LIFEPOINT HOSPITALS, INC.
Form 10-Q
October 25, 2013

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

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Form 10-Q

_____

(Mark One)

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

For the quarterly period ended September 30, 2013

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	(I.R.S. Employer
Incorporation or Organization)	Identification No.)
103 Powell Court	
Brentwood, Tennessee	37027
(Address Of Principal Executive Offices)	(Zip Code)

(615) 372-8500

(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 þ 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 þ 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 þ 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 þ

As of October 18, 2013, the number of outstanding shares of the registrant's Common Stock was 47,016,247.

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,	
	2013	2012	2013	2012
Revenues before provision for doubtful accounts	$ 1,092.9	$ 984.9	$ 3,268.8	$ 2,963.1
Provision for doubtful accounts	193.2	164.7	543.1	464.6
Revenues	899.7	820.2	2,725.7	2,498.5
Salaries and benefits	422.2	390.3	1,277.5	1,130.2
Supplies	140.6	129.3	429.4	382.7
Other operating expenses	222.6	205.3	667.0	589.5
Other income	(20.0)	(12.0)	(36.7)	(14.7)
Depreciation and amortization	57.4	47.7	169.1	139.7
Interest expense, net	24.0	24.5	70.5	75.7
Gain on settlement of pre-acquisition contingent obligation	-	-	(5.6)	-
Debt transaction costs	0.3	4.4	4.7	4.4
Impairment charge	-	-	-	3.1
	847.1	789.5	2,575.9	2,310.6
Income from continuing operations before income taxes	52.6	30.7	149.8	187.9
Provision for income taxes	18.5	11.4	55.5	69.8
Income from continuing operations	34.1	19.3	94.3	118.1
Income from discontinued operations, net of income taxes	0.3	-	0.7	0.2
Net income	34.4	19.3	95.0	118.3
Less: Net income attributable to noncontrolling interests	(1.6)	(0.1)	(2.4)	(2.7)
Net income attributable to LifePoint Hospitals, Inc.	$ 32.8	$ 19.2	$ 92.6	$ 115.6

Basic earnings per share attributable to LifePoint Hospitals, Inc. stockholders:				
Continuing operations	$ 0.70	$ 0.40	$ 1.99	$ 2.44
Discontinued operations	-	-	0.01	0.01
Net income	$ 0.70	$ 0.40	$ 2.00	$ 2.45
Diluted earnings per share attributable to LifePoint Hospitals, Inc. stockholders:				
Continuing operations	$ 0.68	$ 0.39	$ 1.93	$ 2.38
Discontinued operations	-	-	0.01	-
Net income	$ 0.68	$ 0.39	$ 1.94	$ 2.38
Weighted average shares and dilutive securities outstanding:				
Basic	46.5	47.5	46.3	47.3
Diluted	47.8	48.8	47.6	48.5
Amounts attributable to LifePoint Hospitals, Inc. stockholders:				
Income from continuing operations, net of income taxes	$ 32.5	$ 19.2	$ 91.9	$ 115.4
Income from discontinued operations, net of income taxes	0.3	-	0.7	0.2
Net income	$ 32.8	$ 19.2	$ 92.6	$ 115.6

See accompanying notes

LIFEPOINT HOSPITALS, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS

(Dollars in millions, except per share amounts)

	September 30, 2013 (Unaudited)	December 31, 2012 (a)
ASSETS		
Current assets:		
Cash and cash equivalents	$ 194.8	$ 85.0
Accounts receivable, less allowances for doubtful accounts of $719.7 and $558.4 at September 30, 2013 and December 31, 2012, respectively	569.1	518.8
Inventories	96.3	97.0
Prepaid expenses	29.9	31.8
Deferred tax assets	179.4	142.5
Other current assets	62.6	50.2
	1,132.1	925.3
Property and equipment:		
Land	103.1	101.9
Buildings and improvements	1,833.5	1,815.2
Equipment	1,382.4	1,289.7
Construction in progress (estimated costs to complete and equip after September 30, 2013 is $56.2)	91.1	81.0
	3,410.1	3,287.8
Accumulated depreciation	(1,408.5)	(1,256.9)
	2,001.6	2,030.9
Deferred loan costs, net	21.6	21.9
Intangible assets, net	76.5	84.5
Other	38.2	47.8
Goodwill	1,627.7	1,611.8
Total assets	$ 4,897.7	$ 4,722.2
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 103.9	$ 117.4
Accrued salaries	121.0	128.2
Income taxes payable	34.9	0.7
Other current liabilities	211.2	185.3
Current maturities of long-term debt	577.6	13.3

	1,048.6	444.9
Long-term debt	1,151.8	1,696.5
Deferred income tax liabilities	230.8	249.2
Long-term portion of reserves for self-insurance claims	142.6	133.0
Other long-term liabilities	95.5	79.2
Long-term income tax liability	16.7	16.9
Total liabilities	2,686.0	2,619.7
Redeemable noncontrolling interests	30.6	29.4
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; 65,403,816 and 64,472,700 shares issued at September 30, 2013 and December 31, 2012, respectively	0.6	0.6
Capital in excess of par value	1,458.0	1,403.5
Accumulated other comprehensive income	0.2	0.2
Retained earnings	1,311.4	1,218.8
Common stock in treasury, at cost, 18,392,369 and 17,544,668 shares at September 30, 2013 and December 31, 2012, respectively	(611.1)	(572.6)
Total LifePoint Hospitals, Inc. stockholders' equity	2,159.1	2,050.5
Noncontrolling interests	22.0	22.6
Total equity	2,181.1	2,073.1
Total liabilities and equity	$ 4,897.7	$ 4,722.2

(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,	
	2013	2012	2013	2012
Cash flows from operating activities:				
Net income	$ 34.4	$ 19.3	$ 95.0	$ 118.3
Adjustments to reconcile net income to net cash provided by operating activities:				
Income from discontinued operations	(0.3)	-	(0.7)	(0.2)
Stock-based compensation	6.0	7.0	19.1	20.3
Depreciation and amortization	57.4	47.7	169.1	139.7
Amortization of physician minimum revenue guarantees	4.1	4.9	13.1	14.7
Amortization of debt discounts and deferred loan costs	6.8	7.8	19.9	23.4
Gain on settlement of pre-acquisition contingent obligation	-	-	(5.6)	-
Debt transaction costs	0.3	4.4	4.7	4.4
Impairment charge	-	-	-	3.1
Deferred income tax benefit	(9.9)	(9.4)	(53.6)	(48.0)
Reserve for self-insurance claims, net of payments	0.8	1.8	7.5	(1.0)
Increase (decrease) in cash from operating assets and liabilities, net of effects from acquisitions and divestitures:				
Accounts receivable	(7.6)	(6.7)	(26.2)	(42.4)
Inventories and other current assets	(9.1)	(9.5)	(4.3)	(2.2)
Accounts payable and accrued expenses	6.6	40.3	(19.4)	22.2
Income taxes payable/receivable	14.7	(22.9)	34.2	9.7
Other	(0.1)	(0.4)	0.6	0.3
Net cash provided by operating activities - continuing operations	104.1	84.3	253.4	262.3
Net cash provided by (used in) operating activities - discontinued operations	0.2	-	-	(0.7)
Net cash provided by operating activities	104.3	84.3	253.4	261.6
Cash flows from investing activities:				
Purchases of property and equipment	(32.7)	(47.3)	(108.5)	(157.4)
Acquisitions, net of cash acquired	(12.2)	(162.3)	(18.4)	(182.4)
Other	(1.7)	(0.1)	(0.3)	(0.4)
Net cash used in investing activities	(46.6)	(209.7)	(127.2)	(340.2)

Cash flows from financing activities:				
Proceeds from borrowings	-	490.0	323.0	490.0
Payments of borrowings	(3.7)	(443.7)	(320.9)	(443.7)
Repurchases of common stock	(31.3)	(0.3)	(38.5)	(6.2)
Payment of debt financing costs	(7.3)	(9.6)	(8.3)	(9.6)
Proceeds from exercise of stock options	6.2	15.9	34.4	21.4
Proceeds from (refunds of) employee stock purchase plans	-	0.8	(0.2)	1.3
Distributions to noncontrolling interests	(1.3)	(1.4)	(4.1)	(2.8)
Sales of redeemable noncontrolling interests	-	-	-	1.6
Capital lease payments and other	(0.5)	(0.7)	(1.8)	(1.7)
Net cash (used in) provided by financing activities	(37.9)	51.0	(16.4)	50.3
Change in cash and cash equivalents	19.8	(74.4)	109.8	(28.3)
Cash and cash equivalents at beginning of period	175.0	172.3	85.0	126.2
Cash and cash equivalents at end of period	$ 194.8	$ 97.9	$ 194.8	$ 97.9
Supplemental disclosure of cash flow information:				
Interest payments	$ 5.3	$ 7.0	$ 40.7	$ 43.8
Capitalized interest	$ 0.4	$ 0.6	$ 1.1	$ 1.9
Income tax payments, net	$ 14.0	$ 43.7	$ 75.4	$ 108.3

See accompanying notes

LIFEPOINT HOSPITALS, INC.

CONDENSED CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY

For the Nine Months Ended September 30, 2013

Unaudited

(In Millions)

	LifePoint Hospitals, Inc. Stockholders							
	Common Stock		Capital in Excess of	Accumulated Other Comprehensive	Retained	Treasury	Noncontrolling	
	Shares	Amount	Par Value	Income	Earnings	Stock	Interests	Total
Balance at December 31, 2012 (a)	46.9	$ 0.6	$ 1,403.5	$ 0.2	$ 1,218.8	$ (572.6)	$ 22.6	$ 2,073.1
Net income	-	-	-	-	92.6	-	2.4	95.0
Exercise of stock options and tax benefits of stock-based awards	1.0	-	36.4	-	-	-	-	36.4
Stock activity in connection with employee stock purchase plan	-	-	(0.2)	-	-	-	-	(0.2)
Stock-based compensation	-	-	19.1	-	-	-	-	19.1
Repurchases of common stock, at cost	(0.9)	-	-	-	-	(38.5)	-	(38.5)
Noncash change in noncontrolling interests as a result of acquisition and other	-	-	(0.8)	-	-	-	1.1	0.3
Cash distributions to noncontrolling interests	-	-	-	-	-	-	(4.1)	(4.1)
Balance at September 30, 2013	47.0	$ 0.6	$ 1,458.0	$ 0.2	$ 1,311.4	$ (611.1)	$ 22.0	$ 2,181.1

(a) Derived from audited consolidated financial statements.

See accompanying notes

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2013

Unaudited

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

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, 2013, on a consolidated basis, the Company operated 57 hospital campuses in 20 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.

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, 2013 are not necessarily indicative of the results that may be expected for the year ending December 31, 2013. 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, 2012.

Recently Issued Accounting Pronouncement

In February 2013, the Financial Accounting Standards Board issued Accounting Standards Update No. 2013-2, "Comprehensive Income – Reporting of Amounts Reclassified Out of Accumulated Other Comprehensive Income" ("ASU 2013-2"). ASU 2013-2 requires entities to report the effect of significant reclassifications out of accumulated other comprehensive income on the respective line items in net income if the amount being reclassified is required under GAAP to be reclassified in its entirety to net income. For other amounts that are not required under GAAP to be reclassified in their entirety to net income in the same reporting period, an entity is required to cross-reference other disclosures required under GAAP that provide additional detail about those amounts. The Company adopted ASU 2013-2 during the first quarter of 2013. At September 30, 2013, the Company's only component of accumulated other comprehensive income relates to the unrealized gains on changes in the funded status of its pension benefit obligation. During the three and nine months ended September 30, 2013, there were no reclassifications out of accumulated other comprehensive income into net income.

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, 2013

Unaudited

On April 5, 2012, a settlement agreement (the "Rural Floor Settlement") was signed between the U.S. Department of Health and Human Services ("HHS"), the Secretary of HHS, the Centers for Medicare and Medicaid Services ("CMS") and a large number of healthcare service providers, including the Company's hospitals. The Rural Floor Settlement is intended to resolve all claims that have been brought or could have been brought relating to CMS's calculation of the rural floor budget neutrality adjustment that was created by the Balanced Budget Act of 1997 from federal fiscal year 1998 through and including federal fiscal year 2011 for healthcare service providers that participated in certain court cases and group appeals. As a result of the Rural Floor Settlement, the Company recognized $33.0 million of additional Medicare revenue during the nine months ended September 30, 2012.

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, 2013 and 2012 (in millions):

	Three Months Ended September 30,				Nine Months Ended September 30,			
	2013		2012		2013		2012	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 296.0	32.9 %	$ 279.2	34.0 %	$ 903.6	33.2 %	$ 881.3	35.3 %
Medicaid	133.9	14.9	124.7	15.2	385.1	14.1	368.3	14.7
HMOs, PPOs and other private insurers	446.0	49.6	397.8	48.5	1,370.2	50.3	1,185.9	47.5
Self-pay	200.8	22.3	170.4	20.8	558.7	20.5	491.1	19.7
Other	16.2	1.8	12.8	1.6	51.2	1.8	36.5	1.4
Revenues before provision for doubtful accounts	1,092.9	121.5	984.9	120.1	3,268.8	119.9	2,963.1	118.6
Provision for doubtful accounts	(193.2)	(21.5)	(164.7)	(20.1)	(543.1)	(19.9)	(464.6)	(18.6)
Revenues	$ 899.7	100.0 %	$ 820.2	100.0 %	$ 2,725.7	100.0 %	$ 2,498.5	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, 2013 (in millions):

Balance at January 1, 2013	$ 558.4
Additions recognized as a reduction to revenues	543.1
Accounts written off, net of recoveries	(381.8)
Balance at September 30, 2013	$ 719.7

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2013

Unaudited

The allowances for doubtful accounts as a percent of gross accounts receivable, net of contractual discounts were 55.8% and 51.8% as of September 30, 2013 and December 31, 2012, respectively. The increase in the resulting ratio of the allowances for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts, as of September 30, 2013 as compared to December 31, 2012 is primarily the result of a timing difference in the recognition of additional allowances for doubtful accounts and the write-off of aged and fully reserved accounts receivable during the nine months ended September 30, 2013. Additionally, as of September 30, 2013 and December 31, 2012, the allowances for doubtful accounts plus certain contractual allowances and discounts related to self-pay patients as a percentage of self-pay receivables were comparable at 84.8% and 85.0%, 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 depreciation and overhead costs, which were $42.5 million and $44.2 million for the three months ended September 30, 2013 and 2012, respectively, and $133.5 million and $127.9 million for the nine months ended September 30, 2013 and 2012, respectively.

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"), senior secured incremental term loans (the "Incremental Term Loans") and senior secured revolving credit facility (the "Revolving Facility") under its senior secured credit agreement with, among others, Citibank, N.A. ("Citibank"), as administrative agent, and the lenders party thereto (the "Senior Credit Agreement"), 6.625% unsecured senior notes due October 1, 2020 (the "6.625% Senior Notes"), 3½% convertible senior subordinated notes due May 15, 2014 (the "3½% Notes") and 3¼% convertible senior subordinated debentures due August 15, 2025 (the "3¼% Debentures") as of September 30, 2013 and December 31, 2012 were as follows (in millions):

	Carrying Amount		Fair Value	
	September 30, 2013	December 31, 2012	September 30, 2013	December 31, 2012
Term Facility	$ 435.9	$ 444.4	$ 434.8	$ 437.7
Incremental Term Loans, excluding unamortized discount	$ 322.6	$ -	$ 321.8	$ -
Revolving Facility	$ -	$ 85.0	$ -	$ 83.7
6.625% Senior Notes	$ 400.0	$ 400.0	$ 418.0	$ 431.0
3 ½ % Notes, excluding unamortized discount	$ 575.0	$ 575.0	$ 609.5	$ 592.3
3 ¼ % Debentures, excluding unamortized discount	$ -	$ 225.0	$ -	$ 225.0

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2013

Unaudited

The fair values of the Term Facility, the Incremental Term Loans, the Revolving Facility and the 6.625% Senior Notes were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10. The fair values of the 3½% Notes and the 3¼% Debentures were estimated based on the quoted market prices determined using the closing share price of the Company's common stock and categorized as Level 1 within the fair value hierarchy in accordance with ASC 820-10. As more fully discussed in Note 7, the Company repurchased all of the outstanding 3¼% Debentures with the proceeds from the issuance of the Incremental Term Loans under the Senior Credit Agreement.

Note 5. Acquisitions

Gain on Settlement of Pre-Acquisition Contingent Obligation

In connection with an acquisition completed in 2012, the Company's management made reasonable estimates and recorded an estimated obligation representing the fair values of its 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 the Company originally estimated. As a result, during the nine months ended September 30, 2013, the Company reduced its originally recorded contingent obligations and recognized a gain of approximately $5.6 million included under the caption "Gain on settlement of pre-acquisition contingent obligation" in the accompanying condensed consolidated statements of operations.

The Company will continue to analyze and refine its estimates of the remaining contingent obligations to the seller as changes in facts and circumstances warrant. The Company's management does not control and cannot predict with certainty the progress or final outcome of any discussions with third parties, such as government agencies. Therefore, the final amounts paid in settlement of the remaining contingent obligations, if any, could materially differ from amounts currently recorded. Any such changes in estimate will impact the Company's future results of operations and cash flows.

Scott Memorial Hospital

In May 2012, the Company entered into a joint venture agreement with Norton Healthcare, Inc. to form the Regional Healthcare Network of Kentucky and Southern Indiana ("RHN"), the purpose of which is to own and operate hospitals in non-urban communities in the Kentucky and Southern Indiana region. Effective January 1, 2013, RHN acquired Scott Memorial Hospital ("Scott Memorial"), a 25 bed hospital located in Scottsburg, Indiana for approximately $9.5 million, including net working capital. The Company has committed to invest in Scott Memorial an additional $3.0 million in capital expenditures and improvements over the next five years. The results of operations of Scott

Memorial are included in the Company's results of operations beginning on January 1, 2013.

Note 6. 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, 2012 and did not incur an impairment charge.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2013

Unaudited

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, 2013 and December 31, 2012 (in millions):

	September 30, 2013	December 31, 2012
Amortized intangible assets:		
Contract-based physician minimum revenue guarantees		
Gross carrying amount	$ 89.6	$ 90.2
Accumulated amortization	(52.4)	(49.2)
Net total	37.2	41.0
Non-competition agreements		
Gross carrying amount	34.7	34.7
Accumulated amortization	(23.6)	(19.9)
Net total	11.1	14.8
Other amortized intangible assets		
Gross carrying amount	2.4	2.4
Accumulated amortization	(2.4)	(1.5)
Net total	-	0.9
Total amortized intangible assets		
Gross carrying amount	126.7	127.3
Accumulated amortization	(78.4)	(70.6)
Net total	48.3	56.7

Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	24.9	24.8
Licenses, provider numbers, accreditations and other	3.3	3.0
Net total	28.2	27.8
Total intangible assets:		
Gross carrying amount	154.9	155.1
Accumulated amortization	(78.4)	(70.6)
Net total	$ 76.5	$ 84.5

Contract-Based Physician Minimum Revenue Guarantees

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

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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, 2013 and December 31, 2012, the Company's liability for contract-based physician minimum revenue guarantees was $14.9 million and $15.2 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.

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 7. Long-term Debt

Issuance and Extinguishment

On February 6, 2013, the Company amended its Senior Credit Agreement pursuant to which it issued $325.0 million of Incremental Term Loans. The proceeds from the Incremental Term Loans were used to repurchase all of the outstanding 3¼% Debentures, plus accrued and unpaid interest.

The Incremental Term Loans mature on July 24, 2017 and require quarterly repayments, which commenced on March 31, 2013, in an amount equal to 0.25% of the aggregate principal amount of all Incremental Term Loans, with the remaining outstanding balance paid at maturity. The Incremental Term Loans bear interest at a rate equal to either an adjusted base rate ("ABR") or an adjusted London Interbank Offer Rate ("LIBOR") from time to time in effect, at the Company's option, plus an applicable margin above the specified index as follows: (i) in the case of borrowings accruing interest at a rate based on ABR, ABR plus an applicable margin of 1.50% per annum, and (ii) in the case of borrowings accruing interest at a rate based on LIBOR, LIBOR plus an applicable margin of 2.50% per annum. The Company may prepay the Incremental Term Loans at any time without any prepayment premium.

The Incremental Term Loans are guaranteed, on a senior basis, by the subsidiaries of the Company that guarantee the Senior Credit Agreement. The Incremental Term Loans are secured by the collateral that secures the Senior Credit Agreement, consisting of a perfected first priority lien on, and pledge of, all of the capital stock and intercompany notes owned by the Company and each guarantor. The Incremental Term Loans rank pari passu with the outstanding borrowings under the Term Facility.

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Classification

As of September 30, 2013, the Company classified the 3½% Notes, including unamortized discount, as current under the caption "Current maturities of long-term debt" in the accompanying unaudited condensed consolidated balance sheet. The 3½% Notes are convertible prior to March 15, 2014 under the following circumstances: (1) if the price of the Company's common stock reaches a specified threshold during specified periods; (2) if the trading price of the 3½% Notes is below a specified threshold; or (3) upon the occurrence of specified corporate transactions or other events. On or after March 15, 2014, holders may convert the 3½% Notes at any time prior to the close of business on the scheduled trading day immediately preceding May 15, 2014, regardless of whether any of the foregoing circumstances has occurred. The Company is currently working to secure financing to repay the borrowings outstanding under the 3½% Notes on or after March 15, 2014.

Debt Transaction Costs

On August 23, 2013, the Company amended its Senior Credit Agreement and its 6.625% Senior Notes pursuant to which it modified certain restrictive covenants regarding subsidiary guarantees. In connection with these amendments as well as the issuance of the Incremental Term Loans and the repurchase of the 3¼% Debentures, the Company paid $8.3 million in debt financing costs and recognized $4.7 million in debt transaction costs during the nine months ended September 30, 2013. The debt transaction costs associated with these transactions include the write-offs of $3.5 million of previously capitalized deferred loan costs related to the 3¼% Debentures and $1.2 million of new non-capital costs related to the issuance of the Incremental Term Loans and the covenant modifications made to the Senior Credit Agreement and the 6.625% Senior Notes.

In connection with the Company's replacement of its prior credit agreement with the Senior Credit Agreement during the nine months ended September 30, 2012, the Company paid $9.6 million in debt financing costs and recognized $4.4 million in debt transaction costs. The debt transaction costs include the write-offs of $2.4 million of previously capitalized deferred loan costs and $2.0 million of new non-capital costs related to the issuance of the Senior Credit Agreement.

Note 8. Common Stock in Treasury and Repurchases of Common Stock

The Company's Board of Directors has authorized the repurchase of outstanding shares of its common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other customary factors in accordance with a repurchase plan adopted in 2011, as subsequently amended and extended in February 2013 (the "Repurchase Plan"). The Repurchase Plan provides for the repurchase of up to $350.0 million in

shares of the Company's common stock through August 20, 2014, although the Company is not obligated to repurchase any specific number of shares. The Company has designated the shares repurchased in accordance with the Repurchase Plan as treasury stock.

The Company repurchased approximately 0.7 million shares for an aggregate purchase price, including commissions, of $30.1 million at an average purchase price of $45.76 per share in accordance with the Repurchase Plan for both the three and nine months ended September 30, 2013. The Company repurchased a nominal number of shares for an aggregate purchase price, including commissions, of $0.1 million at an average purchase price of $35.01 per share in accordance with the Repurchase Plan during the nine months ended September 30, 2012. There were no repurchases made in accordance with the Repurchase Plan during the three months ended September 30, 2012. Through September 30, 2013, the Company had repurchased approximately 5.0 million shares for an aggregate purchase price, including commissions, of approximately $184.7 million in accordance with the Repurchase Plan. As of September 30, 2013, the Company had remaining authority to repurchase up to an additional $165.3 million in shares in accordance with the Repurchase Plan. In connection with the Repurchase Plan, the Company has entered into a trading plan in accordance with Rule 10b5-1 of the Securities Exchange Act of 1934, as amended, to facilitate repurchases of the Company's common stock during the Company's blackout period (the "10b5-1 Trading Plan"). The 10b5-1 Trading Plan became effective on September 16, 2013 and will expire on October 29, 2013.

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Additionally, the Company redeems shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to the Company's Amended and Restated 1998 Long-Term Incentive Plan (the "1998 LTIP") and Amended and Restated Management Stock Purchase Plan ("MSPP"). The Company redeemed approximately 0.2 million shares vested under the 1998 LTIP and MSPP during each of the nine months ended September 30, 2013 and 2012 for aggregate purchase price of approximately $8.4 million and $6.1 million, respectively. The Company has designated these shares as treasury stock.

Note 9. 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, performance shares and deferred stock units) to certain officers, employees and non-employee directors in accordance with the Company's various stockholder-approved stock-based compensation plans. The Company accounts for its stock-based awards in accordance with the provisions of ASC 718-10, "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 1998 LTIP and 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 issuance in accordance with the 1998 LTIP or the ODSICP.

Stock Options

Prior to replacing the 1998 LTIP and the ODSICP with the 2013 LTIP, the Company granted options to purchase 735,200 and 789,800 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 and 2012, respectively. Additionally, in accordance with the 2013 LTIP, the Company granted options to purchase 60,600 shares of the Company's common stock to certain officers and employees during the nine months ended September 30, 2013. Options to purchase shares granted to the Company's officers and employees in accordance with the 1998 LTIP and the 2013 LTIP were granted with an

exercise price equal to the fair market value of the Company's common stock on the day prior to the grant date. The options granted during the nine months ended September 30, 2013 and 2012 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.

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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, 2013 and 2012:

	Nine Months Ended September 30,	
	2013	2012
Expected volatility	31.0 %	36.0 %
Risk-free interest rate, minimum	0.04 %	0.03 %
Risk-free interest rate, maximum	2.74 %	1.97 %
Expected dividends	-	-
Average expected term (years)	5.3	5.3
Fair value per share of stock options granted	$ 11.96	$ 12.18

The total intrinsic value of stock options exercised during the nine months ended September 30, 2013 and 2012 was $11.7 million and $8.2 million, respectively. The Company received $6.2 million and $15.9 million in cash from stock option exercises for the three months ended September 30, 2013 and 2012, respectively, and $34.4 million and $21.4 million in cash from stock option exercises for the nine months ended September 30, 2013 and 2012, respectively. The actual tax benefit realized for the tax deductions from stock option exercises totaled $0.7 million and $2.8 million for the nine months ended September 30, 2013 and 2012, respectively.

As of September 30, 2013, there was $10.6 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.

Other Stock-Based Awards

Prior to replacing the 1998 LTIP and the ODSICP with the 2013 LTIP, the Company granted 410,000 and 521,011 shares of other stock-based awards to certain officers, employees and non-employee directors in accordance with the 1998 LTIP and the ODSICP during the nine months ended September 30, 2013 and 2012, respectively. Additionally, in accordance with the 2013 LTIP, the Company granted 52,962 other stock-based awards to certain officers, employees, and non-employee directors during the nine months ended September 30, 2013. The fair value of these other stock-based awards is determined based on the closing price of the Company’s common stock on the day prior to the grant date. The other stock-based awards granted during the nine months ended September 30, 2013 and 2012

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 other stock-based awards granted during the nine months ended September 30, 2013 and 2012, 322,000 and 320,000, respectively, were performance-based awards. In addition to requiring continuing service of an employee, the vesting of these performance-based awards is contingent upon the satisfaction of certain financial goals, specifically related to the achievement of targeted annual revenues or earnings goals within a three-year period. If these goals are achieved, the performance-based awards will cliff-vest three years after the grant date. The performance criteria for the 320,000 performance-based awards granted during 2012 have been certified as met by the Compensation Committee of the Company's Board of Directors, however, these awards are still subject to continuing service requirements and the three year cliff-vesting provisions. For purposes of estimating compensation expense for the performance-based awards granted during the nine months ended September 30, 2013, the Company has assumed that the performance goals will be achieved. If the performance goals are not met for the performance-based awards granted during the nine months ended September 30, 2013, no compensation expense will be recognized, and any previously recognized compensation expense will be reversed.

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Notwithstanding the specific grant vesting requirements, other stock-based awards granted in accordance with the 1998 LTIP become fully vested upon the death or disability of the participant. Additionally, in the event of termination without cause of a participant, other stock-based awards otherwise subject to cliff-vesting become vested in a percentage equal to the number of full months of continuous employment following the date of grant through the date of termination divided by the total number of months in the vesting period, and in the case of performance-based awards, only in the event that the performance goals are attained. Additionally, subject to certain limitations and notwithstanding the specific grant vesting requirements, awards granted in accordance with the 2013 LTIP may become fully exercisable or vested within the sole discretion and direction of a committee appointed by the Company's Board of Directors to administer the plan.

As of September 30, 2013, there was $20.0 million of total estimated unrecognized compensation cost related to other stock-based awards granted in accordance with the 2013 LTIP, the 1998 LTIP and MSPP. 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 1.7 years.

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, 2013 and 2012 (in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
Other stock-based awards	$ 4.3	$ 4.4	$ 12.5	$ 12.4
Stock options	1.7	2.6	6.6	7.9
Total stock-based compensation expense	$ 6.0	$ 7.0	$ 19.1	$ 20.3
Tax benefit on stock-based compensation expense	$ 2.4	$ 2.8	$ 7.6	$ 8.1

The Company did not capitalize any stock-based compensation cost during the three or nine months ended September 30, 2013 or 2012. As of September 30, 2013, there was $30.6 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 1.6 years.

Note 10. 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.

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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.

During August 2012, Minden Medical Center (“Minden”) finalized an independent review of the medical necessity of certain services rendered to patients in its intensive outpatient psychiatric program (“IOP”), which was managed by a third party, Allegiance Health Management, Inc. (“Allegiance”). This review was commenced by Minden in 2011 and, in August 2011, the hospital voluntarily disclosed its concerns regarding its billing of these services to the OIG pursuant to the OIG’s self-disclosure protocol. On January 3, 2012, Minden received notice that it had been accepted into the OIG’s self-disclosure protocol. At the time, Allegiance also managed the IOP at Bolivar Medical Center, a hospital owned by a subsidiary of the Company (“Bolivar”). On February 23, 2012, Bolivar received a subpoena from the OIG seeking information about its IOP program and its relationship with Allegiance. The Company believes that the OIG has served similar subpoenas on other non-LifePoint facilities that had contracts with Allegiance. In September 2013, the Company finalized settlement agreements for both the Minden and Bolivar matters. The final settlement amounts are expected to be paid during the fourth quarter of 2013. The Company's reserves for uninsured litigation at September 30, 2013 include these final settlement amounts.

In connection with the Company’s acquisition of Marquette General Health System (“Marquette General”), Marquette General Hospital, Inc. (the “Marquette Seller”) self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. The self-disclosure is pending with CMS. To the extent that the Marquette 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 Marquette Seller. The Company has made reasonable estimates of these potential liabilities and at September 30, 2013 has recorded an aggregate of $18.0 million representing the fair values of its potential obligation to the Marquette Seller. The Company’s management does not control and cannot predict with certainty the progress or final outcome of any discussions with third parties, such as government agencies. Therefore, the final amounts paid in settlement of these contingent obligations, if any, could materially differ from amounts currently recorded. Any such changes in estimate will impact the Company’s future results of operations and cash flows.

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 relates to concerns regarding the medical necessity 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 Company is cooperating with the government in addressing these matters.

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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 $32.4 million at September 30, 2013. The actual amount of such commitments to be subsequently advanced to physicians is estimated at $14.9 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.

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 $91.1 million in costs related to uncompleted projects as of September 30, 2013, which is included under the caption "Construction in progress" in the Company's accompanying unaudited condensed consolidated balance sheet. At September 30, 2013, these uncompleted projects had an estimated cost to complete and equip of approximately $56.2 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.

Hospital Support Center Lease

The Company has entered into an agreement with an unrelated third party to lease a new hospital support center with a targeted occupancy date in the fourth quarter of 2013. Under the terms of the lease agreement, the Company will lease from the third party the newly constructed hospital support center for a period of approximately 15 years

following construction completion. The Company's management has determined that it has substantially all of the risks of ownership of the new hospital support center during the construction period and in accordance with ASC 840-40, "Leases – Sale-Leaseback Transactions" ("ASC 840-40") has recorded an asset under the caption "Construction in progress" and related financing obligation under the caption "Other long-term liabilities" in the accompanying unaudited condensed consolidated balance sheets of $35.2 million as of September 30, 2013. This asset and related liability represents the cumulative costs incurred to date and funded by the unrelated third party to construct the new hospital support center. Once construction is complete, the Company will consider the applicable requirements of ASC 840-40 for sale-leaseback treatment, including the transfer back of all risks of ownership to the unrelated third party and whether the Company has any continuing involvement in the leased property. Currently, the Company anticipates that its lease agreement will qualify as a financing lease in accordance with ASC 840-40 and accordingly, the Company will recognize depreciation expense on the related asset and amortize the related financing obligation over the expected lease agreement term.

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Note 11. 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, 2013 and 2012 (dollars and shares in millions, except per share amounts):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
Numerator for basic and diluted earnings per share attributable to LifePoint Hospitals, Inc.:				
Income from continuing operations	$ 34.1	$ 19.3	$ 94.3	$ 118.1
Less: Net income attributable to noncontrolling interests	(1.6)	(0.1)	(2.4)	(2.7)
Income from continuing operations attributable to LifePoint Hospitals, Inc. stockholders	32.5	19.2	91.9	115.4
Income from discontinued operations, net of income taxes	0.3	-	0.7	0.2
Net income attributable to LifePoint Hospitals, Inc.	$ 32.8	$ 19.2	$ 92.6	$ 115.6
Denominator:				
Weighted average shares outstanding - basic	46.5	47.5	46.3	47.3
Effect of dilutive securities: stock options and other stock-based awards	1.3	1.3	1.3	1.2
Weighted average shares outstanding - diluted	47.8	48.8	47.6	48.5
Basic earnings per share attributable to LifePoint Hospitals, Inc. stockholders:				
Continuing operations	$ 0.70	$ 0.40	$ 1.99	$ 2.44
Discontinued operations	-	-	0.01	0.01
Net income	$ 0.70	$ 0.40	$ 2.00	$ 2.45
Diluted earnings per share attributable to LifePoint Hospitals, Inc. stockholders:				

Continuing operations	$ 0.68	$ 0.39	$ 1.93	$ 2.38
Discontinued operations	-	-	0.01	-
Net income	$ 0.68	$ 0.39	$ 1.94	$ 2.38

The 3½% Notes and the 3¼% Debentures are included in the calculation of diluted earnings per share whether or not the contingent requirements have been met for conversion if the conversion price of $51.79 and $61.22, respectively, is less than the average market price of the Company's common stock for the period. Upon conversion, the par value is settled in cash, and only the conversion premium is settled in shares of the Company's common stock. The impact of the 3½% Notes has been excluded for the three and nine months ended September 30, 2013 and 2012 because the effects would have been anti-dilutive. Additionally, the impact of the 3¼% Debentures has been excluded for the nine months ended September 30, 2013 and the three and nine months ended September 30, 2012 because the effects would have been anti-dilutive. During the nine months ended September 30, 2013, as more fully discussed in Note 7, the Company repurchased all of the outstanding 3¼% Debentures with the proceeds from the issuance of the Incremental Term Loans under the Senior Credit Agreement. Additionally, certain outstanding stock-based awards have been excluded from the calculation of diluted earnings per share to the extent they were anti-dilutive for the three and nine months ended September 30, 2013 and 2012.

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Note 12. Guarantor and Non-Guarantor Supplementary Information

The 6.625% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by substantially all of the Company's existing subsidiaries that guarantee the Senior Credit Agreement. The following presents the condensed consolidating financial information for the parent issuer, guarantor subsidiaries, non-guarantor subsidiaries, certain eliminations and the Company for the three and nine months ended September 30, 2013 and 2012 and as of September 30, 2013 and December 31, 2012:

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	$ -	$ 870.7	$ 222.2	$ -	$ 1,092.9
Provision for doubtful accounts	-	165.9	27.3	-	193.2
Revenues	-	704.8	194.9	-	899.7
Salaries and benefits	6.0	330.3	85.9	-	422.2
Supplies	-	105.5	35.1	-	140.6
Other operating expenses	-	180.4	42.2	-	222.6
Other income	-	(16.2)	(3.8)	-	(20.0)
Equity in earnings of affiliates	(46.9)	-	-	46.9	-
Depreciation and amortization	-	45.5	11.9	-	57.4
Interest expense, net	5.5	16.2	2.3	-	24.0
Debt transaction costs	0.3	-	-	-	0.3
Management (income) fees	-	(2.2)	2.2	-	-
Income from continuing operations	(35.1)	659.5	175.8	46.9	847.1

before taxes	35.1	45.3	19.1	(46.9)	52.6
Provision for income taxes	2.3	16.2	-	-	18.5
Income from continuing operations	32.8	29.1	19.1	(46.9)	34.1
Income from discontinued operations, net of taxes	-	0.3	-	-	0.3
Net income	32.8	29.4	19.1	(46.9)	34.4
Less: Net income attributable to noncontrolling interests	-	(0.3)	(1.3)	-	(1.6)
Net income attributable to LifePoint Hospitals, Inc.	$ 32.8	$ 29.1	$ 17.8	$ (46.9)	$ 32.8

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Condensed Consolidating Statements of Operations
For the Three Months Ended September 30, 2012

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 844.1	$ 140.8	$ -	$ 984.9
Provision for doubtful accounts	-	142.5	22.2	-	164.7
Revenues	-	701.6	118.6	-	820.2
Salaries and benefits	7.0	326.4	56.9	-	390.3
Supplies	-	107.3	22.0	-	129.3
Other operating expenses	-	180.8	24.5	-	205.3
Other income	-	(11.7)	(0.3)	-	(12.0)
Equity in earnings of affiliates	(31.7)	-	-	31.7	-
Depreciation and amortization	-	40.8	6.9	-	47.7
Interest expense, net	5.3	17.3	1.9	-	24.5
Debt transaction costs	4.4	-	-	-	4.4
Management (income) fees	-	(2.0)	2.0	-	-
	(15.0)	658.9	113.9	31.7	789.5
Income from continuing operations before taxes	15.0	42.7	4.7	(31.7)	30.7
(Benefit) provision for income taxes	(4.2)	15.6	-	-	11.4
Net income	19.2	27.1	4.7	(31.7)	19.3
Less: Net (income) loss attributable to noncontrolling interests	-	(1.1)	1.0	-	(0.1)
Net income attributable to LifePoint Hospitals, Inc.	$ 19.2	$ 26.0	$ 5.7	$ (31.7)	$ 19.2

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LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2013

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	$ -	$ 2,608.8	$ 660.0	$ -	$ 3,268.8
Provision for doubtful accounts	-	459.4	83.7	-	543.1
Revenues	-	2,149.4	576.3	-	2,725.7
Salaries and benefits	19.1	993.3	265.1	-	1,277.5
Supplies	-	320.7	108.7	-	429.4
Other operating expenses	0.5	538.3	128.2	-	667.0
Other income	-	(32.6)	(4.1)	-	(36.7)
Equity in earnings of affiliates	(129.8)	-	-	129.8	-
Depreciation and amortization	-	136.0	33.1	-	169.1
Interest expense, net	13.6	50.3	6.6	-	70.5
Gain on settlement of pre-acquisition contingent obligation	-	-	(5.6)	-	(5.6)
Debt transaction costs	4.7	-	-	-	4.7
Management (income) fees	-	(6.3)	6.3	-	-
	(91.9)	1,999.7	538.3	129.8	2,575.9
Income from continuing operations before taxes	91.9	149.7	38.0	(129.8)	149.8
(Benefit) provision for income taxes	(0.7)	56.2	-	-	55.5
Income from continuing operations	92.6	93.5	38.0	(129.8)	94.3
Income from discontinued operations, net of taxes	-	0.7	-	-	0.7
Net income	92.6	94.2	38.0	(129.8)	95.0
Less: Net income attributable to noncontrolling interests	-	(0.6)	(1.8)	-	(2.4)
Net income attributable to LifePoint Hospitals, Inc.	$ 92.6	$ 93.6	$ 36.2	$ (129.8)	$ 92.6

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LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2013

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Statements of Operations
For the Nine Months Ended September 30, 2012

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 2,581.7	$ 381.4	$ -	$ 2,963.1
Provision for doubtful accounts	-	402.1	62.5	-	464.6
Revenues	-	2,179.6	318.9	-	2,498.5
Salaries and benefits	20.3	973.3	136.6	-	1,130.2
Supplies	-	325.5	57.2	-	382.7
Other operating expenses	-	523.9	65.6	-	589.5
Other income	-	(13.4)	(1.3)	-	(14.7)
Equity in earnings of affiliates	(152.7)	-	-	152.7	-
Depreciation and amortization	-	119.1	20.6	-	139.7
Interest expense, net	18.3	52.6	4.8	-	75.7
Debt transaction costs	4.4	-	-	-	4.4
Impairment charge	-	3.1	-	-	3.1
Management (income) fees	-	(6.1)	6.1	-	-
	(109.7)	1,978.0	289.6	152.7	2,310.6
Income from continuing operations before taxes	109.7	201.6	29.3	(152.7)	187.9
(Benefit) provision for income taxes	(5.9)	75.7	-	-	69.8
Income from continuing operations	115.6	125.9	29.3	(152.7)	118.1
Income from discontinued operations, net of taxes	-	0.2	-	-	0.2
Net income	115.6	126.1	29.3	(152.7)	118.3
Less: Net income attributable to noncontrolling interests	-	(0.9)	(1.8)	-	(2.7)
Net income attributable to LifePoint Hospitals, Inc.	$ 115.6	$ 125.2	$ 27.5	$ (152.7)	$ 115.6

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LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2013

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Balance Sheets
September 30, 2013

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$ -	$ 138.8	$ 56.0	$ -	$ 194.8
Accounts receivable, net	-	460.7	108.4	-	569.1
Inventories	-	75.7	20.6	-	96.3
Prepaid expenses	0.2	25.8	3.9	-	29.9
Deferred tax assets	179.4	-	-	-	179.4
Other current assets	-	47.8	14.8	-	62.6
	179.6	748.8	203.7	-	1,132.1
Property and equipment:					
Land	-	75.0	28.1	-	103.1
Buildings and improvements	-	1,537.4	296.1	-	1,833.5
Equipment	-	1,247.7	134.7	-	1,382.4
Construction in progress	-	86.0	5.1	-	91.1
	-	2,946.1	464.0	-	3,410.1
Accumulated depreciation	-	(1,298.1)	(110.4)	-	(1,408.5)
	-	1,648.0	353.6	-	2,001.6
Deferred loan costs, net	21.6	-	-	-	21.6
Intangible assets, net	-	42.7	33.8	-	76.5
Investments in subsidiaries	1,792.1	-	-	(1,792.1)	-
Other	3.3	20.7	14.2	-	38.2
Goodwill	-	1,444.6	183.1	-	1,627.7
Total assets	$ 1,996.6	$ 3,904.8	$ 788.4	$ (1,792.1)	$ 4,897.7
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	$ -	$ 79.7	$ 24.2	$ -	$ 103.9

Accrued salaries	-	96.2	24.8	-	121.0
Income taxes payable	34.9	-	-	-	34.9
Other current liabilities	21.2	154.6	35.4	-	211.2
Current maturities of long-term debt	576.1	0.9	0.6	-	577.6
	632.2	331.4	85.0	-	1,048.6
Long-term debt	1,141.9	6.7	3.2	-	1,151.8
Intercompany	(2,184.1)	1,978.7	205.4	-	-
Deferred income tax liabilities	230.8	-	-	-	230.8
Long-term portion of reserves for self-insurance claims	-	121.3	21.3	-	142.6
Other long-term liabilities	-	56.0	39.5	-	95.5
Long-term income tax liability	16.7	-	-	-	16.7
Total liabilities	(162.5)	2,494.1	354.4	-	2,686.0
Redeemable noncontrolling interests	-	-	30.6	-	30.6
Total LifePoint Hospitals, Inc. stockholders' equity	2,159.1	1,409.2	382.9	(1,792.1)	2,159.1
Noncontrolling interests	-	1.5	20.5	-	22.0
Total equity	2,159.1	1,410.7	403.4	(1,792.1)	2,181.1
Total liabilities and equity	$ 1,996.6	$ 3,904.8	$ 788.4	$ (1,792.1)	$ 4,897.7

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2013

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Balance Sheets
December 31, 2012

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$ -	$ 26.8	$ 58.2	$ -	$ 85.0
Accounts receivable, net	-	410.1	108.7	-	518.8
Inventories	-	76.9	20.1	-	97.0
Prepaid expenses	0.1	28.0	3.7	-	31.8
Deferred tax assets	142.5	-	-	-	142.5
Other current assets	-	37.9	12.3	-	50.2
	142.6	579.7	203.0	-	925.3
Property and equipment:					
Land	-	74.7	27.2	-	101.9
Buildings and improvements	-	1,524.2	291.0	-	1,815.2
Equipment	-	1,172.2	117.5	-	1,289.7
Construction in progress	-	76.2	4.8	-	81.0
	-	2,847.3	440.5	-	3,287.8
Accumulated depreciation	-	(1,175.5)	(81.4)	-	(1,256.9)
	-	1,671.8	359.1	-	2,030.9
Deferred loan costs, net	21.9	-	-	-	21.9
Intangible assets, net	-	48.0	36.5	-	84.5
Investments in subsidiaries	1,663.1	-	-	(1,663.1)	-
Other	1.5	27.3	19.0	-	47.8
Goodwill	-	1,440.4	171.4	-	1,611.8
Total assets	$ 1,829.1	$ 3,767.2	$ 789.0	$ (1,663.1)	$ 4,722.2
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	$ -	$ 92.9	$ 24.5	$ -	$ 117.4
Accrued salaries	-	105.0	23.2	-	128.2
Income taxes payable	0.7	-	-	-	0.7

Other current liabilities	12.4	137.4	35.5	-	185.3
Current maturities of long-term debt	11.3	1.3	0.7	-	13.3
	24.4	336.6	83.9	-	444.9
Long-term debt	1,688.6	5.8	2.1	-	1,696.5
Intercompany	(2,200.5)	1,963.1	237.4	-	-
Deferred income tax liabilities	249.2	-	-	-	249.2
Long-term portion of reserves for self-insurance claims	-	106.7	26.3	-	133.0
Other long-term liabilities	-	39.5	39.7	-	79.2
Long-term income tax liability	16.9	-	-	-	16.9
Total liabilities	(221.4)	2,451.7	389.4	-	2,619.7
Redeemable noncontrolling interests	-	-	29.4	-	29.4
Total LifePoint Hospitals, Inc. stockholders' equity	2,050.5	1,314.1	349.0	(1,663.1)	2,050.5
Noncontrolling interests	-	1.4	21.2	-	22.6
Total equity	2,050.5	1,315.5	370.2	(1,663.1)	2,073.1
Total liabilities and equity	$ 1,829.1	$ 3,767.2	$ 789.0	$ (1,663.1)	$ 4,722.2

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2013

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	$ 29.4	$ 19.1	$ (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	-	45.5	11.9	-	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	-	(1.3)	2.1	-	0.8
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	2.0	(9.6)	-	(7.6)
Inventories and other current assets	(0.1)	(12.4)	3.4	-	(9.1)
Accounts payable and accrued expenses	11.2	11.0	(15.6)	-	6.6
Income taxes payable/receivable	14.7	-	-	-	14.7
Other	-	0.8	(0.9)	-	(0.1)
Net cash provided by operating activities - continuing operations	14.9	78.4	10.8	-	104.1

Net cash provided by operating activities - discontinued operations	-	0.2	-	-	0.2
Net cash provided by operating activities	14.9	78.6	10.8	-	104.3
Cash flows from investing activities:					
Purchases of property and equipment	-	(24.2)	(8.5)	-	(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)	(36.4)	(8.6)	-	(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
Proceeds from (distributions to) noncontrolling interests	-	0.3	(1.6)	-	(1.3)
Change in intercompany balances with affiliates, net	22.8	(10.6)	(12.2)	-	-
Capital lease payments and other	-	(0.3)	(0.2)	-	(0.5)
Net cash used in financing activities	(13.3)	(10.6)	(14.0)	-	(37.9)
Change in cash and cash equivalents	-	31.6	(11.8)	-	19.8
Cash and cash equivalents at beginning of period	-	107.2	67.8	-	175.0
Cash and cash equivalents at end of period	$ -	$ 138.8	$ 56.0	$ -	$ 194.8

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2013

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Statements of Cash Flows
For the Three Months Ended September 30, 2012

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 19.2	$ 27.1	$ 4.7	$ (31.7)	$ 19.3
Adjustments to reconcile net income to net cash provided by operating activities:					
Equity in earnings of affiliates	(31.7)	-	-	31.7	-
Stock-based compensation	7.0	-	-	-	7.0
Depreciation and amortization	-	40.8	6.9	-	47.7
Amortization of physician minimum revenue guarantees	-	4.5	0.4	-	4.9
Amortization of debt discounts and deferred loan costs	7.8	-	-	-	7.8
Debt transaction costs	4.4	-	-	-	4.4
Deferred income tax benefit	(9.4)	-	-	-	(9.4)
Reserve for self-insurance claims, net of payments	-	(0.3)	2.1	-	1.8
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	(1.3)	(5.4)	-	(6.7)
Inventories and other current assets	(0.1)	(6.4)	(3.0)	-	(9.5)
Accounts payable and accrued expenses	9.4	19.8	11.1	-	40.3
Income taxes payable/receivable	(22.9)	-	-	-	(22.9)
Other	-	0.4	(0.8)	-	(0.4)
Net cash (used in) provided by operating activities	(16.3)	84.6	16.0	-	84.3
Cash flows from investing activities:					
Purchases of property and equipment	-	(44.0)	(3.3)	-	(47.3)
Acquisitions, net of cash acquired	-	(26.9)	(135.4)	-	(162.3)

Other	-	(0.1)	-	-	(0.1)
Net cash used in investing activities	-	(71.0)	(138.7)	-	(209.7)
Cash flows from financing activities:					
Proceeds from borrowings	490.0	-	-	-	490.0
Payments of borrowings	(443.7)	-	-	-	(443.7)
Repurchases of common stock	(0.3)	-	-	-	(0.3)
Payment of debt financing costs	(9.6)	-			(9.6)
Proceeds from exercise of stock options	15.9	-	-	-	15.9
Proceeds from employee stock purchase plans	0.8	-	-	-	0.8
Proceeds from (distributions to) noncontrolling interests	-	0.3	(1.7)	-	(1.4)
Change in intercompany balances with affiliates, net	(36.8)	(107.8)	144.6	-	-
Capital lease payments and other	-	(0.7)	-	-	(0.7)
Net cash provided by (used in) financing activities	16.3	(108.2)	142.9	-	51.0
Change in cash and cash equivalents	-	(94.6)	20.2	-	(74.4)
Cash and cash equivalents at beginning of period	-	149.8	22.5	-	172.3
Cash and cash equivalents at end of period	$ -	$ 55.2	$ 42.7	$ -	$ 97.9

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2013

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	$ 94.2	$ 38.0	$ (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	-	136.0	33.1	-	169.1
Amortization of physician minimum revenue guarantees	-	12.0	1.1	-	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	-	3.6	3.9	-	7.5
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	(31.1)	4.9	-	(26.2)
Inventories and other current assets	(0.1)	(6.0)	1.8	-	(4.3)
Accounts payable and accrued expenses	8.8	(24.2)	(4.0)	-	(19.4)
Income taxes payable/receivable	34.2	-	-	-	34.2
Other	-	0.8	(0.2)	-	0.6
Net cash (used in) provided by operating activities	(4.2)	184.6	73.0	-	253.4

Cash flows from investing activities:					
Purchases of property and equipment	-	(88.3)	(20.2)	-	(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)	(106.1)	(19.3)	-	(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
Refunds of employee stock purchase plans	(0.2)	-	-	-	(0.2)
Proceeds from (distributions to) noncontrolling interests	-	1.0	(5.1)	-	(4.1)
Change in intercompany balances with affiliates, net	16.5	33.7	(50.2)	-	-
Capital lease payments and other	-	(1.2)	(0.6)	-	(1.8)
Net cash provided by (used in) financing activities	6.0	33.5	(55.9)	-	(16.4)
Change in cash and cash equivalents	-	112.0	(2.2)	-	109.8
Cash and cash equivalents at beginning of period	-	26.8	58.2	-	85.0
Cash and cash equivalents at end of period	$ -	$ 138.8	$ 56.0	$ -	$ 194.8

LIFEPOINT HOSPITALS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2013

Unaudited

LIFEPOINT HOSPITALS, INC.
Condensed Consolidating Statements of Cash Flows
For the Nine Months Ended September 30, 2012

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 115.6	$ 126.1	$ 29.3	$ (152.7)	$ 118.3
Adjustments to reconcile net income to net cash provided by operating activities:					
Income from discontinued operations	-	(0.2)	-	-	(0.2)
Equity in earnings of affiliates	(152.7)	-	-	152.7	-
Stock-based compensation	20.3	-	-	-	20.3
Depreciation and amortization	-	119.1	20.6	-	139.7
Amortization of physician minimum revenue guarantees	-	13.5	1.2	-	14.7
Amortization of debt discounts and deferred loan costs	23.4	-	-	-	23.4
Debt transaction costs	4.4	-	-	-	4.4
Impairment charge	-	3.1	-	-	3.1
Deferred income tax benefit	(48.0)	-	-	-	(48.0)
Reserve for self-insurance claims, net of payments	-	(2.4)	1.4	-	(1.0)
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	(27.0)	(15.4)	-	(42.4)
Inventories and other current assets	(0.1)	1.8	(3.9)	-	(2.2)
Accounts payable and accrued expenses	8.3	4.6	9.3	-	22.2
Income taxes payable/receivable	9.7	-	-	-	9.7
Other	-	1.0	(0.7)	-	0.3
Net cash (used in) provided by operating activities - continuing operations	(19.1)	239.6	41.8	-	262.3

Net cash used in operating activities - discontinued operations	-	(0.7)	-	-	(0.7)
Net cash (used in) provided by operating activities	(19.1)	238.9	41.8	-	261.6
Cash flows from investing activities:					
Purchases of property and equipment	-	(146.5)	(10.9)	-	(157.4)
Acquisitions, net of cash acquired	-	(26.9)	(155.5)	-	(182.4)
Other	(0.2)	(0.2)	-	-	(0.4)
Net cash used in investing activities	(0.2)	(173.6)	(166.4)	-	(340.2)
Cash flows from financing activities:					
Proceeds from borrowings	490.0	-	-	-	490.0
Payments of borrowings	(443.7)	-	-	-	(443.7)
Repurchases of common stock	(6.2)	-	-	-	(6.2)
Payment of debt financing costs	(9.6)	-	-	-	(9.6)
Proceeds from exercise of stock options	21.4	-	-	-	21.4
Proceeds from employee stock purchase plans	1.3	-	-	-	1.3
Proceeds from (distributions to) noncontrolling interests	-	0.9	(3.7)	-	(2.8)
Sales of redeemable noncontrolling interests	-	-	1.6	-	1.6
Change in intercompany balances with affiliates, net	(33.9)	(115.9)	149.8	-	-
Capital lease payments and other	-	(1.3)	(0.4)	-	(1.7)
Net cash provided by (used in) financing activities	19.3	(116.3)	147.3	-	50.3
Change in cash and cash equivalents	-	(51.0)	22.7	-	(28.3)
Cash and cash equivalents at beginning of period	-	106.2	20.0	-	126.2
Cash and cash equivalents at end of period	$ -	$ 55.2	$ 42.7	$ -	$ 97.9

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, 2012 (the "2012 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 (the "SEC") and/or release to the public. In addition, our senior management makes forward-looking statements orally to analysts, investors, the media and others. Broadly speaking, forward-looking statements include: projections of our revenues, net income, earnings per share, capital expenditures, cash flows, debt repayments, interest rates, operating statistics and data or other financial items; 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 Medical Center 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 and future debt; our business strategy and operating philosophy; effects of competition in a hospital's market; costs of providing care to our patients; changes in interest rates; 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 investments in information systems and to add new technologies, modernize facilities and expand services available at our facilities and the expectation that capital commitments could be a significant component of future acquisitions; implementation of supply chain management and revenue cycle functions; impact of accounting methodologies; increasing professional fees; industry and general economic trends; patient shifts to lower cost healthcare plans which generally provide lower reimbursement; reimbursement changes, including changes for cost containment and policy considerations and changes resulting from state budgetary restrictions; timing of the receipt and the amount of reimbursement payments under the New Mexico state program; patient volumes and related revenues; claims and legal actions relating to professional liabilities, governmental investigations; 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" or similar expressions. You should not undu 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 2012 Annual Report on Form 10-K. Any factor described in this report and in the 2012 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 2012 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, 2013, on a consolidated basis, we operated 57 hospital campuses in 20 states, having a total of 6,565 licensed beds. We generate revenues primarily through hospital services offered at our facilities. We generated revenues of $899.7 million and $820.2 million during the three months ended September 30, 2013 and 2012, respectively, and $2,725.7 million and $2,498.5 million during the nine months ended September 30, 2013 and 2012, respectively. We derived revenues from the Medicare and Medicaid programs, collectively of 47.8% and 49.2% during the three months ended September 30, 2013 and 2012, respectively, and 47.3% and 50.0% during the nine months ended September 30, 2013 and 2012, 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 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 in the manufacturing sector than other parts of the U.S., generally.

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

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

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

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

Business Strategy

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

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

As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have entered into agreements with a third party to provide certain nonclinical business functions, including 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. We fully implemented our payroll processing function in 2011. We expect to complete the implementations of the supply chain management and revenue cycle functions by the end of 2014.

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 alters the U.S. healthcare system and is intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicaid eligibility in some states, 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 a majority of the measures contained in the Affordable Care Act do not take effect until 2013 and 2014, certain of the reductions in Medicare spending, such as negative adjustments to the Medicare hospital inpatient and outpatient prospective payment system market basket updates and the incorporation of productivity adjustments to the Medicare program's annual inflation updates, became effective prior to 2013. Although the expansion of health insurance coverage should increase revenues from providing care to certain previously uninsured individuals, many of these provisions of the Affordable Care Act will not become effective until 2014 or later. The impact of such expansion remains uncertain, may be gradual and may not offset scheduled decreases in reimbursement.

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. In response to the ruling, a number of states, including eight states in which we operate, have indicated that they will not expand their Medicaid programs. As a result, some low-income persons in those states may not have insurance coverage as intended by the Affordable Care Act. In addition, several bills have been and may continue to be introduced in Congress to repeal or amend all or significant provisions of the Affordable Care Act.

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

Medicare and Medicaid Reimbursement

Medicare payment methodologies have been, and are expected to continue to be, revised significantly based on cost containment and policy considerations. 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 ("ATRA") require further reductions in Medicare payments, and the Budget Control Act of 2011 ("BCA") imposes a 2% reduction in Medicare spending effective as of April 1, 2013.

On April 10, 2013, President Obama released his proposed budget for federal fiscal year ("FFY") 2014 (the "Proposed Budget"). The Proposed Budget would replace the BCA's automatic spending reductions for the Medicare Program for 2014 with $400 billion in Medicare and Medicaid spending cuts over the next 10 years. The Proposed Budget would achieve these reductions by, among other things, reducing Medicare coverage of bad debts, reducing payments to critical access hospitals, reducing payments to inpatient rehabilitation and skilled nursing facilities, 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 19, 2013, CMS published its hospital inpatient patient prospective system ("IPPS") final rule for FFY 2014, which began on October 1, 2013. Among other things, the rule provides a payment rate increase of 0.7% for hospitals that successfully report the quality measures for the Hospital Inpatient Quality Reporting Program (formerly the Reporting Hospital Quality Data for Annual Payment Update Program) and a payment rate reduction of 1.3% for hospitals that do not. The rate increase is based on a proposed hospital market basket increase of 2.5%, which is reduced by (i) a multi-factor productivity adjustment of 0.5%, (ii) a 0.3% reduction required by the Affordable Care Act, (iii) a 0.8% documentation and coding recoupment adjustment required by the ATRA, and (iv) a 0.2% adjustment to offset the cost of changes to the Medicare program's admission and medical review criteria for hospital inpatient services (discussed in more detail below). With respect to the documentation and coding recoupment adjustment required by the ATRA, CMS indicated in the final rule that it expects to make additional adjustments in FFYs 2015, 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.

With respect to the Medicare program's admission and medical review criteria for inpatient services, the final IPPS rule modifies CMS's policy on how Medicare contractors will review inpatient hospital services for payment purposes. Under the final rule, in addition to services designated by CMS as inpatient-only services, surgical procedures, diagnostic tests, and other treatments will generally be considered to be appropriate for inpatient admission and inpatient hospital payment under Medicare Part A when the treating physician expects the beneficiary to require a stay that crosses at least two midnights and admits the beneficiary to the hospital based on that expectation. The final IPPS rule specifies that the timeframe used in determining the expectation of a stay surpassing two midnights begins when the beneficiary starts receiving services, including outpatient observation services or services in an emergency department, operating room or other treatment area, in the hospital. As for medical review, the final IPPS rule establishes a presumption that inpatient hospital claims with lengths of stay greater than two midnights after the formal admission following the order will be presumed generally appropriate for reimbursement under Medicare Part A and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care. However, inpatient hospital claims with lengths of stay less than two midnights after the formal admission following the order will not be subject to that presumption and may be reviewed by Medicare contractors and recovery auditors for appropriateness for Medicare Part A payment. When reviewing such claims, the final rule requires Medicare contractors and recovery auditors to evaluate (i) the physician order for inpatient admission to the hospital, (ii) the medical documentation supporting the expectation that care would span at least two midnights, and (iii) the medical documentation supporting a decision that it was reasonable and necessary to keep the patient at the hospital to receive such care. While the final IPPS rule became effective on October 1, 2013, CMS has indicated that, for a period of 90 days after the effective date of the rule, it will not permit recovery auditors to review inpatient admissions of one midnight or less that began on or after October 1, 2013. During such implementation period, CMS

will instruct Medicare Administrative Contractors to review, on a pre-payment basis, a small sample (approximately 10-25) of inpatient hospital claims spanning less than two midnights after admission 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.

In addition to establishing the payment rate update and modifying the Medicare program's admission and medical review criteria for hospital inpatient services, the IPPS final rule for FFY 2014 also implements the Affordable Care Act's modifications to the Medicare program's DSH payment methodology. Under the final rule, in FFY 2014, DSH hospitals will receive 25% of the amount they would have received under the current statutory formula for Medicare DSH payments. The remaining amount, which is equal to 75% of what otherwise would have been paid as Medicare DSH payments under the current statutory formula, will be reduced by the percentage change in uninsured individuals under the age of 65 from 2013 to 2014 (as normalized to reflect the October 1 commencement date for each FFY) minus 0.1% and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period. However, instead of actually measuring the amount of uncompensated care that is provided by DSH hospitals, CMS will use Medicaid days and Medicare Supplemental Security Income ("SSI") days as proxies for determining levels of uncompensated care. While difficult to predict, the use of Medicaid and Medicare SSI days to approximate levels of uncompensated care could have an adverse effect on DSH hospitals that are located in states that have opted to not expand their Medicaid programs. CMS estimates that the proposed changes will reduce Medicare DSH payments to hospitals by approximately $500 million in FFY 2014.

On September 18, 2013, CMS issued a final rule regarding the Medicaid state DSH allotment reductions that are required by the Affordable Care Act. The final rule sets forth the methodology that will be used to implement the required $500 million and $600 million in Medicaid DSH allocation reductions in FFY 2014 and FFY 2015, respectively, but it does not set forth the methodology that will be used to implement the Medicaid DSH allocation reductions required in FFYs 2016 and beyond. CMS has indicated that the methodology used to implement those reductions will be the subject of a future rulemaking. Both the Proposed Budget and current proposals in Congress would delay the cuts to the Medicare and Medicaid DSH programs. However, we cannot predict whether the Proposed Budget or any other legislation postponing or reducing the cuts to the Medicare and Medicaid DSH programs will be approved by Congress.

Finally, the IPPS final rule for FFY 2014 also includes the expiration of both the Medicare dependent hospital ("MDH") program and the temporary expansion of the Medicare low-volume hospital ("LVH") program that had been implemented by the Affordable Care Act and the ATRA. The MDH program historically provided enhanced payment support for rural hospitals that had no more than 100 beds and at least 60% of their inpatient days or discharges covered by Medicare. The Affordable Care Act and the ATRA had extended the MDH through FFY 2013. The LVH program provides additional Medicare reimbursement for general acute care hospitals that are located a certain distance from another general acute care hospital and have less than a certain number of Medicare discharges each fiscal year and had been temporarily expanded by the Affordable Care Act and the ATRA through FFY 2013. Legislation has been introduced in Congress to extend both the MDH program and the expansion to the LVH program for an additional year, but we cannot predict whether any such legislation will be enacted. The expiration of both the MDH program and the temporary expansion of the LVH program will result in a projected aggregate reduction in payments from the Medicare program of approximately $266 million and $175 million, respectively, in FFY 2014. If neither of these programs are extended, we anticipate that our reimbursement will be reduced by approximately $5.0 million for the fourth quarter of 2013 and by approximately $20.0 million for 2014.

On July 19, 2013, CMS published its hospital outpatient prospective payment system ("OPPS") proposed rule for calendar year ("CY") 2014, which begins on January 1, 2014. Among other things, the proposed rule provides for a

payment rate increase of 1.8% percent for hospitals that meet the reporting requirements of the Medicare Hospital Outpatient Quality Reporting ("OQR") Program and a payment rate decrease of 0.2% for hospitals that do not. The proposed rate increase is based on a proposed hospital market basket increase of 2.5%, which is reduced by a multi-factor productivity adjustment of 0.4% and an additional 0.3% reduction required by the Affordable Care Act. The proposed rule also makes several other changes to the OPPS, including packaging seven new categories of supporting items and services that will now be included in the Medicare program's payment for the primary service, collapsing the current five levels of outpatient visit codes to one unique code for each type of outpatient hospital visits (i.e., clinic, 24-hour emergency department visit, and non-24 hour emergency department visit), and adding five new reporting measures to the OQR Program.

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 2013, CMS issued a final rule that would have applied the SGR and resulted in an aggregate reduction of 26.5% to all physician payments under the PFS for CY 2013. The ATRA delayed application of the SGR and extended CY 2011 PFS payment rates through December 31, 2013.

On July 8, 2013, CMS published the PFS proposed rule for CY 2014. Under the proposed rule, payment rates to physicians would be reduced by 24.4% based on the application of the SGR. We cannot predict whether Congress will pass legislation to avert the proposed rate cut in CY 2014 or will otherwise adopt a permanent fix for the issues that are created by the application of the SGR. If the payment reduction contained in the proposed rule is not averted, the reimbursement received by our employed physicians, the physicians to whom our hospitals have provided recruitment assistance, and the physician members of our medical staffs would be adversely affected.

Adoption of Electronic Health Records

The 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 ("ARRA"). The HITECH Act includes provisions designed to increase the use of EHR by both physicians and hospitals. EHR meaningful use objectives and measures that hospitals and physicians must meet in order to qualify for incentive payments will be implemented in three stages. Stage 1 has been in effect since 2011; however, on 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. 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") that are designed to protect the confidentiality, availability and integrity of health information. The privacy standards apply to individually identifiable information held or disclosed by a covered entity in any form, whether communicated electronically, on paper or orally, impose extensive administrative requirements on us, require our compliance with rules governing the use and disclosure of this health information, and require us to impose these rules, by contract, on any business associate to whom we disclose such information in order to perform functions on our behalf. The security standards require us to establish and maintain reasonable and appropriate administrative, technical and physical safeguards to ensure the integrity, confidentiality and the availability of electronic health and related financial information. In addition, our facilities will continue to remain subject to any state laws that are more restrictive than the privacy regulations issued under HIPAA.

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

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

In addition to the privacy and security requirements, we also are subject to the administrative simplification provisions of HIPAA, which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. In January 2009, CMS published its 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. Implementation of ICD-10 will require a significant investment in technology and training. We may experience delays in reimbursement while our facilities and the payors from which we seek reimbursement make the transition to ICD-10. On August 24, 2012, CMS released a final rule that revised the effective date of the ICD-10 transition to October 1, 2014. If any of our hospitals fail to implement the new coding system by the deadline, the affected hospital will not be paid for services. We are not able to predict the overall financial impact of 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. Our hospitals have experienced an increase in self-pay revenues over the past several years due to a combination of broad economic factors, including high levels of unemployment in many of our markets, reductions in state Medicaid budgets and increasing numbers of individuals and employers who choose not to purchase insurance or who purchase insurance plans with high deductibles. 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 $9.4 million and $26.9 million during the nine months ended September 30, 2013 and 2012, respectively. This represents a net period over period decrease in revenues of $17.5 million. This change impacted almost entirely our hospital, Memorial Medical Center of Las Cruces, New Mexico ("MMC"). We recognized revenues of approximately $7.1 million under the New Mexico SCPP during the three months ended September 30, 2013, and we anticipate that the New Mexico SCPP reimbursement for the fourth quarter of 2013 will approximate $7.1 million which is in accordance with our original financial plan. We expect that the New Mexico SCPP will be reconfigured effective January 1, 2014. Currently, for 2014, we anticipate annual reimbursement under the New Mexico SCPP to approximate between $6.0 million and $9.0 million. 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 (i) our hospital support center, (ii) our same-hospital operations, (iii) the results of Scott Memorial Hospital ("Scott Memorial"), which we acquired effective January 1, 2013 though our joint venture with Norton Healthcare, Inc., (iv) Marquette General Health System ("Marquette General"), which we acquired effective September 1, 2012, Twin County Regional Hospital ("Twin County"), in which we acquired an 80% interest effective April 1, 2012, each through Duke LifePoint Healthcare, in which we own a controlling interest with a wholly-controlled affiliate of Duke University Health System, Inc. and (v) Woods Memorial Hospital ("Woods Memorial"), which we acquired effective July 1, 2012. Continuing operations information excludes the results of our hospitals that have previously been disposed.

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

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

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

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 53 hospitals operated during the three and nine months ended September 30, 2013 and 2012. Same-hospital information excludes the results of Scott Memorial, Marquette General, Twin County, Woods Memorial and our hospitals that have previously been disposed.

For the Three Months Ended September 30, 2013 and 2012

Operating Results Summary

The following table summarizes the results of operations for the three months ended September 30, 2013 and 2012 (dollars in millions):

	Three Months Ended September 30,					
	2013			2012		
	Amount	% of Revenues		Amount	% of Revenues	
Revenues before provision for doubtful accounts	$ 1,092.9	121.5	%	$ 984.9	120.1	%
Provision for doubtful accounts	193.2	21.5		164.7	20.1	
Revenues	899.7	100.0		820.2	100.0	
Salaries and benefits	422.2	46.9		390.3	47.6	
Supplies	140.6	15.6		129.3	15.8	
Other operating expenses	222.6	24.8		205.3	25.0	
Other income	(20.0)	(2.2)		(12.0)	(1.5)	
Depreciation and amortization	57.4	6.3		47.7	5.9	
Interest expense, net	24.0	2.7		24.5	3.0	
Debt transaction costs	0.3	-		4.4	0.5	
	847.1	94.1		789.5	96.3	
Income from continuing operations before income taxes	52.6	5.9		30.7	3.7	
Provision for income taxes	18.5	2.1		11.4	1.4	
Income from continuing operations	34.1	3.8		19.3	2.3	
Less: Net income attributable to noncontrolling interests	(1.6)	(0.2)		(0.1)	(0.1)	
Income from continuing operations attributable to LifePoint Hospitals, Inc.	$ 32.5	3.6	%	$ 19.2	2.2	%

Revenues

The following table presents the components of revenues for the three months ended September 30, 2013 and 2012 (dollars in millions):

	Three Months Ended September 30,			
	2013	2012	Increase	% Increase
Continuing operations:				
Revenues before provision for doubtful accounts	$ 1,092.9	$ 984.9	$ 108.0	11.0 %
Provision for doubtful accounts	193.2	164.7	28.5	17.3
Revenues	$ 899.7	$ 820.2	$ 79.5	9.7
Same-hospital:				
Revenues before provision for doubtful accounts	$ 974.6	$ 940.1	$ 34.5	3.7 %
Provision for doubtful accounts	188.3	160.5	27.8	17.4
Revenues	$ 786.3	$ 779.6	$ 6.7	0.8

Our revenues before provision for doubtful accounts by payor and approximate percentages of revenues were as follows for the three months ended September 30, 2013 and 2012 (in millions):

	Three Months Ended September 30,			
	2013		2012	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 296.0	32.9 %	$ 279.2	34.0 %
Medicaid	133.9	14.9	124.7	15.2
HMOs, PPOs and other private insurers	446.0	49.6	397.8	48.5
Self-pay	200.8	22.3	170.4	20.8
Other	16.2	1.8	12.8	1.6
Revenues before provision for doubtful accounts	1,092.9	121.5	984.9	120.1
Provision for doubtful accounts	(193.2)	(21.5)	(164.7)	(20.1)
Revenues	$ 899.7	100.0 %	$ 820.2	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, 2013 and 2012:

	Three Months Ended September 30,			
	2013	2012	Increase	% Increase
Revenues per equivalent admission - continuing operations	$ 7,683	$ 7,249	$ 434	6.0
Revenues per equivalent admission - same-hospital	$ 7,364	$ 7,204	$ 160	2.2

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, 2013 and 2012:

	Three Months Ended September 30,	Increase	% Increase

	2013	2012	(Decrease)	(Decrease)
Continuing operations:				
Admissions	48,671	48,766	(95)	(0.2)
Equivalent admissions	117,097	113,147	3,950	3.5
Medicare case mix index	1.37	1.29	0.08	6.2
Average length of stay (days)	4.5	4.5	-	-
Inpatient surgeries	13,341	13,283	58	0.4
Outpatient surgeries	45,514	41,379	4,135	10.0
Emergency room visits	296,240	293,657	2,583	0.9
Outpatient factor	2.40	2.32	0.08	3.4
Same-hospital:				
Admissions	44,896	46,899	(2,003)	(4.3)
Equivalent admissions	106,772	108,223	(1,451)	(1.3)
Medicare case mix index	1.35	1.30	0.05	3.8
Average length of stay (days)	4.3	4.3	-	-
Inpatient surgeries	12,005	12,668	(663)	(5.2)
Outpatient surgeries	41,101	39,720	1,381	3.5
Emergency room visits	277,836	281,736	(3,900)	(1.4)
Outpatient factor	2.38	2.31	0.07	3.0

For the three months ended September 30, 2013, our same-hospital revenues before provision for doubtful accounts increased $34.5 million, or 3.7%, to $974.6 million as compared to $940.1 million for the same period last year. This increase was primarily driven by growth in same-hospital revenues before provision for doubtful accounts from self-pay payors and higher contracted rates from HMOs, PPOs and other private insurers. Our same-hospital self-pay revenue increased primarily as a result of pricing increases as well as an increase in self-pay admissions and equivalent admissions due to higher self-pay emergency room visits and overall high levels of unemployment in the majority of our communities. Increases in our self-pay revenues contributed to an increase in our provision for doubtful accounts, as further discussed in our analysis of our provision for doubtful accounts.

These increases were partially offset by a decrease in same-hospital admissions and equivalent admissions from Medicare, Medicaid, HMOs, PPOs and other private insurers. For the three months ended September 30, 2013, our same-hospital admissions and equivalent admissions decreased 4.3% and 1.3%, respectively, as compared to the same period last year primarily because of a continued decline in our one day stay admissions and a 1.4% decrease in emergency room visits which can result in subsequent admissions or inpatient surgeries.

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, 2013 and 2012 (dollars in millions):

	Three Months Ended September 30,					
	2013	% of Revenues	2012	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Continuing operations:						
Related key indicators:						
Charity care write-offs	$ 33.2	3.7 %	$ 29.6	3.6 %	$ 3.6	12.0 %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 200.8	22.3 %	$ 170.4	20.8 %	$ 30.4	17.8 %
Net revenue days outstanding (at end of period)	59.7	N/A	60.4	N/A	(0.7)	(1.2) %
Same-hospital:						
Related key indicators:						
Charity care write-offs	$ 32.1	4.1 %	$ 28.8	3.7 %	$ 3.3	11.2 %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 193.3	24.6 %	$ 166.7	21.4 %	$ 26.6	16.0 %
Net revenue days outstanding (at end of period)	62.0	N/A	54.9	N/A	7.1	12.9 %

For the three months ended September 30, 2013, our provision for doubtful accounts increased by $28.5 million, or 17.3%, to $193.2 million on a continuing operations basis and by $27.8 million, or 17.4%, to $188.3 million on a same-hospital basis as compared to the same period last year. This increase was primarily the result of increases in self-pay revenues during the three months ended September 30, 2013. Same-hospital self-pay revenues increased by $26.6 million over the same period last year and represented 24.6% of revenues. Self-pay revenues continued to increase for both our inpatient and outpatient services, which were primarily driven by higher self-pay volumes. The provision for doubtful accounts relates principally to self-pay amounts due from patients. The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations, "Critical Accounting Estimates," in the 2012 Annual Report on Form 10-K.

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

Our net revenue days outstanding at September 30, 2013 improved slightly to 59.7 days compared to 60.4 days at September 30, 2012 on a continuing operations basis. However, our net revenue days outstanding at September 30, 2012 included just 30 days of net revenue for Marquette General. After normalizing for a full quarter of revenue for Marquette General, we estimated that on a continuing operations basis our net revenue days outstanding would have been 57.2 at September 30, 2012. On a same-hospital basis, our net revenue days outstanding at September 30, 2013 increased to 62.0 days compared to 54.9 days at September 30, 2012. Including the normalizing adjustment for Marquette General for the prior year, our net revenue days outstanding increased on both a continuing operations and same-hospital basis primarily as a result of the transition of a number of our hospitals into our shared centralized resources revenue cycle function, an increase in the payment lag times for certain of our payors and the overall impact of higher levels of prepayment Medicare audit withholdings.

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, 2013 and 2012:

	Three Months Ended September 30,					
	2013	% of Revenues	2012	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 422.2	46.9 %	$ 390.3	47.6 %	$ 31.9	8.2 %
Man-hours per equivalent admission	105.4	N/A	103.4	N/A	2.0	1.9 %
Salaries and benefits per equivalent admission	$ 3,594	N/A	$ 3,475	N/A	$ 119	3.4 %

For the three months ended September 30, 2013, our salaries and benefits expense increased to $422.2 million, or 8.2%, as compared to $390.3 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, 2013 and 2012:

	Three Months Ended September 30,					
	2013	% of Revenues	2012	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 140.6	15.6 %	$ 129.3	15.8 %	$ 11.3	8.8 %
Supplies per equivalent admission	$ 1,202	N/A	$ 1,141	N/A	$ 61	5.3 %

For the three months ended September 30, 2013, our supplies expense increased to $140.6 million, or 8.8%, as compared to $129.3 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, 2013 and 2012 (dollars in millions):

	Three Months Ended September 30,					
	2013	% of Revenues	2012	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Professional fees	$ 34.9	3.9 %	$ 28.5	3.5 %	$ 6.4	22.4 %
Utilities	18.6	2.1	17.1	2.1	1.5	8.7
Repairs and maintenance	24.3	2.7	21.8	2.7	2.5	11.0
Rents and leases	9.7	1.1	8.6	1.0	1.1	14.6
Insurance	10.3	1.1	9.3	1.1	1.0	10.4
Physician recruiting	6.4	0.7	7.2	0.9	(0.8)	(11.1)
Contract services	63.8	7.1	54.0	6.6	9.8	18.2
Non-income taxes	25.8	2.9	22.5	2.7	3.3	15.1
Other	28.8	3.2	36.3	4.4	(7.5)	(20.7)
	$ 222.6	24.8	$ 205.3	25.0	$ 17.3	8.4 %

For the three months ended September 30, 2013, our other operating expenses increased to $222.6 million, or 8.4%, as compared to $205.3 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 professional fees and contract services, partially offset by a decrease in same-hospital other expenses.

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

Our same-hospital contract services expense increased primarily as a result of increased fees and expenses related to the implementation of our shared centralized resource initiatives at several of our hospitals.

Finally, our same-hospital other expenses were higher during the three months ended September 30, 2012 as compared to the same period of the current year primarily as a result of approximately $5.2 million of additional legal and consulting fees primarily related to the acquisitions of Marquette General effective September 1, 2012 and Woods

Memorial effective July 1, 2012.

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, 2013, we recognized $11.9 million and $8.1 million in Medicare and Medicaid EHR incentive payments, respectively, as compared to $4.8 million and $7.2 million in Medicare and Medicaid EHR incentive payments recognized in the same period last year.

Depreciation and Amortization

For the three months ended September 30, 2013, our depreciation and amortization expense increased by $9.7 million, or 20.2% to $57.4 million, or 6.3% of revenues, as compared to $47.7 million, or 5.9% 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

Our interest expense decreased by $0.5 million, or 2.1%, to $24.0 million for the three months ended September 30, 2013, as compared to $24.5 million for the same period in the prior year. Effective July 24, 2012, we replaced our prior credit agreement with a new senior secured credit agreement with, among others, Citibank, N.A., as administrative agent, and the lenders party thereto (the "Senior Credit Agreement"). Additionally, on February 6, 2013, we amended our Senior Credit Agreement pursuant to which we issued incremental term loans (the "Incremental Term Loans"). The proceeds from the Incremental Term Loans were used to repurchase our 3¼% convertible senior subordinated debentures due August 15, 2025 (the "3¼% Debentures"). The decrease in our interest expense is primarily attributable to a decrease in the applicable effective interest on the Senior Credit Agreement for the three months ended September 30, 2013 as compared to the applicable effective interest on the prior credit agreement and the 3¼% Debentures for the same period last year. For a further discussion of our debt and corresponding interest rates, see "Liquidity and Capital Resources — Debt."

Debt Transaction Costs

In connection with certain debt transactions and modifications completed during the three months ended September 30, 2013 and 2012, we recognized debt transaction costs of $0.3 million and $4.4 million, respectively.

Provision for Income Taxes

Our provision for income taxes was $18.5 million, or 2.1% of revenues, for the three months ended September 30, 2013, as compared to $11.4 million, or 1.4% of revenues, for the same period last year. The $7.1 million increase in the provision for income taxes was primarily attributable to a $21.9 million increase in income from continuing operations before income taxes for the three months ended September 30, 2013, as compared to the same period last year. The effective tax rate decreased to 36.3% for the three months ended September 30, 2013, as compared to 37.4% for the three months ended September 30, 2012, primarily due to lower non-deductible expenses and a larger reversal of accrued interest expense and taxes in connection with the lapses of statutes of limitations during the three months ended September 30, 2013, as compared to the same period last year.

For the Nine Months Ended September 30, 2013 and 2012

Operating Results Summary

The following table summarizes the results of operations for the nine months ended September 30, 2013 and 2012 (dollars in millions):

	Nine Months Ended September 30,					
	2013			2012		
	Amount	% of Revenues		Amount	% of Revenues	
Revenues before provision for doubtful accounts	$ 3,268.8	119.9	%	$ 2,963.1	118.6	%
Provision for doubtful accounts	543.1	19.9		464.6	18.6	
Revenues	2,725.7	100.0		2,498.5	100.0	
Salaries and benefits	1,277.5	46.9		1,130.2	45.2	
Supplies	429.4	15.8		382.7	15.3	
Other operating expenses	667.0	24.3		589.5	23.7	
Other income	(36.7)	(1.3)		(14.7)	(0.6)	
Depreciation and amortization	169.1	6.2		139.7	5.6	
Interest expense, net	70.5	2.6		75.7	3.0	
Gain on settlement of pre-acquisition contingent obligation	(5.6)	(0.2)		-	-	
Debt transaction costs	4.7	0.2		4.4	0.2	
Impairment charge	-	-		3.1	0.1	
	2,575.9	94.5		2,310.6	92.5	
Income from continuing operations before income taxes	149.8	5.5		187.9	7.5	
Provision for income taxes	55.5	2.0		69.8	2.8	
Income from continuing operations	94.3	3.5		118.1	4.7	
Less: Net income attributable to noncontrolling interests	(2.4)	(0.1)		(2.7)	(0.1)	
Income from continuing operations attributable to LifePoint Hospitals, Inc.	$ 91.9	3.4	%	$ 115.4	4.6	%

Revenues

The following table presents the components of revenues for the nine months ended September 30, 2013 and 2012 (dollars in millions):

	Nine Months Ended September 30,		Increase	% Increase	
	2013	2012	(Decrease)	(Decrease)	
Continuing operations:					
Revenues before provision for doubtful accounts	$ 3,268.8	$ 2,963.1	$ 305.7	10.3	%
Provision for doubtful accounts	543.1	464.6	78.5	16.9	
Revenues	$ 2,725.7	$ 2,498.5	$ 227.2	9.1	
Same-hospital:					
Revenues before provision for doubtful accounts	$ 2,929.7	$ 2,903.0	$ 26.7	0.9	%
Provision for doubtful accounts	518.7	457.8	60.9	13.3	
Revenues	$ 2,411.0	$ 2,445.2	$ (34.2)	(1.4)	

The following table shows the sources of our revenues before provision for doubtful accounts by payor, including adjustments to estimated reimbursement amounts and provision for doubtful accounts, for the nine months ended September 30, 2013 and 2012 (in millions):

	Nine Months Ended September 30,			
	2013		2012	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 903.6	33.2 %	$ 881.3	35.3 %
Medicaid	385.1	14.1	368.3	14.7
HMOs, PPOs and other private insurers	1,370.2	50.3	1,185.9	47.5
Self-pay	558.7	20.5	491.1	19.7
Other	51.2	1.8	36.5	1.4
Revenues before provision for doubtful accounts	3,268.8	119.9	2,963.1	118.6
Provision for doubtful accounts	(543.1)	(19.9)	(464.6)	(18.6)
Revenues	$ 2,725.7	100.0 %	$ 2,498.5	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, 2013 and 2012:

	Nine Months Ended September 30,			
	2013	2012	Increase	% Increase
Revenues per equivalent admission - continuing operations	$ 7,775	$ 7,450	$ 325	4.4
Revenues per equivalent admission - same-hospital	$ 7,522	$ 7,451	$ 71	1.0

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, 2013 and 2012:

	Nine Months Ended

	September 30,		Increase	% Increase
	2013	2012	(Decrease)	(Decrease)
Continuing operations:				
Admissions	150,140	148,326	1,814	1.2
Equivalent admissions	350,577	335,365	15,212	4.5
Medicare case mix index	1.37	1.29	0.08	6.2
Average length of stay (days)	4.6	4.4	0.2	4.5
Inpatient surgeries	40,173	40,008	165	0.4
Outpatient surgeries	135,410	127,402	8,008	6.3
Emergency room visits	876,840	851,182	25,658	3.0
Outpatient factor	2.34	2.26	0.08	3.5
Same-hospital:				
Admissions	138,936	145,524	(6,588)	(4.5)
Equivalent admissions	320,525	328,157	(7,632)	(2.3)
Medicare case mix index	1.34	1.30	0.04	3.1
Average length of stay (days)	4.4	4.4	-	-
Inpatient surgeries	36,206	39,141	(2,935)	(7.5)
Outpatient surgeries	122,559	125,015	(2,456)	(2.0)
Emergency room visits	822,485	833,485	(11,000)	(1.3)
Outpatient factor	2.31	2.26	0.05	2.2

For the nine months ended September 30, 2013, our same-hospital revenues before provision for doubtful accounts increased $26.7 million, or 0.9%, to $2,929.7 million as compared to $2,903.0 million for the same period last year. This increase was primarily driven by growth in same-hospital revenues before provision for doubtful accounts from self-pay payors, higher contracted rates from HMOs, PPOs and other private insurers and an improvement in our appeal success results relating to Medicare recovery contractor audits. Our same-hospital self-pay revenue increased primarily as a result of pricing increases as well as an increase in self-pay admissions and equivalent admissions due to higher self-pay emergency room visits and overall high levels of unemployment in the majority of our communities. Increases in our self-pay revenues contributed to an increase in our provision for doubtful accounts, as further discussed in our analysis of our provision for doubtful accounts.

These increases were partially offset by a decrease in same-hospital admissions and equivalent admissions from Medicare, Medicaid, HMOs, PPOs and other private insurers, the absence during the current period of certain favorable amounts that were recognized during the same period in the prior year, recent reimbursement changes to the New Mexico SCPP, as well as decreases in Medicare reimbursement as a result of certain provisions of the Budget Control Act of 2011 that were effective April 1, 2013.

For the nine months ended September 30, 2013, our same-hospital admissions and equivalent admissions decreased 4.5% and 2.3%, respectively, as compared to the same period last year primarily because of a continued decline in our one day stay admissions and a 1.3% decrease in emergency room visits which can result in subsequent admissions or inpatient surgeries. Additionally, our equivalent admissions were negatively impacted by a 2.0% decrease in outpatient surgeries during the nine months ended September 30, 2013 as compared to the same period last year.

During the nine months ended September 30, 2012, a settlement agreement (the “Rural Floor Settlement”) was signed between HHS, the Secretary of HHS, CMS and a large number of healthcare service providers, including our hospitals. The Rural Floor Settlement is intended to resolve all claims that have been brought or could have been brought relating to CMS’s calculation of the rural floor budget neutrality adjustment that was created by the Balanced Budget Act of 1997 from federal fiscal year 1998 through and including federal fiscal year 2011 for healthcare service providers that participated in certain court cases and group appeals. As a result of the Rural Floor Settlement, we recognized $33.0 million of additional Medicare revenue for the nine months ended September 30, 2012. Furthermore, we recognized additional revenues before provision for doubtful accounts during the nine months ended September 30, 2012 of approximately $10.2 million as a result of our participation in two new supplemental payment programs in the states of North Carolina and West Virginia. We did not experience similar favorable amounts during the nine months ended September 30, 2013. The amount and timing of revenue recognized for supplemental payment programs are often dependent upon a variety of factors including state budgetary limitations, program approval procedures and other factors.

Finally, during the nine months ended September 30, 2013, we recognized revenues of approximately $9.4 million in accordance with the New Mexico SCPP as compared to approximately $26.9 million of revenue recognized during the nine months ended September 30, 2012, representing a net period over period decrease in revenues of $17.5 million. Included in the $9.4 million in net revenues recognized during the nine months ended September 30, 2013 are adjustments to our reimbursement under the New Mexico SCPP for the first two quarters of 2013 and the final two

quarters of 2012.

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, 2013 and 2012 (dollars in millions):

	Nine Months Ended September 30,								
	2013	% of Revenues		2012	% of Revenues		Increase (Decrease)	% Increase (Decrease)	
Continuing operations:									
Related key indicators:									
Charity care write-offs	$ 105.4	3.9	%	$ 80.7	3.2	%	$ 24.7	30.6	%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 558.7	20.5	%	$ 491.1	19.7	%	$ 67.6	13.8	%
Net revenue days outstanding (at end of period)	59.7	N/A		60.4	N/A		(0.7)	(1.2)	%
Same-hospital:									
Related key indicators:									
Charity care write-offs	$ 102.1	4.2	%	$ 79.5	3.3	%	$ 22.6	28.3	%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 537.5	22.3	%	$ 485.7	19.9	%	$ 51.8	10.7	%
Net revenue days outstanding (at end of period)	62.0	N/A		54.9	N/A		7.1	12.9	%

For the nine months ended September 30, 2013, our provision for doubtful accounts increased by $78.5 million, or 16.9%, to $543.1 million on a continuing operations basis and by $60.9 million, or 13.3%, to $518.7 million on a same-hospital basis as compared to the same period last year. This increase was primarily the result of increases in self-pay revenues during the nine months ended September 30, 2013. Same-hospital self-pay revenues increased by $51.8 million over the same period last year and represented 22.3% of revenues. Self-pay revenues continued to increase for both our inpatient and outpatient services, which were primarily driven by higher self-pay volumes. Additionally, as a result of a decrease in our reimbursement under the New Mexico SCPP, we have experienced an increase of approximately $17.5 million in our charity care write-offs during the nine months ended September 30, 2013, as compared to the same period in the prior year. The provision for doubtful accounts relates principally to self-pay amounts due from patients. The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations, “Critical Accounting Estimates,” in the 2012 Annual Report on Form 10-K.

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

Our net revenue days outstanding at September 30, 2013 improved slightly to 59.7 days compared to 60.4 days at September 30, 2012 on a continuing operations basis. However, our net revenue days outstanding at September 30, 2012 included just 30 days of net revenue for Marquette General. After normalizing for a full quarter of revenue for Marquette General, we estimated that on a continuing operations basis our net revenue days outstanding would have been 57.2 at September 30, 2012. On a same-hospital basis, our net revenue days outstanding at September 30, 2013 increased to 62.0 days compared to 54.9 days at September 30, 2012. Including the normalizing adjustment for Marquette General for the prior year, our net revenue days outstanding increased on both a continuing operations and same-hospital basis primarily as a result of the transition of a number of our hospitals into our shared centralized resources revenue cycle function, an increase in the payment lag times for certain of our payors and the overall impact of higher levels of prepayment Medicare audit withholdings.

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, 2013 and 2012:

	Nine Months Ended September 30,					
	2013	% of Revenues	2012	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 1,277.5	46.9 %	$ 1,130.2	45.2 %	$ 147.3	13.0 %
Man-hours per equivalent admission	106.5	N/A	101.5	N/A	5.0	4.9 %
Salaries and benefits per equivalent admission	$ 3,647	N/A	$ 3,378	N/A	$ 269	8.0 %

For the nine months ended September 30, 2013, our salaries and benefits expense increased to $1,277.5 million, or 13.0%, as compared to $1,130.2 million for the same period last year primarily as 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, 2013 and 2012:

	Nine Months Ended September 30,					
	2013	% of Revenues	2012	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 429.4	15.8 %	$ 382.7	15.3 %	$ 46.7	12.2 %
Supplies per equivalent admission	$ 1,225	N/A	$ 1,141	N/A	$ 84	7.4 %

For the nine months ended September 30, 2013, our supplies expense increased to $429.4 million, or 12.2%, as compared to $382.7 million for the same period last year and our supplies per equivalent admission increased to $1,225, or 7.4%, as compared to $1,141 for the same period last year as a result of our recent acquisitions. This increase was partially offset by a decrease in our same-hospital supplies expense for pharmacy and other supplies as a result of our continuing efforts to effectively manage our supply costs and increased cost savings associated with participation in a group purchasing organization.

Other Operating Expenses

The following table summarizes our other operating expenses for the nine months ended September 30, 2013 and 2012 (dollars in millions):

	Nine Months Ended September 30,							
	2013	% of Revenues	2012	% of Revenues	Increase (Decrease)	% Increase (Decrease)		
Professional fees	$ 102.3	3.8 %	$ 84.4	3.4 %	$ 17.9	21.2	%	
Utilities	52.7	1.9	46.8	1.9	5.9	12.8		
Repairs and maintenance	72.0	2.6	63.6	2.5	8.4	13.1		
Rents and leases	28.8	1.1	24.8	1.0	4.0	16.3		
Insurance	29.1	1.1	29.7	1.2	(0.6)	(2.0)		
Physician recruiting	20.4	0.7	21.9	0.9	(1.5)	(7.1)		
Contract services	191.8	7.0	156.5	6.3	35.3	22.6		
Non-income taxes	75.4	2.8	68.0	2.7	7.4	10.9		
Other	94.5	3.3	93.8	3.8	0.7	0.7		
	$ 667.0	24.3	$ 589.5	23.7	$ 77.5	13.2	%	

For the nine months ended September 30, 2013, our other operating expenses increased to $667.0 million, or 13.2%, as compared to $589.5 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 professional fees and contract services, partially offset by a decrease in same-hospital other expenses.

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

Our same-hospital contract services expense increased primarily as a result of increased fees and expenses related to our conversion of the clinical and patient accounting information system applications as well as the implementation of our shared centralized resource initiatives at several of our hospitals.

Finally, our same-hospital other expenses were higher during nine months ended September 30, 2012 as compared to the same period of the current year primarily as a result of approximately $6.0 million of additional legal and consulting fees primarily related to the acquisitions of Marquette General effective September 1, 2012, Woods Memorial effective July 1, 2012 and Twin County effective April 1, 2012.

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, 2013, we recognized $23.2 million and $13.5 million in Medicare and Medicaid EHR incentive payments, respectively, as compared to $4.8 million and $9.9 million in Medicare and Medicaid EHR incentive payments recognized in the same period last year.

Depreciation and Amortization

For the nine months ended September 30, 2013, our depreciation and amortization expense increased by $29.4 million, or 21.1% to $169.1 million, or 6.2% of revenues, as compared to $139.7 million, or 5.6% 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

Our interest expense decreased by $5.2 million, or 6.9%, to $70.5 million for the nine months ended September 30, 2013, as compared to $75.7 million for the same period in the prior year. Effective July 24, 2012, we replaced our prior credit agreement with the Senior Credit Agreement. Additionally, on February 6, 2013, we amended our Senior Credit Agreement pursuant to which we issued the Incremental Term Loans. The proceeds from the Incremental Term Loans were used to repurchase the 3¼% Debentures. The decrease in our interest expense is primarily attributable to a decrease in the applicable effective interest on the Senior Credit Agreement for the nine months ended September 30, 2013 as compared to the applicable effective interest on the prior credit agreement and the 3¼% Debentures for the same period last year. 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 and 2012, we recognized debt transaction costs of $4.7 million and $4.4 million, respectively.

Impairment Charge

During the nine months ended September 30, 2012, we incurred a $3.1 million impairment charge from continuing operations. This impairment charge relates to the write-off of certain capitalized information system costs which we have determined are no longer a necessary component of our ongoing information technology strategy.

Provision for Income Taxes

Our provision for income taxes was $55.5 million, or 2.0% of revenues, for the nine months ended September 30, 2013, as compared to $69.8 million, or 2.8% of revenues, for the same period last year. The $14.3 million decrease in our provision for income taxes was primarily attributable to a $38.1 million decrease in income from continuing operations before income taxes in the nine months ended September 30, 2013, as compared to the same period last year. The effective tax rate was comparable at 37.7% for both the nine months ended September 30, 2013 and 2012.

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Liquidity and Capital Resources

Liquidity

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

The following table presents summarized cash flow information for the three and nine months ended September 30, 2013 and 2012 (in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
Net cash provided by operating activities - continuing operations	$ 104.1	$ 84.3	$ 253.4	$ 262.3
Less: Purchases of property and equipment	(32.7)	(47.3)	(108.5)	(157.4)
Free operating cash flow	71.4	37.0	144.9	104.9
Acquisitions, net of cash acquired	(12.2)	(162.3)	(18.4)	(182.4)
Proceeds from borrowings	-	490.0	323.0	490.0
Payments of borrowings	(3.7)	(443.7)	(320.9)	(443.7)
Repurchases of common stock	(31.3)	(0.3)	(38.5)	(6.2)
Payment of debt financing costs	(7.3)	(9.6)	(8.3)	(9.6)
Proceeds from exercise of stock options	6.2	15.9	34.4	21.4
Other	(3.3)	(1.4)	(6.4)	(2.7)
Net increase in cash and cash equivalents	$ 19.8	$ (74.4)	$ 109.8	$ (28.3)

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.

For the three months ended September 30, 2013, our cash flows provided by continuing operations were positively impacted by higher net income as well as a decrease in the amount and timing of cash payments for income taxes. These factors were partially offset by an increase during the three months ended September 30, 2013 in the amount and timing of cash payments for accounts payable and accrued salaries.

For the nine months ended September 30, 2013, our cash flows provided by continuing operations were positively impacted by a decrease in the amount and timing of cash payments made for self-insurance claims and income taxes partially offset by an increase in the amount and timing of cash payments for accounts payable and accrued salaries. Additionally, our cash flows provided by continuing operations for the nine months ended September 30, 2012 were positively impacted by the receipt of approximately $33.0 million related to the Rural Floor Settlement.

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, 2013 and 2012 (dollars in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
Capital projects	$ 16.2	$ 15.2	$ 38.0	$ 59.1
Routine	10.6	10.8	29.1	28.0
Information systems	5.9	21.3	41.4	70.3
	32.7	47.3	108.5	157.4
Depreciation expense	55.9	46.2	164.5	135.2
Ratio of capital expenditures to depreciation expense	58.5 %	102.4 %	66.0 %	116.4 %

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. During 2012, we experienced a higher level of spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. While we expect the total level of spending for capital expenditures in 2013 to be consistent with 2012, we anticipate a reduction in information systems expenditures for 2013 as compared to 2012.

Debt

An analysis and roll-forward of our long-term debt, including current maturities, during the first nine months of 2013 is as follows (in millions):

	December 31, 2012	Proceeds from Borrowings	Payments of Borrowings	Other (a)	Amortization of Debt Discounts	September 30, 2013
Senior Credit Agreement:						
Term Facility	$ 444.4	$ -	$ (8.5)	$ -	$ -	$ 435.9
Incremental Term Loans	-	325.0	(2.4)	-	-	322.6
Revolving Facility	85.0	-	(85.0)	-	-	-
6.625% Senior Notes	400.0	-	-	-	-	400.0
3½% Notes	575.0	-	-	-	-	575.0
3¼ % Debentures	225.0	-	(225.0)	-	-	-
Unamortized debt discounts	(29.5)	(2.0)	-	-	16.0	(15.5)
Capital leases	9.9	-	(1.8)	3.3	-	11.4
	$ 1,709.8	$ 323.0	$ (322.7)	$ 3.3	$ 16.0	$ 1,729.4

(a) Represents the assumption of capital lease obligations in connection with certain acquisitions completed during the nine months ended September 30, 2013.

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, 2013 and December 31, 2012 (dollars in millions):

	September 30, 2013	December 31, 2012	Increase (Decrease)
Current portion of long-term debt	$ 577.6	$ 13.3	$ 564.3
Long-term debt	1,151.8	1,696.5	(544.7)
Unamortized discounts on debt instruments	15.5	29.5	(14.0)
Total debt, excluding unamortized discounts	1,744.9	1,739.3	5.6
Total LifePoint Hospitals, Inc. stockholders' equity	2,159.1	2,050.5	108.6
Total capitalization	$ 3,904.0	$ 3,789.8	$ 114.2
Total debt to total capitalization	44.7 %	45.9 %	(120) bps
Percentage of:			
Fixed rate debt, excluding unamortized discounts	56.5 %	69.6 %	
Variable rate debt, excluding unamortized discounts	43.5	30.4	
	100.0 %	100.0 %	
Percentage of:			
Senior debt, excluding unamortized discounts	67.0 %	54.0 %	
Subordinated debt, excluding unamortized discounts	33.0	46.0	
	100.0 %	100.0 %	

Capital Resources

Senior Credit Agreement

Terms

The Senior Credit Agreement matures on July 24, 2017 and provides for a $450.0 million senior secured term loan facility (the “Term Facility”), $325.0 million of 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. The Incremental Term Loans require scheduled quarterly repayments, which began on March 31, 2013, in an amount equal to 0.25% of the aggregate principal amount of all Incremental Term Loans, with the remaining outstanding balance paid at maturity. The 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, 2013, we had $24.1 million in letters of credit outstanding that were 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 $325.9 million as of September 30, 2013.

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. The Senior Credit Agreement is guaranteed on a senior basis by our subsidiaries with certain limited exceptions.

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, 2013, the applicable annual interest rates under the Term Facility and the Incremental Term Loans were 1.93% and 2.68%, respectively, which were based on the 30-day adjusted LIBOR plus the applicable margins. The 30-day adjusted LIBOR was 0.18% for both the Term Facility and the Incremental Term Loans as of September 30, 2013.

Covenants

The Senior Credit Agreement requires us to satisfy a maximum total leverage ratio not to exceed 5.00:1.00 through June 30, 2014 with a step-down to 4.75:1.00 through June 30, 2015, 4.50:1.00 through June 30, 2016 and 4.25:1.00 through the remaining term and as determined on a trailing four quarter basis. We were in compliance with this covenant as of September 30, 2013.

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 net proceeds from this issuance were partially used to repay a portion of the then outstanding borrowings under the Term B Loans. The 6.625% Senior Notes bear interest at the rate of 6.625% per year, payable semi-annually on April 1 and October 1, which began on April 1, 2011. 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 up to 35% of the aggregate principal amount of the 6.625% Senior Notes, at any time before October 1, 2013, with the net cash proceeds of one or more qualified equity offerings at a redemption price equal to 106.625% of the principal amount to be redeemed, plus accrued and unpaid interest, provided that at least 65% of the aggregate principal amount of the 6.625% Senior Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of any such qualified equity offering.

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.

3½% Notes

The 3½% convertible senior subordinated notes due May 15, 2014 (the "3½% Notes") bear interest at the rate of 3½% per year, payable semi-annually on May 15 and November 15. The 3½% Notes are convertible prior to March 15, 2014 under the following circumstances: (1) if the price of our common stock reaches a specified threshold during specified periods; (2) if the trading price of the 3½% Notes is below a specified threshold; or (3) upon the occurrence of specified corporate transactions or other events. On or after March 15, 2014, holders may convert the 3½% Notes at any time prior to the close of business on the scheduled trading day immediately preceding May 15, 2014, regardless of whether any of the foregoing circumstances has occurred. As of September 30, 2013, we classified all of the outstanding 3½% Notes as current under the caption "Current maturities of long-term debt" in the accompanying unaudited condensed consolidated balance sheet. We are currently working to secure financing to repay our borrowings outstanding under the 3½% Notes on or after March 15, 2014.

Subject to certain exceptions, we will deliver cash and shares of our common stock upon conversion of each $1,000 principal amount of the 3½% Notes as follows: (i) an amount in cash, which we refer to as the "principal return", equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, the lesser of the daily conversion value for such volume-weighted average price trading day and $50; and (ii) a number of shares in an amount equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, any excess of the daily conversion value above $50. Our ability to pay the principal return in cash is subject to important limitations imposed by the Senior Credit Agreement and the agreements or indentures governing any additional indebtedness that we incur in the future. If we do not make any payments we are obligated to make under the terms of the 3½% Notes, holders may declare an event of default.

The initial conversion rate is 19.3095 shares of our common stock per $1,000 principal amount of the 3½% Notes (subject to certain events). This represents an initial conversion price of approximately $51.79 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Upon the occurrence of a fundamental change (as specified in the indenture), each holder of the 3½% Notes may require us to purchase some or all of the 3½% Notes at a purchase price in cash equal to 100% of the principal amount of the 3½% Notes surrendered, plus any accrued and unpaid interest.

The indenture for the 3½% Notes does not contain any financial covenants or any restrictions on the payment of dividends, the incurrence of senior or secured debt or other indebtedness, or the issuance or repurchase of securities by us. The indenture contains no covenants or other provisions to protect holders of the 3½% Notes in the event of a highly leveraged transaction or other events that do not constitute a fundamental change.

Liquidity and Capital Resources Outlook

We expect the level of spending for capital expenditures in 2013 to be consistent with 2012. We are reconfiguring some of our hospitals to more effectively accommodate patient services and to provide for a greater variety of services, as well as implementing various information system initiatives in our efforts to comply with the HITECH Act. For the three and nine months ended September 30, 2013, we spent $5.9 million and $41.4 million, respectively, on information systems. At September 30, 2013, we had uncompleted projects with an estimated additional cost to complete and equip of approximately $56.2 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, 2013, there were no material changes in our contractual obligations as presented in our 2012 Annual Report on Form 10-K or our quarterly report on Form 10-Q for the three months ended March 31, 2013.

Off-Balance Sheet Arrangements

We had standby letters of credit outstanding of $24.1 million as of September 30, 2013, 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 Pronouncement

In February 2013, the Financial Accounting Standards Board issued Accounting Standards Update No. 2013-2, "Comprehensive Income – Reporting of Amounts Reclassified Out of Accumulated Other Comprehensive Income" ("ASU 2013-2"). ASU 2013-2 requires entities to report the effect of significant reclassifications out of accumulated other comprehensive income on the respective line items in net income if the amount being reclassified is required under GAAP to be reclassified in its entirety to net income. For other amounts that are not required under GAAP to be reclassified in their entirety to net income in the same reporting period, an entity is required to cross-reference other disclosures required under GAAP that provide additional detail about those amounts. We adopted ASU 2013-2 during the first quarter of 2013. At September 30, 2013, our only component of accumulated other comprehensive income relates to the unrealized gains on changes in the funded status of its pension benefit obligation. During the three and nine months ended September 30, 2013, there were no reclassifications out of accumulated other comprehensive income into net income.

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 10 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
- Hospital support center lease.

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, 2013, we had outstanding debt, excluding $15.5 million of unamortized discounts, of $1,744.9 million, 43.5%, or $758.5 million, of which was subject to variable rates of interest.

The carrying amounts and fair values of the Term Facility, the Incremental Term Loans and the Revolving Facility under the Senior Credit Agreement, the 6.625% Senior Notes, the 3½% Notes and the 3¼% Debentures as of September 30, 2013 and December 31, 2012 were as follows (in millions):

	Carrying Amount		Fair Value	
	September 30, 2013	December 31, 2012	September 30, 2013	December 31, 2012
Term Facility	$ 435.9	$ 444.4	$ 434.8	$ 437.7
Incremental Term Loans, excluding unamortized discount	$ 322.6	$ -	$ 321.8	$ -
Revolving Facility	$ -	$ 85.0	$ -	$ 83.7
6.625% Senior Notes	$ 400.0	$ 400.0	$ 418.0	$ 431.0
3 ½ % Notes, excluding unamortized discount	$ 575.0	$ 575.0	$ 609.5	$ 592.3
3 ¼ % Debentures, excluding unamortized discount	$ -	$ 225.0	$ -	$ 225.0

The fair values of the Term Facility, the Incremental Term Loans, the Revolving Facility and the 6.625% Senior Notes were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10, “Fair Value Measurements and Disclosures” (“ASC 820-10”). The fair values of the 3½% Notes and the 3¼% Debentures were estimated based on the quoted market prices determined using the closing share price of our common stock and categorized as Level 1 within the fair value hierarchy in accordance with ASC 820-10.

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, 2013. As a result, the interest rate market risk implicit in these investments at September 30, 2013, 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, 2013 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 Office of the Inspector General ("OIG"), the Department of Justice ("DOJ") and other governmental fraud and abuse programs. Certain of our individual facilities have received, and from time to time, other facilities may receive, 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.

During August 2012, Minden Medical Center ("Minden") finalized an independent review of the medical necessity of certain services rendered to patients in its intensive outpatient psychiatric program ("IOP"), which was managed by a third party, Allegiance Health Management, Inc. ("Allegiance"). This review was commenced by Minden in 2011 and, in August 2011, the hospital voluntarily disclosed its concerns regarding its billing of these services to the OIG pursuant to the OIG's self-disclosure protocol. On January 3, 2012, Minden received notice that it had been accepted into the OIG's self-disclosure protocol. At the time, Allegiance also managed the IOP at Bolivar Medical Center, a hospital owned by a subsidiary of the Company ("Bolivar"). On February 23, 2012, Bolivar received a subpoena from the OIG seeking information about its IOP program and its relationship with Allegiance. We believe that the OIG has served similar subpoenas on other non-LifePoint facilities that had contracts with Allegiance. In September 2013, we finalized settlement agreements for both the Minden and Bolivar matters. The final settlement amounts are expected to be paid during the fourth quarter of 2013. Our reserves for uninsured litigation at September 30, 2013 include these final settlement amounts.

In connection with our acquisition of Marquette General, Marquette General Hospital, Inc. (the "Marquette Seller") self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. The self-disclosure is pending with CMS. To the extent that the Marquette 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 Marquette Seller. We have made reasonable estimates of these potential liabilities and at September 30, 2013 have recorded an aggregate of $18.0 million representing the fair values of our potential obligation to the Marquette Seller. We do not control and cannot predict with certainty the progress or final outcome of any discussions with third parties, such as government agencies. Therefore, the final amounts paid in settlement of these contingent obligations, if any, could materially differ from amounts currently recorded. Any such changes in estimate will impact our future results of operations and cash flows.

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 relates to concerns regarding the medical necessity 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 Company is cooperating with the government in addressing these matters.

Item 1A. Risk Factors.

There have been no material changes in our risk factors from those disclosed in the 2012 Annual Report on Form 10-K.

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

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 "Repurchase Plan"). The Repurchase Plan provides for the repurchase of up to $350.0 million in shares of our common stock through August 20, 2014, although we are not obligated to repurchase any specific number of shares. We have designated the shares repurchased in accordance with the Repurchase Plan as treasury stock.

We repurchased approximately 0.7 million shares for an aggregate purchase price, including commissions, of $30.1 million at an average purchase price of $45.76 per share in accordance with the Repurchase Plan for both the three and nine months ended September 30, 2013. We repurchased a nominal number of shares for an aggregate purchase price, including commissions, of $0.1 million at an average purchase price of $35.01 per share in accordance with the Repurchase Plan during the nine months ended September 30, 2012. There were no repurchases made in accordance with the Repurchase Plan during the three months ended September 30, 2012. Through September 30, 2013, we had repurchased approximately 5.0 million shares for an aggregate purchase price, including commissions, of approximately $184.7 million in accordance with the Repurchase Plan. As of September 30, 2013, we had remaining authority to repurchase up to an additional $165.3 million in shares in accordance with the Repurchase Plan. In connection with the Repurchase Plan, we have entered into a trading plan in accordance with Rule 10b5-1 of the Securities Exchange Act of 1934, as amended, to facilitate repurchases of our common stock during our blackout period (the "10b5-1 Trading Plan"). The 10b5-1 Trading Plan became effective on September 16, 2013 and will expire on October 29, 2013.

Additionally, we redeem shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to our Amended and Restated 1998 Long-Term Incentive Plan (the "1998 LTIP") and Amended and Restated Management Stock Purchase Plan ("MSPP"). We redeemed approximately 0.2 million shares vested under the 1998 LTIP and MSPP during each of the nine months ended September 30, 2013 and 2012 for an aggregate purchase price of approximately $8.4 million and $6.1 million, 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, 2013:

	Total Number of Shares Purchased (a)	Weighted Average Price Paid per Share	Total Number of Shares Purchased as Part of a Publicly Announced Program	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Program (In millions)
July 1, 2013 to July 31, 2013	6,129	$ 48.62	-	$ 195.4
August 1, 2013 to August 31, 2013	-	$ -	-	$ 195.4
September 1, 2013 to September 30, 2013	676,356	$ 45.78	657,404	$ 165.3
Total	682,485	$ 45.81	657,404	$ 165.3

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

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	- Fourth Amended and Restated By-Laws of LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 15, 2010, File No. 000-51251).
4.1	- Fourth Supplemental Indenture, dated as of August 23, 2013, by and among LifePoint Hospitals, Inc. the guarantors named herein and The Bank of New York Mellon Trust Company, N.A., as Trustee, to the Indenture, dated as of September 23, 2010, as supplemented (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated August 26, 2013, File No. 000-51251).
10.1	- Credit Agreement Amendment No. 2, dated as of August 23, 2013, by and among LifePoint Hospitals, Inc., the lenders party thereto, Citibank, N.A., as administrative agent and consented to by Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC, as lead arrangers, to that certain Credit Agreement, dated as of July 24, 2012, among LifePoint Hospitals, Inc., the lenders party thereto, the Administrative Agent, Bank of America, N.A. and Barclays Bank PLC, as co-syndication agents and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as joint lead arrangers and joint bookrunners, as amended by Incremental Facility Amendment No. 1 dated as of February 6, 2013 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated August 26, 2013, File No. 000-51251).
10.2	- Voluntary Resignation Agreement and General Release by and between Jeffrey S. Sherman and HSGCP, LLC, dated September 4, 2013 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated September 6, 2013, File No. 000-51251).*
10.3	- Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Outside Director Restricted Stock Unit Award Agreement (filed herewith).*
10.4	- Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (time-based vesting) (filed herewith).*
10.5	- Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (performance-based vesting) (filed herewith).*
10.6	- Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Non-Qualified Stock Option Award

Agreement (filed herewith).*

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.

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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 25, 2013

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