounts Receivable and Accounts Payable

The carrying amounts reported in the accompanying unaudited condensed 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.

Long-Term Debt

The carrying amounts and fair values of the Company's senior secured term loan facility (the "Term Facility") and senior secured incremental term loans (the "Incremental Term Loans") under its senior secured credit agreement with, among others, Citibank, N.A. as administrative agent, and the lenders party thereto (the "Senior Credit Agreement"), 6.625% unsecured senior notes due October 1, 2020 (the "6.625% Senior Notes"), 5.5% unsecured senior notes due December 1, 2021 (the "5.5% Senior Notes") and 3½% convertible senior subordinated notes due May 15, 2014 (the "3½% Notes") as of September 30, 2014 and December 31, 2013 were as follows (in millions):

	Carrying Amount		Fair Value	
	September 30, 2014	December 31, 2013	September 30, 2014	December 31, 2013
Senior Credit Agreement:				
Term Facility	$ 424.7	$ 433.1	$ 421.0	$ 434.2
Incremental Term Loans, excluding unamortized discount	$ 222.6	$ 222.6	$ 221.4	$ 224.2
6.625% Senior Notes	$ 400.0	$ 400.0	$ 423.0	$ 425.0
5.5% Senior Notes, excluding unamortized premium	$ 1,100.0	$ 700.0	$ 1,116.5	$ 703.5
3 ½ % Notes, excluding unamortized discount	$ -	$ 575.0	$ -	$ 622.4

The fair values of the Term Facility, the Incremental Term Loans, the 6.625% Senior Notes and the 5.5% Senior Notes were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10. The fair values of the 3½% Notes were

estimated based on the quoted market prices determined using the closing share price of the Company's common stock and categorized as Level 1 within the fair value hierarchy in accordance with ASC 820-10. As more fully discussed in Note 8, effective May 12, 2014, the Company issued $400.0 million of additional 5.5% Senior Notes at a premium of $12.0 million for total net proceeds from the issuance of $412.0 million. The net proceeds from this additional issuance were used to fund, in part, the cash-settled portion of the maturity or conversion of the 3½% Notes on or before May 15, 2014.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

Note 5. Acquisitions

Conemaugh Health System ("Conemaugh")

Effective September 1, 2014, through Duke LifePoint Healthcare, the Company acquired Conemaugh for total consideration, including net working capital, of approximately $125.0 million, comprised of $115.0 million in cash and the issuance of a warrant with an estimated fair value of $10.0 million. The warrant provides the seller rights to purchase 290,514 shares of the Company's common stock, exercisable ratably beginning one year from the date of issuance to three years after the date of issuance. The warrant expires ten years from the date of issuance. The warrants, classified as a liability and included under the caption "Other long-term liabilities" in the Company's accompanying unaudited condensed consolidated balance sheets, were valued using an option pricing model and will be marked-to-market until settlement.

Conemaugh is comprised of Conemaugh Memorial Medical Center, a 470 bed acute care hospital, 39 bed rehabilitation facility and 30 bed long-term care facility located in Johnstown, Pennsylvania, Meyersdale Medical Center, a 20 bed critical access hospital located in Meyersdale, Pennsylvania, and Miners Medical Center, a 30 bed acute care hospital located in Hastings, Pennsylvania. The Company has committed to invest in Conemaugh an additional $425.0 million in capital expenditures and improvements over the next ten years. The results of operations of Conemaugh are included in the Company's results of operations beginning on September 1, 2014. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company's acquisition of Conemaugh have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the subsequent settlement for purchased working capital and final appraisals. The Company expects to finalize its analysis over the next twelve months.

In connection with the Company's acquisition of Conemaugh, the seller self-disclosed various potentially non-compliant physician arrangements under the Centers for Medicare and Medicaid Services ("CMS") voluntary self-disclosure protocol. This self-disclosure is pending with CMS. To the extent that the potential settlement exceeds the seller's indemnification threshold in accordance with the asset purchase agreement, the Company will likely be responsible for funding any deficit. As part of the Company's preliminary purchase price allocation, the Company has made a reasonable estimate of its potential exposure for this matter and at September 30, 2014 has

recorded a reserve of $14.0 million.

Haywood Regional Medical Center (“Haywood”)

Effective August 1, 2014, through Duke LifePoint Healthcare, the Company acquired Haywood, a 169 bed acute care hospital located in Clyde, North Carolina for approximately $28.5 million, including net working capital. The Company has committed to invest in Haywood an additional $36.0 million in capital expenditures and improvements over the next eight years. The results of operations of Haywood are included in the Company’s results of operations beginning on August 1, 2014. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company’s acquisition of Haywood have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the subsequent settlement for purchased working capital and final appraisals. The Company expects to finalize its analysis over the next twelve months.

WestCare Health System (“WestCare”)

Effective August 1, 2014, through Duke LifePoint Healthcare, the Company acquired WestCare for approximately $19.0 million, including net working capital and the assumption of certain capital leases. WestCare is comprised of Harris Regional Hospital, an 86 bed acute care hospital located in Sylva, North Carolina, and Swain County Hospital, a 48 bed critical access hospital located in Bryson City, North Carolina. The Company has committed to invest in WestCare an additional $43.0 million in capital expenditures and improvements over the next eight years. The results of operations of WestCare are included in the Company’s results of operations beginning on August 1, 2014. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company’s acquisition of WestCare have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the subsequent settlement for purchased working capital and final appraisals. The Company expects to finalize its analysis over the next twelve months.

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Rutherford Regional Medical Center ("Rutherford")

Effective June 1, 2014, through Duke LifePoint Healthcare, the Company acquired an 80% interest in an entity that owns Rutherford, a 143 bed acute care hospital located in Rutherfordton, North Carolina for approximately $27.2 million, including net working capital. The Company has committed to invest in Rutherford an additional $60.0 million in capital expenditures and improvements over the next ten years. The results of operations of Rutherford are included in the Company's results of operations beginning on June 1, 2014. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company's acquisition of Rutherford have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the subsequent settlement for purchased working capital and final appraisals. The Company expects to finalize its analysis during 2014.

Wilson Medical Center ("Wilson")

Effective March 1, 2014, through Duke LifePoint Healthcare, the Company acquired an 80% interest in an entity that owns Wilson, a 294 bed hospital and 90 bed long-term care facility located in Wilson, North Carolina for approximately $59.8 million, including net working capital. The Company has committed to invest in Wilson an additional $120.0 million in capital expenditures and improvements over the next ten years. The results of operations of Wilson are included in the Company's results of operations beginning on March 1, 2014. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company's acquisition of Wilson have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the subsequent settlement for purchased working capital and final appraisals. The Company expects to finalize its analysis during 2014.

Note 6. Divestiture

In September 2014, the Company entered into a definitive agreement to sell certain assets of River Parishes and discontinue its operation. The Company expects to complete the transaction during the fourth quarter of 2014. Included in the Company's consolidated results of operations are net operating losses before income taxes attributable to River Parishes of $1.1 million and $1.0 million for the three months ended September 30, 2014 and 2013, respectively, and $1.2 million and $3.5 million for the nine months ended September 30, 2014 and 2013, respectively. The assets that have been classified as held for sale in connection with the River Parishes transaction totaled $3.7 million and are included under the caption "Other current assets" in the accompanying unaudited condensed consolidated balance sheet as of September 30, 2014.

In connection with the Company's entry into a definitive agreement to sell certain assets of River Parishes and discontinue its operation, the Company recognized an impairment charge of $12.2 million, or $0.16 loss per diluted share, during the three months ended September 30, 2014. The impairment charge includes the write-down of property, equipment and allocated goodwill to their estimated fair values.

Note 7. Goodwill and Intangible Assets

Goodwill

The Company accounts for its acquisitions in accordance with ASC 805-10, "Business Combinations" using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350-10, "Intangibles — Goodwill and Other" goodwill and intangible assets with indefinite lives are reviewed by the Company at least annually for impairment. The Company's business comprises a single reporting unit for impairment test purposes. For the purposes of these analyses, the Company's estimates of fair value are based on a combination of the income approach, which estimates the fair value of the Company based on its future discounted cash flows, and the market approach, which estimates the fair value of the Company based on comparable market prices. The Company performed its most recent annual impairment test as of October 1, 2013 and did not incur an impairment charge.

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Intangible Assets

Summary of Intangible Assets

The following table provides information regarding the Company's intangible assets, which are included in the accompanying unaudited condensed consolidated balance sheets at September 30, 2014 and December 31, 2013 (in millions):

	September 30, 2014	December 31, 2013
Amortized intangible assets:		
Contract-based physician minimum revenue guarantees		
Gross carrying amount	$ 63.2	$ 73.4
Accumulated amortization	(34.3)	(39.4)
Net total	28.9	34.0
Non-competition agreements		
Gross carrying amount	23.9	24.5
Accumulated amortization	(15.7)	(14.1)
Net total	8.2	10.4
Total amortized intangible assets		
Gross carrying amount	87.1	97.9
Accumulated amortization	(50.0)	(53.5)
Net total	37.1	44.4
Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	27.9	24.9
Licenses, provider numbers, accreditations and other	4.1	3.3
Net total	32.0	28.2
Total intangible assets:		
Gross carrying amount	119.1	126.1
Accumulated amortization	(50.0)	(53.5)
Net total	$ 69.1	$ 72.6

Contract-Based Physician Minimum Revenue Guarantees

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

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460-10, "Guarantees" ("ASC 460-10"). In accordance with ASC 460-10, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized over the period of the physician contract, which typically ranges from four to five years and is included as an expense under the caption "Other operating expenses" in the accompanying unaudited condensed consolidated statements of operations. As of September 30, 2014 and December 31, 2013, the Company's liability for contract-based physician minimum revenue guarantees was $10.6 million and $11.5 million, respectively. These amounts are included as a current liability under the caption "Other current liabilities" in the Company's accompanying unaudited condensed consolidated balance sheets.

Non-Competition Agreements

The Company has entered into non-competition agreements with certain physicians and other individuals which are amortized on a straight-line basis over the term of the agreements.

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Certificates of Need and Certificates of Need Exemptions

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

Licenses, Provider Numbers, Accreditations and Other

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

Note 8. Long-Term Debt

Issuance of Additional 5.5% Senior Notes

Effective May 12, 2014, the Company issued in a private placement $400.0 million of additional 5.5% Senior Notes with terms substantially identical to those of the initial offering of the 5.5% Senior Notes completed on December 6, 2013. The additional notes were issued at a premium of $12.0 million for total net proceeds from the issuance of $412.0 million which were used to fund, in part, the cash-settled portion of the maturity or conversion of the 3½% Notes on or before May 15, 2014. Including the impact of the premium, the additional 5.5% Senior Notes were issued at an effective rate of 4.9%. In connection with the issuance of the additional 5.5% Senior Notes, the Company capitalized $5.5 million of deferred loan costs.

Maturity and Conversion of 3½% Notes

Effective May 15, 2014, the 3½% Notes matured. Prior to maturity, certain holders of the 3½% Notes exercised their right to convert per $1,000 in principal held for (i) an amount in cash, equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, the lesser of the daily conversion value for such volume-weighted average price trading day and $50; and (ii) a number of shares of the Company's common stock in an amount equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, any excess of the daily conversion value above $50. Upon maturity or conversion of the 3½% Notes, the Company delivered to the holders cash of approximately $574.2 million and approximately 0.6 million shares of its common stock previously held in treasury at an average historical cost basis of $35.86 per share, or $23.0 million.

Note 9. Income Taxes

The Company's income tax provision was $55.2 million for an effective income tax rate of 34.7% during the nine months ended September 30, 2014 as compared to $55.5 million for an effective income tax rate of 37.7% during the nine months ended September 30, 2013. The Company's effective income tax rate was lower during the nine months ended September 30, 2014 as a result of the reversal of a previously established valuation allowance against its deferred tax assets for federal net operating losses generated by the Company's physician practice operations in the state of Michigan, which were previously thought to be unrecoverable. The impact of the reversal during the nine months ended September 30, 2014 resulted in an increase to net income of $6.0 million, or $0.13 per diluted share.

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Note 10. Common Stock in Treasury

The Company's Board of Directors has authorized the repurchase of outstanding shares of its common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other customary factors in accordance with a repurchase plan adopted in 2011, as subsequently amended and extended in February 2013 (the "2011 Repurchase Plan") and a repurchase plan adopted in the first quarter of 2014 (the "2014 Repurchase Plan"). The 2011 Repurchase Plan provided for the repurchase of up to $350.0 million in shares of the Company's common stock, and the Company has repurchased all shares authorized for repurchase under this plan. The 2014 Repurchase Plan provides for the repurchase of up to $150.0 million in shares of the Company's common stock through October 1, 2015. The Company is not obligated to repurchase any specific number of shares under the 2014 Repurchase Plan. The Company has designated the shares repurchased in accordance with its repurchase plans as treasury stock.

In connection with the 2011 Repurchase Plan, the Company repurchased approximately 3.0 million and 0.7 million shares for an aggregate purchase price, including commissions, of $164.7 million and $30.1 million at an average purchase price of $54.33 and $45.76 per share during the nine months ended September 30, 2014 and 2013, respectively. As of September 30, 2014, the Company had remaining authority to repurchase the entire $150.0 million in shares in accordance with the 2014 Repurchase Plan.

Additionally, the Company redeems shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to the Company's various stockholder approved stock-based compensation plans. The Company redeemed approximately 0.1 million and 0.2 million shares vested under these plans for an aggregate purchase price of approximately $7.6 million and $8.4 million during the nine months ended September 30, 2014 and 2013, respectively. The Company has designated these shares as treasury stock.

Furthermore, as more fully discussed in Note 8, upon the conversion of the 3½% Notes on or before May 15, 2014, the Company delivered to holders of the 3½% Notes approximately 0.6 million shares of its common stock previously held in treasury at an average historical cost basis of $35.86 per share, or $23.0 million.

Note 11. Stock-Based Compensation

Overview

The Company issues stock-based awards, including stock options and other stock-based awards (nonvested stock, restricted stock, restricted stock units and performance shares) to certain officers, employees and non-employee directors in accordance with the Company's various stockholder-approved stock-based compensation plans. The Company accounts for its stock-based awards in accordance with the provisions of ASC 718-10, "Compensation – Stock Compensation" ("ASC 718-10"), and accordingly recognizes compensation expense over each of the stock-based award's requisite service period based on the estimated grant date fair value.

Effective June 4, 2013, upon the approval of the Company's stockholders, the Company replaced the Amended and Restated 1998 Long-Term Incentive Plan (the "1998 LTIP") and the Amended and Restated Outside Directors Stock and Incentive Compensation Plan (the "ODSICP") with the 2013 Long-Term Incentive Plan (the "2013 LTIP"), a new combined plan covering all of the Company's employees and non-employee directors. The 2013 LTIP provides for 3.6 million shares available for grant at a rate of 1.00 share for each stock option or appreciation rights award granted and 2.09 shares for each full-value award granted. No shares remain available for new awards to be granted under the 1998 LTIP or the ODSICP.

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Stock Options

The Company granted options to purchase 716,150 and 60,600 shares of the Company's common stock to certain officers and employees in accordance with the 2013 LTIP during the nine months ended September 30, 2014 and 2013, respectively. Additionally, the Company granted options to purchase 735,200 shares of the Company's common stock to certain officers and employees in accordance with the 1998 LTIP during the nine months ended September 30, 2013 prior to its replacement with the 2013 LTIP. Options to purchase shares granted to the Company's officers and employees in accordance with the 2013 LTIP and the 1998 LTIP were granted with an exercise price equal to the fair market value of the Company's common stock on the day of grant, determined based on the closing price on the trading date immediately prior to the grant date. The options granted during the nine months ended September 30, 2014 and 2013 become ratably exercisable beginning one year from the date of grant to three years after the date of grant and expire ten years from the date of grant.

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

The following table shows the weighted average assumptions the Company used to develop the fair value estimates under its HW-II option valuation model and the resulting estimates of weighted-average fair value per share of stock options granted during the nine months ended September 30, 2014 and 2013:

	Nine Months Ended September 30,	
	2014	2013
Expected volatility	29.0 %	31.0 %
Risk-free interest rate, minimum	0.05 %	0.04 %
Risk-free interest rate, maximum	2.71 %	2.74 %
Expected dividends	-	-
Average expected term (years)	5.4	5.3
Fair value per share of stock options granted	$ 13.95	$ 11.96

The total intrinsic value of stock options exercised during the nine months ended September 30, 2014 and 2013 was $14.0 million and $11.7 million, respectively. The Company received $4.8 million and $6.2 million in cash from stock option exercises for the three months ended September 30, 2014 and 2013, respectively, and $23.1 million and $34.4 million in cash from stock option exercises for the nine months ended September 30, 2014 and 2013, respectively. The actual tax benefit realized for the tax deductions from stock option exercises was $2.3 million and $0.7 million for the nine months ended September 30, 2014 and 2013, respectively.

As of September 30, 2014, there was $12.2 million of total estimated unrecognized compensation cost related to stock option compensation arrangements. Total estimated unrecognized compensation cost will be adjusted for future changes in estimated forfeitures. The Company expects to recognize that cost over a weighted average period of 1.3 years.

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Other Stock-Based Awards

The Company granted 369,871 and 52,962 restricted stock units to certain officers, employees and non-employee directors in accordance with the 2013 LTIP during the nine months ended September 30, 2014 and 2013, respectively. Additionally, the Company granted 410,000 restricted stock units to certain officers and employees in accordance with the 1998 LTIP during the nine months ended September 30, 2013 prior to its replacement with the 2013 LTIP. Excluding the fair value of the performance-based awards granted during the nine months ended September 30, 2014, the fair value of these restricted stock units was determined based on the closing price of the Company's common stock on the day prior to the grant date. The restricted stock units granted during the nine months ended September 30, 2014 and 2013 have either cliff-vesting periods from the grant date of three years, cliff-vesting periods from the grant date of six months and one day or ratable vesting periods beginning one year from the date of grant to three years after the date of grant.

Of the restricted stock units granted during the nine months ended September 30, 2014, 236,000 were performance-based awards. In addition to requiring continuing service of the employee, the percentage of these restricted stock units that are earned at the end of the performance period is determined based on the Company's three-year annualized total shareholder return relative to a peer group, Standard and Poor's Global Industry Classification Standard's Sub-industry: Health Care Facilities with over $500.0 million in revenues or its equivalent. The number of shares payable at the end of the three-year performance period ranges from 0% to 100% of the targeted units, with any portion of the award that exceeds 100% up to 200% of the targeted units settled in cash equal to the fair market value on the date certification of the level of performance is achieved. For valuation purposes, the awards were bifurcated into their two independent sub-award components for the portion that would be settled in the Company's common stock and for the portion that would be settled in cash and their respective fair values were estimated using the Monte-Carlo simulation valuation model. The Company recognizes compensation expense for the portion of the award that would ultimately be settled in the Company's common stock for the targeted units at its Monte-Carlo simulation value if the requisite service period is rendered, even if the market condition is never satisfied. The Company will classify as a liability and recognize compensation expense for the portion of the award that would ultimately be settled in cash for the targeted units at its Monte-Carlo simulation value that will be marked-to-market until settlement.

Of the restricted stock units granted during the nine months ended September 30, 2013, 322,000 were performance-based awards that, in addition to requiring continuing service of an employee, the vesting of which is contingent upon the satisfaction of certain financial goals, specifically related to the achievement of targeted annual revenues or earnings goals within a three-year period. If these goals are achieved, the performance-based awards will cliff-vest three years after the grant date. The performance criteria for the 322,000 performance-based awards granted during the nine months ended September 30, 2013 have not been met and are still subject to continuing service requirements and the three year cliff-vesting provisions. For purposes of estimating compensation expense for these performance-based awards, the Company has assumed that the performance goals will be achieved. If the performance goals are not met for these performance-based awards, no compensation expense will be recognized, and any

previously recognized compensation expense will be reversed.

Notwithstanding the specific grant vesting requirements, award agreements under the 2013 LTIP and the 1998 LTIP may provide for accelerated vesting in certain circumstances. Generally, award agreements provide for full vesting upon the death or disability of the participant. Some award agreements also provide for partial or full vesting upon involuntary termination of employment, provided that if the award is performance-based then the accelerated vesting would occur only if the performance goals are attained.

As of September 30, 2014, there was $27.7 million of total estimated unrecognized compensation cost related to other stock-based awards. Total estimated unrecognized compensation cost will be adjusted for future changes in estimated forfeitures. The Company expects to recognize that cost over a weighted average period of 1.8 years.

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The following table summarizes the Company's total stock-based compensation expense as well as the total recognized tax benefits related thereto for the three and nine months ended September 30, 2014 and 2013 (in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Equity awards:				
Other stock-based awards	$ 4.9	$ 4.3	$ 13.4	$ 12.5
Stock options	2.4	1.7	7.0	6.6
	7.3	6.0	20.4	19.1
Liability awards:				
Other stock-based awards	1.0	-	1.7	-
Total stock-based compensation expense	$ 8.3	$ 6.0	$ 22.1	$ 19.1
Tax benefit on stock-based compensation expense	$ 3.2	$ 2.4	$ 8.7	$ 7.6

The Company did not capitalize any stock-based compensation cost during the three or nine months ended September 30, 2014 or 2013. As of September 30, 2014, there was $39.9 million of total estimated unrecognized compensation cost related to all of the Company's stock-based compensation arrangements. Total estimated unrecognized compensation cost may be adjusted for future changes in estimated forfeitures. The Company expects to recognize that cost over a weighted-average period of 1.7 years.

Note 12. Commitments and Contingencies

Legal Proceedings and General Liability Claims

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

In addition, hospitals are subject to the regulation and oversight of various state and federal governmental agencies. Further, under the federal False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against hospitals that submit false claims for payments to, or improperly retain overpayments from, governmental payors. Some states have adopted similar state whistleblower and false claims provisions. Although the healthcare industry has seen numerous ongoing investigations related to compliance and billing practices, hospitals, in particular, continue to be a primary enforcement target for the Office of the Inspector General ("OIG"), the Department of Justice ("DOJ") and other governmental fraud and abuse programs. Certain of the Company's individual facilities have received, and from time to time, other facilities may receive, inquiries from federal and state agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on the Company's financial position, results of operations and liquidity.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 imposed an affirmative obligation on healthcare providers to report and refund any overpayments received. "Overpayments" in this context include any amount received from a government program by a provider to which it is not entitled, regardless of the cause. Such overpayments are deemed to be fraudulent and become violations of the False Claims Act if not reported and refunded within 60 days of identification. Hospitals can meet the obligation to report and refund in three ways: (1) refunding overpayments directly to the program; (2) self-disclosing the overpayment to the OIG via its voluntary self-disclosure protocol (with respect to False Claims Act and other violations not related to the Stark law); and (3) self-disclosing to the CMS via the self-referral disclosure protocol (with respect to overpayments caused by potential violations of the Stark law only) for which CMS has the authority to reduce the amounts otherwise owed.

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In connection with the Company's acquisitions of Marquette General Health System ("Marquette General") and Conemaugh, the two sellers self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. These self-disclosures are pending with CMS. With respect to Marquette General, to the extent that the seller's satisfaction of its retained liabilities, including those under its CMS voluntary self-disclosure, causes its net proceeds from the acquisition to be less than $15.0 million, the Company has agreed to pay additional purchase consideration to the seller. With respect to Conemaugh, to the extent that the potential settlement exceeds the seller's indemnification threshold in accordance with the asset purchase agreement, the Company will likely be responsible for funding any deficit. The Company has made reasonable estimates of its potential exposure for these two matters and at September 30, 2014 has recorded reserves for Marquette General and Conemaugh of $18.0 million and $14.0 million, respectively.

On September 16, 2013, the Company and two of its hospitals made a voluntary self-disclosure to the Civil Division of the DOJ. The voluntary self-disclosure related to concerns regarding the clinical appropriateness of certain interventional cardiology procedures conducted by one physician in each of these hospitals' cardiac catheterization laboratories. On September 24, 2013, the U.S. Attorney's Office in the district in which one of these hospitals is located served a subpoena requesting information related to the subject matter of the voluntary self-disclosure. The hospital that received the subpoena has produced responsive documents, including patient files. The Company continues to cooperate with the government in addressing these matters, including a review of procedures that were performed by these physicians.

The government investigations are ongoing, no patient claims have been made and it is not possible to estimate what, if any, claims will be brought. When appropriate, and following reviews by independent interventional cardiologists, the Company intends to notify those patients of these two physicians who may have received an unnecessary procedure of such fact. Patients from the hospitals at which these two physicians practiced may assert claims against the hospital that, if successful, could result in the hospitals being found liable. The government investigations may also result in damages, fines and penalties. The Company cannot, however, reasonably estimate the potential liability in connection with these matters, and no liability has been recorded as of September 30, 2014.

The Company does not control and cannot predict with certainty the progress or final outcome of discussions with government agencies, investigations and legal proceedings against the Company. Therefore, the final amounts paid to resolve the foregoing matters could be material and could materially differ from amounts currently recorded, if any. Any such changes in estimate will impact the Company's future results of operations and cash flows.

Physician Commitments

The Company has committed to provide certain financial assistance pursuant to recruiting agreements with various physicians practicing in the communities it serves. In consideration for a physician's relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician, normally over a period of one year, to assist in establishing the physician's practice. The Company has committed to advance a maximum amount of approximately $27.2 million at September 30, 2014. The actual amount of such commitments to be subsequently advanced to physicians is estimated at $10.6 million and often depends upon the financial results of a physician's private practice during the guarantee period. Generally, amounts advanced under the recruiting agreements may be forgiven pro rata over a period of 36 to 48 months contingent upon the physician continuing to practice in the respective community. Pursuant to the Company's standard physician recruiting agreement, any breach or non-fulfillment by a physician under the physician recruiting agreement gives the Company the right to recover any payments made to the physician under the agreement. Additionally, the Company is subject to annual commitments for certain physician recruiting activities, including the continuation of existing or initiation of new activities with several of its facilities.

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Capital Expenditure Commitments

The Company is reconfiguring some of its hospitals to more effectively accommodate patient services and to provide for a greater variety of services, as well as implementing various information system initiatives in its efforts to comply with the Health Information Technology for Economic and Clinical Health Act. The Company has incurred approximately $74.8 million in costs related to uncompleted projects as of September 30, 2014, which is included under the caption “Construction in progress” in the Company’s accompanying unaudited condensed consolidated balance sheet. At September 30, 2014, these uncompleted projects had an estimated cost to complete and equip of approximately $88.1 million. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities. As part of the Company’s current acquisition strategy, management expects capital expenditure commitments to be a significant component of future purchase transactions. At September 30, 2014, the Company estimated its total remaining capital expenditure commitments, including commitments for routine projects, to be approximately $1,670.0 million.

Acquisitions

The Company has historically acquired businesses with prior operating histories. Acquired businesses may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, medical and general professional liabilities, workers compensation liabilities, previous tax liabilities and unacceptable business practices. Although the Company institutes policies designed to conform practices to its standards following completion of acquisitions, there can be no assurance that the Company will not become liable for past activities that may later be asserted to be improper by private plaintiffs or government agencies. Although the Company generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

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Note 13. Earnings Per Share

The following table sets forth the computation of basic and diluted earnings per share for the three and nine months ended September 30, 2014 and 2013 (dollars and shares in millions, except per share amounts):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Numerator for basic and diluted earnings per share attributable to LifePoint Hospitals, Inc.:				
Income from continuing operations	$ 28.7	$ 34.1	$ 108.2	$ 94.3
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(1.2)	(1.6)	(4.5)	(2.4)
Income from continuing operations attributable to LifePoint Hospitals, Inc. stockholders	27.5	32.5	103.7	91.9
Income from discontinued operations, net of income taxes	-	0.3	-	0.7
Net income attributable to LifePoint Hospitals, Inc.	$ 27.5	$ 32.8	$ 103.7	$ 92.6
Denominator:				
Weighted average shares outstanding - basic	44.8	46.5	45.1	46.3
Effect of dilutive securities:				
Stock options and other stock-based awards	1.9	1.3	1.7	1.3
Convertible debt instruments	-	-	0.3	-
Weighted average shares outstanding - diluted	46.7	47.8	47.1	47.6
Basic earnings per share attributable to LifePoint Hospitals, Inc. stockholders:				
Continuing operations	$ 0.61	$ 0.70	$ 2.30	$ 1.99
Discontinued operations	-	-	-	0.01
Net income	$ 0.61	$ 0.70	$ 2.30	$ 2.00

Diluted earnings per share attributable to LifePoint Hospitals, Inc. stockholders:				
Continuing operations	$ 0.59	$ 0.68	$ 2.20	$ 1.93
Discontinued operations	-	-	-	0.01
Net income	$ 0.59	$ 0.68	$ 2.20	$ 1.94

The Company’s convertible debt instruments have been included in the calculation of diluted earnings per share whether or not the contingent requirements were met for conversion when their conversion price was less than the average market price of the Company’s common stock for the period the convertible debt instruments were outstanding. Additionally, certain outstanding stock-based awards have been included in the calculation of diluted earnings per share to the extent they were dilutive for the three or nine months ended September 30, 2014 and 2013.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

Note 14. Guarantor and Non-Guarantor Supplementary Information

The 6.625% Senior Notes and the 5.5% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by substantially all of the Company's existing subsidiaries that guarantee the Senior Credit Agreement. The guarantees are subject to customary release provisions set forth in the agreements for the 6.625% Senior Notes and the 5.5% Senior Notes.

The condensed consolidating financial information for the parent issuer, 100% owned guarantor subsidiaries, non-guarantor subsidiaries, certain eliminations and the Company is presented below for the three and nine months ended September 30, 2014 and 2013 and as of September 30, 2014 and December 31, 2013. Prior year amounts have been reclassified to conform to current year presentation.

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Statements of Operations
For the Three Months Ended September 30, 2014

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 904.9	$ 483.3	$ -	$ 1,388.2
Provision for doubtful accounts	-	157.0	65.2	-	222.2
Revenues	-	747.9	418.1	-	1,166.0
Salaries and benefits	8.3	343.6	206.9	-	558.8
Supplies	-	105.9	74.6	-	180.5
Other operating expenses	-	194.2	91.4	-	285.6
Other income	-	(10.5)	(4.1)	-	(14.6)
Equity in earnings of affiliates	(44.6)	-	-	44.6	-

Depreciation and amortization	-	45.1	23.7	-	68.8
Interest expense, net	8.9	17.0	2.7	-	28.6
Impairment charge	-	12.2	-	-	12.2
Management (income) fees	-	(5.0)	5.0	-	-
	(27.4)	702.5	400.2	44.6	1,119.9
Income from continuing operations before taxes	27.4	45.4	17.9	(44.6)	46.1
(Benefit) provision for income taxes	(0.1)	17.5	-	-	17.4
Net income	27.5	27.9	17.9	(44.6)	28.7
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(0.2)	(1.0)	-	(1.2)
Net income attributable to LifePoint Hospitals, Inc.	$ 27.5	$ 27.7	$ 16.9	$ (44.6)	$ 27.5

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Statements of Operations
For the Three Months Ended September 30, 2013

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 828.4	$ 264.5	$ -	$ 1,092.9
Provision for doubtful accounts	-	156.5	36.7	-	193.2
Revenues	-	671.9	227.8	-	899.7
Salaries and benefits	6.0	314.5	101.7	-	422.2
Supplies	-	99.0	41.6	-	140.6
Other operating expenses	-	174.2	48.4	-	222.6
Other income	-	(14.9)	(5.1)	-	(20.0)
Equity in earnings of affiliates	(46.9)	-	-	46.9	-
Depreciation and amortization	-	43.6	13.8	-	57.4
Interest expense, net	5.5	16.1	2.4	-	24.0
Debt transaction costs	0.3	-	-	-	0.3
Management (income) fees	-	(3.3)	3.3	-	-
	(35.1)	629.2	206.1	46.9	847.1
Income from continuing operations before taxes	35.1	42.7	21.7	(46.9)	52.6
Provision for income taxes	2.3	16.2	-	-	18.5
Income from continuing operations	32.8	26.5	21.7	(46.9)	34.1
Income from discontinued operations, net of taxes	-	0.3	-	-	0.3
Net income	32.8	26.8	21.7	(46.9)	34.4
Less: Net income attributable to noncontrolling interests and					

redeemable noncontrolling interests	-	(0.3)	(1.3)	-	(1.6)
Net income attributable to LifePoint Hospitals, Inc.	$ 32.8	$ 26.5	$ 20.4	$ (46.9)	$ 32.8

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Statements of Operations
For the Nine Months Ended September 30, 2014

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 2,604.7	$ 1,212.5	$ -	$ 3,817.2
Provision for doubtful accounts	-	425.7	171.3	-	597.0
Revenues	-	2,179.0	1,041.2	-	3,220.2
Salaries and benefits	22.1	991.6	508.4	-	1,522.1
Supplies	-	313.0	187.0	-	500.0
Other operating expenses	-	562.1	225.3	-	787.4
Other income	-	(39.3)	(10.2)	-	(49.5)
Equity in earnings of affiliates	(158.5)	-	-	158.5	-
Depreciation and amortization	-	136.5	54.3	-	190.8
Interest expense, net	35.0	51.7	7.1	-	93.8
Impairment charge	-	12.2	-	-	12.2
Management (income) fees	-	(15.0)	15.0	-	-
	(101.4)	2,012.8	986.9	158.5	3,056.8
Income from continuing operations before taxes	101.4	166.2	54.3	(158.5)	163.4
(Benefit) provision for income taxes	(2.3)	57.5	-	-	55.2
Net income	103.7	108.7	54.3	(158.5)	108.2
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(0.6)	(3.9)	-	(4.5)

Net income attributable to LifePoint Hospitals, Inc.	$ 103.7	$ 108.1	$ 50.4	$ (158.5)	$ 103.7

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Statements of Operations
For the Nine Months Ended September 30, 2013

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 2,486.8	$ 782.0	$ -	$ 3,268.8
Provision for doubtful accounts	-	432.2	110.9	-	543.1
Revenues	-	2,054.6	671.1	-	2,725.7
Salaries and benefits	19.1	946.3	312.1	-	1,277.5
Supplies	-	301.9	127.5	-	429.4
Other operating expenses	0.5	519.9	146.6	-	667.0
Other income	-	(30.5)	(6.2)	-	(36.7)
Equity in earnings of affiliates	(129.8)	-	-	129.8	-
Depreciation and amortization	-	130.6	38.5	-	169.1
Interest expense, net	13.6	50.1	6.8	-	70.5
Gain on settlement of pre-acquisition contingent obligation	-	-	(5.6)	-	(5.6)
Debt transaction costs	4.7	-	-	-	4.7
Management (income) fees	-	(9.8)	9.8	-	-
	(91.9)	1,908.5	629.5	129.8	2,575.9
Income from continuing operations before taxes	91.9	146.1	41.6	(129.8)	149.8
(Benefit) provision for income taxes	(0.7)	56.2	-	-	55.5
Income from continuing operations	92.6	89.9	41.6	(129.8)	94.3
Income from discontinued operations, net of taxes	-	0.7	-	-	0.7
Net income	92.6	90.6	41.6	(129.8)	95.0
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(0.6)	(1.8)	-	(2.4)
Net income attributable to LifePoint					

Hospitals, Inc.	$ 92.6	$ 90.0	$ 39.8	$ (129.8)	$ 92.6

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Balance Sheets
September 30, 2014

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$ -	$ 123.2	$ 139.8	$ -	$ 263.0
Accounts receivable, net	-	469.8	271.2	-	741.0
Inventories	-	71.6	43.5	-	115.1
Prepaid expenses	0.2	29.2	15.8	-	45.2
Income taxes receivable	43.4				43.4
Deferred tax assets	116.8	-	-	-	116.8
Other current assets	-	55.0	37.2	-	92.2
	160.4	748.8	507.5	-	1,416.7
Property and equipment:					
Land	-	72.5	62.9	-	135.4
Buildings and improvements	-	1,569.5	610.5	-	2,180.0
Equipment	-	1,270.2	306.2	-	1,576.4
Construction in progress	-	54.2	20.6	-	74.8
	-	2,966.4	1,000.2	-	3,966.6
Accumulated depreciation	-	(1,409.4)	(206.0)	-	(1,615.4)
	-	1,557.0	794.2	-	2,351.2
Deferred loan costs, net	32.8	-	-	-	32.8
Intangible assets, net	-	35.1	34.0	-	69.1
Investments in subsidiaries	1,998.9	-	-	(1,998.9)	-
Due from subsidiaries	2,426.0	-	-	(2,426.0)	-
Other	5.1	19.5	18.4	-	43.0
Goodwill	-	1,441.9	195.7	-	1,637.6
Total assets	$ 4,623.2	$ 3,802.3	$ 1,549.8	$ (4,424.9)	$ 5,550.4
LIABILITIES AND EQUITY					

Current liabilities:					
Accounts payable	$ -	$ 99.4	$ 65.4	$ -	$ 164.8
Accrued salaries	-	122.2	71.5	-	193.7
Other current liabilities	35.7	111.1	77.6	-	224.4
Current maturities of long-term debt	14.0	0.8	1.5	-	16.3
	49.7	333.5	216.0	-	599.2
Long-term debt	2,143.5	49.2	13.1	-	2,205.8
Due to Parent	-	1,746.7	679.3	(2,426.0)	-
Deferred income tax liabilities	218.4	-	-	-	218.4
Long-term portion of reserves for self-insurance claims	-	101.2	27.3	-	128.5
Other long-term liabilities	10.0	22.2	53.9	-	86.1
Long-term income tax liability	19.2	-	-	-	19.2
Total liabilities	2,440.8	2,252.8	989.6	(2,426.0)	3,257.2
Redeemable noncontrolling interests	-	-	84.6	-	84.6
Total LifePoint Hospitals, Inc. stockholders' equity	2,182.4	1,548.0	450.9	(1,998.9)	2,182.4
Noncontrolling interests	-	1.5	24.7	-	26.2
Total equity	2,182.4	1,549.5	475.6	(1,998.9)	2,208.6
Total liabilities and equity	$ 4,623.2	$ 3,802.3	$ 1,549.8	$ (4,424.9)	$ 5,550.4

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Balance Sheets
December 31, 2013

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$ -	$ 558.3	$ 79.6	$ -	$ 637.9
Accounts receivable, net	-	444.3	151.4	-	595.7
Inventories	-	73.4	28.6	-	102.0
Prepaid expenses	0.1	30.6	7.3	-	38.0
Deferred tax assets	147.7	-	-	-	147.7
Other current assets	-	53.0	19.9	-	72.9
	147.8	1,159.6	286.8	-	1,594.2
Property and equipment:					
Land	-	76.0	36.3	-	112.3
Buildings and improvements	-	1,570.1	449.5	-	2,019.6
Equipment	-	1,256.4	213.5	-	1,469.9
Construction in progress	-	45.6	13.1	-	58.7
	-	2,948.1	712.4	-	3,660.5
Accumulated depreciation	-	(1,309.0)	(154.3)	-	(1,463.3)
	-	1,639.1	558.1	-	2,197.2
Deferred loan costs, net	31.1	-	-	-	31.1
Intangible assets, net	-	40.3	32.3	-	72.6
Investments in subsidiaries	1,853.1	-	-	(1,853.1)	-
Due from subsidiaries	2,760.4	-	-	(2,760.4)	-
Other	3.4	22.4	14.9	-	40.7
Goodwill	-	1,435.1	215.9	-	1,651.0
Total assets	$ 4,795.8	$ 4,296.5	$ 1,108.0	$ (4,613.5)	$ 5,586.8
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	$ -	$ 99.1	$ 36.8	$ -	$ 135.9
Accrued salaries	-	102.1	37.5	-	139.6

Other current liabilities	14.8	146.4	36.0	-	197.2
Current maturities of long-term debt	581.4	0.7	0.9	-	583.0
	596.2	348.3	111.2	-	1,055.7
Long-term debt	1,739.8	50.0	4.0	-	1,793.8
Due to Parent	-	2,324.8	435.6	(2,760.4)	-
Deferred income tax liabilities	233.1	-	-	-	233.1
Long-term portion of reserves for self-insurance claims	-	113.5	26.3	-	139.8
Other long-term liabilities	-	20.2	35.2	-	55.4
Long-term income tax liability	16.6	-	-	-	16.6
Total liabilities	2,585.7	2,856.8	612.3	(2,760.4)	3,294.4
Redeemable noncontrolling interests	-	-	59.8	-	59.8
Total LifePoint Hospitals, Inc. stockholders' equity	2,210.1	1,438.2	414.9	(1,853.1)	2,210.1
Noncontrolling interests	-	1.5	21.0	-	22.5
Total equity	2,210.1	1,439.7	435.9	(1,853.1)	2,232.6
Total liabilities and equity	$ 4,795.8	$ 4,296.5	$ 1,108.0	$ (4,613.5)	$ 5,586.8

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Statements of Cash Flows
For the Three Months Ended September 30, 2014

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 27.5	$ 27.9	$ 17.9	$ (44.6)	$ 28.7
Adjustments to reconcile net income to net cash provided by operating activities:					
Equity in earnings of affiliates	(44.6)	-	-	44.6	-
Stock-based compensation	7.3	-	-	-	7.3
Depreciation and amortization	-	45.1	23.7	-	68.8
Amortization of physician minimum revenue guarantees	-	3.1	0.4	-	3.5
Amortization of debt discounts, premium and deferred loan costs	1.2	-	-	-	1.2
Impairment charge	-	12.2	-	-	12.2
Deferred income taxes	28.2	-	-	-	28.2
Reserve for self-insurance claims, net of payments	-	2.8	(1.8)	-	1.0
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	(7.7)	(20.7)	-	(28.4)
Inventories and other current assets	0.1	(0.6)	7.2	-	6.7
Accounts payable and accrued expenses	22.8	6.7	(0.8)	-	28.7
Income taxes payable/receivable	(26.7)	-	-	-	(26.7)
Other	0.1	(0.2)	0.2	-	0.1
Net cash provided by operating activities	15.9	89.3	26.1	-	131.3
Cash flows from investing activities:					

Purchases of property and equipment	-	(27.1)	(9.9)	-	(37.0)
Acquisitions, net of cash acquired	-	(7.9)	(164.2)	-	(172.1)
Other	(0.5)	1.1	(1.2)	-	(0.6)
Net cash used in investing activities	(0.5)	(33.9)	(175.3)	-	(209.7)
Cash flows from financing activities:					
Payments of borrowings	(2.8)	-	-	-	(2.8)
Repurchases of common stock	(0.4)	-	-	-	(0.4)
Payment of debt financing costs	(0.8)	-	-	-	(0.8)
Proceeds from exercise of stock options	4.8	-	-	-	4.8
Change in intercompany balances with affiliates, net	(16.1)	(167.8)	183.9	-	-
Other	(0.1)	0.7	(2.0)	-	(1.4)
Net cash (used in) provided by financing activities	(15.4)	(167.1)	181.9	-	(0.6)
Change in cash and cash equivalents	-	(111.7)	32.7	-	(79.0)
Cash and cash equivalents at beginning of period	-	234.9	107.1	-	342.0
Cash and cash equivalents at end of period	$ -	$ 123.2	$ 139.8	$ -	$ 263.0

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Statements of Cash Flows
For the Three Months Ended September 30, 2013

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 32.8	$ 26.8	$ 21.7	$ (46.9)	$ 34.4
Adjustments to reconcile net income to net cash provided by operating activities:					
Income from discontinued operations	-	(0.3)	-	-	(0.3)
Equity in earnings of affiliates	(46.9)	-	-	46.9	-
Stock-based compensation	6.0	-	-	-	6.0
Depreciation and amortization	-	43.6	13.8	-	57.4
Amortization of physician minimum revenue guarantees	-	3.7	0.4	-	4.1
Amortization of debt discounts and deferred loan costs	6.8	-	-	-	6.8
Debt transaction costs	0.3	-	-	-	0.3
Deferred income tax benefit	(9.9)	-	-	-	(9.9)
Reserve for self-insurance claims, net of payments	-	(0.3)	1.1	-	0.8
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	2.6	(10.2)	-	(7.6)
Inventories and other current assets	(0.1)	(12.3)	3.3	-	(9.1)
Accounts payable and accrued expenses	11.2	10.6	(15.2)	-	6.6
Income taxes payable/receivable	14.7	-	-	-	14.7
Other	-	(0.2)	0.1	-	(0.1)
Net cash provided by operating activities - continuing operations	14.9	74.2	15.0	-	104.1
Net cash provided by operating activities - discontinued operations	-	0.2	-	-	0.2
Net cash provided by operating activities	14.9	74.4	15.0	-	104.3

Cash flows from investing activities:

Purchases of property and equipment	-	(23.5)	(9.2)	-	(32.7)
Acquisitions, net of cash acquired	-	(12.2)	-	-	(12.2)
Other	(1.6)	-	(0.1)	-	(1.7)
Net cash used in investing activities	(1.6)	(35.7)	(9.3)	-	(46.6)
Cash flows from financing activities:					
Payments of borrowings	(3.7)	-	-	-	(3.7)
Repurchases of common stock	(31.3)	-	-	-	(31.3)
Payment of debt financing costs	(7.3)	-			(7.3)
Proceeds from exercise of stock options	6.2	-	-	-	6.2
Change in intercompany balances with affiliates, net	22.8	(6.3)	(16.5)	-	-
Other	-	0.2	(2.0)	-	(1.8)
Net cash used in financing activities	(13.3)	(6.1)	(18.5)	-	(37.9)
Change in cash and cash equivalents	-	32.6	(12.8)	-	19.8
Cash and cash equivalents at beginning of period	-	105.2	69.8	-	175.0
Cash and cash equivalents at end of period	$ -	$ 137.8	$ 57.0	$ -	$ 194.8

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Statements of Cash Flows
For the Nine Months Ended September 30, 2014

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 103.7	$ 108.7	$ 54.3	$ (158.5)	$ 108.2
Adjustments to reconcile net income to net cash provided by operating activities:					
Equity in earnings of affiliates	(158.5)	-	-	158.5	-
Stock-based compensation	20.4	-	-	-	20.4
Depreciation and amortization	-	136.5	54.3	-	190.8
Amortization of physician minimum revenue guarantees	-	10.0	1.2	-	11.2
Amortization of debt discounts, premium and deferred loan costs	12.8	-	-	-	12.8
Impairment charge	-	12.2	-	-	12.2
Deferred income tax benefit	23.1	-	-	-	23.1
Reserve for self-insurance claims, net of payments	-	4.7	1.0	-	5.7
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	(37.0)	(19.7)	-	(56.7)
Inventories and other current assets	(0.1)	18.0	9.2	-	27.1
Accounts payable and accrued expenses	23.5	(38.4)	12.0	-	(2.9)
Income taxes payable/receivable	(46.0)	-	-	-	(46.0)
Other	-	1.3	0.7	-	2.0
Net cash (used in) provided by operating activities	(21.1)	216.0	113.0	-	307.9
Cash flows from investing activities:					

Purchases of property and equipment	-	(64.4)	(26.3)	-	(90.7)
Acquisitions, net of cash acquired	-	(10.6)	(249.3)	-	(259.9)
Other	(1.7)	1.5	(0.8)	-	(1.0)
Net cash used in investing activities	(1.7)	(73.5)	(276.4)	-	(351.6)
Cash flows from financing activities:					
Proceeds from borrowings	412.0	-	-	-	412.0
Payments of borrowings	(582.6)	-	-	-	(582.6)
Repurchases of common stock	(172.3)	-	-	-	(172.3)
Payment of debt financing costs	(6.7)	-	-	-	(6.7)
Proceeds from exercise of stock options	23.1	-	-	-	23.1
Change in intercompany balances with affiliates, net	349.5	(578.2)	228.7	-	-
Other	(0.2)	0.6	(5.1)	-	(4.7)
Net cash provided by (used in) financing activities	22.8	(577.6)	223.6	-	(331.2)
Change in cash and cash equivalents	-	(435.1)	60.2	-	(374.9)
Cash and cash equivalents at beginning of period	-	558.3	79.6	-	637.9
Cash and cash equivalents at end of period	$ -	$ 123.2	$ 139.8	$ -	$ 263.0

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2014

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Statements of Cash Flows
For the Nine Months Ended September 30, 2013

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 92.6	$ 90.6	$ 41.6	$ (129.8)	$ 95.0
Adjustments to reconcile net income to net cash provided by operating activities:					
Income from discontinued operations	-	(0.7)	-	-	(0.7)
Equity in earnings of affiliates	(129.8)	-	-	129.8	-
Stock-based compensation	19.1	-	-	-	19.1
Depreciation and amortization	-	130.6	38.5	-	169.1
Amortization of physician minimum revenue guarantees	-	11.9	1.2	-	13.1
Amortization of debt discounts and deferred loan costs	19.9	-	-	-	19.9
Gain on settlement of pre-acquisition contingent obligation	-	-	(5.6)	-	(5.6)
Debt transaction costs	4.7	-	-	-	4.7
Deferred income tax benefit	(53.6)	-	-	-	(53.6)
Reserve for self-insurance claims, net of payments	-	0.3	7.2	-	7.5
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	(21.0)	(5.2)	-	(26.2)
Inventories and other current assets	(0.1)	(5.9)	1.7	-	(4.3)
Accounts payable and accrued expenses	8.8	(21.2)	(7.0)	-	(19.4)
Income taxes payable/receivable	34.2	-	-	-	34.2
Other	-	0.2	0.4	-	0.6
Net cash (used in) provided by operating activities	(4.2)	184.8	72.8	-	253.4

Cash flows from investing activities:					
Purchases of property and equipment	-	(81.8)	(26.7)	-	(108.5)
Acquisitions, net of cash acquired	-	(18.4)	-	-	(18.4)
Other	(1.8)	0.6	0.9	-	(0.3)
Net cash used in investing activities	(1.8)	(99.6)	(25.8)	-	(127.2)
Cash flows from financing activities:					
Proceeds from borrowings	323.0	-	-	-	323.0
Payments of borrowings	(320.9)	-	-	-	(320.9)
Repurchases of common stock	(38.5)	-	-	-	(38.5)
Payment of debt financing costs	(8.3)	-	-	-	(8.3)
Proceeds from exercise of stock options	34.4	-	-	-	34.4
Change in intercompany balances with affiliates, net	16.5	27.5	(44.0)	-	-
Other	(0.2)	0.1	(6.0)	-	(6.1)
Net cash provided by (used in) financing activities	6.0	27.6	(50.0)	-	(16.4)
Change in cash and cash equivalents	-	112.8	(3.0)	-	109.8
Cash and cash equivalents at beginning of period	-	25.0	60.0	-	85.0
Cash and cash equivalents at end of period	$ -	$ 137.8	$ 57.0	$ -	$ 194.8

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.

We recommend that you read this discussion together with our unaudited condensed consolidated financial statements and related notes included elsewhere in this report, as well as our Annual Report on Form 10-K for the year ended December 31, 2013 (the "2013 Annual Report on Form 10-K"). Unless otherwise indicated, all relevant financial and statistical information included herein relates to our continuing operations. Additionally, unless the context indicates otherwise, LifePoint Hospitals, Inc. and its subsidiaries are referred to in this section as "we," "our," or "us."

We make forward-looking statements in this report, other reports and in statements we file with the United States Securities and Exchange Commission and/or release to the public. In addition, our senior management makes forward-looking statements orally to analysts, investors, the media and others. Broadly speaking, forward-looking statements include: projections of our revenues, net income, earnings per share, capital expenditures, cash flows, debt repayments, interest rates, operating statistics and data or other financial items; efforts to reduce the cost of providing healthcare while increasing quality; descriptions of plans or objectives of our management for future operations, services or growth plans including acquisitions, divestitures, business strategies, core strategies and other initiatives, including our relationship with Duke University Health System, Inc. through Duke LifePoint Healthcare; interpretations of Medicare and Medicaid laws and regulations and their effect on our business; and descriptions of assumptions underlying or relating to any of the foregoing.

In this report, for example, we make forward-looking statements, including statements discussing our expectations about: future financial performance and condition; future liquidity and capital resources; future cash flows; existing debt; changes in depreciation and amortization expenses; our business strategy and operating philosophy; effects of competition in a hospital's market; costs of providing care to our patients; our compliance with new and existing laws and regulations as well as costs and benefits associated with compliance; the impact of national healthcare reform; other income from electronic health records ("EHR"); anticipated capital expenditures, including routine projects, investments in information systems and capital projects related to recent acquisitions and the expectation that capital commitments could be a significant component of future acquisitions; timeframes for completion of capital projects; implementation of supply chain management and revenue cycle functions; the impact of accounting methodologies; industry and general economic trends; patient shifts to lower cost healthcare plans which generally provide lower reimbursement; reimbursement changes, including policy considerations and changes resulting from state budgetary restrictions; the amount of reimbursement payments under the New Mexico state program; the closing date of the sale of River Parishes; patient volumes and related revenues; claims and legal actions relating to professional liabilities; governmental investigations and voluntary self-disclosures; and physician recruiting and retention.

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

There are several factors, some beyond our control that could cause results to differ significantly from our expectations. Some of these factors, as well as other factors such as market, operational, liquidity, interest rate and

other risks, are described in Part I, Item 1A. Risk Factors and Part II, Item 7A. Quantitative and Qualitative Disclosures about Market Risk of the 2013 Annual Report on Form 10-K. Any factor described in this report and in the 2013 Annual Report on Form 10-K could by itself, or together with one or more factors, adversely affect our business, results of operations and/or financial condition. There may be factors not described in this report or in the 2013 Annual Report on Form 10-K that could also cause results to differ from our expectations.

Overview

We operate general acute care hospitals primarily in non-urban communities in the United States ("U.S."). At September 30, 2014, on a consolidated basis, we operated 68 hospital campuses in 21 states, having a total of 8,334 licensed beds. We generate revenues primarily through hospital services offered at our facilities. We generated revenues of $1,166.0 million and $899.7 million during the three months ended September 30, 2014 and 2013, respectively, and $3,220.2 million and $2,725.7 million during the nine months ended September 30, 2014 and 2013, respectively. We derived revenues from the Medicare and Medicaid programs, collectively, of 44.9% and 47.8% during the three months ended September 30, 2014 and 2013, respectively, and 45.2% and 47.3% during the nine months ended September 30, 2014 and 2013, respectively. Payments made to our hospitals pursuant to the Medicare and Medicaid programs for services rendered rarely exceed our costs for such services. As a result, we rely largely on payments made by private or commercial payors, together with certain limited services provided to Medicare recipients, to generate an operating profit. The hospital industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial payors. This places a premium on efficient operation, the ability to reduce or control costs and the need to leverage the benefits of our organization across all of our hospitals.

Competitive and Structural Environment

The environment in which our hospitals operate is extremely competitive. In addition to competitive concerns, many of our communities are experiencing slow growth, and in some cases, population losses. We believe this trend has occurred primarily as a result of recent challenging economic conditions because the economies in the non-urban communities in which our hospitals primarily operate are often dependent on a small number of larger employers, especially manufacturing or other facilities. This causes the economies of our communities to be more sensitive to economic downturns and slower to rebound when the overall U.S. economy improves.

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

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

We believe other key factors in our competition for patients is the quality of our patient care and the perception of that quality in the communities where our hospitals are located, which may be influenced by, among other things, the

technology, service lines and capital improvements made at our facilities and by the skills and experience of our non-physician employees involved in patient care.

Business Strategy

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

- Measurement and improvement of quality of patient care and perceptions of such quality in communities where our hospitals are located;
- Targeted recruiting of primary care physicians and physicians in key specialties;
- Retention of physicians and efforts to improve physician satisfaction, including employing a greater number of primary care physicians as well as physicians in certain specialties;
- Retention and, where needed, recruitment of non-physician employees involved in patient care and efforts to improve employee satisfaction;
- Targeted investments in new technologies, new service lines and capital improvements at our facilities;
- Improvements in management of expenses and revenue cycle;
- Negotiation of improved reimbursement rates with non-governmental payors;
- Strategic growth through acquisition and integration of hospitals and other healthcare facilities where valuations are attractive and we can identify opportunities for improved financial performance through our management or ownership; and
- Developing strategic partnerships with not-for-profit healthcare providers to achieve growth in new regions.

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

Regulatory Environment

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

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

areas of the Office of the Inspector General (“OIG”), the Department of Justice (“DOJ”) and other governmental fraud and abuse programs.

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively the "Affordable Care Act") dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, providing additional funding for Medicaid in states that choose to expand their programs, reducing Medicare and Medicaid disproportionate share hospital ("DSH") payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, and instituting certain private health insurance reforms. Although some of the measures contained in the Affordable Care Act did not take effect until 2014 or do not take effect until later, certain of the reductions in Medicare spending, such as negative adjustments to the Medicare hospital inpatient and outpatient prospective payment system market basket updates and the incorporation of productivity adjustments to the Medicare program's annual inflation updates, became effective prior to 2014. During the first nine months of 2014, and primarily as a result of the expansion of health insurance coverage, we experienced an increase in revenues from providing care to certain previously uninsured individuals. While we expect this trend to continue, the future impact and timing of such expansion remains difficult to predict, will be gradual and may not offset scheduled decreases in reimbursement.

There have been and likely will continue to be a number of legal challenges to various provisions of the Affordable Care Act. For example, in 2012, the U.S. Supreme Court upheld the constitutionality of the Affordable Care Act, including the "individual mandate" provisions of the Affordable Care Act that generally require all individuals to obtain healthcare insurance or pay a penalty. However, the U.S. Supreme Court also held that the provision of the Affordable Care Act that authorized the Secretary of the Department of Health and Human Services ("HHS") to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. As a result, at September 30, 2014, only eight of the states in which we operate are currently implementing expansions to their Medicaid programs. Accordingly, some low-income persons in other states that are not expanding Medicaid may not have insurance coverage as intended by the Affordable Care Act. In addition, on July 22, 2014, the U.S. Court of Appeals for the District of Columbia and the U.S. Court of Appeals for the Fourth Circuit issued conflicting rulings on whether premium subsidies may be made available to individuals residing in the 36 states that have federally-run health insurance exchanges. The unavailability of premium subsidies for individuals purchasing their insurance through federally-run health insurance exchanges would result in many of those individuals dropping their coverage and increasing the number of uninsured.

The Affordable Care Act changes how healthcare services are covered, delivered, and reimbursed. The net effect of the Affordable Care Act on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, gradual implementation and possible amendment, as well as the uncertainty as to the extent to which states will choose to expand their Medicaid program and the extent to which individuals will elect coverage. In addition, a number of the provisions of the Affordable Care Act that were scheduled to become effective in 2014, such as the employer mandate, the Small Business Health Option Program, and the state run exchange verification of income and Medicaid agency electronic notification of eligibility for tax credit and subsidy requirements, have been delayed until 2015 or 2016, and additional delays in the implementation of these or other provisions of the Affordable Care Act could be imposed in the future. As a result, we are unable to predict with any certainty the net effect on our business, financial condition or results of operations of the expected increases in insured individuals using our facilities, the reductions in government healthcare reimbursement spending,

and numerous other provisions of the Affordable Care Act that may affect us. We are also unable to predict with a high level of precision how providers, payors, employers and other market participants will continue to respond to the various reform provisions because many provisions will not be implemented for several years under the Affordable Care Act's implementation schedule. Furthermore, several bills have been and may continue to be introduced in Congress to delay, defund or repeal implementation of or amend all significant provisions of the Affordable Care Act, and the results of such legislative efforts may impact our business in the future.

Medicare and Medicaid Reimbursement

Medicare payment methodologies have been, and are expected to continue to be, revised significantly based on cost containment and policy considerations. The Centers for Medicare and Medicaid Services ("CMS") has already begun to implement some of the Medicare reimbursement reductions required by the Affordable Care Act. These revisions will likely be more frequent and significant as more of the Affordable Care Act's changes and cost-saving measures become effective. Additionally, the Middle Class Tax Relief and Job Creation Act of 2012 and the American Taxpayer Relief Act of 2012 require further reductions in Medicare payments, and the Budget Control Act of 2011 ("BCA") imposed a 2% reduction in Medicare spending effective as of April 1, 2013.

On March 4, 2014, the Office of Management and Budget released President Obama's proposed budget for federal fiscal year ("FFY") 2015 (the "Proposed Budget"). Among other things, the Proposed Budget would reduce Medicare spending by $400 billion from FFY 2015 to FFY 2024. The Proposed Budget would achieve these reductions by, among other things, reducing payments to Medicare providers, reducing payments for prescription drugs covered under Medicare Part B and Part D, and increasing financial liabilities for certain Medicare beneficiaries. We cannot predict whether the Proposed Budget will be implemented in whole or in part or whether Congress will take other legislative action to reduce spending on the Medicare and Medicaid programs. Additionally, future efforts to reduce the federal deficit may result in additional revisions to and payment reductions for the amounts we receive for our services.

On August 22, 2014, CMS published its hospital inpatient patient prospective system ("IPPS") final rule for FFY 2015, which began on October 1, 2014. Among other things, the final rule provides a payment rate increase of 1.4% for hospitals that successfully report the quality measures for the Hospital Inpatient Quality Reporting ("IQR") Program (formerly the Reporting Hospital Quality Data for Annual Payment Update Program) and are meaningful EHR users. The rate increase is based on a hospital market basket increase of 2.9%, which is reduced by (i) a multi-factor productivity adjustment of 0.5%, (ii) a 0.2% reduction required by the Affordable Care Act, and (iii) a 0.8% documentation and coding recoupment adjustment required by the American Taxpayer Relief Act of 2012 ("ATRA"). Hospitals that do not successfully report quality data under the IQR Program will be subject to a one-fourth reduction of the hospital market basket increase prior to the application of any applicable statutory adjustments. In addition, hospitals that are not meaningful EHR users are also subject to an additional one-fourth reduction of the hospital market basket increase. With respect to the documentation and coding recoupment adjustment required by the ATRA, CMS indicated that it expects to make similar adjustments in FFYs 2016 and 2017 in order to recoup the entire $11 billion that it is required to recover by the ATRA to offset the additional increase in aggregate payments to hospitals that Congress believes occurred from FFY 2008 through FFY 2013 solely as a result of the transition to the MS-DRG system and that was not recaptured by the adjustments that were mandated by the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007.

In addition to establishing the payment rate update, the IPPS final rule for FFY 2015 also makes a number of other changes to the Medicare program's IPPS. Among other things, the final rule implements a 1.0% payment decrease required by the Affordable Care Act for hospitals that rank in the top quartile for the rate of hospital acquired conditions and updates the measures and financial incentives in Medicare's hospital value-based purchasing and readmissions reduction programs. In addition, the IPPS final rule for FFY 2015 updates the factors used to determine the amount and distribution of Medicare DSH payments to hospitals and establishes the uncompensated care amount which will be distributed to qualifying hospitals in FFY 2015 at $7.65 billion, which is less than the $8.56 billion that was originally estimated in the IPPS proposed rule for FFY 2015, which was published on May 15, 2014. The final

rule also revises the labor market areas used for the IPPS wage index system based on the most recent core-based statistical area delineations issued by the Office of Management and Budget based on 2010 census data. Under the final rule, in order to mitigate the potentially negative impacts of the new labor market areas, CMS will generally phase the new wage index in over a one year period, with the wage index for FFY 2015, being a 50/50 blend of the former wage index and the new wage index. Overall, CMS estimates that the rate increase, when combined with reductions under the Hospital Readmissions Reduction Program, changes to Medicare DSH payments, the expiration of certain statutory provisions that provided special temporary increases in payments to low-volume and Medicare dependent hospitals, and other changes to IPPS payment policies, will decrease IPPS payments to hospitals by 0.6% or $734 million in FFY 2015.

On July 14, 2014, CMS published its hospital outpatient prospective payment system ("OPPS") proposed rule for calendar year ("CY") 2015, which begins on January 1, 2015. Among other things, the proposed rule provides for a payment rate increase of 2.1% percent for hospitals that meet the reporting requirements of the Medicare Hospital Outpatient Quality Reporting ("OQR") Program and a payment rate increase of 0.1% for hospitals that do not. The proposed rate increase is based on a proposed hospital market basket increase of 2.7%, which is reduced by a multi-factor productivity adjustment of 0.4% and an additional 0.2% reduction required by the Affordable Care Act. The proposed rule also makes several other changes to the Medicare program's OPPS, including implementing (with modifications) the policy for comprehensive Ambulatory Payment Classifications ("APCs") that was finalized in the OPPS final rule for CY 2014 and that would create 28 comprehensive APCs that combine certain items and services that are related to the performance of a primary service into a single payment for the comprehensive service under the OPPS, revising the requirements for physician certification of hospital inpatient services such that a physician certification is only required for outlier and long-stay cases of 20 days or more, and requiring hospitals and physicians to provide additional information about services provided in off-campus provider-based departments on their claim forms.

In September 2014, in response to concerns that the Medicare program's denials of reimbursement for short-term care have caused a significant growth in claim appeals, CMS announced that it was offering an administrative agreement to any hospital willing to withdraw its pending appeals in exchange for timely partial payment in an amount equal to 68% of the net allowable amount of the claims at issue. CMS has encouraged hospitals with inpatient status claims currently in the appeals process (or within the timeframe to request an appeal) and with dates of admission prior to October 1, 2013, to make use of this administrative agreement mechanism to alleviate the administrative burden of current appeals on both the hospital and Medicare system. Hospitals have until October 31, 2014 to participate in the settlement.

On October 1, 2014, the Texas Health and Human Services Commission ("THHSC") issued a notice to hospitals participating in a Texas Medicaid waiver program. The waiver, from CMS, allows the state to receive federal matching Medicaid funds for certain local government/hospital affiliations. According to the notice, a review conducted by CMS identified some of these affiliations it believes may be inconsistent with the waiver. As a result of these findings, CMS notified THHSC that it is deferring the federal portion of the Medicaid payments associated with these affiliations. One of our hospitals in Texas participates in this program; however, the CMS deferral has not impacted this hospital. Furthermore, the funding this hospital receives under this program is immaterial to its operations. THHSC stated that it intends to work closely with CMS in connection with this review with the goal of resolving the matter. Because these discussions are ongoing, we are unable to estimate the future financial impact that this review may have on our results of operations.

"Two Midnight Rule"

In the Medicare program's hospital IPPS final rule for FFY 2014, CMS issued the "two midnight rule," which revised its longstanding guidance to hospitals and physicians relating to when hospital inpatient admissions are deemed to be reasonable and necessary for payment under Medicare Part A. Under the two midnight rule, in addition to services that are designated as inpatient-only, surgical procedures, diagnostic tests and other treatments are generally

appropriate for inpatient hospital admission and payment under Medicare Part A when the physician (i) expects the beneficiary to require a stay that crosses at least two midnights and (ii) admits the beneficiary to the hospital based upon that expectation. Conversely, hospital stays in which the physician expects the beneficiary to require care that spans less than two midnights are generally inappropriate for payment under Medicare Part A, and should be treated and billed as outpatient services under Part B.

While the IPPS final rule for FFY 2014 became effective on October 1, 2013, CMS initially indicated that, for a period of 90 days after the effective date of the rule, it would not permit recovery auditors and other Medicare review contractors to review inpatient admissions of one midnight or less that began between October 1, 2013 and December 31, 2013. CMS subsequently extended that delay to inpatient admissions that occur on or prior to September 30, 2014. CMS did, however, instruct Medicare Administrative Contractors ("MACs") to review, on a pre-payment basis, a small sample (approximately 10 – 25) of inpatient hospital claims relating to admissions that occur between March 31, 2014 and September 30, 2014, and that span less than two midnights after admission in order to determine each hospital's compliance with the new inpatient admission and medical review criteria. Hospitals can rebill denied inpatient hospital admissions in accordance with the rule.

On April 1, 2014, President Obama signed the Protecting Access to Medicare Act of 2014 (“PAMA”) into law. Among other things, PAMA extends the delay of the enforcement of the two midnight rule by recovery auditor and other Medicare review contractors through March 31, 2015, and authorizes CMS to continue to allow MACs to review, on a pre-payment basis, a small sample of inpatient hospital claims relating to admissions that span less than two midnights and that occur between March 31, 2014, and March 31, 2015, in order to determine hospital compliance with the new inpatient admission and medical review criteria.

On May 15, 2014, CMS solicited comments in the IPPS proposed rule for FFY 2015 regarding the development of an alternative payment methodology under the Medicare program for short inpatient hospital stays. Among other things, CMS is seeking input on how to define a short inpatient hospital stay for Medicare payment purposes and how to determine the appropriate payment amounts for short inpatient hospital stays. In the IPPS final rule for FFY 2015, CMS indicated it would consider the comments received in future rulemaking.

We cannot predict whether Congress or CMS will further delay the review of inpatient admissions of one midnight or less by recovery auditors or other Medicare review contractors or the impact that any such reviews will have on our business and results of operations and when they are allowed by CMS. In addition, legislation has been introduced in Congress that, among other things, would generally prohibit Medicare review contractors from denying claims due to the length of a patient’s stay or a determination that services could have been provided in an outpatient setting and require CMS to develop a new payment methodology for services that are provided during short inpatient hospital stays. Federal lawsuits have also been filed challenging the two midnight rule primarily on the grounds that the implementation of the rule itself, and the payment reduction associated with the rule (i.e., 0.2% IPPS payment reduction to hospitals) violate the Administrative Procedure Act. We cannot predict whether the legislation that has been introduced in Congress will be adopted or, if adopted, the amount of reimbursement that would be paid under any alternative payment methodology that is developed by CMS. We also cannot predict whether the federal court challenges to the two midnight rule will be successful.

Physician Services

Physician services are reimbursed under the Medicare physician fee schedule (“PFS”) system, under which CMS has assigned a national relative value unit (“RVU”) to most medical procedures and services that reflects the various resources required by a physician to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service, practice expense (overhead) attributable to the service and malpractice insurance expense attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs then aggregated. The aggregated amount is multiplied by a conversion factor that accounts for inflation and targeted growth in Medicare expenditures (as calculated by the sustainable growth rate (“SGR”)) to arrive at the payment amount for each service.

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

payment decreases has been averted by Congressional action. For CY 2014, CMS issued a final rule that would have applied the SGR and resulted in an aggregate reduction of 20.1% to all physician payments under the PFS for CY 2014. The Pathway for SGR Reform Act of 2013, which was enacted on December 26, 2013 (the "Pathway Act") delayed the application of the SGR and provided for a 0.5% increase in PFS payment rates through March 31, 2014. PAMA extends the 0.5% increase in PFS payment rates established by the Pathway Act through December 31, 2014. It also provides that there will be no increase to the CY 2015 PFS from January 1, 2015 through March 31, 2015.

On July 11, 2014, CMS published the PFS proposed rule for CY 2015. Since updates to the PFS are pre-determined based on a statutory formula that cannot be changed by CMS, the proposed rule did not include any proposal or announcement regarding updates or changes to the PFS. However, in March 2014, prior to the enactment of PAMA, CMS estimated that payments to physicians in CY 2015 would be reduced by 20.9%. We cannot predict whether Congress will pass legislation, such as the SGR Repeal and Medicare Provider Payment Modernization Act, to avert the rate cut for the remainder of CY 2015 and/or otherwise adopt a permanent fix for the issues that are created by the application of the SGR. If the payment reduction to the PFS is not averted prior to March 31, 2015, the reimbursement received by our employed physicians, the physicians to whom our hospitals have provided recruitment assistance, and the physician members of our medical staffs would be adversely affected.

Protecting Access to Medicare Act of 2014

As previously noted, on April 1, 2014, President Obama signed in to law the Protecting Access to Medicare Act of 2014, or PAMA. In addition to delaying the enforcement of the two midnight rule and extending the PFS payment rate increase provided by the Pathway Act, PAMA made changes to a number of payment and other provisions of the Medicare and Medicaid programs. Among other things, PAMA:

- Extends the Medicare dependent hospital program, which provides enhanced payment support for rural hospitals that have no more than 100 beds and at least 60% of their inpatient days or discharges covered by the Medicare program, through March 31, 2015;
- Extends the Medicare low volume hospital program, which provides additional Medicare reimbursement for general acute care hospitals that are located 15 road miles from another general acute care hospital and have less than 1,600 Medicare discharges each fiscal year, through March 31, 2015;
- Extends the Transitional Medicare Assistance Program, which provides Medicaid insurance coverage for families transitioning from welfare to work, through March 31, 2015;
- Establishes a value based purchasing program for skilled nursing facilities that, beginning October 1, 2018, will withhold 2% of the Medicare program's payments to skilled nursing facilities and re-distribute between 50% to 70% of the amount that is withheld to high performing facilities with reduced hospital readmissions;
- Delays until October 1, 2017, the Medicaid state DSH allotment reductions required by the Affordable Care Act that were scheduled to become effective on October 1, 2016, and extends those reductions through FFY 2024; and
- Realigns the Medicare sequester for FFY 2024 so that there will be a 4.0% sequester for the first six months of FFY 2024 and a 0% sequester for the second six months of FFY 2024, instead of a 2.0% sequester for the full 12-month period.

Adoption of Electronic Health Records

The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") was enacted into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act includes provisions designed to increase the use of EHR by both physicians and hospitals. EHR meaningful use objectives and measures that hospitals and physicians must meet in order to qualify for incentive payments will be implemented in three stages. Stage 1 has been in effect since 2011; however, on September 4, 2012, HHS released final requirements for Stage 2, which took effect on October 1, 2013. We strive to comply with the EHR meaningful use requirements of the HITECH Act in time to qualify for the maximum available incentive payments. Our compliance has and will continue to result in significant costs including business process changes, professional services focused on successfully designing and implementing our EHR solutions along with costs associated with the hardware and software components of the project. As we complete our full implementation of certified EHR technology in accordance with all three phases of the program, our EHR incentive payments will decline and ultimately end. We currently estimate that at a minimum total costs incurred to comply will be recovered through the total EHR incentive payments over the projected lifecycle of this initiative.

An important component of the effective implementation of our EHR initiatives involves our uninterrupted access to reliable information systems. In late 2011, we entered into an agreement with a third party technology provider to design and operate a hosted data center for our critical third party information systems. In addition to providing a hosted data center, the third party technology provider offers help desk end-user support for certain clinical

information systems, provides help desk and support functions for certain clinical information system applications, performs backups and recoveries of certain critical data, and monitors critical systems to facilitate the identifications of and rapid responses to certain system issues. We believe this agreement provides us with a single technology platform for the delivery of critical third party information systems for the majority of our hospitals and will improve the effectiveness and efficiency of key information support functions in a cost-effective and high quality manner.

Privacy and Security Requirements and Administrative Simplification Provisions

We are subject to the privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the HITECH Act, which are designed to protect the confidentiality, availability and integrity of health information. The HIPAA privacy and security regulations apply to health plans, health care clearinghouses, and healthcare providers that transmit health information in an electronic form in connection with HIPAA standard transactions. The HIPAA privacy standards, which apply to individually identifiable information held or disclosed by a covered entity in any form, whether communicated electronically, on paper or orally, impose extensive administrative requirements on us, require our compliance with rules governing the use and disclosure of this health information, and require us to impose these rules, by contract, on any business associate to whom we disclose such information in order to perform functions on our behalf. They also create rights for patients in their health information, such as the right to access and amend their health information and to request an accounting for certain disclosures of their health information. The HIPAA security standards require us to establish and maintain reasonable and appropriate administrative, technical and physical safeguards to ensure the integrity, confidentiality and the availability of electronic health and related financial information. In addition, our facilities will continue to remain subject to any state laws that are more restrictive than the privacy regulations issued under HIPAA. Also, in January 2014, the Federal Trade Commission (the "FTC") ruled that Section 5 of the Federal Trade Commission Act gives the FTC the authority to regulate as unfair business practices companies' inadequate data security programs that may expose consumers to fraud, identity theft and privacy intrusions.

The HITECH Act, among other things, strengthened the HIPAA privacy and security requirements, significantly increased the penalties for violations of the HIPAA privacy and security regulations, imposed varying civil monetary penalties and created a private cause of action for state attorneys general for certain HIPAA violations, extended HIPAA's security provisions to business associates, and created new security breach notification requirements. The HITECH Act also created a federal breach notification law that mirrors protections that many states have passed in recent years. In 2011, HHS initiated a pilot audit program that ran through December 2012 in the first phase of HHS implementation of the HITECH Act's requirements of periodic audits of covered entities and business associates to ensure their compliance with the HIPAA privacy and security regulations. On February 24, 2014, HHS announced its plan to survey 1,200 organizations as a first step in selecting organizations for the next round of HIPAA audits. We cannot predict whether our hospitals will be selected in the future for an audit or the results of such an audit.

On January 17, 2013, HHS issued a final HIPAA omnibus rule (the "Final HIPAA Rule"), which became effective on March 26, 2013, that modified prior HIPAA regulations and implemented many of the provisions of the HITECH Act. Our facilities were required to comply with the applicable requirements of the Final HIPAA Rule beginning on September 23, 2013, except that certain agreements with business associates qualified for an extended compliance date of September 23, 2014. The Final HIPAA Rule modifications include, among other things: making our facilities' business associates directly liable for compliance with certain of the privacy and security rules' requirements; making our facilities' liable for violations by their business associates if HHS determines an agency relationship exists between the facility and the business associate under federal agency law; adding limitations on the use and disclosure of health information for marketing and fundraising purposes, and prohibiting the sale of health information without individual authorization; expanding our patients' rights to receive electronic copies of their health information and to restrict disclosures to a health plan concerning treatment for which our patient has paid out of pocket in full; requiring modifications to, and redistribution of, our facilities notice of privacy practices; rules addressing enforcement of noncompliance with HIPAA due to willful neglect; an increased and tiered civil money penalty structure; and modifications to the breach notification rules that replace the "risk of harm" standard with a "low probability of compromise" standard, which would require our facilities to prepare a four factor risk assessment for impermissible uses and disclosures of health information. We cannot predict the financial impact to our hospitals in implementing the provisions of the Final HIPAA Rule.

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In addition to the privacy and security requirements, we also are subject to the administrative simplification provisions of HIPAA, which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. In January 2009, CMS published its 10th revision of International Statistical Classification of Diseases and Related Health Problems ("ICD-10") and related changes to the formats used for certain electronic transactions. ICD-10 contains significantly more diagnostic and procedural codes than the existing ICD-9 coding system, and as a result, the coding for the services provided in our hospitals and clinics will require much greater specificity. While providers were previously required to begin using the ICD-10 coding system on October 1, 2014, PAMA delayed the effective date of the ICD-10 transition to October 1, 2015. Implementation of ICD-10 will require a significant investment in technology and training. We may experience delays in reimbursement while our facilities and the payors from which we seek reimbursement make the transition to ICD-10. If any of our hospitals fail to implement the new coding system by the deadline, the affected hospital will not be paid for services. We are not able to predict the overall financial impact of our transition to ICD-10.

Revenue Sources

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

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

Revenues from health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services. These discounted arrangements often limit our ability to increase charges in response to increasing costs. We actively negotiate with these payors in an effort to maintain or increase the pricing of our healthcare services; however, we have no control over patients switching their healthcare coverage to a payor with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. We expect this trend to continue in the coming years.

Self-pay revenues are primarily generated through the treatment of uninsured patients. During the nine months ended September 30, 2014, our self-pay revenues decreased primarily as a result of a decrease in admissions as well as a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our hospitals have experienced in recent years, including increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who choose not to purchase insurance or who purchase insurance plans with high deductibles and high co-payments. Additionally, certain of our hospitals participate in federal, state and local programs that provide for supplemental support and funding for the care of indigent patients and changes in these programs can impact our financial position and results of operations. For example, as a result of changes made to one such program in New Mexico, the Sole Community Provider Program ("New Mexico SCPP"), we recognized revenues of approximately $2.6 million and $7.7 million during the three and nine months ended September 30, 2014, respectively. In contrast, during the three and nine months ended September 30, 2013, we recognized revenues of approximately $7.1 million and $9.4 million, respectively. This represents a net period over period decrease in revenues of $4.5 million and $1.7 million during the three and nine months ended September 30, 2014, respectively, as compared to the same periods of the prior year. This change primarily impacted one of our hospitals, Memorial Medical Center of Las Cruces, New Mexico. Any changes to the New Mexico SCPP, for whatever reason, could have a material adverse effect on our financial position or results of operations in the period the changes occur.

To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. Our provision for doubtful accounts serves to reduce our reported revenues.

Results of Operations

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

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

bps. Basis point change.

Continuing operations. Continuing operations information includes the results of our hospital support center, our same-hospital operations and our recent acquisitions completed in 2014 and 2013. Additionally, continuing operations information includes the results of River Parishes Hospital ("River Parishes"), which was classified as held for sale as of September 30, 2014.

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

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

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

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

N/A. Not applicable.

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

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

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

Same-hospital. Same-hospital information includes the results of our hospital support center and the same 56 hospitals operated during the three and nine months ended September 30, 2014 and 2013. Same-hospital information excludes the results of our recent acquisitions completed in 2014 and 2013, with the exception of Scott Memorial Hospital, which we acquired effective January 1, 2013 through our joint venture with Norton Healthcare, Inc. and which is included in our same-hospital information. Additionally, same-hospital information excludes our hospitals that have

previously been disposed, in addition to River Parishes, which was classified as held for sale as of September 30, 2014.

For the Three Months Ended September 30, 2014 and 2013

Operating Results Summary

The following table summarizes the results of operations for the three months ended September 30, 2014 and 2013 (dollars in millions):

	Three Months Ended September 30,					
	2014			2013		
	Amount	% of Revenues		Amount	% of Revenues	
Revenues before provision for doubtful accounts	$ 1,388.2	119.1	%	$ 1,092.9	121.5	%
Provision for doubtful accounts	222.2	19.1		193.2	21.5	
Revenues	1,166.0	100.0		899.7	100.0	
Salaries and benefits	558.8	47.9		422.2	46.9	
Supplies	180.5	15.5		140.6	15.6	
Other operating expenses	285.6	24.4		222.6	24.8	
Other income	(14.6)	(1.2)		(20.0)	(2.2)	
Depreciation and amortization	68.8	6.0		57.4	6.3	
Interest expense, net	28.6	2.4		24.0	2.7	
Debt transaction costs	-	-		0.3	-	
Impairment charge	12.2	1.0		-	-	
	1,119.9	96.0		847.1	94.1	
Income from continuing operations before income taxes	46.1	4.0		52.6	5.9	
Provision for income taxes	17.4	1.5		18.5	2.1	
Income from continuing operations	28.7	2.5		34.1	3.8	
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(1.2)	(0.1)		(1.6)	(0.2)	
Income from continuing operations attributable to LifePoint Hospitals, Inc.	$ 27.5	2.4	%	$ 32.5	3.6	%

Revenues

The following table presents the components of revenues for the three months ended September 30, 2014 and 2013 (dollars in millions):

	Three Months Ended September 30,			
	2014	2013	Increase	% Increase
Continuing operations:				
Revenues before provision for doubtful accounts	$ 1,388.2	$ 1,092.9	$ 295.3	27.0 %
Provision for doubtful accounts	222.2	193.2	29.0	15.0
Revenues	$ 1,166.0	$ 899.7	$ 266.3	29.6
Same-hospital:				
Revenues before provision for doubtful accounts	$ 1,156.9	$ 1,082.8	$ 74.1	6.8 %
Provision for doubtful accounts	194.2	190.4	3.8	2.0
Revenues	$ 962.7	$ 892.4	$ 70.3	7.9

Our revenues before provision for doubtful accounts by payor and approximate percentages of revenues were as follows for the three months ended September 30, 2014 and 2013 (in millions):

	Three Months Ended September 30,			
	2014		2013	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 361.7	31.0 %	$ 296.0	32.9 %
Medicaid	161.7	13.9	133.9	14.9
HMOs, PPOs and other private insurers	631.0	54.1	446.0	49.6
Self-pay	207.9	17.8	200.8	22.3
Other	25.9	2.3	16.2	1.8
Revenues before provision for doubtful accounts	1,388.2	119.1	1,092.9	121.5
Provision for doubtful accounts	(222.2)	(19.1)	(193.2)	(21.5)
Revenues	$ 1,166.0	100.0 %	$ 899.7	100.0 %

Our revenues per equivalent admission from continuing operations and on a same-hospital basis were as follows for the three months ended September 30, 2014 and 2013:

	Three Months Ended September 30,			
	2014	2013	Increase	% Increase
Revenues per equivalent admission - continuing operations	$ 8,041	$ 7,683	$ 358	4.7
Revenues per equivalent admission - same-hospital	$ 7,931	$ 7,686	$ 245	3.2

Revenues Before Provision for Doubtful Accounts

The following table shows the key drivers of our revenues before provision for doubtful accounts for the three months ended September 30, 2014 and 2013:

	Three Months Ended September 30,	Increase	% Increase

	2014	2013	(Decrease)	(Decrease)
Continuing operations:				
Admissions	56,599	48,671	7,928	16.3
Equivalent admissions	144,994	117,097	27,897	23.8
Medicare case mix index	1.38	1.37	0.01	0.7
Average length of stay (days)	4.8	4.5	0.3	6.7
Inpatient surgeries	15,672	13,341	2,331	17.5
Outpatient surgeries	56,101	45,514	10,587	23.3
Total surgeries	71,773	58,855	12,918	21.9
Emergency room visits	359,701	296,240	63,461	21.4
Outpatient factor	2.57	2.40	0.17	7.1
Same-hospital:				
Admissions	47,939	48,339	(400)	(0.8)
Equivalent admissions	121,382	116,110	5,272	4.5
Medicare case mix index	1.39	1.37	0.02	1.5
Average length of stay (days)	4.5	4.5	-	-
Inpatient surgeries	13,132	13,230	(98)	(0.7)
Outpatient surgeries	47,621	45,235	2,386	5.3
Total surgeries	60,753	58,465	2,288	3.9
Emergency room visits	306,973	292,059	14,914	5.1
Outpatient factor	2.53	2.40	0.13	5.4

For the three months ended September 30, 2014, our same-hospital revenues before provision for doubtful accounts increased $74.1 million, or 6.8%, to $1,156.9 million as compared to $1,082.8 million for the same period last year. This increase was primarily driven by increases in our same-hospital equivalent admissions, higher contracted rates from HMOs, PPOs and other private insurers as well as the favorable impact of healthcare reform. For the three months ended September 30, 2014, our same-hospital equivalent admissions increased 4.5% as compared to the same period last year, primarily as a result of a 3.9% increase in total surgeries and a 5.1% increase in emergency room visits. Additionally, we experienced a payor mix shift from self-pay payors to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate.

Provision for Doubtful Accounts

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts for the three months ended September 30, 2014 and 2013 (dollars in millions):

	Three Months Ended September 30,					
	2014	% of Revenues	2013	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Continuing operations:						
Related key indicators:						
Charity care write-offs	$ 15.1	1.3 %	$ 33.2	3.7 %	$ (18.1)	(54.3) %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 207.9	17.8 %	$ 200.8	22.3 %	$ 7.1	3.5 %
Net revenue days outstanding (at end of period)	60.0	N/A	59.7	N/A	0.3	0.5 %
Same-hospital:						
Related key indicators:						
Charity care write-offs	$ 9.2	1.0 %	$ 33.1	3.7 %	$ (23.9)	(72.3) %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 176.4	18.3 %	$ 198.2	22.2 %	$ (21.8)	(11.0) %
Net revenue days outstanding (at end of period)	57.5	N/A	59.8	N/A	(2.3)	(3.8) %

Our provision for doubtful accounts relates principally to amounts due from patients included in our self-pay population and other amounts such as co-payments and deductibles due from patients included in other payor categories. For the three months ended September 30, 2014, our provision for doubtful accounts increased by $29.0 million, or 15.0%, to $222.2 million on a continuing operations basis and by $3.8 million, or 2.0%, to $194.2 million on a same-hospital basis as compared to the same period last year. Same-hospital self-pay revenues decreased by

$21.8 million over the same period last year. The decrease in same-hospital self-pay revenue is primarily due to a shift from self-pay payors to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population as a result of healthcare reform and the expansion of Medicaid coverage. However, as patient financial responsibility has continued to increase with higher co-payment and deductible obligations, our provision for doubtful accounts has increased to reflect the difficulty in collecting these amounts. The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations, "Critical Accounting Estimates," in the 2013 Annual Report on Form 10-K.

Our net revenue days outstanding at September 30, 2014 increased to 60.0 days compared to 59.7 days at September 30, 2013 on a continuing operations basis. However, our net revenue days outstanding at September 30, 2014 included just a partial quarter of revenues related to our hospital acquisitions completed during the three months ended September 30, 2014. After normalizing for a full quarter of revenues for our hospital acquisitions completed during the three months ended September 30, 2014, we estimate that on a continuing operations basis our net revenue days outstanding would have been 55.4 days at September 30, 2014. On a same-hospital basis, our net revenue days outstanding at September 30, 2014 improved to 57.5 days compared to 59.8 days at September 30, 2013.

Expenses and Other Income

Salaries and Benefits

The following table summarizes our salaries and benefits, man-hours per equivalent admission and salaries and benefits per equivalent admission for the three months ended September 30, 2014 and 2013:

	Three Months Ended September 30,					
	2014	% of Revenues	2013	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 558.8	47.9 %	$ 422.2	46.9 %	$ 136.6	32.3 %
Man-hours per equivalent admission	106	N/A	106	N/A	-	- %
Salaries and benefits per equivalent admission	$ 3,777	N/A	$ 3,594	N/A	$ 183	5.1 %

For the three months ended September 30, 2014, our salaries and benefits expense increased to $558.8 million, or 32.3%, as compared to $422.2 million for the same period last year primarily a result of our recent acquisitions and the impact of an increasing number of employed physicians and their related support staff.

Supplies

The following table summarizes our supplies and supplies per equivalent admission for the three months ended September 30, 2014 and 2013:

Three Months Ended September 30,

	2014	% of Revenues	2013	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 180.5	15.5 %	$ 140.6	15.6 %	$ 39.9	28.4 %
Supplies per equivalent admission	$ 1,243	N/A	$ 1,202	N/A	$ 41	3.4 %

For the three months ended September 30, 2014, our supplies expense increased to $180.5 million, or 28.4%, as compared to $140.6 million for the same period last year primarily as a result of our recent acquisitions.

Other Operating Expenses

The following table summarizes our other operating expenses for the three months ended September 30, 2014 and 2013 (dollars in millions):

	Three Months Ended September 30,					
	2014	% of Revenues	2013	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Professional fees	$ 41.7	3.6 %	$ 34.9	3.9 %	$ 6.8	19.7 %
Utilities	24.1	2.1	18.6	2.1	5.5	29.1
Repairs and maintenance	31.8	2.7	24.3	2.7	7.5	30.9
Rents and leases	11.4	1.0	9.7	1.1	1.7	17.1
Insurance	13.1	1.1	10.3	1.1	2.8	27.3
Physician recruiting	6.2	0.5	6.4	0.7	(0.2)	(4.1)
Contract services	82.8	7.1	63.8	7.1	19.0	29.7
Non-income taxes	32.1	2.7	25.8	2.9	6.3	24.0
Other	42.4	3.6	28.8	3.2	13.6	47.8
	$ 285.6	24.4	$ 222.6	24.8	$ 63.0	28.3 %

For the three months ended September 30, 2014, our other operating expenses increased to $285.6 million, or 28.3%, as compared to $222.6 million for the same period last year primarily as a result of our recent acquisitions. Additionally, our same-hospital other operating expenses increased primarily as a result of increases in same-hospital contract services and other expenses. Our same-hospital contract services expense increased primarily as a result of increased fees and expenses related to the completion of our shared centralized resource initiatives at the majority of our hospitals. Our same-hospital other expenses increased as a result of additional transactional expenses related to our recent acquisitions, including legal and consulting fees.

Other Income

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the three months ended September 30, 2014, we recognized $14.6 million in Medicare and Medicaid EHR incentive payments, collectively, as compared to $20.0 million recognized in the same period last year.

Depreciation and Amortization

For the three months ended September 30, 2014, our depreciation and amortization expense increased by $11.4 million, or 20.0% to $68.8 million, or 6.0% of revenues, as compared to $57.4 million, or 6.3% of revenues for the same period last year. Our depreciation and amortization expense increased primarily as a result of our recent acquisitions as well as a result of significant increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. Accordingly, we anticipate that our depreciation and amortization expense will continue to increase in future periods as a result of these factors in addition to the impact of capital expenditure commitments associated with our recent acquisitions.

Interest Expense, Net

Our interest expense increased by $4.6 million, or 19.1% to $28.6 million for the three months ended September 30, 2014 as compared to $24.0 million for the same period last year. The increase in our interest expense is primarily attributable to an increase in our total debt outstanding during the three months ended September 30, 2014 as compared to the same period last year. On December 6, 2013, we issued in a private placement $700.0 million of 5.5% unsecured senior notes due December 1, 2021 (the "5.5% Senior Notes") with The Bank of New York Mellon Trust Company, N.A., as trustee. The net proceeds from this issuance were partially used to repay $100.0 million of our senior secured incremental term loans (the "Incremental Term Loans"). Subsequently, on May 12, 2014, we issued $400.0 million of additional 5.5% Senior Notes with terms substantially identical to those of the initial offering. The additional notes were issued at a premium of $12.0 million for total net proceeds from the issuance of $412.0 million which were used to fund, in part, the cash-settled portion of the maturity or conversion of our outstanding 3½% convertible senior subordinated notes due May 15, 2014 (the "3½% Notes"). Including the impact of the premium, the additional 5.5% Senior Notes were issued at an effective rate of 4.9%. For a further discussion of our debt and corresponding interest rates, see "Liquidity and Capital Resources — Debt."

Impairment Charge

In connection with our entry into a definitive agreement to sell certain assets of River Parishes and discontinue its operation, we recognized an impairment charge of $12.2 million, or $0.16 loss per diluted share, during the three months ended September 30, 2014. The impairment charge includes the write-down of property, equipment and allocated goodwill to their estimated fair values.

Provision for Income Taxes

Our provision for income taxes was $17.4 million, or 1.5% of revenues, for the three months ended September 30, 2014, as compared to $18.5 million, or 2.1% of revenues, for the same period last year. The $1.1 million decrease in the provision for income taxes was primarily attributable to a decrease in our income from continuing operations before income taxes for the three months ended September 30, 2014, as compared to the same period last year. The effective tax rate increased to 38.6% for the three months ended September 30, 2014, as compared to 36.3% for the same period last year, primarily due to lower non-deductible expenses and a larger reversal of accrued interest expense and taxes in connection with lapses of statutes of limitations during the three months ended September 30, 2013.

For the Nine Months Ended September 30, 2014 and 2013

Operating Results Summary

The following table summarizes the results of operations for the nine months ended September 30, 2014 and 2013 (dollars in millions):

	Nine Months Ended September 30,					
	2014			2013		
	Amount	% of Revenues		Amount	% of Revenues	
Revenues before provision for doubtful accounts	$ 3,817.2	118.5	%	$ 3,268.8	119.9	%
Provision for doubtful accounts	597.0	18.5		543.1	19.9	
Revenues	3,220.2	100.0		2,725.7	100.0	
Salaries and benefits	1,522.1	47.3		1,277.5	46.9	
Supplies	500.0	15.5		429.4	15.8	
Other operating expenses	787.4	24.4		667.0	24.3	
Other income	(49.5)	(1.5)		(36.7)	(1.3)	
Depreciation and amortization	190.8	5.9		169.1	6.2	
Interest expense, net	93.8	2.9		70.5	2.6	
Gain on settlement of pre-acquisition contingent obligation	-	-		(5.6)	(0.2)	
Debt transaction costs	-	-		4.7	0.2	
Impairment charge	12.2	0.4		-	-	
	3,056.8	94.9		2,575.9	94.5	
Income from continuing operations before income taxes	163.4	5.1		149.8	5.5	
Provision for income taxes	55.2	1.7		55.5	2.0	
Income from continuing operations	108.2	3.4		94.3	3.5	
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(4.5)	(0.2)		(2.4)	(0.1)	
Income from continuing operations attributable to LifePoint Hospitals, Inc.	$ 103.7	3.2	%	$ 91.9	3.4	%

Revenues

The following table presents the components of revenues for the nine months ended September 30, 2014 and 2013 (dollars in millions):

	Nine Months Ended September 30,			
	2014	2013	Increase	% Increase
Continuing operations:				
Revenues before provision for doubtful accounts	$ 3,817.2	$ 3,268.8	$ 548.4	16.8 %
Provision for doubtful accounts	597.0	543.1	53.9	9.9
Revenues	$ 3,220.2	$ 2,725.7	$ 494.5	18.1
Same-hospital:				
Revenues before provision for doubtful accounts	$ 3,350.6	$ 3,239.7	$ 110.9	3.4 %
Provision for doubtful accounts	537.4	535.3	2.1	0.4
Revenues	$ 2,813.2	$ 2,704.4	$ 108.8	4.0

Our revenues before provision for doubtful accounts by payor and approximate percentages of revenues were as follows for the nine months ended September 30, 2014 and 2013 (in millions):

	Nine Months Ended September 30,			
	2014		2013	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 1,003.5	31.2 %	$ 903.6	33.2 %
Medicaid	451.7	14.0	385.1	14.1
HMOs, PPOs and other private insurers	1,745.2	54.2	1,370.2	50.3
Self-pay	547.4	17.0	558.7	20.5
Other	69.4	2.1	51.2	1.8
Revenues before provision for doubtful accounts	3,817.2	118.5	3,268.8	119.9
Provision for doubtful accounts	(597.0)	(18.5)	(543.1)	(19.9)
Revenues	$ 3,220.2	100.0 %	$ 2,725.7	100.0 %

Our revenues per equivalent admission from continuing operations and on a same-hospital basis were as follows for the nine months ended September 30, 2014 and 2013:

	Nine Months Ended September 30,			
	2014	2013	Increase	% Increase
Revenues per equivalent admission - continuing operations	$ 8,114	$ 7,775	$ 339	4.4
Revenues per equivalent admission - same-hospital	$ 7,962	$ 7,777	$ 185	2.4

Revenues Before Provision for Doubtful Accounts

The following table shows the key drivers of our revenues before provision for doubtful accounts for the nine months ended September 30, 2014 and 2013:

	Nine Months Ended September 30,		Increase	% Increase
	2014	2013	(Decrease)	(Decrease)
Continuing operations:				
Admissions	161,335	150,140	11,195	7.5
Equivalent admissions	396,884	350,577	46,307	13.2
Medicare case mix index	1.37	1.37	-	-
Average length of stay (days)	4.8	4.6	0.2	4.3
Inpatient surgeries	43,219	40,173	3,046	7.6
Outpatient surgeries	154,355	135,410	18,945	14.0
Total surgeries	197,574	175,583	21,991	12.5
Emergency room visits	984,816	876,840	107,976	12.3
Outpatient factor	2.46	2.34	0.12	5.1
Same-hospital:				
Admissions	144,986	149,122	(4,136)	(2.8)
Equivalent admissions	353,331	347,753	5,578	1.6
Medicare case mix index	1.38	1.37	0.01	0.7
Average length of stay (days)	4.5	4.6	(0.1)	(2.2)
Inpatient surgeries	38,530	39,806	(1,276)	(3.2)
Outpatient surgeries	138,407	134,543	3,864	2.9
Total surgeries	176,937	174,349	2,588	1.5
Emergency room visits	879,350	864,682	14,668	1.7
Outpatient factor	2.44	2.33	0.11	4.7

For the nine months ended September 30, 2014, our same-hospital revenues before provision for doubtful accounts increased $110.9 million, or 3.4%, to $3,350.6 million as compared to $3,239.7 million for the same period last year. This increase was primarily driven by increases in our same-hospital equivalent admissions, higher contracted rates from HMOs, PPOs and other private insurers as well as the favorable impact of healthcare reform. For the nine months ended September 30, 2014, our same-hospital equivalent admissions increased 1.6% as compared to the same period last year, primarily as a result of a 1.5% increase in total surgeries and a 1.7% increase in emergency room visits. Additionally, we experienced a payor mix shift from self-pay payors to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate.

Provision for Doubtful Accounts

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts for the nine months ended September 30, 2014 and 2013 (dollars in millions):

	Nine Months Ended September 30,					
	2014	% of Revenues	2013	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Continuing operations:						
Related key indicators:						
Charity care write-offs	$ 66.3	2.1 %	$ 105.4	3.9 %	$ (39.1)	(37.1) %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 547.4	17.0 %	$ 558.7	20.5 %	$ (11.3)	(2.0) %
Net revenue days outstanding (at end of period)	60.0	N/A	59.7	N/A	0.3	0.5 %
Same-hospital:						
Related key indicators:						
Charity care write-offs	$ 54.1	1.9 %	$ 105.1	3.9 %	$ (51.0)	(48.5) %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 483.8	17.2 %	$ 550.5	20.4 %	$ (66.7)	(12.1) %
Net revenue days outstanding (at end of period)	57.5	N/A	59.8	N/A	(2.3)	(3.8) %

Our provision for doubtful accounts relates principally to amounts due from patients included in our self-pay population and other amounts such as co-payments and deductibles due from patients included in other payor categories. For the nine months ended September 30, 2014, our provision for doubtful accounts increased by $53.9

million, or 9.9%, to $597.0 million on a continuing operations basis and by $2.1 million, or 0.4%, to $537.4 million on a same-hospital basis as compared to the same period last year. Same-hospital self-pay revenues decreased by $66.7 million over the same period last year. The decrease in same-hospital self-pay revenue is primarily due to a shift from self-pay payors to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population as a result of healthcare reform and the expansion of Medicaid coverage. However, as patient financial responsibility has continued to increase with higher co-payment and deductible obligations, our provision for doubtful accounts has increased to reflect the difficulty in collecting these amounts. The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations, "Critical Accounting Estimates," in the 2013 Annual Report on Form 10-K.

Our net revenue days outstanding at September 30, 2014 increased to 60.0 days compared to 59.7 days at September 30, 2013 on a continuing operations basis. However, our net revenue days outstanding at September 30, 2014 included just a partial quarter of revenues related to our hospital acquisitions completed during the three months ended September 30, 2014. After normalizing for a full quarter of revenues for our hospital acquisitions completed during the three months ended September 30, 2014, we estimate that on a continuing operations basis our net revenue days outstanding would have been 55.4 days at September 30, 2014. On a same-hospital basis, our net revenue days outstanding at September 30, 2014 improved to 57.5 days compared to 59.8 days at September 30, 2013.

Expenses and Other Income

Salaries and Benefits

The following table summarizes our salaries and benefits, man-hours per equivalent admission and salaries and benefits per equivalent admission for the nine months ended September 30, 2014 and 2013:

	Nine Months Ended September 30,					
	2014	% of Revenues	2013	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 1,522.1	47.3 %	$ 1,277.5	46.9 %	$ 244.6	19.1 %
Man-hours per equivalent admission	107	N/A	107	N/A	-	- %
Salaries and benefits per equivalent admission	$ 3,805	N/A	$ 3,647	N/A	$ 158	4.3 %

For the nine months ended September 30, 2014, our salaries and benefits expense increased to $1,522.1 million, or 19.1%, as compared to $1,277.5 million for the same period last year primarily a result of our recent acquisitions and the impact of an increasing number of employed physicians and their related support staff.

Supplies

The following table summarizes our supplies and supplies per equivalent admission for the nine months ended September 30, 2014 and 2013:

Nine Months Ended September 30,

	2014	% of Revenues	2013	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 500.0	15.5 %	$ 429.4	15.8 %	$ 70.6	16.4 %
Supplies per equivalent admission	$ 1,260	N/A	$ 1,225	N/A	$ 35	2.9 %

For the nine months ended September 30, 2014, our supplies expense increased to $500.0 million, or 16.4%, as compared to $429.4 million for the same period last year primarily as a result of our recent acquisitions.

Other Operating Expenses

The following table summarizes our other operating expenses for the nine months ended September 30, 2014 and 2013 (dollars in millions):

	Nine Months Ended September 30,							
	2014	% of Revenues	2013	% of Revenues	Increase (Decrease)	% Increase (Decrease)		
Professional fees	$ 116.1	3.6 %	$ 102.3	3.8 %	$ 13.8	13.5	%	
Utilities	64.8	2.0	52.7	1.9	12.1	22.7		
Repairs and maintenance	87.3	2.7	72.0	2.6	15.3	21.3		
Rents and leases	31.4	1.0	28.8	1.1	2.6	9.2		
Insurance	37.0	1.1	29.1	1.1	7.9	27.0		
Physician recruiting	18.0	0.6	20.4	0.7	(2.4)	(12.0)		
Contract services	231.6	7.2	191.8	7.0	39.8	20.7		
Non-income taxes	89.9	2.8	75.4	2.8	14.5	19.2		
Other	111.3	3.4	94.5	3.3	16.8	17.8		
	$ 787.4	24.4	$ 667.0	24.3	$ 120.4	18.0	%	

For the nine months ended September 30, 2014, our other operating expenses increased to $787.4 million, or 18.0%, as compared to $667.0 million for the same period last year primarily as a result of our recent acquisitions. Additionally, our same-hospital other operating expenses increased primarily as a result of increases in same-hospital contract services and other expenses. Our same-hospital contract services expense increased primarily as a result of increased fees and expenses related to the completion of our shared centralized resource initiatives at the majority of our hospitals. Our same-hospital other expenses increased as a result of additional transactional expenses related to our recent acquisitions, including legal and consulting fees.

Other Income

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the nine months ended September 30, 2014, we recognized $49.5 million in Medicare and Medicaid EHR incentive payments, collectively, as compared to $36.7 million recognized in the same period last year.

Depreciation and Amortization

For the nine months ended September 30, 2014, our depreciation and amortization expense increased by $21.7 million, or 12.8% to $190.8 million, or 5.9% of revenues, as compared to $169.1 million, or 6.2% of revenues for the same period last year. Our depreciation and amortization expense increased primarily as a result of our recent acquisitions as well as a result of significant increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. Accordingly, we anticipate that our depreciation and amortization expense will continue to increase in future periods as a result of these factors in addition to the impact of capital expenditure commitments associated with our recent acquisitions.

Interest Expense, Net

Our interest expense increased by $23.3 million, or 33.1% to $93.8 million for the nine months ended September 30, 2014 as compared to $70.5 million for the same period last year. The increase in our interest expense is primarily attributable to an increase in our total debt outstanding during the nine months ended September 30, 2014 as compared to the same period last year. On December 6, 2013, we issued in a private placement $700.0 million of our 5.5% Senior Notes. The net proceeds from this issuance were partially used to repay $100.0 million of our Incremental Term Loans. Subsequently, on May 12, 2014, we issued $400.0 million of additional 5.5% Senior Notes with terms substantially identical to those of the initial offering. The additional notes were issued at a premium of $12.0 million for total net proceeds from the issuance of $412.0 million which were used to fund, in part, the cash-settled portion of the maturity or conversion of our outstanding 3½% Notes. Including the impact of the premium, the additional 5.5% Senior Notes were issued at an effective rate of 4.9%. For a further discussion of our debt and corresponding interest rates, see “Liquidity and Capital Resources — Debt.”

Gain on Settlement of Pre-Acquisition Contingent Obligation

In connection with an acquisition completed in 2012, we made reasonable estimates and recorded an estimated obligation representing the fair values of our potential contingent obligations to the seller pursuant to the asset purchase agreement. Subsequently, the seller finalized its settlement of certain of these obligations at an amount that was less than we originally estimated. As a result, during the nine months ended September 30, 2013, we reduced our originally recorded contingent obligations and recognized a gain of approximately $5.6 million.

Debt Transaction Costs

In connection with certain debt transactions and modifications completed during the nine months ended September 30, 2013, we recognized debt transaction costs of $4.7 million.

Impairment Charge

In connection with our entry into a definitive agreement to sell certain assets of River Parishes and discontinue its operation, we recognized an impairment charge of $12.2 million, or $0.16 loss per diluted share, during the nine months ended September 30, 2014. The impairment charge includes the write-down of property, equipment and allocated goodwill to their estimated fair values.

Provision for Income Taxes

Our provision for income taxes was $55.2 million, or 1.7% of revenues, for the nine months ended September 30, 2014, as compared to $55.5 million, or 2.0% of revenues, for the same period last year. The effective tax rate decreased to 34.7% for the nine months ended September 30, 2014, as compared to 37.7% for the nine months ended September 30, 2013. Our effective tax rate was lower in the current period as a result of the reversal of a $6.0 million previously established valuation allowance against our deferred tax assets for federal net operating losses generated by

our Michigan physician practice operations which were previously thought to be unrecoverable.

Liquidity and Capital Resources

Liquidity

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

The following table presents summarized cash flow information for the three and nine months ended September 30, 2014 and 2013 (in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net cash provided by operating activities - continuing operations	$ 131.3	$ 104.1	$ 307.9	$ 253.4
Less: Purchases of property and equipment	(37.0)	(32.7)	(90.7)	(108.5)
Free operating cash flow	94.3	71.4	217.2	144.9
Acquisitions, net of cash acquired	(172.1)	(12.2)	(259.9)	(18.4)
Proceeds from borrowings	-	-	412.0	323.0
Payments of borrowings	(2.8)	(3.7)	(582.6)	(320.9)
Repurchases of common stock	(0.4)	(31.3)	(172.3)	(38.5)
Payment of debt financing costs	(0.8)	(7.3)	(6.7)	(8.3)
Proceeds from exercise of stock options	4.8	6.2	23.1	34.4
Other	(2.0)	(3.3)	(5.7)	(6.4)
Net change in cash and cash equivalents	$ (79.0)	$ 19.8	$ (374.9)	$ 109.8

The non-GAAP metric of free operating cash flow is an important liquidity measure for us. Our computation of free operating cash flow consists of net cash flows provided by continuing operations less cash flows used for the purchase of property and equipment. We believe that free operating cash flow is useful to investors and management as a measure of the ability of our business to generate cash and to repay and incur additional debt. Computations of free operating cash flow may differ from company to company. Therefore, free operating cash flow should be used as a complement to, and in conjunction with, our consolidated statements of cash flows presented in our unaudited condensed consolidated financial statements included elsewhere in this report.

Our cash flows provided by continuing operations for the three and nine months ended September 30, 2014 were positively impacted by higher net income, excluding the impact of certain non-cash charges, as well as an increase in the amount and timing of EHR incentive payments and a decrease in the amount and timing of cash payments for accounts payable, accrued salaries and other accrued expenses. These factors were partially offset by an increase in our outstanding accounts receivable related to certain of our recent acquisitions.

Capital Expenditures

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

The following table reflects our capital expenditures for the three and nine months ended September 30, 2014 and 2013 (dollars in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Capital and routine projects	$ 27.8	$ 26.8	$ 66.6	$ 67.1
Information systems	9.2	5.9	24.1	41.4
	37.0	32.7	90.7	108.5
Depreciation expense	68.1	55.9	188.6	164.5
Ratio of capital expenditures to depreciation expense	54.3 %	58.5 %	48.1 %	66.0 %

We have a formal and intensive review procedure for the authorization of capital expenditures. The most important financial measure of acceptability for a discretionary capital project is whether its projected discounted cash flow return on investment exceeds our projected cost of capital for that project. We expect to continue to invest in information systems, modern technologies, emergency room and operating room expansions, the construction of medical office buildings for physician expansion and the reconfiguration of the flow of patient care. Additionally, we may from time to time replace existing hospital buildings with new buildings as we evaluate ongoing repair and maintenance costs and other factors that impact the future operations of the existing buildings.

We expect our total spend on capital expenditures in 2014 to be slightly less than 2013. Because many of our currently scheduled projects, including many of those related to our recent acquisitions, require extensive planning and coordination, most of the spending will occur during the latter part of the year. Additionally, we expect to spend less on information systems in 2014 as compared to 2013.

Debt

An analysis and roll-forward of our long-term debt, including current maturities, during the first nine months of 2014 is as follows (in millions):

December 31, 2013	Proceeds from Borrowings	Payments of Borrowings	Other (a)	Amortization of Debt Discounts and Premium	September 30, 2014

Senior Credit Agreement:						
Term Facility	$ 433.1	$ -	$ (8.4)	$ -	$ -	$ 424.7
Incremental Term Loans	222.6	-	-	-	-	222.6
6.625% Senior Notes	400.0	-	-	-	-	400.0
5.5% Senior Notes	700.0	400.0	-	-		1,100.0
3½% Notes	575.0	-	(574.2)	(0.8)	-	-
Unamortized debt discounts	(9.5)	-	-	-	8.4	(1.1)
Unamortized debt premium	-	12.0	-	-	(0.7)	11.3
Capital and financing leases	55.6	-	(1.4)	10.4	-	64.6
	$ 2,376.8	$ 412.0	$ (584.0)	$ 9.6	$ 7.7	$ 2,222.1

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(a) Represents the difference between the original par value of the 3½% Notes and the cash settled conversion equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, the lesser of the daily conversion value for such volume-weighted average price trading day and $50, in addition to the assumption of capital lease obligations in connection with certain acquisitions completed during the nine months ended September 30, 2014.

We use leverage, or our total debt to total capitalization ratio, to make financing decisions. The following table illustrates our financial statement leverage and the classification of our debt at September 30, 2014 and December 31, 2013 (dollars in millions):

	September 30, 2014	December 31, 2013	Increase (Decrease)
Current portion of long-term debt	$ 16.3	$ 583.0	$ (566.7)
Long-term debt	2,205.8	1,793.8	412.0
Unamortized discounts on debt instruments	1.1	9.5	(8.4)
Unamortized premium on debt instrument	(11.3)	-	(11.3)
Total debt, excluding unamortized discounts and premium	2,211.9	2,386.3	(174.4)
Total LifePoint Hospitals, Inc. stockholders' equity	2,182.4	2,210.1	(27.7)
Total capitalization	$ 4,394.3	$ 4,596.4	$ (202.1)
Total debt to total capitalization	50.3 %	51.9 %	(160) bps
Percentage of:			
Fixed rate debt, excluding unamortized discounts and premium	70.7 %	72.5 %	
Variable rate debt, excluding unamortized discounts and premium	29.3	27.5	
	100.0 %	100.0 %	
Percentage of:			
Senior debt, excluding unamortized discounts and premium	100.0 %	75.9 %	
Subordinated debt, excluding unamortized discounts and premium	-	24.1	
	100.0 %	100.0 %	

Capital Resources

Senior Credit Agreement

Terms

The Company’s senior secured credit agreement with, among others, Citibank, N.A., as administrative agent, and the lenders party thereto (the “Senior Credit Agreement”), which was issued effective July 24, 2012 and matures on July 24, 2017, provides for the senior secured term loan facility (the “Term Facility”), the Incremental Term Loans and a $350.0 million senior secured revolving credit facility (the “Revolving Facility”). The Term Facility requires scheduled quarterly repayments in an amount equal to 2.5% per annum for each of the first, second and third years and 5.0% per annum for the fourth year and first three quarters of the fifth year, with the balance due at maturity. Additionally, the Term Facility and Incremental Term Loans are subject to mandatory repayments based on excess cash flow, as well as upon the occurrence of certain other events, as specifically described in the Senior Credit Agreement. The Senior Credit Agreement is guaranteed on a senior basis by our subsidiaries with certain limited exceptions.

Letters of Credit and Availability

The Revolving Facility may be utilized for letters of credit and swingline loans up to a maximum of $75.0 million and $25.0 million, respectively. Issued letters of credit and outstanding swingline loans reduce the amounts available under the Revolving Facility. As of September 30, 2014, we had $22.4 million in letters of credit outstanding that were primarily related to the self-insured retention level of our general and professional liability insurance and workers' compensation programs as security for the payment of claims. Under the terms of the Senior Credit Agreement, amounts available for borrowing under the Revolving Facility were $327.6 million as of September 30, 2014.

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

Interest Rates

Interest on the outstanding borrowings under the Senior Credit Agreement is payable at our option at either an adjusted London Interbank Offer Rate ("LIBOR") or an adjusted base rate plus an applicable margin. The applicable margin under the Senior Credit Agreement ranges from 1.50% to 2.50% for LIBOR loans and from 0.50% to 1.50% for adjusted base rate loans based on our total leverage ratio, calculated in accordance with the Senior Credit Agreement.

As of September 30, 2014, the applicable annual interest rates under the Term Facility and the Incremental Term Loans were 2.16% and 2.66%, respectively, which were based on the 30-day adjusted LIBOR plus the applicable margins. The 30-day adjusted LIBOR was 0.16% for both the Term Facility and the Incremental Term Loans as of September 30, 2014.

Covenants

The Senior Credit Agreement requires us to satisfy a maximum total leverage ratio calculated on a trailing four quarter basis not to exceed the following thresholds for the indicated date ranges:

Date Range	Maximum Total Leverage Ratio
July 1, 2014 to June 30, 2015	4.75:1.00
July 1, 2015 to June 30, 2016	4.50:1.00
July 1, 2016 to June 30, 2017	4.25:1.00

We were in compliance with this covenant as of September 30, 2014.

In addition, the Senior Credit Agreement contains certain customary affirmative and negative covenants, which among other things, limits our ability to incur additional debt, create liens, merge, consolidate, enter into acquisitions, sell assets, effect sale leaseback transactions, pay dividends, pay subordinated debt and effect transactions with its affiliates. It does not contain provisions that would accelerate the maturity dates upon a downgrade in our credit rating. However, a downgrade in our credit rating could adversely affect our ability to obtain other capital sources in the future and could increase our cost of borrowings.

6.625% Senior Notes

Effective September 23, 2010, we issued in a private placement $400.0 million of 6.625% unsecured senior notes due October 1, 2020 (the "6.625% Senior Notes") with The Bank of New York Mellon Trust Company, N.A., as trustee. The 6.625% Senior Notes bear interest at the rate of 6.625% per year, payable semi-annually on April 1 and October 1. The 6.625% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by substantially all of our existing and future subsidiaries that guarantee the Senior Credit Agreement.

We may redeem the 6.625% Senior Notes, in whole or in part, at any time prior to October 1, 2015 at a price equal to 100% of the principal amount of the notes redeemed plus an applicable makewhole premium, plus accrued and unpaid interest, if any, to the date of redemption. We may redeem the 6.625% Senior Notes, in whole or in part, at any time on or after October 1, 2015, plus accrued and unpaid interest, if any, to the date of redemption plus a redemption price equal to a percentage of the principal amount of the notes redeemed based on the following redemption schedule:

October 1, 2015 to September 30, 2016	103.313 %
October 1, 2016 to September 30, 2017	102.208 %
October 1, 2017 to September 30, 2018	101.104 %
October 1, 2018 and thereafter	100.000 %

If we experience a change of control under certain circumstances, we must offer to repurchase all of the notes at a price equal to 101.000% of their principal amount, plus accrued and unpaid interest, if any, to the repurchase date.

The 6.625% Senior Notes contain customary affirmative and negative covenants, which among other things, limit our ability to incur additional debt, create liens, pay dividends, effect transactions with our affiliates, sell assets, pay subordinated debt, merge, consolidate, enter into acquisitions and effect sale leaseback transactions.

5.5% Senior Notes

Effective December 6, 2013 and again on May 12, 2014, we issued in two separate private placements $700.0 million and $400.0 million, respectively, of the 5.5% Senior Notes with The Bank of New York Mellon Trust Company, N.A., as trustee. Collectively, the 5.5% Senior Notes mature on December 1, 2021 and bear interest at the rate of 5.5% per year, payable semi-annually on June 1 and December 1. The 5.5% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by certain of our existing and future domestic subsidiaries.

We may redeem up to 35% of the aggregate principal amount of the 5.5% Senior Notes, at any time before December 1, 2016, with the net cash proceeds of certain equity offerings at a redemption price equal to 105.500% of the principal amount to be redeemed, plus accrued and unpaid interest, provided that at least 65% of the aggregate principal amount of the 5.5% Senior Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of any such qualified equity offering.

We may redeem the 5.5% Senior Notes, in whole or in part, at any time prior to December 1, 2016 at a price equal to 100% of the principal amount of the notes redeemed plus an applicable make-whole premium, plus accrued and unpaid interest, if any, to the date of redemption. We may redeem the 5.5% Senior Notes, in whole or in part, at any time on or after December 1, 2016, plus accrued and unpaid interest, if any, to the date of redemption plus a redemption price equal to a percentage of the principal amount of the notes redeemed based on the following redemption schedule:

December 1, 2016 to November 30, 2017	104.125 %
December 1, 2017 to November 30, 2018	102.750 %
December 1, 2018 to November 30, 2019	101.375 %
December 1, 2019 and thereafter	100.000 %

If we experience a change in control under certain circumstances, we must offer to purchase the notes at a purchase price equal to 101% of the principal amount, plus accrued and unpaid interest to the date of purchase.

The 5.5% Senior Notes contain customary affirmative and negative covenants, which among other things, limit our ability to incur additional debt, create liens, pay dividends, effect transactions with our affiliates, sell assets, pay subordinated debt, merge, consolidate, enter into acquisitions and effect sale leaseback transactions.

3½% Notes

Effective May 15, 2014, our 3½% Notes matured. Prior to maturity, certain holders of the 3½% Notes exercised their right to convert per $1,000 in principal held for (i) an amount in cash, equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, the lesser of the daily conversion value for such volume-weighted average price trading day and $50; and (ii) a number of shares of our common stock in an amount equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, any excess of the daily conversion value above $50. Upon maturity or conversion of the 3½% Notes, we delivered to the holders cash of approximately $574.2 million and approximately 0.6 million shares of our common stock previously held in treasury at an average historical cost basis of $35.86 per share, or $23.0 million.

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Liquidity and Capital Resources Outlook

We expect our total spend on capital expenditures in 2014 to be slightly less than 2013. Because many of our currently scheduled projects, including many of those related to our recent acquisitions, require extensive planning and coordination, most of the spending will occur during the latter part of the year. Additionally, we expect to spend less on information systems in 2014 as compared to 2013. At September 30, 2014, we had uncompleted projects with an estimated additional cost to complete and equip of approximately $88.1 million. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the Senior Credit Agreement.

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

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

Contractual Obligations

We have various contractual obligations, which are recorded as liabilities in our condensed consolidated financial statements. Other items, such as certain purchase commitments and other executory contracts, are not recognized as liabilities in our condensed 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. During the three months ended September 30, 2014, we committed to invest an additional $504.0 million in capital expenditures and improvements over the next eight to ten years in connection with our hospital acquisitions completed during the third quarter of 2014. Except for these additional capital expenditure commitments, there were no other material changes in our contractual obligations during the three months ended September 30, 2014.

Off-Balance Sheet Arrangements

We had standby letters of credit outstanding of $22.4 million as of September 30, 2014, all of which relates to the self-insured retention levels of our professional and general liability insurance and workers' compensation programs as security for the payment of claims.

Recently Issued Accounting Pronouncements

ASU No. 2014-9, "Revenue from Contracts with Customers"

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2014-9, "Revenue from Contracts with Customers" ("ASU 2014-9"). ASU 2014-9 provides for a single comprehensive principles-based standard for the recognition of revenue across all industries through the application of the following five-step process:

Step 1: Identify the contract(s) with a customer.

Step 2: Identify the performance obligations in the contract.

Step 3: Determine the transaction price.

Step 4: Allocate the transaction price to the performance obligations in the contract.

Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

Among other provisions and in addition to expanded disclosure about the nature, amount, timing and uncertainty of revenue as well as certain additional quantitative and qualitative disclosures, ASU 2014-9 changes the healthcare industry specific presentation guidance under ASU 2011-7, "Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities." The provisions of ASU 2014-9 are effective for annual periods beginning after December 15, 2016, including interim periods within those years. Early adoption is not permitted. We are currently evaluating the impact that the adoption of ASU 2014-9 will have on its revenue recognition policies and procedures, financial position, result of operations, cash flows, financial disclosures and control framework.

ASU No. 2014-8, "Presentation of Financial Statements and Property, Plant, and Equipment - Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity"

In April 2014, the FASB issued ASU No. 2014-8, "Presentation of Financial Statements and Property, Plant, and Equipment - Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity" ("ASU 2014-8"). Among other provisions and in addition to expanded disclosures, ASU 2014-8 changes the definition of what components of an entity qualify for discontinued operations treatment and reporting from a reportable segment, operating segment, reporting unit, subsidiary or asset group to only those components of an entity that represent a strategic shift that has, or will have, a major effect on an entity's operations and financial results. Additionally, ASU 2014-8 requires disclosure about a disposal of an individually significant component of an entity that does not qualify for discontinued operations presentation in the financial statements, including the pretax profit or loss, attributable to the component of an entity for the period in which it is disposed of or is classified as held for sale. The disclosure of this information is required for all of the same periods that are presented in the entity's results of operations for the period.

As more fully discussed in Note 6, during the three months ended September 30, 2014, we entered into a definitive agreement to sell certain assets of River Parishes. We have determined that the sale of River Parishes does not qualify for discontinued operations treatment in accordance with the provisions of ASU 2014-8. However, we have made the additional required disclosures.

Critical Accounting Estimates

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

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

Our critical accounting estimates include the following areas:

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

Contingencies

Please refer to Note 12 to our accompanying unaudited condensed consolidated financial statements included elsewhere in this report for a discussion of our material financial contingencies, including:

- Legal proceedings and general liability claims;
- Physician commitments;
- Capital expenditure commitments; and
- Acquisitions.

Item 3. Quantitative and Qualitative Disclosures About Market Risk.

Interest Rates

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

Outstanding Debt

As of September 30, 2014, we had outstanding debt, excluding a $1.1 million unamortized discount and an $11.3 million unamortized premium, of $2,211.9 million, 29.3%, or $647.3 million, of which was subject to variable rates of interest.

The carrying amounts and fair values of the Term Facility and the Incremental Term Loans under the Senior Credit Agreement, the 6.625% Senior Notes, the 5.5% Senior Notes and the 3½% Notes as of September 30, 2014 and December 31, 2013 were as follows (in millions):

	Carrying Amount		Fair Value	
	September 30, 2014	December 31, 2013	September 30, 2014	December 31, 2013
Senior Credit Agreement:				
Term Facility	$ 424.7	$ 433.1	$ 421.0	$ 434.2
Incremental Term Loans, excluding unamortized discount	$ 222.6	$ 222.6	$ 221.4	$ 224.2
6.625% Senior Notes	$ 400.0	$ 400.0	$ 423.0	$ 425.0
5.5% Senior Notes, excluding unamortized premium	$ 1,100.0	$ 700.0	$ 1,116.5	$ 703.5
3 ½ % Notes, excluding unamortized discount	$ -	$ 575.0	$ -	$ 622.4

The fair values of the Term Facility, the Incremental Term Loans, the 6.625% Senior Notes and the 5.5% Senior Notes were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10, “Fair Value Measurements and Disclosures” (“ASC 820-10”). The fair values of the 3½% Notes were estimated based on the quoted market prices determined using the closing share price of our common stock and categorized as Level 1 within the fair value hierarchy in accordance with ASC 820-10. As more fully discussed in Note 8 to our accompanying unaudited condensed consolidated financial statements included elsewhere in this report, effective May 12, 2014, we issued $400.0 million of additional 5.5% Senior Notes at a premium of $12.0 million for total net proceeds from the issuance of $412.0 million. The net proceeds from this additional issuance were used to fund, in part, the cash-settled portion of the maturity or conversion of the 3½% Notes on or before May 15, 2014.

Cash Balances

Certain of our outstanding cash balances are invested overnight with high credit quality financial institutions. We do not hold direct investments in auction rate securities, collateralized debt obligations, structured investment vehicles or mortgage-backed securities. We did not have significant exposure to changing interest rates on invested cash at September 30, 2014. As a result, the interest rate market risk implicit in these investments at September 30, 2014, if any, was low.

Item 4. Controls and Procedures.

We carried out an evaluation, under the supervision and with the participation of management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as of the end of the period covered by this report pursuant to Rule 13a-15 of the Securities Exchange Act of 1934, as amended (the “Exchange Act”). Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us (including our consolidated subsidiaries) in reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported on a timely basis.

There has been no change in our internal control over financial reporting during the three months ended September 30, 2014 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

PART II – OTHER INFORMATION

Item 1. Legal Proceedings.

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

In addition, hospitals are subject to the regulation and oversight of various state and federal governmental agencies. Further, under the federal False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against hospitals that submit false claims for payments to, or improperly retain overpayments from, governmental payors. Some states have adopted similar state whistleblower and false claims provisions. Although the healthcare industry has seen numerous ongoing investigations related to compliance and billing practices, hospitals, in particular, continue to be a primary enforcement target for the OIG, DOJ and other governmental fraud and abuse programs. Certain of our individual facilities have received, and from time to time, other facilities may receive, inquiries from federal and state agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on our financial position, results of operations and liquidity.

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

In connection with our acquisitions of Marquette General Health System ("Marquette General") and Conemaugh Health System ("Conemaugh"), the two sellers self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. These self-disclosures are pending with CMS. With respect to Marquette General, to the extent that the seller's satisfaction of its retained liabilities, including those under its CMS voluntary self-disclosure, causes its net proceeds from the acquisition to be less than $15.0 million, we have agreed to pay additional purchase consideration to the seller. With respect to Conemaugh, to the extent that the potential settlement exceeds the seller's cash or cash equivalent indemnification threshold in accordance with the asset purchase agreement, we will likely be responsible for funding any deficit. We have made reasonable estimates of its potential exposure for these two matters and at September 30, 2014 have recorded reserves for Marquette General and Conemaugh of $18.0 million and $14.0 million, respectively.

On September 16, 2013, we and two of our hospitals made a voluntary self-disclosure to the Civil Division of the DOJ. The voluntary self-disclosure related to concerns regarding the clinical appropriateness of certain interventional

cardiology procedures conducted by one physician in each of these hospitals' cardiac catheterization laboratories. On September 24, 2013, the U.S. Attorney's Office in the district in which one of these hospitals is located served a subpoena requesting information related to the subject matter of the voluntary self-disclosure. The hospital that received the subpoena has produced responsive documents, including patient files. We continue to cooperate with the government in addressing these matters, including a review of procedures that were performed by these physicians.

The government investigations are ongoing, no patient claims have been made and it is not possible to estimate what, if any, claims will be brought. When appropriate, and following reviews by independent interventional cardiologists, we intend to notify those patients of these two physicians who may have received an unnecessary procedure of such fact. Patients from the hospitals at which these two physicians practiced may assert claims against the hospital that, if successful, could result in the hospitals being found liable. The government investigations may also result in damages, fines and penalties. We cannot, however, reasonably estimate the potential liability in connection with these matters, and no liability has been recorded as of September 30, 2014.

We do not control and cannot predict with certainty the progress or final outcome of discussions with government agencies, investigations and legal proceedings against us. Therefore, the final amounts paid to resolve the foregoing matters could be material and could materially differ from amounts currently recorded, if any. Any such changes in estimate will impact our future results of operations and cash flows.

Item 1A. Risk Factors.

There have been no material changes in our risk factors from those disclosed in the 2013 Annual Report on Form 10-K.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds.

On September 1, 2014, as partial consideration in connection with our acquisition of Conemaugh Health System, we issued a warrant to Conemaugh Health System Inc. with rights to purchase 290,514 shares of our common stock at an exercise price of $74.15 per share. The warrant becomes exercisable ratably beginning one year from the date of issuance to three years after the date of issuance. The warrant expires ten years from the date of issuance. No underwriters were involved with the issuance of the warrant. The warrant was issued in reliance on an exemption from registration requirements of the Securities Act of 1933, as amended (the "Securities Act") afforded by Section 4(a)(2) of the Securities Act and Rule 506 of Regulation D thereunder, as a transaction not involving a public offering.

Additionally, our Board of Directors has authorized the repurchase of outstanding shares of our common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other customary factors in accordance with a repurchase plan adopted in 2011, as subsequently amended and extended in February 2013 (the "2011 Repurchase Plan") and a repurchase plan adopted in the first quarter of 2014 (the "2014 Repurchase Plan"). The 2011 Repurchase Plan provided for the repurchase of up to $350.0 million in shares of our common stock, and we have repurchased all shares authorized for repurchase under this plan. The 2014 Repurchase Plan provides for the repurchase of up to $150.0 million in shares of our common stock through October 1, 2015. We are not obligated to repurchase any specific number of shares under the 2014 Repurchase Plan. We have designated the shares repurchased in accordance with our repurchase plans as treasury stock.

In connection with the 2011 Repurchase Plan, we repurchased approximately 3.0 million and 0.7 million shares for an aggregate purchase price, including commissions, of $164.7 million and $30.1 million at an average purchase price of $54.33 and $45.76 per share during the nine months ended September 30, 2014 and 2013, respectively. As of September 30, 2014, we had remaining authority to repurchase the entire $150.0 million in shares in accordance with the 2014 Repurchase Plan.

We also redeem shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to our various stockholder approved stock-based compensation plans. We redeemed approximately 0.1 million and 0.2 million shares vested under these plans for an aggregate purchase price of approximately $7.6 million and $8.4 million during the nine months ended September 30, 2014 and 2013, respectively. We have designated these shares as treasury stock.

The following table summarizes our share repurchase activity by month for the three months ended September 30, 2014:

	Total Number of Shares	Approximate Dollar Value of Shares that

	Total Number of Shares Purchased (a)	Weighted Average Price Paid per Share	Purchased as Part of a Publicly Announced Program	May Yet Be Purchased Under the Program (In millions)
July 1, 2014 to July 31, 2014	5,108	$ 63.10	-	$ 150.0
August 1, 2014 to August 31, 2014	-	$ -	-	$ 150.0
September 1, 2014 to September 30, 2014	1,429	$ 73.13	-	$ 150.0
Total	6,537	$ 69.14	-	$ 150.0

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

Item 6. Exhibits

Exhibit Number		Description of Exhibits
3.1	-	Amended and Restated Certificate of Incorporation (incorporated by reference from exhibits to the Registration Statement on Form S-8 filed by LifePoint Hospitals, Inc. on April 19, 2005, File No. 333-124151).
3.2	-	Fifth Amended and Restated By-Laws of LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed September 17, 2014, File No. 000-51251).
4.1	-	Indenture, dated as of December 6, 2013, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Bank of New York Mellon Trust Company, N.A., as trustee, (including the Form of 5.5% Senior Notes due 2021) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 9, 2013, File No. 000-51251).
4.2	-	Registration Rights Agreement, dated as of May 12, 2014, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Barclays Capital Inc. as representative of the several initial purchasers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed May 13, 2014, File No. 000-51251).
31.1	-	Certification of the Chief Executive Officer of LifePoint Hospitals, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	-	Certification of the Chief Financial Officer of LifePoint Hospitals, Inc. pursuant to Section 302 of the Sarbanes Oxley Act of 2002.
32.1	-	Certification of the Chief Executive Officer of LifePoint Hospitals, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	-	Certification of the Chief Financial Officer of LifePoint Hospitals, Inc. pursuant to Section 906 of the Sarbanes Oxley Act of 2002.
101.INS	-	XBRL Instance Document**
101.SCH	-	XBRL Taxonomy Extension Schema Document**
101.CAL	-	XBRL Taxonomy Calculation Linkbase Document**
101.DEF	-	XBRL Taxonomy Definition Linkbase Document**

101.LAB - XBRL Taxonomy Label Linkbase Document**

101.PRE - XBRL Taxonomy Presentation Linkbase Document**

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* — Management Compensation Plan or Arrangement

** — Furnished electronically herewith

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

LifePoint Hospitals, Inc.

By:/s/ Michael S. Coggin

Michael S. Coggin

Senior Vice President and

Chief Accounting Officer

(Principal Accounting Officer)

Date: October 24, 2014

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