LIFEPOINT HEALTH, INC.
Form 10-Q
July 31, 2015
Table of Contents

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

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Form 10-Q

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(Mark One)

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

For the quarterly period ended June 30, 2015

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 Health, Inc.

(Exact Name of Registrant as Specified in its Charter)

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

(615) 920-7000

(Registrant's Telephone Number, Including Area Code)

LifePoint Hospitals, Inc.

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

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

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

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

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

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

As of July 24, 2015, the number of outstanding shares of the registrant’s Common Stock was 44,408,519.

Table of Contents

LifePoint Health, Inc.

TABLE OF CONTENTS

PART I - FINANCIAL INFORMATION		
Item 1.	Financial Statements	1
Item 2.	Management’s Discussion and Analysis of Financial Condition and Results of Operations	28
Item 3.	Quantitative and Qualitative Disclosures About Market Risk	57
Item 4.	Controls and Procedures	57
PART II - OTHER INFORMATION		
Item 1.	Legal Proceedings	58
Item 1A.	Risk Factors	59
Item 2.	Unregistered Sales of Equity Securities and Use of Proceeds	60
Item 6.	Exhibits	61

Table of Contents

PART I – FINANCIAL INFORMATION

Item 1. Financial Statements.

LIFEPOINT HEALTH, INC.

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS

Unaudited

(In millions, except per share amounts)

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	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Revenues before provision for doubtful accounts	$ 1,469.8	$ 1,246.2	$ 2,921.4	$ 2,429.0
Provision for doubtful accounts	199.4	199.2	387.3	374.8
Revenues	1,270.4	1,047.0	2,534.1	2,054.2
Salaries and benefits	606.8	488.5	1,218.0	963.3
Supplies	194.1	162.5	390.9	319.5
Other operating expenses	308.7	258.3	602.3	501.8
Other income	(14.2)	(21.0)	(25.9)	(34.9)
Depreciation and amortization	68.9	60.9	136.9	122.0
Interest expense, net	28.1	31.3	56.5	65.2
Impairment charges	-	-	11.6	-
	1,192.4	980.5	2,390.3	1,936.9
Income before income taxes	78.0	66.5	143.8	117.3
Provision for income taxes	28.2	24.7	52.0	37.8
Net income	49.8	41.8	91.8	79.5
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(3.4)	(2.7)	(6.5)	(3.3)
Net income attributable to LifePoint Health, Inc.	$ 46.4	$ 39.1	$ 85.3	$ 76.2

Earnings per share attributable to LifePoint Health, Inc. stockholders:				
Basic	$ 1.05	$ 0.88	$ 1.93	$ 1.69
Diluted	$ 1.00	$ 0.84	$ 1.84	$ 1.61
Weighted average shares and dilutive securities outstanding:				
Basic	44.2	44.5	44.2	45.2
Diluted	46.4	46.5	46.2	47.3

See accompanying notes

Table of Contents

LIFEPOINT HEALTH, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS

(Dollars in millions, except per share amounts)

	June 30, 2015 (Unaudited)	December 31, 2014 (a)
ASSETS		
Current assets:		
Cash and cash equivalents	$ 422.8	$ 191.5
Accounts receivable, less allowances for doubtful accounts of $724.3 and $709.5 at June 30, 2015 and December 31, 2014, respectively	724.5	752.6
Inventories	118.0	115.2
Prepaid expenses	50.5	45.4
Income taxes receivable	14.1	33.0
Deferred tax assets	68.2	72.8
Other current assets	39.8	85.7
	1,437.9	1,296.2
Property and equipment:		
Land	132.7	134.8
Buildings and improvements	2,184.5	2,155.9
Equipment	1,629.0	1,633.8
Construction in progress (estimated costs to complete and equip after June 30, 2015 is $157.1)	96.3	72.9
	4,042.5	3,997.4
Accumulated depreciation	(1,714.2)	(1,619.9)
	2,328.3	2,377.5
Deferred loan costs, net	28.9	31.7
Intangible assets, net	69.4	69.1
Other assets	54.2	46.4
Goodwill	1,634.4	1,636.1
Total assets	$ 5,553.1	$ 5,457.0
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 154.8	$ 158.5
Accrued salaries	186.9	202.4
Other current liabilities	227.8	203.2
Current maturities of long-term debt	24.9	19.2

	594.4	583.3
Long-term debt	2,186.2	2,199.3
Deferred income tax liabilities	186.8	187.5
Long-term portion of reserves for self-insurance claims	144.0	133.2
Other long-term liabilities	85.1	84.7
Total liabilities	3,196.5	3,188.0
Redeemable noncontrolling interests	89.4	87.1
Equity:		
LifePoint Health, Inc. stockholders' equity:		
Preferred stock, $0.01 par value; 10,000,000 shares authorized; no shares issued	-	-
Common stock, $0.01 par value; 90,000,000 shares authorized; 66,572,998 and 66,245,310 shares issued at June 30, 2015 and December 31, 2014, respectively	0.7	0.7
Capital in excess of par value	1,529.3	1,496.2
Accumulated other comprehensive loss	(4.4)	(4.4)
Retained earnings	1,558.4	1,473.1
Common stock in treasury, at cost, 22,165,729 and 21,672,250 shares at June 30, 2015 and December 31, 2014, respectively	(844.8)	(811.0)
Total LifePoint Health, Inc. stockholders' equity	2,239.2	2,154.6
Noncontrolling interests	28.0	27.3
Total equity	2,267.2	2,181.9
Total liabilities and equity	$ 5,553.1	$ 5,457.0

(a) Derived from audited consolidated financial statements.

See accompanying notes

Table of Contents

LIFEPOINT HEALTH, INC.

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

Unaudited

(In Millions)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Cash flows from operating activities:				
Net income	$ 49.8	$ 41.8	$ 91.8	$ 79.5
Adjustments to reconcile net income to net cash provided by operating activities:				
Stock-based compensation	7.4	6.4	15.0	13.1
Depreciation and amortization	68.9	60.9	136.9	122.0
Amortization of physician minimum revenue guarantees	3.1	3.8	6.3	7.7
Amortization of debt discounts, premium and deferred loan costs	1.3	4.3	2.5	11.6
Impairment charges	-	-	11.6	-
Deferred income taxes (benefit)	(1.5)	36.5	10.8	(5.1)
Reserve for self-insurance claims, net of payments	4.7	(1.4)	8.8	4.7
Increase (decrease) in cash from operating assets and liabilities, net of effects from acquisitions and divestitures:				
Accounts receivable	21.0	22.2	27.2	(28.3)
Inventories, prepaid expenses and other current assets	39.0	(2.7)	53.1	20.4
Accounts payable, accrued salaries and other current liabilities	(18.3)	(31.3)	(14.3)	(31.6)
Income taxes payable/receivable	11.0	(71.8)	19.0	(19.3)
Other	2.0	(0.7)	(0.7)	1.9
Net cash provided by operating activities	188.4	68.0	368.0	176.6
Cash flows from investing activities:				
Purchases of property and equipment	(53.1)	(31.2)	(94.2)	(53.7)
Acquisitions, net of cash acquired	(12.5)	(27.2)	(25.8)	(87.8)
Proceeds from sale of hospital	18.8	-	18.8	-
Other	1.6	0.1	1.8	(0.4)
Net cash used in investing activities	(45.2)	(58.3)	(99.4)	(141.9)

Cash flows from financing activities:				
Proceeds from borrowings	-	412.0	-	412.0
Payments of borrowings	(2.8)	(579.8)	(5.6)	(579.8)
Repurchases of common stock	-	(36.1)	(33.8)	(171.9)
Proceeds from exercise of stock options	3.8	11.1	10.8	18.3
Other	(3.3)	(7.2)	(8.7)	(9.2)
Net cash used in financing activities	(2.3)	(200.0)	(37.3)	(330.6)
Change in cash and cash equivalents	140.9	(190.3)	231.3	(295.9)
Cash and cash equivalents at beginning of period	281.9	532.3	191.5	637.9
Cash and cash equivalents at end of period	$ 422.8	$ 342.0	$ 422.8	$ 342.0
Supplemental disclosure of cash flow information:				
Interest payments	$ 47.1	$ 56.9	$ 51.6	$ 60.6
Capitalized interest	$ 0.4	$ 0.1	$ 0.8	$ 0.3
Income tax payments, net	$ 18.6	$ 60.0	$ 22.2	$ 62.3

See accompanying notes

Table of Contents

LIFEPOINT HEALTH, INC.

CONDENSED CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY

For the Six Months Ended June 30, 2015

Unaudited

(In Millions)

	LifePoint Health, Inc. Stockholders							
	Common Stock		Capital in Excess of	Accumulated Other Comprehensive	Retained	Treasury	Noncontrolling	
	Shares	Amount	Par Value	Loss	Earnings	Stock	Interests	Total
Balance at December 31, 2014 (a)	44.6	$ 0.7	$ 1,496.2	$ (4.4)	$ 1,473.1	$ (811.0)	$ 27.3	$ 2,181.9
Net income	-	-	-	-	85.3	-	2.3	87.6
Exercise of stock options and tax benefits of stock-based awards	0.3	-	17.7	-	-	-	-	17.7
Stock-based compensation	-	-	15.0	-	-	-	-	15.0
Repurchases of common stock, at cost	(0.5)	-	-	-	-	(33.8)	-	(33.8)
Noncash change in noncontrolling interests as a result of acquisition and other	-	-	0.4	-	-	-	(0.3)	0.1
Cash distributions to noncontrolling interests	-	-	-	-	-	-	(1.3)	(1.3)
Balance at June 30, 2015	44.4	$ 0.7	$ 1,529.3	$ (4.4)	$ 1,558.4	$ (844.8)	$ 28.0	$ 2,267.2

(a) Derived from audited consolidated financial statements.

See accompanying notes

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

Note 1. Organization, Basis of Presentation and Accounting Standards Not Yet Adopted

Organization

LifePoint Health, Inc., formerly known as LifePoint Hospitals, Inc., a Delaware corporation, acting through its subsidiaries, owns and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities in 20 states throughout the United States ("U.S."). Unless the context otherwise indicates, LifePoint Health, Inc. and its subsidiaries are referred to herein as the "Company."

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 six months ended June 30, 2015 are not necessarily indicative of the results that may be expected for the year ending December 31, 2015. 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, 2014.

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

Accounting Standards Not Yet Adopted

ASU 2015-3, "Simplifying the Presentation of Debt Issuance Costs"

In April 2015, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2015-3, "Simplifying the Presentation of Debt Issuance Costs" ("ASU 2015-3"). ASU 2015-3 requires that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts, rather than separately as an asset. ASU 2015-3 is effective for annual reporting periods beginning after December 15, 2015, including interim periods within those years, and is to be applied retrospectively. Early adoption is permitted. The Company does not expect the adoption of ASU 2015-3 will have an impact on its results of operations or cash flows.

ASU 2015-2, "Consolidation"

In February 2015, the FASB issued ASU 2015-2 "Consolidation" ("ASU 2015-2"). ASU 2015-2 includes amendments that are intended to improve targeted areas of consolidation for legal entities including reducing the number of consolidation models from four to two and simplifying the FASB Accounting Standards Codification ("ASC"). The provisions of ASU 2015-2 are effective for annual reporting periods beginning after December 15, 2015. The amendments may be applied retrospectively in previously issued financial statements for one or more years with a cumulative effect adjustment to retained earnings as of the beginning of the first year restated. Early adoption is permitted. The Company is currently evaluating the impact that the adoption of ASU 2015-2 will have on its financial position, results of operation, cash flows and financial disclosures.

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

ASU 2014-9, “Revenue from Contracts with Customers”

In May 2014, the FASB issued ASU 2014-9, “Revenue from Contracts with Customers” (“ASU 2014-9”). ASU 2014-9 provides for a single comprehensive principles-based standard for the recognition of revenue across all industries through the application of the following five-step process:

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

Step 2: Identify the performance obligations in the contract.

Step 3: Determine the transaction price.

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

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

Among other provisions and in addition to expanded disclosure about the nature, amount, timing and uncertainty of revenue, as well as certain additional quantitative and qualitative disclosures, ASU 2014-9 changes the healthcare industry specific presentation guidance under ASU 2011-7, “Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities.” The provisions of ASU 2014-9 are effective for annual reporting periods beginning after December 15, 2017, including interim periods within those years. Early adoption is not permitted. The Company is currently evaluating the impact that the adoption of ASU 2014-9 will have on its revenue recognition policies and procedures, financial position, results of operations, cash flows, financial disclosures and control framework.

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 accompanying unaudited condensed consolidated financial statements are recorded at the net amount expected to be received.

The Company's revenues before provision for doubtful accounts by payor and approximate percentages of revenues were as follows for the three and six months ended June 30, 2015 and 2014 (in millions):

	Three Months Ended June 30,				Six Months Ended June 30,			
	2015		2014		2015		2014	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 370.0	29.1 %	$ 325.0	31.0 %	$ 747.9	29.5 %	$ 641.8	31.2 %
Medicaid	207.4	16.3	149.8	14.3	404.8	16.0	290.0	14.1
HMOs, PPOs and other private insurers	683.0	53.8	577.6	55.1	1,364.1	53.8	1,114.2	54.3
Self-pay	178.4	14.0	172.3	16.5	342.7	13.5	339.5	16.5
Other	31.0	2.5	21.5	2.1	61.9	2.5	43.5	2.1
Revenues before provision for doubtful accounts	1,469.8	115.7	1,246.2	119.0	2,921.4	115.3	2,429.0	118.2
Provision for doubtful accounts	(199.4)	(15.7)	(199.2)	(19.0)	(387.3)	(15.3)	(374.8)	(18.2)
Revenues	$ 1,270.4	100.0 %	$ 1,047.0	100.0 %	$ 2,534.1	100.0 %	$ 2,054.2	100.0 %

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

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 six months ended June 30, 2015 (in millions):

Balance at January 1, 2015	$ 709.5
Additions recognized as a reduction to revenues	387.3
Accounts written off, net of recoveries	(372.5)
Balance at June 30, 2015	$ 724.3

The allowances for doubtful accounts as a percent of gross accounts receivable, net of contractual discounts were 50.0% and 48.5% as of June 30, 2015 and December 31, 2014, respectively. Additionally, as of June 30, 2015 and December 31, 2014, the allowances for doubtful accounts plus certain contractual allowances and discounts related to self-pay patients as a percentage of self-pay receivables were 87.6% and 88.4%, 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 health support center overhead costs, which were $61.7 million and $53.9 million for the three months ended June 30, 2015 and 2014, respectively, and $115.6 million and $106.1 million for the six months ended June 30, 2015 and 2014, respectively. Included in the Company's health support center

overhead costs are depreciation and amortization expense related primarily to the Company's information systems platforms of $7.9 million and $7.3 million for the three months ended June 30, 2015 and 2014, respectively, and $16.0 million and $14.6 million for the six months ended June 30, 2015 and 2014, respectively.

Note 4. Fair Value of Financial Instruments

In accordance with 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.

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

Long-Term Debt

The carrying amounts and fair values of the Company's senior secured term loan facility (the "Term Facility") and senior secured incremental term loans (the "Incremental Term Loans") under its senior secured credit agreement with, among others, Citibank, N.A. as administrative agent, and the lenders party thereto (the "Senior Credit Agreement"), 6.625% unsecured senior notes due October 1, 2020 (the "6.625% Senior Notes"), and 5.5% unsecured senior notes due December 1, 2021 (the "5.5% Senior Notes") as of June 30, 2015 and December 31, 2014 were as follows (in millions):

	Carrying Amount		Fair Value	
	June 30, 2015	December 31, 2014	June 30, 2015	December 31, 2014
Senior Credit Agreement:				
Term Facility	$ 416.3	$ 421.9	$ 415.2	$ 420.3
Incremental Term Loans, excluding unamortized debt discount	$ 222.6	$ 222.6	$ 222.0	$ 222.0
6.625% Senior Notes	$ 400.0	$ 400.0	$ 417.0	$ 422.0
5.5% Senior Notes, excluding unamortized debt premium	$ 1,100.0	$ 1,100.0	$ 1,138.5	$ 1,130.3

The fair values of the Company's long-term debt instruments were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10.

Common Stock Warrant

As partial consideration in connection with the Company's acquisition of Conemaugh Health System ("Conemaugh"), the Company issued a warrant to the seller. The warrant, classified as a liability, is marked-to-market using an option pricing model which considers the warrant's contractual term, a combination of both historical volatility and implied volatility from traded options of the Company's common stock, risk-free interest rates and dividend assumptions. Since all significant inputs are market-based and observable, the warrant is categorized as Level 2

within the fair value hierarchy in accordance with ASC 820-10. As of June 30, 2015 and December 31, 2014, the fair value of the warrant was approximately $11.6 million and $9.2 million, respectively. These amounts are included in the accompanying unaudited condensed consolidated balance sheets under the caption “Other long-term liabilities”.

Note 5. Acquisitions

Nason Hospital

Effective February 1, 2015, the Company acquired Nason Hospital (“Nason”), a 45 bed acute care hospital located in Roaring Spring, Pennsylvania for approximately $3.5 million, including net working capital. The Company has committed to invest in Nason an additional $8.5 million in capital expenditures and improvements over the next ten years. The results of operations of Nason are included in the Company’s results of operations beginning on February 1, 2015. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company’s acquisition of Nason have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the final appraisals. The Company expects to finalize its analysis during 2015.

Other

The Company completed certain ancillary service-line acquisitions and finalized net working capital settlements related to its 2014 acquisitions for a total of $22.3 million during the six months ended June 30, 2015.

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

Note 6. Divestitures and Impairment Charges

Effective May 1, 2015, the Company sold Putnam Community Medical Center ("Putnam") located in Palatka, Florida for $18.8 million, including net working capital. Included in the accompanying unaudited condensed consolidated statements of operations is a net loss before income taxes attributable to Putnam of $2.7 million for the six months ended June 30, 2015 and net income before income taxes attributable to Putnam of $2.3 million for the six months ended June 30, 2014.

In connection with the Company's sale of Putnam, the Company recognized an impairment charge of $8.6 million, $5.6 million net of income taxes, or $0.12 loss per diluted share, during the six months ended June 30, 2015. The impairment charge includes the write-down of property, equipment, allocated goodwill and certain other assets to their estimated fair values.

Additionally, during the six months ended June 30, 2015, the Company recognized additional impairment charges totaling $3.0 million, $1.9 million net of income taxes, or $0.04 loss per diluted share, related to the finalization of the divestitures of Lakeland Community Hospital, Northwest Medical Center and Russellville Hospital which were sold effective January 1, 2015.

Note 7. Goodwill and Intangible Assets

Goodwill

The Company accounts for its acquisitions in accordance with ASC 805-10, "Business Combinations" using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350-10, "Intangibles — Goodwill

and Other" goodwill and intangible assets with indefinite lives are reviewed by the Company at least annually for impairment. The Company's business comprises a single reporting unit for impairment test purposes. For the purposes of these analyses, the Company's estimates of fair value are based on a combination of the income approach, which estimates the fair value of the Company based on its future discounted cash flows, and the market approach, which estimates the fair value of the Company based on comparable market prices. The Company performed its most recent annual impairment test as of October 1, 2014 and did not incur an impairment charge.

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

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 June 30, 2015 and December 31, 2014 (in millions):

	June 30, 2015	December 31, 2014
Amortized intangible assets:		
Contract-based physician minimum revenue guarantees		
Gross carrying amount	$ 54.2	$ 62.3
Accumulated amortization	(32.3)	(35.5)
Net total	21.9	26.8
Non-competition agreements and other		
Gross carrying amount	25.1	23.6
Accumulated amortization	(17.2)	(15.9)
Net total	7.9	7.7
Total amortized intangible assets		
Gross carrying amount	79.3	85.9
Accumulated amortization	(49.5)	(51.4)
Net total	29.8	34.5
Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	29.8	29.5
Licenses, provider numbers, accreditations and other	9.8	5.1
Net total	39.6	34.6

Total intangible assets:		
Gross carrying amount	118.9	120.5
Accumulated amortization	(49.5)	(51.4)
Net total	$ 69.4	$ 69.1

Contract-Based Physician Minimum Revenue Guarantees

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

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460-10, "Guarantees" ("ASC 460-10"). In accordance with ASC 460-10, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized over the period of the physician contract, which typically ranges from four to five years and is included as an expense under the caption "Other operating expenses" in the accompanying unaudited condensed consolidated statements of operations. The Company's liability for contract-based physician minimum revenue guarantees was $8.4 million and $9.3 million as of June 30, 2015 and December 31, 2014, respectively. These amounts are included in the accompanying unaudited condensed consolidated balance sheets under the caption "Other current liabilities".

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.

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

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

Note 8. Common Stock in Treasury

The Company's Board of Directors has authorized the repurchase of outstanding shares of its common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other customary factors in accordance with a repurchase plan adopted in 2011, as subsequently amended and extended in February 2013 (the "2011 Repurchase Plan"), a repurchase plan adopted in 2014 (the "2014 Repurchase Plan") and a repurchase plan adopted on June 3, 2015 (the "2015 Repurchase Plan"). The 2011 Repurchase Plan provided for the repurchase of up to $350.0 million in shares of the Company's common stock, and the Company has repurchased all shares authorized for repurchase under this plan. The 2014 Repurchase Plan provides for the repurchase of up to $150.0 million in shares of the Company's common stock through October 1, 2015. The 2015 Repurchase Plan provides for the repurchase of up to $150.0 million in shares of the Company's common stock through December 3, 2016. The Company is not obligated to repurchase any specific number of shares under any of its repurchase plans. The Company has designated the shares repurchased in accordance with its repurchase plans as treasury stock.

In connection with the 2011 Repurchase Plan, the Company repurchased approximately 3.0 million shares for an aggregate purchase price, including commissions, of $164.7 million at an average purchase price of $54.33 per share during the six months ended June 30, 2014. In connection with the 2014 Repurchase Plan, the Company repurchased approximately 0.4 million shares for an aggregate purchase price, including commissions, of $25.0

million at an average purchase price of $67.86 per share during the six months ended June 30, 2015. As of June 30, 2015, the Company had remaining authority to repurchase $75.0 million and $150.0 million in shares in accordance with the 2014 Repurchase Plan and 2015 Repurchase Plan, respectively.

Additionally, the Company redeems shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to the Company's various stockholder approved stock-based compensation plans. The Company redeemed 0.1 million shares vested under these plans during each of the six months ended June 30, 2015 and 2014 for an aggregate purchase price of approximately $8.8 million and $7.2 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 and performance shares) to certain officers, employees and non-employee directors in accordance with the Company's stockholder-approved 2013 Long-Term Incentive Plan (the "2013 LTIP"). 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.

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

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

Stock Options

The Company granted options to purchase 823,750 and 712,950 shares of the Company's common stock to certain officers and employees in accordance with the 2013 LTIP during the six months ended June 30, 2015 and 2014, respectively. Options to purchase shares granted to the Company's officers and employees in accordance with the 2013 LTIP were granted with an exercise price equal to the fair market value of the Company's common stock on the day of grant, determined based on the closing price on the trading date immediately prior to the grant date. The options granted during the six months ended June 30, 2015 and 2014 become ratably exercisable beginning one year from the date of grant to three years after the date of grant and expire ten years from the date of grant.

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

The following table shows the weighted average assumptions the Company used to develop the fair value estimates under its HW-II option valuation model and the resulting estimates of weighted-average fair value per share of stock options granted during the six months ended June 30, 2015 and 2014:

	Six Months Ended June 30,

	2015	2014
Expected volatility	29.0 %	29.0 %
Risk-free interest rate, minimum	0.01 %	0.05 %
Risk-free interest rate, maximum	2.20 %	2.71 %
Expected dividends	-	-
Average expected term (years)	5.3	5.4
Fair value per share of stock options granted	$ 18.66	$ 13.95

The total intrinsic value of stock options exercised during the six months ended June 30, 2015 and 2014 was $8.1 million and $9.5 million, respectively. The Company received $3.8 million and $11.1 million in cash from stock option exercises for the three months ended June 30, 2015 and 2014, respectively, and $10.8 million and $18.3 million in cash from stock option exercises for the six months ended June 30, 2015 and 2014, respectively. The actual tax benefit realized for the tax deductions from stock option exercises was $1.9 million and $1.2 million for the six months ended June 30, 2015 and 2014, respectively.

As of June 30, 2015, there was $18.6 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 1.5 years.

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

Other Stock-Based Awards

The Company granted a total of 289,919 and 366,271 restricted stock units and performance-based restricted stock units to certain officers, employees and non-employee directors in accordance with the 2013 LTIP during the six months ended June 30, 2015 and 2014, respectively. The fair value of the restricted stock units was determined based on the closing price of the Company's common stock on the trading date immediately prior to the grant date. The fair value of the performance-based restricted stock units was estimated using the Monte-Carlo simulation valuation model as more fully described below. The restricted stock units and performance-based restricted stock units granted during the six months ended June 30, 2015 and 2014 generally have either cliff-vesting periods from the grant date of three years, cliff-vesting periods from the grant date of six months and one day or ratable vesting periods beginning one year from the date of grant to three years after the date of grant.

Of the restricted stock units granted during the six months ended June 30, 2015 and 2014, 145,000 and 236,000, respectively, were performance-based awards. In addition to requiring continuing service of the employee, the percentage of these restricted stock units that are earned at the end of the performance period is determined based on the Company's three-year annualized total shareholder return relative to a peer group, Standard and Poor's Global Industry Classification Standard's Sub-industry: Health Care Facilities with over $500.0 million in revenues or its equivalent. For the performance-based restricted stock units granted during the six months ended June 30, 2015, the number of shares payable at the end of the three-year performance period ranges from 0% to 200% of the targeted units. For the performance-based restricted stock units granted during the six months ended June 30, 2014, the number of shares payable at the end of the three-year performance period ranges from 0% to 100% of the targeted units, with any portion of the award that exceeds 100% up to 200% of the targeted units settled in cash equal to the fair market value on the date certification of the level of performance is achieved. For valuation purposes, these awards were bifurcated into their two independent sub-award components for the portion that would be settled in the Company's common stock and for the portion that would be settled in cash. The Company recognizes compensation expense for the portion of the performance-based restricted stock units that will ultimately be settled in the Company's common stock for the targeted units if the requisite service period is rendered, even if the market condition is never satisfied. Additionally, the Company classifies as a liability and recognizes compensation expense for the portion of the award that will ultimately be settled in cash for the targeted units at its Monte-Carlo simulation value which has been marked-to-market.

As of June 30, 2015, there was $35.9 million of total estimated unrecognized compensation cost related to other stock-based awards. Total estimated unrecognized compensation cost will be adjusted for future changes in estimated forfeitures. The Company expects to recognize that cost over a weighted average period of 1.7 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 six months ended June 30, 2015 and 2014 (in millions):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Equity awards:				
Other stock-based awards	$ 4.8	$ 4.2	$ 9.5	$ 8.5
Stock options	2.6	2.2	5.5	4.6
	7.4	6.4	15.0	13.1
Liability awards:				
Other stock-based awards	3.0	0.5	3.7	0.7
Total stock-based compensation expense	$ 10.4	$ 6.9	$ 18.7	$ 13.8
Tax benefit on stock-based compensation expense	$ 4.1	$ 2.7	$ 7.4	$ 5.5

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

The Company did not capitalize any stock-based compensation cost during the three or six months ended June 30, 2015 or 2014. As of June 30, 2015, there was $54.5 million of total estimated unrecognized compensation cost related to all of the Company's stock-based compensation arrangements. Total estimated unrecognized compensation cost may be adjusted for future changes in estimated forfeitures. The Company expects to recognize that cost over a weighted-average period of 1.7 years.

Note 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. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without the Company's knowledge. Although the healthcare industry has seen numerous ongoing investigations related to compliance and billing practices, hospitals, in particular, continue to be a primary enforcement target for the Office of Inspector General ("OIG"), the Department of Justice ("DOJ") and other governmental fraud and abuse programs. Certain of the Company's individual facilities have received, and from time to time, other facilities may receive, inquiries or subpoenas from fiscal intermediaries, federal and state agencies. Any proceedings against the Company may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on the Company's financial position, results of operations and liquidity.

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

In connection with the Company's acquisitions of Marquette General Hospital ("Marquette General") and Conemaugh, the two sellers self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. These self-disclosures are pending with CMS. With respect to Marquette General, to the extent that the seller's satisfaction of its retained liabilities, including those under its CMS voluntary self-disclosure, causes its net proceeds from the acquisition to be less than $15.0 million, the Company has agreed to pay additional purchase consideration to the seller. With respect to Conemaugh, to the extent that the potential settlement exceeds the seller's indemnification threshold in accordance with the asset purchase agreement, the Company will likely be responsible for funding any deficit. The Company's management believes it has made reasonable estimates of its potential exposure for these two matters and at June 30, 2015 has recorded a reserve for Marquette General of $18.0 million.

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

On September 16, 2013, the Company and two of its hospitals, Vaughan Regional Medical Center, located in Selma, Alabama, and Raleigh General Hospital, located in Raleigh, West Virginia, made a voluntary self-disclosure to the Civil Division of the DOJ. The voluntary self-disclosure related to concerns regarding the clinical appropriateness of certain interventional cardiology procedures conducted by one physician in each of these hospitals' cardiac catheterization laboratories. On September 24, 2013, the U.S. Attorney's Office in the Southern District of West Virginia served a subpoena on Raleigh General Hospital. Raleigh General Hospital produced responsive documents to the subpoena, including patient files. The government investigations are ongoing and the Company continues to cooperate with the government in addressing these matters. Following reviews by independent interventional cardiologists, the Company notified patients of these two physicians who may have received an unnecessary procedure of such fact.

The Company and/or Vaughan Regional Medical Center and several of the Company's subsidiaries, as well as Dr. Seydi V. Aksut and certain parties unaffiliated with the Company, are named defendants in 28 individual lawsuits filed since December 2014, and two putative class action lawsuits, all filed in the Circuit Court of Dallas County, Alabama. These lawsuits allege that patients at Vaughan Regional Medical Center received improper interventional cardiology procedures. One of the putative class action lawsuits, filed on November 21, 2014, seeks certification of a class consisting of all Alabama citizens who underwent an invasive cardiology procedure at any LifePoint owned Alabama hospital and who received notice regarding the medical necessity of that procedure. The other putative class action lawsuit, filed on February 6, 2015, seeks certification of a class of individuals that underwent an interventional cardiology procedure that was not medically necessary and performed by Dr. Aksut. This action asserts, among other claims, claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), which, if successful, would result in the awarding of treble damages for any injury resulting from the RICO violation and attorneys' fees. In March 2015, the Company removed this action to the U.S. District Court in Mobile, Alabama and filed a motion to dismiss and for summary judgment, as well as a stay of discovery pending resolution of these motions. On April 17, 2015 the court entered an order granting the requested stay of discovery.

Through July 31, 2015, the Company, and two of its subsidiaries, including Raleigh General Hospital, as well as Dr. Kenneth Glaser, have been named in 17 individual lawsuits filed in the circuit court of Raleigh County, West Virginia. These lawsuits allege that patients at Raleigh General Hospital received unnecessary interventional cardiology procedures. Through July 31, 2015, 23 additional patients have notified Raleigh General Hospital that they intend to file lawsuits against the hospital.

The lawsuits identified above variously seek compensatory and punitive damages, costs, attorneys' fees and other available damages. Additional claims, including claims involving patients to whom the Company did not send notice, have been threatened and may be asserted against the Company or the hospital. Any present or future claims that are

ultimately successful could result in the Company and/or the hospitals being found liable and the government investigations may also result in damages, fines and penalties. Such liability, damages and penalties could be material. The Company cannot, however, reasonably estimate the potential liability, if any, in connection with any of these matters, and no liability has been recorded as of June 30, 2015.

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

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

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 $19.3 million at June 30, 2015. The actual amount of such commitments to be subsequently advanced to physicians is estimated at $8.4 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 facilities 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 $96.3 million in costs related to uncompleted projects as of June 30, 2015, which is included under the caption "Construction in progress" in the accompanying unaudited condensed consolidated balance sheet. At June 30, 2015, these uncompleted projects had an estimated cost to complete and equip of approximately $157.1 million. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities. As part of the Company's current acquisition strategy, management expects capital expenditure commitments to be a significant component of future purchase transactions. At June 30, 2015, the Company estimated its total remaining capital expenditure commitments, including commitments for routine projects, to be approximately $1,595.4 million.

Acquisitions

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

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

Note 11. Earnings Per Share

The following table sets forth the computation of basic and diluted earnings per share for the three and six months ended June 30, 2015 and 2014 (dollars and shares in millions, except per share amounts):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Numerator for basic and diluted earnings per share attributable to LifePoint Health, Inc.:				
Net income	$ 49.8	$ 41.8	$ 91.8	$ 79.5
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(3.4)	(2.7)	(6.5)	(3.3)
Net income attributable to LifePoint Health, Inc.	$ 46.4	$ 39.1	$ 85.3	$ 76.2
Denominator:				
Weighted average shares outstanding - basic	44.2	44.5	44.2	45.2
Effect of dilutive securities:				
Stock options and other stock-based awards	2.2	1.7	2.0	1.6
Convertible debt instruments	-	0.3	-	0.5
Weighted average shares outstanding - diluted	46.4	46.5	46.2	47.3
Earnings per share attributable to LifePoint Health, Inc. stockholders:				
Basic	$ 1.05	$ 0.88	$ 1.93	$ 1.69
Diluted	$ 1.00	$ 0.84	$ 1.84	$ 1.61

The Company's previously outstanding convertible debt instruments have been included in the calculation of diluted earnings per share for the three and six months ended June 30, 2014 whether or not the contingent requirements were met for conversion when their conversion price was less than the average market price of the Company's common stock for the period the convertible debt instruments were outstanding. Additionally, certain outstanding stock-based awards have been included in the calculation of diluted earnings per share to the extent they were dilutive for the three and six months ended June 30, 2015 and 2014.

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

Note 12. Guarantor and Non-Guarantor Supplementary Information

The 6.625% Senior Notes and the 5.5% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by substantially all of the Company's existing subsidiaries that guarantee the Company's Senior Credit Agreement. The guarantors are 100% owned by the Company. Additionally, the guarantees are full and unconditional and are subject to customary release provisions as set forth in the agreements for the 6.625% Senior Notes and the 5.5% Senior Notes.

The condensed consolidating financial information for the parent issuer, 100% owned guarantor subsidiaries, non-guarantor subsidiaries, certain eliminations and the Company is presented below for the three and six months ended June 30, 2015 and 2014 and as of June 30, 2015 and December 31, 2014.

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Operations
For the Three Months Ended June 30, 2015

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 856.3	$ 613.5	$ -	$ 1,469.8
Provision for doubtful accounts	-	131.6	67.8	-	199.4
Revenues	-	724.7	545.7	-	1,270.4
Salaries and benefits	10.4	332.1	264.3	-	606.8
Supplies	-	104.6	89.5	-	194.1

Other operating expenses	1.1	190.0	117.6	-	308.7
Other income	-	(8.0)	(6.2)	-	(14.2)
Equity in earnings of affiliates	(71.6)	-	-	71.6	-
Depreciation and amortization	-	44.5	24.4	-	68.9
Interest expense, net	8.3	16.5	3.3	-	28.1
Management (income) fees	-	(17.0)	17.0	-	-
	(51.8)	662.7	509.9	71.6	1,192.4
Income before income taxes	51.8	62.0	35.8	(71.6)	78.0
Provision for income taxes	5.4	22.8	-	-	28.2
Net income	46.4	39.2	35.8	(71.6)	49.8
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(1.7)	(1.7)	-	(3.4)
Net income attributable to LifePoint Health, Inc.	$ 46.4	$ 37.5	$ 34.1	$ (71.6)	$ 46.4

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

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

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 861.8	$ 384.4	$ -	$ 1,246.2
Provision for doubtful accounts	-	140.4	58.8	-	199.2
Revenues	-	721.4	325.6	-	1,047.0
Salaries and benefits	6.9	323.5	158.1	-	488.5
Supplies	-	104.4	58.1	-	162.5
Other operating expenses	-	187.2	71.1	-	258.3
Other income	-	(15.2)	(5.8)	-	(21.0)
Equity in earnings of affiliates	(57.6)	-	-	57.6	-
Depreciation and amortization	-	46.1	14.8	-	60.9
Interest expense, net	11.8	17.7	1.8	-	31.3
Management (income) fees	-	(4.9)	4.9	-	-
	(38.9)	658.8	303.0	57.6	980.5
Income before income taxes	38.9	62.6	22.6	(57.6)	66.5
(Benefit) provision for income taxes	(0.2)	24.9	-	-	24.7
Net income	39.1	37.7	22.6	(57.6)	41.8
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(0.2)	(2.5)	-	(2.7)

Net income attributable to LifePoint Health, Inc.	$ 39.1	$ 37.5	$ 20.1	$ (57.6)	$ 39.1

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Operations
For the Six Months Ended June 30, 2015

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 1,691.3	$ 1,230.1	$ -	$ 2,921.4
Provision for doubtful accounts	-	246.8	140.5	-	387.3
Revenues	-	1,444.5	1,089.6	-	2,534.1
Salaries and benefits	18.7	663.4	535.9	-	1,218.0
Supplies	-	209.4	181.5	-	390.9
Other operating expenses	(0.2)	368.8	233.7	-	602.3
Other income	-	(17.8)	(8.1)	-	(25.9)
Equity in earnings of affiliates	(131.1)	-	-	131.1	-
Depreciation and amortization	-	89.9	47.0	-	136.9
Interest expense, net	16.9	32.9	6.7	-	56.5
Impairment charges	-	11.6	-	-	11.6
Management (income) fees	-	(25.5)	25.5	-	-
	(95.7)	1,332.7	1,022.2	131.1	2,390.3
Income before income taxes	95.7	111.8	67.4	(131.1)	143.8
Provision for income taxes	10.4	41.6	-	-	52.0
Net income	85.3	70.2	67.4	(131.1)	91.8
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(1.9)	(4.6)	-	(6.5)
Net income attributable to LifePoint					

Health, Inc.	$ 85.3	$ 68.3	$ 62.8	$ (131.1)	$ 85.3

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Operations
For the Six Months Ended June 30, 2014

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 1,699.8	$ 729.2	$ -	$ 2,429.0
Provision for doubtful accounts	-	268.7	106.1	-	374.8
Revenues	-	1,431.1	623.1	-	2,054.2
Salaries and benefits	13.8	648.0	301.5	-	963.3
Supplies	-	207.1	112.4	-	319.5
Other operating expenses	-	367.9	133.9	-	501.8
Other income	-	(28.8)	(6.1)	-	(34.9)
Equity in earnings of affiliates	(113.9)	-	-	113.9	-
Depreciation and amortization	-	91.4	30.6	-	122.0
Interest expense, net	26.1	34.7	4.4	-	65.2
Management (income) fees	-	(10.0)	10.0	-	-
	(74.0)	1,310.3	586.7	113.9	1,936.9
Income before income taxes	74.0	120.8	36.4	(113.9)	117.3
(Benefit) provision for income taxes	(2.2)	40.0	-	-	37.8
Net income	76.2	80.8	36.4	(113.9)	79.5
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(0.4)	(2.9)	-	(3.3)

Net income attributable to LifePoint Health, Inc.	$ 76.2	$ 80.4	$ 33.5	$ (113.9)	$ 76.2

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

LIFEPOINT HEALTH, INC.
Condensed Consolidating Balance Sheets
June 30, 2015

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$ -	$ 316.7	$ 106.1	$ -	$ 422.8
Accounts receivable, net	-	447.6	276.9	-	724.5
Inventories	-	71.3	46.7	-	118.0
Prepaid expenses	-	32.8	17.7	-	50.5
Income taxes receivable	14.1	-	-	-	14.1
Deferred tax assets	68.2	-	-	-	68.2
Other current assets	-	22.4	17.4	-	39.8
	82.3	890.8	464.8	-	1,437.9
Property and equipment:					
Land	-	70.7	62.0	-	132.7
Buildings and improvements	-	1,531.7	652.8	-	2,184.5
Equipment	-	1,280.1	348.9	-	1,629.0
Construction in progress	-	65.6	30.7	-	96.3
	-	2,948.1	1,094.4	-	4,042.5
Accumulated depreciation	-	(1,448.6)	(265.6)	-	(1,714.2)
	-	1,499.5	828.8	-	2,328.3
Deferred loan costs, net	28.9	-	-	-	28.9
Intangible assets, net	-	29.7	39.7	-	69.4
Investments in subsidiaries	2,157.1	-	-	(2,157.1)	-
Due from subsidiaries	2,329.3	-	-	(2,329.3)	-

Other assets	8.0	21.7	24.5	-	54.2
Goodwill	-	1,435.3	199.1	-	1,634.4
Total assets	$ 4,605.6	$ 3,877.0	$ 1,556.9	$ (4,486.4)	$ 5,553.1
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	$ -	$ 85.2	$ 69.6	$ -	$ 154.8
Accrued salaries	-	110.0	76.9	-	186.9
Other current liabilities	18.1	130.5	79.2	-	227.8
Current maturities of long-term debt	22.5	1.0	1.4	-	24.9
	40.6	326.7	227.1	-	594.4
Long-term debt	2,125.7	48.4	12.1	-	2,186.2
Due to Parent	-	1,729.2	600.1	(2,329.3)	-
Deferred income tax liabilities	186.8	-	-	-	186.8
Long-term portion of reserves for self-insurance claims	-	107.2	36.8	-	144.0
Other long-term liabilities	13.3	25.5	46.3	-	85.1
Total liabilities	2,366.4	2,237.0	922.4	(2,329.3)	3,196.5
Redeemable noncontrolling interests	-	-	89.4	-	89.4
Total LifePoint Health, Inc. stockholders' equity	2,239.2	1,638.4	518.7	(2,157.1)	2,239.2
Noncontrolling interests	-	1.6	26.4	-	28.0
Total equity	2,239.2	1,640.0	545.1	(2,157.1)	2,267.2
Total liabilities and equity	$ 4,605.6	$ 3,877.0	$ 1,556.9	$ (4,486.4)	$ 5,553.1

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

LIFEPOINT HEALTH, INC.
Condensed Consolidating Balance Sheets
December 31, 2014

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$ -	$ 62.0	$ 129.5	$ -	$ 191.5
Accounts receivable, net	-	451.4	301.2	-	752.6
Inventories	-	71.3	43.9	-	115.2
Prepaid expenses	0.1	29.1	16.2	-	45.4
Income taxes receivable	33.0	-	-	-	33.0
Deferred tax assets	72.8	-	-	-	72.8
Other current assets	-	53.5	32.2	-	85.7
	105.9	667.3	523.0	-	1,296.2
Property and equipment:					
Land	-	70.0	64.8	-	134.8
Buildings and improvements	-	1,542.2	613.7	-	2,155.9
Equipment	-	1,289.9	343.9	-	1,633.8
Construction in progress	-	49.6	23.3	-	72.9
	-	2,951.7	1,045.7	-	3,997.4
Accumulated depreciation	-	(1,398.3)	(221.6)	-	(1,619.9)
	-	1,553.4	824.1	-	2,377.5
Deferred loan costs, net	31.7	-	-	-	31.7
Intangible assets, net	-	34.6	34.5	-	69.1
Investments in subsidiaries	2,025.6	-	-	(2,025.6)	-
Due from subsidiaries	2,352.1	-	-	(2,352.1)	-
Other assets	6.6	19.4	20.4	-	46.4
Goodwill	-	1,440.5	195.6	-	1,636.1

Total assets	$ 4,521.9	$ 3,715.2	$ 1,597.6	$ (4,377.7)	$ 5,457.0
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	$ -	$ 90.4	$ 68.1	$ -	$ 158.5
Accrued salaries	-	130.9	71.5	-	202.4
Other current liabilities	14.5	112.7	76.0	-	203.2
Current maturities of long-term debt	16.9	0.9	1.4	-	19.2
	31.4	334.9	217.0	-	583.3
Long-term debt	2,137.5	49.1	12.7	-	2,199.3
Due to Parent	-	1,634.6	717.5	(2,352.1)	-
Deferred income tax liabilities	187.5	-	-	-	187.5
Long-term portion of reserves for self-insurance claims	-	103.1	30.1	-	133.2
Other long-term liabilities	10.9	24.7	49.1	-	84.7
Total liabilities	2,367.3	2,146.4	1,026.4	(2,352.1)	3,188.0
Redeemable noncontrolling interests	-	-	87.1	-	87.1
Total LifePoint Health, Inc. stockholders' equity	2,154.6	1,567.0	458.6	(2,025.6)	2,154.6
Noncontrolling interests	-	1.8	25.5	-	27.3
Total equity	2,154.6	1,568.8	484.1	(2,025.6)	2,181.9
Total liabilities and equity	$ 4,521.9	$ 3,715.2	$ 1,597.6	$ (4,377.7)	$ 5,457.0

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Cash Flows
For the Three Months Ended June 30, 2015

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 46.4	$ 39.2	$ 35.8	$ (71.6)	$ 49.8
Adjustments to reconcile net income to net cash (used in) provided by operating activities:					
Equity in earnings of affiliates	(71.6)	-	-	71.6	-
Stock-based compensation	7.4	-	-	-	7.4
Depreciation and amortization	-	44.5	24.4	-	68.9
Amortization of physician minimum revenue guarantees	-	2.7	0.4	-	3.1
Amortization of debt discounts, premium and deferred loan costs	1.3	-	-	-	1.3
Deferred income tax benefit	(1.5)	-	-	-	(1.5)
Reserve for self-insurance claims, net of payments	-	2.1	2.6	-	4.7
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	4.0	17.0	-	21.0
Inventories, prepaid expenses and other current assets	-	25.2	13.8	-	39.0
Accounts payable, accrued salaries and other current liabilities	(16.2)	(8.2)	6.1	-	(18.3)
Income taxes payable/receivable	11.0	-	-	-	11.0
Other	0.5	1.2	0.3	-	2.0

Net cash (used in) provided by operating activities	(22.7)	110.7	100.4	-	188.4
Cash flows from investing activities:					
Purchases of property and equipment	-	(17.3)	(35.8)	-	(53.1)
Acquisitions, net of cash acquired	-	(1.2)	(11.3)	-	(12.5)
Proceeds from sale of hospital	-	18.8	-	-	18.8
Other	1.8	(1.3)	1.1	-	1.6
Net cash provided by (used in) investing activities	1.8	(1.0)	(46.0)	-	(45.2)
Cash flows from financing activities:					
Payments of borrowings	(2.8)	-	-	-	(2.8)
Proceeds from exercise of stock options	3.8	-	-	-	3.8
Change in intercompany balances with affiliates, net	20.0	42.8	(62.8)	-	-
Other	(0.1)	-	(3.2)	-	(3.3)
Net cash provided by (used in) financing activities	20.9	42.8	(66.0)	-	(2.3)
Change in cash and cash equivalents	-	152.5	(11.6)	-	140.9
Cash and cash equivalents at beginning of period	-	164.2	117.7	-	281.9
Cash and cash equivalents at end of period	$ -	$ 316.7	$ 106.1	$ -	$ 422.8

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

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

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 39.1	$ 37.7	$ 22.6	$ (57.6)	$ 41.8
Adjustments to reconcile net income to net cash (used in) provided by operating activities:					
Equity in earnings of affiliates	(57.6)	-	-	57.6	-
Stock-based compensation	6.4	-	-	-	6.4
Depreciation and amortization	-	46.1	14.8	-	60.9
Amortization of physician minimum revenue guarantees	-	3.3	0.5	-	3.8
Amortization of debt discounts, premium and deferred loan costs	4.3	-	-	-	4.3
Deferred income taxes	36.5	-	-	-	36.5
Reserve for self-insurance claims, net of payments	-	(1.4)	-	-	(1.4)
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	2.9	19.3	-	22.2
Inventories, prepaid expenses and other current assets	(0.3)	(5.2)	2.8	-	(2.7)
Accounts payable, accrued salaries and other current liabilities	(21.0)	(16.6)	6.3	-	(31.3)
Income taxes payable/receivable	(71.8)	-	-	-	(71.8)
Other	-	0.2	(0.9)	-	(0.7)
Net cash (used in) provided by operating activities	(64.4)	67.0	65.4	-	68.0

Cash flows from investing activities:					
Purchases of property and equipment	-	(21.6)	(9.6)	-	(31.2)
Acquisitions, net of cash acquired	-	-	(27.2)	-	(27.2)
Other	(0.4)	1.0	(0.5)	-	0.1
Net cash used in investing activities	(0.4)	(20.6)	(37.3)	-	(58.3)
Cash flows from financing activities:					
Proceeds from borrowings	412.0	-	-	-	412.0
Payments of borrowings	(579.8)	-	-	-	(579.8)
Repurchases of common stock	(36.1)	-	-	-	(36.1)
Proceeds from exercise of stock options	11.1	-	-	-	11.1
Change in intercompany balances with affiliates, net	263.2	(253.2)	(10.0)	-	-
Other	(5.6)	(0.1)	(1.5)	-	(7.2)
Net cash provided by (used in) financing activities	64.8	(253.3)	(11.5)	-	(200.0)
Change in cash and cash equivalents	-	(206.9)	16.6	-	(190.3)
Cash and cash equivalents at beginning of period	-	441.8	90.5	-	532.3
Cash and cash equivalents at end of period	$ -	$ 234.9	$ 107.1	$ -	$ 342.0

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Cash Flows
For the Six Months Ended June 30, 2015

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 85.3	$ 70.2	$ 67.4	$ (131.1)	$ 91.8
Adjustments to reconcile net income to net cash provided by operating activities:					
Equity in earnings of affiliates	(131.1)	-	-	131.1	-
Stock-based compensation	15.0	-	-	-	15.0
Depreciation and amortization	-	89.9	47.0	-	136.9
Amortization of physician minimum revenue guarantees	-	5.4	0.9	-	6.3
Amortization of debt discounts, premium and deferred loan costs	2.5	-	-	-	2.5
Impairment charges	-	11.6	-	-	11.6
Deferred income taxes	10.8	-	-	-	10.8
Reserve for self-insurance claims, net of payments	-	2.1	6.7	-	8.8
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	3.3	23.9	-	27.2
Inventories, prepaid expenses and other current assets	0.1	44.9	8.1	-	53.1
Accounts payable, accrued salaries and other current liabilities	3.3	(35.7)	18.1	-	(14.3)

Income taxes payable/receivable	19.0	-	-	-	19.0
Other	(0.2)	(1.4)	0.9	-	(0.7)
Net cash provided by operating activities	4.7	190.3	173.0	-	368.0
Cash flows from investing activities:					
Purchases of property and equipment	-	(45.7)	(48.5)	-	(94.2)
Acquisitions, net of cash acquired	-	(5.2)	(20.6)	-	(25.8)
Proceeds from sale of hospital	-	18.8	-	-	18.8
Other	1.2	1.5	(0.9)	-	1.8
Net cash provided by (used in) investing activities	1.2	(30.6)	(70.0)	-	(99.4)
Cash flows from financing activities:					
Payments of borrowings	(5.6)	-	-	-	(5.6)
Repurchases of common stock	(33.8)	-	-	-	(33.8)
Proceeds from exercise of stock options	10.8	-	-	-	10.8
Change in intercompany balances with affiliates, net	22.8	94.6	(117.4)	-	-
Other	(0.1)	0.4	(9.0)	-	(8.7)
Net cash (used in) provided by financing activities	(5.9)	95.0	(126.4)	-	(37.3)
Change in cash and cash equivalents	-	254.7	(23.4)	-	231.3
Cash and cash equivalents at beginning of period	-	62.0	129.5	-	191.5
Cash and cash equivalents at end of period	$ -	$ 316.7	$ 106.1	$ -	$ 422.8

Table of Contents

LIFEPOINT HEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2015

Unaudited

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Cash Flows
For the Six Months Ended June 30, 2014

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 76.2	$ 80.8	$ 36.4	$ (113.9)	$ 79.5
Adjustments to reconcile net income to net cash (used in) provided by operating activities:					
Equity in earnings of affiliates	(113.9)	-	-	113.9	-
Stock-based compensation	13.1	-	-	-	13.1
Depreciation and amortization	-	91.4	30.6	-	122.0
Amortization of physician minimum revenue guarantees	-	6.9	0.8	-	7.7
Amortization of debt discounts, premium and deferred loan costs	11.6	-	-	-	11.6
Deferred income tax benefit	(5.1)	-	-	-	(5.1)
Reserve for self-insurance claims, net of payments	-	1.9	2.8	-	4.7
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	(29.3)	1.0	-	(28.3)
Inventories, prepaid expenses and other current assets	(0.2)	18.6	2.0	-	20.4

Accounts payable, accrued salaries and other current liabilities	0.7	(45.1)	12.8	-	(31.6)
Income taxes payable/receivable	(19.3)	-	-	-	(19.3)
Other	(0.1)	1.5	0.5	-	1.9
Net cash (used in) provided by operating activities	(37.0)	126.7	86.9	-	176.6
Cash flows from investing activities:					
Purchases of property and equipment	-	(37.3)	(16.4)	-	(53.7)
Acquisitions, net of cash acquired	-	(2.7)	(85.1)	-	(87.8)
Other	(1.2)	0.4	0.4	-	(0.4)
Net cash used in investing activities	(1.2)	(39.6)	(101.1)	-	(141.9)
Cash flows from financing activities:					
Proceeds from borrowings	412.0	-	-	-	412.0
Payments of borrowings	(579.8)	-	-	-	(579.8)
Repurchases of common stock	(171.9)	-	-	-	(171.9)
Proceeds from exercise of stock options	18.3	-	-	-	18.3
Change in intercompany balances with affiliates, net	365.6	(410.4)	44.8	-	-
Other	(6.0)	(0.1)	(3.1)	-	(9.2)
Net cash provided by (used in) financing activities	38.2	(410.5)	41.7	-	(330.6)
Change in cash and cash equivalents	-	(323.4)	27.5	-	(295.9)
Cash and cash equivalents at beginning of period	-	558.3	79.6	-	637.9
Cash and cash equivalents at end of period	$ -	$ 234.9	$ 107.1	$ -	$ 342.0

Table of Contents

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, 2014 (the "2014 Annual Report on Form 10-K"). Unless otherwise indicated, all relevant financial and statistical information included herein relates to our consolidated operations. Additionally, unless the context indicates otherwise, LifePoint Health, Inc., formerly known as 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 Securities and Exchange Commission and/or release to the public. In addition, our senior management makes forward-looking statements orally to analysts, investors, the media and others. Broadly speaking, forward-looking statements include: projections of our revenues, net income, earnings per share, capital expenditures, cash flows, debt repayments, interest rates, operating statistics and data or other financial items; efforts to reduce the cost of providing healthcare while increasing quality; descriptions of plans or objectives of our management for future operations, services or growth plans including acquisitions, divestitures, business strategies, core strategies and other initiatives, including our relationship with Duke University Health System, Inc. through Duke LifePoint Healthcare; interpretations of Medicare and Medicaid laws and regulations and their effect on our business; and descriptions of assumptions underlying or relating to any of the foregoing.

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

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

There are several factors, some beyond our control that could cause results to differ significantly from our expectations. Some of these factors, as well as other factors such as market, operational, liquidity, interest rate and other risks, are described in Part I, Item 1A. Risk Factors and Part II, Item 7A. Quantitative and Qualitative Disclosures about Market Risk of the 2014 Annual Report on Form 10-K. Any factor described in this report and in the 2014 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 2014 Annual Report on Form 10-K that could also cause results to differ from our expectations.

Table of Contents

Overview

We own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities in 20 states throughout the United States ("U.S."). At June 30, 2015, on a consolidated basis, we operated 64 hospital campuses, having a total of 7,870 licensed beds. We generate revenues primarily through patient services offered at our facilities. We generated revenues of $1,270.4 million and $1,047.0 million during the three months ended June 30, 2015 and 2014, respectively, and $2,534.1 million and $2,054.2 million during the six months ended June 30, 2015 and 2014, respectively. During the three months ended June 30, 2015 and 2014, respectively, we derived 45.4% and 45.3% of our revenues, collectively, from the Medicare and Medicaid programs and 45.5% and 45.3% during the six months ended June 30, 2015 and 2014, respectively. Payments made to our facilities pursuant to the Medicare and Medicaid programs for services rendered rarely exceed our costs for such services. As a result, we rely largely on payments made by private or commercial payors, together with certain limited services provided to Medicare recipients, to generate an operating profit. The healthcare industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial 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 facilities.

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 mainly as a result of recent challenging economic conditions because the economies in the non-urban communities in which our hospitals primarily operate are often dependent on a small number of larger employers, especially manufacturing or other facilities. This causes the economies of our communities to be more sensitive to economic downturns and slower to rebound when the overall U.S. economy improves.

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

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

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

Table of Contents

Business Strategy

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

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

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

Regulatory Environment

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

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 Inspector General ("OIG"), the Department of Justice ("DOJ") and other governmental fraud and abuse programs.

Table of Contents

Health Care Reform

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

There have been and likely will continue to be a number of legal challenges to various provisions of the Affordable Care Act. For example, in 2012, the U.S. Supreme Court upheld the constitutionality of the Affordable Care Act, including the "individual mandate" provisions of the Affordable Care Act that generally require all individuals to obtain healthcare insurance or pay a penalty. However, the U.S. Supreme Court also held that the provision of the Affordable Care Act that authorized the Secretary of the Department of Health and Human Services ("HHS") to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. As a result, at June 30, 2015, only nine of the states in which we operate are currently implementing expansions to their Medicaid programs. Accordingly, some low-income persons in other states that are not expanding Medicaid may not have insurance coverage as intended by the Affordable Care Act. In addition, CMS has recently indicated that in light of the availability of federal funding for Medicaid expansion, it may not be willing to continue to provide certain uncompensated care funding, which would likely have a more significant impact in the states that have not expanded their Medicaid programs.

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 programs and the extent to which individuals will elect coverage. In addition, a number of the provisions of the Affordable Care Act that were scheduled to become effective in 2014, such as the employer mandate, the Small Business Health Option Program, and the state-run exchange verification of income and Medicaid agency electronic notification of eligibility for tax credit and subsidy requirements, have been delayed until 2015 or 2016, and additional delays in the implementation of these or other provisions of the Affordable Care Act could be imposed in the future. As a result, we are unable to predict with any certainty the net effect on our business, financial condition or results of operations of the expected increases in insured individuals using our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions of the Affordable Care Act that may affect us. We are also unable to predict with a

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

Table of Contents

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 imposed a 2% reduction in Medicare spending effective as of April 1, 2013.

On February 2, 2015, the Office of Management and Budget released President Obama's proposed budget for federal fiscal year ("FFY") 2016 (the "Proposed Budget"). Among other things, the Proposed Budget would reduce Medicare spending by approximately $400 billion over the next 10 years. The Proposed Budget would achieve these reductions by, among other things, reducing Medicare coverage of bad debt, reducing payments to hospitals for graduate medical education programs, reducing payments to critical access hospitals, reducing payments to hospitals for services that are provided at off-campus hospital outpatient departments, and increasing financial liabilities for certain Medicare beneficiaries. On May 5, 2015, Congress adopted a budget resolution for FFY 2016. Among other things, the resolution contains non-binding language supporting the repeal of the Affordable Care Act (including its reductions in Medicare spending), but requiring approximately $430 billion in Medicare savings over the next 10 years. We cannot predict whether the Proposed Budget or the Congressional budget resolution 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 April 17, 2015, CMS published its hospital inpatient patient prospective system ("IPPS") proposed rule for FFY 2016, which begins on October 1, 2015. Among other things, the proposed rule provides a payment rate increase of 1.1% for hospitals that successfully report the quality measures for the Hospital Inpatient Quality Reporting ("IQR") Program and are meaningful EHR users. The rate increase is based on a proposed hospital market basket increase of 2.7%, which is reduced by (i) a multi-factor productivity adjustment of 0.6%, (ii) a 0.2% reduction required by the Affordable Care Act, and (iii) a 0.8% documentation and coding recoupment adjustment required by the ATRA. Hospitals that do not successfully report quality data under the IQR Program will be subject to a 25% reduction of the hospital market basket increase prior to the application of any applicable statutory adjustments. Hospitals that are not meaningful EHR users are also subject to an additional 50% reduction of the hospital market basket increase.

In addition to establishing the payment rate update, the IPPS proposed rule for FFY 2016 also makes a number of other changes to the Medicare program's IPPS. Among other things, the proposed rule makes updates to the measures used in the IQR, Hospital Value-Based Purchasing, Hospital Acquired Conditions Reduction, and Hospital Readmissions Reduction Programs and would distribute $6.4 billion in Medicare DSH payments to hospitals in FFY 2016, which would be a decrease of $1.3 billion from the estimated amount that will be distributed for FFY 2015. Overall, CMS estimates that under the proposed rule, total IPPS payments to hospitals will increase by 0.3% or $120 million in FFY 2016.

On July 8, 2015, CMS published its hospital outpatient prospective payment system ("OPPS") proposed rule for calendar year ("CY") 2016, which begins on January 1, 2016. Among other things, the proposed rule provides for a payment rate decrease of 0.1% for hospitals that meet the reporting requirements of the Medicare Hospital Outpatient Quality Reporting ("OQR") Program and a payment rate decrease of 2.1% for hospitals that do not. The proposed rate decrease is based on a proposed hospital market basket increase of 2.7%, which is reduced by a multi-factor productivity adjustment of 0.6% and an additional 0.2% reduction required by the Affordable Care Act. There is an additional 2.0% reduction to redress inflation in the OPPS payment rates resulting from excess packaged payments for laboratory tests that were expected to be packaged into OPPS payment rates that continued to be paid separately outside of the OPPS. The proposed rule also makes several other changes to the Medicare program's OPPS, including the implementation of a new conditional packaging status indicator for laboratory tests that would assist hospitals in receiving separate payment for laboratory tests that are provided without other OPPS payments, the restructuring of the OPPS Ambulatory Payment Classifications ("APCs") that would result in fewer APCs overall for nine clinical APC families, the creation of a Comprehensive Ambulatory Payment Classification for comprehensive observation services, and the addition of two new reporting measures to the OQR Program. Overall, CMS estimates that under the proposed rule, OPPS payments to providers would decrease by 0.2% or $43 million in FFY 2016.

Table of Contents

On July 14, 2015, CMS published a proposed rule that would create a new model, called the Comprehensive Care for Joint Replacement Model ("CCJR Model"). The CCJR Model would test, for a five year period, bundled payment and quality measurement for episodes of care, which would generally begin on the date of the initial hospitalization for the procedure and continue for a period of 90 days thereafter, associated with hip and knee replacement surgeries. Under the proposed rule, for each year of the CCJR Model demonstration period, CMS would set Medicare episode prices for each participating hospital that includes payment for all related services received by eligible Medicare fee-for-service beneficiaries who have hip and knee procedures at that facility. All providers and suppliers would be paid under the usual payment system rules and procedures of the Medicare program for episode services throughout the applicable year. Following the end of a CCJR Model performance year, actual spending for the episode (total expenditures for related services under Medicare Parts A and B) would be compared to the Medicare episode price for the responsible hospital. Depending on the hospital's quality and episode spending performance, the hospital would either receive an additional payment from Medicare or would be required to repay Medicare for a portion of the episode spending. CMS has proposed to implement the CCJR Model in 75 metropolitan statistical areas (MSAs), including some MSAs where the Company has facilities, and most hospitals in those MSAs would be required to participate.

"Two-Midnight Rule"

In the Medicare program's IPPS final rule for FFY 2014, CMS issued the "Two-Midnight Rule," which revised its longstanding guidance to hospitals and physicians relating to when hospital inpatient admissions are deemed to be reasonable and necessary for payment under Medicare Part A and provides that, in addition to services that are designated as inpatient-only, surgical procedures, diagnostic tests and other treatments are generally only appropriate for inpatient hospital admission and payment under Medicare Part A when the physician (i) expects the beneficiary to require a stay that crosses at least two midnights and (ii) admits the beneficiary to the hospital based upon that expectation.

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

On April 1, 2014, President Obama signed the Protecting Access to Medicare Act of 2014 ("PAMA") into law. Among other things, PAMA prohibited CMS from allowing recovery auditors to conduct inpatient hospital patient status reviews on claims with dates of admission October 1, 2013 through March 31, 2015, and permitted CMS to continue

to allow MACs to review, on a pre-payment basis, a small sample of inpatient hospital claims relating to admissions that span less than two midnights and that occur on or after October 1, 2013 but before March 31, 2015, in order to determine hospital compliance with the new inpatient admission and medical review criteria. The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), which was signed into law by President Obama on April 16, 2015, extended the prohibition on recovery auditor inpatient hospital patient status reviews on claims with dates of admission through September 30, 2015, but it did allow CMS and its MACs to continue to conduct their pre-payment, "probe and educate" reviews for claims with dates of admission through that same date.

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

Table of Contents

On July 8, 2015, as part of the OPPS proposed rule for CY 2016, CMS proposed modifications to the Two-Midnight Rule. Under the proposed rule, for stays that are expected to last less than two midnights, an inpatient admission would be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician if the documentation in the medical record supports the admitting physician's determination that an inpatient admission was necessary. The admitting physician's determination would be subject to medical review, and, CMS has indicated that despite the proposed modifications, its expectation would continue to be that inpatient stays under 24 hours would rarely qualify for an exception to the two-midnight benchmark. The proposed rule does not change the standard for stays that are expected to be two midnights or longer, and, as a result, those stays would still generally be considered appropriate for Medicare Part A payment.

In addition to proposing modifications to the Medicare Part A payment standard for stays that are expected to last less than two midnights, the OPPS proposed rule for CY 2016 also makes changes to how CMS will educate providers about and enforce the Two-Midnight Rule. The proposed rule states that effective as of October 1, 2015, CMS will use Quality Improvement Organization ("QIO") contractors, and not MACs, to perform "probe and educate" audits and other reviews of short inpatient stays. Under the new review strategy, recovery auditor reviews of short inpatient stays would be limited to hospitals that have consistently high denial rates based on QIO patient status reviews or fail to improve their performance after QIO educational intervention and that are referred to the recovery auditor by the QIO.

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

Physician Services

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

amount has historically been 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. Since 2003, Congress has passed multiple legislative acts delaying application of the SGR to the PFS.

Table of Contents

On April 16, 2015, President Obama signed MACRA into law. Among other things, MACRA replaces the SGR formula with new systems for establishing the annual updates to payments made under the PFS. Under MACRA, PFS payment rates would remain at their current levels through June 30, 2015, and would then be increased by 0.5% for the remainder of CY 2015. PFS payment rates would be increased by 0.5% a year from CY 2016 through 2019 and would then remain at their CY 2019 levels through CY 2025. Beginning in CY 2019, amounts paid to individual physicians would be subject to adjustment through either the Merit-Based Incentive Payment System ("MIPS") or the Alternative Payment Model ("APM") program. Physicians who participate in the MIPS program, which would essentially consolidate the existing Physician Quality Reporting System, the Value-Based Modifier, and the Meaningful Use of EHR incentive programs, would be subject to positive, zero, or negative performance adjustments depending on how the physician's performance compared to a performance threshold. In addition, from CY 2019 through CY 2024, MACRA provides an additional $500 million per year for an additional performance adjustment for physicians who participate in MIPS and achieve exceptional performance. Physicians who participate in an APM program and receive a substantial amount of their revenue from an alternative payment model would receive, from CY 2019 through 2024, a lump-sum payment equal to 5% of their Medicare payments in the prior year for services paid under the PFS. Beginning in CY 2026, PFS payment rates for physicians participating in an APM program would be increased by 0.75% a year. Payments for other providers would be increased by 0.25% per year.

On July 15, 2015, CMS published the PFS proposed rule for CY 2016. Among other things, the proposed rule implements the 0.5% increase in PFS payment rates for CY 2016 that is specified by MACRA. In addition, the proposed rule also makes modifications to the Physician Quality Reporting System ("PQRS"), establishes separate payment and a payment rate for two advance care planning services provided to Medicare beneficiaries provided by physicians and other practitioners, and makes a number of updates to the regulations that implement the requirements of the federal physician self-referral law (Stark law). The proposed changes to the regulations that implement the Stark law are intended to accommodate delivery and payment system reform and to reduce the burden on and facilitate compliance by hospitals and other healthcare providers and include, among other things, a new exception that would permit payments to physicians for the employment of certain non-physician practitioners and clarifying changes to existing exceptions that could reduce perceived or actual technical non-compliance with the Stark law in areas that do not present a risk of abuse.

Medicare Access and CHIP Reauthorization Act of 2015

In addition to delaying the enforcement of the Two-Midnight Rule and repealing the SGR, MACRA made changes to a number of payment and other provisions of the Medicare and Medicaid programs. Among other things, MACRA:

- Extends the Medicare dependent hospital program, which provides enhanced payment support for rural hospitals that have no more than 100 beds and at least 60% of their inpatient days or discharges covered by the Medicare program, until October 1, 2017;
- Extends the Medicare low volume hospital program, which provides additional Medicare reimbursement for general acute care hospitals that are located 15 road miles from another general acute care hospital and have less than 1,600

Medicare discharges each fiscal year, until October 1, 2017;

- Extends funding for the Children's Health Insurance Program through FFY 2017;
- Permanently extends the Transitional Medicare Assistance Program, which provides Medicaid insurance coverage for families transitioning from welfare to work; and
- Delays until October 1, 2018, the Medicaid state DSH allotment reductions required by the Affordable Care Act that were scheduled to become effective October 1, 2017, and extends those reductions through FFY 2025.

The costs associated with the repeal of the SGR and the extension of the Medicare and Medicaid programs noted above would be partly covered by increased premiums for Medicare beneficiaries with relatively high income, reducing the updates to the Medicare program's payment rates for certain providers of post-acute-care and long-term care services to 1% in 2018, and phasing the one-time 3.2 percentage point increase in IPPS payment rates that hospitals are scheduled to receive in FFY 2018 when the recoupments required by the ATRA have been completed in at 0.5 percentage points per year over six years beginning in FFY 2018.

Table of Contents

Adoption of Electronic Health Records

The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted into law as part of the American Recovery and Reinvestment Act of 2009, 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. We strive to comply with the EHR meaningful use requirements of the HITECH Act in time to qualify for the maximum available incentive payments. Our compliance has and will continue to result in significant costs including business process changes, professional services focused on successfully designing and implementing our EHR solutions along with costs associated with the hardware and software components of the project. As we complete our full implementation of certified EHR technology, our EHR incentive payments will decline and ultimately end. We currently estimate that at a minimum total costs incurred to comply will be recovered through the total EHR incentive payments over the projected lifecycle of this initiative.

Privacy and Security Requirements and Administrative Simplification Provisions

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

The HITECH Act, among other things, strengthened the HIPAA privacy and security requirements, significantly increased the penalties for violations of the HIPAA privacy and security regulations, imposed varying civil monetary penalties and created a private cause of action for state attorneys general for certain HIPAA violations, extended HIPAA's security provisions to business associates, and created new security breach notification requirements. The HITECH Act also created a federal breach notification law that mirrors protections that many states have passed in recent years. In 2014, HHS announced its plan to survey approximately 800 organizations as the first step in selecting organizations for HIPAA audits, which are expected to occur in 2015. HHS officials have indicated that these audits will consist of a combination of remote audits and comprehensive onsite evaluations of covered entities and business associates and will focus on compliance with the HIPAA privacy, security and breach notification rules. HHS officials have also indicated that these audits could lead to compliance reviews or enforcement actions against organizations that fail to respond appropriately to audit requests or for which an audit reveals significant compliance issues.

Table of Contents

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

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

Table of Contents

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. Beginning in 2014, our self-pay revenues began to decrease primarily as a result of a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our hospitals have experienced in recent years, including increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who choose not to purchase insurance or who purchase insurance plans with high deductibles and high co-payments.

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.

Table of Contents

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 points.

Consolidated. Consolidated information includes the results of our health support center, our same-hospital operations and the results of our recent acquisitions completed in 2015 and 2014. Additionally, consolidated information includes the results of our hospitals that have previously been disposed.

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

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

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

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

N/A. Not applicable.

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

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

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

Same-hospital. Same-hospital information includes the results of our health support center and the same 56 hospitals operated during the three months ended June 30, 2015 and 2014. Same-hospital information excludes our hospitals that have previously been disposed.

Table of Contents

For the Three Months Ended June 30, 2015 and 2014

Operating Results Summary

The following table summarizes the results of operations for the three months ended June 30, 2015 and 2014 (dollars in millions):

	Three Months Ended June 30,					
	2015			2014		
	Amount	% of Revenues		Amount	% of Revenues	
Revenues before provision for doubtful accounts	$ 1,469.8	115.7	%	$ 1,246.2	119.0	%
Provision for doubtful accounts	199.4	15.7		199.2	19.0	
Revenues	1,270.4	100.0		1,047.0	100.0	
Salaries and benefits	606.8	47.8		488.5	46.7	
Supplies	194.1	15.3		162.5	15.5	
Other operating expenses	308.7	24.2		258.3	24.6	
Other income	(14.2)	(1.1)		(21.0)	(2.0)	
Depreciation and amortization	68.9	5.5		60.9	5.9	
Interest expense, net	28.1	2.2		31.3	3.0	
	1,192.4	93.9		980.5	93.7	
Income before income taxes	78.0	6.1		66.5	6.3	
Provision for income taxes	28.2	2.2		24.7	2.3	
Net income	49.8	3.9		41.8	4.0	
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(3.4)	(0.3)		(2.7)	(0.3)	
Net income attributable to LifePoint Health, Inc.	$ 46.4	3.6	%	$ 39.1	3.7	%

Revenues

The following table presents the components of revenues for the three months ended June 30, 2015 and 2014 (dollars in millions):

	Three Months Ended June 30,		Increase	% Increase	
	2015	2014	(Decrease)	(Decrease)	
Consolidated:					
Revenues before provision for doubtful accounts	$ 1,469.8	$ 1,246.2	$ 223.6	17.9	%
Provision for doubtful accounts	199.4	199.2	0.2	0.1	
Revenues	$ 1,270.4	$ 1,047.0	$ 223.4	21.3	
Same-hospital:					
Revenues before provision for doubtful accounts	$ 1,227.0	$ 1,185.3	$ 41.7	3.5	%
Provision for doubtful accounts	179.6	182.5	(2.9)	(1.6)	
Revenues	$ 1,047.4	$ 1,002.8	$ 44.6	4.5	

Table of Contents

Our revenues before provision for doubtful accounts by payor and approximate percentages of revenues were as follows for the three months ended June 30, 2015 and 2014 (in millions):

	Three Months Ended June 30,			
	2015		2014	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 370.0	29.1 %	$ 325.0	31.0 %
Medicaid	207.4	16.3	149.8	14.3
HMOs, PPOs and other private insurers	683.0	53.8	577.6	55.1
Self-pay	178.4	14.0	172.3	16.5
Other	31.0	2.5	21.5	2.1
Revenues before provision for doubtful accounts	1,469.8	115.7	1,246.2	119.0
Provision for doubtful accounts	(199.4)	(15.7)	(199.2)	(19.0)
Revenues	$ 1,270.4	100.0 %	$ 1,047.0	100.0 %

Our revenues per equivalent admission on a consolidated and same-hospital basis were as follows for the three months ended June 30, 2015 and 2014:

	Three Months Ended June 30,			
	2015	2014	Increase	% Increase
Revenues per equivalent admission - consolidated	$ 8,332	$ 8,012	$ 320	4.0
Revenues per equivalent admission - same-hospital	$ 8,367	$ 8,154	$ 213	2.6

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 June 30, 2015 and 2014:

	Three Months Ended June 30, 2015	2014	Increase (Decrease)	% Increase (Decrease)
Consolidated:				
Admissions	57,448	52,670	4,778	9.1
Equivalent admissions	152,486	130,680	21,806	16.7
Medicare case mix index	1.42	1.36	0.06	4.4
Average length of stay (days)	4.9	4.9	-	-
Inpatient surgeries	15,881	14,070	1,811	12.9
Outpatient surgeries	61,012	52,420	8,592	16.4
Total surgeries	76,893	66,490	10,403	15.6
Emergency room visits	363,191	327,683	35,508	10.8
Outpatient factor	2.66	2.48	0.18	7.1
Same-hospital:				
Admissions	47,434	49,516	(2,082)	(4.2)
Equivalent admissions	125,185	122,979	2,206	1.8
Medicare case mix index	1.41	1.37	0.04	2.9
Average length of stay (days)	4.9	4.9	-	-
Inpatient surgeries	12,571	13,358	(787)	(5.9)
Outpatient surgeries	50,210	50,254	(44)	(0.1)
Total surgeries	62,781	63,612	(831)	(1.3)
Emergency room visits	315,541	303,412	12,129	4.0
Outpatient factor	2.64	2.48	0.16	6.4

Table of Contents

For the three months ended June 30, 2015, our same-hospital revenues before provision for doubtful accounts increased $41.7 million, or 3.5%, to $1,227.0 million as compared to $1,185.3 million for the same period last year. This increase was primarily driven by increases in our same-hospital equivalent admissions as well as higher contracted rates from HMOs, PPOs and other private insurers. For the three months ended June 30, 2015, our same-hospital equivalent admissions increased 1.8% as compared to the same period last year, primarily as a result of a 4.0% increase in emergency room visits, partially offset by a 1.3% decrease in total surgeries. The decrease in our same-hospital total surgeries was primarily attributable to declines in low acuity outpatient surgeries. Additionally, our same-hospital revenues per equivalent admission increased 2.6% as compared to the same period last year.

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 June 30, 2015 and 2014 (dollars in millions):

	Three Months Ended June 30,								
	2015	% of Revenues		2014	% of Revenues		Increase (Decrease)	% Increase (Decrease)	
Consolidated:									
Related key indicators:									
Charity care write-offs	$ 21.3	1.7	%	$ 20.1	1.9	%	$ 1.2	5.8	%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 178.4	14.0	%	$ 172.3	16.5	%	$ 6.1	3.5	%
Net revenue days outstanding (at end of period)	53.3	N/A		57.6	N/A		(4.3)	(7.5)	%
Same-hospital:									
Related key indicators:									
Charity care write-offs	$ 14.1	1.3	%	$ 18.3	1.8	%	$ (4.2)	(23.1)	%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 167.7	16.0	%	$ 156.4	15.6	%	$ 11.3	7.2	%
Net revenue days outstanding (at end of period)	54.1	N/A		56.8	N/A		(2.7)	(4.8)	%

Our provision for doubtful accounts relates principally to amounts due from patients included in our self-pay population and other amounts such as co-payments and deductibles due from patients included in other payor categories. For the three months ended June 30, 2015, our provision for doubtful accounts increased slightly by $0.2 million, or 0.1%, to $199.4 million on a consolidated basis and decreased by $2.9 million, or 1.6%, to $179.6 million

on a same-hospital basis as compared to the same period last year. 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 2014 Annual Report on Form 10-K.

Our net revenue days outstanding at June 30, 2015 improved to 53.3 days compared to 57.6 days at June 30, 2014 on a consolidated basis. On a same-hospital basis, our net revenue days outstanding at June 30, 2015 improved to 54.1 days compared to 56.8 days at June 30, 2014.

Table of Contents

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 June 30, 2015 and 2014:

	Three Months Ended June 30,					
	2015	% of Revenues	2014	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 606.8	47.8 %	$ 488.5	46.7 %	$ 118.3	24.2 %
Man-hours per equivalent admission	109	N/A	106	N/A	3	2.7 %
Salaries and benefits per equivalent admission	$ 3,970	N/A	$ 3,733	N/A	$ 237	6.3 %

For the three months ended June 30, 2015, our salaries and benefits expense increased to $606.8 million, or 24.2%, as compared to $488.5 million for the same period last year primarily a result of our recent acquisitions and the impact of an increasing number of employed physicians and their related support staff.

Supplies

The following table summarizes our supplies and supplies per equivalent admission for the three months ended June 30, 2015 and 2014:

	Three Months Ended June 30,					
	2015	% of Revenues	2014	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 194.1	15.3 %	$ 162.5	15.5 %	$ 31.6	19.5 %
Supplies per equivalent admission	$ 1,271	N/A	$ 1,243	N/A	$ 28	2.3 %

For the three months ended June 30, 2015, our supplies expense increased to $194.1 million, or 19.5%, as compared to $162.5 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 June 30, 2015 and 2014 (dollars in millions):

	Three Months Ended June 30,							
	2015	% of Revenues	2014	% of Revenues	Increase (Decrease)	% Increase (Decrease)		
Professional fees	$ 47.7	3.7 %	$ 37.4	3.6 %	$ 10.3	27.5 %		
Utilities	22.2	1.8	20.8	2.0	1.4	6.8		
Repairs and maintenance	33.6	2.6	28.5	2.7	5.1	17.8		
Rents and leases	12.9	1.0	9.5	0.9	3.4	35.1		
Insurance	14.9	1.2	13.8	1.3	1.1	8.2		
Physician recruiting	5.5	0.4	5.8	0.6	(0.3)	(4.9)		
Contract services	91.7	7.2	77.0	7.4	14.7	19.1		
Non-income taxes	34.3	2.7	29.1	2.8	5.2	17.8		
Other	45.9	3.6	36.4	3.3	9.5	26.4		
	$ 308.7	24.2	$ 258.3	24.6	$ 50.4	19.5 %		

Table of Contents

For the three months ended June 30, 2015, our other operating expenses increased to $308.7 million, or 19.5%, as compared to $258.3 million for the same period last year primarily as a result of our recent acquisitions.

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 June 30, 2015, we recognized $14.2 million in Medicare and Medicaid EHR incentive payments, collectively, as compared to $21.0 million recognized in the same period last year.

Depreciation and Amortization

For the three months ended June 30, 2015, our depreciation and amortization expense increased by $8.0 million, or 13.3% to $68.9 million, or 5.5% of revenues, as compared to $60.9 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 increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. Accordingly, we anticipate that our depreciation and amortization expense will continue to increase in future periods as a result of these factors in addition to the impact of capital expenditure commitments associated with our recent acquisitions.

Interest Expense, Net

Our interest expense decreased by $3.2 million, or 10.4% to $28.1 million for the three months ended June 30, 2015 as compared to $31.3 million for the same period last year. The decrease in our interest expense is partially attributable to a decrease in our total debt outstanding during the three months ended June 30, 2015 as compared to the same period last year. Additionally, for the three months ended June 30, 2015, the effective interest rate on our weighted average borrowings decreased to 4.8% as compared to 5.1% for the same period last year. For a further discussion of our debt and corresponding interest rates, see “Liquidity and Capital Resources — Debt.”

Provision for Income Taxes

Our provision for income taxes was $28.2 million, or 2.2% of revenues, for the three months ended June 30, 2015, as compared to $24.7 million, or 2.3% of revenues, for the same period last year. The increase in the provision for

income taxes for the three months ended June 30, 2015 was primarily attributable to an increase in our income before income taxes for the three months ended June 30, 2015, as compared to the same period last year. This increase was partially offset by a decrease in our effective tax rate to 37.8% for the three months ended June 30, 2015, as compared to 38.7% for the same period last year as a result of various state tax planning initiatives.

Table of Contents

For the Six Months Ended June 30, 2015 and 2014

Operating Results Summary

The following table summarizes the results of operations for the six months ended June 30, 2015 and 2014 (dollars in millions):

	Six Months Ended June 30,					
	2015			2014		
	Amount	% of Revenues		Amount	% of Revenues	
Revenues before provision for doubtful accounts	$ 2,921.4	115.3	%	$ 2,429.0	118.2	%
Provision for doubtful accounts	387.3	15.3		374.8	18.2	
Revenues	2,534.1	100.0		2,054.2	100.0	
Salaries and benefits	1,218.0	48.1		963.3	46.9	
Supplies	390.9	15.4		319.5	15.6	
Other operating expenses	602.3	23.7		501.8	24.4	
Other income	(25.9)	(1.0)		(34.9)	(1.7)	
Depreciation and amortization	136.9	5.4		122.0	5.9	
Interest expense, net	56.5	2.2		65.2	3.2	
Impairment charges	11.6	0.5		-	-	
	2,390.3	94.3		1,936.9	94.3	
Income before income taxes	143.8	5.7		117.3	5.7	
Provision for income taxes	52.0	2.1		37.8	1.8	
Net income	91.8	3.6		79.5	3.9	
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(6.5)	(0.2)		(3.3)	(0.2)	
Net income attributable to LifePoint Health, Inc.	$ 85.3	3.4	%	$ 76.2	3.7	%

Revenues

The following table presents the components of revenues for the six months ended June 30, 2015 and 2014 (dollars in millions):

	Six Months Ended June 30, 2015	2014	Increase (Decrease)	% Increase (Decrease)	
Consolidated:					
Revenues before provision for doubtful accounts	$ 2,921.4	$ 2,429.0	$ 492.4	20.3	%
Provision for doubtful accounts	387.3	374.8	12.5	3.3	
Revenues	$ 2,534.1	$ 2,054.2	$ 479.9	23.4	
Same-hospital:					
Revenues before provision for doubtful accounts	$ 2,421.2	$ 2,316.3	$ 104.9	4.5	%
Provision for doubtful accounts	342.5	344.3	(1.8)	(0.5)	
Revenues	$ 2,078.7	$ 1,972.0	$ 106.7	5.4	

Table of Contents

Our revenues before provision for doubtful accounts by payor and approximate percentages of revenues were as follows for the six months ended June 30, 2015 and 2014 (in millions):

	Six Months Ended June 30,			
	2015		2014	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 747.9	29.5 %	$ 641.8	31.2 %
Medicaid	404.8	16.0	290.0	14.1
HMOs, PPOs and other private insurers	1,364.1	53.8	1,114.2	54.3
Self-pay	342.7	13.5	339.5	16.5
Other	61.9	2.5	43.5	2.1
Revenues before provision for doubtful accounts	2,921.4	115.3	2,429.0	118.2
Provision for doubtful accounts	(387.3)	(15.3)	(374.8)	(18.2)
Revenues	$ 2,534.1	100.0 %	$ 2,054.2	100.0 %

Our revenues per equivalent admission on a consolidated and same-hospital basis were as follows for the six months ended June 30, 2015 and 2014:

	Six Months Ended June 30,			
	2015	2014	Increase	% Increase
Revenues per equivalent admission - consolidated	$ 8,396	$ 8,155	$ 241	3.0
Revenues per equivalent admission - same-hospital	$ 8,416	$ 8,297	$ 119	1.4

The following table shows the key drivers of our revenues before provision for doubtful accounts for the six months ended June 30, 2015 and 2014:

	Six Months Ended June 30,		Increase	% Increase
	2015	2014	(Decrease)	(Decrease)
Consolidated:				
Admissions	118,501	104,736	13,765	13.1
Equivalent admissions	301,822	251,890	49,932	19.8
Medicare case mix index	1.41	1.37	0.04	2.9
Average length of stay (days)	5.0	4.8	0.2	4.2
Inpatient surgeries	32,066	27,547	4,519	16.4
Outpatient surgeries	118,573	98,254	20,319	20.7
Total surgeries	150,639	125,801	24,838	19.7
Emergency room visits	727,303	625,115	102,188	16.3

Outpatient factor	2.55	2.41	0.14	5.9
Same-hospital:				
Admissions	97,665	98,785	(1,120)	(1.1)
Equivalent admissions	246,995	237,677	9,318	3.9
Medicare case mix index	1.41	1.38	0.03	2.2
Average length of stay (days)	5.0	4.9	0.1	2.0
Inpatient surgeries	25,305	26,278	(973)	(3.7)
Outpatient surgeries	97,383	94,351	3,032	3.2
Total surgeries	122,688	120,629	2,059	1.7
Emergency room visits	625,746	581,090	44,656	7.7
Outpatient factor	2.53	2.41	0.12	5.1

Table of Contents

For the six months ended June 30, 2015, our same-hospital revenues before provision for doubtful accounts increased $104.9 million, or 4.5%, to $2,421.2 million as compared to $2,316.3 million for the same period last year. This increase was primarily driven by increases in our same-hospital equivalent admissions as well as higher contracted rates from HMOs, PPOs and other private insurers. For the six months ended June 30, 2015, our same-hospital equivalent admissions increased 3.9% as compared to the same period last year, primarily as a result of a 1.7% increase in total surgeries and a 7.7% increase in emergency room visits. Additionally, our same-hospital revenues per equivalent admission increased 1.4% as compared to the same period last year.

Provision for Doubtful Accounts

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts for the six months ended June 30, 2015 and 2014 (dollars in millions):

	Six Months Ended June 30,								
	2015	% of Revenues		2014	% of Revenues		Increase (Decrease)	% Increase (Decrease)	
Consolidated:									
Related key indicators:									
Charity care write-offs	$ 44.9	1.8	%	$ 51.2	2.5	%	$ (6.3)	(12.3)	%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 342.7	13.5	%	$ 339.5	16.5	%	$ 3.2	0.9	%
Net revenue days outstanding (at end of period)	53.3	N/A		57.6	N/A		(4.3)	(7.5)	%
Same-hospital:									
Related key indicators:									
Charity care write-offs	$ 31.2	1.5	%	$ 47.9	2.4	%	$ (16.7)	(34.9)	%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 312.0	15.0	%	$ 309.1	15.7	%	$ 2.9	0.9	%
Net revenue days outstanding (at end of period)	54.1	N/A		56.8	N/A		(2.7)	(4.8)	%

Our provision for doubtful accounts relates principally to amounts due from patients included in our self-pay population and other amounts such as co-payments and deductibles due from patients included in other payor categories. For the six months ended June 30, 2015, our provision for doubtful accounts increased by $12.5 million, or 3.3%, to $387.3 million on a consolidated basis and decreased by $1.8 million, or 0.5%, to $342.5 million on a same-hospital basis as compared to the same period last year. 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 2014 Annual Report on Form 10-K.

Our net revenue days outstanding at June 30, 2015 improved to 53.3 days compared to 57.6 days at June 30, 2014 on a consolidated basis. On a same-hospital basis, our net revenue days outstanding at June 30, 2015 improved to 54.1 days compared to 56.8 days at June 30, 2014.

Table of Contents

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 six months ended June 30, 2015 and 2014:

	Six Months Ended June 30,					
	2015	% of Revenues	2014	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 1,218.0	48.1 %	$ 963.3	46.9 %	$ 254.7	26.4 %
Man-hours per equivalent admission	110	N/A	108	N/A	2	2.3 %
Salaries and benefits per equivalent admission	$ 4,034	N/A	$ 3,819	N/A	$ 215	5.7 %

For the six months ended June 30, 2015, our salaries and benefits expense increased to $1,218.0 million, or 26.4%, as compared to $963.3 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 six months ended June 30, 2015 and 2014:

	Six Months Ended June 30,					
	2015	% of Revenues	2014	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 390.9	15.4 %	$ 319.5	15.6 %	$ 71.4	22.3 %
Supplies per equivalent admission	$ 1,295	N/A	$ 1,268	N/A	$ 27	2.1 %

For the six months ended June 30, 2015, our supplies expense increased to $390.9 million, or 22.3%, as compared to $319.5 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 six months ended June 30, 2015 and 2014 (dollars in millions):

	Six Months Ended June 30,							
	2015	% of Revenues	2014	% of Revenues	Increase (Decrease)	% Increase (Decrease)		
Professional fees	$ 93.6	3.7 %	$ 74.4	3.6 %	$ 19.2	25.8 %		
Utilities	45.2	1.8	40.7	2.0	4.5	11.1		
Repairs and maintenance	68.4	2.7	55.5	2.7	12.9	23.2		
Rents and leases	26.0	1.0	20.0	1.0	6.0	30.0		
Insurance	29.0	1.1	23.9	1.2	5.1	21.4		
Physician recruiting	11.0	0.4	11.8	0.6	(0.8)	(6.1)		
Contract services	180.4	7.1	148.8	7.2	31.6	21.2		
Non-income taxes	66.8	2.6	57.8	2.8	9.0	15.4		
Other	81.9	3.3	68.9	3.3	13.0	19.0		
	$ 602.3	23.7	$ 501.8	24.4	$ 100.5	20.0 %		

For the six months ended June 30, 2015, our other operating expenses increased to $602.3 million, or 20.0%, as compared to $501.8 million for the same period last year primarily as a result of our recent acquisitions.

Table of Contents

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 six months ended June 30, 2015, we recognized $25.9 million in Medicare and Medicaid EHR incentive payments, collectively, as compared to $34.9 million recognized in the same period last year.

Depreciation and Amortization

For the six months ended June 30, 2015, our depreciation and amortization expense increased by $14.9 million, or 12.2% to $136.9 million, or 5.4% of revenues, as compared to $122.0 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 increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. Accordingly, we anticipate that our depreciation and amortization expense will continue to increase in future periods as a result of these factors in addition to the impact of capital expenditure commitments associated with our recent acquisitions.

Interest Expense, Net

Our interest expense decreased by $8.7 million, or 13.5% to $56.5 million for the six months ended June 30, 2015 as compared to $65.2 million for the same period last year. The decrease in our interest expense is partially attributable to a decrease in our total debt outstanding during the six months ended June 30, 2015 as compared to the same period last year. Additionally, for the six months ended June 30, 2015, the effective interest rate on our weighted average borrowings decreased to 4.8% as compared to 5.2% for the same period last year. For a further discussion of our debt and corresponding interest rates, see “Liquidity and Capital Resources — Debt.”

Impairment Charges

In connection with the sale of Putnam Community Medical Center effective May 1, 2015, we recognized an impairment charge of $8.6 million, $5.6 million net of income taxes, or $0.12 loss per diluted share, during the six months ended June 30, 2015. The impairment charge includes the write-down of property, equipment, allocated goodwill and certain other assets to their estimated fair values.

Additionally, during the six months ended June 30, 2015, we recognized additional impairment charges totaling $3.0 million, $1.9 million net of income taxes, or $0.04 loss per diluted share, related to the finalization of the divestitures of Lakeland Community Hospital, Northwest Medical Center and Russellville Hospital which were sold effective January 1, 2015.

Provision for Income Taxes

Our provision for income taxes was $52.0 million, or 2.1% of revenues, for the six months ended June 30, 2015, as compared to $37.8 million, or 1.8% of revenues, for the same period last year. The increase in the provision for income taxes for the six months ended June 30, 2015 was primarily attributable to an increase in our income before income taxes for the six months ended June 30, 2015, as compared to the same period last year and an increase in our effective tax rate. The effective tax rate increased to 37.9% for the six months ended June 30, 2015, as compared to 33.2% for the same period last year. Our effective tax rate was lower for the six months ended June 30, 2014 as a result of the reversal of a $6.0 million valuation allowance that was established in 2013 against our deferred tax assets for federal net operating losses generated by our Michigan physician practice operations which were previously thought to be unrecoverable.

Table of Contents

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash flows provided by our operations and our debt borrowings. We believe that our internally generated cash flows and the amounts available under our senior secured credit agreement with, among others, Citibank, N.A., as administrative agent, and the lenders party thereto (the "Senior Credit Agreement"), will be adequate to service existing debt, finance internal growth and fund capital expenditures and certain small to mid-size hospital acquisitions. Certain larger hospital acquisitions may, however, require additional financing.

The following table presents summarized cash flow information for the three and six months ended June 30, 2015 and 2014 (in millions):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Net cash provided by operating activities	$ 188.4	$ 68.0	$ 368.0	$ 176.6
Less: Purchases of property and equipment	(53.1)	(31.2)	(94.2)	(53.7)
Free operating cash flow	135.3	36.8	273.8	122.9
Acquisitions, net of cash acquired	(12.5)	(27.2)	(25.8)	(87.8)
Proceeds from sale of hospital	18.8	-	18.8	-
Proceeds from borrowings	-	412.0	-	412.0
Payments of borrowings	(2.8)	(579.8)	(5.6)	(579.8)
Repurchases of common stock	-	(36.1)	(33.8)	(171.9)
Proceeds from exercise of stock options	3.8	11.1	10.8	18.3
Other	(1.7)	(7.1)	(6.9)	(9.6)
Net change in cash and cash equivalents	$ 140.9	$ (190.3)	$ 231.3	$ (295.9)

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 operating activities 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 accompanying unaudited condensed consolidated financial statements included elsewhere in this report.

Our cash flows provided by operating activities for the three months ended June 30, 2015 as compared to the same period last year were positively impacted by higher net income, increases in the amount and timing of cash receipts related to certain Medicaid DSH programs and decreases in the amount and timing of payments for interest and income taxes.

Our cash flows provided by operating activities for the six months ended June 30, 2015 as compared to the same period last year were positively impacted by higher net income, improvements in our collection efforts of outstanding accounts receivable as a result of the successful obtainment of provider numbers for the Medicare and Medicaid programs at certain of our recently acquired facilities, increases in the amount and timing of cash receipts related to certain Medicaid DSH programs and EHR incentive payments, in addition to decreases in the amount and timing of payments for interest and income taxes.

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.

Table of Contents

The following table reflects our capital expenditures for the three and six months ended June 30, 2015 and 2014 (dollars in millions):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Capital and routine projects	$ 47.5	$ 22.3	$ 78.5	$ 38.8
Information systems	5.6	8.9	15.7	14.9
	53.1	31.2	94.2	53.7
Depreciation expense	68.5	60.1	135.7	120.5
Ratio of capital expenditures to depreciation expense	77.5 %	51.9 %	69.4 %	44.6 %

We have a formal and intensive review procedure for the authorization of capital expenditures that exceed an established threshold. One of the most important financial measures of acceptability for a discretionary capital project is whether its projected discounted cash flow return on investment exceeds our projected cost of capital for that project. We expect to continue to invest in information systems, modern technologies, emergency room and operating room expansions, the construction of medical office buildings for physician expansion and the reconfiguration of the flow of patient care. Additionally, we may from time to time replace existing hospital buildings with new buildings as we evaluate ongoing repair and maintenance costs and other factors that impact the future operations of the existing buildings. We expect the total level of spending for capital expenditures to be greater in 2015 as compared to 2014 as a result of our various capital commitments in connection with certain of our recent acquisitions.

Debt

An analysis and roll-forward of our long-term debt, including current maturities, during the first half of 2015 is as follows (in millions):

	December 31, 2014	Payments of Borrowings	Amortization of Debt Discount and Premium	June 30, 2015
Senior Credit Agreement:				
Term Facility	$ 421.9	$ (5.6)	$ -	$ 416.3
Incremental Term Loans	222.6	-	-	222.6

6.625% Senior Notes	400.0	-	-	400.0
5.5% Senior Notes	1,100.0	-		1,100.0
Unamortized debt discount	(1.0)	-	0.2	(0.8)
Unamortized debt premium	10.9	-	(0.8)	10.1
Capital and financing leases	64.1	(1.2)	-	62.9
	$ 2,218.5	$ (6.8)	$ (0.6)	$ 2,211.1

Table of Contents

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, all of which was senior, as either fixed rate or variable rate at June 30, 2015 and December 31, 2014 (dollars in millions):

	June 30, 2015	December 31, 2014	Increase (Decrease)
Current portion of long-term debt	$ 24.9	$ 19.2	$ 5.7
Long-term debt	2,186.2	2,199.3	(13.1)
Unamortized discount on debt instrument	0.8	1.0	(0.2)
Unamortized premium on debt instrument	(10.1)	(10.9)	0.8
Total debt, excluding unamortized discount and premium	2,201.8	2,208.6	(6.8)
Total LifePoint Health, Inc. stockholders' equity	2,239.2	2,154.6	84.6
Total capitalization	$ 4,441.0	$ 4,363.2	$ 77.8
Total debt to total capitalization	49.6 %	50.6 %	(100) bps
Percentage of:			
Fixed rate debt, excluding unamortized discount and premium	71.0 %	70.8 %	
Variable rate debt, excluding unamortized discount and premium	29.0	29.2	
	100.0 %	100.0 %	

Capital Resources

Senior Credit Agreement

Terms

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

Letters of Credit and Availability

The Revolving Facility may be utilized for letters of credit and swingline loans up to a maximum of $75.0 million and $25.0 million, respectively. Issued letters of credit and outstanding swingline loans reduce the amounts available under the Revolving Facility. As of June 30, 2015, we had $18.7 million in letters of credit outstanding that were primarily related to the self-insured retention level of our general and professional liability insurance and workers' compensation programs as security for the payment of claims. Under the terms of the Senior Credit Agreement, amounts available for borrowing under the Revolving Facility were $331.3 million as of June 30, 2015.

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.

Table of Contents

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 June 30, 2015, the applicable annual interest rates under the Term Facility and the Incremental Term Loans were 1.94% and 2.69%, respectively, which were based on the 30-day adjusted LIBOR plus the applicable margins. The 30-day adjusted LIBOR was 0.19% for both the Term Facility and the Incremental Term Loans as of June 30, 2015.

Covenants

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

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

We were in compliance with this covenant as of June 30, 2015.

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

6.625% Senior Notes

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

We may redeem the 6.625% Senior Notes, in whole or in part, at any time prior to October 1, 2015 at a price equal to 100% of the principal amount of the notes redeemed plus an applicable make-whole 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.

Table of Contents

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

5.5% Senior Notes

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

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

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

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

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

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

Liquidity and Capital Resources Outlook

We expect the total level of spending for capital expenditures to be greater in 2015 as compared to 2014 as a result of our various capital commitments in connection with certain of our recent acquisitions. At June 30, 2015, we had uncompleted projects with an estimated additional cost to complete and equip of approximately $157.1 million. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings

available under the Senior Credit Agreement.

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

We believe that cash generated from our operations and borrowings available under the Senior Credit Agreement will be sufficient to meet our working capital needs, the purchase prices for certain small to mid-size hospital 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.

Table of Contents

Contractual Obligations

We have various contractual obligations, which are recorded as liabilities in our accompanying unaudited condensed consolidated financial statements. Other items, such as certain purchase commitments and other executory contracts, are not recognized as liabilities in our accompanying unaudited 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 June 30, 2015, there were no material changes in our contractual obligations as presented in our 2014 Annual Report on Form 10-K.

Off-Balance Sheet Arrangements

As of June 30, 2015, we had $18.7 million in letters of credit outstanding that were primarily related to the self-insured retention level of our general and professional liability insurance and workers' compensation programs as security for the payment of claims.

Accounting Policies Not Yet Adopted

ASU 2015-3, "Simplifying the Presentation of Debt Issuance Costs"

In April 2015, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2015-3, "Simplifying the Presentation of Debt Issuance Costs" ("ASU 2015-3"). ASU 2015-3 requires that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts, rather than separately as an asset. ASU 2015-3 is effective for annual reporting periods beginning after December 15, 2015, including interim periods within those years, and is to be applied retrospectively. Early adoption is permitted. We do not expect the adoption of ASU 2015-3 will have an impact on our results of operations or cash flows.

ASU 2015-2, "Consolidation"

In February 2015, the FASB issued ASU 2015-2 "Consolidation" ("ASU 2015-2"). ASU 2015-2 includes amendments that are intended to improve targeted areas of consolidation for legal entities including reducing the number of consolidation models from four to two and simplifying the FASB Accounting Standards Codification. The provisions of ASU 2015-2 are effective for annual reporting periods beginning after December 15, 2015. The amendments may

be applied retrospectively in previously issued financial statements for one or more years with a cumulative effect adjustment to retained earnings as of the beginning of the first year restated. Early adoption is permitted. We are currently evaluating the impact that the adoption of ASU 2015-2 will have on our financial position, results of operation, cash flows and financial disclosures.

ASU 2014-9, “Revenue from Contracts with Customers”

In May 2014, the FASB issued ASU 2014-9, “Revenue from Contracts with Customers” (“ASU 2014-9”). ASU 2014-9 provides for a single comprehensive principles-based standard for the recognition of revenue across all industries through the application of the following five-step process:

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

Step 2: Identify the performance obligations in the contract.

Step 3: Determine the transaction price.

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

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

Table of Contents

Among other provisions and in addition to expanded disclosure about the nature, amount, timing and uncertainty of revenue as well as certain additional quantitative and qualitative disclosures, ASU 2014-9 changes the healthcare industry specific presentation guidance under ASU 2011-7, “Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities.” The provisions of ASU 2014-9 are effective for annual reporting periods beginning after December 15, 2017, including interim periods within those years. Early adoption is not permitted. We are currently evaluating the impact that the adoption of ASU 2014-9 will have on its revenue recognition policies and procedures, financial position, results of operations, cash flows, financial disclosures and control framework.

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
- Acquisitions.

Table of Contents

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 June 30, 2015, we had outstanding debt, excluding a $0.8 million unamortized debt discount and a $10.1 million unamortized debt premium, of $2,201.8 million, 29.0%, or $638.9 million, of which was subject to variable rates of interest.

The carrying amounts and fair values of the Term Facility and the Incremental Term Loans under the Senior Credit Agreement, the 6.625% Senior Notes and the 5.5% Senior Notes as of June 30, 2015 and December 31, 2014 were as follows (in millions):

	Carrying Amount		Fair Value	
	June 30, 2015	December 31, 2014	June 30, 2015	December 31, 2014
Senior Credit Agreement:				
Term Facility	$ 416.3	$ 421.9	$ 415.2	$ 420.3
Incremental Term Loans, excluding unamortized debt discount	$ 222.6	$ 222.6	$ 222.0	$ 222.0
6.625% Senior Notes	$ 400.0	$ 400.0	$ 417.0	$ 422.0
5.5% Senior Notes, excluding unamortized debt premium	$ 1,100.0	$ 1,100.0	$ 1,138.5	$ 1,130.3

The fair values of our long-term debt instruments were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10, “Fair Value Measurements and Disclosures”.

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 June

30, 2015. As a result, the interest rate market risk implicit in these investments at June 30, 2015, 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 June 30, 2015 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Table of Contents

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. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without our knowledge. Although the healthcare industry has seen numerous ongoing investigations related to compliance and billing practices, hospitals, in particular, continue to be a primary enforcement target for the OIG, the 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 or subpoenas from fiscal intermediaries, federal and state agencies. Any proceedings against us may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on 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 the later of 60 days of identification or the date any corresponding cost report is due (if applicable). Hospitals can meet the obligation to report and refund in three ways: (1) refunding overpayments directly to the program; (2) self-disclosing the overpayment to the OIG via its voluntary self-disclosure protocol (with respect to False Claims Act and other violations not related to the Stark law); and (3) self-disclosing to CMS via the self-referral disclosure protocol (with respect to overpayments caused by potential violations of the Stark law only) for which CMS has the authority to reduce the amounts otherwise owed.

In connection with our acquisitions of Marquette General Hospital ("Marquette General") and Conemaugh Health System ("Conemaugh"), the two sellers self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. These self-disclosures are pending with CMS. With respect to Marquette General, to the extent that the seller's satisfaction of its retained liabilities, including those under its CMS voluntary self-disclosure, causes its net proceeds from the acquisition to be less than $15.0 million, we have agreed to pay additional purchase consideration to the seller. With respect to Conemaugh, to the extent that the potential settlement

exceeds the seller's cash or cash equivalent indemnification threshold in accordance with the asset purchase agreement, we will likely be responsible for funding any deficit. We believe we have made reasonable estimates of our potential exposure for these two matters, and at June 30, 2015, we have recorded a reserve for Marquette General of $18.0 million.

On September 16, 2013, we and two of our hospitals, Vaughan Regional Medical Center, located in Selma, Alabama, and Raleigh General Hospital, located in Raleigh, West Virginia, made a voluntary self-disclosure to the Civil Division of the DOJ. The voluntary self-disclosure related to concerns regarding the clinical appropriateness of certain interventional cardiology procedures conducted by one physician in each of these hospitals' cardiac catheterization laboratories. On September 24, 2013, the U.S. Attorney's Office in the Southern District of West Virginia served a subpoena on Raleigh General Hospital. Raleigh General Hospital produced responsive documents to the subpoena, including patient files. The government investigations are ongoing and we continue to cooperate with the government in addressing these matters. Following reviews by independent interventional cardiologists, we notified patients of these two physicians who may have received an unnecessary procedure of such fact.

Table of Contents

We and/or Vaughan Regional Medical Center and several of our subsidiaries, as well as Dr. Seydi V. Aksut and certain parties unaffiliated with us, are named defendants in 28 individual lawsuits filed since December 2014, and two putative class action lawsuits, all filed in the Circuit Court of Dallas County, Alabama. These lawsuits allege that patients at Vaughan Regional Medical Center received improper interventional cardiology procedures. One of the putative class action lawsuits, filed on November 21, 2014, seeks certification of a class consisting of all Alabama citizens who underwent an invasive cardiology procedure at any LifePoint owned Alabama hospital and who received notice regarding the medical necessity of that procedure. The other putative class action lawsuit, filed on February 6, 2015, seeks certification of a class of individuals that underwent an interventional cardiology procedure that was not medically necessary and performed by Dr. Aksut. This action asserts, among other claims, claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), which, if successful, would result in the awarding of treble damages for any injury resulting from the RICO violation and attorneys' fees. In March 2015, we removed this action to the U.S. District Court in Mobile, Alabama and filed a motion to dismiss and for summary judgment, as well as a stay of discovery pending resolution of these motions. On April 17, 2015 the court entered an order granting the requested stay of discovery.

Through July 31, 2015, we, and two of our subsidiaries, including Raleigh General Hospital, as well as Dr. Kenneth Glaser, have been named in 17 individual lawsuits filed in the circuit court of Raleigh County, West Virginia. These lawsuits allege that patients at Raleigh General Hospital received unnecessary interventional cardiology procedures. Through July 31, 2015, 23 additional patients have notified Raleigh General Hospital that they intend to file lawsuits against the hospital.

The lawsuits identified above variously seek compensatory and punitive damages, costs, attorneys' fees and other available damages. Additional claims, including claims involving patients to whom we did not send notice, have been threatened and may be asserted against us or the hospital. Any present or future claims that are ultimately successful could result in us and/or the hospitals being found liable and the government investigations may also result in damages, fines and penalties. Such liability, damages and penalties could be material. We cannot, however, reasonably estimate the potential liability, if any, in connection with any of these matters, and no liability has been recorded as of June 30, 2015.

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

Item 1A. Risk Factors.

There have been no material changes in our risk factors from those disclosed in the 2014 Annual Report on Form 10-K.

Table of Contents

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 "2011 Repurchase Plan"), a repurchase plan adopted in 2014 (the "2014 Repurchase Plan") and a repurchase plan adopted on June 3, 2015 (the "2015 Repurchase Plan"). The 2011 Repurchase Plan provided for the repurchase of up to $350.0 million in shares of our common stock, and we have repurchased all shares authorized for repurchase under this plan. The 2014 Repurchase Plan provides for the repurchase of up to $150.0 million in shares of our common stock through October 1, 2015. The 2015 Repurchase Plan provides for the repurchase of up to $150.0 million in shares of our common stock through December 3, 2016. We are not obligated to repurchase any specific number of shares under any of our repurchase plans. We have designated the shares repurchased in accordance with our repurchase plans as treasury stock.

In connection with the 2011 Repurchase Plan, we repurchased approximately 3.0 million shares for an aggregate purchase price, including commissions, of $164.7 million at an average purchase price of $54.33 per share during the six months ended June 30, 2014. In connection with the 2014 Repurchase Plan, we repurchased approximately 0.4 million shares for an aggregate purchase price, including commissions, of $25.0 million at an average purchase price of $67.86 per share during the six months ended June 30, 2015. As of June 30, 2015, we had remaining authority to repurchase $75.0 million and $150.0 million in shares in accordance with the 2014 Repurchase Plan and 2015 Repurchase Plan, respectively.

Additionally, we redeem shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to our various stockholder approved stock-based compensation plans. We redeemed approximately 0.1 million shares vested under these plans during each of the six months ended June 30, 2015 and 2014 for an aggregate purchase price of approximately $8.8 million and $7.2 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 June 30, 2015:

	Total Number of Shares Purchased	Weighted Average Price Paid per Share	Total Number of Shares Purchased as Part of a Publicly Announced Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs (In millions)
April 1, 2015 to April 30, 2015	-	$ -	-	$ 75.0
May 1, 2015 to May 31, 2015	-	$ -	-	$ 75.0

June 1, 2015 to June 30, 2015 (a)	290	$ 73.80	-	$ 225.0
Total	290	$ 73.80	-	$ 225.0

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

Table of Contents

Item 6. Exhibits

Exhibit Number		Description of Exhibits
3.1	-	Amended and Restated Certificate of Incorporation of LifePoint Health, Inc., as amended (filed herewith).
3.2	-	Sixth Amended and Restated By-Laws of LifePoint Health, Inc. (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed May 11, 2015, File No. 000-51251).
10.1	-	Amendment to the LifePoint Health, Inc. 2013 Long-Term Incentive Plan (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed June 4, 2015, File No. 000-51251).*
31.1	-	Certification of the Chief Executive Officer of LifePoint Health, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	-	Certification of the Chief Financial Officer of LifePoint Health, Inc. pursuant to Section 302 of the Sarbanes Oxley Act of 2002.
32.1	-	Certification of the Chief Executive Officer of LifePoint Health, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	-	Certification of the Chief Financial Officer of LifePoint Health, Inc. pursuant to Section 906 of the Sarbanes Oxley Act of 2002.
101.INS	-	XBRL Instance Document**
101.SCH	-	XBRL Taxonomy Extension Schema Document**
101.CAL	-	XBRL Taxonomy Calculation Linkbase Document**
101.DEF	-	XBRL Taxonomy Definition Linkbase Document**
101.LAB	-	XBRL Taxonomy Label Linkbase Document**
101.PRE	-	XBRL Taxonomy Presentation Linkbase Document**

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* — Management Compensation Plan or Arrangement

** — Furnished electronically herewith

Table of Contents

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 Health, Inc.

By:/s/ Michael S. Coggin

Michael S. Coggin

Senior Vice President and

Chief Accounting Officer

(Principal Accounting Officer)

Date: July 31, 2015

Table of Contents

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