UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-Q

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

For the quarterly period ended September 30, 2018

Commission file number 001-15925

COMMUNITY HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**13-3893191**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
4000 Meridian Boulevard **Franklin, Tennessee**	**37067**
(Address of principal executive offices)	*(Zip Code)*

615-465-7000
(Registrant's telephone number)

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 every Interactive Data File required to be submitted 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 such files). Yes ☑ No ☐

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

Large accelerated filer ☑	Accelerated filer ☐	Smaller reporting company ☐
Non-accelerated filer ☐		Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

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

As of October 22, 2018, there were outstanding 116,284,414 shares of the Registrant's Common Stock, $0.01 par value.

Table of Contents

Community Health Systems, Inc.

Form 10-Q

For the Three and Nine Months Ended September 30, 2018

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF LOSS
(In millions, except share and per share data)
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	**2017**	**2018**	**2017**
Operating revenues (net of contractual allowances and discounts)		$ 4,333		$ 14,323
Provision for bad debts		667		2,028
Net operating revenues (see Note 1)	$ 3,451	3,666	$ 10,702	12,295
Operating costs and expenses:				
Salaries and benefits	1,585	1,724	4,850	5,704
Supplies	565	610	1,773	2,056
Other operating expenses	858	911	2,646	2,984
Government and other legal settlements and related costs	2	1	9	(32)
Electronic health records incentive reimbursement	(1)	(2)	(2)	(25)
Rent	83	93	257	306
Depreciation and amortization	173	206	531	665
Impairment and (gain) loss on sale of businesses, net	112	33	314	363
Total operating costs and expenses	3,377	3,576	10,378	12,021
Income from operations	74	90	324	274
Interest expense, net	256	238	720	706
Loss (gain) from early extinguishment of debt	27	4	(32)	35
Equity in earnings of unconsolidated affiliates	(5)	(5)	(17)	(13)
Loss from continuing operations before income taxes	(204)	(147)	(347)	(454)
Provision for (benefit from) income taxes	104	(59)	58	(74)
Loss from continuing operations	(308)	(88)	(405)	(380)
Discontinued operations, net of taxes:				
Loss from operations of entities sold or held for sale	-	(1)	-	(4)
Impairment of hospitals sold or held for sale	-	(1)	-	(6)
Loss from discontinued operations, net of taxes	-	(2)	-	(10)
Net loss	(308)	(90)	(405)	(390)
Less: Net income attributable to noncontrolling interests	17	20	55	56
Net loss attributable to Community Health Systems, Inc. stockholders	$ (325)	$ (110)	$ (460)	$ (446)
Basic loss per share attributable to Community Health Systems, Inc. common stockholders:				
Continuing operations	$ (2.88)	$ (0.96)	$ (4.08)	$ (3.91)
Discontinued operations	-	(0.02)	-	(0.08)
Net loss	$ (2.88)	$ (0.98)	$ (4.08)	$ (3.99)
Diluted loss per share attributable to Community Health Systems, Inc. common stockholders:				
Continuing operations	$ (2.88)	$ (0.96)	$ (4.08)	$ (3.91)
Discontinued operations	-	(0.02)	-	(0.08)
Net loss	$ (2.88)	$ (0.98)	$ (4.08)	$ (3.99)
Weighted-average number of shares outstanding:				
Basic	112,865,482	111,935,738	112,667,077	111,701,812
Diluted	112,865,482	111,935,738	112,667,077	111,701,812

See accompanying notes to the condensed consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE LOSS
(In millions)
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	**2017**	**2018**	**2017**
Net loss	$ (308)	$ (90)	$ (405)	$ (390)
Other comprehensive income (loss), net of income taxes:				
Net change in fair value of interest rate swaps, net of tax	2	5	26	8
Net change in fair value of available-for-sale securities, net of tax	-	2	(2)	7
Amortization and recognition of unrecognized pension cost components, net of tax	-	1	1	2
Other comprehensive income	2	8	25	17
Comprehensive loss	(306)	(82)	(380)	(373)
Less: Comprehensive income attributable to noncontrolling interests	17	20	55	56
Comprehensive loss attributable to Community Health Systems, Inc. stockholders	$ (323)	$ (102)	$ (435)	$ (429)

See accompanying notes to the condensed consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
(In millions, except share data)
(Unaudited)

	September 30, 2018	December 31, 2017
ASSETS		
Current assets:		
Cash and cash equivalents	$ 335	$ 563
Patient accounts receivable (see Note 1)	2,347	2,384
Supplies	424	444
Prepaid income taxes	17	17
Prepaid expenses and taxes	191	198
Other current assets	410	462
Total current assets	3,724	4,068
Property and equipment	10,986	11,497
Less accumulated depreciation and amortization	(4,416)	(4,445)
Property and equipment, net	6,570	7,052
Goodwill	4,631	4,723
Deferred income taxes	-	62
Other assets, net	1,544	1,545
Total assets	$ 16,469	$ 17,450
LIABILITIES AND STOCKHOLDERS' DEFICIT		
Current liabilities:		
Current maturities of long-term debt	$ 35	$ 33
Accounts payable	816	967
Accrued liabilities:		
Employee compensation	630	685
Accrued interest	258	229
Other	740	442
Total current liabilities	2,479	2,356
Long-term debt	13,535	13,880
Deferred income taxes	39	19
Other long-term liabilities	1,051	1,360
Total liabilities	17,104	17,615
Redeemable noncontrolling interests in equity of consolidated subsidiaries	495	527
STOCKHOLDERS' DEFICIT		
Community Health Systems, Inc. stockholders' deficit:		
Preferred stock, $.01 par value per share, 100,000,000 shares authorized; none issued	-	-
Common stock, $.01 par value per share, 300,000,000 shares authorized; 116,245,071 shares issued and outstanding at September 30, 2018, and 114,651,004 shares issued and outstanding at December 31, 2017	1	1
Additional paid-in capital	2,011	2,014
Accumulated other comprehensive loss	(8)	(21)
Accumulated deficit	(3,209)	(2,761)
Total Community Health Systems, Inc. stockholders' deficit	(1,205)	(767)
Noncontrolling interests in equity of consolidated subsidiaries	75	75
Total stockholders' deficit	(1,130)	(692)
Total liabilities and stockholders' deficit	$ 16,469	$ 17,450

See accompanying notes to the condensed consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(In millions)
(Unaudited)

	Nine Months Ended September 30,	
	2018	**2017**
Cash flows from operating activities:		
Net loss	$ (405)	$ (390)
Adjustments to reconcile net loss to net cash provided by operating activities:		
Depreciation and amortization	531	665
Government and other legal settlements and related costs	9	8
Stock-based compensation expense	10	20
Impairment of hospitals sold or held for sale	-	6
Impairment and (gain) loss on sale of businesses, net	314	363
(Gain) loss from early extinguishment of debt	(32)	35
Other non-cash expenses, net	25	24
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:		
Patient accounts receivable	38	229
Supplies, prepaid expenses and other current assets	14	(37)
Accounts payable, accrued liabilities and income taxes	(47)	(215)
Other	(17)	(91)
Net cash provided by operating activities	440	617
Cash flows from investing activities:		
Acquisitions of facilities and other related businesses	(21)	(4)
Purchases of property and equipment	(413)	(428)
Proceeds from disposition of hospitals and other ancillary operations	228	1,666
Proceeds from sale of property and equipment	7	4
Purchases of available-for-sale securities and equity securities	(50)	(85)
Proceeds from sales of available-for-sale securities and equity securities	75	133
Increase in other investments	(76)	(95)
Net cash (used in) provided by investing activities	(250)	1,191
Cash flows from financing activities:		
Repurchase of restricted stock shares for payroll tax withholding requirements	(1)	(5)
Deferred financing costs and other debt-related costs	(93)	(66)
Proceeds from noncontrolling investors in joint ventures	2	5
Redemption of noncontrolling investments in joint ventures	(27)	(5)
Distributions to noncontrolling investors in joint ventures	(74)	(79)
Borrowings under credit agreements	24	839
Issuance of long-term debt	1,033	3,100
Proceeds from ABL and receivables facility	587	26
Repayments of long-term indebtedness	(1,869)	(5,271)
Net cash used in financing activities	(418)	(1,456)
Net change in cash and cash equivalents	(228)	352
Cash and cash equivalents at beginning of period	563	238
Cash and cash equivalents at end of period	$ 335	$ 590
Supplemental disclosure of cash flow information:		
Interest payments	$ (637)	$ (630)
Income tax refunds (payments), net	$ 17	$ (5)

See accompanying notes to the condensed consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED)

1. BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES

The unaudited condensed consolidated financial statements of Community Health Systems, Inc. (the "Parent" or "Parent Company") and its subsidiaries (the "Company") as of September 30, 2018 and December 31, 2017 and for the three-month and nine-month periods ended September 30, 2018 and 2017, have been prepared in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP"). In the opinion of management, such information contains all adjustments, consisting only of normal recurring adjustments, necessary for a fair presentation of the results for such periods. All intercompany transactions and balances have been eliminated. The results of operations for the three and nine months ended September 30, 2018, are not necessarily indicative of the results to be expected for the full fiscal year ending December 31, 2018. Certain information and disclosures normally included in the notes to condensed consolidated financial statements have been condensed or omitted as permitted by the rules and regulations of the Securities and Exchange Commission (the "SEC"). The Company believes the disclosures are adequate to make the information presented not misleading. The accompanying unaudited condensed consolidated financial statements should be read in conjunction with the consolidated financial statements and notes thereto for the year ended December 31, 2017, contained in the Company's Annual Report on Form 10-K filed with the SEC on February 28, 2018 ("2017 Form 10-K").

Noncontrolling interests in less-than-wholly-owned consolidated subsidiaries of the Parent are presented as a component of total equity on the condensed consolidated balance sheets to distinguish between the interests of the Parent Company and the interests of the noncontrolling owners. Noncontrolling interests that are redeemable or may become redeemable at a fixed or determinable price at the option of the holder or upon the occurrence of an event outside of the control of the Company are presented in mezzanine equity on the condensed consolidated balance sheets.

Throughout these notes to the condensed consolidated financial statements, Community Health Systems, Inc., and its consolidated subsidiaries are referred to on a collective basis as the "Company." This drafting style is not meant to indicate that the publicly traded Parent or any particular subsidiary of the Parent owns or operates any asset, business, or property. The hospitals, operations and businesses described in this filing are owned and operated by distinct and indirect subsidiaries of Community Health Systems, Inc.

Revenue Recognition. On January 1, 2018, the Company adopted the new revenue recognition accounting standard issued by the Financial Accounting Standards Board ("FASB") and codified in the FASB Accounting Standards Codification ("ASC") as topic 606 ("ASC 606"). The revenue recognition standard in ASC 606 outlines a single comprehensive model for recognizing revenue as performance obligations, defined in a contract with a customer as goods or services transferred to the customer in exchange for consideration, are satisfied. The standard also requires expanded disclosures regarding the Company's revenue recognition policies and significant judgments employed in the determination of revenue.

The Company applied the modified retrospective approach to all contracts when adopting ASC 606. As a result, at the adoption of ASC 606 the majority of what was previously classified as the provision for bad debts in the statement of operations is now reflected as implicit price concessions (as defined in ASC 606) and therefore included as a reduction to net operating revenues in 2018. For changes in credit issues not assessed at the date of service, the Company will prospectively recognize those amounts in other operating expenses on the statement of operations. For periods prior to the adoption of ASC 606, the provision for bad debts has been presented consistent with the previous revenue recognition standards that required it to be presented separately as a component of net operating revenues. Additionally, upon adoption of Topic 606 the allowance for doubtful accounts of approximately $3.9 billion as of January 1, 2018 was reclassified as a component of net patient accounts receivable. Other than these changes in presentation on the condensed consolidated statement of operations and condensed consolidated balance sheet, the adoption of ASC 606 did not have a material impact on the consolidated results of operations for the three and nine months ended September 30, 2018, and the Company does not expect it to have a material impact on its consolidated results of operations for the remainder of 2018 and on a prospective basis.

As part of the adoption of ASC 606, the Company elected two of the available practical expedients provided for in the standard. First, the Company does not adjust the transaction price for any financing components as those were deemed to be insignificant. Additionally, the Company expenses all incremental customer contract acquisition costs as incurred as such costs are not material and would be amortized over a period less than one year.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Net Operating Revenues

Upon the adoption of ASC 606, net operating revenues are recorded at the transaction price estimated by the Company to reflect the total consideration due from patients and third-party payors in exchange for providing goods and services in patient care. These services are considered to be a single performance obligation and have a duration of less than one year. Revenues are recorded as these goods and services are provided. The transaction price, which involves significant estimates, is determined based on the Company's standard charges for the goods and services provided, with a reduction recorded for price concessions related to third party contractual arrangements as well as patient discounts and other patient price concessions. During the three and nine months ended September 30, 2018, the impact of changes to the inputs used to determine the transaction price was considered immaterial to the current period.

Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from the Centers for Medicare & Medicaid Services and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Under these supplemental programs, the Company recognizes revenue and related expenses in the period in which amounts are estimable and collection is reasonably assured. Reimbursement under these programs is reflected in net operating revenues and fees, taxes or other program-related costs are reflected in other operating expenses.

The Company's net operating revenues during the three and nine months ended September 30, 2018 and 2017 have been presented in the table based on an allocation of the estimated transaction price with the patient between the primary patient classification of insurance coverage (in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
Medicare	$ 875	$ 978	$ 2,852	$ 3,343
Medicaid	469	496	1,407	1,626
Managed Care and other third-party payors	2,065	2,171	6,292	7,111
Self-pay	42	21	151	215
Total	$ 3,451	$ 3,666	$ 10,702	$ 12,295

Patient Accounts Receivable

Patient accounts receivable are recorded at net realizable value based on certain assumptions determined by each payor. For third-party payors including Medicare, Medicaid, and Managed Care, the net realizable value is based on the estimated contractual reimbursement percentage, which is based on current contract prices or historical paid claims data by payor. For self-pay accounts receivable, which includes patients who are uninsured and the patient responsibility portion for patients with insurance, the net realizable value is determined using estimates of historical collection experience without regard to aging category. These estimates are adjusted for estimated conversions of patient responsibility portions, expected recoveries and any anticipated changes in trends.

Patient accounts receivable can be impacted by the effectiveness of the Company's collection efforts. Additionally, significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect the net realizable value of accounts receivable. The Company also continually reviews the net realizable value of accounts receivable by monitoring historical cash collections as a percentage of trailing net operating revenues, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, the composition of self-pay receivables between pure self-pay patients and the patient responsibility portion of third-party insured receivables and the impact of recent acquisitions and dispositions.

Final settlements for some payors and programs are subject to adjustment based on administrative review and audit by third parties. As a result of these final settlements, the Company has recorded amounts due to third-party payors of $140 million and $156 million as of September 30, 2018 and December 31, 2017, respectively, and these amounts are included in accrued liabilities-other in the accompanying condensed consolidated balance sheets. Amounts due from third-party payors were $150 million and $153 million as of September 30, 2018 and December 31, 2017, respectively, and are included in other current assets in the accompanying condensed consolidated balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 2014.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Charity Care

In the ordinary course of business, the Company renders services to patients who are financially unable to pay for hospital care. The Company's policy is to not pursue collections for such amounts; therefore, the related charges for those patients who are financially unable to pay and that otherwise do not qualify for reimbursement from a governmental program are not reported in net operating revenues, and are thus classified as charity care. The Company determines amounts that qualify for charity care primarily based on the patient's household income relative to the federal poverty level guidelines, as established by the federal government.

These charity care services are estimated to be $121 million and $116 million for the three months ended September 30, 2018 and 2017, respectively, and $350 million and $358 million for the nine months ended September 30, 2018 and 2017, respectively, representing the value (at the Company's standard charges) of these charity care services that are excluded from net operating revenues. The estimated cost incurred by the Company to provide these charity care services to patients who are unable to pay was approximately $15 million for both of the three-month periods ended September 30, 2018 and 2017, and $43 million and $45 million for the nine months ended September 30, 2018 and 2017, respectively. The estimated cost of these charity care services was determined using a ratio of cost to gross charges and applying that ratio to the gross charges associated with providing care to charity patients for the period.

Accounting for the Impairment or Disposal of Long-Lived Assets. During the nine months ended September 30, 2018, the Company recorded a total combined impairment charge and loss on disposal of approximately $314 million, of which (i) approximately $225 million was recorded to reduce the carrying value of certain hospitals that have been sold or deemed held for sale based on the difference between the carrying value of the hospital disposal groups compared to estimated fair value less costs to sell, (ii) approximately $29 million was recorded to write-off the value of a promissory note received as consideration for the sale of three hospitals in 2017 where the buyer recently entered into bankruptcy proceedings, and (iii) approximately $60 million was recorded primarily to adjust the carrying value of other long-lived assets at several underperforming hospitals that have ceased operations or where the Company is in discussions with potential buyers for divestiture at a sales price that indicates a fair value below carrying value. Included in the carrying value of the hospital disposal groups at September 30, 2018 is a net allocation of approximately $113 million of goodwill allocated from the hospital operations reporting unit goodwill based on a calculation of the disposal groups' relative fair value compared to the total reporting unit. The Company will continue to evaluate the potential for further impairment of the long-lived assets of underperforming hospitals as well as evaluating offers for potential sales. Based on such analysis, additional impairment charges may be recorded in the future.

During the nine months ended September 30, 2017, the Company recorded a total impairment charge of approximately $363 million to reduce the carrying value of certain hospitals that were deemed held for sale based on the difference between the carrying value of the hospital disposal groups compared to estimated fair value less costs to sell. Included in the carrying value of the hospital disposal groups is a net allocation of approximately $229 million of goodwill allocated from the hospital operations reporting unit goodwill based on a calculation of the disposal groups' relative fair value compared to the total reporting unit.

New Accounting Pronouncements. In January 2016, the FASB issued Accounting Standards Update ("ASU") 2016-01, which amends the measurement, presentation and disclosure requirements for equity investments, other than those accounted for under the equity method or that require consolidation of the investee. The ASU eliminates the classification of equity investments as available-for-sale with any changes in fair value of such investments recognized in other comprehensive income, and requires entities to measure equity investments at fair value, with any changes in fair value recognized in net income. This ASU is effective for fiscal years beginning after December 15, 2017, with early adoption permitted. To adopt this ASU, companies must record a cumulative-effect adjustment to beginning retained earnings at the beginning of the period of adoption. The Company adopted this ASU on January 1, 2018, and the adoption of this ASU did not have a material impact on its consolidated results of operations or financial position. Upon adoption, the Company recorded a reclassification of $6 million from accumulated other comprehensive loss as a decrease to accumulated deficit.

In February 2016, the FASB issued ASU 2016-02, which amends the accounting for leases, requiring lessees to recognize most leases on their balance sheet with a right-of-use asset and a corresponding lease liability. Leases will be classified as either finance or operating leases, which will impact the expense recognition of such leases over the lease term. The ASU also modifies the lease classification criteria for lessors and eliminates some of the real estate leasing guidance previously applied for certain leasing transactions. This ASU is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. The Company expects to adopt this ASU on January 1, 2019. In July 2018, the FASB issued ASU 2018-11, which provides entities relief from the transition requirements in ASU 2016-02 by allowing them to elect not to recast prior comparative periods. The Company plans to elect this method of transition upon adoption of this ASU. Because of the number of leases the Company utilizes to support its operations,

the adoption of this ASU is expected to have a significant impact on the Company's consolidated financial position and results of operations. The Company has organized an implementation group of cross-functional departmental management to ensure the completeness of its lease information, analyze the appropriate classification of current leases under the new standard, and develop new processes to execute, approve and classify leases on an ongoing basis. The Company has also engaged outside experts to assist in the development and execution of this plan, as well as the identification and selection of software tools and processes to maintain lease information critical to applying the new standard. Management is currently evaluating the extent of this anticipated impact on the Company's consolidated financial position and results of operations, and the quantitative and qualitative factors that will impact the Company as part of the adoption of this ASU, as well as any changes to its leasing strategy that may occur because of the changes to the accounting and recognition of leases. As part of the Company's final implementation efforts during the fourth quarter of 2018, management intends to finalize the quantitative inputs that will determine the impact on the consolidated financial statements from adopting the new standard, including the schedule of future rent payments and the appropriate discount rate used to determine the lease liability and right of use asset for outstanding leases at the date of adoption.

In March 2017, the FASB issued ASU 2017-07, which changes the presentation of the components of net periodic benefit cost for sponsors of defined benefit plans for pensions. Under the changes in this ASU, the service cost component of net periodic benefit cost is reported in the same income statement line as other employee compensation costs arising from services during the reporting period. The other components of net periodic benefit cost are presented separately in a line item outside of operating income. This ASU is effective for fiscal years beginning after December 15, 2017, with early adoption permitted. The Company adopted this ASU on January 1, 2018, and the adoption of this ASU did not have a material impact on the Company's consolidated financial position or results of operations.

In August 2017, the FASB issued ASU 2017-12, which amends hedge accounting recognition and disclosure requirements to improve transparency and simplify the application of hedge accounting for certain hedging instruments. The amendments in this ASU that will have an impact on the Company include simplification of the periodic hedge effectiveness assessment, elimination of the benchmark interest rate concept for interest rate swaps, and enhancement of the ability to use the critical-terms match method for its cash flow hedges of forecasted interest payments. This ASU is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. The Company early adopted this ASU on January 1, 2018, and the adoption of this ASU did not have a material impact on the Company's consolidated financial position or results of operations.

In February 2018, the FASB issued ASU 2018-02, which allows a reclassification from accumulated other comprehensive income to retained earnings for the stranded tax effects in accumulated other comprehensive income resulting from the enactment of the comprehensive tax legislation commonly referred to as the Tax Cuts and Jobs Act (the "Tax Act") and corresponding accounting treatment recorded in the fourth quarter of 2017. The ASU is effective for all entities for fiscal years beginning after December 15, 2018, and interim periods within those fiscal years. Early adoption of the amendments in this ASU is permitted, including adoption in any interim period for reporting periods for which financial statements have not yet been issued. The Company early adopted this ASU on January 1, 2018, and the Company has elected to reclassify $6 million from accumulated other comprehensive loss to a decrease to accumulated deficit for these stranded tax effects. The stranded tax effects included in this adjustment relate solely to the reduction of the federal corporate tax rate as a result of the Tax Act. The Company's accounting policy on releasing the income tax effects of amounts from Accumulated other comprehensive loss has been to apply such amounts on a portfolio basis.

In August 2018, the FASB issued ASU 2018-15 to provide guidance on the accounting for implementation costs incurred in a cloud computing arrangement that is accounted for as a service contract. This ASU requires entities to account for such costs consistent with the guidance on capitalizing costs associated with developing or obtaining internal-use software. The ASU is effective for all entities for fiscal years beginning after December 15, 2019, and interim periods within those fiscal years, with early adoption permitted. The Company is currently evaluating the impact that adoption of this ASU will have on its consolidated financial position and results of operations.

2. ACCOUNTING FOR STOCK-BASED COMPENSATION

Stock-based compensation awards have been granted under the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan, amended and restated as of March 20, 2013 (the "2000 Plan"), and the Community Health Systems, Inc. Amended and Restated 2009 Stock Option and Award Plan, which was amended and restated as of March 14, 2018 and approved by the Company's stockholders at the annual meeting of stockholders held on May 15, 2018 (the "2009 Plan").

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The 2000 Plan allowed for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code (the "IRC"), as well as stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Prior to being amended in 2009, the 2000 Plan also allowed for the grant of phantom stock. Persons eligible to receive grants under the 2000 Plan include the Company's directors, officers, employees and consultants. All options granted under the 2000 Plan have been "nonqualified" stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date. Options granted prior to 2005 have a 10-year contractual term, options granted in 2005 through 2007 have an eight-year contractual term and options granted in 2008 through 2011 have a 10-year contractual term. The Company has not granted stock option awards under the 2000 Plan since 2011. Pursuant to the amendment and restatement of the 2000 Plan dated March 20, 2013, no further grants will be awarded under the 2000 Plan.

The 2009 Plan provides for the grant of incentive stock options intended to qualify under Section 422 of the IRC and for the grant of stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Persons eligible to receive grants under the 2009 Plan include the Company's directors, officers, employees and consultants. To date, all options granted under the 2009 Plan have been "nonqualified" stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date. Options granted in 2011 or later have a 10-year contractual term. As of September 30, 2018, 8,680,357 shares of unissued common stock were reserved for future grants under the 2009 Plan.

The exercise price of all options granted under the 2000 Plan and the 2009 Plan has been equal to the fair value of the Company's common stock on the option grant date.

The following table reflects the impact of total compensation expense related to stock-based equity plans on the reported operating results for the respective periods (in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
Effect on loss from continuing operations before income taxes	$ (3)	$ (6)	$ (10)	$ (20)
Effect on net loss	$ (2)	$ (4)	$ (8)	$ (13)

At September 30, 2018, $15 million of unrecognized stock-based compensation expense related to outstanding unvested restricted stock and restricted stock units (the terms of which are summarized below) was expected to be recognized over a weighted-average period of 22 months. There is no expense to be recognized related to stock options. There were no modifications to awards during the three or nine months ended September 30, 2018 and 2017.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Options outstanding and exercisable under the 2000 Plan and the 2009 Plan as of September 30, 2018, and changes during each of the three-month periods following December 31, 2017, were as follows (in millions, except share and per share data):

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term	Aggregate Intrinsic Value as of September 30, 2018
Exercisable at December 31, 2017	1,115,667	$ 31.56		
Granted	-	-		
Exercised	-	-		
Forfeited and cancelled	(383,666)	32.19		
Outstanding at March 31, 2018	732,001	31.23		
Granted	-	-		
Exercised	-	-		
Forfeited and cancelled	(46,174)	32.76		
Outstanding at June 30, 2018	685,827	31.12		
Granted	-	-		
Exercised	-	-		
Forfeited and cancelled	(48,539)	30.68		
Outstanding at September 30, 2018	637,288	$ 31.16	2.1 years	$ -
Exercisable at September 30, 2018	637,288	$ 31.16	2.1 years	$ -

No stock options were granted during the nine months ended September 30, 2018 and 2017. The aggregate intrinsic value (calculated as the number of in-the-money stock options multiplied by the difference between the Company's closing stock price on the last trading day of the reporting period ($3.46) and the exercise price of the respective stock options) in the table above represents the amount that would have been received by the option holders had all option holders exercised their options on September 30, 2018. This amount changes based on the market value of the Company's common stock. There were no options exercised during the three or nine months ended September 30, 2018 and 2017. The aggregate intrinsic value of options vested and expected to vest approximates that of the outstanding options.

The Company has also awarded restricted stock under the 2000 Plan and the 2009 Plan to employees of certain subsidiaries. The restrictions on these shares generally lapse in one-third increments on each of the first three anniversaries of the award date. Certain of the restricted stock awards granted to the Company's senior executives contain a performance objective that must be met in addition to any time-based vesting requirements. If the applicable performance objective is not attained, the awards will be forfeited in their entirety. For such performance-based awards granted prior to 2017, once the target performance objective was attained, restrictions lapse in one-third increments on each of the first three anniversaries of the award date. For performance-based awards granted beginning in March 2017, the performance objectives are measured cumulatively over a three-year period. With respect to these performance-based awards granted beginning in March 2017, if the applicable target performance objective is met at the end of three years, then the portion of the restricted stock award subject to such performance objective will vest in full. Additionally, for these awards, based on the level of achievement for the applicable performance objective within the parameters specified in the award, the number of shares to be issued in connection with the vesting of the award will be adjusted to decrease or increase the number of shares specified in the original award. Notwithstanding the above-mentioned performance objectives and vesting requirements, the restrictions with respect to restricted stock granted under the 2000 Plan and the 2009 Plan will lapse earlier in the event of death, disability or termination of employment by the Company for any reason other than for cause of the holder of the restricted stock, or change in control of the Company. Restricted stock awards subject to performance standards that have not yet been satisfied are not considered outstanding for purposes of determining earnings per share until the performance objectives have been satisfied.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Restricted stock outstanding under the 2000 Plan and the 2009 Plan as of September 30, 2018, and changes during each of the three-month periods following December 31, 2017, were as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested at December 31, 2017	2,643,919	$ 16.17
Granted	1,911,000	4.58
Vested	(981,326)	25.73
Forfeited	(88,673)	13.24
Unvested at March 31, 2018	3,484,920	7.20
Granted	31,000	3.97
Vested	(67,329)	9.87
Forfeited	(52,335)	4.30
Unvested at June 30, 2018	3,396,256	7.09
Granted	-	-
Vested	-	-
Forfeited	(16,667)	5.97
Unvested at September 30, 2018	3,379,589	7.10

Restricted stock units (“RSUs”) have been granted to the Company’s outside directors under the 2000 Plan and the 2009 Plan. On March 1, 2017, each of the Company’s then-serving outside directors who were expected to stand for re-election at the 2017 Annual Meeting of Stockholders received a grant under the 2009 Plan of 18,498 RSUs. On March 1, 2018, each of the Company’s outside directors received a grant under the 2009 Plan of 37,118 RSUs. Each of the 2017 and 2018 grants had a grant date fair value of approximately $170,000. Vesting of these RSUs occurs in one-third increments on each of the first three anniversaries of the award date or upon the director’s earlier cessation of service on the board, other than for cause.

RSUs outstanding under the 2000 Plan and the 2009 Plan as of September 30, 2018, and changes during each of the three-month periods following December 31, 2017, were as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested at December 31, 2017	172,078	$ 12.78
Granted	296,944	4.58
Vested	(71,116)	15.51
Forfeited	-	-
Unvested at March 31, 2018	397,906	6.17
Granted	-	-
Vested	-	-
Forfeited	-	-
Unvested at June 30, 2018	397,906	6.17
Granted	-	-
Vested	-	-
Forfeited	-	-
Unvested at September 30, 2018	397,906	6.17

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

3. COST OF REVENUE

Substantially all of the Company's operating costs and expenses are "cost of revenue" items. Operating costs that could be classified as general and administrative by the Company would include the Company's corporate office costs at its Franklin, Tennessee office, which were $46 million and $42 million for the three months ended September 30, 2018 and 2017, respectively, and $141 million and $135 million for the nine months ended September 30, 2018 and 2017, respectively. Included in these corporate office costs is stock-based compensation of $3 million and $6 million for the three months ended September 30, 2018 and 2017, respectively, and $10 million and $20 million for the nine months ended September 30, 2018 and 2017, respectively.

4. USE OF ESTIMATES

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements. Actual results could differ from these estimates under different assumptions or conditions.

5. ACQUISITIONS AND DIVESTITURES

Acquisitions

The Company accounts for all transactions that represent business combinations using the acquisition method of accounting, where the identifiable assets acquired, the liabilities assumed and any noncontrolling interest in the acquired entity are recognized and measured at their fair values on the date the Company obtains control in the acquiree. Such fair values that are not finalized for reporting periods following the acquisition date are estimated and recorded as provisional amounts. Adjustments to these provisional amounts during the measurement period (defined as the date through which all information required to identify and measure the consideration transferred, the assets acquired, the liabilities assumed and any noncontrolling interests has been obtained, limited to one year from the acquisition date) are recorded when identified. Goodwill is determined as the excess of the fair value of the consideration conveyed in the acquisition over the fair value of the net assets acquired.

During the nine months ended September 30, 2018, one or more subsidiaries of the Company paid approximately $21 million to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by the Company's affiliated hospitals. In connection with these acquisitions, during the nine months ended September 30, 2018, the Company allocated less than $1 million of the consideration paid to property and equipment and net working capital and the remainder, approximately $21 million consisting of intangible assets that do not qualify for separate recognition, to goodwill. No hospitals were acquired in 2017 or during the nine months ended September 30, 2018.

Acquisition and integration expenses related to prospective and closed acquisitions included in other operating expenses on the condensed consolidated statements of loss were less than $1 million during both of the three-month periods ended September 30, 2018 and 2017, and approximately $2 million and approximately $1 million during the nine-month periods ended September 30, 2018 and 2017.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Divestitures

The following table provides a summary of hospitals included in continuing operations that the Company divested during the year ended December 31, 2017 and the nine months ended September 30, 2018:

Hospital	Buyer	City, State	Licensed Beds	Effective Date
2018 Divestitures:				
Munroe Regional Medical Center	Adventist Health System	Ocala, FL	425	August 1, 2018
Tennova - Dyersburg Regional	West Tennessee Healthcare	Dyersburg, TN	225	June 1, 2018
Tennova - Regional Jackson	West Tennessee Healthcare	Jackson, TN	150	June 1, 2018
Tennova - Volunteer Martin	West Tennessee Healthcare	Martin, TN	100	June 1, 2018
Williamson Memorial Hospital	Mingo Health Partners, LLC	Williamson, WV	76	June 1, 2018
Byrd Regional Hospital	Allegiance Health Management	Leesville, LA	60	June 1, 2018
Tennova Healthcare - Jamestown	Rennova Health, Inc.	Jamestown, TN	85	June 1, 2018
Bayfront Health Dade City	Adventist Health System	Dade City, FL	120	April 1, 2018
2017 Divestitures:				
Highlands Regional Medical Center	HCA Holdings, Inc. (“HCA”)	Sebring, FL	126	November 1, 2017
Merit Health Northwest Mississippi	Curae Health, Inc.	Clarksdale, MS	181	November 1, 2017
Weatherford Regional Medical Center	HCA	Weatherford, TX	103	October 1, 2017
Brandywine Hospital	Reading Health System	Coatesville, PA	169	October 1, 2017
Chestnut Hill Hospital	Reading Health System	Philadelphia, PA	148	October 1, 2017
Jennersville Hospital	Reading Health System	West Grove, PA	63	October 1, 2017
Phoenixville Hospital	Reading Health System	Phoenixville, PA	151	October 1, 2017
Pottstown Memorial Medical Center	Reading Health System	Pottstown, PA	232	October 1, 2017
Yakima Regional Medical and Cardiac Center	Regional Health	Yakima, WA	214	September 1, 2017
Toppenish Community Hospital	Regional Health	Toppenish, WA	63	September 1, 2017
Memorial Hospital of York	PinnacleHealth System	York, PA	100	July 1, 2017
Lancaster Regional Medical Center	PinnacleHealth System	Lancaster, PA	214	July 1, 2017
Heart of Lancaster Regional Medical Center	PinnacleHealth System	Lititz, PA	148	July 1, 2017
Carlisle Regional Medical Center	PinnacleHealth System	Carlisle, PA	165	July 1, 2017
Tomball Regional Medical Center	HCA	Tomball, TX	350	July 1, 2017
South Texas Regional Medical Center	HCA	Jourdanton, TX	67	July 1, 2017
Deaconess Hospital	MultiCare Health System	Spokane, WA	388	July 1, 2017
Valley Hospital	MultiCare Health System	Spokane Valley, WA	123	July 1, 2017
Lake Area Medical Center	CHRISTUS Health	Lake Charles, LA	88	June 30, 2017
Easton Hospital	Steward Health, Inc.	Easton, PA	196	May 1, 2017
Sharon Regional Health System	Steward Health, Inc.	Sharon, PA	258	May 1, 2017
Northside Medical Center	Steward Health, Inc.	Youngstown, OH	355	May 1, 2017
Trumbull Memorial Hospital	Steward Health, Inc.	Warren, OH	311	May 1, 2017
Hillside Rehabilitation Hospital	Steward Health, Inc.	Warren, OH	69	May 1, 2017
Wuesthoff Health System – Rockledge	Steward Health, Inc.	Rockledge, FL	298	May 1, 2017
Wuesthoff Health System – Melbourne	Steward Health, Inc.	Melbourne, FL	119	May 1, 2017
Sebastian River Medical Center	Steward Health, Inc.	Sebastian, FL	154	May 1, 2017
Stringfellow Memorial Hospital	The Health Care Authority of the City of Anniston	Anniston, AL	125	May 1, 2017
Merit Health Gilmore Memorial	Curae Health, Inc.	Amory, MS	95	May 1, 2017
Merit Health Batesville	Curae Health, Inc.	Batesville, MS	112	May 1, 2017

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

A discontinued operation in U.S. GAAP is a disposal that represents a strategic shift that has (or will have) a major effect on an entity's operations and financial results. Additional disclosures are required for significant components of the entity that are disposed of or are held for sale but do not qualify as discontinued operations. The divestitures above do not meet the criteria for reporting as discontinued operations and are included in continuing operations for the nine months ended September 30, 2018 and 2017.

On May 1, 2017, one or more subsidiaries of the Company sold AllianceHealth Pryor (52 licensed beds) in Pryor, Oklahoma, and its associated assets to Ardent Health Services Inc. for approximately $1 million in cash. This hospital has been reported in the condensed consolidated statements of loss in discontinued operations.

Net operating revenues and loss from discontinued operations for the three and nine months ended September 30, 2017 are as follows (in millions):

	Three Months Ended September 30, 2017	Nine Months Ended September 30, 2017
Net operating revenues	$ 19	$ 64
Loss from operations of entities sold or held for sale before income taxes	$ (2)	$ (6)
Impairment of hospitals sold or held for sale	(2)	(9)
Loss on sale, net	-	(1)
Loss from discontinued operations, before taxes	(4)	(16)
Income tax benefit	(2)	(6)
Loss from discontinued operations, net of taxes	$ (2)	$ (10)

The following table discloses amounts included in the condensed consolidated balance sheet for the hospitals classified as held for sale as of September 30, 2018 and December 31, 2017 (in millions):

	September 30, 2018	December 31, 2017
Other current assets	$ 19	$ 8
Other assets, net	113	12
Accrued liabilities	31	2

Other Hospital Closures

During the three months ended June 30, 2018, the Company completed the planned closure of Twin Rivers Regional Medical Center in Kennett, Missouri. The Company recorded an impairment charge of approximately $4 million during the three months ended June 30, 2018, to adjust the fair value of the supplies, inventory and long-lived assets of this hospital, including property and equipment and capitalized software costs, based on their estimated fair value and future utilization.

6. INCOME TAXES

The total amount of unrecognized benefit that would impact the effective tax rate, if recognized, was approximately $7 million as of September 30, 2018. A total of approximately $4 million of interest and penalties is included in the amount of the liability for uncertain tax positions at September 30, 2018. It is the Company's policy to recognize interest and penalties related to unrecognized benefits in its condensed consolidated statements of loss as income tax expense.

It is possible the amount of unrecognized tax benefit could change in the next 12 months as a result of a lapse of the statute of limitations and settlements with taxing authorities; however, the Company does not anticipate the change will have a material impact on the Company's condensed consolidated results of operations or condensed consolidated financial position.

The Company's federal income tax returns for the 2009 and 2010 tax years have been settled with the Internal Revenue Service. The results of these examinations were not material to the Company's consolidated results of operations or consolidated financial position. The Company's federal income tax returns for the 2014 and 2015 tax years remain under examination by the Internal

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Revenue Service. The Company believes the results of these examinations will not be material to its consolidated results of operations or consolidated financial position. The Company has extended the federal statute of limitations through June 30, 2019 for Community Health Systems, Inc. for the tax periods ended December 31, 2007, 2008, 2009 and 2010, and through December 31, 2019 for the tax periods ended December 31, 2014 and 2015.

The Company's effective tax rates were (51.0)% and 40.1% for the three months ended September 30, 2018 and 2017, respectively, and (16.7)% and 16.3% for the nine months ended September 30, 2018 and 2017, respectively. The difference in the Company's effective tax rate for the three months ended September 30, 2018, when compared to the three months ended September 30, 2017, was primarily due to the non-deductible portion of the amounts payable by the Company pursuant to the global resolution and settlement agreements related to certain HMA matters entered into with the U.S. Department of Justice as announced on September 25, 2018, the U.S. Federal limitation on deductibility of interest expense and non-deductible goodwill written off as part of the net impairment and (gain) loss on sale of businesses for the three months ended September 30, 2018 compared to the three months ended September 30, 2017. The difference in the Company's effective tax rate for the nine months ended September 30, 2018 when compared to the nine months ended September 30, 2017, was primarily due to the items noted above, as well as a disproportionate decrease in income from continuing operations before income taxes when compared to the decrease in net income attributable to noncontrolling interest for those same periods, which is not tax affected in our condensed consolidated financial statements.

Cash paid for income taxes, net of refunds received, resulted in a net refund of $8 million and less than $1 million during the three months ended September 30, 2018 and 2017, respectively, and a net refund of $17 million and net cash paid of $5 million during the nine months ended September 30, 2018 and 2017, respectively.

On December 22, 2017, the U.S. government enacted the Tax Act, which made broad and complex changes to the U.S. tax code, including a permanent reduction in the U.S. federal corporate tax rate from 35% to 21% ("Rate Reduction").

The Tax Act also made other changes to the U.S. tax code, which changes included, but were not limited to (1) creating a new limitation on deductible interest expense; (2) changing rules related to uses and limitations of net operating loss carryforwards; and (3) modifying the rules governing the deductibility of certain executive compensation.

In December 2017, the SEC staff issued Staff Accounting Bulletin ("SAB 118"), which provides guidance on accounting for the tax effects of the Tax Act. SAB 118 provides a measurement period that should not extend beyond one year from the Tax Act's enactment date for companies to complete the accounting under ASC 740. In accordance with SAB 118, a company must reflect the income tax effects of those aspects of the Tax Act for which the accounting under ASC 740 is complete. To the extent that a company's accounting for certain income tax effects of the Tax Act is incomplete but the company is able to determine a reasonable estimate, it must record a provisional estimate in the financial statements. If a company cannot determine a provisional estimate to be included in the financial statements, it should continue to apply ASC 740 on the basis of the provisions of the tax laws that were in effect immediately before the enactment of the Tax Act.

The Company has not completed the accounting for the income tax effects of the Tax Act. At December 31, 2017, the Company recorded a discrete net tax expense of $32 million primarily related to provisional amounts under SAB 118 for the remeasurement of U.S. deferred tax assets and liabilities due to Rate Reduction. No changes were recorded to this provisional estimate during the nine months ended September 30, 2018. However, this estimate may differ from the final accounting as supplemental legislation, regulatory guidance or evolving technical interpretations become available.

At September 30, 2018, the Company was not able to reasonably estimate and, therefore, has not recorded a provisional amount for the Tax Act's impact on certain state valuation allowances. The Company will complete its accounting for the Tax Act in the fourth quarter of 2018 in accordance with the prescribed measurement period under SAB 118.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

7. GOODWILL AND OTHER INTANGIBLE ASSETS

Goodwill

The changes in the carrying amount of goodwill for the nine months ended September 30, 2018 are as follows (in millions):

Balance as of December 31, 2017	
Goodwill	$ 7,537
Accumulated impairment losses	(2,814)
	4,723
Goodwill acquired as part of acquisitions during current year	21
Goodwill allocated to hospitals held for sale	(113)
Balance as of September 30, 2018	
Goodwill	7,445
Accumulated impairment losses	(2,814)
	$ 4,631

Goodwill is allocated to each identified reporting unit, which is defined as an operating segment or one level below the operating segment (referred to as a component of the entity). Management has determined that the Company's operating segments meet the criteria to be classified as reporting units. At September 30, 2018, the Company had approximately $4.6 billion of goodwill recorded.

Goodwill is evaluated for impairment annually and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. During 2017, the Company adopted ASU 2017-04, which allows a company to record a goodwill impairment when the reporting unit's carrying value exceeds the fair value determined in step one. In 2017, consistent with prior years, the Company performed its annual goodwill evaluation during the fourth quarter as of September 30, 2017, and then an updated evaluation as of November 30, 2017 due to the identification of certain impairment indicators. With the elimination of the time-intensive step two calculation to determine the implied value of goodwill, the Company has considered the additional benefits of performing the annual goodwill evaluation later in the fourth quarter to coincide with the timing of the next fiscal year's budgeting and financial projection process. Based on these considerations, the Company has elected to change the annual goodwill impairment measurement date to October 31. The next annual goodwill evaluation will be performed during the fourth quarter of 2018 with an October 31, 2018 measurement date, or sooner if the Company identifies certain indicators of impairment.

The Company estimates the fair value of the related reporting units using both a discounted cash flow model as well as a market multiple model. The cash flow forecasts are adjusted by an appropriate discount rate based on the Company's estimate of a market participant's weighted-average cost of capital. These models are both based on the Company's best estimate of future revenues and operating costs and are reconciled to the Company's consolidated market capitalization, with consideration of the amount a potential acquirer would be required to pay, in the form of a control premium, in order to gain sufficient ownership to set policies, direct operations and control management decisions.

As noted above, during the three months ended December 31, 2017, the Company identified certain indicators of impairment occurring following its annual goodwill evaluation that required an interim goodwill impairment evaluation, which was performed as of November 30, 2017. Those indicators were primarily a further decline in the Company's market capitalization and fair value of the Company's long-term debt during November 2017. The Company performed an estimated calculation of fair value in step one of the impairment test at November 30, 2017, which indicated that the carrying value of the hospital operations reporting unit exceeded its fair value. As a result of this evaluation and the early adoption of ASU 2017-04, the Company recorded a non-cash impairment charge of $1.419 billion to goodwill during the three months ended December 31, 2017.

The reduction in the Company's fair value and the resulting goodwill impairment charge recorded during 2017 reduced the carrying value of the Company's hospital operations reporting unit to an amount equal to its estimated fair value. This increases the risk that future declines in fair value could result in goodwill impairment. The determination of fair value in the Company's goodwill impairment analysis is based on an estimate of fair value for each reporting unit utilizing known and estimated inputs at the evaluation date. Some of those inputs include, but are not limited to, the most recent price of the Company's common stock or fair value of long-term debt, estimates of future revenue and expense growth, estimated market multiples, expected capital expenditures, income tax rates, and costs of invested capital. Future estimates of fair value could be adversely affected if the actual outcome of one or more of

these assumptions changes materially in the future, including further decline in the Company's stock price or fair value of long-term debt, lower than expected hospital volumes, higher market interest rates or increased operating costs. Such changes impacting the calculation of fair value could result in a material impairment charge in the future.

The determination of fair value of the Company's hospital operations reporting unit as part of its goodwill impairment measurement represents a Level 3 fair value measurement in the fair value hierarchy due to its use of internal projections and unobservable measurement inputs.

These impairment charges do not have an impact on the calculation of the Company's financial covenants under the Company's Credit Facility.

Intangible Assets

No intangible assets other than goodwill were acquired during the nine months ended September 30, 2018. The gross carrying amount of the Company's other intangible assets subject to amortization was $8 million and $18 million at September 30, 2018 and December 31, 2017, respectively, and the net carrying amount was less than $1 million and $10 million at September 30, 2018 and December 31, 2017, respectively. The carrying amount of the Company's other intangible assets not subject to amortization was $72 million and $79 million at September 30, 2018 and December 31, 2017, respectively. Other intangible assets are included in other assets, net on the Company's condensed consolidated balance sheets. Substantially all of the Company's intangible assets are contract-based intangible assets related to operating licenses, management contracts, tradenames, or non-compete agreements entered into in connection with prior acquisitions.

The weighted-average remaining amortization period for the intangible assets subject to amortization is approximately two years. There are no expected residual values related to these intangible assets. Amortization expense on these intangible assets was $1 million for both of the three-month periods ended September 30, 2018 and 2017, and $2 million and $3 million for the nine months ended September 30, 2018 and 2017, respectively. Amortization expense on intangible assets is estimated to be less than $1 million for the remainder of 2018 and in 2019 through 2021.

The gross carrying amount of capitalized software for internal use was approximately $1.2 billion at both September 30, 2018 and December 31, 2017, and the net carrying amount was approximately $350 million and $416 million at September 30, 2018 and December 31, 2017, respectively. The estimated amortization period for capitalized internal-use software is generally three years, except for capitalized costs related to significant system conversions, which is generally eight to ten years. There is no expected residual value for capitalized internal-use software. At September 30, 2018, there was approximately $40 million of capitalized costs for internal-use software that is currently in the development stage and will begin amortization once the software project is complete and ready for its intended use. Amortization expense on capitalized internal-use software was $35 million and $46 million during the three months ended September 30, 2018 and 2017, respectively, and $105 million and $141 million for the nine months ended September 30, 2018 and 2017, respectively. Amortization expense on capitalized internal-use software is estimated to be $32 million for the remainder of 2018, $113 million in 2019, $78 million in 2020, $58 million in 2021, $35 million in 2022, $21 million in 2023 and $13 million thereafter.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

8. EARNINGS PER SHARE

The following table sets forth the components of the numerator and denominator for the computation of basic and diluted (loss) earnings per share for loss from continuing operations, discontinued operations and net loss attributable to Community Health Systems, Inc. common stockholders (in millions, except share data):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
Numerator:				
Loss from continuing operations, net of taxes	$ (308)	$ (88)	$ (405)	$ (380)
Less: Income from continuing operations attributable to noncontrolling interests, net of taxes	17	20	55	56
Loss from continuing operations attributable to Community Health Systems, Inc. common stockholders — basic and diluted	$ (325)	$ (108)	$ (460)	$ (436)
Loss from discontinued operations, net of taxes	$ -	$ (2)	$ -	$ (10)
Less: Loss from discontinued operations attributable to noncontrolling interests, net of taxes	-	-	-	-
Loss from discontinued operations attributable to Community Health Systems, Inc. common stockholders — basic and diluted	$ -	$ (2)	$ -	$ (10)
Denominator:				
Weighted-average number of shares outstanding — basic	112,865,482	111,935,738	112,667,077	111,701,812
Effect of dilutive securities:				
Restricted stock awards	-	-	-	-
Employee stock options	-	-	-	-
Other equity-based awards	-	-	-	-
Weighted-average number of shares outstanding — diluted	112,865,482	111,935,738	112,667,077	111,701,812

The Company generated a loss from continuing operations attributable to Community Health Systems, Inc. common stockholders for the three and nine-month periods ended September 30, 2018 and 2017, so the effect of dilutive securities is not considered because their effect would be antidilutive. If the Company had generated income from continuing operations, the effect of restricted stock awards on the diluted shares calculation would have been an increase of 4,001 shares and 148,768 shares during the three months ended September 30, 2018 and 2017, respectively, and 41,705 shares and 147,618 shares for the nine months ended September 30, 2018 and 2017, respectively.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
Dilutive securities outstanding not included in the computation of earnings per share because their effect is antidilutive:				
Employee stock options and restricted stock awards	3,474,782	2,454,467	2,395,881	2,774,171

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

9. STOCKHOLDERS' DEFICIT

Authorized capital shares of the Company include 400,000,000 shares of capital stock consisting of 300,000,000 shares of common stock and 100,000,000 shares of preferred stock. Each of the aforementioned classes of capital stock has a par value of $0.01 per share. Shares of preferred stock, none of which were outstanding as of September 30, 2018, may be issued in one or more series having such rights, preferences and other provisions as determined by the Board of Directors without approval by the holders of common stock.

On November 6, 2015, the Company adopted an open market repurchase program for up to 10,000,000 shares of the Company's common stock, not to exceed $300 million in repurchases. The repurchase program will expire on the earlier of November 5, 2018, when the maximum number of shares has been repurchased, or when the maximum dollar amount has been expended. During the year ended December 31, 2015, the Company repurchased and retired 532,188 shares at a weighted-average price of $27.31 per share, which is the cumulative number of shares repurchased and retired under this program. No shares were repurchased under this program during the years ended December 31, 2016 and 2017. In addition, no shares were repurchased under this program during the nine months ended September 30, 2018.

The Company is a holding company which operates through its subsidiaries. The Company's Credit Facility and the indentures governing each series of our outstanding notes contain various covenants under which the assets of the subsidiaries of the Company are subject to certain restrictions relating to, among other matters, dividends and distributions, as referenced in the paragraph below.

With the exception of a special cash dividend of $0.25 per share paid by the Company in December 2012, historically, the Company has not paid any cash dividends. Subject to certain exceptions, the Company's Credit Facility limits the ability of the Company's subsidiaries to pay dividends and make distributions to the Company, and limits the Company's ability to pay dividends and/or repurchase stock, to an amount not to exceed $200 million in the aggregate plus an additional $25 million in any particular year plus the aggregate amount of proceeds from the exercise of stock options, subject to certain restrictions. The indentures governing each series of our outstanding notes also restrict the Company's subsidiaries from, among other matters, paying dividends and making distributions to the Company, which thereby limits the Company's ability to pay dividends and/or repurchase stock. As of September 30, 2018, under the most restrictive test in these agreements (and subject to certain exceptions), the Company has approximately $200 million available with which to pay permitted dividends and/or repurchase shares of stock or make other restricted payments.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The following schedule presents the reconciliation of the carrying amount of total equity, equity attributable to the Company, and equity attributable to the noncontrolling interests for the nine-month period ended September 30, 2018 (in millions):

		Community Health Systems, Inc. Stockholders					
	Redeemable Noncontrolling Interest	Common Stock	Additional Paid-In Capital	Accumulated Other Comprehensive Income (Loss)	Accumulated Deficit	Noncontrolling Interest	Total Stockholders' Deficit
Balance, December 31, 2017	$ 527	$ 1	$ 2,014	$ (21)	$ (2,761)	$ 75	$ (692)
Comprehensive income (loss)	32	-	-	25	(460)	23	(412)
Adoption of new accounting standards	-	-	-	(12)	12	-	-
Contributions from noncontrolling interests	-	-	-	-	-	2	2
Distributions to noncontrolling interests	(53)	-	-	-	-	(21)	(21)
Purchase of subsidiary shares from noncontrolling interests	(24)	-	(5)	-	-	(3)	(8)
Other reclassifications of noncontrolling interests	1	-	-	-	-	(1)	(1)
Noncontrolling interests in acquired entity	6	-	-	-	-	-	-
Adjustment to redemption value of redeemable noncontrolling interests	6	-	(6)	-	-	-	(6)
Cancellation of restricted stock for tax withholdings on vested shares	-	-	(2)	-	-	-	(2)
Share-based compensation	-	-	10	-	-	-	10
Balance, September 30, 2018	$ 495	$ 1	$ 2,011	$ (8)	$ (3,209)	$ 75	$ (1,130)

The following schedule discloses the effects of changes in the Company's ownership interest in its less-than-wholly-owned subsidiaries on Community Health Systems, Inc. stockholders' deficit (in millions):

	Nine Months Ended September 30, 2018
Net loss attributable to Community Health Systems, Inc. stockholders	$ (460)
Transfers from the noncontrolling interests:	
Net decrease in Community Health Systems, Inc. paid-in-capital for purchase of subsidiary partnership interests	(5)
Net transfers from the noncontrolling interests	(5)
Change to Community Health Systems, Inc. stockholders' deficit from net loss attributable to Community Health Systems, Inc. stockholders and transfers to noncontrolling interests	$ (465)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

10. LONG-TERM DEBT

Long-term debt, net of unamortized debt issuance costs and discounts or premiums, consists of the following (in millions):

	September 30, 2018	December 31, 2017
Credit Facility:		
Term G Loan	$ -	$ 1,037
Term H Loan	1,722	1,903
8% Senior Notes due 2019	155	1,925
7 1/8% Senior Notes due 2020	121	1,200
5 1/8% Senior Secured Notes due 2021	1,000	1,000
6 7/8% Senior Notes due 2022	2,632	3,000
6 1/4% Senior Secured Notes due 2023	3,100	3,100
8 5/8% Secured Notes due 2024	1,033	-
Junior-Priority Secured Notes due 2023	1,770	-
Junior-Priority Secured Notes due 2024	1,355	-
Receivables Facility	-	565
ABL Facility	538	-
Capital lease obligations	270	304
Other	48	48
Less: Unamortized deferred debt issuance costs and note premium	(174)	(169)
Total debt	13,570	13,913
Less: Current maturities	(35)	(33)
Total long-term debt	$ 13,535	$ 13,880

Credit Facility

The Company's wholly-owned subsidiary, CHS/Community Health Systems, Inc. ("CHS"), has senior secured financing under a credit facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent (the "Credit Facility"), which at December 31, 2017 included (i) a revolving credit facility with commitments through January 27, 2019 of approximately $929 million, of which a $739 million portion represented extended commitments maturing January 27, 2021 (the "Revolving Facility"), (ii) a Term G facility due 2019 (the "Term G Facility"), and (iii) a Term H facility due 2021 (the "Term H Facility). The Revolving Facility includes a subfacility for letters of credit.

The loans under the Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at CHS' option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the NYFRB Rate (as defined) plus 0.50% or (3) the adjusted London Interbank Offered Rate ("LIBOR") on such day for a three-month interest period commencing on the second business day after such day plus 1% or (b) LIBOR. In addition, the margin in respect of the Revolving Facility will be subject to adjustment determined by reference to a leverage-based pricing grid. Based on our current leverage, loans in respect of the Revolving Facility currently accrue interest at a rate per annum equal to LIBOR plus 2.75%, in the case of LIBOR borrowings, and Alternate Base Rate plus 1.75%, in the case of Alternate Base Rate borrowings. Prior to the Credit Facility amendment discussed below, the Term G Loan and Term H Loan accrued interest at a rate per annum equal to LIBOR plus 2.75% and 3.00%, respectively, in the case of LIBOR borrowings, and Alternate Base Rate plus 1.75% and 2.00%, respectively, in the case of Alternate Base Rate borrowings. The Term G Loan and the Term H Loan are subject to a 1.00% LIBOR floor and a 2.00% Alternate Base Rate floor.

Under the Term H Facility, CHS is required to make amortization payments in aggregate amounts equal to 1% of the original principal amount of the Term H Facility each year. After December 31, 2016, no additional amortization payments were required to be made under the Term G Facility.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The term loan facility must be prepaid in an amount equal to (1) 100% of the net cash proceeds of certain asset sales and dispositions by the Company and its subsidiaries, subject to certain exceptions and reinvestment rights (as further described below), (2) 100% of the net cash proceeds of issuances of certain debt obligations or receivables-based financing by the Company and its subsidiaries, subject to certain exceptions, and (3) 75%, subject to reduction to a lower percentage based on the Company's first lien net leverage ratio (as defined in the Credit Facility generally as the ratio of first lien net debt on the date of determination to the Company's consolidated EBITDA, as defined, for the four quarters most recently ended prior to such date), of excess cash flow (as defined) for any year, subject to certain exceptions. Voluntary prepayments and commitment reductions are permitted in whole or in part, without any premium or penalty, subject to minimum prepayment or reduction requirements.

The borrower under the Credit Facility is CHS. All of the obligations under the Credit Facility are unconditionally guaranteed by the Company and certain of its existing and subsequently acquired or organized domestic subsidiaries. All obligations under the Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of the Company, CHS and each subsidiary guarantor, including equity interests held by the Company, CHS or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries, and subject to the ABL Facility as described in Note 15. Such assets constitute substantially the same assets, subject to certain exceptions, that secure (i) on a first lien basis CHS' obligations under the 2021 Senior Secured Notes and the 6¼% Senior Secured Notes and the 8⅝% Senior Secured Notes (in each case, as defined below) and (ii) on a junior-priority basis the 2023 Junior-Priority Notes (as defined below) and the 2024 Junior-Priority Notes (in each case, as defined below).

CHS has agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to LIBOR borrowings under the Revolving Facility times the maximum aggregate amount available to be drawn under all letters of credit outstanding under the subfacility for letters of credit. The issuer of any letter of credit issued under the subfacility for letters of credit will also receive a customary fronting fee and other customary processing charges. CHS is obligated to pay commitment fees of 0.50% per annum (subject to adjustment based upon the Company's leverage ratio) on the unused portion of the Revolving Facility.

The Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting the Company's and its subsidiaries' ability, subject to certain exceptions, to, among other things (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of the Company's businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change the Company's fiscal year. The Company is also required to comply with specified financial covenants (consisting of a first lien net debt to consolidated EBITDA leverage ratio) and various affirmative covenants. Under the Credit Facility, the first lien net debt to consolidated EBITDA ratio is calculated as the ratio of total first lien debt, less unrestricted cash and cash equivalents, to consolidated EBITDA, as defined in the Credit Facility. The calculation of consolidated EBITDA as defined in the Credit Facility is a trailing 12-month calculation that begins with net income attributable to the Company, with certain pro forma adjustments to consider the impact of material acquisitions or divestitures, and adjustments for interest, taxes, depreciation and amortization, net income attributable to noncontrolling interests, stock compensation expense, restructuring costs, and the financial impact of other non-cash or non-recurring items recorded during any such 12-month period. For the 12-month period ended September 30, 2018, the first lien net debt to consolidated EBITDA ratio financial covenant under the Credit Facility limited the ratio of first lien net debt to consolidated EBITDA, as defined, to less than or equal to 5.0 to 1.0. The Company was in compliance with all such covenants at September 30, 2018, with a first lien net debt to consolidated EBITDA ratio of approximately 4.6 to 1.0.

Events of default under the Credit Facility include, but are not limited to, (1) CHS' failure to pay principal, interest, fees or other amounts under the credit agreement when due (taking into account any applicable grace period), (2) any representation or warranty proving to have been materially incorrect when made, (3) covenant defaults subject, with respect to certain covenants, to an available cure, (4) bankruptcy and insolvency events, (5) a cross default to certain other debt, (6) certain undischarged judgments (not paid within an applicable grace period), (7) a change of control (as defined), (8) certain ERISA-related defaults and (9) the invalidity or impairment of specified security interests, guarantees or subordination provisions in favor of the administrative agent or lenders under the Credit Facility.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

As of September 30, 2018, the availability for additional borrowings under the Credit Facility, subject to certain limitations as set forth in the Credit Facility, was approximately $425 million pursuant to the Revolving Facility, of which $86 million is in the form of outstanding letters of credit. CHS has the ability to amend the Credit Facility to provide for one or more tranches of term loans or increases in the Revolving Facility in an aggregate principal amount of up to $500 million. As of September 30, 2018, the weighted-average interest rate under the Credit Facility, excluding swaps, was 6.5%.

2018 Financing Activity

On February 26, 2018, the Credit Facility was amended, with requisite revolving lender approval, to remove the consolidated EBITDA to interest expense ratio financial covenant, to replace the senior secured net debt to consolidated EBITDA ratio financial covenant with a first lien net debt to consolidated EBITDA ratio financial covenant, and to reduce the extended revolving credit commitments to $650 million (for a total of $840 million in revolving credit commitments when combined with the non-extended portion of the revolving credit facility). The new financial covenant provides for a maximum first lien net debt to consolidated EBITDA ratio of 5.25 to 1.0, reducing to 5.0 to 1.0 on July 1, 2018, 4.75 to 1.0 on January 1, 2019, 4.5 to 1.0 on January 1, 2020 and 4.25 to 1.0 on July 1, 2020. In addition, the Company agreed pursuant to the amendment to modify its ability to retain asset sale proceeds, and instead to apply them to prepayments of term loans based on pro forma first lien leverage. To the extent the pro forma ratio of first lien net debt to consolidated EBITDA is greater than or equal to 4.5 to 1.0, 100% of net cash proceeds of asset sales will be applied to prepay term loans; to the extent the pro forma first lien leverage ratio is less than 4.5 to 1.0 but greater than or equal to 4.0 to 1.0, 50% of such proceeds will be applied to prepay term loans; and to the extent the first lien leverage ratio is less than 4.0 to 1.0, there will be no requirement to prepay term loans with such proceeds. These ratios will be determined on a pro forma basis giving appropriate effect to the relevant asset sales and corresponding prepayments of term loans.

On March 23, 2018, the Company and CHS entered into the Fourth Amendment and Restatement Agreement to the Credit Facility (the "Agreement"). In addition to including the changes described in the paragraph above, the Company further modified its ability to retain asset sale proceeds, and instead to apply them to prepayments of term loans based on pro forma first lien leverage. To the extent the pro forma ratio of first lien net debt to consolidated EBITDA is greater than or equal to 4.25 to 1.0, 100% of net cash proceeds of asset sales will be applied to prepay term loans; to the extent the pro forma first lien leverage ratio is less than 4.25 to 1.0 but greater than or equal to 3.75 to 1.0, 50% of such proceeds will be applied to prepay term loans; and to the extent the first lien leverage ratio is less than 3.75 to 1.0, there will be no requirement to prepay term loans with such proceeds. The Agreement also amended the Credit Facility to permit CHS to incur debt under either an asset-based loan ("ABL") facility in an amount up to $1.0 billion or maintain its Asset-Backed Securitization program. The Revolving Facility would be reduced to $425 million upon the effectiveness of the contemplated ABL facility. The Agreement also reduced the availability for incremental tranches of term loans or increases in the Revolving Facility to $500 million and removed the secured net leverage incurrence test with respect to junior secured debt. Term G Loans will accrue interest at a rate per annum initially equal to LIBOR plus 3.00%, in the case of LIBOR borrowings, and Alternate Base Rate plus 2.00%, in the case of Alternate Base Rate borrowing. Term H Loans will accrue interest at a rate per annum initially equal to LIBOR plus 3.25%, in the case of LIBOR borrowings, and Alternate Base Rate plus 2.25%, in the case of Alternate Base Rate borrowing.

On April 3, 2018, the Company and CHS entered into an asset-based loan (ABL) credit agreement (the "ABL Credit Agreement") (as further described below), with JPMorgan Chase Bank, N.A., as administrative agent, and the lenders and other agents party thereto. Pursuant to the ABL Credit Agreement, the lenders have extended to CHS a revolving asset-based loan facility (the "ABL Facility") in the maximum aggregate principal amount of $1.0 billion, subject to borrowing base capacity. The ABL facility includes borrowing capacity available for letters of credit of $50 million. CHS and all domestic subsidiaries of CHS that guarantee CHS' other outstanding senior and senior secured indebtedness guarantee the obligations of CHS under the ABL Facility. In conjunction with the closing of the ABL Facility, the wholly-owned special-purpose entity that owned the Receivables pledged under the previous Receivables Facility became a subsidiary guarantor under the Credit Facility and CHS' outstanding notes. Subject to certain exceptions, all obligations under the ABL Facility and the related guarantees are secured by a perfected first-priority security interest in substantially all of the Receivables, deposit, collection and other accounts and contract rights, books, records and other instruments related to the foregoing of the Company, CHS and the guarantors as well as a perfected junior-priority security interest in substantially all of the other assets of the Company, CHS and the guarantors, subject to customary exceptions and intercreditor arrangements. The revolving credit commitments under the Credit Facility were reduced to $425 million upon the effectiveness of the ABL Facility. In connection with entering into the ABL Credit Agreement and the ABL Facility, the Company repaid in full and terminated its Receivables Facility. The outstanding borrowings pursuant to the ABL Facility at September 30, 2018 totaled $538 million on the condensed consolidated balance sheet.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Borrowings under the ABL Facility bear interest at a rate per annum equal to an applicable percentage, plus, at the Borrower's option, either (a) an Alternative base rate or (b) a LIBOR rate. From and after December 31, 2018, the applicable percentage under the ABL Facility will be determined based on excess availability as a percentage of the maximum commitment amount under the ABL facility at a rate per annum of 1.25%, 1.50% and 1.75% for loans based on the Alternative base rate and 2.25%, 2.50% and 2.75% for loans based on the LIBOR rate. From and after September 30, 2018, the applicable commitment fee rate under the ABL Facility is determined based on average utilization as a percentage of the maximum commitment amount under the ABL Facility at a rate per annum of either 0.50% or 0.625% times the unused portion of the ABL facility.

Principal amounts outstanding under the ABL Facility will be due and payable in full on April 3, 2023. The ABL Facility includes a 91-day springing maturity applicable if more than $250 million in the aggregate principal amount of the Borrower's 8% Senior Notes due 2019, Term G loans due 2019, 7.125% Senior Notes due 2020, Term H loans due 2021, 5.125% Senior Secured Notes due 2021, 6.875% Senior Notes due 2022 or 6.25% Senior Secured Notes due 2023 or refinancings thereof are scheduled to mature or similarly become due on a date prior to April 3, 2023.

On June 22, 2018, CHS completed its previously announced offers to exchange certain of its outstanding senior unsecured notes due 2019, 2020 and 2022 for new junior-priority secured notes due 2023 and 2024, the terms and amounts of which are further discussed below.

On July 6, 2018, CHS completed a private offering of $1.033 billion aggregate principal amount of 8 5⁄8% Senior Secured Notes due 2024 (the "8 5⁄8% Senior Secured Notes"). The terms of the 8 5⁄8% Senior Secured Notes are discussed below. Using the proceeds from the offering, the Company repaid the outstanding balance owed under the Term G Loan and paid fees and expenses related to the offering.

8% Senior Notes due 2019

On November 22, 2011, CHS completed a private offering of $1.0 billion aggregate principal amount of 8% Senior Notes due 2019 (the "8% Senior Notes"). The net proceeds from this issuance, together with available cash on hand, were used to finance the purchase of up to $1.0 billion aggregate principal amount of CHS' then outstanding 8 7⁄8% Senior Notes due 2015 and related fees and expenses. On March 21, 2012, CHS completed an offering of an additional $1.0 billion aggregate principal amount of 8% Senior Notes, which were issued in a private placement (at a premium of 102.5%). The net proceeds from this issuance were used to finance the purchase of approximately $850 million aggregate principal amount of CHS' then outstanding 8 7⁄8% Senior Notes due 2015, to pay related fees and expenses and for general corporate purposes. The 8% Senior Notes bear interest at 8% per annum, payable semiannually in arrears on May 15 and November 15. Interest on the 8% Senior Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

CHS is entitled, at its option, to redeem all or a portion of the 8% Senior Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the period set forth below:

Period	Redemption Price
November 15, 2017 to November 14, 2019	100.000 %

Pursuant to a registration rights agreement entered into at the time of the issuance of the 8% Senior Notes, as a result of an exchange offer made by CHS, substantially all of the 8% Senior Notes issued in November 2011 and March 2012 were exchanged in May 2012 for new notes (the "8% Exchange Notes") having terms substantially identical in all material respects to the 8% Senior Notes (except that the 8% Exchange Notes were issued under a registration statement pursuant to the Securities Act of 1933, as amended (the "1933 Act")). References to the 8% Senior Notes shall also be deemed to include the 8% Exchange Notes unless the context provides otherwise.

On June 22, 2018, CHS issued approximately $1.770 billion aggregate principal amount of new Junior-Priority Secured Notes due 2023 (the "2023 Junior-Priority Notes") in exchange for the same amount of 8% Senior Notes. The terms of the 2023 Junior-Priority Notes are described below. Following this exchange, CHS had $155 million aggregate principal amount of 8% Senior Notes outstanding.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

7 1/8% Senior Notes due 2020

On July 18, 2012, CHS completed a public offering of 7 1/8% Senior Notes due 2020 (the "7 1/8% Senior Notes"). The net proceeds from this issuance were used to finance the purchase or redemption of $934 million aggregate principal amount of CHS' then outstanding 8 7/8% Senior Notes due 2015, to pay for consents delivered in connection with a related tender offer, to pay related fees and expenses, and for general corporate purposes. The 7 1/8% Senior Notes bear interest at 7.125% per annum, payable semiannually in arrears on July 15 and January 15. Interest on the 7 1/8% Senior Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

CHS is entitled, at its option, to redeem all or a portion of the 7 1/8% Senior Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the period set forth below:

Period	Redemption Price
July 15, 2018 to July 14, 2020	100.000 %

On June 22, 2018, CHS issued approximately $1.079 billion aggregate principal amount of new Junior-Priority Secured Notes due 2024 (the "2024 Junior-Priority Notes") in exchange for the same amount of 7 1/8% Senior Notes. The terms of the 2024 Junior-Priority Notes are described below. Following this exchange, CHS had $121 million aggregate principal amount of 7 1/8% Senior Notes outstanding.

5 1/8% Senior Secured Notes due 2021

On January 27, 2014, CHS completed a private offering of $1.0 billion aggregate principal amount of 5 1/8% Senior Secured Notes due 2021 (the "2021 Senior Secured Notes"). The net proceeds from this issuance were used to finance the HMA merger. The 2021 Senior Secured Notes bear interest at 5.125% per annum, payable semiannually in arrears on February 1 and August 1. Interest on the 2021 Senior Secured Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

The 2021 Senior Secured Notes and the related guarantees are secured by (i) first-priority liens on the collateral (the "Non-ABL Priority Collateral") that also secures on a first-priority basis the Credit Facilities (subject to certain exceptions), the 6 1/4% Senior Secured Notes and the 8 5/8% Senior Secured Notes and (ii) second-priority liens on the collateral (the "ABL-Priority Collateral") that secures on a first-priority basis the ABL Facility (and also secures on a second-priority basis the Credit Facilities and the 6 1/4% Senior Secured Notes and the 8 5/8% Senior Secured Notes), in each case subject to permitted liens described in the indenture governing the 2021 Senior Secured Notes.

CHS is entitled, at its option, to redeem all or a portion of the 2021 Senior Secured Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
February 1, 2018 to January 31, 2019	102.563 %
February 1, 2019 to January 31, 2020	101.281 %
February 1, 2020 to January 31, 2021	100.000 %

Pursuant to a registration rights agreement entered into at the time of the issuance of the 2021 Senior Secured Notes, as a result of an exchange offer made by CHS, all of the 2021 Senior Secured Notes issued in January 2014 were exchanged in October 2014 for new notes (the "2021 Exchange Notes") having terms substantially identical in all material respects to the 2021 Senior Secured Notes (except that the exchange notes were issued under a registration statement pursuant to the 1933 Act). References to the 2021 Senior Secured Notes shall be deemed to be the 2021 Exchange Notes unless the context provides otherwise.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

6 7/8% Senior Notes due 2022

On January 27, 2014, CHS completed a private offering of $3.0 billion aggregate principal amount of 6 7/8% Senior Notes due 2022 (the "6 7/8% Senior Notes"). The net proceeds from this issuance were used to finance the HMA merger. The 6 7/8% Senior Notes bear interest at 6.875% per annum, payable semiannually in arrears on February 1 and August 1. Interest on the 6 7/8% Senior Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

CHS is entitled, at its option, to redeem all or a portion of the 6 7/8% Senior Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
February 1, 2018 to January 31, 2019	103.438 %
February 1, 2019 to January 31, 2020	101.719 %
February 1, 2020 to January 31, 2022	100.000 %

Pursuant to a registration rights agreement entered into at the time of the issuance of the 6 7/8% Senior Notes, as a result of an exchange offer made by CHS, all of the 6 7/8% Senior Notes issued in January 2014 were exchanged in October 2014 for new notes (the "6 7/8% Exchange Notes") having terms substantially identical in all material respects to the 6 7/8% Senior Notes (except that the exchange notes were issued under a registration statement pursuant to the 1933 Act). References to the 6 7/8% Senior Notes shall be deemed to be the 6 7/8% Exchange Notes unless the context provides otherwise.

On June 22, 2018, CHS issued approximately $276 million aggregate principal amount of the 2024 Junior-Priority Notes in exchange for approximately $368 million of 6 7/8% Senior Notes. Following this exchange, CHS had $2.632 billion aggregate principal amount of 6 7/8% Senior Notes outstanding.

6 1/4% Senior Secured Notes due 2023

On March 16, 2017, CHS completed a public offering of $2.2 billion aggregate principal amount of 6 1/4% Senior Secured Notes due 2023 (the "6 1/4% Senior Secured Notes"). The net proceeds from this issuance were used to finance the purchase or redemption of $700 million aggregate principal amount of CHS' then outstanding 2018 Senior Secured Notes and related fees and expenses, and the repayment of $1.445 billion of the Term F Facility. On May 12, 2017, CHS completed a tack-on offering of $900 million aggregate principal amount of 6 1/4% Senior Secured Notes, increasing the total aggregate principal amount of 6 1/4% Senior Secured Notes to $3.1 billion. A portion of the net proceeds from this issuance were used to finance the repayment of approximately $713 million aggregate principal amount of CHS' then outstanding Term A Facility and related fees and expenses. The tack-on notes have identical terms, other than issue date and issue price as the 6 1/4% Senior Secured Notes issued on March 16, 2017. The 6 1/4% Senior Secured Notes bear interest at 6.250% per annum, payable semiannually in arrears on March 31 and September 30, commencing September 30, 2017. Interest on the 6 1/4% Senior Secured Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

The 6 1/4% Senior Secured Notes and the related guarantees are secured by (i) first-priority liens on the Non-ABL Priority Collateral that also secures on a first-priority basis the Credit Facilities (subject to certain exceptions), the 2021 Senior Secured Notes and the 8 5/8% Senior Secured Notes and (ii) second-priority liens on the ABL-Priority Collateral that secures on a first-priority basis the ABL Facility (and also secures on a second-priority basis the Credit Facilities and the 2021 Senior Secured Notes and the 8 5/8% Senior Secured Notes), in each case subject to permitted liens described in the indenture governing the 6 1/4% Senior Secured Notes.

CHS is entitled, at its option, to redeem all or a portion of the 6 1/4% Senior Secured Notes at any time prior to March 31, 2020, upon not less than 30 nor more than 60 days' notice, at a price equal to 100% of the principal amount of the 6 1/4% Senior Secured Notes redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the indenture governing the 6 1/4% Senior Secured Notes. In addition, CHS may redeem up to 40% of the aggregate principal amount of the 6 1/4% Senior Secured Notes at any time prior to March 31, 2020 using the net proceeds from certain equity offerings at the redemption price of 106.250% of the principal amount of the 6 1/4% Senior Secured Notes redeemed, plus accrued and unpaid interest, if any.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

CHS may redeem some or all of the 6 ¼% Senior Secured Notes at any time on or after March 31, 2020 upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
March 31, 2020 to March 30, 2021	103.125 %
March 31, 2021 to March 30, 2022	101.563 %
March 31, 2022 to March 30, 2023	100.000 %

Junior-Priority Secured Notes due 2023

On June 22, 2018, CHS completed a private offering of $1.770 billion aggregate principal amount of the 2023 Junior-Priority Notes in exchange for the same amount of 8% Senior Notes. The 2023 Junior-Priority Notes bear interest at (i) 11% per annum from June 22, 2018 to, but excluding, June 22, 2019 and (ii) 9 ⅞% per annum from June 22, 2019 until maturity, payable semiannually in arrears on June 30 and December 31. Interest on the 2023 Junior-Priority Notes accrues from the date of original issuance with the first interest payment date on December 31, 2018. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

The 2023 Junior-Priority Notes and the related guarantees are secured by (i) second-priority liens on the Non-ABL Priority Collateral that secures on a first-priority basis the Credit Facilities (subject to certain exceptions), the 2021 Senior Secured Notes, the 6 ¼% Senior Secured Notes and the 8 ⅝% Senior Secured Notes and (ii) third-priority liens on the ABL-Priority Collateral that secures on a first-priority basis the ABL Facility (and also secures on a second-priority basis the Credit Facilities, the 2021 Senior Secured Notes, the 6 ¼% Senior Secured Notes and the 8 ⅝% Senior Secured Notes), in each case subject to permitted liens described in the indenture governing the 2023 Junior-Priority Notes.

Prior to June 30, 2020, CHS may redeem some or all of the 2023 Junior-Priority Notes at a redemption price equal to 100% of the principal amount of the notes redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the indenture governing the 2023 Junior-Priority Notes. After June 30, 2020, CHS is entitled, at its option, to redeem all or a portion of the 2023 Junior-Priority Notes upon not less than 15 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
June 30, 2020 to June 29, 2021	107.406 %
June 30, 2021 to June 29, 2022	103.703 %
June 30, 2022 to June 29, 2023	100.000 %

In addition, at any time prior to June 30, 2020, CHS may redeem up to 40% of the aggregate principal amount of the 2023 Junior-Priority Notes with the proceeds of certain equity offerings at 109.875%, plus accrued and unpaid interest, if any, to, but excluding, the applicable redemption date.

Junior-Priority Secured Notes due 2024

On June 22, 2018, CHS completed a private offering of $1.355 billion aggregate principal amount of the 2024 Junior-Priority Notes in exchange for approximately $1.079 billion of 7 ⅛% Senior Notes and approximately $368 million of 6 ⅞% Senior Notes. The 2024 Junior-Priority Notes bear interest at a rate of 8 ⅛% per annum, payable semiannually in arrears on June 30 and December 31. Interest on the 2024 Junior-Priority Notes accrues from the date of original issuance with the first interest payment date on December 31, 2018. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The 2024 Junior-Priority Notes and the related guarantees are secured by (i) second-priority liens on the Non-ABL Priority Collateral that secures on a first-priority basis the Credit Facilities (subject to certain exceptions), the 2021 Senior Secured Notes, the 6 ¼% Senior Secured Notes and the 8 ⅝% Senior Secured Notes and (ii) third-priority liens on the ABL-Priority Collateral that secures on a first-priority basis the ABL Facility (and also secures on a second-priority basis the Credit Facilities, the 2021 Senior Secured Notes, the 6 ¼% Senior Secured Notes and the 8 ⅝% Senior Secured Notes), in each case subject to permitted liens described in the indenture governing the 2024 Junior-Priority Notes.

Prior to June 30, 2021, CHS may redeem some or all of the 2024 Junior-Priority Notes at a redemption price equal to 100% of the principal amount of the notes redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the indenture governing the 2024 Junior-Priority Notes. After June 30, 2021, CHS is entitled, at its option, to redeem all or a portion of the 2024 Junior-Priority Notes upon not less than 15 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
June 30, 2021 to June 29, 2022	104.063 %
June 30, 2022 to June 29, 2023	102.031 %
June 30, 2023 to June 29, 2024	100.000 %

In addition, at any time prior to June 30, 2021, CHS may redeem up to 40% of the aggregate principal amount of the 2024 Junior-Priority Notes with the proceeds of certain equity offerings at 108.125%, plus accrued and unpaid interest, if any, to, but excluding, the applicable redemption date.

The indentures governing each of the 2023 Junior-Priority Notes and 2024 Junior-Priority Notes also prohibit CHS from purchasing, repurchasing, redeeming, defeasing or otherwise acquiring or retiring any outstanding 8% Senior Notes and 7 ⅛% Senior Notes after the consummation of the exchange offers described above with: (a) cash or cash equivalents on hand as of the consummation of such exchange offers; (b) cash generated from operations; (c) proceeds from assets sales; or (d) proceeds from the issuance of, or in exchange for, secured debt, in each case, prior to the date that is 60 days prior to the relevant maturity dates of such 8% Senior Notes and 7 ⅛% Senior Notes, as applicable.

8 ⅝% Senior Secured Notes due 2024

On July 6, 2018, CHS completed a private offering of $1.033 billion aggregate principal amount of the 8 ⅝% Senior Secured Notes". The terms of the 8 ⅝% Senior Secured Notes are governed by an indenture, dated as of July 6, 2018, among CHS, the Company, the subsidiary guarantors party thereto, Regions Bank, as trustee and Credit Suisse AG, as collateral agent. The 8 ⅝% Senior Secured Notes bear interest at a rate of 8 ⅝% per year payable semi-annually in arrears on January 15 and July 15 of each year, commencing on January 15, 2019. The Notes are unconditionally guaranteed on a senior-priority secured basis by the Company and each of the CHS current and future domestic subsidiaries that provide guarantees under CHS, senior secured credit facilities, CHS, ABL facility, any capital market debt securities of CHS (including CHS, outstanding senior notes) and certain other long-term debt of CHS.

The 8 ⅝% Senior Secured Notes and the related guarantees are secured by (i) first-priority liens on the Non-ABL Priority Collateral that also secures on a first-priority basis the Credit Facilities (subject to certain exceptions), the 2021 Senior Secured Notes and the 6 ¼% Senior Secured Notes and (ii) second-priority liens on the ABL-Priority Collateral that secures on a first-priority basis the ABL Facility (and also secures on a second-priority basis the Credit Facilities and the 2021 Senior Secured Notes and the 6 ¼% Senior Secured Notes), in each case subject to permitted liens described in the indenture governing the 8 ⅝% Senior Secured Notes.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Prior to January 15, 2021, CHS may redeem some or all of the 8⅝% Senior Secured Notes at a redemption price equal to 100% of the principal amount of the notes redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the indenture governing the 8⅝% Senior Secured Notes. After January 15, 2021, CHS is entitled, at its option, to redeem all or a portion of the 8⅝% Senior Secured Notes upon not less than 15 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
January 15, 2021 to January 14, 2022	104.313 %
January 15, 2022 to January 14, 2023	102.156 %
January 15, 2023 to January 14, 2024	100.000 %

In addition, at any time prior to January 15, 2021, CHS may redeem up to 40% of the aggregate principal amount of the 8⅝% Senior Secured Notes with the proceeds of certain equity offerings at 108.625%, plus accrued and unpaid interest, if any, to, but excluding, the applicable redemption date.

Receivables Facility

Prior to the effectiveness of the ABL Facility described above, CHS, through certain of its subsidiaries, participated in an accounts receivable loan agreement (the "Receivables Facility") with a group of lenders and banks, Credit Agricolé Corporate and Investment Bank, as a managing agent and as the administrative agent. Patient-related accounts receivable (the "Receivables") for certain affiliated hospitals served as collateral for the outstanding borrowings under the Receivables Facility. The interest rate on the borrowings was based on the commercial paper rate plus an applicable interest rate spread. The Receivables Facility was repaid in full and terminated upon the effectiveness of the ABL Facility on April 3, 2018.

Loss (Gain) from Early Extinguishment of Debt

The financing and repayment transactions discussed above resulted in a loss from early extinguishment of debt of $27 million and $4 million for the three months ended September 30, 2018 and 2017, respectively, and an after-tax loss of $21 million and after-tax loss of $2 million for the three months ended September 30, 2018 and 2017, respectively. Gain from early extinguishment of debt was $32 million and a loss from early extinguishment of debt of $35 million for the nine months ended September 30, 2018 and 2017, respectively, and an after-tax gain of $25 million and an after-tax loss of $22 million for the nine months ended September 30, 2018 and 2017, respectively.

Other Debt

As of September 30, 2018, other debt consisted primarily of other obligations maturing in various installments through 2028.

To limit the effect of changes in interest rates on a portion of the Company's long-term borrowings, the Company is a party to six separate interest swap agreements in effect at September 30, 2018, with an aggregate notional amount for currently effective swaps of $1.5 billion. On each of these swaps, the Company receives a variable rate of interest based on the three-month LIBOR in exchange for the payment of a fixed rate of interest. See Note 11 for additional information regarding these swaps.

The Company paid interest of $151 million and $221 million on borrowings during the three months ended September 30, 2018 and 2017, respectively, and $637 million and $630 million for the nine months ended September 30, 2018 and 2017, respectively.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

11. FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Company using available market information as of September 30, 2018 and December 31, 2017, and valuation methodologies considered appropriate. The estimates presented in the table below are not necessarily indicative of amounts the Company could realize in a current market exchange (in millions):

	September 30, 2018		December 31, 2017	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Assets:				
Cash and cash equivalents	$ 335	$ 335	$ 563	$ 563
Investments in equity securities	147	147	-	-
Available-for-sale securities	115	115	252	252
Trading securities	-	-	37	37
Liabilities:				
Contingent Value Right	-	-	2	2
Credit Facility	1,699	1,698	2,902	2,826
8% Senior Notes due 2019	155	151	1,922	1,637
7⅛% Senior Notes due 2020	121	107	1,192	897
5⅛% Senior Secured Notes due 2021	982	974	978	902
6⅞% Senior Notes due 2022	2,590	1,486	2,943	1,729
6¼% Senior Secured Notes due 2023	3,066	2,949	3,061	2,800
Junior-Priority Secured Notes due 2023	1,749	1,600	-	-
Junior-Priority Secured Notes due 2024	1,337	1,135	-	-
8⅝% Secured Notes due 2024	1,021	1,074	-	-
ABL Facility and other debt	580	580	611	611

The carrying value of the Company's long-term debt in the above table is presented net of unamortized deferred debt issuance costs. The estimated fair value is determined using the methodologies discussed below in accordance with accounting standards related to the determination of fair value based on the U.S. GAAP fair value hierarchy as discussed in Note 12. The estimated fair value for financial instruments with a fair value that does not equal its carrying value is considered a Level 1 valuation. The Company utilizes the market approach and obtains indicative pricing from the administrative agent to the Credit Facility to determine fair values or through publicly available subscription services such as Bloomberg where relevant.

Cash and cash equivalents. The carrying amount approximates fair value due to the short-term maturity of these instruments (less than three months).

Investments in equity securities. Estimated fair value is based on closing price as quoted in public markets.

Available-for-sale securities. Estimated fair value is based on closing price as quoted in public markets or other various valuation techniques.

Trading securities. Estimated fair value is based on closing price as quoted in public markets.

Contingent Value Right. Estimated fair value is based on the closing price as quoted on the public market where the CVR is traded.

Credit Facility. Estimated fair value is based on publicly available trading activity and supported with information from the Company's bankers regarding relevant pricing for trading activity among the Company's lending institutions.

8% Senior Notes due 2019. Estimated fair value is based on the closing market price for these notes.

7⅛% Senior Notes due 2020. Estimated fair value is based on the closing market price for these notes.

5⅛% Senior Secured Notes due 2021. Estimated fair value is based on the closing market price for these notes.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

6 7/8% Senior Notes due 2022. Estimated fair value is based on the closing market price for these notes.

6 1/4% Senior Secured Notes due 2023. Estimated fair value is based on the closing market price for these notes.

Junior-Priority Secured Notes due 2023. Estimated fair value is based on the closing market price for these notes.

Junior-Priority Secured Notes due 2024. Estimated fair value is based on the closing market price for these notes.

8 5/8% Secured Notes due 2024. Estimated fair value is based on the closing market price for these notes.

ABL Facility and other debt. The carrying amount of the ABL Facility and all other debt (which, at December 31, 2017 includes the Receivables Facility) approximates fair value due to the nature of these obligations.

Interest rate swaps. The fair value of interest rate swap agreements is the amount at which they could be settled, based on estimates calculated by the Company using a discounted cash flow analysis based on observable market inputs and validated by comparison to estimates obtained from the counterparty. The Company incorporates credit valuation adjustments ("CVAs") to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. In adjusting the fair value of its interest rate swap agreements for the effect of nonperformance or credit risk, the Company has considered the impact of any netting features included in the agreements.

The Company assesses the effectiveness of its hedge instruments on a quarterly basis. For the nine months ended September 30, 2018 and 2017, the Company completed an assessment of the cash flow hedge instruments and determined the hedges to be highly effective. The Company has also determined that the ineffective portion of the hedges do not have a material effect on the Company's condensed consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements expose the Company to credit risk in the event of nonperformance by such counterparties. However, at September 30, 2018, the Company does not anticipate nonperformance by these counterparties. The Company does not hold or issue derivative financial instruments for trading purposes.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Interest rate swaps consisted of the following at September 30, 2018:

Swap #	Notional Amount (in millions)	Fixed Interest Rate	Termination Date	Asset (Liability) Fair Value (in millions)
1	$ 200	2.515%	August 30, 2019	$ -
2	200	2.613%	August 30, 2019	-
3	300	2.738%	August 30, 2020	1
4	300	2.892%	August 30, 2020	-
5	300	2.363%	January 27, 2021	4
6	200	2.368%	January 27, 2021	3

The Company is exposed to certain risks relating to its ongoing business operations. The risk managed by using derivative instruments is interest rate risk. Interest rate swaps are entered into to manage interest rate fluctuation risk associated with the term loans in the Credit Facility. Companies are required to recognize all derivative instruments as either assets or liabilities at fair value in the condensed consolidated statement of financial position. The Company designates its interest rate swaps as cash flow hedges. For derivative instruments that are designated and qualify as cash flow hedges, the effective portion of the gain or loss on the derivative is reported as a component of other comprehensive income ("OCI") and reclassified into earnings in the same period or periods during which the hedged transactions affect earnings. Gains and losses on the derivative representing either hedge ineffectiveness or hedge components excluded from the assessment of effectiveness are recognized in current earnings.

Assuming no change in interest rates in effect as of September 30, 2018, approximately $1 million of interest expense resulting from the spread between the fixed and floating rates defined in each interest rate swap agreement will be recognized during the next 12 months. If interest rate swaps do not remain highly effective as a cash flow hedge, the derivatives' gains or losses resulting from the change in fair value reported through OCI will be reclassified into earnings.

The following tabular disclosure provides the amount of pre-tax gain (loss) recognized as a component of OCI during the three and nine months ended September 30, 2018 and 2017 (in millions):

	Amount of Pre-Tax Gain (Loss) Recognized in OCI (Effective Portion)			
	Three Months Ended September 30,		Nine Months Ended September 30,	
Derivatives in Cash Flow Hedging Relationships	2018	2017	2018	2017
Interest rate swaps	$ 2	$ -	$ 25	$ (8)

The following tabular disclosure provides the location of the effective portion of the pre-tax loss reclassified from accumulated other comprehensive loss ("AOCL") into interest expense on the condensed consolidated statements of loss during the three and nine months ended September 30, 2018 and 2017 (in millions):

	Amount of Pre-Tax Loss Reclassified from AOCL into Income (Effective Portion)			
	Three Months Ended September 30,		Nine Months Ended September 30,	
Location of Loss Reclassified from AOCL into Income (Effective Portion)	2018	2017	2018	2017
Interest expense, net	$ 1	$ 7	$ 8	$ 24

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The fair values of derivative instruments in the condensed consolidated balance sheets as of September 30, 2018 and December 31, 2017 were as follows (in millions):

	Asset Derivatives				Liability Derivatives			
	September 30, 2018		December 31, 2017		September 30, 2018		December 31, 2017	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives designated as hedging instruments	Other assets, net	$ 8	Other assets, net	$ 1	Other long-term liabilities	$ -	Other long-term liabilities	$ 18

12. FAIR VALUE

Fair Value Hierarchy

Fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, the Company utilizes the U.S. GAAP fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

The inputs used to measure fair value are classified into the following fair value hierarchy:

Level 1: Quoted market prices in active markets for identical assets or liabilities.

Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.

Level 3: Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability. Transfers between levels within the fair value hierarchy are recognized by the Company on the date of the change in circumstances that requires such transfer. There were no transfers between levels during the nine-month periods ending September 30, 2018 or September 30, 2017.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The following table sets forth, by level within the fair value hierarchy, the financial assets and liabilities recorded at fair value on a recurring basis as of September 30, 2018 and December 31, 2017 (in millions):

	September 30, 2018	Level 1	Level 2	Level 3
Investments in equity securities	$ 147	$ 147	$ -	$ -
Available-for-sale securities	115	-	115	-
Fair value of interest rate swap agreements	8	-	8	-
Total assets	$ 270	$ 147	$ 123	$ -
Contingent Value Right (CVR)	$ -	$ -	$ -	$ -
Fair value of interest rate swap agreements	-	-	-	-
Total liabilities	$ -	$ -	$ -	$ -

	December 31, 2017	Level 1	Level 2	Level 3
Available-for-sale securities	$ 252	$ 132	$ 120	$ -
Trading securities	37	37	-	-
Fair value of interest rate swap agreements	1	-	1	-
Total assets	$ 290	$ 169	$ 121	$ -
Contingent Value Right (CVR)	$ 2	$ 2	$ -	$ -
CVR-related liability	256	-	-	256
Fair value of interest rate swap agreements	18	-	18	-
Total liabilities	$ 276	$ 2	$ 18	$ 256

Investments in Equity Securities, Available-for-sale Securities and Trading Securities

Investments in equity securities and trading securities classified as Level 1 are measured using quoted market prices. Level 2 available-for-sale securities primarily consisted of bonds and notes issued by the United States government and its agencies and domestic and foreign corporations. The estimated fair values of these securities are determined using various valuation techniques, including a multi-dimensional relational model that incorporates standard observable inputs and assumptions such as benchmark yields, reported trades, broker/dealer quotes, issuer spreads, benchmark securities, bids/offers and other pertinent reference data.

Contingent Value Right (CVR)

The CVR represents the estimate of the fair value for the contingent consideration paid to HMA shareholders as part of the HMA merger. The CVR is listed on the Nasdaq and the valuation at September 30, 2018 is based on the quoted trading price for the CVR on the last day of the period. Changes in the estimated fair value of the CVR are recorded through the condensed consolidated statements of loss.

CVR-related Liability

The CVR-related legal liability (prior to being reclassified as a current liability on the Company's condensed consolidated balance sheet as noted below) represented the Company's estimate of fair value of the liability associated with the legal matters assumed in the HMA merger, which at December 31, 2017 was included in other long-term liabilities in the accompanying condensed consolidated balance sheet. This liability did not include those matters previously accrued by HMA as a probable contingency, which were settled and paid during the year ended December 31, 2015. To develop the estimate of fair value, the Company engaged an independent third-party valuation firm to measure the liability. The valuation was made utilizing the Company's estimates of future outcomes for each legal case and simulating future outcomes based on the timing, probability and distribution of several scenarios using a Monte Carlo simulation model. Other inputs were then utilized for discounting the liability to the measurement date. The HMA legal matters underlying this fair value estimate were evaluated by management to determine the likelihood and impact of each of the potential outcomes. Using that information, as well as the potential correlation and variability associated with each case, a fair value was determined for the estimated future cash outflows to conclude or settle the HMA legal matters included in the analysis, excluding legal fees (which are expensed as incurred). Because of the unobservable nature of the majority of the inputs used to value the liability, the Company classified the fair value measurement as a Level 3 measurement in the fair value hierarchy. Changes in the fair value of the CVR related legal liability were recorded in future periods through the condensed consolidated statements of loss.

At September 30, 2018, the Company recorded the CVR-related legal liability at the amount agreed to in the final global resolution and settlement of the HMA legal matters and reclassified the balance to current other accrued liabilities on the condensed consolidated balance sheet, as further discussed below in Note 14.

Fair Value of Interest Rate Swap Agreements

The valuation of the Company's interest rate swap agreements is determined using market valuation techniques, including discounted cash flow analysis on the expected cash flows of each agreement. This analysis reflects the contractual terms of the agreement, including the period to maturity, and uses observable market-based inputs, including forward interest rate curves. The fair value of interest rate swap agreements are determined by netting the discounted future fixed cash payments and the discounted expected variable cash receipts. The variable cash receipts are based on the expectation of future interest rates based on observable market forward interest rate curves and the notional amount being hedged.

The Company incorporates CVAs to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. In adjusting the fair value of its interest rate swap agreements for the effect of nonperformance or credit risk, the Company has considered the impact of any netting features included in the agreements. The CVA on the Company's interest rate swap agreements had an immaterial effect on the fair value of the related asset or liability at September 30, 2018. The CVA on the Company's interest rate swap agreements resulted in a decrease in the fair value of the related liability of $1 million and an after-tax adjustment of less than $1 million to OCI at December 31, 2017.

The majority of the inputs used to value the Company's interest rate swap agreements, including the forward interest rate curves and market perceptions of the Company's credit risk used in the CVAs, are observable inputs available to a market participant. As a result, the Company has determined that the interest rate swap valuations are classified in Level 2 of the fair value hierarchy.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

13. EMPLOYEE BENEFIT PLANS

The Company provides an unfunded Supplemental Executive Retirement Plan ("SERP") for certain members of its executive management. The Company uses a December 31 measurement date for the benefit obligations and a January 1 measurement date for its net periodic costs for the SERP. Variances from actuarially assumed rates will result in increases or decreases in benefit obligations and net periodic cost in future periods. Benefits expense under the SERP was $2 million and $3 million for the three months ended September 30, 2018 and 2017, respectively, and $6 million and $10 million for the nine months ended September 30, 2018 and 2017, respectively. The accrued benefit liability for the SERP totaled $73 million and $83 million at September 30, 2018 and December 31, 2017, respectively, and is included in other long-term liabilities on the condensed consolidated balance sheets. The weighted-average assumptions used in determining net periodic cost for the three months ended September 30, 2018 was a discount rate of 3.4% and annual salary increase of 2.0%. The Company had equity investment securities in a rabbi trust generally designated to pay benefits of the SERP in the amounts of $85 million and $99 million at September 30, 2018 and December 31, 2017, respectively. These amounts are included in other assets, net on the condensed consolidated balance sheets.

During 2017 and the nine months ended September 30, 2018, certain members of executive management of the Company that were participants in the SERP retired and met the requirements for payout of their SERP retirement benefit. The SERP payout provisions require payment to the participant in an actuarially determined lump sum amount nine months after the participant retires from the Company. Such amounts were paid out of the rabbi trust. As required by the pension accounting rules in U.S. GAAP, the Company recognized a non-cash settlement loss of $1 million and approximately $2 million during the nine months ended September 30, 2018 and 2017, respectively, and will recognize a non-cash settlement loss of less than $1 million during the three months ending December 31, 2018, which represents a pro-rata portion of the accumulated unrecognized actuarial loss out of accumulated other comprehensive loss.

14. CONTINGENCIES

The Company is a party to various legal, regulatory and governmental proceedings incidental to its business. Based on current knowledge, management does not believe that loss contingencies arising from pending legal, regulatory and governmental matters, including the matters described herein, will have a material adverse effect on the condensed consolidated financial position or liquidity of the Company. However, in light of the inherent uncertainties involved in pending legal, regulatory and governmental matters, some of which are beyond the Company's control, and the very large or indeterminate damages sought in some of these matters, an adverse outcome in one or more of these matters could be material to the Company's results of operations or cash flows for any particular reporting period.

With respect to all legal, regulatory and governmental proceedings, the Company considers the likelihood of a negative outcome. If the Company determines the likelihood of a negative outcome with respect to any such matter is probable and the amount of the loss can be reasonably estimated, the Company records an accrual for the estimated loss for the expected outcome of the matter. If the likelihood of a negative outcome with respect to material matters is reasonably possible and the Company is able to determine an estimate of the possible loss or a range of loss, whether in excess of a related accrued liability or where there is no accrued liability, the Company discloses the estimate of the possible loss or range of loss. However, the Company is unable to estimate a possible loss or range of loss in some instances based on the significant uncertainties involved in, and/or the preliminary nature of, certain legal, regulatory and governmental matters.

In connection with the spin-off of Quorum Health Corporation ("QHC"), the Company agreed to indemnify QHC for certain liabilities relating to outcomes or events occurring prior to April 29, 2016, the closing date of the spin-off, including (i) certain claims and proceedings that were known to be outstanding at or prior to the consummation of the spin-off and involved multiple facilities and (ii) certain claims, proceedings and investigations by governmental authorities or private plaintiffs related to activities occurring at or related to QHC's healthcare facilities prior to the closing date of the spin-off, but only to the extent, in the case of clause (ii), that such claims are covered by insurance policies maintained by the Company, including professional liability and employer practices. In this regard, the Company continues to be responsible for HMA Legal Matters (as defined below) covered by the CVR agreement that relate to QHC's business, and any amounts payable by the Company in connection therewith will continue to reduce the amount payable by the Company in respect of the CVRs. Notwithstanding the foregoing, the Company is not required to indemnify QHC in respect of any claims or proceedings arising out of or related to the business operations of Quorum Health Resources, LLC at any time or QHC's compliance with the corporate integrity agreement. Subsequent to the spin-off of QHC, the Office of the Inspector General provided the Company with written assurance that it would look solely at QHC for compliance for its facilities under the Company's

Corporate Integrity Agreement; however, the Office of the Inspector General declined to enter into a separate corporate integrity agreement with QHC. In addition, on August 4, 2017, the Company initiated an arbitration against QHC for unpaid amounts due from QHC related to a Computer Data Processing Transition Services Agreement and a Shared Services Transition Services Agreement ("TSAs") entered into between QHC and the Company in connection with the spin-off. QHC filed a counterclaim, claiming breach of contract and tortious interference, among others. The Company believes QHC's counterclaims are without merit. The arbitration began on June 18, 2018 and continued through June 27, 2018. It reconvened on October 1, 2018 and concluded on October 8, 2018. On June 25, 2018, the arbitration panel issued a partial order that the TSAs were enforceable contracts that would continue by their terms until their expiration in April 2021. QHC had attempted to challenge the legal enforceability of both of those agreements. The Company expects a ruling on all remaining issues by January 15, 2019.

HMA Legal Matters and Related CVR Agreement

The CVR agreement entitles the holder to receive a one-time cash payment of up to $1.00 per CVR, subject to downward adjustment based on the final resolution of certain litigation, investigations (whether formal or informal, including subpoenas), or other actions or proceedings related to HMA or its affiliates existing on or prior to July 29, 2013 (the date of the Company's merger agreement with HMA) as more specifically provided in the CVR agreement (all such matters are referred to as the "HMA Legal Matters"), which include, but are not limited to, investigation and litigation matters as previously disclosed by HMA in public filings with the SEC and/or as described in more detail below. The adjustment reducing the ultimate amount paid to holders of the CVR is determined based on the amount of losses incurred by the Company in connection with the HMA Legal Matters as more specifically provided in the CVR agreement, which generally includes the amount paid for damages, costs, fees and expenses (including, without limitation, attorneys' fees and expenses), and all fines, penalties, settlement amounts, indemnification obligations and other liabilities (all such losses are referred to as "HMA Losses"). If the aggregate amount of HMA Losses exceeds a deductible of $18 million, then the amount payable in respect of each CVR shall be reduced (but not below zero) by an amount equal to the quotient obtained by dividing: (a) the product of (i) all losses in excess of the deductible and (ii) 90%; by (b) the number of CVRs outstanding on the date on which final resolution of the existing litigation occurs. There are 264,544,053 CVRs outstanding as of the date hereof. If total HMA Losses (including HMA Losses that have occurred to date as noted in the table below) exceed approximately $312 million, then the holders of the CVRs will not be entitled to any payment in respect of the CVRs.

The CVRs do not have a finite payment date. Any payments the Company makes under the CVR agreement will be payable within 60 days after the final resolution of the HMA Legal Matters. The CVRs are unsecured obligations of CHS and all payments under the CVRs will be subordinated in right of payment to the prior payment in full of all of the Company's senior obligations (as defined in the CVR agreement), which include outstanding indebtedness of the Company (subject to certain exceptions set forth in the CVR agreement) and the HMA Losses. The CVR agreement permits the Company to acquire all or some of the CVRs, whether in open market transactions, private transactions or otherwise. As of September 30, 2018, the Company had acquired no CVRs.

Underlying the CVR agreement are a number of claims included in the HMA Legal Matters asserted against HMA. On September 25, 2018, the Company announced a global resolution and settlement agreements ending the U.S. Department of Justice investigation and settling qui tam lawsuits that were initiated and pending, and known to the Company, before the Company's acquisition of HMA. The Company previously recorded an estimated liability at fair value of the remaining underlying claims that are covered by the CVR agreement in connection with those claims as part of the acquired assets and liabilities at the date of acquisition pursuant to the provisions of Financial Accounting Standards Board Accounting Standards Codification Topic 805 "Business Combinations." As further discussed below, this liability has been adjusted as of September 30, 2018, to take into account the settlement amount contemplated by the global settlement agreements, including interest, of $266 million and has been reclassified as a current liability in other accrued liabilities on the condensed consolidated balance sheet at September 30, 2018. This settlement amount will be paid by the Company in the fourth quarter of 2018. In addition, although future legal fees (which are expensed as incurred) and any attorney fees claimed for reimbursement by the relators associated with the HMA Legal Matters (including the global settlement noted above) have not been accrued or included in the table below, such legal fees and attorney fees are to be taken into account in determining the total amount of reductions applied to the amounts owed to CVR holders. The Company is currently in the process of reviewing the final payment amount required for the CVR as defined in the CVR agreement. However, based on the total costs incurred and settlements paid (including with respect to the global settlement) as summarized below, the Company anticipates that no payment will be due to the CVR holders.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The following table represents the impact of legal expenses paid or incurred and settlements paid or deemed final as of September 30, 2018 on the amounts owed to CVR holders (in millions):

		Allocation of Expenses and Settlements Paid		
	Total Expenses and Settlement Cost	Deductible	Company's Responsibility at 10%	Reduction to Amount Owed to CVR Holders at 90%
As of December 31, 2017	$ 64	$ 18	$ 4	$ 42
Settlements deemed final	266	-	23	243
Settlements paid	-	-	-	-
Legal expenses and other costs incurred and/or paid during the nine months ended September 30, 2018	2	-	2	-
As of September 30, 2018	$ 332	$ 18	$ 29	$ 285

Medicare/Medicaid Billing Lawsuits

Beginning during the week of December 16, 2013, eleven qui tam lawsuits filed by private individuals against HMA were unsealed in various United States district courts. The United States has elected to intervene in all or part of eight of these matters; namely U.S. ex rel. Craig Brummer v. Health Management Associates, Inc. et al. (Middle District Georgia) ("Brummer"); U.S. ex rel. Ralph D. Williams v. Health Management Associates, Inc. et al. (Middle District Georgia) ("Williams"); U.S. ex rel. Scott H. Plantz, M.D. et al. v. Health Management Associates, Inc., et al. (Northern District Illinois) ("Plantz"); U.S. ex rel. Thomas L. Mason, M.D. et al. v. Health Management Associates, Inc. et al. (Western District North Carolina) ("Mason"); U.S. ex rel. Jacqueline Meyer, et al. v. Health Management Associates, Inc., Gary Newsome et al. ("Jacqueline Meyer") (District of South Carolina); U.S. ex rel. George Miller, et al. v. Health Management Associates, Inc. (Eastern District of Pennsylvania) ("Miller"); U.S. ex rel. Bradley Nurkin v. Health Management Associates, Inc. et al. (Middle District of Florida) ("Nurkin"); and U.S. ex rel. Paul Meyer v. Health Management Associates, Inc. et al. (Southern District Florida) ("Paul Meyer"). The United States has elected to intervene with respect to allegations in these cases that certain HMA hospitals inappropriately admitted patients and then submitted reimbursement claims for treating those individuals to federal healthcare programs in violation of the False Claims Act or that certain HMA hospitals had inappropriate financial relationships with physicians which violated the Stark law, the Anti-Kickback Statute, and the False Claims Act. Certain of these complaints also allege the same actions violated various state laws which prohibit false claims. The United States has declined to intervene in three of the eleven matters, namely U.S. ex rel. Anita France, et al. v. Health Management Associates, Inc. (Middle District Florida) ("France") which involved allegations of wrongful billing and was settled; U.S. ex rel. Sandra Simmons v. Health Management Associates, Inc. et al. (Eastern District Oklahoma) ("Simmons") which alleges unnecessary surgery by an employed physician and which was settled as to all allegations except alleged wrongful termination; and U.S. ex rel. David Napoliello, M.D. v. Health Management Associates, Inc. (Middle District Florida) ("Napoliello") which alleges inappropriate admissions. On September 25, 2018, the Company announced a global resolution and settlement agreements ending the U.S. Department of Justice investigation and settling these qui tam lawsuits. The global settlement includes a total payment, including interest, of $266 million, which will be paid by the Company in the fourth quarter of 2018. Additionally, under the terms of the global settlement, the Company's existing corporate integrity agreement ("CIA") has been amended and extended. The extension began immediately and effectively adds two years to the existing CIA, with the amended CIA now running through 2021.

Other Probable Contingencies

Becker v. Community Health Systems, Inc. d/b/a Community Health Systems Professional Services Corporation d/b/a Community Health Systems d/b/a Community Health Systems PSC, Inc. d/b/a Rockwood Clinic P.S. and Rockwood Clinic, P.S. (Superior Court, Spokane, Washington). This suit was filed on February 29, 2012, by a former chief financial officer at Rockwood Clinic in Spokane, Washington. Becker claims he was wrongfully terminated for allegedly refusing to certify a budget for Rockwood Clinic in 2012. On February 29, 2012, he also filed an administrative complaint with the Department of Labor, Occupational Safety and Health Administration alleging that he is a whistleblower under Sarbanes-Oxley, which was dismissed by the agency and was appealed to an administrative law judge for a hearing that occurred on January 19-26, 2016. In a decision dated November 9, 2016, the law judge awarded Becker approximately $1.9 million for front pay, back pay and emotional damages with attorney fees to be later determined.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The Company has appealed the award to the Administrative Review Board and is awaiting its decision. At a hearing on July 27, 2012, the trial court dismissed Community Health Systems, Inc. from the state case and subsequently certified the state case for an interlocutory appeal of the denial to dismiss his employer and the management company. The appellate court accepted the interlocutory appeal, and it was argued on April 30, 2014. On August 14, 2014, the court denied the Company's appeal. On October 20, 2014, the Company filed a petition to review the denial with the Washington Supreme Court. The appeal was accepted and oral argument was heard on June 9, 2015. On September 15, 2015, the court denied the Company's appeal and remanded to the trial court; a previous trial setting of September 12, 2016 has been vacated and not reset. The Company continues to vigorously defend these actions.

Summary of Recorded Amounts

The table below presents a reconciliation of the beginning and ending liability balances (in millions) during the nine months ended September 30, 2018, with respect to the Company's determination of the final settlement value for the liability recorded in connection with HMA Legal Matters that were not previously accrued by HMA, and the remaining contingencies of the Company in respect of which an accrual has been recorded. In addition, future legal fees (which are expensed as incurred) and costs related to possible indemnification and criminal investigation matters associated with the HMA Legal Matters have not been accrued or included in the table below. Furthermore, although not accrued, such costs, if incurred, will be taken into account in determining the total amount of reductions applied to the amounts owed to CVR holders.

	CVR-Related Liability	Other Probable Contingencies
Balance as of December 31, 2017	$ 256	$ 14
Expense	10	6
Reserve for insured claim	-	4
Cash payments	-	(4)
Balance as of September 30, 2018	$ 266	$ 20

With respect to the "Other Probable Contingencies" referenced in the chart above, in accordance with applicable accounting guidance, the Company establishes a liability for litigation, regulatory and governmental matters for which, based on information currently available, the Company believes that a negative outcome is known or is probable and the amount of the loss is reasonably estimable. For all such matters (whether or not discussed in this contingencies footnote), such amounts have been recorded in other accrued liabilities on the consolidated balance sheet and are included in the table above in the "Other Probable Contingencies" column. Due to the uncertainties and difficulty in predicting the ultimate resolution of these contingencies, the actual amount could differ from the estimated amount reflected as a liability on the consolidated balance sheet.

In the aggregate, attorneys' fees and other costs incurred but not included in the table above related to probable contingencies, and CVR-related contingencies accounted for at fair value, totaled less than $1 million and $1 million for the three months ended September 30, 2018 and 2017, respectively, and $2 million for both of the nine-month periods ended September 30, 2018 and 2017, and are included in other operating expenses in the accompanying condensed consolidated statements of loss.

Matters for which an Outcome Cannot be Assessed

For the following legal matter, due to the uncertainties surrounding the ultimate outcome of the case, the Company cannot at this time assess what the outcome may be and is further unable to determine any estimate of loss or range of loss.

Class Action Shareholder Federal Securities Cases. Three purported class action cases have been filed in the United States District Court for the Middle District of Tennessee; namely, Norfolk County Retirement System v. Community Health Systems, Inc., et al., filed May 9, 2011; De Zheng v. Community Health Systems, Inc., et al., filed May 12, 2011; and Minneapolis Firefighters Relief Association v. Community Health Systems, Inc., et al., filed June 21, 2011. All three seek class certification on behalf of purchasers of the Company's common stock between July 27, 2006 and April 11, 2011 and allege that misleading statements resulted in artificially inflated prices for the Company's common stock. In December 2011, the cases were consolidated for pretrial purposes and NYC Funds and its counsel were selected as lead plaintiffs/lead plaintiffs' counsel. In lieu of ruling on the Company's motion to dismiss, the court permitted the plaintiffs to file a first amended consolidated class action complaint, which was filed on October 5, 2015. The Company's motion to dismiss was filed on November 4, 2015 and oral argument was held on April 11, 2016. The Company's motion

to dismiss was granted on June 16, 2016 and on June 27, 2016, the plaintiffs filed a notice of appeal to the Sixth Circuit Court of Appeals. The matter was heard on May 3, 2017. On December 13, 2017, the Sixth Circuit reversed the trial court's dismissal of the case and remanded it to the District Court. The Company filed a renewed partial motion to dismiss on February 9, 2018, which was denied by the District Court on September 24, 2018. The Company also filed a petition for a writ of certiorari to the United States Supreme Court on April 18, 2018 seeking review of the Sixth Circuit's decision. The United States Supreme Court denied the petition for a writ of certiorari on October 1, 2018. Plaintiff's motion for class certification is pending. The Company believes this consolidated matter is without merit and will vigorously defend this case.

15. SUBSEQUENT EVENTS

On October, 1, 2018, one or more subsidiaries of the Company sold AllianceHealth Deaconess (238 licensed beds) in Oklahoma City, Oklahoma and its associated assets to a subsidiary of INTEGRIS Health for approximately $7 million in cash pursuant to the terms of a definitive agreement which had been entered into on June 26, 2018.

On October 11, 2018, one or more subsidiaries of the Company signed a definitive agreement for the sale of Mary Black Health System – Spartanburg (207 licensed beds) in Spartanburg, South Carolina, and Mary Black Health System – Gaffney (125 licensed beds) in Gaffney, South Carolina and their associated assets to Spartanburg Regional Healthcare System in Spartanburg, South Carolina.

On October 25, 2018, one or more subsidiaries of the Company announced the planned closure on December 28, 2018 of Physicians Regional Medical Center (401 licensed beds) in Knoxville, Tennessee and Lakeway Regional Hospital (135 licensed beds) in Morristown, Tennessee.

16. SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION

The Senior Notes due 2019, 2020 and 2022, which are senior unsecured obligations of CHS, the 5 ⅛% Senior Secured Notes due 2021, and the 6 ¼% Senior Secured Notes due 2023 (collectively, "the Notes") are registered securities and are guaranteed on a senior basis by the Company and by certain of its existing and subsequently acquired or organized 100% owned domestic subsidiaries. In addition, equity interests in non-guarantors have been pledged as collateral except for three hospitals owned jointly with non-profit, health organizations. The Notes are fully and unconditionally guaranteed on a joint and several basis, with exceptions considered customary for such guarantees, limited to the release of the guarantee when a subsidiary guarantor's capital stock is sold, or a sale of all of the subsidiary guarantor's assets used in operations. The following condensed consolidating financial statements present Community Health Systems, Inc. (as parent guarantor), CHS (as the issuer), the subsidiary guarantors, the subsidiary non-guarantors and eliminations. These condensed consolidating financial statements have been prepared and presented in accordance with SEC Regulation S-X Rule 3-10 "Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered."

The accounting policies used in the preparation of this financial information are consistent with those elsewhere in the condensed consolidated financial statements of the Company, except as noted below:

- Intercompany receivables and payables are presented gross in the supplemental condensed consolidating balance sheets.
- Cash flows from intercompany transactions are presented in cash flows from financing activities, as changes in intercompany balances with affiliates, net.
- Income tax expense is allocated from the parent guarantor to the income producing operations (other guarantors and non-guarantors) and the issuer through stockholders' deficit. As this approach represents an allocation, the income tax expense allocation is considered non-cash for statement of cash flow purposes.
- Interest expense, net has been presented to reflect net interest expense and interest income from outstanding long-term debt and intercompany balances.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The Company's intercompany activity consists primarily of daily cash transfers for purposes of cash management, the allocation of certain expenses and expenditures paid for by the Parent on behalf of its subsidiaries, and the push down of investment in its subsidiaries. This activity also includes the intercompany transactions between consolidated entities as part of the ABL Facility and Receivables Facility that are further discussed in Note 10. The Company's subsidiaries generally do not purchase services from one another; thus, the intercompany transactions do not represent revenue generating transactions. All intercompany transactions eliminate in consolidation.

From time to time, subsidiaries of the Company sell and/or repurchase noncontrolling interests in consolidated subsidiaries, which may change subsidiaries between guarantors and non-guarantors. Amounts for prior periods have been revised to reflect the status of guarantors and non-guarantors as of September 30, 2018.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Loss
Three Months Ended September 30, 2018

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net operating revenues	$ -	$ 1	$ 2,095	$ 1,355	$ -	$ 3,451
Operating costs and expenses:						
Salaries and benefits	-	-	804	781	-	1,585
Supplies	-	-	365	200	-	565
Other operating expenses	-	-	572	286	-	858
Government and other legal settlements and related costs	-	-	2	-	-	2
Electronic health records incentive reimbursement	-	-	-	(1)	-	(1)
Rent	-	-	43	40	-	83
Depreciation and amortization	-	-	107	66	-	173
Impairment and (gain) loss on sale of businesses, net	-	15	76	21	-	112
Total operating costs and expenses	-	15	1,969	1,393	-	3,377
(Loss) income from operations	-	(14)	126	(38)	-	74
Interest expense, net	-	115	149	(8)	-	256
Loss from early extinguishment of debt	-	27	-	-	-	27
Equity in earnings of unconsolidated affiliates	325	272	(39)	-	(563)	(5)
(Loss) income from continuing operations before income taxes	(325)	(428)	16	(30)	563	(204)
(Benefit from) provision for income taxes	-	(103)	293	(86)	-	104
(Loss) income from continuing operations	(325)	(325)	(277)	56	563	(308)
Discontinued operations, net of taxes:						
Loss from discontinued operations, net of taxes	-	-	-	-	-	-
Net (loss) income	(325)	(325)	(277)	56	563	(308)
Less: Net income attributable to noncontrolling interests	-	-	-	17	-	17
Net (loss) income attributable to Community Health Systems, Inc. stockholders	$ (325)	$ (325)	$ (277)	$ 39	$ 563	$ (325)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Loss
Three Months Ended September 30, 2017

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Operating revenues (net of contractual allowances and discounts)	$ -	$ (5)	$ 2,661	$ 1,677	$ -	$ 4,333
Provision for bad debts	-	-	440	227	-	667
Net operating revenues	-	(5)	2,221	1,450	-	3,666
Operating costs and expenses:						
Salaries and benefits	-	-	897	827	-	1,724
Supplies	-	-	399	211	-	610
Other operating expenses	-	-	593	318	-	911
Government and other legal settlements and related costs	-	-	1	-	-	1
Electronic health records incentive reimbursement	-	-	(1)	(1)	-	(2)
Rent	-	-	50	43	-	93
Depreciation and amortization	-	-	127	79	-	206
Impairment and (gain) loss on sale of businesses, net	-	-	29	4	-	33
Total operating costs and expenses	-	-	2,095	1,481	-	3,576
(Loss) income from operations	-	(5)	126	(31)	-	90
Interest expense, net	-	84	156	(2)	-	238
Loss from early extinguishment of debt	-	4	-	-	-	4
Equity in earnings of unconsolidated affiliates	110	28	22	-	(165)	(5)
Loss from continuing operations before income taxes	(110)	(121)	(52)	(29)	165	(147)
(Benefit from) provision for income taxes	-	(11)	(22)	(26)	-	(59)
(Loss) income from continuing operations	(110)	(110)	(30)	(3)	165	(88)
Discontinued operations, net of taxes:						
Loss from operations of entities sold or held for sale	-	-	(1)	-	-	(1)
Impairment of hospitals sold or held for sale	-	-	-	(1)	-	(1)
Loss from discontinued operations, net of taxes	-	-	(1)	(1)	-	(2)
Net (loss) income	(110)	(110)	(31)	(4)	165	(90)
Less: Net income attributable to noncontrolling interests	-	-	-	20	-	20
Net (loss) income attributable to Community Health Systems, Inc. stockholders	$ (110)	$ (110)	$ (31)	$ (24)	$ 165	$ (110)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Loss
Nine Months Ended September 30, 2018

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net operating revenues	$ -	$ (7)	$ 6,488	$ 4,221	$ -	$ 10,702
Operating costs and expenses:						
Salaries and benefits	-	-	2,437	2,413	-	4,850
Supplies	-	-	1,148	625	-	1,773
Other operating expenses	-	-	1,742	904	-	2,646
Government and other legal settlements and related costs	-	-	9	-	-	9
Electronic health records incentive reimbursement	-	-	-	(2)	-	(2)
Rent	-	-	133	124	-	257
Depreciation and amortization	-	-	329	202	-	531
Impairment and gain (loss) on sale of businesses, net	-	29	96	189	-	314
Total operating costs and expenses	-	29	5,894	4,455	-	10,378
(Loss) income from operations	-	(36)	594	(234)	-	324
Interest expense, net	-	304	434	(18)	-	720
(Gain) loss from early extinguishment of debt	-	(33)	1	-	-	(32)
Equity in earnings of unconsolidated affiliates	460	351	181	-	(1,009)	(17)
Loss from continuing operations before income taxes	(460)	(658)	(22)	(216)	1,009	(347)
(Benefit from) provision for income taxes	-	(198)	342	(86)	-	58
(Loss) income from continuing operations	(460)	(460)	(364)	(130)	1,009	(405)
Loss from discontinued operations, net of taxes	-	-	-	-	-	-
Net (loss) income	(460)	(460)	(364)	(130)	1,009	(405)
Less: Net income attributable to noncontrolling interests	-	-	-	55	-	55
Net (loss) income attributable to Community Health Systems, Inc. stockholders	$ (460)	$ (460)	$ (364)	$ (185)	$ 1,009	$ (460)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Loss
Nine Months Ended September 30, 2017

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Operating revenues (net of contractual allowances and discounts)	$ -	$ (17)	$ 8,252	$ 6,088	$ -	$ 14,323
Provision for bad debts	-	-	1,306	722	-	2,028
Net operating revenues	-	(17)	6,946	5,366	-	12,295
Operating costs and expenses:						
Salaries and benefits	-	-	2,721	2,983	-	5,704
Supplies	-	-	1,240	816	-	2,056
Other operating expenses	-	-	1,797	1,187	-	2,984
Government and other legal settlements and related costs	-	-	(32)	-	-	(32)
Electronic health records incentive reimbursement	-	-	(12)	(13)	-	(25)
Rent	-	-	152	154	-	306
Depreciation and amortization	-	-	376	289	-	665
Impairment and gain (loss) on sale of businesses, net	-	-	108	255	-	363
Total operating costs and expenses	-	-	6,350	5,671	-	12,021
(Loss) income from operations	-	(17)	596	(305)	-	274
Interest expense, net	-	241	456	9	-	706
Loss from early extinguishment of debt	-	35	-	-	-	35
Equity in earnings of unconsolidated affiliates	446	198	256	-	(913)	(13)
Loss from continuing operations before income taxes	(446)	(491)	(116)	(314)	913	(454)
(Benefit from) provision for income taxes	-	(45)	87	(116)	-	(74)
Loss from continuing operations	(446)	(446)	(203)	(198)	913	(380)
Discontinued operations, net of taxes:						
Loss from operations of entities sold or held for sale	-	-	(3)	(1)	-	(4)
Impairment of hospitals sold or held for sale	-	-	(4)	(2)	-	(6)
Loss from discontinued operations, net of taxes	-	-	(7)	(3)	-	(10)
Net (loss) income	(446)	(446)	(210)	(201)	913	(390)
Less: Net income attributable to noncontrolling interests	-	-	-	56	-	56
Net (loss) income attributable to Community Health Systems, Inc. stockholders	$ (446)	$ (446)	$ (210)	$ (257)	$ 913	$ (446)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Comprehensive Loss
Three Months Ended September 30, 2018

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net (loss) income	$ (325)	$ (325)	$ (277)	$ 56	$ 563	$ (308)
Other comprehensive income (loss), net of income taxes:						
Net change in fair value of interest rate swaps, net of tax	2	2	-	-	(2)	2
Net change in fair value of available-for-sale securities, net of tax	-	-	-	-	-	-
Amortization and recognition of unrecognized pension cost components, net of tax	-	-	-	-	-	-
Other comprehensive income (loss)	2	2	-	-	(2)	2
Comprehensive (loss) income	(323)	(323)	(277)	56	561	(306)
Less: Comprehensive income attributable to noncontrolling interests	-	-	-	17	-	17
Comprehensive (loss) income attributable to Community Health Systems, Inc. stockholders	$ (323)	$ (323)	$ (277)	$ 39	$ 561	$ (323)

Condensed Consolidating Statement of Comprehensive Loss
Three Months Ended September 30, 2017

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net (loss) income	$ (110)	$ (110)	$ (31)	$ (4)	$ 165	$ (90)
Other comprehensive (loss) income, net of income taxes:						
Net change in fair value of interest rate swaps, net of tax	5	5	-	-	(5)	5
Net change in fair value of available-for-sale securities, net of tax	2	2	2	-	(4)	2
Amortization and recognition of unrecognized pension cost components, net of tax	1	1	1	-	(2)	1
Other comprehensive income	8	8	3	-	(11)	8
Comprehensive (loss) income	(102)	(102)	(28)	(4)	154	(82)
Less: Comprehensive income attributable to noncontrolling interests	-	-	-	20	-	20
Comprehensive (loss) income attributable to Community Health Systems, Inc. stockholders	$ (102)	$ (102)	$ (28)	$ (24)	$ 154	$ (102)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Comprehensive Loss
Nine Months Ended September 30, 2018

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
	(In millions)					
Net (loss) income	$ (460)	$ (460)	$ (364)	$ (130)	$ 1,009	$ (405)
Other comprehensive income (loss), net of income taxes:						
Net change in fair value of interest rate swaps, net of tax	26	26	-	-	(26)	26
Net change in fair value of available-for-sale securities, net of tax	(2)	(2)	(2)	-	4	(2)
Amortization and recognition of unrecognized pension cost components, net of tax	1	1	1	-	(2)	1
Other comprehensive income	25	25	(1)	-	(24)	25
Comprehensive (loss) income	(435)	(435)	(365)	(130)	985	(380)
Less: Comprehensive income attributable to noncontrolling interests	-	-	-	55	-	55
Comprehensive (loss) income attributable to Community Health Systems, Inc. stockholders	$ (435)	$ (435)	$ (365)	$ (185)	$ 985	$ (435)

Condensed Consolidating Statement of Comprehensive Loss
Nine Months Ended September 30, 2017

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
	(In millions)					
Net (loss) income	$ (446)	$ (446)	$ (210)	$ (201)	$ 913	$ (390)
Other comprehensive income (loss), net of income taxes:						
Net change in fair value of interest rate swaps, net of tax	8	8	-	-	(8)	8
Net change in fair value of available-for-sale securities, net of tax	7	7	7	-	(14)	7
Amortization and recognition of unrecognized pension cost components, net of tax	2	2	2	-	(4)	2
Other comprehensive income	17	17	9	-	(26)	17
Comprehensive (loss) income	(429)	(429)	(201)	(201)	887	(373)
Less: Comprehensive income attributable to noncontrolling interests	-	-	-	56	-	56
Comprehensive (loss) income attributable to Community Health Systems, Inc. stockholders	$ (429)	$ (429)	$ (201)	$ (257)	$ 887	$ (429)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Balance Sheet
September 30, 2018

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)			
ASSETS						
Current assets:						
Cash and cash equivalents	$ -	$ -	$ 247	$ 88	$ -	$ 335
Patient accounts receivable	-	-	1,921	426	-	2,347
Supplies	-	-	280	144	-	424
Prepaid income taxes	17	-	-	-	-	17
Prepaid expenses and taxes	-	-	159	32	-	191
Other current assets	-	-	120	290	-	410
Total current assets	17	-	2,727	980	-	3,724
Intercompany receivable	-	12,836	6,110	7,149	(26,095)	-
Property and equipment, net	-	-	4,246	2,324	-	6,570
Goodwill	-	-	2,833	1,798	-	4,631
Deferred income taxes	-	-	-	-	-	-
Other assets, net	-	26	841	677	-	1,544
Net investment in subsidiaries	-	21,319	11,261	-	(32,580)	-
Total assets	$ 17	$ 34,181	$ 28,018	$ 12,928	$ (58,675)	$ 16,469
LIABILITIES AND DEFICIT						
Current liabilities:						
Current maturities of long-term debt	$ -	$ -	$ 27	$ 8	$ -	$ 35
Accounts payable	-	-	542	274	-	816
Accrued interest	-	258	-	-	-	258
Accrued liabilities	-	-	859	511	-	1,370
Total current liabilities	-	258	1,428	793	-	2,479
Long-term debt	-	13,251	184	100	-	13,535
Intercompany payable	1,174	21,808	25,543	12,722	(61,247)	-
Deferred income taxes	39	-	-	-	-	39
Other long-term liabilities	9	-	717	325	-	1,051
Total liabilities	1,222	35,317	27,872	13,940	(61,247)	17,104
Redeemable noncontrolling interests in equity of consolidated subsidiaries	-	-	-	495	-	495
Deficit:						
Community Health Systems, Inc. stockholders' deficit:						
Common stock	1	-	-	-	-	1
Additional paid-in capital	2,011	353	673	(279)	(747)	2,011
Accumulated other comprehensive loss	(8)	(8)	(8)	(10)	26	(8)
Accumulated deficit	(3,209)	(1,481)	(519)	(1,293)	3,293	(3,209)
Total Community Health Systems, Inc. stockholders' deficit	(1,205)	(1,136)	146	(1,582)	2,572	(1,205)
Noncontrolling interests in equity of consolidated subsidiaries	-	-	-	75	-	75
Total deficit	(1,205)	(1,136)	146	(1,507)	2,572	(1,130)
Total liabilities and deficit	$ 17	$ 34,181	$ 28,018	$ 12,928	$ (58,675)	$ 16,469

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Balance Sheet
December 31, 2017

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
ASSETS						
Current assets:						
Cash and cash equivalents	$ -	$ -	$ 499	$ 64	$ -	$ 563
Patient accounts receivable, net of allowance for doubtful accounts	-	-	1,861	523	-	2,384
Supplies	-	-	288	156	-	444
Prepaid income taxes	17	-	-	-	-	17
Prepaid expenses and taxes	-	-	146	52	-	198
Other current assets	-	-	152	310	-	462
Total current assets	17	-	2,946	1,105	-	4,068
Intercompany receivable	-	13,381	5,092	7,873	(26,346)	-
Property and equipment, net	-	-	4,448	2,604	-	7,052
Goodwill	-	-	2,882	1,841	-	4,723
Deferred income taxes	62	-	-	-	-	62
Other assets, net	15	39	1,594	939	(1,042)	1,545
Net investment in subsidiaries	-	21,742	10,890	-	(32,632)	-
Total assets	$ 94	$ 35,162	$ 27,852	$ 14,362	$ (60,020)	$ 17,450
LIABILITIES AND DEFICIT						
Current liabilities:						
Current maturities of long-term debt	$ -	$ -	$ 25	$ 8	$ -	$ 33
Accounts payable	-	-	663	304	-	967
Accrued interest	-	228	1	-	-	229
Accrued liabilities	-	-	644	483	-	1,127
Total current liabilities	-	228	1,333	795	-	2,356
Long-term debt	-	12,998	779	103	-	13,880
Intercompany payable	833	21,607	23,465	13,876	(59,781)	-
Deferred income taxes	19	-	-	-	-	19
Other long-term liabilities	9	1,018	997	378	(1,042)	1,360
Total liabilities	861	35,851	26,574	15,152	(60,823)	17,615
Redeemable noncontrolling interests in equity of consolidated subsidiaries	-	-	-	527	-	527
Deficit:						
Community Health Systems, Inc. stockholders' deficit:						
Common stock	1	-	-	-	-	1
Additional paid-in capital	2,014	(252)	960	(524)	(184)	2,014
Accumulated other comprehensive loss	(21)	(21)	(4)	(4)	29	(21)
(Accumulated deficit) retained earnings	(2,761)	(416)	322	(864)	958	(2,761)
Total Community Health Systems, Inc. stockholders' deficit	(767)	(689)	1,278	(1,392)	803	(767)
Noncontrolling interests in equity of consolidated subsidiaries	-	-	-	75	-	75
Total deficit	(767)	(689)	1,278	(1,317)	803	(692)
Total liabilities and deficit	$ 94	$ 35,162	$ 27,852	$ 14,362	$ (60,020)	$ 17,450

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Cash Flows
Nine Months Ended September 30, 2018

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net cash provided by (used in) operating activities	$ 45	$ (250)	$ 361	$ 284	$ -	$ 440
Cash flows from investing activities:						
Acquisitions of facilities and other related businesses	-	-	(3)	(18)	-	(21)
Purchases of property and equipment	-	-	(313)	(100)	-	(413)
Proceeds from disposition of hospitals and other ancillary operations	-	-	10	218	-	228
Proceeds from sale of property and equipment	-	-	2	5	-	7
Purchases of available-for-sale securities and equity securities	-	-	(30)	(20)	-	(50)
Proceeds from sales of available-for-sale securities and equity securities	-	-	55	20	-	75
Increase in other investments	-	-	(36)	(40)	-	(76)
Net cash (used in) provided by investing activities	-	-	(315)	65	-	(250)
Cash flows from financing activities:						
Repurchase of restricted stock shares for payroll tax withholding requirements	(1)	-	-	-	-	(1)
Deferred financing costs and other debt-related costs	-	(93)	-	-	-	(93)
Proceeds from noncontrolling investors in joint ventures	-	-	-	2	-	2
Redemption of noncontrolling investments in joint ventures	-	-	-	(27)	-	(27)
Distributions to noncontrolling investors in joint ventures	-	-	-	(74)	-	(74)
Changes in intercompany balances with affiliates, net	(44)	(10)	276	(222)	-	-
Borrowings under credit agreements	-	-	22	2	-	24
Issuance of long-term debt	-	1,033	-	-	-	1,033
Proceeds from ABL and receivables facility	-	538	49	-	-	587
Repayments of long-term indebtedness	-	(1,218)	(645)	(6)	-	(1,869)
Net cash (used in) provided by financing activities	(45)	250	(298)	(325)	-	(418)
Net change in cash and cash equivalents	-	-	(252)	24	-	(228)
Cash and cash equivalents at beginning of period	-	-	499	64	-	563
Cash and cash equivalents at end of period	$ -	$ -	$ 247	$ 88	$ -	$ 335

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Cash Flows
Nine Months Ended September 30, 2017

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net cash (used in) provided by operating activities	$ (44)	$ (228)	$ 688	$ 201	$ -	$ 617
Cash flows from investing activities:						
Acquisitions of facilities and other related businesses	-	-	-	(4)	-	(4)
Purchases of property and equipment	-	-	(277)	(151)	-	(428)
Proceeds from disposition of hospitals and other ancillary operations	-	-	593	1,073	-	1,666
Proceeds from sale of property and equipment	-	-	3	1	-	4
Purchases of available-for-sale securities and equity securities	-	-	(57)	(28)	-	(85)
Proceeds from sales of available-for-sale securities and equity securities	-	-	84	49	-	133
Investment in other non-operating assets	-	-	(72)	(23)	-	(95)
Net cash (used in) provided by investing activities	-	-	274	917	-	1,191
Cash flows from financing activities:						
Repurchase of restricted stock shares for payroll tax withholding requirements	(5)	-	-	-	-	(5)
Deferred financing costs and other debt-related costs	-	(65)	(1)	-	-	(66)
Proceeds from noncontrolling investors in joint ventures	-	-	-	5	-	5
Redemption of noncontrolling investments in joint ventures	-	-	-	(5)	-	(5)
Distributions to noncontrolling investors in joint ventures	-	-	-	(79)	-	(79)
Changes in intercompany balances with affiliates, net	49	1,413	(434)	(1,028)	-	-
Borrowings under credit agreements	-	795	27	17	-	839
Issuance of long-term debt	-	3,100	-	-	-	3,100
Proceeds from receivables facility	-	-	26	-	-	26
Repayments of long-term indebtedness	-	(5,015)	(232)	(24)	-	(5,271)
Net cash provided by (used in) financing activities	44	228	(614)	(1,114)	-	(1,456)
Net change in cash and cash equivalents	-	-	348	4	-	352
Cash and cash equivalents at beginning of period	-	-	176	62	-	238
Cash and cash equivalents at end of period	$ -	$ -	$ 524	$ 66	$ -	$ 590

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

You should read this discussion together with our condensed consolidated financial statements and the accompanying notes included herein.

Throughout this Quarterly Report on Form 10-Q, we refer to Community Health Systems, Inc., or the Parent Company, and its consolidated subsidiaries in a simplified manner and on a collective basis, using words like "we," "our," "us" and the "Company". This drafting style is suggested by the Securities and Exchange Commission, or SEC, and is not meant to indicate that the publicly traded Parent Company or any particular subsidiary of the Parent Company owns or operates any asset, business or property. The hospitals, operations and businesses described in this filing are owned and operated by distinct and indirect subsidiaries of Community Health Systems, Inc.

Executive Overview

We are one of the largest publicly traded hospital companies in the United States and a leading operator of general acute care hospitals and outpatient facilities in communities across the country. We provide healthcare services through the hospitals that we own and operate and affiliated businesses in non-urban and selected urban markets throughout the United States. We generate revenues by providing a broad range of general and specialized hospital healthcare services and outpatient services to patients in the communities in which we are located. As of September 30, 2018, we owned or leased 118 hospitals, comprised of 116 general acute care hospitals and two stand-alone rehabilitation or psychiatric hospitals. For the hospitals that we own and operate, we are paid for our services by governmental agencies, private insurers and directly by the patients we serve.

We have been implementing a portfolio rationalization and deleveraging strategy by divesting hospitals and non-hospital businesses that are attractive to strategic and other buyers. Generally, these businesses are not in one of our strategically beneficial service areas, are less complementary to our business strategy and/or have lower operating margins. In connection with our announced divestiture initiative, we have received offers from strategic buyers to buy certain of our assets. After considering these offers, we have divested or may divest hospitals and non-hospital businesses when we find such offers to be attractive and in line with our operating strategy.

Completed Divestiture and Acquisition Activity

The following table provides a summary of hospitals included in continuing operations that we divested during the year ended December 31, 2017 and the nine months ended September 30, 2018:

Hospital	Buyer	City, State	Licensed Beds	Effective Date
2018 Divestitures				
Bayfront Health Dade City	Adventist Health System	Dade City, FL	120	April 1, 2018
Tennova - Dyersburg Regional	West Tennessee Healthcare	Dyersburg, TN	225	June 1, 2018
Tennova - Regional Jackson	West Tennessee Healthcare	Jackson, TN	150	June 1, 2018
Tennova - Volunteer Martin	West Tennessee Healthcare	Martin, TN	100	June 1, 2018
Williamson Memorial Hospital	Mingo Health Partners, LLC	Williamson, WV	76	June 1, 2018
Byrd Regional Hospital	Allegiance Health Management	Leesville, LA	60	June 1, 2018
Tennova Healthcare - Jamestown	Rennova Health, Inc.	Jamestown, TN	85	June 1, 2018
Munroe Regional Medical Center	Adventist Health System	Ocala, FL	425	August 1, 2018
2017 Divestitures				
Easton Hospital	Steward Health, Inc.	Easton, PA	196	May 1, 2017
Sharon Regional Health System	Steward Health, Inc.	Sharon, PA	258	May 1, 2017
Northside Medical Center	Steward Health, Inc.	Youngstown, OH	355	May 1, 2017
Trumbull Memorial Hospital	Steward Health, Inc.	Warren, OH	311	May 1, 2017
Hillside Rehabilitation Hospital	Steward Health, Inc.	Warren, OH	69	May 1, 2017
Wuesthoff Health System – Rockledge	Steward Health, Inc.	Rockledge, FL	298	May 1, 2017
Wuesthoff Health System – Melbourne	Steward Health, Inc.	Melbourne, FL	119	May 1, 2017
Sebastian River Medical Center	Steward Health, Inc.	Sebastian, FL	154	May 1, 2017
Stringfellow Memorial Hospital	The Health Care Authority of the City of Anniston	Anniston, AL	125	May 1, 2017
Merit Health Gilmore Memorial	Curae Health, Inc.	Amory, MS	95	May 1, 2017
Merit Health Batesville	Curae Health, Inc.	Batesville, MS	112	May 1, 2017
Lake Area Medical Center	CHRISTUS Health	Lake Charles, LA	88	June 30, 2017
Memorial Hospital of York	PinnacleHealth System	York, PA	100	July 1, 2017
Lancaster Regional Medical Center	PinnacleHealth System	Lancaster, PA	214	July 1, 2017
Heart of Lancaster Regional Medical Center	PinnacleHealth System	Lititz, PA	148	July 1, 2017
Carlisle Regional Medical Center	PinnacleHealth System	Carlisle, PA	165	July 1, 2017
Tomball Regional Medical Center	HCA	Tomball, TX	350	July 1, 2017
South Texas Regional Medical Center	HCA	Jourdanton, TX	67	July 1, 2017
Deaconess Hospital	MultiCare Health System	Spokane, WA	388	July 1, 2017
Valley Hospital	MultiCare Health System	Spokane Valley, WA	123	July 1, 2017
Yakima Regional Medical and Cardiac Center	Regional Health	Yakima, WA	214	September 1, 2017
Toppenish Community Hospital	Regional Health	Toppenish, WA	63	September 1, 2017
Weatherford Regional Medical Center	HCA	Weatherford, TX	103	October 1, 2017
Brandywine Hospital	Reading Health System	Coatesville, PA	169	October 1, 2017
Chestnut Hill Hospital	Reading Health System	Philadelphia, PA	148	October 1, 2017
Jennersville Hospital	Reading Health System	West Grove, PA	63	October 1, 2017
Phoenixville Hospital	Reading Health System	Phoenixville, PA	151	October 1, 2017
Pottstown Memorial Medical Center	Reading Health System	Pottstown, PA	232	October 1, 2017
Highlands Regional Medical Center	HCA	Sebring, FL	126	November 1, 2017
Merit Health Northwest Mississippi	Curae Health, Inc.	Clarksdale, MS	181	November 1, 2017

On June 26, 2018, we signed a definitive agreement for the sale of AllianceHealth Deaconess (238 licensed beds) in Oklahoma City, Oklahoma, and its associated assets to a subsidiary of INTEGRIS Health. We closed on the sale of this hospital on October 1, 2018.

On July 18, 2018, we signed a definitive agreement for the sale of Sparks Regional Medical Center (492 licensed beds) in Fort Smith, Arkansas, and Sparks Medical Center (103 licensed beds) in Van Buren, Arkansas and its associated assets to subsidiaries of Baptist Health.

On October 11, 2018, we signed a definitive agreement for the sale of Mary Black Health System – Spartanburg (207 licensed beds) in Spartanburg, South Carolina, and Mary Black Health System – Gaffney (125 licensed beds) in Gaffney, South Carolina and their associated assets to Spartanburg Regional Healthcare System in Spartanburg, South Carolina.

During 2017, as reflected in the chart above, we completed the divestiture of 30 hospitals included in continuing operations. These 30 hospitals represented annual net operating revenues in 2016 of approximately $3.4 billion, and we received total net proceeds of approximately $1.7 billion in connection with the disposition of these hospitals.

During 2018, we have completed the divestiture of nine hospitals. These nine hospitals represented annual net operating revenues in 2017 of approximately $649 million, and we received total net proceeds of approximately $234 million in connection with the disposition of these hospitals. In addition, we have entered into definitive agreements to sell five additional hospitals, which divestitures have not yet been completed.

In addition to the divestiture of these hospitals in 2017 and 2018, we continue to receive interest from potential buyers for certain of our hospitals. We are pursuing these additional interests for sale transactions involving hospitals which, together with the hospitals that are currently subject to definitive agreements and the hospitals that have been divested during 2018, had a combined total of at least $2.0 billion in annual net operating revenues and combined mid-single digit Adjusted EBITDA margins during 2017. These sale transactions are currently in various stages of negotiation with potential buyers. There can be no assurance that these potential divestitures (or the potential divestitures currently subject to definitive agreements) will be completed, or if they are completed, the ultimate timing of the completion of these divestitures.

There may be changes from time to time in the composition of the particular hospitals in respect of which we are pursuing potential divestitures as the result of various factors, including changes in any potential buyer or the negotiations with respect to the potential sale of any such hospital. The potential divestitures noted above, as well as the divestitures that were completed in 2017 and 2018 and the divestitures that are currently subject to definitive agreements, are intended to further implement our portfolio rationalization and deleveraging strategy as described above. When consistent with this strategy, we intend to continue to evaluate offers from potential buyers for additional divestitures in order to optimize our hospital asset portfolio.

Operating results and statistical data for the nine months ended September 30, 2017, exclude hospitals still owned and hospitals divested during the nine months ended September 30, 2017, that were previously classified as discontinued operations for accounting purposes.

During the nine months ended September 30, 2018, we paid approximately $21 million to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by our hospitals.

Overview of Operating Results

Our net operating revenues for the three months ended September 30, 2018 decreased $215 million to approximately $3.5 billion compared to approximately $3.7 billion for the three months ended September 30, 2017. On a same-store basis, net operating revenues for the three months ended September 30, 2018 increased $105 million compared to the three months ended September 30, 2017.

We had a loss from continuing operations of $308 million during the three months ended September 30, 2018, compared to a loss from continuing operations of $88 million for the three months ended September 30, 2017. Loss from continuing operations for the three months ended September 30, 2018 included the following:

- an after-tax charge of $1 million for government and other legal settlements, net of related legal expenses,
- an after-tax charge of $89 million for the impairment of goodwill and long-lived assets of hospitals sold or held for sale based on their estimated fair values,
- an after-tax charge of $2 million for employee termination benefits and other restructuring costs,
- an after-tax charge of $21 million for loss from early extinguishment of debt,
- an after-tax charge of $3 million from settlement adjustments to the CVR agreement liability related to the Health Management Associates, Inc., or HMA, legal proceedings, and related legal expenses, and
- a deferred tax provision of $23 million related to the write-off of deferred tax assets due to the nondeductible components of the settlement liability for the HMA legal proceedings noted above.

Loss from continuing operations for the three months ended September 30, 2017 included the following:

- an after-tax charge of $1 million for government and other legal settlements, net of related legal expenses,
- an after-tax charge of $21 million for the impairment of goodwill and long-lived assets of hospitals sold or held for sale based on their estimated fair values,
- an after-tax charge of $1 million for employee termination benefits and other restructuring costs,
- an after-tax charge of $2 million for loss from early extinguishment of debt, and
- an after-tax charge of $4 million from fair value adjustments on the CVR agreement liability related to the HMA legal proceedings, and related legal expenses.

Consolidated inpatient admissions for the three months ended September 30, 2018, decreased 12.4%, compared to the three months ended September 30, 2017. Consolidated adjusted admissions for the three months ended September 30, 2018, decreased 12.2%, compared to the three months ended September 30, 2017. Same-store inpatient admissions for the three months ended September 30, 2018, decreased 2.3%, compared to the three months ended September 30, 2017, and same-store adjusted admissions for the three months ended September 30, 2018, decreased 0.8%, compared to the three months ended September 30, 2017.

Our net operating revenues for the nine months ended September 30, 2018 decreased $1.6 billion to approximately $10.7 billion compared to approximately $12.3 billion for the nine months ended September 30, 2017. On a same-store basis, net operating revenues for the nine months ended September 30, 2018 increased $265 million compared to the nine months ended September 30, 2017.

We had a loss from continuing operations of $405 million during the nine months ended September 30, 2018, compared to a loss from continuing operations of $380 million for the nine months ended September 30, 2017. Loss from continuing operations for the nine months ended September 30, 2018 included the following:

- an after-tax charge of $7 million for government and other legal settlements, net of related legal expenses,
- an after-tax charge of $261 million for the impairment of goodwill and long-lived assets of hospitals sold or held for sale based on their estimated fair values,
- an after-tax charge of $13 million for employee termination benefits and other restructuring costs,
- after-tax income of $25 million for gain from early extinguishment of debt,
- an after-tax charge of $10 million from settlement and fair value adjustments on the CVR agreement liability related to the HMA legal proceedings, and related legal expenses, and
- a deferred tax provision of $23 million related to the write-off of deferred tax assets due to the nondeductible components of the settlement liability for the HMA legal proceedings noted above.

Loss from continuing operations for the nine months ended September 30, 2017 included the following:

- after-tax income of $21 million for government and other legal settlements, net of related legal expenses, primarily as a result of the previously announced settlement of the shareholder derivative action in January 2017,
- an after-tax charge of $320 million for the impairment of goodwill and long-lived assets of hospitals sold or held for sale based on their estimated fair values,
- an after-tax charge of $3 million for employee termination benefits and other restructuring costs,
- an after-tax charge of $22 million for loss from early extinguishment of debt, and
- an after-tax charge of $5 million from fair value adjustments on the CVR agreement liability related to the HMA legal proceedings, and related legal expenses.

Consolidated inpatient admissions for the nine months ended September 30, 2018, decreased 16.5%, compared to the nine months ended September 30, 2017, and consolidated adjusted admissions for the nine months ended September 30, 2018, decreased 16.9%, compared to the nine months ended September 30, 2017. Same-store inpatient admissions for the nine months ended September 30, 2018, decreased 2.4%, compared to the nine months ended September 30, 2017, and same-store adjusted admissions for the nine months ended September 30, 2018, decreased 0.9%, compared to the nine months ended September 30, 2017.

Self-pay revenues represented approximately 1.2% and 0.6% of net operating revenues for the three months ended September 30, 2018 and 2017, respectively, 1.4% and 1.8% for the nine months ended September 30, 2018 and 2017, respectively. The amount of foregone revenue related to providing charity care services as a percentage of net operating revenues was approximately 3.5% and 3.2% for the three months ended September 30, 2018 and 2017, respectively, 3.3% and 2.9% for the nine months ended September 30, 2018 and 2017, respectively. Direct and indirect costs incurred in providing charity care services as a percentage of net operating revenues was approximately 0.4% for both the three-month and the nine-month periods ended September 30, 2018 and 2017.

The U.S. Congress and certain state legislatures have introduced and passed a large number of proposals and legislation designed to make major changes in the healthcare system, including changes that have increased access to health insurance. The most prominent of these recent efforts, the Affordable Care Act, affects how healthcare services are covered, delivered and reimbursed. It mandates that substantially all U.S. citizens maintain health insurance and increases health insurance coverage through a combination of public program expansion and private sector health insurance reforms.

However, the future of the Affordable Care Act is uncertain. Since the 2016 presidential election, significant changes have been made to the Affordable Care Act, its implementation, and its interpretation. The current presidential administration and certain members of Congress have stated their intent to repeal or make additional significant changes to the law. For example, as part of the tax reform legislation which was enacted in December 2017, Congress eliminated the financial penalty associated with the individual mandate, effective January 1, 2019, which may result in fewer individuals electing to purchase health insurance. In addition, final rules issued in 2018 expand availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. These changes may impact the number of individuals who elect to purchase health insurance or the scope of such coverage, if purchased. Of critical importance to us will be the potential impact of any changes specific to the Medicaid funding and expansion provisions of the Affordable Care Act. We operate hospitals in five of the ten states that experienced the largest reductions in uninsured rates among adult residents between 2013 and 2015. In general, the states with the greatest reductions in the number of uninsured adult residents have expanded Medicaid. A number of states have opted out of the Medicaid coverage expansion provisions, but could ultimately decide to expand their programs at a later date. Of the 20 states in which we operated hospitals that were included in continuing operations as of September 30, 2018, 10 states have taken action to expand their Medicaid programs. At this time, the other 10 states have not, including Florida, Alabama, Tennessee and Texas, where we operated a significant number of hospitals as of September 30, 2018. Some states use, or have applied to use, waivers granted by CMS to implement expansion, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. CMS administrators have indicated that they are increasing state flexibility in the administration of Medicaid programs. For example, CMS has granted a limited number of state applications for waivers that allow a state to condition Medicaid enrollment on work or other community engagement. Several states have similar applications pending.

The Affordable Care Act makes a number of changes to Medicare and Medicaid, such as reductions to the Medicare annual market basket update for federal fiscal years 2010 through 2019, a productivity offset to the Medicare market basket update, and a reduction to the Medicare and Medicaid disproportionate share hospital payments, each of which could adversely impact the reimbursement received under these programs. The Affordable Care Act also includes provisions aimed at reducing fraud, waste and abuse in the healthcare industry.

We believe that the Affordable Care Act has had a positive impact on net operating revenues and income from continuing operations as the result of the expansion of private sector and Medicaid coverage that has occurred. However, legislative and executive branch efforts related to healthcare reform could result in increased prices for consumers purchasing health insurance coverage or the sale of insurance plans that contain gaps in coverage, which could destabilize insurance markets and impact the rates of uninsured or underinsured adults. Other provisions of the Affordable Care Act, such as requirements related to employee health insurance coverage and changes to Medicare and Medicaid reimbursement, have increased our operating costs or adversely impacted the reimbursement we receive.

It is difficult to predict the ongoing effect of the Affordable Care Act due to executive orders, changes to the law's implementation, clarifications and modifications resulting from the rule-making process, judicial interpretations resulting from court challenges to its constitutionality and interpretation, whether and how many states ultimately decide to expand Medicaid coverage, the number of uninsured who elect to purchase health insurance coverage, budgetary issues at federal and state levels, and efforts to change or repeal the statute. We may not be able to fully realize the positive impact the Affordable Care Act may otherwise have on our business, results of operations, cash flow, capital resources and liquidity. We cannot predict whether we will be able to modify certain aspects of our operations to offset any potential adverse consequences from the Affordable Care Act or the impact of any alternative provisions that may be adopted.

In recent years, a number of laws, including the Affordable Care Act and MACRA, have promoted shifting from traditional fee-for-service reimbursement models to alternative payment models that tie reimbursement to quality and cost of care. CMS currently administers various ACOs and bundled payment demonstration projects and has indicated that it will continue to pursue similar initiatives.

The federal government has implemented a number of regulations and programs designed to promote the use of EHR technology and pursuant to the Health Information Technology for Economic and Clinical Health Act, or HITECH, established requirements for a Medicare and Medicaid incentive payments program for eligible hospitals and professionals that adopt and meaningfully use certified EHR technology. These payments are available for a maximum period of five or six years, depending on the program. Our hospital facilities have been implementing EHR technology on a facility-by-facility basis since 2011. We recognize incentive reimbursement related to the Medicare or Medicaid incentives as we are able to implement the certified EHR technology and meet the defined "meaningful use criteria," and information from completed cost report periods is available from which to calculate the incentive

reimbursement. The timing of recognizing incentive reimbursement does not correlate with the timing of recognizing operating expenses and incurring capital costs in connection with the implementation of EHR technology which may result in material period-to-period changes in our future results of operations.

Eligible hospitals and professionals that have not demonstrated meaningful use of certified EHR technology and have not applied and qualified for a hardship exception are subject to payment adjustments. Eligible hospitals are subject to a reduced market basket update to the inpatient prospective payment system standardized amount as of 2015 and for each subsequent fiscal year. Eligible professionals are subject to a 1% per year cumulative reduction applied to the MPFS amount for covered professional services, subject to a cap of 5%. Payment adjustments for eligible professionals failing to demonstrate meaningful use will no longer be applicable beginning in 2019, when the program is scheduled to be replaced by MIPS.

As a result of our current levels of cash, available borrowing capacity, long-term outlook on our debt repayments, the refinancing of our term loans and our continued projection of our ability to generate cash flows, we anticipate that we will be able to invest the necessary capital in our business over the next twelve months. We believe there continues to be ample opportunity for growth in substantially all of our markets by decreasing the need for patients to travel outside their communities for healthcare services through the provision of services at our facilities. Furthermore, we will continue to strive to improve operating efficiencies and procedures in order to improve our profitability at our hospitals.

Sources of Revenue

The following table presents the approximate percentages of net operating revenues by payor source for the periods indicated. The data for the periods presented are not strictly comparable due to the effect that hospital acquisitions and divestitures have had on these statistics.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
Medicare	25.3 %	26.7 %	26.7 %	27.2 %
Medicaid	13.6	13.5	13.1	13.2
Managed Care and other third-party payors	59.9	59.2	58.8	57.8
Self-pay	1.2	0.6	1.4	1.8
Total	100.0 %	100.0 %	100.0 %	100.0 %

As shown above, we receive a substantial portion of our revenues from the Medicare and Medicaid programs. Included in Managed Care and other third-party payors is operating revenues from insurance companies with which we have insurance provider contracts, Medicare managed care, insurance companies for which we do not have insurance provider contracts, workers' compensation carriers and non-patient service revenue, such as rental income and cafeteria sales. In the future, we generally expect revenues received from the Medicare and Medicaid programs to increase due to the general aging of the population. In addition, the Affordable Care Act has increased the number of insured patients in states that have expanded Medicaid, which in turn, has reduced the percentage of revenues from self-pay patients. However, it is unclear whether the trend of increased coverage will continue, due in part to the elimination of the financial penalty associated with the individual mandate, effective January 1, 2019. Further, the Affordable Care Act imposes significant reductions in amounts the government pays Medicare managed care plans. The trend toward increased enrollment in Medicare managed care may adversely affect our operating revenue growth. Other provisions in the Affordable Care Act impose minimum medical-loss ratios and require insurers to meet specific benefit requirements. Furthermore, in the normal course of business, managed care programs, insurance companies and employers actively negotiate the amounts paid to hospitals. The trend toward increased enrollment in managed care may adversely affect our operating revenue growth. There can be no assurance that we will retain our existing reimbursement arrangements or that these third-party payors will not attempt to further reduce the rates they pay for our services.

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-based reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for the treatment of patients covered by Medicare, Medicaid and non-governmental payors are generally less than the standard billing rates. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net loss by an insignificant amount in each of the three-month and nine-month periods ended September 30, 2018 and 2017.

The payment rates under the Medicare program for hospital inpatient and outpatient acute care services are based on a prospective payment system, depending upon the diagnosis of a patient's condition. These rates are indexed for inflation annually, although increases have historically been less than actual inflation. On August 2, 2017, CMS issued the final rule to increase this index by 2.7% for hospital inpatient acute care services that are reimbursed under the prospective payment system, beginning October 1, 2017. The final rule provides for a 0.6% multifactor productivity reduction and a 0.75% reduction to hospital inpatient rates implemented pursuant to the Affordable Care Act, which, together with other payment adjustments, will yield an estimated net 1.3% increase in reimbursement for hospitals. An additional reduction applies to hospitals that do not submit required patient quality data. We are complying with this data submission requirement. Further, CMS has indicated that Medicare disproportionate share payments and changes to additional uncompensated care payments will increase overall inpatient hospital payment rates by approximately 0.6%. Payments may also be affected by admission and medical review criteria for inpatient services commonly known as the "two midnight rule." Under the rule, for admissions on or after October 1, 2013, services to Medicare beneficiaries are only payable as inpatient hospital services when there is a reasonable expectation that the hospital care is medically necessary and will be required across two midnights, absent unusual circumstances. Stays expected to need less than two midnights of hospital care are subject to medical review on a case-by-case basis. Reductions in the rate of increase or overall reductions in Medicare reimbursement may cause a decline in the growth of our net operating revenues.

Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from CMS and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Similar programs are also being considered by other states. The programs are generally authorized for a specified period of time and require CMS's approval to be extended. CMS has indicated that it will take into account a state's status with respect to expanding its Medicaid program in considering whether to extend these supplemental programs. We are unable to predict whether or on what terms CMS will extend the supplemental programs in the states in which we operate. As a result of existing supplemental programs, we recognize revenue and related expenses in the period in which the fixed and determinable amounts are estimable and collection is reasonably assured. Reimbursement under these programs is reflected in net operating revenues and included as Medicaid revenue in the table above, and fees, taxes or other program related costs are reflected in other operating expenses.

Results of Operations

Our hospitals offer a variety of services involving a broad range of inpatient and outpatient medical and surgical services. These include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic services, psychiatric and rehabilitation services. The strongest demand for hospital services generally occurs during January through April and the weakest demand for these services generally occurs during the summer months. Accordingly, eliminating the effects of new acquisitions and/or divestitures, our net operating revenues and earnings are historically highest during the first quarter and lowest during the third quarter.

The following tables summarize, for the periods indicated, selected operating data.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
Operating results, as a percentage of net operating revenues:				
Net operating revenues	100.0 %	100.0 %	100.0 %	100.0 %
Operating expenses (a)	(89.7)	(91.0)	(89.1)	(89.4)
Depreciation and amortization	(5.0)	(5.6)	(5.0)	(5.4)
Impairment and (gain) loss on sale of businesses, net	(3.2)	(0.9)	(2.9)	(3.0)
Income from operations	2.1	2.5	3.0	2.2
Interest expense, net	(7.3)	(6.5)	(6.7)	(5.7)
(Loss) gain from early extinguishment of debt	(0.8)	(0.1)	0.3	(0.3)
Equity in earnings of unconsolidated affiliates	0.1	0.1	0.2	0.1
Loss from continuing operations before income taxes	(5.9)	(4.0)	(3.2)	(3.7)
(Provision for) benefit from income taxes	(3.0)	1.6	(0.6)	0.6
Loss from continuing operations	(8.9)	(2.4)	(3.8)	(3.1)
Loss from discontinued operations, net of taxes	-	(0.1)	-	(0.1)
Net loss	(8.9)	(2.5)	(3.8)	(3.2)
Less: Net income attributable to noncontrolling interests	(0.5)	(0.5)	(0.5)	(0.4)
Net loss attributable to Community Health Systems, Inc. stockholders	(9.4)%	(3.0)%	(4.3)%	(3.6)%

	Three Months Ended September 30, 2018	Nine Months Ended September 30, 2018
Percentage (decrease) increase from prior year:		
Net operating revenues	(5.9)%	(13.0)%
Admissions	(12.4)	(16.5)
Adjusted admissions (b)	(12.2)	(16.9)
Average length of stay	-	-
Net loss attributable to Community Health Systems, Inc. (c)	195.5	3.1
Same-store percentage increase (decrease) from prior year (d):		
Net operating revenues	3.2 %	2.6 %
Admissions	(2.3)	(2.4)
Adjusted admissions (b)	(0.8)	(0.9)

(a) Operating expenses include salaries and benefits, supplies, other operating expenses, government and other legal settlements and related costs, electronic health records incentive reimbursement and rent.
(b) Adjusted admissions is a general measure of combined inpatient and outpatient volume. We computed adjusted admissions by multiplying admissions by gross patient revenues and then dividing that number by gross inpatient revenues.
(c) Includes loss from discontinued operations.
(d) Includes acquired hospitals to the extent we operated them in both periods and excludes our hospitals that have previously been classified as discontinued operations for accounting purposes. In addition, also excludes information for the hospitals sold or closed during 2017 and 2018.

Three Months Ended September 30, 2018 Compared to Three Months Ended September 30, 2017

Net operating revenues decreased by 5.9% to approximately $3.5 billion for the three months ended September 30, 2018, from approximately $3.7 billion for the three months ended September 30, 2017. Net operating revenues on a same-store basis from hospitals that were operated throughout both periods increased $105 million, or 3.2%, during the three months ended September 30, 2018, as compared to the three months ended September 30, 2017. The increase in same-store net operating revenues was attributable to improved pricing due to higher acuity, partially offset by a decline in inpatient admissions and adjusted admissions. Non-same-store net operating revenues decreased $319 million during the three months ended September 30, 2018, in comparison to the prior year period, with the decrease attributable primarily to the divestiture of hospitals during 2017 and 2018. On a consolidated basis, inpatient admissions decreased by 12.4% during the three months ended September 30, 2018 as compared to the three months ended September 30, 2017. Also on a consolidated basis, adjusted admissions decreased by 12.2% during the three months ended September 30, 2018 as compared to the three months ended September 30, 2017. On a same-store basis, net operating revenues per adjusted admission increased 4.0%, while inpatient admissions decreased by 2.3% and adjusted admissions decreased by 0.8% for the three months ended September 30, 2018, compared to the three months ended September 30, 2017.

Operating expenses, as a percentage of net operating revenues, increased from 97.5% during the three months ended September 30, 2017 to 97.9% during the three months ended September 30, 2018. Operating expenses, excluding depreciation and amortization and impairment and (gain) loss on sale of businesses, as a percentage of net operating revenues, decreased from 91.0% for the three months ended September 30, 2017 to 89.7% for the three months ended September 30, 2018. Salaries and benefits, as a percentage of net operating revenues, decreased from 47.0% for the three months ended September 30, 2017 to 45.9% for the three months ended September 30, 2018. This decrease in salaries and benefits, as a percentage of net operating revenues, was primarily due to improved staffing and benefit expense management. Supplies, as a percentage of net operating revenues, decreased from 16.6% for the three months ended September 30, 2017 to 16.4% for the three months ended September 30, 2018. Other operating expenses, as a percentage of net operating revenues, remained consistent at 24.9% for both of the three-month periods ended September 30, 2018 and 2017. Expense related to government and other legal settlements and related costs, as a percentage of net operating revenues, increased from less than 0.1% for the three months ended September 30, 2017 to 0.1% for the three months ended September 30, 2018. Rent, as a percentage of net operating revenues, decreased from 2.5% for the three months ended September 30, 2017 to 2.4% for the three months ended September 30, 2018.

Depreciation and amortization, as a percentage of net operating revenues, decreased from 5.6% for the three months ended September 30, 2017 to 5.0% for the three months ended September 30, 2018, primarily due to ceasing depreciation on property and equipment at hospitals sold or held for sale.

Impairment and (gain) loss on sale of businesses was $112 million for the three months ended September 30, 2018, compared to $33 million for the three months ended September 30, 2017. Impairment of goodwill and long-lived assets for the three months ended September 30, 2018 included (i) impairment of approximately $47 million related to impairment of the long-lived assets and reporting unit goodwill allocated to hospitals classified as held for sale during the three months ended September 30, 2018, (ii) approximately $15 million recorded to write-off the remaining value of a promissory note received as consideration for the sale of three hospitals in 2017 where the buyer recently entered into bankruptcy proceedings, and (iii) approximately $50 million recorded primarily to adjust the carrying value of other long-lived assets at several underperforming hospitals that have ceased operations or where we are in discussions with potential buyers for divestiture at a sales price that indicates a fair value below carrying value. Impairment of goodwill and long-lived assets for the three months ended September 30, 2017 included impairment of approximately $33 million related to impairment of the long-lived assets and reporting unit goodwill allocated to hospitals classified as held for sale during the three months ended September 30, 2017.

Interest expense, net, increased by $18 million to $256 million for the three months ended September 30, 2018 compared to $238 million for the three months ended September 30, 2017, primarily due to an increase in interest rates during the three months ended September 30, 2018, compared to the same period in 2017, which resulted in an increase in interest expense of $32 million. This increase was partially offset by a decrease in our average outstanding debt during the three months ended September 30, 2018, which resulted in a decrease in interest expense of $14 million. Additionally, an increase in major construction projects during the three months ended September 30, 2018 resulted in more interest being capitalized, and a decrease in interest expense of $1 million, compared to the same period in 2017.

Loss from early extinguishment of debt of $27 million was recognized during the three months ended September 30, 2018, which resulted primarily from the issuance of notes and repayment of Term G Loan as discussed further in Capital Resources. Loss from early extinguishment of debt of $4 million was recognized during the three months ended September 30, 2017, which resulted from the repayment of certain outstanding notes and term loans under the Credit Facility.

Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, remained consistent at 0.1% for both of the three-month periods ended September 30, 2018 and 2017.

The net results of the above-mentioned changes resulted in loss from continuing operations before income taxes increasing $57 million from loss of $147 million for the three months ended September 30, 2017 to loss of $204 million for the three months ended September 30, 2018.

Our provision for income taxes for the three months ended September 30, 2018 was $104 million compared to benefit from income taxes on loss from continuing operations for income taxes of $59 million for the three months ended September 30, 2017. Our effective tax rates were (51.0)% and 40.1% for the three months ended September 30, 2018 and 2017, respectively. The difference in the Company’s effective tax rate for the three months ended September 30, 2018, when compared to the three months ended September 30, 2017, was primarily due to the non-deductible portion of the amounts payable by us pursuant to the global resolution and settlement agreements related to certain HMA matters entered into with the U.S. Department of Justice as announced on September 25, 2018, the U.S. Federal limitation on deductibility of interest expense, and non-deductible goodwill written off as part of the net impairment and (gain) loss on sale of businesses for the three months ended September 30, 2018 compared to the three months ended September 30, 2017.

Loss from continuing operations, as a percentage of net operating revenues, increased from (2.4)% for the three months ended September 30, 2017 to (8.9)% for the three months ended September 30, 2018.

No discontinued operations were separately reported for the three months ended September 30, 2018. Discontinued operations for the three months ended September 30, 2017 include the results of operations of certain hospitals owned or leased by us as of September 30, 2017, which were classified as being held for sale or sold. The operation of these hospitals resulted in a loss, net of taxes, of $1 million for the three months ended September 30, 2017. An after-tax impairment charge of $1 million was recorded during the three months ended September 30, 2017, based on the difference between the estimated fair value and the carrying value of the assets held for sale. Overall, discontinued operations consisted of a loss, net of taxes, of $2 million for the three month period ended September 30, 2017.

Net loss, as a percentage of net operating revenues, increased from (2.5)% for the three months ended September 30, 2017 to (8.9)% for the three months ended September 30, 2018.

Net income attributable to noncontrolling interests, as a percentage of net operating revenues, remained consistent at 0.5% for both of the three-month periods ended September 30, 2018 and 2017.

Net loss attributable to Community Health Systems, Inc. was $325 million for the three months ended September 30, 2018, compared to $110 million for the three months ended September 30, 2017.

Nine Months Ended September 30, 2018 Compared to Nine Months Ended September 30, 2017

Net operating revenues decreased by 13.0% to approximately $10.7 billion for the nine months ended September 30, 2018, from approximately $12.3 billion for the nine months ended September 30, 2017. Net operating revenues on a same-store basis from hospitals that were operated throughout both periods increased $265 million or 2.6% during the nine months ended September 30, 2018, as compared to the nine months ended September 30, 2017. The increase in same-store net operating revenues was attributable to improved pricing due to higher acuity, partially offset by a decline in inpatient admissions and adjusted admissions. Non-same-store net operating revenues decreased $1.9 billion during the nine months ended September 30, 2018, in comparison to the prior year period, with the decrease attributable primarily to the divestiture of hospitals during 2017 and 2018. On a consolidated basis, inpatient admissions decreased by 16.5% and adjusted admissions decreased by 16.9% during the nine months ended September 30, 2018 as compared to the nine months ended September 30, 2017. On a same-store basis, net operating revenues per adjusted admission increased 3.6%, while inpatient admissions decreased by 2.4% and adjusted admissions decreased by 0.9% for the nine months ended September 30, 2018, compared to the nine months ended September 30, 2017.

Operating expenses, as a percentage of net operating revenues, decreased from 97.8% during the nine months ended September 30, 2017 to 97.0% during the nine months ended September 30, 2018. Operating expenses, excluding depreciation and amortization and impairment and (gain) loss on sale of businesses, as a percentage of net operating revenues, decreased from 89.4% for the nine months ended September 30, 2017 to 89.1% for the nine months ended September 30, 2018. Salaries and benefits, as a percentage of net operating revenues, decreased from 46.4% for the nine months ended September 30, 2017 to 45.3% for the nine months ended September 30, 2018. This decrease in salaries and benefits, as a percentage of net operating revenues, was primarily due to improved staffing and benefit expense management. Supplies, as a percentage of net operating revenues, decreased from 16.7% for the nine months ended September 30, 2017 to 16.6% for the nine months ended September 30, 2018. Other operating expenses, as a percentage of net operating revenues, increased from 24.3% for the nine months ended September 30, 2017 to 24.7% for the nine months ended September 30, 2018, primarily as a result of higher medical specialist fees, an increase in purchased services and higher information systems expense. Government and other legal settlements and related costs, as a percentage of net operating revenues, decreased from income of 0.3% for the nine months ended September 30, 2017 to expense of 0.1% for the nine months ended September 30, 2018 primarily due to the gain recorded from the settlement of the shareholder derivative action in January 2017. Rent, as a percentage of net operating revenues, decreased from 2.5% for the nine months ended September 30, 2017 to 2.4% for the nine months ended September 30, 2018.

Depreciation and amortization, as a percentage of net operating revenues, decreased from 5.4% for the nine months ended September 30, 2017 to 5.0% for the nine months ended September 30, 2018, primarily due to ceasing depreciation on property and equipment at hospitals sold or held for sale.

Impairment and (gain) loss on sale of businesses was $314 million for the nine months ended September 30, 2018, compared to $363 million for the nine months ended September 30, 2017. Impairment of goodwill and long-lived assets for the nine months ended September 30, 2018 included (i) impairment of $225 million recorded to reduce the carrying value of certain hospitals that have been sold or deemed held for sale based on the difference between the carrying value of the hospital disposal groups compared to estimated fair value less costs to sell, (ii) approximately $29 million recorded to write-off the value of a promissory note received as consideration for the sale of three hospitals in 2017 where the buyer recently entered into bankruptcy proceedings, and (iii) approximately $60 million recorded primarily to adjust the carrying value of other long-lived assets at several underperforming hospitals that have ceased operation or where we are in discussions with potential buyers for divestiture at a sales price that indicates a fair value below carrying value. Impairment of goodwill and long-lived assets for the nine months ended September 30, 2017 included impairment of approximately $363 million related to impairment of the long-lived assets and reporting unit goodwill allocated to hospitals classified as held for sale during the nine months ended September 30, 2017.

Interest expense, net, increased by $14 million to $720 million for the nine months ended September 30, 2018 compared to $706 million for the nine months ended September 30, 2017, primarily due to an increase in interest rates during the nine months ended September 30, 2018, compared to the same period in 2017, which resulted in an increase in interest expense of $76 million. This increase was partially offset by a decrease in our average outstanding debt during the nine months ended September 30, 2018, which resulted in a decrease in interest expense of $58 million. Additionally, an increase in major construction projects during the nine months ended September 30, 2018 resulted in more interest being capitalized, and a decrease in interest expense of $4 million, compared to the same period in 2017.

Gain from early extinguishment of debt of $32 million was recognized during the nine months ended September 30, 2018 which resulted primarily from the refinancing and exchange of certain of our outstanding notes and repayment of a portion of our term loans under the Credit Facility as discussed further in Capital Resources. Loss from early extinguishment of debt of $35 million was recognized during the nine months ended September 30, 2017, which resulted from the repayment of certain outstanding notes and term loans under the Credit Facility.

Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, increased from 0.1% for the nine months ended September 30, 2017 to 0.2% for the nine months ended September 30, 2018.

The net results of the above-mentioned changes resulted in loss from continuing operations before income taxes decreasing $107 million from loss of $454 million for the nine months ended September 30, 2017 to loss of $347 million for the nine months ended September 30, 2018.

Our provision for income taxes for the nine months ended September 30, 2018 was $58 million compared to benefit from income taxes on loss from continuing operations for income taxes of $74 million. Our effective tax rates were (16.7)% and 16.3% for the nine months ended September 30, 2018 and 2017, respectively. The difference in the Company's effective tax rate for the nine months ended September 30, 2018 when compared to the nine months ended September 30, 2017, was primarily due to the non-deductible portion of the amounts payable by us pursuant to the global resolution and settlement agreements related to certain HMA matters entered into with the U.S. Department of Justice as announced on September 25, 2018, the U.S. Federal limitation on deductibility of interest expense, the non-deductible goodwill written off as part of the net impairment and (gain) loss on sale of businesses for the nine months ended September 30, 2018 compared to the nine months ended September 30, 2017, and a disproportionate decrease in income from continuing operations before income taxes when compared to the decrease in net income attributable to noncontrolling interest for those same periods, which is not tax affected in our condensed consolidated financial statements.

Loss from continuing operations, as a percentage of net operating revenues, increased from (3.1)% for the nine months ended September 30, 2017 to (3.8)% for the nine months ended September 30, 2018.

No discontinued operations were separately reported for the nine months ended September 30, 2018. Discontinued operations for the nine months ended September 30, 2017 include the results of operations of certain hospitals owned or leased by us as of September 30, 2017, which were classified as being held for sale or sold. The operation of these hospitals resulted in a loss, net of taxes, of $4 million for the nine months ended September 30, 2017. An after-tax impairment charge of $6 million was recorded during the nine months ended September 30, 2017, based on the difference between the estimated fair value and the carrying value of the assets held for sale. Overall, discontinued operations consisted of a loss, net of taxes, of $10 million during the nine months ended September 30, 2017.

Net loss, as a percentage of net operating revenues, increased from (3.2)% for the nine months ended September 30, 2017 to (3.8)% for the nine months ended September 30, 2018.

Net income attributable to noncontrolling interests, as a percentage of net operating revenues, increased from 0.4% for the nine months ended September 30, 2017 to 0.5% for the nine months ended September 30, 2018.

Net loss attributable to Community Health Systems, Inc. was $460 million for the nine months ended September 30, 2018, compared to $446 million for the nine months ended September 30, 2017.

Liquidity and Capital Resources

Net cash provided by operating activities decreased $177 million, from approximately $617 million for the nine months ended September 30, 2017, to approximately $440 million for the nine months ended September 30, 2018. The decrease in cash provided by operating activities was primarily the result of higher interest payments due to the timing of payments and higher interest rates resulting from the refinancing activity during the nine months ended September 30, 2018, as well as from a decline in cash flow from patient accounts receivable collections. Other contributors to the lower cash provided by operating activities include the net cash received related to government settlements and related legal costs, as well as the loss of cash flow contributed from previously divested hospitals and a decrease in cash received from HITECH incentive reimbursement. Such decreases were offset by improvements in cash flow from supplies, prepaid expenses and other current assets and lower malpractice claim payments compared to the same period in 2017. Total cash paid for interest during the nine months ended September 30, 2018 increased to approximately $637 million compared to $630 million for the nine months ended September 30, 2017. Cash paid for interest for the year ending December 31, 2018 is expected to be approximately $945 million. Cash paid for income taxes, net of refunds received, resulted in a net refund of $17 million for the nine months ended September 30, 2018, compared to $5 million paid for income taxes for the nine months ended September 30, 2017.

Our net cash used in investing activities was approximately $250 million for the nine months ended September 30, 2018, compared to net cash provided by investing activities of approximately $1.2 billion for the nine months ended September 30, 2017, a decrease of approximately $1.4 billion. The cash used in investing activities was primarily impacted by a decrease in proceeds from the disposition of hospitals and other ancillary operations of $1.4 billion as a result of fewer hospital dispositions in the first nine months of 2018 compared to the same period in 2017, a decrease in cash provided by the net impact of the purchases and sales of available-for-sale securities and equity securities of $23 million and an increase of $17 million in the cash used in the acquisition of facilities and other related equipment (for physician practices, clinics and other ancillary businesses as there were no hospital acquisitions during either the nine months ended September 30, 2018 or 2017). These increases in cash outflows were offset by a decrease in the cash used in the purchase of property and equipment of $15 million, an increase in the proceeds from the sale of property and equipment of $3 million, and a decrease in cash used for other investments (primarily from internal-use software expenditures and physician recruiting costs) of $19 million for the nine months ended September 30, 2018 compared to the same period in 2017.

Our net cash used in financing activities was $418 million for the nine months ended September 30, 2018, compared to approximately $1.5 billion for the nine months ended September 30, 2017, a decrease of approximately $1.0 billion. The decrease in cash used in financing activities, in comparison to the prior year period, is primarily due to the net effect of our debt repayment, refinancing activity, and cash paid for deferred financing costs and other debt-related costs.

There have been no material changes outside of the ordinary course of business to our upcoming cash obligations during the nine months ended September 30, 2018 from those disclosed in our 2017 Form 10-K, other than arising from the Fourth Amendment and Restatement Agreement to the Credit Facility, the ABL Facility, the exchange offers for our outstanding notes and the repayment of our Term G Loans using the proceeds from issuance of the 8⅝% Senior Secured Notes (as discussed further in Capital Resources below).

Capital Expenditures

Cash expenditures for purchases of facilities and other related businesses were $21 million for the nine months ended September 30, 2018, compared to $4 million for the nine months ended September 30, 2017. Our expenditures for the nine months ended September 30, 2018 and 2017 were related to the purchase of physician practices and other ancillary services.

Excluding the cost to construct replacement hospitals, our cash expenditures for routine capital for the nine months ended September 30, 2018 totaled $410 million compared to $422 million for the nine months ended September 30, 2017. These capital expenditures related primarily to the purchase of additional equipment, minor renovations and information systems infrastructure. Costs to construct replacement hospitals totaled $3 million for the nine months ended September 30, 2018, compared to $6 million for the nine months ended September 30, 2017. The costs to construct replacement hospitals for the nine months ended September 30, 2018 represent both planning and construction costs for the replacement facility at La Porte, Indiana. The costs to construct replacement hospitals for the nine months ended September 30, 2017 represent both planning and construction costs for the replacement hospital in York, Pennsylvania. In conjunction with the sale of Memorial Hospital of York on July 1, 2017, we no longer have any planned costs to construct this replacement hospital.

Pursuant to a hospital purchase agreement from our March 1, 2016 acquisition of La Porte Hospital and Starke Hospital, we committed to build replacement facilities in both La Porte, Indiana and Knox, Indiana. Under the terms of such agreement, construction of the replacement hospital for LaPorte Hospital is required to be completed within five years of the date of acquisition, or March 2021. In addition, construction of the replacement facility for Starke Hospital is required to be completed within five years of the date we enter into a new lease with Starke County, Indiana, the hospital lessor, or in the event we do not enter into a new lease with Starke County, construction shall be completed by September 30, 2026. We have not entered into a new lease with the lessor for Starke Hospital and currently anticipate completing construction of the Starke Hospital replacement facility in 2026. Construction costs, including equipment costs, for the La Porte and Starke replacement facilities are currently estimated to be approximately $125 million and $15 million, respectively.

Capital Resources

Net working capital was approximately $1.2 billion at September 30, 2018, compared to $1.7 billion at December 31, 2017. Net working capital decreased by approximately $467 million between December 31, 2017 and September 30, 2018. This decrease is primarily due to the decrease in cash and increase in other current liabilities, partially offset by a decrease in accounts payable during the nine months ended September 30, 2018.

We have senior secured financing under a credit facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent, which at December 31, 2017 included (i) a revolving credit facility with commitments through January 27, 2019 of approximately $929 million, of which a $739 million portion represented extended commitments maturing January 27, 2021, or the Revolving Facility, (ii) a Term G facility due 2019, or the Term G Facility, and (iii) a Term H facility due 2021, or the Term H Facility. The Revolving Facility includes a subfacility for letters of credit.

As of September 30, 2018, the availability for additional borrowings under the Credit Facility, subject to certain limitations as set forth in the Credit Facility, was approximately $425 million pursuant to the Revolving Facility, of which $86 million is in the form of outstanding letters of credit. CHS has the ability to amend the Credit Facility to provide for one or more tranches of term loans or increases in the Revolving Facility in an aggregate principal amount of up to $500 million. As of September 30, 2018, the weighted-average interest rate under the Credit Facility, excluding swaps, was 6.5%.

The loans under the Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at our option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the NYFRB Rate (as defined) plus 0.50% or (3) the adjusted LIBOR rate on such day for a three-month interest period commencing on the second business day after such day plus 1% or (b) LIBOR. In addition, the margin in respect of the Revolving Facility will be subject to adjustment determined by reference to a leverage-based pricing grid. Based on our current leverage, loans in respect of the Revolving Facility currently accrue interest at a rate per annum equal to LIBOR plus 2.75%, in the case of LIBOR borrowings, and Alternate Base Rate plus 1.75%, in the case of Alternate Base Rate borrowings. Prior to the Credit Facility amendment discussed below, the Term G Loan and Term H Loan accrued interest at a rate per annum equal to LIBOR plus 2.75% and 3.00%, respectively, in the case of LIBOR borrowings, and Alternate Base Rate plus 1.75% and 2.00%, respectively, in the case of Alternate Base Rate borrowings. The Term G Loan and the Term H Loan are subject to a 1.00% LIBOR floor and a 2.00% Alternate Base Rate floor.

Under the Term H Facility, we are required to make amortization payments in aggregate amounts equal to 1% of the original principal amount of the Term H Facility each year. As of December 31, 2016, no additional amortization payments were required to be made under the Term G Facility.

The term loan facility must be prepaid in an amount equal to (1) 100% of the net cash proceeds of certain asset sales and dispositions by us and our subsidiaries, subject to certain exceptions and reinvestment rights (as further described below), (2) 100% of the net cash proceeds of issuances of certain debt obligations or receivables-based financing by us and our subsidiaries, subject to certain exceptions, and (3) 75%, subject to reduction to a lower percentage based on our first lien net leverage ratio (as defined in the Credit Facility generally as the ratio of first lien net debt on the date of determination to our consolidated EBITDA, as defined, for the four quarters most recently ended prior to such date), of excess cash flow (as defined) for any year, subject to certain exceptions. Voluntary prepayments and commitment reductions are permitted in whole or in part, without any premium or penalty, subject to minimum prepayment or reduction requirements.

The borrower under the Credit Facility is our wholly-owned subsidiary CHS/Community Health Systems, Inc., or CHS. All of our obligations under the Credit Facility are unconditionally guaranteed by Community Health Systems, Inc. and certain of its existing and subsequently acquired or organized domestic subsidiaries. All obligations under the Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of Community Health Systems, Inc., CHS and each subsidiary guarantor, including equity interests held by us or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries. Such assets constitute substantially the same assets, subject to certain exceptions, that secure CHS' obligations under its outstanding senior secured notes.

We have agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to LIBOR borrowings under the Revolving Facility times the maximum aggregate amount available to be drawn under all letters of credit outstanding under the subfacility for letters of credit. The issuer of any letter of credit issued under the subfacility for letters of credit will also receive a customary fronting fee and other customary processing charges. We are obligated to pay commitment fees of 0.50% per annum (subject to adjustment based upon our leverage ratio), on the unused portion of the Revolving Facility.

The Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting our and our subsidiaries' ability, subject to certain exceptions, to, among other things, (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of our businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change our fiscal year. We and our subsidiaries are also required to comply with specified financial covenants (consisting of a maximum first lien net debt to consolidated EBITDA leverage ratio) and various affirmative covenants. Under the Credit Facility, the first lien net debt to consolidated EBITDA leverage ratio is calculated as the ratio of total first lien debt, less unrestricted cash and cash equivalents, to consolidated EBITDA, as defined in the Credit Facility. The calculation of consolidated EBITDA as defined in the Credit Facility is a trailing 12-month calculation that begins with net income attributable to us, with certain pro forma adjustments to consider the impact of material acquisitions or divestitures, and adjustments for interest, taxes, depreciation and amortization, net income attributable to noncontrolling interests, stock compensation expense, restructuring costs, and the financial impact of other non-cash or non-recurring items recorded during any such 12-month period. For the 12-month period ended September 30, 2018, the first lien net debt to consolidated EBITDA leverage ratio financial covenant under the Credit Facility limited the ratio of first lien net debt to consolidated EBITDA, as defined, to less than or equal to 5.0 to 1.0. We were in compliance with all such covenants at September 30, 2018, with a first lien net debt to consolidated EBITDA leverage ratio of approximately 4.6 to 1.0.

Events of default under the Credit Facility include, but are not limited to, (1) our failure to pay principal, interest, fees or other amounts under the credit agreement when due (taking into account any applicable grace period), (2) any representation or warranty proving to have been materially incorrect when made, (3) covenant defaults subject, with respect to certain covenants, to an available cure, (4) bankruptcy and insolvency events, (5) a cross default to certain other debt, (6) certain undischarged judgments (not paid within an applicable grace period), (7) a change of control (as defined), (8) certain ERISA-related defaults and (9) the invalidity or impairment of specified security interests, guarantees or subordination provisions in favor of the administrative agent or lenders under the Credit Facility.

On March 16, 2017, CHS completed a public offering of $2.2 billion aggregate principal amount of 6¼% Senior Secured Notes due 2023, or the 6¼% Senior Secured Notes. The net proceeds from this issuance were used to finance the purchase or redemption of $700 million aggregate principal amount of the 2018 Senior Secured Notes and related fees and expenses, and the repayment of $1.445 billion of the Term F Facility. On May 12, 2017, CHS completed a tack-on offering of $900 million aggregate principal amount of 6¼% Senior Secured Notes, increasing the total aggregate principal amount of 6¼% Senior Secured Notes to $3.1 billion. A portion of the net proceeds from this issuance were used to finance the repayment of approximately $713 million aggregate principal amount of CHS' then outstanding Term A Facility and related fees and expenses. The tack-on notes have identical terms, other than issue date and issue price as the 6¼% Senior Secured Notes issued on March 16, 2017. The 6¼% Senior Secured Notes bear interest at 6.250% per annum, payable semiannually in arrears on June 30 and September 30, commencing September 30, 2017. Interest on the 6¼% Senior Secured Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months. The 2021 Senior Secured Notes, the 6¼% Senior Secured Notes and the 8⅝% Senior Secured Notes are secured by a first-priority lien subject to a shared lien of equal priority with certain other obligations, including obligations under the Credit Facility, and subject to prior ranking liens permitted by the indentures governing the 2021 Senior Secured Notes, the 6¼% Senior Secured Notes and the 8⅝% Senior Secured Notes on substantially the same assets, subject to certain exceptions, that secure CHS' obligations under the Credit Facility.

On February 26, 2018, the Credit Facility was amended, with requisite revolving lender approval, to remove the consolidated EBITDA to interest expense ratio financial covenant, to replace the senior secured net debt to consolidated EBITDA ratio financial covenant with a first lien net debt to consolidated EBITDA ratio financial covenant, and to reduce the extended revolving credit commitments to $650 million (for a total of $840 million in revolving credit commitments when combined with the non-extended portion of the revolving credit facility). The new financial covenant provides for a maximum first lien net debt to consolidated EBITDA ratio of 5.25 to 1.0, reducing to 5.0 to 1.0 on July 1, 2018, 4.75 to 1.0 on January 1, 2019, 4.5 to 1.0 on January 1, 2020 and 4.25 to 1.0 on July 1, 2020. In addition, we agreed pursuant to the amendment to modify its ability to retain asset sale proceeds, and instead to apply them to prepayments of term loans based on pro forma first lien leverage. To the extent the pro forma ratio of first lien net debt to consolidated EBITDA is greater than or equal to 4.5 to 1.0, 100% of net cash proceeds of asset sales will be applied to prepay term loans; to the extent the first lien leverage ratio is less than 4.5 to 1.0 but greater than or equal to 4.0 to 1.0, 50% of such proceeds will be applied to prepay term loans; and to the extent the pro forma first lien leverage ratio is less than 4.0 to 1.0, there will be no requirement to prepay term loans with such proceeds. These ratios will be determined on a pro forma basis giving appropriate effect to the relevant asset sales and corresponding prepayments of term loans.

On March 23, 2018, we and CHS, entered into the Fourth Amendment and Restatement Agreement to the Credit Facility, or the Agreement. In addition to including the changes described in the paragraph above, we further modified our ability to retain asset sale proceeds, and instead to apply them to prepayments of term loans based on pro forma first lien leverage. To the extent the pro forma ratio of first lien net debt to consolidated EBITDA is greater than or equal to 4.25 to 1.0, 100% of net cash proceeds of asset sales will be applied to prepay term loans; to the extent the pro forma first lien leverage ratio is less than 4.25 to 1.0 but greater than or equal to 3.75 to 1.0, 50% of such proceeds will be applied to prepay term loans; and to the extent the first lien leverage ratio is less than 3.75 to 1.0, there will be no requirement to prepay term loans with such proceeds. The Agreement also amended the Credit Facility to permit CHS to incur debt under either an asset-based loan facility, or ABL, in an amount up to $1.0 billion or maintain its Asset-Backed Securitization program. The Revolving Facility would be reduced to $425 million upon the effectiveness of the contemplated ABL facility. The Agreement also reduced the availability for incremental tranches of term loans or increases in the Revolving Facility to $500 million and removed the secured net leverage incurrence test with respect to junior secured debt. Term G Loans will accrue interest at a rate per annum initially equal to LIBOR plus 3.00%, in the case of LIBOR borrowings, and Alternate Base Rate plus 2.00%, in the case of Alternate Base Rate borrowing. Term H Loans will accrue interest at a rate per annum initially equal to LIBOR plus 3.25%, in the case of LIBOR borrowings, and Alternate Base Rate plus 2.25%, in the case of Alternate Base Rate borrowing.

Prior to the effectiveness of the ABL Facility described below, CHS, through certain of its subsidiaries, participated in an accounts receivable loan agreement, or the Receivables Facility, with a group of lenders and banks, Credit Agricolé Corporate and Investment Bank, as a managing agent and as the administrative agent. Patient-related accounts receivable, or the Receivables, for certain affiliated hospitals served as collateral for the outstanding borrowings under the Receivables Facility. The interest rate on the borrowings was based on the commercial paper rate plus an applicable interest rate spread. The Receivables Facility was repaid in full and terminated upon the effectiveness of the ABL Facility on April 3, 2018.

On April 3, 2018, we and CHS entered into an asset-based loan (ABL) credit agreement, or the ABL Credit Agreement, with JPMorgan Chase Bank, N.A., as administrative agent, and the lenders and other agents party thereto. Pursuant to the ABL Credit Agreement, the lenders have extended to CHS a revolving asset-based loan facility, or the ABL Facility, in the maximum aggregate principal amount of $1.0 billion, subject to borrowing base capacity. The ABL Facility includes borrowing capacity available for letters of credit of $50 million. CHS and all domestic subsidiaries of CHS that guarantee CHS' other outstanding senior and senior secured indebtedness guarantee the obligations of CHS under the ABL Facility. Subject to certain exceptions, all obligations under the ABL Facility and the related guarantees are secured by a perfected first-priority security interest in substantially all of the Receivables, deposit, collection and other accounts and contract rights, books, records and other instruments related to the foregoing of the Company, CHS and the guarantors as well as a perfected junior-priority security interest in substantially all of the other assets of the Company, CHS and the guarantors, subject to customary exceptions and intercreditor arrangements. The revolving credit commitments under the Credit Facility were reduced to $425 million upon the effectiveness of the ABL facility. In connection with entering into the ABL Credit Agreement and the ABL Facility, we repaid in full and terminated our Receivables Facility. The outstanding borrowings pursuant to the ABL Facility at September 30, 2018 totaled $538 million on the condensed consolidated balance sheet.

Borrowings under the ABL Facility bear interest at a rate per annum equal to an applicable percentage, plus, at the Borrower's option, either (a) an Alternative base rate or (b) a LIBOR rate. From and after December 31, 2018, the applicable percentage under the ABL Facility will be determined based on excess availability as a percentage of the maximum commitment amount under the ABL facility at a rate per annum of 1.25%, 1.50% and 1.75% for loans based on the Alternative base rate and 2.25%, 2.50% and 2.75% for loans based on the LIBOR rate. From and after September 30, 2018, the applicable commitment fee rate under the ABL Facility is determined based on average utilization as a percentage of the maximum commitment amount under the ABL Facility at a rate per annum of either 0.50% or 0.625% times the unused portion of the ABL facility.

Principal amounts outstanding under the ABL Facility will be due and payable in full on April 3, 2023. The ABL Facility includes a 91-day springing maturity applicable if more than $250 million in the aggregate principal amount of the Borrower's 8% Senior Notes due 2019, Term G loans due 2019, 7.125% Senior Notes due 2020, Term H loans due 2021, 5.125% Senior Secured Notes due 2021, 6.875% Senior Notes due 2022 or 6.25% Senior Secured Notes due 2023 or refinancings thereof are scheduled to mature or similarly become due on a date prior to April 3, 2023.

The ABL Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting our ability, subject to certain exceptions, to, among other things (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) engage in mergers, acquisitions and asset sales, (7) conduct transactions with affiliates, (8) alter the nature of the Company's, CHS' or the guarantors' businesses, (9) grant certain guarantees with respect to physician practices, (10) engage in sale and leaseback transactions or (11) change our fiscal year. We are also required to comply with a consolidated fixed coverage ratio and various affirmative covenants. The consolidated fixed coverage ratio is calculated as the ratio of (x) consolidated EBITDA (as defined in the ABL Facility) less capital expenditures to (y) the sum of consolidated interest expense (as defined in the ABL Facility), scheduled principal payments, income taxes and restricted payments made in cash or in permitted investments. For purposes of calculating the consolidated fixed charge coverage ratio, the calculation of consolidated EBITDA as defined in the ABL Facility is a trailing 12-month calculation that begins with consolidated net income attributable to Holdings, with certain adjustments for interest, taxes, depreciation and amortization, net income attributable to noncontrolling interests, stock compensation expense, restructuring costs, and the financial impact of other non-cash or non-recurring items recorded during any such 12-month period.

Events of default under the ABL Facility include, but are not limited to, (1) CHS' failure to pay principal, interest, fees or other amounts under the ABL Credit Agreement when due (taking into account any applicable grace period), (2) any representation or warranty proving to have been materially incorrect when made, (3) covenant defaults subject, with respect to certain covenants, to an available cure and applicable grace periods, (4) bankruptcy and insolvency events, (5) a cross default to certain other debt, (6) certain undischarged judgments (not paid within an applicable grace period), (7) a change of control (as defined), (8) certain ERISA-related defaults and (9) the invalidity or impairment of specified security interests, guarantees or subordination provisions in favor of the ABL Agent or lenders under the ABL Facility.

On June 22, 2018, CHS completed offers to exchange (i) up to $1.925 billion aggregate principal amount of its new Junior-Priority Secured Notes due 2023, or the 2023 Junior-Priority Notes, in exchange for any and all of its $1.925 billion aggregate principal amount of outstanding 8% Senior Notes, (ii) up to $1.200 billion aggregate principal amount of its new Junior-Priority Secured Notes due 2024, or the 2024 Junior-Priority Notes, in exchange for any and all of its $1.200 billion aggregate principal amount of outstanding 7 ⅛% Senior Notes, and (iii) to the extent that less than all of the outstanding 8% Senior Notes and 7 ⅛% Senior Notes were tendered in the exchange offers, up to an aggregate principal amount of 2024 Junior-Priority Notes equal to, when taken together with the total notes issued in exchange for the validly tendered and accepted 8% Senior Notes and 7 ⅛% Senior Notes, $3.125 billion, in exchange for its outstanding 6 ⅞% Senior Notes. Upon completion of the exchange offers, CHS issued (i) approximately $1.770 billion aggregate principal amount of the 2023 Junior-Priority Notes in exchange for the same amount of 8% Senior Notes, (ii) approximately $1.079 billion aggregate principal amount of the 2024 Junior-Priority Notes in exchange for the same amount of 7 ⅛% Senior Notes and (iii) approximately $276 million aggregate principal amount of the 2024 Junior-Priority Notes in exchange for approximately $368 million of 6 ⅞% Senior Notes.

On July 6, 2018, CHS completed an offering of $1.033 billion aggregate principal amount of 8⅝% Senior Secured Notes due 2024, or the 8⅝% Senior Secured Notes. We used the proceeds from this offering to repay the outstanding balance owed under the Term G Loan and pay fees and expenses related to the offering. The terms of the 8⅝% Senior Secured Notes are governed by an indenture, dated as of July 6, 2018, among CHS, the Company, the subsidiary guarantors party thereto, Regions Bank, as trustee and Credit Suisse AG, as collateral agent. The 8⅝% Senior Secured Notes bear interest at a rate of 8⅝% per year payable semi-annually in arrears on January 15 and July 15 of each year, commencing on January 15, 2019. The 8⅝% Senior Secured Notes are unconditionally guaranteed on a senior-priority secured basis by us and each of the CHS current and future domestic subsidiaries that provide guarantees under CHS' senior secured credit facilities, CHS' ABL facility, any capital market debt securities of CHS (including CHS' outstanding senior notes) and certain other long-term debt of CHS.

As of September 30, 2018, we are currently a party to interest rate swap agreements to limit the effect of changes in interest rates on approximately 66.4% of our variable rate debt. On each of these swaps, we receive a variable rate of interest based on the three-month LIBOR, in exchange for the payment by us of a fixed rate of interest. See Note 11 in the footnotes to the condensed consolidated financial statements for further information on our interest rate swap agreements.

The Credit Facility and the indentures that govern our outstanding notes contain various covenants that limit our ability to take certain actions, including our ability to:

- incur, assume or guarantee additional indebtedness;
- issue redeemable stock and preferred stock;
- repurchase capital stock;
- make restricted payments, including paying dividends and making certain loans, acquisitions and investments;
- redeem debt that is subordinated in right of payment to our outstanding notes;
- create liens;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- impair the security interests;
- enter into agreements that restrict dividends and certain other payments from subsidiaries;
- merge, consolidate, sell or otherwise dispose of substantially all of our assets;
- enter into transactions with affiliates; and
- guarantee certain obligations.

The indentures governing each of the 2023 Junior-Priority Notes and 2024 Junior-Priority Notes also prohibit CHS from purchasing, repurchasing, redeeming, defeasing or otherwise acquiring or retiring any outstanding 8% Senior Notes and 7⅛% Senior Notes after the consummation of the exchange offers described above with: (a) cash or cash equivalents on hand as of the consummation of such exchange offers; (b) cash generated from operations; (c) proceeds from assets sales; or (d) proceeds from the issuance of, or in exchange for, secured debt, in each case, prior to the date that is 60 days prior to the relevant maturity dates of such 8% Senior Notes and 7⅛% Senior Notes, as applicable.

In addition, our Credit Facility contains restrictive covenants and requires us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet these restricted covenants and financial ratios and tests can be affected by events beyond our control, and we cannot assure you that we will meet those tests. A breach of any of these covenants could result in a default under our Credit Facility and/or the indentures that govern our outstanding notes. Upon the occurrence of an event of default under our Credit Facility or indentures that govern our outstanding notes, all amounts outstanding under our Credit Facility and the indentures that govern our outstanding notes may become immediately due and payable and all commitments under the Credit Facility to extend further credit may be terminated.

We believe that internally generated cash flows, availability for additional borrowings under our Credit Facility, of approximately $425 million, of which approximately $86 million is in the form of outstanding letters of credit, the availability under our new ABL Facility and our ability to amend the Credit Facility to provide for one or more incremental tranches of term loans and revolving credit commitments in an aggregate principal amount of up to $500 million, in each case subject to certain limitations as set forth in the Credit Facility, as well as our continued access to the capital markets, will be sufficient to finance acquisitions, capital expenditures, working capital requirements, and any equity or debt repurchases or other debt repayments we may elect to make through the next 12 months. In addition, we are currently required to utilize proceeds received from dispositions of assets, subject to certain exceptions, to repay outstanding debt.

We may elect from time to time to purchase our common stock under our open market repurchase program adopted on November 6, 2015, which authorizes us to purchase up to 10,000,000 shares of our common stock, not to exceed $300 million in repurchases (we have currently repurchased 532,188 shares under such program, all of which shares were repurchased during the three months ended December 31, 2015). This repurchase program will expire on the earlier of November 5, 2018, when the maximum number of shares has been repurchased, or when the maximum dollar amount has been expended. In addition, we may elect from time to time to purchase our outstanding debt in open market purchases, privately negotiated transactions or otherwise. Any such equity or debt repurchases will depend upon prevailing market conditions, our liquidity requirements, contractual restrictions, applicable securities laws requirements, and other factors.

The ratio of earnings to fixed charges is a measure of our ability to meet our fixed obligations related to our indebtedness. The following table shows the ratio of earnings to fixed charges for the nine months ended September 30, 2018:

	Nine Months Ended September 30, 2018
Ratio of earnings to fixed charges (1)	*

(1) Fixed charges include interest expensed and capitalized during the year plus an estimate of the interest component of rent expense. There are no shares of preferred stock outstanding. See exhibit 12 filed as part of this Report for the calculation of this ratio.

* For the nine months ended September 30, 2018, earnings were insufficient to cover fixed charges by approximately $363 million.

Off-balance Sheet Arrangements

In the past, we have utilized operating leases as a financing tool for obtaining the operations of specified hospitals without acquiring, through ownership, the related assets of the hospital and without a significant outlay of cash at the front end of the lease. We utilize the same operating strategies to improve operations at those hospitals held under operating leases as we do at those hospitals that we own. We have not entered into any operating leases for hospital operations since December 2000. At September 30, 2018, we operated two hospitals under operating leases that had an immaterial impact on our consolidated operating results. The terms of the two operating leases we currently have in place expire between December 2020 and January 2028, not including lease extension options. If we allow these leases to expire, we would no longer generate revenues nor incur expenses from these hospitals.

Noncontrolling Interests

We have sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. As of September 30, 2018, we have hospitals in 18 of the markets we serve, with noncontrolling physician ownership interests ranging from less than 1% to 40%. In addition, we have eight other hospitals with noncontrolling interests owned by non-profit entities. Redeemable noncontrolling interests in equity of consolidated subsidiaries was $495 million and $527 million as of September 30, 2018 and December 31, 2017, respectively, and noncontrolling interests in equity of consolidated subsidiaries was $75 million at both September 30, 2018 and December 31, 2017. The amount of net income attributable to noncontrolling interests was $17 million and $20 million for the three months ended September 30, 2018 and 2017, respectively, and $55 million and $56 million for the nine months ended September 30, 2018 and 2017, respectively. As a result of the change in the Stark Law “whole hospital” exception included in the Affordable Care Act, we are not permitted to introduce physician ownership at any of our hospital facilities that did not have physician ownership at the time of the adoption of the Affordable Care Act, or increase the aggregate

percentage of physician ownership in any of our former or existing hospital joint ventures in excess of the aggregate physician ownership level held at the time of the adoption of the Affordable Care Act.

Reimbursement, Legislative and Regulatory Changes

Ongoing legislative and regulatory efforts could reduce or otherwise adversely affect the payments we receive from Medicare and Medicaid and other payors. Within the statutory framework of the Medicare and Medicaid programs, there are substantial areas subject to administrative rulings, interpretations and discretion which may further affect payments made under those programs, and the federal and state governments might, in the future, reduce the funds available under those programs or require more stringent utilization and quality reviews of hospital facilities. Additionally, there may be a continued rise in managed care programs and additional restructuring of the financing and delivery of healthcare in the United States. These events could cause our future financial results to decline. We cannot estimate the impact of Medicare and Medicaid reimbursement changes that have been enacted or are under consideration. We cannot predict whether additional reimbursement reductions will be made or whether any such changes or other restructuring of the financing and delivery of healthcare would have a material adverse effect on our business, financial conditions, results of operations, cash flow, capital resources and liquidity.

Inflation

The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. In addition, our suppliers pass along rising costs to us in the form of higher prices. We have implemented cost control measures, including our case and resource management program, to curb increases in operating costs and expenses. We have generally offset increases in operating costs by increasing reimbursement for services, expanding services and reducing costs in other areas. However, we cannot predict our ability to cover or offset future cost increases, particularly any increases in our cost of providing health insurance benefits to our employees.

Critical Accounting Policies

The discussion and analysis of our financial condition and results of operations are based upon our condensed consolidated financial statements, which have been prepared in accordance with U.S. GAAP. The preparation of these financial statements requires us to make estimates and judgments that affect the reported amount of assets and liabilities, revenues and expenses, and related disclosure of contingent assets and liabilities at the date of our condensed consolidated financial statements. Actual results may differ from these estimates under different assumptions or conditions.

Critical accounting policies are defined as those that are reflective of significant judgments and uncertainties, and potentially result in materially different results under different assumptions and conditions. We believe that our critical accounting policies are limited to those described below.

Revenue Recognition

Upon our adoption of the new revenue recognition standard in the Financial Accounting Standards Board, or FASB, Accounting Standards Codification Topic 606, or ASC 606, we record net operating revenues at the transaction price estimated to reflect the total consideration due from patients and third-party payors in exchange for providing goods and services in patient care. These services are considered to be a single performance obligation and have a duration of less than one year. Revenues are recorded as these goods and services are provided. The transaction price, which involves significant estimates, is determined based on our standard charges for the goods and services provided, with a reduction recorded for price concessions related to third party contractual arrangements as well as patient discounts and patient price concessions. During the nine months ended September 30, 2018, the impact of changes to the inputs used to determine the transaction price was considered immaterial to the current period.

Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from the Centers for Medicare & Medicaid Services and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Under these supplemental programs, the Company recognizes revenue and related expenses in the period in which amounts are estimable and collection is reasonably assured. Reimbursement under these programs is reflected in net operating revenues and fees, taxes or other program-related costs are reflected in other operating expenses.

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. Contractual allowances are calculated and recorded through internally-developed data collection and analysis tools to automate the monthly estimation of required contractual allowances. Within this automated system, payors' historical paid claims data are utilized to calculate the contractual allowances. This data is automatically updated on a monthly basis. All hospital contractual allowance calculations are subjected to monthly review by management to ensure reasonableness and accuracy. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which is one component of the deductions from gross revenues to arrive at net operating revenues (net of contractual allowances and discounts). The process of estimating contractual allowances requires us to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification, historical paid claims data and, when applicable, application of the expected managed care plan reimbursement based on contract terms.

Due to the complexities involved in these estimates, actual payments we receive could be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs and managed care contracts differed by 1% at September 30, 2018 from our estimated reimbursement percentage, net loss for the nine months ended September 30, 2018 would have changed by approximately $84 million, and net accounts receivable at September 30, 2018 would have changed by $107 million. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net loss by an insignificant amount for each of the nine-month periods ended September 30, 2018 and 2017.

Patient Accounts Receivable

Substantially all of our accounts receivable are related to providing healthcare services to patients at our hospitals and affiliated businesses. Collection of these accounts receivable is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and outstanding patient balances for which the primary insurance payor has paid some but not all of the outstanding balance, with the remaining outstanding balance (generally deductibles and co-payments) owed by the patient. For all procedures scheduled in advance, our policy is to verify insurance coverage prior to the date of the procedure. Insurance coverage is not verified in advance of procedures for walk-in and emergency room patients.

We estimate any adjustments to the transaction price for implicit price concessions by reserving a percentage of all self-pay accounts receivable without regard to aging category, based on collection history, adjusted for expected recoveries and any anticipated changes in trends. Our ability to estimate the transaction price and any implicit price concessions is not impacted by not utilizing an aging of our net accounts receivable as we believe that substantially all of the risk exists at the point in time such accounts are identified as self-pay. The percentage used to reserve for all self-pay accounts is based on our collection history. We believe that we collect substantially all of our third-party insured receivables, which include receivables from governmental agencies.

Patient accounts receivable are recorded at net realizable value based on certain assumptions determined by each payor. For third-party payors including Medicare, Medicaid, and Managed Care, the net realizable value is based on the estimated contractual reimbursement percentage, which is based on current contract prices or historical paid claims data by payor. For self-pay accounts receivable, which includes patients who are uninsured and the patient responsibility portion for patients with insurance, the net realizable value is determined using estimates of historical collection experience without regard to aging category. These estimates are adjusted for estimated conversions of patient responsibility portions, expected recoveries and any anticipated changes in trends.

Patient accounts receivable can be impacted by the effectiveness of the Company's collection efforts. Additionally, significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect the net realizable value of accounts receivable. The Company also continually reviews the net realizable value of accounts receivable by monitoring historical cash collections as a percentage of trailing net operating revenues, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, the composition of self-pay receivables between pure self-pay patients and the patient responsibility portion of third-party insured receivables and the impact of recent acquisitions and dispositions. If the actual collection percentage differed by 1% at September 30, 2018 from our estimated collection percentage as a result of a change in expected recoveries, net loss for the nine months ended September 30, 2018 would have changed by $54 million, and net accounts receivable at September 30, 2018 would have changed by $70 million. We also continually review our overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net operating revenues, as well as by analyzing current period net revenue and admissions by payor classification, days revenue outstanding, the composition of self-pay receivables between pure self-pay patients and the patient responsibility portion of third-party insured receivables and the impact of recent acquisitions and dispositions.

Our policy is to write-off gross accounts receivable if the balance is under $10.00 or when such amounts are placed with outside collection agencies. We believe this policy accurately reflects our ongoing collection efforts and is consistent with industry practices. We had approximately $4.8 billion at September 30, 2018 and $4.2 billion December 31, 2017, being pursued by various outside collection agencies. We expect to collect less than 3%, net of estimated collection fees, of the amounts being pursued by outside collection agencies. As these amounts have been written-off, they are not included in our accounts receivable. Collections on amounts previously written-off are recognized as a recovery of net operating revenues when received. However, we take into consideration estimated collections of these future amounts written-off in determining the implicit price concessions used to measure the transaction price for the applicable portfolio of patient accounts receivable.

All of the following information is derived from our hospitals, excluding clinics, unless otherwise noted.

Patient accounts receivable from our hospitals represent approximately 98% of our total consolidated accounts receivable.

Days revenue outstanding, adjusted for the impact of receivables for state Medicaid supplemental payment programs, was 58 days at September 30, 2018 and 56 days at December 31, 2017.

Total gross accounts receivable (prior to allowance for contractual adjustments and implicit price concessions) was approximately $17.3 billion as of September 30, 2018 and approximately $18.6 billion as of December 31, 2017. The approximate percentage of total gross accounts receivable (prior to allowance for contractual adjustments and implicit price concessions) summarized by aging categories is as follows:

As of September 30, 2018

	% of Gross Receivables			
Payor	**0 - 90 Days**	**90 - 180 Days**	**180 - 365 Days**	**Over 365 Days**
Medicare	14 %	1 %	0 %	0 %
Medicaid	7 %	1 %	1 %	1 %
Managed Care and Other	25 %	4 %	3 %	3 %
Self-Pay	10 %	8 %	10 %	12 %

As of December 31, 2017

	% of Gross Receivables			
Payor	**0 - 90 Days**	**90 - 180 Days**	**180 - 365 Days**	**Over 365 Days**
Medicare	13 %	1 %	- %	- %
Medicaid	7 %	1 %	1 %	1 %
Managed Care and Other	24 %	4 %	3 %	3 %
Self-Pay	8 %	7 %	15 %	12 %

The approximate percentage of total gross accounts receivable (prior to allowances for contractual adjustments and implicit price concessions) summarized by payor is as follows:

	September 30, 2018	December 31, 2017
Insured receivables	60.2 %	57.9 %
Self-pay receivables	39.8	42.1
Total	100.0 %	100.0 %

The combined total at our hospitals and clinics for the estimated implicit price concessions for self-pay accounts receivable and allowances for other self-pay discounts and contractuals, as a percentage of gross self-pay receivables, was approximately 89% and 92% at September 30, 2018 and December 31, 2017, respectively. During the three months ended June 30, 2018, we directed the placement with outside collection agencies of approximately $1.3 billion of gross self-pay accounts receivable. Since these receivables were fully reserved at the time of write-off, the overall percentage of reserves for the remaining self-pay accounts receivable decreased. If the receivables that have been written-off, but where collections are still being pursued by outside collection agencies, were included in both the allowances and gross self-pay receivables specified above, the percentage of combined allowances to total self-pay receivables would have been approximately 93% and 94% at September 30, 2018 and December 31, 2017, respectively.

Goodwill and Other Intangibles

Goodwill represents the excess of the fair value of the consideration conveyed in the acquisition over the fair value of net assets acquired. Goodwill is evaluated for impairment annually and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. During 2017, we adopted ASU 2017-04, which allows a company to record a goodwill impairment when the reporting units carrying value exceeds the fair value determined in step one. In 2017, consistent with prior years, we performed our annual goodwill evaluation during the fourth quarter as of September 30, 2017, and then an updated evaluation as of November 30, 2017 due to the identification of certain impairment indicators. With the elimination of the time-intensive step two calculation to determine the implied value of goodwill, we have considered the additional benefits of performing the annual goodwill evaluation later in the fourth quarter to coincide with the timing of the next fiscal year's budgeting and financial projection process. Based on these considerations, we have elected to change the annual goodwill impairment measurement date to October 31. The next annual goodwill evaluation will be performed during the fourth quarter of 2018 with an October 31, 2018 measurement date, or sooner if we identify certain indicators of impairment.

At September 30, 2018, we had approximately $4.6 billion of goodwill recorded, all of which resides at our hospital operations reporting unit.

During the three months ended December 31, 2017, in connection with the preparation of the financial statements included in our 2017 Form 10-K, we identified certain indicators of impairment and performed an interim goodwill impairment evaluation as of November 30, 2017. Those indicators were primarily a further decline in our market capitalization and fair value of our long-term debt during November 2017. We performed an estimated calculation of fair value in step one of the impairment test at November 30, 2017, which indicated that the carrying value of our hospital operations reporting unit exceeded its fair value. As a result of this evaluation and the early adoption of ASU 2017-04, we recorded a non-cash impairment charge of $1.419 billion to goodwill during the three months ended December 31, 2017.

The reduction in our fair value and the resulting goodwill impairment charges recorded during 2016 and 2017 reduced the carrying value of our hospital operations reporting unit to an amount equal to our estimated fair value. This increases the risk that future declines in fair value could result in goodwill impairment. The determination of fair value in step one of our goodwill impairment analysis is based on an estimate of fair value for the hospital operations reporting unit utilizing known and estimated inputs at the evaluation date. Some of those inputs include, but are not limited to, the most recent price of our common stock or fair value of our long-term debt, estimates of future revenue and expense growth, estimated market multiples, expected capital expenditures, income tax rates, and costs of invested capital. Future estimates of fair value could be adversely affected if the actual outcome of one or more of these assumptions changes materially in the future, including further decline in our stock price or fair value of our long-term debt, lower than expected hospital volumes, higher market interest rates or increased operating costs. Such changes impacting the calculation of our fair value could result in a material impairment charge in the future.

Impairment or Disposal of Long-Lived Assets

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

Professional Liability Claims

As part of our business of owning and operating hospitals, we are subject to legal actions alleging liability on our part. We accrue for losses resulting from such liability claims, as well as loss adjustment expenses that are out-of-pocket and directly related to such liability claims. These direct out-of-pocket expenses include fees of outside counsel and experts. We do not accrue for costs that are part of our corporate overhead, such as the costs of our in-house legal and risk management departments. The losses resulting from professional liability claims primarily consist of estimates for known claims, as well as estimates for incurred but not reported claims. The estimates are based on specific claim facts, our historical claim reporting and payment patterns, the nature and level of our hospital operations, and actuarially determined projections. The actuarially determined projections are based on our actual claim data, including historic reporting and payment patterns which have been gathered over an approximately 20-year period. As discussed below, since we purchase excess insurance on a claims-made basis that transfers risk to third-party insurers, the liability we accrue does include an amount for the losses covered by our excess insurance. We also record a receivable for the expected reimbursement of losses covered by our excess insurance. Since we believe that the amount and timing of our future claims payments are reliably determinable, we discount the amount we accrue for losses resulting from professional liability claims using the risk-free interest rate corresponding to the timing of our expected payments.

The net present value of the projected payments was discounted using a weighted-average risk-free rate of 2.2%, 1.8% and 1.6% in 2017, 2016 and 2015, respectively. This liability is adjusted for new claims information in the period such information becomes known to us. Professional malpractice expense includes the losses resulting from professional liability claims and loss adjustment expense, as well as paid excess insurance premiums, and is presented within other operating expenses in the accompanying condensed consolidated statements of loss.

Our processes for obtaining and analyzing claims and incident data are standardized across all of our hospitals and have been consistent for many years. We monitor the outcomes of the medical care services that we provide and for each reported claim, we obtain various information concerning the facts and circumstances related to that claim. In addition, we routinely monitor current key statistics and volume indicators in our assessment of utilizing historical trends. The average lag period between claim occurrence and payment of a final settlement is between three and four years, although the facts and circumstances of individual claims could result in the timing of such payments being different from this average. Since claims are paid promptly after settlement with the claimant is reached, settled claims represent approximately 1.0% of the total liability at the end of any period.

For purposes of estimating our individual claim accruals, we utilize specific claim information, including the nature of the claim, the expected claim amount, the year in which the claim occurred and the laws of the jurisdiction in which the claim occurred. Once the case accruals for known claims are determined, information is stratified by loss layers and retentions, accident years, reported years, geography, and claims relating to the acquired HMA hospitals versus claims relating to our other hospitals. Several actuarial methods are used against this data to produce estimates of ultimate paid losses and reserves for incurred but not reported claims. Each of these methods uses our company-specific historical claims data and other information. This company-specific data includes information regarding our business, including historical paid losses and loss adjustment expenses, historical and current case loss reserves, actual and projected hospital statistical data, a variety of hospital census information, employed physician information, professional liability retentions for each policy year, geographic information and other data.

Based on these analyses, we determine our estimate of the professional liability claims. The determination of management's estimate, including the preparation of the reserve analysis that supports such estimate, involves subjective judgment of management. Changes in reserving data or the trends and factors that influence reserving data may signal fundamental shifts in our future claim development patterns or may simply reflect single-period anomalies. Even if a change reflects a fundamental shift, the full extent of the change may not become evident until years later. Moreover, since our methods and models use different types of data and we select our liability from the results of all of these methods, we typically cannot quantify the precise impact of such factors on our estimates of the liability. Due to our standardized and consistent processes for handling claims and the long history and depth of our company-specific data, our methodologies have produced reliably determinable estimates of ultimate paid losses.

We are primarily self-insured for these claims; however, we obtain excess insurance that transfers the risk of loss to a third-party insurer for claims in excess of our self-insured retentions. Our excess insurance is underwritten on a claims-made basis. For claims reported prior to June 1, 2002, substantially all of our professional and general liability risks were subject to a less than $1 million per occurrence self-insured retention and for claims reported from June 1, 2002 through June 1, 2003, these self-insured retentions were $2 million per occurrence. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 and before June 1, 2014 are self-insured up to $5 million per claim. Substantially all claims reported on or after June 1, 2014 and before June 1, 2018 are self-insured up to $10 million per claim. Substantially all claims reported on or after June 1, 2018 are self-insured up to $15 million per claim. Management, on occasion, has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals has been purchased through commercial insurance companies and generally covers us for liabilities in excess of the self-insured retentions. The excess coverage consists of multiple layers of insurance, the sum of which totals up to $95 million per occurrence and in the aggregate for claims reported on or after June 1, 2003, up to $145 million per occurrence and in the aggregate for claims reported on or after January 1, 2008, up to $195 million per occurrence and in the aggregate for claims reported on or after June 1, 2010, and up to $220 million per occurrence and in the aggregate for claims reported on or after June 1, 2015. In addition, for integrated occurrence malpractice claims, there is an additional $50 million of excess coverage for claims reported on or after June 1, 2014 and an additional $75 million of excess coverage for claims reported on or after June 1, 2015. For certain policy years prior to June 1, 2014, if the first aggregate layer of excess coverage becomes fully utilized, then the self-insured retention will increase to $10 million per claim for any subsequent claims in that policy year until our total aggregate coverage is met. Beginning June 1, 2018, this drop-down provision in the excess policies attaches over the $15 million per claim self-insured retention.

Effective June 1, 2014, the hospitals acquired from HMA were insured on a claims-made basis as described above and through commercial insurance companies as described above for substantially all claims reported on or after June 1, 2014 except for physician-related claims with an occurrence date prior to June 1, 2014. Prior to June 1, 2014, the former HMA hospitals obtained insurance coverage through a wholly-owned captive insurance subsidiary and a risk retention group subsidiary which are domiciled in the Cayman Islands and South Carolina, respectively. Those insurance subsidiaries, which are collectively referred to as the "Insurance Subsidiaries," provided (i) claims-made coverage to all of the former HMA hospitals and (ii) occurrence-basis coverage to most of the physicians employed by the former HMA hospitals. The employed physicians not covered by the Insurance Subsidiaries generally maintained claims-made policies with unrelated third party insurance companies. To mitigate the exposure of the program covering the former HMA hospitals and other healthcare facilities, the Insurance Subsidiaries bought claims-made reinsurance policies from unrelated third parties for claims above self-retention levels of $10 million or $15 million per claim, depending on the policy year.

Effective January 1, 2008, the former Triad hospitals were insured on a claims-made basis as described above and through commercial insurance companies as described above for substantially all claims occurring on or after January 1, 2002 and reported on or after January 1, 2008. Substantially all losses for the former Triad hospitals in periods prior to May 1, 1999 were insured through a wholly-owned insurance subsidiary of HCA, Triad's owner prior to that time, and excess loss policies maintained by HCA. HCA has agreed to indemnify the former Triad hospitals in respect of claims covered by such insurance policies arising prior to May 1, 1999. From May 1, 1999 through December 31, 2006, the former Triad hospitals obtained insurance coverage on a claims incurred basis from HCA's wholly-owned insurance subsidiary with excess coverage obtained from other carriers that is subject to certain deductibles. Effective for claims incurred after December 31, 2006, Triad began insuring its claims from $1 million to $5 million through its wholly-owned captive insurance company, replacing the coverage provided by HCA. Substantially all claims occurring during 2007 were self-insured up to $10 million per claim.

There were no significant changes in our estimate of the reserve for professional liability claims during the nine months ended September 30, 2018.

Income Taxes

We must make estimates in recording provision for income taxes, including determination of deferred tax assets and deferred tax liabilities and any valuation allowances that might be required against the deferred tax assets. We believe that future income will enable us to realize certain deferred tax assets, subject to the valuation allowance we have established.

The total amount of unrecognized benefit that would impact the effective tax rate, if recognized, was approximately $7 million as of September 30, 2018. A total of approximately $4 million of interest and penalties is included in the amount of liability for uncertain tax positions at September 30, 2018. It is our policy to recognize interest and penalties related to unrecognized benefits in our condensed consolidated statements of loss as income tax expense.

It is possible the amount of unrecognized tax benefit could change in the next 12 months as a result of a lapse of the statute of limitations and settlements with taxing authorities; however, we do not anticipate the change will have a material impact on our condensed consolidated results of operations or condensed consolidated financial position.

We, or one of our subsidiaries, file income tax returns in the United States federal jurisdiction and various state jurisdictions. With few exceptions, we are no longer subject to state income tax examinations for years prior to 2014. Our federal income tax returns for the 2009 and 2010 tax years have been settled with the Internal Revenue Service. The results of these examinations were not material to our consolidated results of operations or consolidated financial position. Our federal income tax returns for the 2014 and 2015 tax years remain under examination by the Internal Revenue Service. We believe the results of these examinations will not be material to our consolidated results of operations or consolidated financial position. We have extended the federal statute of limitations through June 30, 2019 for Community Health Systems, Inc. for the tax periods ended December 31, 2007, 2008, 2009 and 2010, and through December 31, 2019 for the tax periods ended December 31, 2014 and 2015.

We have accounted for the effects of the comprehensive tax legislation commonly referred to as the Tax Cuts and Job Act, or the Tax Act, using reasonable estimates based on currently available information and our interpretations thereof, and the estimated impact of the Tax Act during the nine months ended September 30, 2018 and year ended December 31, 2017, may be revised as a result of, among other things, changes in interpretations we have made and the issuance of new tax or accounting guidance. We will complete our accounting for the Tax Act in the fourth quarter of 2018 in accordance with the prescribed measurement period under SAB 118. See Note 6 to the condensed consolidated financial statements in this Quarterly Report on Form 10-Q for additional information.

Recent Accounting Pronouncements

In January 2016, the FASB issued Accounting Standards Update, or ASU, 2016-01, which amends the measurement, presentation and disclosure requirements for equity investments, other than those accounted for under the equity method or that require consolidation of the investee. The ASU eliminates the classification of equity investments as available-for-sale with any changes in fair value of such investments recognized in other comprehensive income, and requires entities to measure equity investments at fair value, with any changes in fair value recognized in net income. This ASU is effective for fiscal years beginning after December 15, 2017, with early adoption permitted. To adopt this ASU, companies must record a cumulative-effect adjustment to beginning retained earnings at the beginning of the period of adoption. We adopted this ASU on January 1, 2018, and the adoption of this ASU did not have a material impact on our consolidated results of operations. Upon adoption, we recorded a reclassification of $6 million from accumulated other comprehensive loss as a decrease to accumulated deficit.

In February 2016, the FASB issued ASU 2016-02, which amends the accounting for leases, requiring lessees to recognize most leases on their balance sheet with a right-of-use asset and a corresponding lease liability. Leases will be classified as either finance or operating leases, which will impact the expense recognition of such leases over the lease term. The ASU also modifies the lease classification criteria for lessors and eliminates some of the real estate leasing guidance previously applied for certain leasing transactions. This ASU is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. We expect to adopt this ASU on January 1, 2019. In July 2018, the FASB issued ASU 2018-11, which provides entities relief from the transition requirements in ASU 2016-02 by allowing them to elect not to recast prior comparative periods. The Company plans to elect this method of transition upon adoption of this ASU. Because of the number of leases we utilize to support our operations, the adoption of this ASU is expected to have a significant impact on our consolidated financial position and results of operations. We have organized an implementation group of cross-functional departmental management to ensure the completeness of its lease information, analyze the appropriate classification of current leases under the new standard, and develop new processes to execute, approve and classify leases on an ongoing basis. We have also engaged outside experts to assist in the development and execution of this plan, as well as the identification and selection of software tools and processes to maintain lease information critical to applying the new standard.

Management is currently evaluating the extent of this anticipated impact on our consolidated financial position and results of operations, and the quantitative and qualitative factors that will impact us as part of the adoption of this ASU, as well as any changes to our leasing strategy that may occur because of the changes to the accounting and recognition of leases. As part of our final implementation efforts during the fourth quarter of 2018, we intend to finalize the quantitative inputs that will determine the impact of adopting the new standard, including the schedule of future rent payments and the appropriate discount rate for outstanding leases at the date of adoption.

In March 2017, the FASB issued ASU 2017-07, which changes the presentation of the components of net periodic benefit cost for sponsors of defined benefit plans for pensions. Under the changes in this ASU, the service cost component of net periodic benefit cost is reported in the same income statement line as other employee compensation costs arising from services during the reporting period. The other components of net periodic benefit cost are presented separately in a line item outside of operating income. This ASU is effective for fiscal years beginning after December 15, 2017, with early adoption permitted. We adopted this ASU on January 1, 2018, and the adoption of this ASU did not have a material impact on our consolidated financial position or results of operations.

In August 2017, the FASB issued ASU 2017-12, which amends hedge accounting recognition and disclosure requirements to improve transparency and simplify the application of hedge accounting for certain hedging instruments. The amendments in this ASU that will have an impact on us include simplification of the periodic hedge effectiveness assessment, elimination of the benchmark interest rate concept for interest rate swaps, and enhancement of the ability to use the critical-terms match method for its cash flow hedges of forecasted interest payments. This ASU is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. We early adopted this ASU on January 1, 2018, and the adoption of this ASU did not have a material impact on our consolidated financial position or results of operations.

In February 2018, the FASB issued ASU 2018-02, which allows for a reclassification from accumulated other comprehensive income to retained earnings for the stranded tax effects in accumulated other comprehensive income resulting from the enactment of the Tax Act and corresponding accounting treatment recorded in the fourth quarter of 2017. The ASU is effective for all entities for fiscal years beginning after December 15, 2018, and interim periods within those fiscal years. Early adoption of the amendments in this ASU is permitted, including adoption in any interim period for reporting periods for which financial statements have not yet been issued. We early adopted this ASU on January 1, 2018, resulting in a reclassification of $6 million from accumulated other comprehensive loss as a decrease to accumulated deficit.

In August 2018, the FASB issued ASU 2018-15 to provide guidance on the accounting for implementation costs incurred in a cloud computing arrangement (CCA) that is a service contract. This ASU requires entities to account for such costs consistent with the guidance on capitalizing costs associated with developing or obtaining internal-use software. The ASU is effective for all entities for fiscal years beginning after December 15, 2019, and interim periods within those fiscal years, with early adoption permitted. We are currently evaluating the impact that adoption of this ASU will have on our consolidated financial position and results of operations.

FORWARD-LOOKING STATEMENTS

Some of the matters discussed in this Report include forward-looking statements. Statements that are predictive in nature, that depend upon or refer to future events or conditions or that include words such as “expects,” “anticipates,” “intends,” “plans,” “believes,” “estimates,” “thinks,” and similar expressions are forward-looking statements. These statements involve known and unknown risks, uncertainties, and other factors that may cause our actual results and performance to be materially different from any future results or performance expressed or implied by these forward-looking statements. These factors include, among other things:

- general economic and business conditions, both nationally and in the regions in which we operate;
- the impact of changes made to the Affordable Care Act, the potential for repeal or additional changes to the Affordable Care Act, its implementation or its interpretation (including through executive orders), as well as changes in other federal, state or local laws or regulations affecting our business;
- the extent to which states support increases, decreases or changes in Medicaid programs, implement health insurance exchanges or alter the provision of healthcare to state residents through regulation or otherwise;
- the future and long-term viability of health insurance exchanges and potential changes to the beneficiary enrollment process;

- risks associated with our substantial indebtedness, leverage and debt service obligations, and the fact that a substantial portion of our indebtedness will mature and become due in the near future, including our ability to refinance such indebtedness on acceptable terms or to incur additional indebtedness;
- demographic changes;
- changes in, or the failure to comply with, governmental regulations;
- potential adverse impact of known and unknown government investigations, audits, and federal and state false claims act litigation and other legal proceedings;
- our ability, where appropriate, to enter into and maintain provider arrangements with payors and the terms of these arrangements, which may be further affected by the increasing consolidation of health insurers and managed care companies and vertical integration efforts involving payors and healthcare providers;
- changes in, or the failure to comply with, contract terms with payors and changes in reimbursement rates paid by federal or state healthcare programs or commercial payors;
- any potential additional impairments in the carrying value of goodwill, other intangible assets, or other long-lived assets, or changes in the useful lives of other intangible assets;
- changes in inpatient or outpatient Medicare and Medicaid payment levels and methodologies;
- the effects related to the continued implementation of the sequestration spending reductions and the potential for future deficit reduction legislation;
- increases in the amount and risk of collectability of patient accounts receivable, including decreases in collectability which may result from, among other things, self-pay growth and difficulties in recovering payments for which patients are responsible, including co-pays and deductibles;
- the efforts of insurers, healthcare providers, large employer groups and others to contain healthcare costs, including the trend toward value-based purchasing;
- our ongoing ability to demonstrate meaningful use of certified EHR technology and recognize income for the related Medicare or Medicaid incentive payments, to the extent such payments have not expired;
- increases in wages as a result of inflation or competition for highly technical positions and rising supply and drug costs due to market pressure from pharmaceutical companies and new product releases;
- liabilities and other claims asserted against us, including self-insured malpractice claims;
- competition;
- our ability to attract and retain, at reasonable employment costs, qualified personnel, key management, physicians, nurses and other healthcare workers;
- trends toward treatment of patients in less acute or specialty healthcare settings, including ambulatory surgery centers or specialty hospitals;
- changes in medical or other technology;
- changes in U.S. GAAP;
- the availability and terms of capital to fund any additional acquisitions or replacement facilities or other capital expenditures;

- our ability to successfully make acquisitions or complete divestitures, including the disposition of hospitals and non-hospital businesses pursuant to our portfolio rationalization and deleveraging strategy, our ability to complete any such acquisitions or divestitures on desired terms or at all (including to realize the anticipated amount of proceeds from contemplated dispositions), the timing of the completion of any such acquisitions or divestitures, and our ability to realize the intended benefits from any such acquisitions or divestitures;
- the impact that changes in our relationships with joint venture or syndication partners could have on effectively operating our hospitals or ancillary services or in advancing strategic opportunities;
- our ability to successfully integrate any acquired hospitals, or to recognize expected synergies from acquisitions;
- the impact of seasonal severe weather conditions, including the timing and amount of insurance recoveries in relation to severe weather events;
- our ability to obtain adequate levels of general and professional liability insurance;
- timeliness of reimbursement payments received under government programs;
- effects related to outbreaks of infectious diseases;
- the impact of prior or potential future cyber-attacks or security breaches;
- any failure to comply with the terms of the Corporate Integrity Agreement;
- the concentration of our revenue in a small number of states;
- our ability to realize anticipated cost savings and other benefits from our current strategic and operational cost savings initiatives;
- changes in interpretations, assumptions and expectations regarding the Tax Act; and
- the other risk factors set forth in our 2017 Form 10-K, and our other public filings with the SEC.

Although we believe that these forward-looking statements are based upon reasonable assumptions, these assumptions are inherently subject to significant regulatory, economic and competitive uncertainties and contingencies, which are difficult or impossible to predict accurately and may be beyond our control. Accordingly, we cannot give any assurance that our expectations will in fact occur, and we caution that actual results may differ materially from those in the forward-looking statements. Given these uncertainties, prospective investors are cautioned not to place undue reliance on these forward-looking statements. These forward-looking statements are made as of the date of this filing. We undertake no obligation to revise or update any forward-looking statements, or to make any other forward-looking statements, whether as a result of new information, future events or otherwise.

Item 3. ***Quantitative and Qualitative Disclosures about Market Risk***

We are exposed to interest rate changes, primarily as a result of our Credit Facility which bears interest based on floating rates. In order to manage the volatility relating to the market risk, we entered into interest rate swap agreements to manage our exposure to these fluctuations, as described under the heading “Liquidity and Capital Resources” in Part I, Item 2. We utilize risk management procedures and controls in executing derivative financial instrument transactions. We do not execute transactions or hold derivative financial instruments for trading purposes. Derivative financial instruments related to interest rate sensitivity of debt obligations are used with the goal of mitigating a portion of the exposure when it is cost effective to do so. As of September 30, 2018, our approximately $1.5 billion notional amount of interest rate swap agreements outstanding represented approximately 66.4% of our variable rate debt.

A 1% change in interest rates on variable rate debt in excess of that amount covered by interest rate swaps would have resulted in interest expense fluctuating approximately $2 million and $5 million for the three months ended September 30, 2018 and 2017, respectively, and $9 million and $24 million for the nine months ended September 30, 2018 and 2017, respectively.

Item 4. ***Controls and Procedures***

Our Chief Executive Officer and Chief Financial Officer, with the participation of other members of management, have evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e)) under the Securities and Exchange Act of 1934, as amended, as of the end of the period covered by this report. Based on such evaluations, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective (at the reasonable assurance level) to ensure that the information required to be included in this report has been recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms and to ensure that the information required to be included in this report was accumulated and communicated to management, including our Chief Executive Officer and Chief Financial Officer, to allow timely decisions regarding required disclosure.

There have been no changes in our internal control over financial reporting during the three months ended September 30, 2018 that have materially affected or are reasonably likely to materially affect our internal controls over financial reporting.

PART II OTHER INFORMATION

Item 1. ***Legal Proceedings***

From time to time, we receive inquiries or subpoenas from state regulators, state Medicaid Fraud Control units, fiscal intermediaries, the Centers for Medicare and Medicaid Services, the Department of Justice and other government entities regarding various Medicare and Medicaid issues. In addition to the matters discussed below, we are currently responding to subpoenas and administrative demands concerning (a) an inquiry regarding sleep labs at two Louisiana hospitals, (b) a civil investigative demand concerning short-term Medicaid eligibility determinations processed by third party vendors at one of our Pennsylvania hospitals, (c) certain cardiology procedures, medical records and quality assurance committee meeting minutes at a formerly owned Tennessee hospital, and (d) a civil investigative demand relating to the Company's adoption of electronic health records technology and the meaningful use program. In addition, we are subject to other claims and lawsuits arising in the ordinary course of our business including lawsuits and claims related to billing practices and the administration of charity care policies at our hospitals. Based on current knowledge, management does not believe that loss contingencies arising from pending legal, regulatory and governmental matters, including the matters described herein, will have a material adverse effect on the consolidated financial position or liquidity of the Company. However, in light of the inherent uncertainties involved in pending legal, regulatory and governmental matters, some of which are beyond our control, and the very large or indeterminate damages sought in some of these matters, an adverse outcome in one or more of these matters could be material to our results of operations or cash flows for any particular reporting period. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Additionally, 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. In September 2014, the Criminal Division of the United States Department of Justice, or DOJ, announced that all qui tam cases will be shared with their Division to determine if a parallel criminal investigation should be opened. The Criminal Division has also frequently stated an intention to pursue corporations in criminal prosecutions. From time to time, we detect issues of non-compliance with Federal healthcare laws pertaining to claims submission and reimbursement practices and/or financial relationships with physicians. We avail ourselves of various mechanisms to address potential overpayments arising out of these issues, including repayment of claims, rebilling of claims, and participation in voluntary disclosure protocols offered by the Centers for Medicare and Medicaid Services and the Office of the Inspector General. Participating in voluntary repayments and voluntary disclosure protocols can have the potential for significant settlement obligations or even enforcement action.

The following legal proceedings are described in detail because, although they may not be required to be disclosed in this Part II, Item 1 under SEC rules, due to the nature of the business of the Company, we believe that the following discussion of these matters may provide useful information to security holders. This discussion does not include claims and lawsuits covered by medical malpractice, general liability or employment practices insurance and risk retention programs, none of which claims or lawsuits would in any event be required to be disclosed in this Part II, Item 1 under SEC rules. Certain of the matters referenced below are also discussed in the Notes to Condensed Consolidated Financial Statements at Part I, Item 1 under Note 14 "Contingencies."

Community Health Systems, Inc. Legal Proceedings

Shareholder Litigation

Class Action Shareholder Federal Securities Cases. Three purported class action cases have been filed in the United States District Court for the Middle District of Tennessee; namely, Norfolk County Retirement System v. Community Health Systems, Inc., et al., filed May 9, 2011; De Zheng v. Community Health Systems, Inc., et al., filed May 12, 2011; and Minneapolis Firefighters Relief Association v. Community Health Systems, Inc., et al., filed June 21, 2011. All three seek class certification on behalf of purchasers of our common stock between July 27, 2006 and April 11, 2011 and allege that misleading statements resulted in artificially inflated prices for our common stock. In December 2011, the cases were consolidated for pretrial purposes and NYC Funds and its counsel were selected as lead plaintiffs/lead plaintiffs' counsel. In lieu of ruling on our motion to dismiss, the court permitted the plaintiffs to file a first amended consolidated class action complaint which was filed on October 5, 2015. Our motion to dismiss was filed on November 4, 2015 and oral argument took place on April 11, 2016. Our motion to dismiss was granted on June 16, 2016 and on June 27, 2016, the plaintiffs filed a notice of appeal to the Sixth Circuit Court of Appeals. The matter was heard on May 3, 2017. On December 13, 2017, the Sixth Circuit reversed the trial court's dismissal of the case and remanded it to the District Court. We filed a renewed partial motion to dismiss on February 9, 2018, which was denied by the District Court on September 24, 2018. We also filed a petition for writ of certiorari with the United States Supreme Court on April 18, 2018 seeking review of the Sixth Circuit's decision. The United States Supreme Court denied the petition for a writ of certiorari on October 1, 2018. Plaintiff's motion for class certification is pending. We believe this consolidated matter is without merit and will vigorously defend this case.

Other Government Investigations

Dothan, Alabama – Independent Lab Billing. On February 12, 2015, our hospital in Dothan, Alabama received a Civil Investigative Demand, or CID, from the United States Department of Justice for information concerning its status as a "covered hospital" under certain lab billing regulations. These regulations discuss permissible billing of the technical component of lab tests performed for hospital patients by an independent laboratory. The CID seeks documentation and explanation whether the hospital qualifies as a covered hospital for billing purposes under the applicable regulations. The hospital received a second CID on April 25, 2018 seeking documents relating to the number of tests performed by a third-party laboratory on behalf of the hospital. However, the Department of Justice has agreed at this time that the hospital need not respond to this second CID. We are cooperating fully with this investigation.

St. Petersburg, Florida – On September 14, 2017, our hospital in St. Petersburg, Florida received a CID from the United States Department of Justice for information concerning its participation in the Florida Low Income Pool Program. The Low Income Pool Program, or LIP, is a funding pool to support healthcare providers that provide uncompensated care to Florida residents who are uninsured or underinsured. The CID seeks documentation related to agreements between the hospital and Pinellas County. We are cooperating fully with this investigation.

Commercial Litigation and Other Lawsuits

Becker v. Community Health Systems, Inc. d/b/a Community Health Systems Professional Services Corporation d/b/a Community Health Systems d/b/a Community Health Systems PSC, Inc. d/b/a Rockwood Clinic P.S. and Rockwood Clinic, P.S. (Superior Court, Spokane, Washington). This suit was filed on February 29, 2012, by a former chief financial officer at Rockwood Clinic in Spokane, Washington. Becker claims he was wrongfully terminated for allegedly refusing to certify a budget for Rockwood Clinic in 2012. On February 29, 2012, he also filed an administrative complaint with the Department of Labor, Occupational Safety and Health Administration alleging that he is a whistleblower under Sarbanes-Oxley, which was dismissed by the agency and was appealed to an administrative law judge for a hearing that occurred on January 19-26, 2016. In a decision dated November 9, 2016, the law judge awarded Becker approximately $1.9 million for front pay, back pay and emotional damages with attorney fees to be later determined. We have appealed the award to the Administrative Review Board and are awaiting its decision. At a hearing on July 27, 2012, the trial court dismissed Community Health Systems, Inc. from the state case and subsequently certified the state case for an interlocutory appeal of the denial to dismiss his employer and the management company. The appellate court accepted the interlocutory appeal, and it was argued on April 30, 2014. On August 14, 2014, the court denied our appeal. On October 20, 2014, we filed a petition to review the denial with the Washington Supreme Court. Our appeal was accepted and oral argument was heard on June 9, 2015. On September 15, 2015, the court denied our appeal and remanded to the trial court; a previous trial setting of September 12, 2016 has been vacated and not reset. We continue to vigorously defend these actions.

Cyber Attack. As previously disclosed on a Current Report on Form 8-K filed by us on August 18, 2014, our computer network was the target of an external, criminal cyber-attack that we believe occurred between April and June, 2014. We and Mandiant (a FireEye Company), the forensic expert engaged by us in connection with this matter, believe the attacker was a foreign "Advanced Persistent Threat" group who used highly sophisticated malware and technology to attack our systems. The attacker was able to bypass our security measures and successfully copy and transfer outside the Company certain non-medical patient identification data (such as patient names, addresses, birthdates, telephone numbers and social security numbers), but not including patient credit card, medical or clinical information. We worked closely with federal law enforcement authorities in connection with their investigation and possible prosecution of those determined to be responsible for this attack. Mandiant has conducted a thorough investigation of this incident and continues to advise us regarding security and monitoring efforts. We have provided appropriate notification to affected patients and regulatory agencies as required by federal and state law. We have offered identity theft protection services to individuals affected by this attack.

We have incurred certain expenses to remediate and investigate this matter. In addition, multiple purported class action lawsuits have been filed against us and certain subsidiaries. These lawsuits allege that sensitive information was unprotected and inadequately encrypted by us. The plaintiffs claim breach of contract and other theories of recovery, and are seeking damages, as well as restitution for any identity theft. On February 4, 2015, the United States Judicial Panel on Multidistrict Litigation ordered the transfer of the purported class actions pending outside of the District Court for the Northern District of Alabama to the District Court for the Northern District of Alabama for coordinated or consolidated pretrial proceedings. A consolidated complaint was filed and we filed a motion to dismiss on September 21, 2015, which was partially argued on February 10, 2016. In an oral ruling from the bench, the court greatly limited the potential class by ruling only plaintiffs with specific injury resulting from the breach had standing to sue. Further, on jurisdictional grounds, the court dismissed Community Health Systems, Inc. from all non-Tennessee based cases. Finally, the court set April 15, 2016 for further argument on whether the remaining plaintiffs have sufficiently stated a cause of action to continue their cases. On April 15, 2016 in an oral ruling from the bench, the court dismissed additional claims and following this oral ruling only eight of the forty plaintiffs remained with significant limitations imposed on their ability to assert claims for damages. These oral rulings were confirmed in a written order filed on September 12, 2016. On October 20, 2016, the plaintiffs filed a renewed motion for interlocutory appeal from the motion to dismiss ruling and on February 15, 2017 this motion was denied. Plaintiffs refiled their motion for permission to seek interlocutory appeal on March 15, 2017, and that motion was also denied. We have settled these class action lawsuits subject to approval by the District Court.

We are also currently responding to two government investigations related to the 2014 cyber-attack. The first is being conducted by various State Attorneys General, and the second is being conducted by the U.S. Department of Health and Human Services Office for Civil Rights. We are cooperating fully with both investigations.

Empire Health Foundation v. CHS/Community Health Systems, Inc., CHS Washington Holdings, LLC, Spokane Washington Hospital Company, LLC, Spokane Valley Washington Hospital Company, LLC. This suit was filed on June 12, 2017 by Empire Health Foundation claiming Deaconess and Valley Hospitals failed to abide by charity care obligations allegedly existing in the 2008 Asset Purchase Agreement between Empire Health System and Company affiliates. The court granted in part and denied in part the hospitals' motion to dismiss on October 11, 2017. The trial for this matter is set for May 28, 2019. We believe these claims are without merit and will vigorously defend the case.

Gibson v. Byrd Regional Medical Center. This case is a purported class action lawsuit filed in the 30th Judicial District Court for the State of Louisiana and served on August 3, 2016, claiming our affiliated Leesville, Louisiana hospital violated payor contracts by allegedly improperly asserting hospital liens against third-party tortfeasors and seeking class certifications for any similarly situated plaintiffs. The court has certified a class and denied our motion for summary judgment. We have appealed both rulings to the Louisiana Third Circuit Court of Appeals. That appeal is pending. We believe these claims are without merit and will vigorously defend the case.

Zwick Partners, LP and Aparna Rao, individually and on behalf of all others similarly situated v. Quorum Health Corporation, Community Health Systems, Inc., Wayne T. Smith, W. Larry Cash, Thomas D. Miller, and Michael J. Culotta. This purported class action lawsuit previously filed in the United States District Court, Middle District of Tennessee was amended on April 17, 2017 to include Community Health Systems, Inc., Wayne T. Smith and W. Larry Cash as additional defendants. The plaintiffs seek to represent a class of QHC shareholders and allege that the failure to record a goodwill and long-lived asset impairment charge against QHC at the time of the spin-off of QHC violated federal securities laws. The District Court denied all defendants' motions to dismiss on April 20, 2018. The plaintiffs amended their complaint on September 14, 2018, and our motion to dismiss the new claims in the amended complaint is pending. Plaintiffs' motion for class certification is also pending. We believe the claims are without merit and will vigorously defend the case.

R2 Investments v Quorum Health Corporation; Community Health Systems, Inc.; Wayne T. Smith; W. Larry Cash; Thomas D. Miller; Michael J. Culotta; John A. Clerico; James S. Ely, III; John A. Fry; William Norris Jennings; Julia B. North; H. Mitchell Watson, Jr.; H. James Williams. This case is pending in the Circuit Court for Williamson County, Tennessee and was served on October 26, 2017. The plaintiff alleges common law fraud and violation of Tennessee securities fraud statutes in connection with its purchase of QHC stock and QHC senior secured notes. The court granted in part and denied in part the director defendants' motion to dismiss and denied the remaining defendants' motions to dismiss on May 11, 2018. We believe the claims are without merit and will vigorously defend the case.

Microsoft Corporation v Community Health Systems, Inc. This case is pending in the District Court for the Middle District of Tennessee and was served on March 16, 2018. The plaintiff alleges willful copyright infringement, contributing copyright infringement, breach of contract, and breach of the implied covenant of good faith and fair dealing in connection with the alleged use of certain Microsoft products by the Company related to certain of our divestitures. We have answered the complaint. We believe the claims are without merit and will vigorously defend the case.

Revenue Cycle Service Center and CHSPSC, LLC v QHCCS, LLC, Quorum Health Corporation and QHCCS, LLC v Community Health Systems, Inc. This case is pending in arbitration and was initiated by the Company on August 4, 2017. The Company is seeking unpaid amounts due from QHC related to a Computer Data Processing Transition Services Agreement and a Shared Services Transition Services Agreement (the "TSAs") entered into between QHC and the Company in connection with the spin-off of QHC. QHC filed a counterclaim, claiming breach of contract and tortious interference, among others. We believe QHC's counterclaims are without merit. The arbitration began on June 18, 2018 and continued through June 27, 2018. It reconvened on October 1, 2018 and concluded on October 8, 2018. On June 25, 2018, the arbitration panel issued a partial order that the TSAs were enforceable contracts and would continue by their terms until their expiration in April 2021. QHC had attempted to challenge the legal enforceability of both of those agreements. We expect a ruling on all remaining issues by January 15, 2019.

Certain Legal Proceedings Related to HMA

Medicare/Medicaid Billing Lawsuits

Beginning during the week of December 16, 2013 eleven qui tam lawsuits filed by private individuals against HMA were unsealed in various United States district courts. The United States has elected to intervene in all or part of eight of these matters; namely *U.S. ex rel. Craig Brummer v. Health Management Associates, Inc. et al. (Middle District Georgia) ("Brummer"); U.S. ex rel. Ralph D. Williams v. Health Management Associates, Inc. et al. (Middle District Georgia) ("Williams"); U.S. ex rel. Scott H. Plantz, M.D. et al. v. Health Management Associates, Inc., et al. (Northern District Illinois) ("Plantz"); U.S. ex rel. Thomas L. Mason, M.D. et al. v. Health Management Associates, Inc. et al. (Western District North Carolina) ("Mason"); U.S. ex rel. Jacqueline Meyer, et al. v. Health Management Associates, Inc., Gary Newsome et al. ("Jacqueline Meyer") (District of South Carolina); U.S. ex rel. George Miller, et al. v. Health Management Associates, Inc. (Eastern District of Pennsylvania) ("Miller"); U.S. ex rel. Bradley Nurkin v. Health Management Associates, Inc. et al. (Middle District of Florida) ("Nurkin"); and U.S. ex rel. Paul Meyer v. Health Management Associates, Inc. et al. (Southern District Florida) ("Paul Meyer")*. The United States has elected to intervene with respect to allegations in these cases that certain HMA hospitals inappropriately admitted patients and then submitted reimbursement claims for treating those individuals to federal healthcare programs in violation of the False Claims Act or that certain HMA hospitals had inappropriate financial relationships with physicians which violated the Stark law, the Anti-Kickback Statute, and the False Claims Act. Certain of these complaints also allege the same actions violated various state laws which prohibit false claims. The United States has declined to intervene in three of the eleven matters, namely *U.S. ex rel. Anita France, et al. v. Health Management Associates, Inc. (Middle District Florida) ("France")* which involved allegations of wrongful billing and was settled; *U.S. ex rel. Sandra Simmons v. Health Management Associates, Inc. et al. (Eastern District Oklahoma) ("Simmons")* which alleges unnecessary surgery by an employed physician and which was settled as to all allegations except alleged wrongful termination; and *U.S. ex rel. David Napoliello, M.D. v. Health Management Associates, Inc. (Middle District Florida) ("Napoliello")* which alleges inappropriate admissions. On April 3, 2014, the Multi District Litigation Panel ordered the transfer and consolidation for pretrial proceedings of the eight intervened cases, plus the Napoliello matter, to the District of the District of Columbia under the name *In Re: Health Management Associates, Inc. Qui Tam Litigation*. On September 25, 2018, we announced a global resolution and settlement agreements ending the U.S. Department of Justice investigation and settling these qui tam lawsuits. The global settlement includes a total payment, including interest, of $266 million, which will be paid in the fourth quarter of 2018. Additionally, under the terms of the global settlement, our existing corporate integrity agreement, or CIA, has been amended and extended. The extension began immediately and effectively adds two years to the existing CIA, with the amended CIA now running through 2021.

Qui Tam Matters Where the Government Declined Intervention

U.S. and the State of Mississippi ex rel. W. Blake Vanderlan, M.D. v. Jackson HMA, LLC d/b/a Central Mississippi Medical Center and Merit Health Central (SD Mississippi). By order filed on August 31, 2017, the court ordered the unsealing of this matter. The unsealing revealed that on August 31, 2017 the United States had declined to intervene in the allegations that certain alleged EMTALA violations at the hospital resulted in a violation of the False Claims Act. The hospital's motion to dismiss is pending. We believe this matter is without merit and will vigorously defend this case.

Securities and Exchange Commission Investigations

On April 25, 2013, HMA received a subpoena from the SEC, issued pursuant to an investigation, requesting documents related to accounts receivable, billing write-downs, contractual adjustments, reserves for doubtful accounts, and accounts receivable aging, and revenue from Medicare, Medicaid and from privately insured or uninsured patients. On June 5, 2013, HMA received a supplemental subpoena from the SEC which requests additional financial reports. Subsequent subpoenas have been directed to us, our accountants, the former accountants for HMA and certain individuals. On July 17, 2014, we received an additional subpoena from the SEC seeking numerous categories of documents relating to the financial statement adjustments taken in the fourth quarter of 2013 in the areas described above. This investigation is ongoing and we are unable to determine the potential impact, if any, of this investigation.

Management of Significant Legal Proceedings

In accordance with our governance documents, including our Governance Guidelines and the charter of the Audit and Compliance Committee, our management of significant legal proceedings is overseen by the independent members of the Board of Directors and, in particular, the Audit and Compliance Committee. The Audit and Compliance Committee is charged with oversight of compliance, regulatory and litigation matters, and enterprise risk management. Management has been instructed to refer all significant legal proceedings and allegations of financial statement fraud, error, or misstatement to the Audit and Compliance Committee for its oversight and evaluation. Consistent with New York Stock Exchange, Nasdaq and Sarbanes-Oxley independence requirements, the Audit and Compliance Committee is comprised entirely of individuals who are independent of our management, and all four members of the Audit and Compliance Committee are "audit committee financial experts" as defined in the Securities Exchange Act of 1934, as amended.

In addition, the Audit and Compliance Committee and the other independent members of the Board of Directors oversee the functions of the voluntary compliance program, including its auditing and monitoring functions and confidential disclosure program. In recent years, the voluntary compliance program has addressed the potential for a variety of billing errors that might be the subject of audits and payment denials by the CMS Recovery Audit Contractors' permanent project, including MS-DRG coding, outpatient hospital and physician coding and billing, and medical necessity for services (including a focus on hospital stays of very short duration). Efforts by management, through the voluntary compliance program, to identify and limit risk from these government audits have included significant policy and guidance revisions, training and education, and auditing. The Board of Directors now oversees and reviews periodic reports of our compliance with the Corporate Integrity Agreement, or CIA, that we entered into with the United States Department of Health and Human Services Office of the Inspector General during 2014 and which was amended and extended in September 2018.

Item 1A. Risk Factors

There have been no material changes with regard to the risk factors previously disclosed in the 2017 Form 10-K.

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

The following table contains information about our purchases of common stock during the three months ended September 30, 2018.

Period	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs(b)	Maximum Number of Shares That May Yet Be Purchased Under the Plans or Programs(b)
July 1, 2018 - July 31, 2018	-	$ -	-	9,467,812
August 1, 2018 - August 31, 2018	-	-	-	9,467,812
September 1, 2018 - September 30, 2018	-	-	-	9,467,812
Total	-	$ -	-	9,467,812

(a) No shares were withheld to satisfy the payment of tax obligations related to the vesting of restricted stock awards.

(b) On November 9, 2015, we announced the adoption of a new open market repurchase program for up to 10,000,000 shares of our common stock, not to exceed $300 million in repurchases. This repurchase program will expire on the earlier of November 5, 2018, when the maximum number of shares has been repurchased, or when the maximum dollar amount has been expended. No shares were repurchased under this program during the three months ended September 30, 2018.

With the exception of a special cash dividend of $0.25 per share paid by us in December 2012, historically, we have not paid any cash dividends. Subject to certain exceptions, our Credit Facility limits the ability of our subsidiaries to pay dividends and make distributions to us, and limits our ability to pay dividends and/or repurchase stock, to an amount not to exceed $200 million in the aggregate plus an additional $25 million in any particular year plus the aggregate amount of proceeds from the exercise of stock options, subject to certain restrictions. The indentures governing each series of our outstanding notes also restrict our subsidiaries from, among other matters, paying dividends and making distributions to us, which thereby limits our ability to pay dividends and/or repurchase stock. As of September 30, 2018, under the most restrictive test in these agreements (and subject to certain exceptions), we have approximately $200 million available with which to pay permitted dividends and/or repurchase shares of our stock or make other restricted payments.

Item 3. Defaults Upon Senior Securities

None.

Item 4. *Mine Safety Disclosures*

Not applicable.

Item 5. *Other Information*

None.

Item 6. ***Exhibits***

No.		Description
4.1	*	Seventeenth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8.000% Senior Notes due 2019, dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as successor Trustee
4.2	*	Fourteenth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 7.125% Senior Notes due 2020, dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee
4.3	*	Eleventh Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 5.125% Senior Secured Notes due 2021, dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto, Regions Bank, as Trustee and Credit Suisse AG, as Collateral Agent
4.4	*	Eleventh Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 6.875% Senior Notes due 2022, dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee
4.5	*	Fourth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 6.250% Senior Secured Notes due 2023, dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee and Credit Suisse AG, as Collateral Agent
4.6	*	First Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s Junior-Priority Secured Notes due 2023, dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto, and Regions Bank, as Trustee and as Junior-Priority Collateral Agent
4.7	*	First Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8.125% Junior-Priority Secured Notes due 2024, dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto, and Regions Bank, as Trustee and as Junior-Priority Collateral Agent
4.8	*	First Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8.625% Senior Secured Notes due 2024, dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee and Credit Suisse AG, as Collateral Agent
12	*	Computation of Ratio of Earnings to Fixed Charges
31.1	*	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	*	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	**	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	**	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
99.1	*	Corporate Integrity Agreement, Amended, dated September 21, 2018, between Community Health Systems, Inc. and the Office of Inspector General of the United States Department of Health and Human Services
101.INS	*	XBRL Instance Document
101.SCH	*	XBRL Taxonomy Extension Schema
101.CAL	*	XBRL Taxonomy Extension Calculation Linkbase
101.DEF	*	XBRL Taxonomy Extension Definition Linkbase
101.LAB	*	XBRL Taxonomy Extension Label Linkbase
101.PRE	*	XBRL Taxonomy Extension Presentation Linkbase

* Filed herewith.
** Furnished herewith

SIGNATURES

Pursuant to the requirements of section 13 or 15(d) 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.

COMMUNITY HEALTH SYSTEMS, INC.
(Registrant)

By: /s/ Wayne T. Smith
Wayne T. Smith
Chairman of the Board and
Chief Executive Officer
(principal executive officer)

By: /s/ Thomas J. Aaron
Thomas J. Aaron
Executive Vice President and
Chief Financial Officer
(principal financial officer)

By: /s/ Kevin J. Hammons
Kevin J. Hammons
Senior Vice President, Assistant Chief Financial
Officer, Chief Accounting Officer and Treasurer
(principal accounting officer)

Date: October 30, 2018

EXHIBIT 4.1

SEVENTEENTH SUPPLEMENTAL INDENTURE (this "**Supplemental Indenture**"), dated as of October 3, 2018, among CHS/COMMUNITY HEALTH SYSTEMS, INC., a Delaware corporation (the "**Issuer**"), the parties identified as New Subsidiary Guarantors on the signature pages hereto (each, a "**New Subsidiary Guarantor**" and, collectively, the "**New Subsidiary Guarantors**") and REGIONS BANK, as successor Trustee under the Indenture (the "**Trustee**").

W I T N E S S E T H:

WHEREAS, each of the Issuer, the Guarantors and the Trustee have heretofore executed and delivered an Indenture as amended, supplemented, waived or otherwise modified (the "**Indenture**"), dated as of November 22, 2011, providing for the issuance of the 8.000% Senior Notes due 2019 (the "**Securities**");

WHEREAS, each of the undersigned New Subsidiary Guarantors has deemed it advisable and in its best interest to execute and deliver this Supplemental Indenture, and to become a New Subsidiary Guarantor under the Indenture; and

WHEREAS, pursuant to Section 9.01(4) of the Indenture, the Trustee, the Issuer and the New Subsidiary Guarantors are authorized to execute and deliver this Supplemental Indenture.

NOW THEREFORE, in consideration of the foregoing and for good and valuable consideration, the receipt of which is hereby acknowledged, the Issuer, the New Subsidiary Guarantors and the Trustee mutually covenant and agree for the equal and ratable benefit of the Holders of the Securities as follows:

SECTION 1. Capitalized Terms. Capitalized terms used herein but not defined shall have the meanings assigned to them in the Indenture.

SECTION 2. Guaranties. Each of the New Subsidiary Guarantors hereby agrees to guarantee the Issuer's obligations under the Securities on the terms and subject to the conditions set forth in Article 10 of the Indenture and to be bound by all other applicable provisions of the Indenture as a Subsidiary Guarantor.

SECTION 3. Ratification of Indenture; Supplemental Indentures Part of Indenture. Except as expressly amended hereby, the Indenture is in all respects ratified and confirmed and all the terms, conditions and provisions thereof shall remain in full force and effect. This Supplemental Indenture shall form a part of the Indenture for all purposes, shall inure to the benefit of the Trustee and every Holder of Securities heretofore or hereafter authenticated and the Issuer, the Trustee and every Holder of Securities heretofore or hereafter authenticated and delivered shall be bound hereby.

SECTION 4. Governing Law. **THIS SUPPLEMENTAL INDENTURE SHALL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK.**

SECTION 5. Trustee Makes No Representation. The Trustee makes no representation as to the validity or sufficiency of this Supplemental Indenture.

SECTION 6. Counterparts. The parties may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement. The exchange of copies of this Supplemental Indenture and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Supplemental Indenture as to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 7. Effect of Headings. The Section headings herein are for convenience only and shall not effect the construction of this Supplemental Indenture.

[*Signature page follows*]

IN WITNESS WHEREOF, the parties have caused this Supplemental Indenture to be duly executed as of the date first above written.

CHS/Community Health Systems, Inc.,
a Delaware corporation

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President, General Counsel and Assistant Secretary

New Subsidiary Guarantors:
La Porte Health System, LLC,
a Delaware limited liability company
La Porte Hospital Company, LLC,
a Delaware limited liability company
Knox Hospital Company, LLC,
a Delaware limited liability company
Carolinas JV Holdings II, LLC,
a Delaware limited liability company

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President and Assistant Secretary

Acting on behalf of each of the New Subsidiary Guarantors set forth above

Regions Bank, as Trustee

By: /s/ Kristine Prall
Kristine Prall
Vice President

[*Signature Page to Seventeenth Supplemental Indenture (2019 Notes)*]

EXHIBIT 4.2

FOURTEENTH SUPPLEMENTAL INDENTURE (this "**Supplemental Indenture**"), dated as of October 3, 2018, among CHS/COMMUNITY HEALTH SYSTEMS, INC., a Delaware corporation (the "**Issuer**"), the parties identified as New Subsidiary Guarantors on the signature pages hereto (each, a "**New Subsidiary Guarantor**" and, collectively, the "**New Subsidiary Guarantors**") and REGIONS BANK, as Trustee under the Indenture (the "**Trustee**").

W I T N E S S E T H:

WHEREAS, each of the Issuer, the Guarantors and the Trustee have heretofore executed and delivered an Indenture as amended, supplemented, waived or otherwise modified (the "**Indenture**"), dated as of July 18, 2012, providing for the issuance of the 7.125% Senior Notes due 2020 (the "**Securities**");

WHEREAS, each of the undersigned New Subsidiary Guarantors has deemed it advisable and in its best interest to execute and deliver this Supplemental Indenture, and to become a New Subsidiary Guarantor under the Indenture; and

WHEREAS, pursuant to Section 9.01(4) of the Indenture, the Trustee, the Issuer and the New Subsidiary Guarantors are authorized to execute and deliver this Supplemental Indenture.

NOW THEREFORE, in consideration of the foregoing and for good and valuable consideration, the receipt of which is hereby acknowledged, the Issuer, the New Subsidiary Guarantors and the Trustee mutually covenant and agree for the equal and ratable benefit of the Holders of the Securities as follows:

SECTION 1. Capitalized Terms. Capitalized terms used herein but not defined shall have the meanings assigned to them in the Indenture.

SECTION 2. Guaranties. Each of the New Subsidiary Guarantors hereby agrees to guarantee the Issuer's obligations under the Securities on the terms and subject to the conditions set forth in Article 10 of the Indenture and to be bound by all other applicable provisions of the Indenture as a Subsidiary Guarantor.

SECTION 3. Ratification of Indenture; Supplemental Indentures Part of Indenture. Except as expressly amended hereby, the Indenture is in all respects ratified and confirmed and all the terms, conditions and provisions thereof shall remain in full force and effect. This Supplemental Indenture shall form a part of the Indenture for all purposes, shall inure to the benefit of the Trustee and every Holder of Securities heretofore or hereafter authenticated and the Issuer, the Trustee and every Holder of Securities heretofore or hereafter authenticated and delivered shall be bound hereby.

SECTION 4. Governing Law. **THIS SUPPLEMENTAL INDENTURE SHALL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK.**

SECTION 5. Trustee Makes No Representation. The Trustee makes no representation as to the validity or sufficiency of this Supplemental Indenture.

SECTION 6. Counterparts. The parties may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement. The exchange of copies of this Supplemental Indenture and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Supplemental Indenture as to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 7. Effect of Headings. The Section headings herein are for convenience only and shall not effect the construction of this Supplemental Indenture.

[*Signature page follows*]

IN WITNESS WHEREOF, the parties have caused this Supplemental Indenture to be duly executed as of the date first above written.

CHS/Community Health Systems, Inc.,
a Delaware corporation

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President, General Counsel and Assistant Secretary

New Subsidiary Guarantors:
La Porte Health System, LLC,
a Delaware limited liability company
La Porte Hospital Company, LLC,
a Delaware limited liability company
Knox Hospital Company, LLC,
a Delaware limited liability company
Carolinas JV Holdings II, LLC,
a Delaware limited liability company

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President and Assistant Secretary

Acting on behalf of each of the New Subsidiary Guarantors set forth above

Regions Bank, as Trustee

By: /s/ Kristine Prall
Kristine Prall
Vice President

[*Signature Page to Fourteenth Supplemental Indenture (2020 Notes)*]

EXHIBIT 4.3

ELEVENTH SUPPLEMENTAL INDENTURE, (this "Supplemental Indenture") dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., a Delaware corporation ("Issuer"), the parties that are signatories hereto as Guarantors (each, a "Guaranteeing Subsidiary" and, collectively, the "Guaranteeing Subsidiaries"), Credit Suisse AG, as Collateral Agent, and Regions Bank, as Trustee under the Indenture referred to below.

W I T N E S S E T H:

WHEREAS, each of the Issuer, the Guarantors, the Trustee and the Collateral Agent have heretofore executed and delivered an indenture dated as of January 27, 2014 (as amended, supplemented, waived or otherwise modified, the "Indenture"), providing for the issuance on such date of an aggregate principal amount of $1,000,000,000 of 5.125% Senior Secured Notes due 2021 (the "Notes") of the Issuer;

WHEREAS, the Indenture provides that the Guaranteeing Subsidiaries shall execute and deliver to the Trustee and the Collateral Agent a supplemental indenture pursuant to which the Guaranteeing Subsidiaries shall unconditionally guarantee all of the Issuer's Obligations under the Notes and the Indenture on the terms and conditions set forth herein and under the Indenture (the "Note Guarantee"), each on the terms and conditions set forth herein; and

WHEREAS, pursuant to Section 9.1 of the Indenture, the Issuer, any Guarantor, the Collateral Agent and the Trustee are authorized to execute and deliver this Supplemental Indenture to amend or supplement the Indenture, without the consent of any Holder;

NOW, THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the receipt of which is hereby acknowledged, the Issuer, the Guaranteeing Subsidiaries, the Collateral Agent and the Trustee mutually covenant and agree for the benefit of the Trustee, the Collateral Agent and the Holders of the Notes as follows:

ARTICLE I
DEFINITIONS

SECTION 1.1. Defined Terms. As used in this Supplemental Indenture, terms defined in the Indenture or in the preamble or recitals hereto are used herein as therein defined. The words "herein," "hereof" and "hereby" and other words of similar import used in this Supplemental Indenture refer to this Supplemental Indenture as a whole and not to any particular section hereof.

ARTICLE II
AGREEMENT TO BE BOUND; GUARANTEE

SECTION 2.1. Agreement to be Bound. Each of the Guaranteeing Subsidiaries hereby becomes a party to the Indenture as a "Guarantor" and as such will have all of the rights and be subject to all of the obligations and agreements of a "Guarantor" under the Indenture.

SECTION 2.2. Guarantee. Each of the Guaranteeing Subsidiaries agrees, on a joint and several basis with all the existing Guarantors, to fully, unconditionally and irrevocably

Guarantee to each Holder of the Notes, the Trustee and the Collateral Agent the Guaranteed Obligations pursuant to Article X of the Indenture as and to the extent provided for therein.

ARTICLE III
MISCELLANEOUS

SECTION 3.1. Notices. All notices and other communications to the Guarantors shall be given as provided in the Indenture.

SECTION 3.2. Merger and Consolidation. Each Guaranteeing Subsidiary shall not sell or otherwise dispose of all or substantially all of its assets to, or consolidate with or merge with or into, another Person (other than the Issuer or any Restricted Subsidiary that is a Guarantor or becomes a Guarantor concurrently with the transaction) except in accordance with Section 4.1(e) of the Indenture.

SECTION 3.3. Release of Guarantee. The Note Guarantees hereunder may be released in accordance with Section 10.2 of the Indenture.

SECTION 3.4. Parties. Nothing expressed or mentioned herein is intended or shall be construed to give any Person, firm or corporation, other than the Holders and the Trustee, any legal or equitable right, remedy or claim under or in respect of this Supplemental Indenture or the Indenture or any provision herein or therein contained.

SECTION 3.5. Governing Law. This Supplemental Indenture shall be governed by, and construed in accordance with, the laws of the State of New York.

SECTION 3.6. Severability. In case any provision in this Supplemental Indenture shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby and such provision shall be ineffective only to the extent of such invalidity, illegality or unenforceability.

SECTION 3.7. Benefits Acknowledged. Each Guaranteeing Subsidiary's Note Guarantee is subject to the terms and conditions set forth in the Indenture. Each Guaranteeing Subsidiary acknowledges that it will receive direct and indirect benefits from the financing arrangements contemplated by the Indenture and this Supplemental Indenture and that the guarantee and waivers made by it pursuant to its Note Guarantee are knowingly made in contemplation of such benefits.

SECTION 3.8. Ratification of Indenture; Supplemental Indentures Part of Indenture. Except as expressly amended hereby, the Indenture is in all respects ratified and confirmed and all the terms, conditions and provisions thereof shall remain in full force and effect. This Supplemental Indenture shall form a part of the Indenture for all purposes, and every Holder of Notes heretofore or hereafter authenticated and delivered shall be bound hereby.

SECTION 3.9. The Trustee and the Collateral Agent. Neither the Trustee nor the Collateral Agent make any representation or warranty as to the validity or sufficiency of this Supplemental Indenture or with respect to the recitals contained herein, all of which recitals are made solely by the other parties hereto.

SECTION 3.10. Counterparts. The parties hereto may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement. The exchange of copies of this Supplemental Indenture and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Supplemental Indenture as to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 3.11. Execution and Delivery. Each Guaranteeing Subsidiary agrees that its Note Guarantee shall remain in full force and effect notwithstanding any absence on each Note of a notation of any such Note Guarantee.

SECTION 3.12. Headings. The headings of the Articles and the Sections in this Supplemental Indenture are for convenience of reference only and shall not be deemed to alter or affect the meaning or interpretation of any provisions hereof.

[*Signature page follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Indenture to be duly executed as of the date first above written.

La Porte Health System, LLC,
a Delaware limited liability company
La Porte Hospital Company, LLC,
a Delaware limited liability company
Knox Hospital Company, LLC,
a Delaware limited liability company
Carolinas JV Holdings II, LLC,
a Delaware limited liability company

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President and Assistant Secretary

Acting on behalf of each of the Guaranteeing Subsidiaries set forth above

Acknowledged by:

CHS/Community Health Systems, Inc.

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President,
General Counsel and
Assistant Secretary

Regions Bank,
as Trustee

By: /s/ Kristine Prall
Kristine Prall
Vice President

[*Signature Page to Eleventh Supplemental Indenture (2021 Notes)*]

Credit Suisse AG, as Collateral Agent

By: /s/ John D. Toronto
Name: John D. Toronto
Title: Authorized Signatory

By: /s/ Andrew Griffin
Name: Andrew Griffin
Title: Authorized Signatory

EXHIBIT 4.4

ELEVENTH SUPPLEMENTAL INDENTURE, (this "Supplemental Indenture") dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., a Delaware corporation ("Issuer"), the parties that are signatories hereto as Guarantors (each, a "Guaranteeing Subsidiary" and, collectively, the "Guaranteeing Subsidiaries") and Regions Bank, as Trustee under the Indenture referred to below.

W I T N E S S E T H:

WHEREAS, each of the Issuer, the Guarantors and the Trustee have heretofore executed and delivered an indenture dated as of January 27, 2014 (as amended, supplemented, waived or otherwise modified, the "Indenture"), providing for the issuance on such date of an aggregate principal amount of $3,000,000,000 of 6.875% Senior Notes due 2022 (the "Notes") of the Issuer;

WHEREAS, the Indenture provides that the Guaranteeing Subsidiaries shall execute and deliver to the Trustee a supplemental indenture pursuant to which the Guaranteeing Subsidiaries shall unconditionally guarantee all of the Issuer's Obligations under the Notes and the Indenture on the terms and conditions set forth herein and under the Indenture (the "Note Guarantee"), each on the terms and conditions set forth herein; and

WHEREAS, pursuant to Section 9.1 of the Indenture, the Issuer, any Guarantor and the Trustee are authorized to execute and deliver this Supplemental Indenture to amend or supplement the Indenture, without the consent of any Holder;

NOW, THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the receipt of which is hereby acknowledged, the Issuer, the Guaranteeing Subsidiaries and the Trustee mutually covenant and agree for the benefit of the Trustee and the Holders of the Notes as follows:

ARTICLE I
DEFINITIONS

SECTION 1.1. Defined Terms. As used in this Supplemental Indenture, terms defined in the Indenture or in the preamble or recitals hereto are used herein as therein defined. The words "herein," "hereof" and "hereby" and other words of similar import used in this Supplemental Indenture refer to this Supplemental Indenture as a whole and not to any particular section hereof.

ARTICLE II
AGREEMENT TO BE BOUND; GUARANTEE

SECTION 2.1. Agreement to be Bound. Each of the Guaranteeing Subsidiaries hereby becomes a party to the Indenture as a "Guarantor" and as such will have all of the rights and be subject to all of the obligations and agreements of a "Guarantor" under the Indenture.

SECTION 2.2. Guarantee. Each of the Guaranteeing Subsidiaries agrees, on a joint and several basis with all the existing Guarantors, to fully, unconditionally and irrevocably

Guarantee to each Holder of the Notes and the Trustee the Guaranteed Obligations pursuant to Article X of the Indenture as and to the extent provided for therein.

ARTICLE III
MISCELLANEOUS

SECTION 3.1. Notices. All notices and other communications to the Guarantors shall be given as provided in the Indenture.

SECTION 3.2. Merger and Consolidation. Each Guaranteeing Subsidiary shall not sell or otherwise dispose of all or substantially all of its assets to, or consolidate with or merge with or into, another Person (other than the Issuer or any Restricted Subsidiary that is a Guarantor or becomes a Guarantor concurrently with the transaction) except in accordance with Section 4.1(e) of the Indenture.

SECTION 3.3. Release of Guarantee. The Note Guarantees hereunder may be released in accordance with Section 10.2 of the Indenture.

SECTION 3.4. Parties. Nothing expressed or mentioned herein is intended or shall be construed to give any Person, firm or corporation, other than the Holders and the Trustee, any legal or equitable right, remedy or claim under or in respect of this Supplemental Indenture or the Indenture or any provision herein or therein contained.

SECTION 3.5. Governing Law. This Supplemental Indenture shall be governed by, and construed in accordance with, the laws of the State of New York.

SECTION 3.6. Severability. In case any provision in this Supplemental Indenture shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby and such provision shall be ineffective only to the extent of such invalidity, illegality or unenforceability.

SECTION 3.7. Benefits Acknowledged. Each Guaranteeing Subsidiary's Note Guarantee is subject to the terms and conditions set forth in the Indenture. Each Guaranteeing Subsidiary acknowledges that it will receive direct and indirect benefits from the financing arrangements contemplated by the Indenture and this Supplemental Indenture and that the guarantee and waivers made by it pursuant to its Note Guarantee are knowingly made in contemplation of such benefits.

SECTION 3.8. Ratification of Indenture; Supplemental Indentures Part of Indenture. Except as expressly amended hereby, the Indenture is in all respects ratified and confirmed and all the terms, conditions and provisions thereof shall remain in full force and effect. This Supplemental Indenture shall form a part of the Indenture for all purposes, and every Holder of Notes heretofore or hereafter authenticated and delivered shall be bound hereby.

SECTION 3.9. The Trustee. The Trustee makes no representation or warranty as to the validity or sufficiency of this Supplemental Indenture or with respect to the recitals contained herein, all of which recitals are made solely by the other parties hereto.

SECTION 3.10. Counterparts. The parties hereto may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement. The exchange of copies of this Supplemental Indenture and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Supplemental Indenture as to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 3.11. Execution and Delivery. Each Guaranteeing Subsidiary agrees that its Note Guarantee shall remain in full force and effect notwithstanding any absence on each Note of a notation of any such Note Guarantee.

SECTION 3.12. Headings. The headings of the Articles and the Sections in this Supplemental Indenture are for convenience of reference only and shall not be deemed to alter or affect the meaning or interpretation of any provisions hereof.

[*Signature page follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Indenture to be duly executed as of the date first above written.

La Porte Health System, LLC,
a Delaware limited liability company
La Porte Hospital Company, LLC,
a Delaware limited liability company
Knox Hospital Company, LLC,
a Delaware limited liability company
Carolinas JV Holdings II, LLC,
a Delaware limited liability company

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President and Assistant Secretary

Acting on behalf of each of the Guaranteeing Subsidiaries set forth above

Acknowledged by:

CHS/Community Health Systems, Inc.

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President,
General Counsel and
Assistant Secretary

Regions Bank,
as Trustee

By: /s/ Kristine Prall
Kristine Prall
Vice President

EXHIBIT 4.5

FOURTH SUPPLEMENTAL INDENTURE, (this "Supplemental Indenture") dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., a Delaware corporation ("Issuer"), each of the parties that is a signatory hereto as a Guarantor (the "Guaranteeing Subsidiary"), Credit Suisse AG, as Collateral Agent, and Regions Bank, as Trustee under the Indenture referred to below.

W I T N E S S E T H:

WHEREAS, each of the Issuer, the Guarantors and the Trustee have heretofore executed and delivered an indenture dated as of March 16, 2017 (as amended, supplemented, waived or otherwise modified, the "Indenture"), providing for the issuance on such date of an aggregate principal amount of $3,100,000,000 of 6.250% Senior Secured Notes due 2023 (the "Notes") of the Issuer;

WHEREAS, the Indenture provides that the Guaranteeing Subsidiaries shall execute and deliver to the Trustee and the Collateral Agent a supplemental indenture pursuant to which the Guaranteeing Subsidiaries shall unconditionally guarantee all of the Issuer's Obligations under the Notes and the Indenture on the terms and conditions set forth herein and under the Indenture (the "Note Guarantee"), each on the terms and conditions set forth herein; and

WHEREAS, pursuant to Section 9.1 of the Indenture, the Issuer, any Guarantor and the Trustee are authorized to execute and deliver this Supplemental Indenture to amend or supplement the Indenture, without the consent of any Holder;

NOW, THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the receipt of which is hereby acknowledged, the Issuer, the Guaranteeing Subsidiaries and the Trustee mutually covenant and agree for the benefit of the Trustee, the Collateral Agent and the Holders of the Notes as follows:

ARTICLE I
DEFINITIONS

SECTION 1.1. Defined Terms. As used in this Supplemental Indenture, terms defined in the Indenture or in the preamble or recitals hereto are used herein as therein defined. The words "herein," "hereof" and "hereby" and other words of similar import used in this Supplemental Indenture refer to this Supplemental Indenture as a whole and not to any particular section hereof.

ARTICLE II
AGREEMENT TO BE BOUND; GUARANTEE

SECTION 2.1. Agreement to be Bound. Each of the Guaranteeing Subsidiaries hereby becomes a party to the Indenture as a "Guarantor" and as such will have all of the rights and be subject to all of the obligations and agreements of a "Guarantor" under the Indenture.

SECTION 2.2. Guarantee. Each of the Guaranteeing Subsidiaries agrees, on a joint and several basis with all the existing Guarantors, to fully, unconditionally and irrevocably

Guarantee to each Holder of the Notes, the Trustee and the Collateral Agent the Guaranteed Obligations pursuant to Article X of the Indenture as and to the extent provided for therein.

ARTICLE III
MISCELLANEOUS

SECTION 3.1. Notices. All notices and other communications to the Guarantors shall be given as provided in the Indenture.

SECTION 3.2. Merger and Consolidation. None of the Guaranteeing Subsidiaries shall sell or otherwise dispose of all or substantially all of its assets to, or consolidate with or merge with or into, another Person (other than the Issuer or any Restricted Subsidiary that is a Guarantor or becomes a Guarantor concurrently with the transaction) except in accordance with Section 4.1(e) of the Indenture.

SECTION 3.3. Release of Guarantee. The Note Guarantees hereunder may be released in accordance with Section 10.2 of the Indenture.

SECTION 3.4. Parties. Nothing expressed or mentioned herein is intended or shall be construed to give any Person, firm or corporation, other than the Holders and the Trustee, any legal or equitable right, remedy or claim under or in respect of this Supplemental Indenture or the Indenture or any provision herein or therein contained.

SECTION 3.5. Governing Law. This Supplemental Indenture shall be governed by, and construed in accordance with, the laws of the State of New York.

SECTION 3.6. Severability. In case any provision in this Supplemental Indenture shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby and such provision shall be ineffective only to the extent of such invalidity, illegality or unenforceability.

SECTION 3.7. Benefits Acknowledged. Each Guaranteeing Subsidiary's Note Guarantee is subject to the terms and conditions set forth in the Indenture. Each Guaranteeing Subsidiary acknowledges that it will receive direct and indirect benefits from the financing arrangements contemplated by the Indenture and this Supplemental Indenture and that the guarantee and waivers made by it pursuant to its Note Guarantee are knowingly made in contemplation of such benefits.

SECTION 3.8. Ratification of Indenture; Supplemental Indentures Part of Indenture. Except as expressly amended hereby, the Indenture is in all respects ratified and confirmed and all the terms, conditions and provisions thereof shall remain in full force and effect. This Supplemental Indenture shall form a part of the Indenture for all purposes, and every Holder of Notes heretofore or hereafter authenticated and delivered shall be bound hereby.

SECTION 3.9. The Trustee and the Collateral Agent. Neither the Trustee nor the Collateral Agent make any representation or warranty as to the validity or sufficiency of this Supplemental Indenture or with respect to the recitals contained herein, all of which recitals are made solely by the other parties hereto.

SECTION 3.10. Counterparts. The parties hereto may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement. The exchange of copies of this Supplemental Indenture and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Supplemental Indenture as to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 3.11. Execution and Delivery. Each Guaranteeing Subsidiary agrees that its Note Guarantee shall remain in full force and effect notwithstanding any absence on each Note of a notation of any such Note Guarantee.

SECTION 3.12. Headings. The headings of the Articles and the Sections in this Supplemental Indenture are for convenience of reference only and shall not be deemed to alter or affect the meaning or interpretation of any provisions hereof.

[*Signature page follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Indenture to be duly executed as of the date first above written.

La Porte Health System, LLC,
a Delaware limited liability company
La Porte Hospital Company, LLC,
a Delaware limited liability company
Knox Hospital Company, LLC,
a Delaware limited liability company
Carolinas JV Holdings II, LLC,
a Delaware limited liability company

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President and Assistant Secretary

Acting on behalf of each of the Guaranteeing Subsidiaries set forth above

Acknowledged by:

CHS/Community Health Systems, Inc.

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President,
General Counsel and
Assistant Secretary

Regions Bank,
as Trustee

By: /s/ Kristine Prall
Kristine Prall
Vice President

[*Signature Page to Fourth Supplemental Indenture (2023 Notes)*]

Credit Suisse AG, as Collateral Agent

By: /s/ John D. Toronto
Name: John D. Toronto
Title: Authorized Signatory

By: /s/ Andrew Griffin
Name: Andrew Griffin
Title: Authorized Signatory

[*Signature Page to Fourth Supplemental Indenture (2023 Notes)*]

EXHIBIT 4.6

FIRST SUPPLEMENTAL INDENTURE, (this "Supplemental Indenture") dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., a Delaware corporation ("Issuer"), the parties that are signatories hereto as Guarantors (each, a "Guaranteeing Subsidiary" and, collectively, the "Guaranteeing Subsidiaries"), Regions Bank, as Junior-Priority Collateral Agent, and Regions Bank, as Trustee under the Indenture referred to below.

W I T N E S S E T H:

WHEREAS, each of the Issuer, the Guarantors, the Trustee and the Junior-Priority Collateral Agent have heretofore executed and delivered an indenture dated as of June 22, 2018 (as amended, supplemented, waived or otherwise modified, the "Indenture"), providing for the issuance on such date of an aggregate principal amount of $1,770,337,000 of Junior-Priority Secured Notes due 2023 (the "Notes") of the Issuer;

WHEREAS, the Indenture provides that the Guaranteeing Subsidiaries shall execute and deliver to the Trustee and the Junior-Priority Collateral Agent a supplemental indenture pursuant to which the Guaranteeing Subsidiaries shall unconditionally guarantee all of the Issuer's Obligations under the Notes and the Indenture on the terms and conditions set forth herein and under the Indenture (the "Note Guarantee"), each on the terms and conditions set forth herein; and

WHEREAS, pursuant to Section 9.1 of the Indenture, the Issuer, any Guarantor, the Junior-Priority Collateral Agent and the Trustee are authorized to execute and deliver this Supplemental Indenture to amend or supplement the Indenture, without the consent of any Holder;

NOW, THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the receipt of which is hereby acknowledged, the Issuer, the Guaranteeing Subsidiaries, the Junior-Priority Collateral Agent and the Trustee mutually covenant and agree for the benefit of the Trustee, the Junior-Priority Collateral Agent and the Holders of the Notes as follows:

ARTICLE I
DEFINITIONS

SECTION 1.1. Defined Terms. As used in this Supplemental Indenture, terms defined in the Indenture or in the preamble or recitals hereto are used herein as therein defined. The words "herein," "hereof" and "hereby" and other words of similar import used in this Supplemental Indenture refer to this Supplemental Indenture as a whole and not to any particular section hereof.

ARTICLE II
AGREEMENT TO BE BOUND; GUARANTEE

SECTION 2.1. Agreement to be Bound. Each of the Guaranteeing Subsidiaries hereby becomes a party to the Indenture as a "Guarantor" and as such will have all of the rights and be subject to all of the obligations and agreements of a "Guarantor" under the Indenture.

SECTION 2.2. Guarantee. Each of the Guaranteeing Subsidiaries agrees, on a joint and several basis with all the existing Guarantors, to fully, unconditionally and irrevocably Guarantee to each Holder of the Notes, the Trustee and the Junior-Priority Collateral Agent the Guaranteed Obligations pursuant to Article X of the Indenture as and to the extent provided for therein.

ARTICLE III
MISCELLANEOUS

SECTION 3.1. Notices. All notices and other communications to the Guarantors shall be given as provided in the Indenture.

SECTION 3.2. Merger and Consolidation. Each Guaranteeing Subsidiary shall not sell or otherwise dispose of all or substantially all of its assets to, or consolidate with or merge with or into, another Person (other than the Issuer or any Restricted Subsidiary that is a Guarantor or becomes a Guarantor concurrently with the transaction) except in accordance with Section 4.1(e) of the Indenture.

SECTION 3.3. Release of Guarantee. The Note Guarantees hereunder may be released in accordance with Section 10.2 of the Indenture.

SECTION 3.4. Parties. Nothing expressed or mentioned herein is intended or shall be construed to give any Person, firm or corporation, other than the Holders and the Trustee, any legal or equitable right, remedy or claim under or in respect of this Supplemental Indenture or the Indenture or any provision herein or therein contained.

SECTION 3.5. Governing Law. This Supplemental Indenture shall be governed by, and construed in accordance with, the laws of the State of New York.

SECTION 3.6. Severability. In case any provision in this Supplemental Indenture shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby and such provision shall be ineffective only to the extent of such invalidity, illegality or unenforceability.

SECTION 3.7. Benefits Acknowledged. Each Guaranteeing Subsidiary's Note Guarantee is subject to the terms and conditions set forth in the Indenture. Each Guaranteeing Subsidiary acknowledges that it will receive direct and indirect benefits from the financing arrangements contemplated by the Indenture and this Supplemental Indenture and that the guarantee and waivers made by it pursuant to its Note Guarantee are knowingly made in contemplation of such benefits.

SECTION 3.8. Ratification of Indenture; Supplemental Indentures Part of Indenture. Except as expressly amended hereby, the Indenture is in all respects ratified and confirmed and all the terms, conditions and provisions thereof shall remain in full force and effect. This Supplemental Indenture shall form a part of the Indenture for all purposes, and every Holder of Notes heretofore or hereafter authenticated and delivered shall be bound hereby.

SECTION 3.9. The Trustee and the Junior-Priority Collateral Agent. Neither the Trustee nor the Junior-Priority Collateral Agent make any representation or warranty as to the validity or sufficiency of this Supplemental Indenture or with respect to the recitals contained herein, all of which recitals are made solely by the other parties hereto.

SECTION 3.10. Counterparts. The parties hereto may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement. The exchange of copies of this Supplemental Indenture and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Supplemental Indenture as to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 3.11. Execution and Delivery. Each Guaranteeing Subsidiary agrees that its Note Guarantee shall remain in full force and effect notwithstanding any absence on each Note of a notation of any such Note Guarantee.

SECTION 3.12. Headings. The headings of the Articles and the Sections in this Supplemental Indenture are for convenience of reference only and shall not be deemed to alter or affect the meaning or interpretation of any provisions hereof.

[*Signature page follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Indenture to be duly executed as of the date first above written.

La Porte Health System, LLC,
La Porte Hospital Company, LLC,
Knox Hospital Company, LLC and
Carolinas JV Holdings II, LLC,
as Guarantors

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President and Assistant Secretary

Acting on behalf of each of the Guarantors set forth above

Acknowledged by:

CHS/COMMUNITY HEALTH SYSTEMS, INC.

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President, General Counsel and Assistant Secretary

REGIONS BANK,
as Trustee

By: /s/ Kristine Prall
Name: Kristine Prall
Title: Vice President

[*Signature Page to First Supplemental Indenture (2023 Junior-Priority Notes)*]

REGIONS BANK,
as Junior-Priority Collateral Agent

By: /s/ Kristine Prall
Name: Kristine Prall
Title: Vice President

By: /s/ Arthur G. Mosley, II
Name: Arthur G. Mosley, II
Title: Vice President

EXHIBIT 4.7

FIRST SUPPLEMENTAL INDENTURE, (this "Supplemental Indenture") dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., a Delaware corporation ("Issuer"), the parties that are signatories hereto as Guarantors (each, a "Guaranteeing Subsidiary" and, collectively, the "Guaranteeing Subsidiaries"), Regions Bank, as Junior-Priority Collateral Agent, and Regions Bank, as Trustee under the Indenture referred to below.

W I T N E S S E T H:

WHEREAS, each of the Issuer, the Guarantors, the Trustee and the Junior-Priority Collateral Agent have heretofore executed and delivered an indenture dated as of June 22, 2018 (as amended, supplemented, waived or otherwise modified, the "Indenture"), providing for the issuance on such date of an aggregate principal amount of $1,354,663,000 of 8.125% Junior-Priority Secured Notes due 2024 (the "Notes") of the Issuer;

WHEREAS, the Indenture provides that the Guaranteeing Subsidiaries shall execute and deliver to the Trustee and the Junior-Priority Collateral Agent a supplemental indenture pursuant to which the Guaranteeing Subsidiaries shall unconditionally guarantee all of the Issuer's Obligations under the Notes and the Indenture on the terms and conditions set forth herein and under the Indenture (the "Note Guarantee"), each on the terms and conditions set forth herein; and

WHEREAS, pursuant to Section 9.1 of the Indenture, the Issuer, any Guarantor, the Junior-Priority Collateral Agent and the Trustee are authorized to execute and deliver this Supplemental Indenture to amend or supplement the Indenture, without the consent of any Holder;

NOW, THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the receipt of which is hereby acknowledged, the Issuer, the Guaranteeing Subsidiaries, the Junior-Priority Collateral Agent and the Trustee mutually covenant and agree for the benefit of the Trustee, the Junior-Priority Collateral Agent and the Holders of the Notes as follows:

ARTICLE I
DEFINITIONS

SECTION 1.1. Defined Terms. As used in this Supplemental Indenture, terms defined in the Indenture or in the preamble or recitals hereto are used herein as therein defined. The words "herein," "hereof" and "hereby" and other words of similar import used in this Supplemental Indenture refer to this Supplemental Indenture as a whole and not to any particular section hereof.

ARTICLE II
AGREEMENT TO BE BOUND; GUARANTEE

SECTION 2.1. Agreement to be Bound. Each of the Guaranteeing Subsidiaries hereby becomes a party to the Indenture as a "Guarantor" and as such will have all of the rights and be subject to all of the obligations and agreements of a "Guarantor" under the Indenture.

SECTION 2.2. Guarantee. Each of the Guaranteeing Subsidiaries agrees, on a joint and several basis with all the existing Guarantors, to fully, unconditionally and irrevocably Guarantee to each Holder of the Notes, the Trustee and the Junior-Priority Collateral Agent the Guaranteed Obligations pursuant to Article X of the Indenture as and to the extent provided for therein.

ARTICLE III
MISCELLANEOUS

SECTION 3.1. Notices. All notices and other communications to the Guarantors shall be given as provided in the Indenture.

SECTION 3.2. Merger and Consolidation. Each Guaranteeing Subsidiary shall not sell or otherwise dispose of all or substantially all of its assets to, or consolidate with or merge with or into, another Person (other than the Issuer or any Restricted Subsidiary that is a Guarantor or becomes a Guarantor concurrently with the transaction) except in accordance with Section 4.1(e) of the Indenture.

SECTION 3.3. Release of Guarantee. The Note Guarantees hereunder may be released in accordance with Section 10.2 of the Indenture.

SECTION 3.4. Parties. Nothing expressed or mentioned herein is intended or shall be construed to give any Person, firm or corporation, other than the Holders and the Trustee, any legal or equitable right, remedy or claim under or in respect of this Supplemental Indenture or the Indenture or any provision herein or therein contained.

SECTION 3.5. Governing Law. This Supplemental Indenture shall be governed by, and construed in accordance with, the laws of the State of New York.

SECTION 3.6. Severability. In case any provision in this Supplemental Indenture shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby and such provision shall be ineffective only to the extent of such invalidity, illegality or unenforceability.

SECTION 3.7. Benefits Acknowledged. Each Guaranteeing Subsidiary's Note Guarantee is subject to the terms and conditions set forth in the Indenture. Each Guaranteeing Subsidiary acknowledges that it will receive direct and indirect benefits from the financing arrangements contemplated by the Indenture and this Supplemental Indenture and that the guarantee and waivers made by it pursuant to its Note Guarantee are knowingly made in contemplation of such benefits.

SECTION 3.8. Ratification of Indenture; Supplemental Indentures Part of Indenture. Except as expressly amended hereby, the Indenture is in all respects ratified and confirmed and all the terms, conditions and provisions thereof shall remain in full force and effect. This Supplemental Indenture shall form a part of the Indenture for all purposes, and every Holder of Notes heretofore or hereafter authenticated and delivered shall be bound hereby.

SECTION 3.9. The Trustee and the Junior-Priority Collateral Agent. Neither the Trustee nor the Junior-Priority Collateral Agent make any representation or warranty as to the validity or sufficiency of this Supplemental Indenture or with respect to the recitals contained herein, all of which recitals are made solely by the other parties hereto.

SECTION 3.10. Counterparts. The parties hereto may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement. The exchange of copies of this Supplemental Indenture and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Supplemental Indenture as to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 3.11. Execution and Delivery. Each Guaranteeing Subsidiary agrees that its Note Guarantee shall remain in full force and effect notwithstanding any absence on each Note of a notation of any such Note Guarantee.

SECTION 3.12. Headings. The headings of the Articles and the Sections in this Supplemental Indenture are for convenience of reference only and shall not be deemed to alter or affect the meaning or interpretation of any provisions hereof.

[*Signature page follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Indenture to be duly executed as of the date first above written.

La Porte Health System, LLC,
La Porte Hospital Company, LLC,
Knox Hospital Company, LLC and
Carolinas JV Holdings II, LLC,
as Guarantors

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President and Assistant Secretary

Acting on behalf of each of the Guarantors set forth above

Acknowledged by:

CHS/COMMUNITY HEALTH SYSTEMS, INC.

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President, General Counsel and Assistant Secretary

REGIONS BANK,
as Trustee

By: /s/ Kristine Prall
Name: Kristine Prall
Title: Vice President

[*Signature Page to First Supplemental Indenture (2024 Junior-Priority Notes)*]

REGIONS BANK,
as Junior-Priority Collateral Agent

By: /s/ Kristine Prall
Name: Kristine Prall
Title: Vice President

By: /s/ Arthur G. Mosley, II
Name: Arthur G. Mosley, II
Title: Vice President

EXHIBIT 4.8

FIRST SUPPLEMENTAL INDENTURE, (this "Supplemental Indenture") dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., a Delaware corporation ("Issuer"), the parties that are signatories hereto as Guarantors (each, a "Guaranteeing Subsidiary" and, collectively, the "Guaranteeing Subsidiaries"), Credit Suisse AG, as Collateral Agent, and Regions Bank, as Trustee under the Indenture referred to below.

W I T N E S S E T H:

WHEREAS, each of the Issuer, the Guarantors, the Trustee and the Collateral Agent have heretofore executed and delivered an indenture dated as of July 6, 2018 (as amended, supplemented, waived or otherwise modified, the "Indenture"), providing for the issuance on such date of an aggregate principal amount of $1,032,607,000 of 8.625% Senior Secured Notes due 2024 (the "Notes") of the Issuer;

WHEREAS, the Indenture provides that the Guaranteeing Subsidiaries shall execute and deliver to the Trustee and the Collateral Agent a supplemental indenture pursuant to which the Guaranteeing Subsidiaries shall unconditionally guarantee all of the Issuer's Obligations under the Notes and the Indenture on the terms and conditions set forth herein and under the Indenture (the "Note Guarantee"), each on the terms and conditions set forth herein; and

WHEREAS, pursuant to Section 9.1 of the Indenture, the Issuer, any Guarantor, the Collateral Agent and the Trustee are authorized to execute and deliver this Supplemental Indenture to amend or supplement the Indenture, without the consent of any Holder;

NOW, THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the receipt of which is hereby acknowledged, the Issuer, the Guaranteeing Subsidiaries, the Collateral Agent and the Trustee mutually covenant and agree for the benefit of the Trustee, the Collateral Agent and the Holders of the Notes as follows:

ARTICLE I
DEFINITIONS

SECTION 1.1. Defined Terms. As used in this Supplemental Indenture, terms defined in the Indenture or in the preamble or recitals hereto are used herein as therein defined. The words "herein," "hereof" and "hereby" and other words of similar import used in this Supplemental Indenture refer to this Supplemental Indenture as a whole and not to any particular section hereof.

ARTICLE II
AGREEMENT TO BE BOUND; GUARANTEE

SECTION 2.1. Agreement to be Bound. Each of the Guaranteeing Subsidiaries hereby becomes a party to the Indenture as a "Guarantor" and as such will have all of the rights and be subject to all of the obligations and agreements of a "Guarantor" under the Indenture.

SECTION 2.2. Guarantee. Each of the Guaranteeing Subsidiaries agrees, on a joint and several basis with all the existing Guarantors, to fully, unconditionally and irrevocably

Guarantee to each Holder of the Notes, the Trustee and the Collateral Agent the Guaranteed Obligations pursuant to Article X of the Indenture as and to the extent provided for therein.

ARTICLE III
MISCELLANEOUS

SECTION 3.1. Notices. All notices and other communications to the Guarantors shall be given as provided in the Indenture.

SECTION 3.2. Merger and Consolidation. Each Guaranteeing Subsidiary shall not sell or otherwise dispose of all or substantially all of its assets to, or consolidate with or merge with or into, another Person (other than the Issuer or any Restricted Subsidiary that is a Guarantor or becomes a Guarantor concurrently with the transaction) except in accordance with Section 4.1(e) of the Indenture.

SECTION 3.3. Release of Guarantee. The Note Guarantees hereunder may be released in accordance with Section 10.2 of the Indenture.

SECTION 3.4. Parties. Nothing expressed or mentioned herein is intended or shall be construed to give any Person, firm or corporation, other than the Holders and the Trustee, any legal or equitable right, remedy or claim under or in respect of this Supplemental Indenture or the Indenture or any provision herein or therein contained.

SECTION 3.5. Governing Law. This Supplemental Indenture shall be governed by, and construed in accordance with, the laws of the State of New York.

SECTION 3.6. Severability. In case any provision in this Supplemental Indenture shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby and such provision shall be ineffective only to the extent of such invalidity, illegality or unenforceability.

SECTION 3.7. Benefits Acknowledged. Each Guaranteeing Subsidiary's Note Guarantee is subject to the terms and conditions set forth in the Indenture. Each Guaranteeing Subsidiary acknowledges that it will receive direct and indirect benefits from the financing arrangements contemplated by the Indenture and this Supplemental Indenture and that the guarantee and waivers made by it pursuant to its Note Guarantee are knowingly made in contemplation of such benefits.

SECTION 3.8. Ratification of Indenture; Supplemental Indentures Part of Indenture. Except as expressly amended hereby, the Indenture is in all respects ratified and confirmed and all the terms, conditions and provisions thereof shall remain in full force and effect. This Supplemental Indenture shall form a part of the Indenture for all purposes, and every Holder of Notes heretofore or hereafter authenticated and delivered shall be bound hereby.

SECTION 3.9. The Trustee and the Collateral Agent. Neither the Trustee nor the Collateral Agent make any representation or warranty as to the validity or sufficiency of this Supplemental Indenture or with respect to the recitals contained herein, all of which recitals are made solely by the other parties hereto.

SECTION 3.10. Counterparts. The parties hereto may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement. The exchange of copies of this Supplemental Indenture and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Supplemental Indenture as to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 3.11. Execution and Delivery. Each Guaranteeing Subsidiary agrees that its Note Guarantee shall remain in full force and effect notwithstanding any absence on each Note of a notation of any such Note Guarantee.

SECTION 3.12. Headings. The headings of the Articles and the Sections in this Supplemental Indenture are for convenience of reference only and shall not be deemed to alter or affect the meaning or interpretation of any provisions hereof.

[*Signature page follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Indenture to be duly executed as of the date first above written.

La Porte Health System, LLC,
La Porte Hospital Company, LLC,
Knox Hospital Company, LLC and
Carolinas JV Holdings II, LLC,
as Guarantors

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President and Assistant Secretary

Acting on behalf of each of the Guarantors set forth above

Acknowledged by:

CHS/COMMUNITY HEALTH SYSTEMS, INC.

By: /s/ Benjamin C. Fordham
Benjamin C. Fordham
Executive Vice President,
General Counsel and Assistant Secretary

REGIONS BANK,
as Trustee

By: /s/ Kristine Prall
Name: Kristine Prall
Title: Vice President

[*Signature Page to First Supplemental Indenture (2024 Notes)*]

CREDIT SUISSE AG, CAYMAN ISLANDS BRANCH, as Collateral Agent

By: /s/ John D. Toronto
Name: John D. Toronto
Title: Authorized Signatory

By: /s/ Andrew Griffin
Name: Andrew Griffin
Title: Authorized Signatory

Exhibit 12

STATEMENT RE: COMPUTATION OF RATIO OF EARNINGS TO FIXED CHARGES
(DOLLARS IN MILLIONS)

	Nine Months Ended September 30, 2018
Earnings	
Loss from continuing operations before benefit from income taxes	$ (347)
Income from equity investees	(17)
Distributed income from equity investees	6
Interest and amortization of deferred finance costs	720
Amortization of capitalized interest	6
Implicit rental interest expense	64
Total Earnings	$ 432
Fixed Charges	
Interest and amortization of deferred finance costs	$ 720
Capitalized interest	11
Implicit rental interest expense	64
Total Fixed Charges	$ 795
Ratio of Earnings to Fixed Charges	*

* For the nine months ended September 30, 2018, earnings were insufficient to cover fixed charges by approximately $363 million.

Exhibit 31.1

CERTIFICATION PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Wayne T. Smith, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Community Health Systems, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and we have:

a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) designed such internal controls over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors:

a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Wayne T. Smith
Wayne T. Smith
Chairman of the Board
and Chief Executive Officer

Date: October 30, 2018

Exhibit 31.2

CERTIFICATION PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Thomas J. Aaron, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Community Health Systems, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and we have:

a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) designed such internal controls over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors:

a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Thomas J. Aaron
Thomas J. Aaron
Executive Vice President and
Chief Financial Officer

Date: October 30, 2018

Exhibit 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Community Health Systems, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2018, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Wayne T. Smith, Chairman of the Board and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Wayne T. Smith
Wayne T. Smith
Chairman of the Board and
Chief Executive Officer

October 30, 2018

Exhibit 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Community Health Systems, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2018, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Thomas J. Aaron, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Thomas J. Aaron
Thomas J. Aaron
Executive Vice President and
Chief Financial Officer

October 30, 2018

EXHIBIT 99.1

CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
COMMUNITY HEALTH SYSTEMS, INC.,
AMENDED

I. PREAMBLE

Effective July 28, 2014, Community Health Systems, Inc. (CHSI) entered into a Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). That CIA is hereby amended and extended for an additional period. Specifically, this amended CIA (hereafter "CIA") will be in effect for three years commencing on its Effective Date. Contemporaneously with this CIA, CHSI is entering into a Settlement Agreement with the United States.

CHSI represents that, prior to this CIA, CHSI voluntarily established a Compliance Program which provides for a Corporate Compliance and Privacy Officer, various compliance committees, a compliance training and education program, a confidential disclosure reporting hotline, and auditing and monitoring activities, and which includes various policies and procedures aimed at ensuring that CHSI's participation in the federal health care programs conforms to all federal and state laws and federal health care program requirements. CHSI shall continue its Compliance Program throughout the term of this CIA and shall do so in accordance with the terms set forth below. CHSI may modify its Compliance Program, as appropriate, but at a minimum, CHSI shall ensure that during the term of this CIA, it shall comply with the obligations set forth herein.

For purposes of this CIA, "CHSI" shall mean the following: (1) Community Health Systems, Inc. and its directly or indirectly wholly-owned subsidiaries and affiliates that provide hospital services; and (2) any other corporation, limited liability company, partnership, or any other legal entity or organization in which CHSI, or a directly or indirectly wholly-owned subsidiary or affiliate of CHSI, owns a direct or indirect equity interest of 50% or more and that provides hospital services.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by CHSI under this amended CIA shall be three years from the effective date of this CIA. The "Effective Date" shall be the date on which the final signatory of this CIA executes this CIA. Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."

B. Sections VII, X, and XI shall expire no later than 120 days after OIG's receipt of: (1) CHSI's final annual report; or (2) any additional materials submitted by CHSI pursuant to OIG's request, whichever is later.

C. The scope of this CIA shall be governed by the following definitions:

1. "Covered Persons" includes:

   a. all owners who are natural persons (other than shareholders who: (1) have an ownership interest of less than 5% and (2) acquired the ownership interest through public trading), officers, directors, and employees of CHSI;

   b. all contractors, subcontractors, agents, and other persons who provide patient care items or services or who perform billing or coding functions on behalf of CHSI, excluding vendors whose sole connection with CHSI is selling or otherwise providing medical supplies or equipment and who do not bill the Federal health care programs for such medical supplies or equipment to CSHI; and

   c. all physicians and other non-physician practitioners who are members of the active medical staff at CHSI.

   Notwithstanding the above, this term does not include part-time or per diem employees, contractors, subcontractors, agents, and other persons who are not reasonably expected to work more than 160 hours per year, except that any such individuals shall become

   "Covered Persons" at the point when they work more than 160 hours

during the calendar year.

2. "Covered Facility" or "Covered Facilities" includes all CHSI hospitals, but shall not include any CHSI hospital that has been designated as a Critical Access Hospital pursuant to 42 U.S.C. § 1395i-4(c)(2).

3. "Relevant Billing Covered Persons" includes Covered Persons involved in the preparation or submission of claims or cost reports for reimbursement from any Federal health care program on behalf of CHSI's Covered Facilities.

4. "Relevant Clinical Covered Persons" includes Covered Persons involved in the delivery of patient care items or services at or on behalf of CHSI's Covered Facilities.

5. "Relevant Case Management Covered Persons" includes Covered Persons who work in or for a Case Management Department and who are involved in case management or utilization review functions relating to inpatient admissions or discharge decisions.

6. "Arrangements" shall mean every arrangement or transaction that:

   a. involves, directly or indirectly, the offer, payment, solicitation, or receipt of anything of value; and is between CHSI and any actual or potential source of health care business or referrals to CHSI or any actual or potential recipient of health care business or referrals from CHSI. The term "source of health care business or referrals" shall mean any individual or entity that refers, recommends, arranges for, orders, leases, or purchases any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program and the term "recipient of health care business or referrals" shall mean any individual or entity (1) to whom CHSI refers an individual for the furnishing or arranging for the furnishing of any item or service, or (2)

from whom CHSI purchases, leases or orders or arranges for or recommends the purchasing, leasing, or ordering of any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program; or

b. is between CHSI and a physician (or a physician's immediate family member (as defined at 42 C.F.R. § 411.351)) who makes a referral (as defined at 42 U.S.C. § 1395nn(h)(5)) to CHSI for designated health services (as defined at 42 U.S.C. § 1395nn(h)(6)).

7. "Focus Arrangements" means every Arrangement that:

a. is between CHSI and any actual source of health care business or referrals to CHSI and involves, directly or indirectly, the offer, payment, or provision of anything of value; or

b. is between CHSI and any physician (or a physician's immediate family member) (as defined at 42 C.F.R. § 411.351)) who makes a referral (as defined at 42 U.S.C. § 1395nn(h)(5)) to CHSI for designated health services (as defined at 42 U.S.C. §1395nn(h))(6)).

Notwithstanding the foregoing provisions of Section II.C.7, any Arrangement that satisfies the requirements of 42 C.F.R. § 411.356 (ownership or investment interests), 42 C.F.R. § 411.357(g) (remuneration unrelated to the provision of designated health services); 42 C.F.R. § 411.357(i) (payments by a physician for items and services); 42 C.F.R. § 411.357(k) (non-monetary compensation); 42 C.F.R. § 411.357(m) (medical staff incidental benefits), 42 C.F.R. § 411.357(o) (compliance training), 42 C.F.R. § 411.357(q) (referral services), 42 C.F.R. § 411.357(s) (professional courtesy), 42 C.F.R. § 357(u) (community-wide health information systems), any exception to the prohibitions of 42 U.S.C. § 1395nn enacted following the Effective Date that does not require a written agreement or that does not constitute a "financial relationship" as

defined by 42 C.F.R. § 411.354 shall not be considered a Focus Arrangement for purposes of this CIA.

8. "Relevant Arrangements Covered Persons" includes all Covered Persons involved in the negotiation, preparation, review, maintenance, and approval for payment of all Arrangements, as defined above, involving CHSI.

III. CORPORATE INTEGRITY OBLIGATIONS

CHSI shall maintain a Compliance Program that includes the following elements:

A. Compliance Management and Oversight

1. *Corporate Compliance and Privacy Officer*. CHSI has appointed a Corporate Compliance and Privacy Officer and shall maintain a Corporate Compliance and Privacy Officer for the term of the CIA. The Corporate Compliance and Privacy Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements. The Corporate Compliance and Privacy Officer shall be a member of senior management of CHSI, shall report directly to the Chief Executive Officer of CHSI, shall make periodic (at least quarterly) reports regarding compliance matters directly to the Audit and Compliance Committee of the Board of Directors of CHSI ("Board of Directors"), and shall be authorized to report on such matters to the Board of Directors at any time. Written documentation of the Corporate Compliance and Privacy Officer's reports to the Board of Directors shall be made available to OIG upon request. The Corporate Compliance and Privacy Officer shall not be or be subordinate to the General Counsel or Chief Financial Officer. The Corporate Compliance and Privacy Officer shall be responsible for monitoring the day- to-day compliance activities engaged in by CHSI as well as for any reporting obligations created under this CIA. Any noncompliance job responsibilities of the Corporate Compliance and Privacy Officer shall be limited and must not interfere with the Corporate Compliance and Privacy Officer's ability to perform the duties outlined in this CIA.

CHSI shall report to OIG, in writing, any change in the identity of the Corporate Compliance and Privacy Officer, or any actions or changes that would affect the

Corporate Compliance and Privacy Officer's ability to perform the duties necessary to meet the obligations in this CIA, within five days after such a change.

2. *Regional and Facility Compliance Officers*. CHSI has appointed individuals to serve as Regional Compliance Officers known as Corporate Compliance Directors. CHSI also has appointed a Facility Compliance Officer for each CHSI Covered Facility. CHSI shall maintain the Corporate Compliance Directors and Facility Compliance Officers for the duration of the CIA. The Corporate Compliance Directors shall be responsible for implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements for the applicable regions, and shall monitor the day-to-day compliance activities for the applicable regions. The Facility Compliance Officers shall be responsible for implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements for the Covered Facilities, and shall monitor the day-to-day compliance activities of the Covered Facilities. The Corporate Compliance Directors shall report to the Corporate Compliance and Privacy Officer (through Senior Compliance Directors), and shall be members of the Corporate Compliance Work Group. The Facility Compliance Officers shall report to their assigned Corporate Compliance Directors for ethics and compliance purposes and shall be independent from CHSI's Legal Department. The Facility Compliance Officers shall make periodic (at least quarterly) written reports regarding compliance matters directly to the Corporate Compliance Directors, and shall be authorized to report on such matters directly to the Corporate Compliance Work Group, the Corporate Compliance and Privacy Officer, and the Board of Directors at any time. CHSI shall report to OIG, in writing any actions or changes that would affect any Facility Compliance Officer's ability to perform the duties necessary to meet the obligations in this CIA, within 30 days after such a change.

3. *Corporate Compliance Committee*. CHSI has an existing Corporate Compliance Committee known as the Corporate Compliance Work Group. CHSI shall maintain this Corporate Compliance Work Group for the duration of the CIA. The Corporate Compliance Work Group shall, at a minimum, include the Corporate Compliance and Privacy Officer, Senior Compliance Directors, Corporate Compliance Directors, and other members of senior management necessary to meet the requirements of this CIA (e.g., senior executives of relevant departments, such as billing, clinical, human resources, audit, and operations). The Corporate Compliance and Privacy Officer shall chair the Corporate Compliance Work Group, and the Corporate Compliance Work Group shall support the Corporate Compliance and Privacy Officer in fulfilling his/her

responsibilities (e.g., shall assist in the analysis of the CHSI's risk areas and shall oversee monitoring of internal and external audits and investigations). The Corporate Compliance Work Group shall meet at least quarterly. The minutes of the Corporate Compliance Work Group meetings shall be made available to OIG upon request.

CHSI shall report to OIG, in writing, any changes in the composition of the Corporate Compliance Work Group, or any actions or changes that would affect the Corporate Compliance Work Group's ability to perform the duties necessary to meet the obligations in this CIA, within 30 days after such a change.

4. *Facility Compliance Committees*. CHSI has established a Facility Compliance Committee at each CHSI Covered Facility. The Facility Compliance Committees shall be maintained for the duration of the CIA and shall include appropriate personnel and other members of senior management at each of CHSI's Covered Facilities necessary to meet the requirements of this CIA (e.g., senior executives of relevant departments, such as billing, clinical, human resources, audit, and operations). The Facility Compliance Committees shall support the Corporate Compliance Directors and Facility Compliance Officers in fulfilling their responsibilities (e.g., shall assist in the analysis of the organization's risk areas and shall oversee monitoring of internal and external audits and investigations). CHSI shall report to OIG, in writing, any actions or changes that would affect any Facility Compliance Committee's ability to perform the duties necessary to meet the obligations of the CIA, within 30 days after such a change.

5. *Board of Directors Compliance Obligations.* The Board of Directors of CHSI shall be responsible for the review and oversight of matters related to compliance with Federal health care program requirements and the obligations of this CIA. The Board of Directors must include independent (i.e., non-executive) members.

The Board of Directors shall, at a minimum, be responsible for the following:

a. meeting at least quarterly to review and oversee CHSI's Compliance Program, including but not limited to the performance of the Corporate Compliance and Privacy Officer and Corporate Compliance Work Group; and

b. for each Reporting Period of the CIA, adopting a resolution, signed by each member of the Board of Directors summarizing its review and oversight of CHSI's compliance

with Federal health care program requirements and the obligations of this CIA.

At minimum, the resolution shall include the following language:

"The Board of Directors of the Board of Directors has made a reasonable inquiry into the operations of CHSI's Compliance Program including the performance of the Corporate Compliance and Privacy Officer and the Corporate Compliance Work Group. Based on its inquiry and review, the Board of Directors has concluded that, to the best of its knowledge, CHSI has implemented an effective Compliance Program to meet Federal health care program requirements and the obligations of the CIA."

If the Board of Directors is unable to provide such a conclusion in the resolution, the Board of Directors shall include in the resolution a written explanation of the reasons why it is unable to provide the conclusion and the steps it is taking to implement an effective Compliance Program at CHSI.

CHSI shall report to OIG, in writing, any changes in the composition of the Board of Directors, or any actions or changes that would affect the Board of Directors' ability to perform the duties necessary to meet the obligations in this CIA, within 30 days after such a change.

B. Written Standards

1. *Code of Conduct*. CHSI has developed, implemented and distributed a written Code of Conduct to all Covered Persons and shall maintain this Code of Conduct for the duration of the CIA. CHSI shall make the promotion of, and adherence to, the Code of Conduct an element in evaluating the performance of all employees. To the extent not already accomplished, within 120 days after the Effective Date, the Code of Conduct shall, at a minimum, set forth:

a. CHSI's commitment to full compliance with all Federal health care program requirements, including its commitment to prepare and submit accurate claims consistent with such requirements;

b. CHSI's requirement that all of its Covered Persons shall be expected to comply with all Federal health care program requirements and with CHSI's own Policies and Procedures;

c. the requirement that all of CHSI's Covered Persons shall be expected to report to the Corporate Compliance and Privacy Officer, or other appropriate individual designated by CHSI, suspected violations of any Federal health care program requirements or of CHSI's own Policies and Procedures; and

d. the right of all individuals to use the Disclosure Program described in Section III.F, and CHSI's commitment to nonretaliation and to maintain, as appropriate, confidentiality and anonymity with respect to such disclosures.

CHSI currently requires all newly employed Covered Persons to certify in writing or electronic form that he or she has received, read, understood, and shall abide by CHSI's Code of Conduct. CHSI shall maintain this practice for the duration of the CIA and shall ensure that New Covered Persons receive the Code of Conduct and shall complete the required certification within 30 days after becoming a Covered Person.

CHSI shall distribute the Code of Conduct to all active medical staff members as described above and shall use its best efforts to encourage such active medical staff members to submit the required certification. The Corporate Compliance and Privacy Officer shall maintain records indicating that the Code of Conduct was distributed to all active medical staff members and whether the certification was completed.

CHSI shall periodically review the Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such review. The Code of Conduct shall be distributed at least annually to all Covered Persons.

2. *Policies and Procedures*. CHSI has developed, implemented, and distributed written Policies and Procedures regarding the operation of its compliance program, including the compliance program requirements outlined in this CIA and in compliance with Federal health care program requirements, and shall maintain these Policies and Procedures for the duration of the CIA.

Within 120 days after the Effective Date, the Policies and Procedures shall address, at a minimum:

a. the subjects relating to the Code of Conduct identified in Section III.B.1;

b. the compliance program requirements outlined in this CIA;

c. CHSI's compliance with Federal health care program requirements, including Federal health care program rules governing medical necessity determinations for inpatient admission; and

d. billing and reimbursement, including:

    i. ensuring proper and accurate submission of claims and cost reports to Federal health care programs;

    ii. ensuring the proper and accurate documentation of medical records;

    iii. ensuring the proper and accurate assignment and designation of patients into inpatient, outpatient, or observation status; and

    iv. ensuring the necessary and appropriate length of stays and timely discharges for all patients.

e. documentation of medical records, including:

    i. ensuring proper and accurate documentation in the pre- admission, admission, case management, billing, coding and reimbursement process;

    ii. ensuring that physicians are aware of relevant Federal health care program requirements governing admission, and any relevant Medicare regulations regarding treatment of a patient as an inpatient;

iii. the personal obligation of each individual involved in the medical documentation process to ensure that such documentation is accurate;

iv. ensuring proper order authentication practices to ensure: (1) physician orders are not implemented without physician knowledge and consent; and (2) unauthorized markings are not added to physician orders without physician knowledge or consent;

v. ensuring that employees do not disregard physician orders relating to the admission of a patient;

vi. the legal sanctions for violations of the Federal health care program requirements; and

vii. examples of proper and improper medical documentation practices.

f. requirements for Case Management employees, including:

i. the Policies and Procedures for determining the medical necessity and appropriateness of inpatient admissions, including applicable Medicare rules and regulations; and

ii. the policies and procedures for proper order authentication and modification.

Within 120 days after the Effective Date, the Policies and Procedures shall be made available to all Covered Persons. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures.

At least annually (and more frequently, if appropriate), CHSI shall assess and update, as necessary, the Policies and Procedures. Within 30 days after the effective date of any revisions, a description of the revisions shall be communicated to all affected Covered Persons and any revised Policies and Procedures shall be made available to all Covered Persons.

Within 120 days after the Effective Date, CHSI shall implement written Policies and Procedures addressing the following: (1) 42 U.S.C. § 1320a-7b(b) (Anti-Kickback Statute) and 42 U.S.C. § 1395nn (Stark Law), and the regulations and other guidance documents related to these statutes, and business or financial arrangements or contracts that generate unlawful Federal health care program business in violation of the Anti- Kickback Statute or the Stark Law; and (2) the requirements set forth in Section III.D (Compliance with the Anti-Kickback Statute and Stark Law). Within 120 days after the Effective Date, these Policies and Procedures shall be made available to all Relevant Arrangements Covered Persons. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures. At least annually (and more frequently, if appropriate), CHSI shall assess and update, as necessary, the Policies and Procedures. Within 30 days after the effective date of any revisions, a description of the revisions shall be communicated to all affected Relevant Arrangements Covered Persons and any revised Policies and Procedures shall be made available to all Relevant Arrangements Covered Persons.

C. Training and Education

CHSI represents that it provides training to its employees on a regular basis concerning a variety of topics. The training covered by this CIA need not be separate and distinct from the regular training provided by CHSI, but instead may be integrated fully into such regular training so long as the training covers the areas specified below.

1. *General Training*. Within 120 days after the Effective Date, CHSI shall provide at least one hour of General Training to each Covered Person. This training, at a minimum, shall explain CHSI's:

a. CIA requirements; and

b. Compliance Program, including the Code of Conduct.

New Covered Persons shall receive the General Training described above within 30 days after becoming a Covered Person or within 120 days after the Effective Date, whichever is later. After receiving the initial General Training described above, each Covered Person shall receive at least one hour of General Training in each subsequent Reporting Period.

2. *Specific Training*. Within 120 days after the Effective Date, each Relevant Covered Person shall receive Specific Training in addition to the General Training required above. This Specific Training shall include the following:

a. Billing and Reimbursement Specific Training. Each Relevant Billing and Reimbursement Covered Person shall receive at least two hours of Billing and Reimbursement Specific Training, which shall include a discussion of:

i. the Federal health care program requirements regarding the accurate coding and submission of claims;

ii. policies, procedures, and other requirements applicable to the documentation of medical records;

ii. the personal obligation of each individual involved in the claims submission process to ensure that such claims are accurate;

iv. applicable reimbursement statutes, regulations, and program requirements and directives;

v. the legal sanctions for violations of the Federal health care program requirements; and

vi. examples of proper and improper claims submission practices.

b. Clinical Documentation and Decision-Making Specific Training. Each Relevant Clinical Covered Person shall receive at least two hours of Clinical Documentation and Decision-Making Specific Training, which shall include a discussion of:

i. policies, procedures, and other Federal health care program requirements applicable to the documentation of medical records;

ii. the role of individual medical necessity determinations in the admission decision;

iii. the importance of accurate documentation in the billing, coding, and reimbursement process;

iv. the personal obligation of each individual involved in the medical documentation process to ensure that such documentation is accurate;

v. the legal sanctions for violations of the Federal health care program requirements; and

vi. examples of proper and improper medical documentation practices.

c. Case Management Specific Training. Each Relevant Case Management Covered Person shall receive at least two hours of Case Management Specific Training, which shall include a discussion of:

i. policies, procedures, and applicable Federal health care program requirements for determining the medical necessity and the appropriateness of inpatient admissions; and

ii. the role and function of any bodies or groups, including contractors, at CHSI that review admission decisions.

d. Arrangements Specific Training. Each Relevant Arrangements Covered Person shall receive at least three hours of Arrangements Specific Training, which shall include a discussion of:

i. Arrangements that potentially implicate the Anti-Kickback Statute or the Stark Law, as well as the regulations and other guidance documents related to these statutes;

ii. CHSI's policies, procedures, and other requirements relating to Arrangements and Focus Arrangements, including but not limited to the Focus Arrangements Tracking System, the

internal review and approval process, and the tracking of remuneration to and from sources of health care business or referrals required by Section III.D of the CIA;

iii. the personal obligation of each individual involved in the development, approval, management, or review of CHSI's Arrangements to know the applicable legal requirements and the CHSI's policies and procedures;

iv. the legal sanctions under the Anti-Kickback Statute and the Stark Law; and

v. examples of violations of the Anti-Kickback Statute and the Stark Law.

New Relevant Covered Persons shall receive Specific Training within 30 days after the beginning of their employment or becoming Relevant Covered Persons, or within 120 days after the Effective Date, whichever is later.

After receiving the initial Specific Training described in this Section, each Relevant Billing Covered Person shall receive at least two hours of Billing and Reimbursement Specific Training, in addition to the General Training, in each subsequent Reporting Period. Each Relevant Clinical Covered Person shall receive at least two hours of Clinical Documentation and Decision-Making Specific Training, in addition to the General Training, in each subsequent Reporting Period. Each Relevant Case Management Covered Person shall receive at least two hours of Case Management Specific Training, in addition to the General Training, in each subsequent Reporting Period. Each Relevant Arrangements Covered Person shall receive at least two hours of Arrangements Specific Training, in addition to the General Training, in each subsequent Reporting Period.

3. *Board Member Training*. Within 120 days after the Effective Date, CHSI shall provide at least one hour of training to each member of the Board of Directors, in addition to the General Training. This training shall address the responsibilities of board members and corporate governance.

New members of the Board of Directors shall receive the Board Member Training described above within 30 days after becoming a member or within 120 days after the Effective Date, whichever is later.

4. *Certification.* Each individual who is required to attend training shall certify, in writing or in electronic form, that he or she has received the required training. The certification shall specify the type of training received and the date received. The Corporate Compliance and Privacy Officer (or designee) shall retain the certifications, along with all course materials.

5. *Qualifications of Trainer.* Persons providing the training shall be knowledgeable about the subject area.

6. *Update of Training.* CHSI shall review the training annually, and, where appropriate, update the training to reflect changes in Federal health care program requirements, any issues discovered during internal audits or the Inpatient Medical Necessity and Appropriateness Review , and any other relevant information.

7. *Computer-based Training.* CHSI may provide the training required under this CIA through appropriate computer-based training approaches. If CHSI chooses to provide computer-based training, it shall make available appropriately qualified and knowledgeable staff or trainers to answer questions or provide additional information to the individuals receiving such training. In addition, if CHSI chooses to provide computer based General or Specific Training, all applicable requirements to provide a number of "hours" of training in this Section may be met with respect to computer-based training by providing the required number of "normative" hours as that term is used in the computer-based training industry.

8. *Exception for Active Medical Staff Members*. CHSI shall make the General Training and Specific Training (as appropriate) described in this section available to all of CHSI's active medical staff members and shall use its best efforts to encourage such active medical staff members to complete the training. The Corporate Compliance and Privacy Officer shall maintain records of all active medical staff members who receive training, including the type of training and the date received.

D. Compliance with the Anti-Kickback Statute and Stark Law

1. *Focus Arrangements Procedures*. Within 120 days after the Effective Date, CHSI shall create procedures reasonably designed to ensure that each existing and new or renewed Focus Arrangement does not violate the Anti-Kickback Statute and/or the Stark Law or the regulations, directives, and guidance related to these statutes (Focus Arrangements Procedures). These procedures shall include the following:

a. creating and maintaining a centralized tracking system for all existing and new or renewed Focus Arrangements (Focus Arrangements Tracking System);

b. tracking remuneration to and from all parties to Focus Arrangements;

c. tracking service and activity logs to ensure that parties to the Focus Arrangement are performing the services required under the applicable Focus Arrangement(s) (if applicable);

d. monitoring the use of leased space, medical supplies, medical devices, equipment, or other patient care items to ensure that such use is consistent with the terms of the applicable Focus Arrangement(s) (if applicable);

e. establishing and implementing a written review and approval process for all Focus Arrangements, the purpose of which is to ensure that all new and existing or renewed Focus Arrangements do not violate the Anti-Kickback Statute and Stark Law, and that includes at least the following: (i) a legal review of all Focus Arrangements by counsel with expertise in the Anti-Kickback Statute and Stark Law, (ii) a process for specifying the business need or business rationale for all Focus Arrangements, and (iii) a process for determining and documenting the fair market value of the remuneration specified in the Focus Arrangement;

f. requiring the Corporate Compliance and Privacy Officer to review the Focus Arrangements Tracking System, internal

review and approval process, and other Focus Arrangements Procedures on at least an annual basis and to provide a report on the results of such review to the Board of Directors; and

g. implementing effective responses when suspected violations of the Anti-Kickback Statute and Stark Law are discovered, including disclosing Reportable Events and quantifying and repaying Overpayments pursuant to Sections III.I and III.J when appropriate.

2. *New or Renewed Arrangements*. Prior to entering into new Focus Arrangements or renewing existing Focus Arrangements, in addition to complying with the Focus Arrangements Procedures set forth above, CHSI shall comply with the following requirements (Focus Arrangements Requirements):

a. Ensure that each Focus Arrangement is set forth in writing and signed by CHSI and the other parties to the Focus Arrangement;

b. Include in the written agreement a requirement that each party to a Focus Arrangement who meets the definition of a Relevant Arrangements Covered Person shall complete at least one hour of training regarding the Anti-Kickback Statute and the Stark Law and examples of arrangements that potentially implicate the Anti-Kickback Statute or the Stark Law. Additionally, CHSI shall provide each party to the Focus Arrangement with a copy of its Code of Conduct and Stark Law and Anti-Kickback Statute Policies and Procedures;

c. Include in the written agreement a certification by the parties to the Focus Arrangement that the parties shall not violate the Anti-Kickback Statute and the Stark Law with respect to the performance of the Arrangement.

3. *Records Retention and Access*. CHSI shall retain and make available to OIG, upon request, the Focus Arrangements Tracking System and all supporting documentation of the Focus Arrangements subject to this Section and, to the

extent available, all non-privileged communications related to the Focus Arrangements and the actual performance of the duties under the Focus Arrangements.

E. Review Procedures

1. General Description

a. *Engagement of Independent Review Organization*. Within 120 days after the Effective Date, CHSI shall engage an entity (or entities), such as an accounting, auditing, or consulting firm (hereinafter "Independent Review Organization" or "IRO"), to perform the reviews listed in this Section III.E. The applicable requirements relating to the IRO are outlined in Appendix A to this CIA, which is incorporated by reference.

b. *Retention of Records*. The IRO and CHSI shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (those exchanged between the IRO and CHSI) related to the reviews.

c. *Responsibilities and Liabilities*. Nothing in this Section III.E affects CHSI's responsibilities or liabilities under any criminal, civil, or administrative laws or regulations applicable to any Federal health care program including, but not limited to, the Anti-Kickback Statute and/or the Stark Law.

2. *Claims Review.* The IRO shall review claims submitted by CHSI Covered Facilities and reimbursed by Medicare, to determine whether the items and services furnished were medically necessary and appropriately documented and whether the claims were correctly coded, submitted and reimbursed (Claims Review) and shall prepare a Claims Review Report, as outlined in Appendix B to this CIA, which is incorporated by reference.

3. *Arrangements Review*. The IRO shall perform an Arrangements Review and prepare an Arrangements Review Report as outlined

in Appendix C to this CIA, which is incorporated by reference. CHSI may engage an IRO to perform the Arrangements Review that is different from the IRO engaged to perform the Claims Review.

4. *Unallowable Cost Review.* For the first Reporting Period, the IRO shall conduct a review of CHSI's compliance with the unallowable cost provisions of the Settlement Agreement. The IRO shall determine whether CHSI has complied with its obligations not to charge to, or otherwise seek payment from, federal or state payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable federal or state payors any unallowable costs included in payments previously sought from the United States, or any state Medicaid program. This unallowable costs analysis shall include, but not be limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by CHSI or any affiliates. To the extent that such cost reports, cost statements, information reports, or payment requests, even if already settled, have been adjusted to account for the effect of the inclusion of the unallowable costs, the IRO shall determine if such adjustments were proper. In making this determination, the IRO may need to review cost reports and/or financial statements from the year in which the Settlement Agreement was executed, as well as from previous years.

5. *Unallowable Cost Review Report.* The IRO shall prepare a report based upon the Unallowable Cost Review performed (Unallowable Cost Review Report). The Unallowable Cost Review Report shall include the IRO's findings and supporting rationale regarding the Unallowable Cost Review and whether CHSI has complied with its obligation not to charge to, or otherwise seek payment from, federal or state payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable federal or state payors any unallowable costs included in payments previously sought from such payor.

6. *Validation Review*. In the event OIG has reason to believe that: (a) CHSI's Claims Review, Arrangements Review, or Unallowable Cost Review fails to conform to the requirements of this CIA; or (b) the IRO's findings or Claims Review, Arrangements Review, or Unallowable Cost Review results are inaccurate, OIG may, at its sole discretion, conduct its own review to determine whether the Claims Review, Arrangements Review, or Unallowable Cost Review complied with the requirements of the CIA and/or the findings or Claims Review, Arrangements Review, or Unallowable

Cost Review results are inaccurate (Validation Review). CHSI shall pay for the reasonable cost of any such review performed by OIG or any of its designated agents. Any Validation Review of Reports submitted as part of CHSI's final Annual Report shall be initiated no later than one year after CHSI's final submission (as described in Section II) is received by OIG.

Prior to initiating a Validation Review, OIG shall notify CHSI of its intent to do so and provide a written explanation of why OIG believes such a review is necessary. To resolve any concerns raised by OIG, CHSI may request a meeting with OIG to: (a) discuss the results of any Claims Review, Arrangements Review, or Unallowable Cost Review submissions or findings; (b) present any additional information to clarify the results of the Claims Review, Arrangements Review, or Unallowable Cost Review or to correct the inaccuracy of the Claims Review, Arrangements Review, or Unallowable Cost Review; and/or (c) propose alternatives to the proposed Validation Review. CHSI agrees to provide any additional information as may be requested by OIG under this Section III.E.6in an expedited manner. OIG will attempt in good faith to resolve any Claims Review, Arrangements Review, or Unallowable Cost Review issues with CHSI prior to conducting a Validation Review. However, the final determination as to whether or not to proceed with a Validation Review shall be made at the sole discretion of OIG.

7. *Independence and Objectivity Certification*. The IRO shall include in its report(s) to CHSI a certification that the IRO has (a) evaluated its professional independence and objectivity with respect to the reviews conducted under this Section III.E and (b) concluded that it is, in fact, independent and objective, in accordance with the requirements specified in Appendix A to this CIA.

F. Disclosure Program

CHSI has an established Disclosure Program that includes a mechanism (e.g., a toll-free compliance telephone line) to enable individuals to disclose, to the Corporate Compliance and Privacy Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with CHSI's policies, conduct, practices, or procedures with respect to a Federal health care program believed by the individual to be a potential violation of criminal, civil, or administrative law. CHSI shall continue to maintain this Disclosure Program for the duration of the CIA. CHSI shall continue to publicize appropriately the existence of the disclosure

mechanism (e.g., via periodic e-mails to employees or by posting the information in prominent common areas).

The Disclosure Program shall continue to emphasize a nonretribution, nonretaliation policy, and shall include a reporting mechanism for anonymous communications for which appropriate confidentiality shall be maintained. Upon receipt of a disclosure, the Corporate Compliance and Privacy Officer (or designee) shall gather all relevant information from the disclosing individual. The Corporate Compliance and Privacy Officer (or designee) shall make a preliminary, good faith inquiry into the allegations set forth in every disclosure to ensure that he or she has obtained all of the information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that it reasonably: (1) permits a determination of the appropriateness of the alleged improper practice; and (2) provides an opportunity for taking corrective action, CHSI shall conduct an internal review of the allegations set forth in the disclosure and ensure that proper follow-up is conducted.

The Corporate Compliance and Privacy Officer (or designee) shall maintain a disclosure log, which shall include a record and summary of each disclosure received (whether anonymous or not), the status of the respective internal reviews, and any corrective action taken in response to the internal reviews.

G. Ineligible Persons

1. *Definitions*. For purposes of this CIA:

a. an "Ineligible Person" shall include an individual or entity who:

i. is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or nonprocurement programs; or

ii. has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

b. "Exclusion Lists" shall include:

i. the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at http://www.oig.hhs.gov); and

ii. the General Services Administration's System for Award Management (available through the Internet at http://www.sam.gov).

2. *Screening Requirements*. CHSI shall ensure that all prospective and current Covered Persons are not Ineligible Persons, by implementing the following screening requirements.

a. CHSI shall screen all prospective Covered Persons against the Exclusion Lists prior to engaging their services and, as part of the hiring or contracting process, shall require such Covered Persons to disclose whether they are Ineligible Persons.

b. CHSI shall screen all Covered Persons against the Exclusion Lists within 120 days after the Effective Date and on a monthly basis thereafter.

c. CHSI shall implement a policy requiring all Covered Persons to disclose immediately any debarment, exclusion, suspension, or other event that makes that person an Ineligible Person.

Nothing in Section III.G affects CHSI's responsibility to refrain from (and liability for) billing Federal health care programs for items or services furnished, ordered, or prescribed by excluded persons. CHSI understands that items or services furnished, ordered or prescribed by excluded persons are not payable by Federal health care programs and that CHSI may be liable for overpayments and/or criminal, civil, and administrative sanctions for employing or contracting with an excluded person regardless of whether CHSI meets the requirements of Section III.G.

3. *Removal Requirement*. If CHSI has actual notice that a Covered Person has become an Ineligible Person, CHSI shall remove such Covered Person from

responsibility for, or involvement with, CHSI's business operations related to the Federal health care programs and shall remove such Covered Person from any position for which the Covered Person's compensation or the items or services furnished, ordered, or prescribed by the Covered Person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds at least until such time as the Covered Person is reinstated into participation in the Federal health care programs. If a physician or other non-physician practitioner with staff privileges at CHSI is determined to be an Ineligible Person, CHSI shall ensure that (i) the medical staff member does not furnish, order, or prescribe any items or services payable in whole or in part by any Federal health care program; and (ii) the medical staff member is not "on call" at CHSI.

4. *Pending Charges and Proposed Exclusions*. If CHSI has actual notice that a Covered Person is charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a), 1320a-7(b)(1)-(3), or is proposed for exclusion during the Covered Person's employment or contract term or during the term of a physician's or other practitioner's medical staff privileges, CHSI shall take all appropriate actions to ensure that the responsibilities of that Covered Person have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, or resident, or any claims submitted to any Federal health care program.

H. Notification of Government Investigation or Legal Proceedings

Within 30 days after discovery, CHSI shall notify OIG, in writing, of any ongoing investigation or legal proceeding known to CHSI conducted or brought by a governmental entity or its agents involving an allegation that CHSI has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. CHSI shall also provide written notice to OIG within 30 days after the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the investigation or proceedings, if any.

I. Repayment of Overpayments

1. *Definition of Overpayments*. For purposes of this CIA, an "Overpayment" shall mean the amount of money CHSI has received in excess of the amount due and payable under any Federal health care program requirements.

2. *Repayment of Overpayments*

a. If, at any time, CHSI identifies or learns of any Overpayment, CHSI shall repay the Overpayment to the appropriate payor (e.g., Medicare contractor) within 60 days after identification of the Overpayment and take remedial steps within 90 days after identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the Overpayment from recurring. If not yet quantified, within 60 days after identification, CHSI shall notify the payor of its efforts to quantify the Overpayment amount along with a schedule of when such work is expected to be completed. Notification and repayment to the payor shall be done in accordance with the payor's policies.

b. Notwithstanding the above, notification and repayment of any Overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

J. Reportable Events

1. *Definition of Reportable Event.* For purposes of this CIA, a "Reportable Event" means anything that involves:

a. a substantial Overpayment;

b. a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized;

c. the employment of or contracting with a Covered Person who is an Ineligible Person as defined by Section III.G.1.a; or

d. the filing of a bankruptcy petition by CHSI.

A Reportable Event may be the result of an isolated event or a series of occurrences.

2. *Reporting of Reportable Events*. If CHSI determines (after a reasonable opportunity to conduct an appropriate review or investigation of the allegations) through any means that there is a Reportable Event, CHSI shall notify OIG, in writing, within 30 days after making the determination that the Reportable Event exists.

3. *Reportable Events under Section III.J.1.a*. For Reportable Events under Section III.J.1.a, the report to OIG shall be made within 30 days of the identification of the Overpayment, and shall include:

a. a description of the steps taken by CHSI to identify and quantify the Overpayment;

b. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

c. a description of CHSI's actions taken to correct the Reportable Event; and

d. any further steps CHSI plans to take to address the Reportable Event and prevent it from recurring.

Within 60 days of identification of the Overpayment, CHSI shall provide OIG with a copy of the notification and repayment to the payor required in Section III.I.2.

4. *Reportable Events under Section III.J.1.b and c*. For Reportable Events under Section III.J.1.b and III.J.1.c, the report to OIG shall include:

a. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

b. a description of CHSI's actions taken to correct the Reportable Event;

c. any further steps CHSI plans to take to address the Reportable Event and prevent it from recurring; and

d. if the Reportable Event has resulted in an Overpayment, a description of the steps taken by CHSI to identify and quantify the Overpayment.

5. *Reportable Events under Section III.J.1.d*. For Reportable Events under Section III.J.1.d, the report to the OIG shall include documentation of the bankruptcy filing and a description of any Federal health care program authorities implicated.

6. *Reportable Events Involving the Stark Law*. Notwithstanding the reporting requirements outlined above, any Reportable Event that involves only a probable violation of section 1877 of the Social Security Act, 42 U.S.C. §1395nn (the Stark Law) should be submitted by CHSI to the Centers for Medicare & Medicaid Services (CMS) through the self-referral disclosure protocol (SRDP), with a copy to the OIG. The requirements of Section III.I.2 that require repayment to the payor of any identified Overpayment within 60 days shall not apply to any Overpayment that may result from a probable violation of only the Stark Law that is disclosed to CMS pursuant to the SRDP. If CHSI identifies a probable violation of the Stark Law and repays the applicable Overpayment directly to the CMS contractor, then CHSI is not required by this Section III.J to submit the Reportable Event to CMS through the SRDP.

IV. SUCCESSOR LIABILITY; CHANGES TO BUSINESS UNITS OR LOCATIONS

A. Sale of Business, Business Unit or Location.

In the event that, after the Effective Date, CHSI proposes to sell any or all of its business, business units or hospitals (whether through a sale of assets, sale of stock, or other type of transaction) that are subject to this CIA, CHSI shall notify OIG of the proposed sale at least 30 days prior to the sale of its business, business unit or location. This notification shall include a description of the business, business unit or location to be sold, a brief description of the terms of the sale, and the name and contact information of the prospective purchaser. This CIA shall be binding on the purchaser of the business,

business unit or location, unless otherwise determined and agreed to in writing by the OIG.

B. Change or Closure of Business, Business Unit or Location

In the event that, after the Effective Date, CHSI changes locations or closes a business, business unit or hospital related to the furnishing of items or services that may be reimbursed by Federal health care programs, CHSI shall notify OIG of this fact as soon as possible, but no later than within 30 days after the date of change or closure of the business, business unit or hospital.

C. Purchase or Establishment of New Business, Business Unit or Location

In the event that, after the Effective Date, CHSI purchases or establishes a new business, business unit or hospital related to the furnishing of items or services that may be reimbursed by Federal health care programs, CHSI shall notify OIG at least 30 days prior to such purchase or the operation of the new business, business unit or hospital. This notification shall include the address of the new business, business unit or hospital, phone number, fax number, the hospital's Medicare and state Medicaid program provider number and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which CHSI currently submits claims. Each new business, business unit or hospital and all Covered Persons at each new business, business unit or hospital shall be subject to the applicable requirements of this CIA unless otherwise agreed to in writing by the OIG.

V. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report

Within 150 days after the Effective Date, CHSI shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA (Implementation Report). The Implementation Report shall, at a minimum, include:

1. The name, address, phone number, and position description of the Corporate Compliance and Privacy Officer required by Section III.A.1, and a summary of other noncompliance job responsibilities the Corporate Compliance and Privacy Officer may have;

2. the name, address, phone number, and position description of each Senior Compliance Director, Corporate Compliance Director, and Facility Compliance Officers required by Section III.A.2, and a summary of other noncompliance job responsibilities each Senior Compliance Director, Corporate Compliance Director, and Facility Compliance officers may have;

3. the names and positions of the members of the Corporate Compliance Work Group required by Section III.A.3;

4. the names and positions of the members of each Facility Compliance Committee required by Section III.A.4;

5. the names of the Board members who are responsible for satisfying the Board of Directors compliance obligations described in Section III.A.5;

6. a copy of CHSI's Code of Conduct required by Section III.B.1;

7. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be available to OIG upon request);

8. a summary of all Policies and Procedures required by Section III.B.2 (copies of the Policies and Procedures shall be made available to OIG upon request);

9. the following information regarding each type of training required by Section III.C:

   a. a description of such training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions;

   b. the number of individuals required to be trained, percentage of individuals actually trained, and an explanation of any exceptions; and

   c. with respect to active medical staff members, the number and percentage who completed the training, the type of training

and the date received, and a description of CHSI's efforts to encourage medical staff members to complete the training.

A copy of all training materials and the documentation supporting this information shall be made available to OIG upon request.

10. a description of (a) the Focus Arrangements Tracking System required by Section III.D.1.a, (b) the internal review and approval process required by Section III.D.1.e; and (c) the tracking and monitoring procedures and other Focus Arrangements Procedures required by Section III.D.1;

11. a description of the Disclosure Program required by Section III.F;

12. the following information regarding the IRO(s): (a) identity, address, and phone number; (b) a copy of the engagement letter; (c) information to demonstrate that the IRO has the qualifications outlined in Appendix A to this CIA; (d) a summary and description of any and all current and prior engagements and agreements between CHSI and the IRO; and (e) a certification from the IRO regarding its professional independence and objectivity with respect to CHSI;

13. a description of the process by which CHSI fulfills the requirements of Section III.G regarding Ineligible Persons;

14. a list of all of CHSI's Covered Facilities (including locations and mailing addresses); the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's Medicare and state Medicaid program provider number and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which CHSI currently submits claims;

15. a description of CHSI's corporate structure, including identification of any parent and sister companies, subsidiaries, and their respective lines of business; and

16. the certifications required by Section V.C.

B. Annual Reports

CHSI shall submit to OIG annually a report with respect to the status of, and findings regarding, CHSI's compliance activities for each of the three Reporting Periods (Annual Report). Each Annual Report shall include, at a minimum:

1. any change in the identity, position description, or other noncompliance job responsibilities of the Corporate Compliance and Privacy Officer, Senior Compliance Directors, Corporate Compliance Directors, and Facility Compliance Officers, and any change in the membership of the Corporate Compliance Work Group described in Section III.A;

2. the dates of each report made by the Corporate Compliance and Privacy Officer to the Board (written documentation of such reports shall be made available upon request);

3. the Board of Directors resolution required by Section III.A.5;

4. a summary of any changes or amendments to CHSI's Code of Conduct required by Section III.B.1 and the reason for such changes, along with a copy of the revised Code of Conduct;

5. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be made available to OIG upon request);

6. a summary of any significant changes or amendments to the Policies and Procedures required by Section III.B.2 and the reasons for such changes (e.g., change in contractor policy);

7. the following information regarding each type of training required by Section III.C:

   a. a description of the initial and annual training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions;

b. the number of individuals required to complete the initial and annual training, the percentage of individuals who actually completed the initial and annual training, and an explanation of any exceptions; and

c. with respect to active medical staff members, the number and percentage who completed the training, the type of training and the date received, and a description of CHSI's efforts to encourage medical staff members to complete the training.

A copy of all training materials and the documentation to support this information shall be made available to OIG upon request;

8. a complete copy of all reports prepared pursuant to Section III.E, along with a copy of the IRO's engagement letter(s);

9. CHSI's response to the reports prepared pursuant to Section III.E, along with corrective action plan(s) related to any issues raised by the reports;

10. a summary and description of any and all current and prior engagements and agreements between CHSI and the IRO (if different from what was submitted as part of the Implementation Report);

11. a certification from the IRO regarding its professional independence and objectivity with respect to CHSI;

12. a summary of Reportable Events (as defined in Section III.J) identified during the Reporting Period and the status of any corrective action relating to all such Reportable Events;

13. a report of the aggregate Overpayments that have been returned to the Federal health care programs. Overpayment amounts shall be broken down into the following categories: Medicare, Medicaid (report each applicable state separately, if applicable), and other Federal health care programs. Overpayment amounts that are routinely reconciled or adjusted pursuant to policies and procedures established by the payor do not need to be included in this aggregate Overpayment report;

14. a summary of the disclosures in the disclosure log required by Section III.F that relate to Federal health care programs (the complete disclosure log shall be made available to OIG upon request);

15. any changes to the process by which CHSI fulfills the requirements of Section III.G regarding Ineligible Persons;

16. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.H. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

17. a description of all changes to the most recently provided list of CHSI's locations (including addresses) as required by Section V.A.14; the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's Medicare and state Medicaid program provider number(s) and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which CHSI currently submits claims; and

18. the certifications required by Section V.C.

The first Annual Report shall be received by OIG no later than 60 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

C. Certifications

The Implementation Report and each Annual Report shall include a certification by the Corporate Compliance and Privacy Officer that:

1. to the best of his or her knowledge, except as otherwise described in the report, CHSI is in compliance with all of the requirements of this CIA;

2. he or she has reviewed the report and has made reasonable inquiry regarding its content and believes that the information in the report is accurate and truthful; and

3. to the best of his or her knowledge, CHSI has complied with its obligations under the Settlement Agreement: (a) not to resubmit to any Federal health care program payors any previously denied claims related to the Covered Conduct addressed in the Settlement Agreement, and not to appeal any such denials of claims; (b) not to charge to or otherwise seek payment from federal or state payors for unallowable costs (as defined in the Settlement Agreement); and (c) to identify and adjust any past charges or claims for unallowable costs.

D. Designation of Information

CHSI shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act (FOIA), 5 U.S.C. § 552. CHSI shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing after the Effective Date, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG:

Administrative and Civil Remedies Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, S.W.
Washington, DC 20201
Telephone: 202.619.2078
Facsimile: 202.205.0604

CHSI:

Andi Bosshart

Senior Vice President, Corporate Compliance and Privacy Officer
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067
Telephone: 615.465.7150
Facsimile: 615.465.3004

Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery, or other means, provided that there is proof that such notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt. Upon request by OIG, CHSI may be required to provide OIG with an electronic copy of each notification or report required by this CIA in searchable portable document format (pdf), in addition to a paper copy.

VII. OIG INSPECTION, AUDIT, AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may examine or request copies of CHSI's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of CHSI's locations for the purpose of verifying and evaluating: (a) CHSI's compliance with the terms of this CIA; and (b) CHSI's compliance with the requirements of the Federal health care programs. The documentation described above shall be made available by CHSI to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit, or reproduction. Furthermore, for purposes of this provision, OIG or its duly authorized representative(s) may interview any of CHSI's employees, contractors, or agents who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. CHSI shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. CHSI's employees may elect to be interviewed with or without a representative of CHSI present.

VIII. DOCUMENT AND RECORD RETENTION

CHSI shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs and to compliance with this CIA for six years (or longer if otherwise required by law) from the Effective Date.

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify CHSI prior to any release by OIG of information submitted by CHSI pursuant to its obligations under this CIA and identified upon submission by CHSI as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, CHSI shall have the rights set forth at 45 C.F.R. § 5.65(d).

X. BREACH AND DEFAULT PROVISIONS

CHSI is expected to fully and timely comply with all of its CIA obligations.

A. Stipulated Penalties for Failure to Comply with Certain Obligations

As a contractual remedy, CHSI and OIG hereby agree that failure to comply with certain obligations as set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as "Stipulated Penalties") in accordance with the following provisions.

1. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CHSI fails to establish and implement any of the following obligations as described in Section III:

   a. a Corporate Compliance and Privacy Officer, Corporate Compliance Directors, and/or Facility Compliance Officers;

   b. a Corporate Compliance Work Group; and/or Facility Compliance Committees;

   c. the Board of Directors compliance obligations;

d. a written Code of Conduct;

e. written Policies and Procedures;

f. the training of Covered Persons, Relevant Covered Persons, and Board Members;

g. a Disclosure Program;

h. Ineligible Persons screening and removal requirements;

i. notification of Government investigations or legal proceedings; and

j. reporting of Reportable Events.

2. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CHSI fails to engage and use an IRO, as required in Section III.E, Appendix A, and Appendix B.

3. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CHSI fails to submit the Implementation Report or any Annual Reports to OIG in accordance with the requirements of Section V by the deadlines for submission.

4. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CHSI fails to submit any Claims Review Report, Unallowable Cost Review Report, or Arrangements Review Report in accordance with the requirements of Section III.E, Appendix B, and Appendix C.

5. A Stipulated Penalty of $1,500 for each day CHSI fails to grant access as required in Section VII. (This Stipulated Penalty shall begin to accrue on the date CHSI fails to grant access.)

6. A Stipulated Penalty of $50,000 for each false certification submitted by or on behalf of CHSI as part of its Implementation Report, Annual Report,

additional documentation to a report (as requested by the OIG), or otherwise required by this CIA.

7. A Stipulated Penalty of $1,000 for each day CHSI fails to comply fully and adequately with any obligation of this CIA. OIG shall provide notice to CHSI stating the specific grounds for its determination that CHSI has failed to comply fully and adequately with the CIA obligation(s) at issue and steps CHSI shall take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after CHSI receives this notice from OIG of the failure to comply.) A Stipulated Penalty as described in this Subsection shall not be demanded for any violation for which OIG has sought a Stipulated Penalty under Subsections 1- 6 of this Section.

B. Timely Written Requests for Extensions

CHSI may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. Notwithstanding any other provision in this Section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after CHSI fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after CHSI receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by OIG at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties

1. *Demand Letter*. Upon a finding that CHSI has failed to comply with any of the obligations described in Section X.A and after determining that Stipulated Penalties are appropriate, OIG shall notify CHSI of: (a) CHSI's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties. (This notification shall be referred to as the "Demand Letter.")

2. *Response to Demand Letter.* Within 10 days after the receipt of the Demand Letter, CHSI shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties or (b) request a hearing before an HHS administrative law

judge (ALJ) to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event CHSI elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until CHSI cures, to OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this CIA and shall be grounds for exclusion under Section X.D.

3. *Form of Payment*. Payment of the Stipulated Penalties shall be made by electronic funds transfer to an account specified by OIG in the Demand Letter.

4. *Independence from Material Breach Determination*. Except as set forth in Section X.D.1.c, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that CHSI has materially breached this CIA, which decision shall be made at OIG's discretion and shall be governed by the provisions in Section X.D, below.

D. Exclusion for Material Breach of this CIA

1. *Definition of Material Breach*. A material breach of this CIA means

a. a repeated or flagrant violation of the obligations under this CIA, including, but not limited to, the obligations addressed in Section X.A.

b. a failure by CHSI to report a Reportable Event, take corrective action, and make the appropriate refunds, as required in Section III.J;

c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C; or

d. a failure to engage and use an IRO in accordance with Section III.E, Appendix A, and Appendix B.

2. *Notice of Material Breach and Intent to Exclude*. The parties agree that a material breach of this CIA by CHSI constitutes an independent basis for CHSI's

exclusion from participation in the Federal health care programs. Upon a determination by OIG that CHSI has materially breached this CIA and that exclusion is the appropriate remedy, OIG shall notify CHSI of: (a) CHSI's material breach; and (b) OIG's intent to exercise its contractual right to impose exclusion. (This notification shall be referred to as the "Notice of Material Breach and Intent to Exclude.")

3. *Opportunity to Cure*. CHSI shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to OIG's satisfaction that:

a. CHSI is in compliance with the obligations of the CIA cited by OIG as being the basis for the material breach;

b. the alleged material breach has been cured; or

c. the alleged material breach cannot be cured within the 30 day period, but that: (i) CHSI has begun to take action to cure the material breach; (ii) CHSI is pursuing such action with due diligence; and (iii) CHSI has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter*. If, at the conclusion of the 30 day period, CHSI fails to satisfy the requirements of Section X.D.3, OIG may exclude CHSI from participation in the Federal health care programs. OIG shall notify CHSI in writing of its determination to exclude CHSI. (This letter shall be referred to as the "Exclusion Letter.") Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect 30 days after the date of CHSI's receipt of the Exclusion Letter. The exclusion shall have national effect. Reinstatement to program participation is not automatic. After the end of the period of exclusion, CHSI may apply for reinstatement by submitting a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution

1. *Review Rights*. Upon OIG's delivery to CHSI of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, CHSI shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they

applied to the Stipulated Penalties or exclusion sought pursuant to this CIA. Specifically, OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board (DAB), in a manner consistent with the provisions in 42 C.F.R. § 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within 10 days after receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after receipt of the Exclusion Letter.

2. *Stipulated Penalties Review*. Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether CHSI was in full and timely compliance with the obligations of this CIA for which OIG demands payment; and (b) the period of noncompliance. CHSI shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to Stipulated Penalties. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders CHSI to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless CHSI requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of OIG, the Stipulated Penalties shall become due and payable 20 days after the DAB issues its decision.

3. *Exclusion Review*. Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be:

a. whether CHSI was in material breach of this CIA;

b. whether such breach was continuing on the date of the Exclusion Letter; and

c. whether the alleged material breach could not have been cured within the 30-day period, but that: (i) CHSI had begun to take action to cure the material breach within that period; (ii) CHSI has pursued and is pursuing such action with due diligence; and (iii) CHSI provided to OIG within that period a

reasonable timetable for curing the material breach and CHSI has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for CHSI, only after a DAB decision in favor of OIG. CHSI's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude CHSI upon the issuance of an ALJ's decision in favor of OIG. If the ALJ sustains the determination of OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that CHSI may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect 20 days after the DAB decision. CHSI shall waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of CHSI, CHSI shall be reinstated effective on the date of the original exclusion.

4. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA.

XI. EFFECTIVE AND BINDING AGREEMENT

CHSI and OIG agree as follows:

A. This CIA shall become final and binding on the date the final signature is obtained on the CIA.

B. This CIA constitutes the complete agreement between the parties and may not be amended except by written consent of the parties to this CIA.

C. OIG may agree to a suspension of CHSI's obligations under this CIA based on a certification by CHSI that it is no longer providing health care items or services that will be billed to any Federal health care program and that it does not have any ownership or control interest, as defined in 42 U.S.C. §1320a-3, in any entity that bills any Federal health care program. If CHSI is relieved of its CIA obligations, CHSI will be required to notify OIG in writing at least 30 days in advance if CHSI plans to resume providing health care items or services that are billed to any Federal health care program or to

obtain an ownership or control interest in any entity that bills any Federal health care program. At such time, OIG shall evaluate whether the CIA will be reactivated or modified.

D. The undersigned CHSI signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatories represent that they are signing this CIA in their official capacities and that they are authorized to execute this CIA.

E. This CIA may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same CIA. Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this CIA.

ON BEHALF OF
CHSI

/s/ Andi Bosshart — September 20, 2018

Andi Bosshart — DATE
CHSI
Senior Vice President, Corporate Compliance and Privacy Officer

/s/ Richard A. Sauber — September 21, 2018

Richard A. Sauber — DATE
Counsel for CHSI
Robbins, Russell, Englert, Orseck, Untereiner & Sauber LLP

/s/ Michael L. Waldman — September 21, 2018

Michael L. Waldman — DATE
Counsel for CHSI
Robbins, Russell, Englert, Orseck, Untereiner & Sauber LLP

ON BEHALF OF THE OFFICE OF INSPECTOR

GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

/s/ Lisa Re — September 21, 2018

LISA RE
Assistant Inspector General for Legal
Affairs Office of Inspector General
U. S. Department of Health and Human Services

DATE

/s/ Sandra Jean Sands — September 21, 2018

SANDRA JEAN SANDS
Senior Counsel
Office of Inspector General
U.S. Department of Health and Human Service

DATE

APPENDIX A

INDEPENDENT REVIEW ORGANIZATION

This Appendix contains the requirements relating to the Independent Review Organization (IRO) required by Section III.E of the CIA.

A. IRO Engagement

1. CHSI shall engage an IRO to perform the Unallowable Cost Review and the Claims Review that possesses the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO shall conduct the reviews in a professionally independent and objective fashion, as set forth in Paragraph E.

2. CHSI shall also engage an IRO to perform the Arrangements Review that possesses the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO shall not have a prohibited relationship to CHSI as set forth in Paragraph F.

3. Within 30 days after OIG receives the information identified in Section V.A.12 of the CIA or any additional information submitted by CHSI in response to a request by OIG, whichever is later, OIG will notify CHSI if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, CHSI may continue to engage the IRO.

4. If CHSI engages a new IRO during the term of the CIA, that IRO must also meet the requirements of this Appendix. If a new IRO is engaged, CHSI shall submit the information identified in Section V.A.12 of the CIA to OIG within 30 days of engagement of the IRO. Within 30 days after OIG receives this information or any additional information submitted by CHSI at the request of OIG, whichever is later, OIG will notify CHSI if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, CHSI may continue to engage the IRO.

B. IRO Qualifications

The IRO shall:

1. assign individuals to conduct the Arrangements Review who are knowledgeable in the requirements of the Anti-Kickback Statute and the Stark Law and the regulations and other guidance documents related to these statutes;

2. possess expertise in fair market valuation issues or have the ability to associate a valuation firm to assist in conducting the transactions review component of the Arrangements Review;

3. assign individuals to conduct the Claims Review who have expertise in the Medicare program requirements applicable to the claims being reviewed;

4. assign individuals to design and select the Claims Review sample who are knowledgeable about the appropriate statistical sampling techniques;

5. assign individuals to conduct the coding review portions of the Claims Review who have a nationally recognized coding certification and who have maintained this certification (e.g., completed applicable continuing education requirements);

6. assign licensed nurses or physicians with relevant education, training and specialized expertise (or other licensed health care professionals acting within their scope of practice and specialized expertise) to make the medical necessity determinations required by the Claims Review; and

7. have sufficient staff and resources to conduct the reviews required by the CIA on a timely basis.

C. IRO Responsibilities

The IRO shall:

1. perform each Arrangements Review, Unallowable Cost Review, and Claims Review in accordance with the specific requirements of the CIA;

2. follow all applicable Medicare program rules and reimbursement guidelines in making assessments in the Claims Review;

3. request clarification from the appropriate authority (e.g., Medicare contractor), if in doubt of the application of a particular Medicare program policy or regulation;

4. respond to all OIG inquires in a prompt, objective, and factual manner; and

5. prepare timely, clear, well-written reports that include all the information required by Appendix B and Appendix C (as applicable) to the CIA.

D. CHSI Responsibilities

CHSI shall ensure that the IRO has access to all records and personnel necessary to complete the reviews listed in Section III.E of this CIA and that all records furnished to the IRO are accurate and complete.

E. IRO Independence and Objectivity

The IRO engaged to perform the Unallowable Cost Review and the Claims Review must perform the reviews in a professionally independent and objective fashion, as defined in the most recent Government Auditing Standards issued by the U.S. Government Accountability Office.

F. IRO Relationship to CHSI

The IRO engaged to perform the Arrangements Review shall not (1) currently represent or currently be employed or engaged by CHSI or (2) have a current or prior relationship to CHSI or its owners, officers, or directors that would cause a reasonable person to question the IRO's objectivity in performing the Arrangements Review.

G. Assertions of Privilege

CHSI shall not assert claims of attorney-client privilege in order to avoid disclosing to OIG information related to or resulting from the IRO's engagement to perform the Arrangements Review. CHSI's engagement letter with the IRO shall include a provision stating that the IRO agrees not to assert claims of work product privilege in order to avoid disclosing to OIG information related to or resulting from its engagement.

H. IRO Removal/Termination

1. *CHSI and IRO*. If CHSI terminates its IRO or if the IRO withdraws from the engagement during the term of the CIA, CHSI must submit a notice explaining (a) its reasons for termination of the IRO or (b) the IRO's reasons for its withdrawal to OIG, no later than 30 days after termination or withdrawal. CHSI must engage a new IRO in accordance with Paragraph A of this Appendix and within 60 days of termination or withdrawal of the IRO.

2. *OIG Removal of IRO*. In the event OIG has reason to believe that the IRO does not possess the qualifications described in Paragraph B, is not independent and objective as set forth in Paragraph E or has a prohibited relationship as set forth in paragraph F (as applicable), or has failed to carry out its responsibilities as described in

Paragraph C, OIG shall notify CHSI in writing regarding OIG's basis for determining that the IRO has not met the requirements of this Appendix. CHSI shall have 30 days from the date of OIG's written notice to provide information regarding the IRO's qualifications, independence, relationship to CHSI or performance of its responsibilities in order to resolve the concerns identified by OIG. If, following OIG's review of any information provided by CHSI regarding the IRO, OIG determines that the IRO has not met the requirements of this Appendix, OIG shall notify CHSI in writing that CHSI shall be required to engage a new IRO in accordance with Paragraph A of this Appendix. CHSI must engage a new IRO within 60 days of its receipt of OIG's written notice. The final determination as to whether or not to require CHSI to engage a new IRO shall be made at the sole discretion of OIG.

APPENDIX B

CLAIMS REVIEW

A. Claims Review. The IRO shall perform the Claims Review annually to cover each of the three Reporting Periods. The IRO shall perform all components of each Claims Review. The Claims Review shall be conducted at four of CHSI's Covered Facilities for each Reporting Period.

1. *Definitions*. For the purposes of the Claims Review, the following definitions shall be used:

   a. Overpayment: The amount of money CHSI has received in excess of the amount due and payable under Medicare program requirements, as determined by the IRO in connection with the Claims Review performed under this Appendix B.

   b. Paid Claim: A claim submitted by CHSI and for which CHSI has received reimbursement from the Medicare program.

   c. Population: The Population shall be defined as all Paid Claims during the 12-month period covered by the Claims Review. In OIG's discretion, OIG may limit the Population to one or more subset(s) of Paid Claims to be reviewed and shall notify CHSI and the IRO of its selection of the Population at least 30 days prior to the end of each Reporting Period. In connection with limiting the Population, OIG may also select the CHSI facilities that will be subject to the Claims Review in each Reporting Period. In order to facilitate OIG's selection, at least 90 days prior to the end of the Reporting Period, CHSI shall furnish to OIG the following information for each CHSI facility for the prior reporting year: (1) Federal health care program revenues, (2) Federal health care program patient census, and (3) Federal health care program payor mix.

      CHSI, or its IRO on behalf of CHSI, may submit proposals identifying suggestions for the subset(s) of Paid Claims to be reviewed and the CHSI facilities to be reviewed at least 90 days prior to the end of each Reporting Period. In connection with limiting the Population, OIG may consider (1) proposals submitted by CHSI or its IRO or (2) information furnished to OIG regarding the results of CHSI's internal risk assessment and internal auditing.

The determination of whether, and in what manner, to limit the Population shall be made at the sole discretion of OIG.

2. *Claims Review Sample.* The IRO shall randomly select and review a sample of 100 Paid Claims (Claims Review Sample) at each CHSI facility selected for review. The Paid Claims shall be reviewed based on the supporting documentation available at CHSI's office or under CHSI's control and applicable Medicare program requirements to determine whether the items and services furnished were medically necessary and appropriately documented, and whether the claim was correctly coded, submitted, and reimbursed. For each Paid Claim in the Claims Review Sample that results in an Overpayment, the IRO shall review the system(s) and process(es) that generated the Paid Claim and identify any problems or weaknesses that may have resulted in the identified Overpayments. The IRO shall provide its observations and recommendations on suggested improvements to the system(s) and the process(es) that generated the Paid Claim.

3. *Other Requirements.*

a. Supplemental Materials. The IRO shall request all documentation and materials required for its review of the Paid Claims in the Claims Review Sample and CHSI shall furnish such documentation and materials to the IRO prior to the IRO initiating its review of the Claims Review Sample. If the IRO accepts any supplemental documentation or materials from CHSI after the IRO has completed its initial review of the Claims Review Sample (Supplemental Materials), the IRO shall identify in the Claims Review Report the Supplemental Materials, the date the Supplemental Materials were accepted, and the relative weight the IRO gave to the Supplemental Materials in its review. In addition, the IRO shall include a narrative in the Claims Review Report describing the process by which the Supplemental Materials were accepted and the IRO's reasons for accepting the Supplemental Materials.

b. Paid Claims without Supporting Documentation. Any Paid Claim for which CHSI cannot produce documentation shall be considered an error and the total reimbursement received by CHSI for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not permitted.

c. Use of First Samples Drawn. For the purposes of the Claims Review Sample discussed in this Appendix, the first set of Paid Claims selected shall be used (i.e., it is not permissible to generate more

than one list of random samples and then select one for use with the Claims Review Sample).

4. *Repayment of Identified Overpayments.* CHSI shall repay within 60 days the Overpayment(s) identified by the IRO in the Claims Review Sample, in accordance with the requirements of 42 U.S.C. § 1320a-7k(d) and any applicable regulations or Centers for Medicare and Medicaid Services (CMS) guidance (the "CMS overpayment rule"). If CHSI determines that the CMS overpayment rule requires that an extrapolated Overpayment be repaid, CHSI shall repay that amount at the mean point estimate as calculated by the IRO. CHSI shall make available to OIG all documentation that reflects the refund of the Overpayment(s) to the payor. OIG, in its sole discretion, may refer the findings of the Claims Review Sample (and any related work papers) received from CHSI to the appropriate Medicare program contractor for appropriate follow up by the payor.

B. Claims Review Report. The IRO shall prepare a Claims Review Report as described in this Appendix for each Claims Review performed. The following information shall be included in the Claims Review Report.

1. *Claims Review Methodology.*

   a. Claims Review Population. A description of the Population subject to the Claims Review.

   b. Claims Review Objective. A clear statement of the objective intended to be achieved by the Claims Review.

   c. Source of Data. A description of (1) the process used to identify Paid Claims in the Population and (2) the specific documentation relied upon by the IRO when performing the Claims Review (e.g., medical records, physician orders, certificates of medical necessity, requisition forms, local medical review policies (including title and policy number), CMS program memoranda (including title and issuance number), Medicare carrier or intermediary manual or bulletins (including issue and date), other policies, regulations, or directives).

   d. Review Protocol. A narrative description of how the Claims Review was conducted and what was evaluated.

   e. Supplemental Materials. A description of any Supplemental Materials as required by A.3.a., above.

2. *Statistical Sampling Documentation.*

   a. A copy of the printout of the random numbers generated by the "Random Numbers" function of the statistical sampling software used by the IRO.

   b. A description or identification of the statistical sampling software package used by the IRO.

3. *Claims Review Findings.*

   a. Narrative Results.

      i. A description of CHSI's billing and coding system(s), including the identification, by position description, of the personnel involved in coding and billing.

      ii. A description of controls in place at CHSI to ensure that all items and services billed to Medicare are medically necessary and appropriately documented.

      iii. A narrative explanation of the IRO's findings and supporting rationale (including reasons for errors, patterns noted, etc.) regarding the Claims Review, including the results of the Claims Review Sample.

   b. Quantitative Results.

      i. Total number and percentage of instances in which the IRO determined that the coding of the Paid Claims submitted by CHSI differed from what should have been the correct coding and in which such difference resulted in an Overpayment to CHSI.

      ii. Total number and percentage of instances in which the IRO determined that a Paid Claim was not appropriately documented and in which such documentation errors resulted in an Overpayment to CHSI.

      iii. Total number and percentage of instances in which the IRO determined that a Paid Claim was for items or services that were not medically necessary and resulted in an Overpayment to CHSI.

iv. Total dollar amount of all Overpayments in the Claims Review Sample.

v. Total dollar amount of Paid Claims included in the Claims Review Sample.

vi. Error Rate in the Claims Review Sample. The Error Rate shall be calculated by dividing the Overpayment in the Claims Review Sample by the total dollar amount associated with the Paid Claims in the Claims Review Sample.

vii. An estimate of the actual Overpayment in the Population at the mean point estimate.

viii. A spreadsheet of the Claims Review results that includes the following information for each Paid Claim: Federal health care program billed, beneficiary health insurance claim number, date of service, code submitted (e.g., DRG, CPT code, etc.), code reimbursed, allowed amount reimbursed by payor, correct code (as determined by the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount.

c. Recommendations. The IRO's report shall include any recommendations for improvements to CHSI's billing and coding system or to CHSI's controls for ensuring that all items and services billed to Medicare are medically necessary and appropriately documented, based on the findings of the Claims Review.

4. *Credentials*. The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Claims Review and (2) performed the Claims Review.

APPENDIX C

ARRANGEMENTS REVIEW

The Arrangements Review shall consist of two components: a systems review and a transactions review. The IRO shall perform all components of each Arrangements Review. If there are no material changes to CHSI's systems, processes, policies, and procedures relating to Arrangements, the Arrangements Systems Review shall be performed for the first Reporting Period only. If CHSI materially changes the Arrangements systems, processes, policies and procedures, the IRO shall perform an Arrangements Systems Review for the Reporting Period in which such changes were made in addition to conducting the systems review for the first Reporting Period. The Arrangements Transactions Review shall be performed annually and shall cover each of the three Reporting Periods.

A. Selection of CHSI Covered Facilities To Be Reviewed. OIG may select four CHSI Covered Facilities that will be subject to the Arrangements Review in each Reporting Period. In order to facilitate OIG's selection, at least 90 days prior to the end of the Reporting Period, CHSI shall furnish to OIG the following information for each CHSI Covered Facility for the prior Reporting Period: the number of arrangements entered into for each Covered Facility.

B. Arrangements Systems Review. The Arrangements Systems Review shall be a review of CHSI's systems, processes, policies, and procedures relating to the initiation, review, approval, and tracking of Arrangements. Specifically, the IRO shall review the following:

1. CHSI's systems, policies, processes, and procedures with respect to creating and maintaining a centralized tracking system for all current existing and new and renewed Focus Arrangements (Focus Arrangements Tracking System), including a detailed description of the information captured in the Focus Arrangements Tracking System;

2. CHSI's systems, policies, processes, and procedures for tracking remuneration to and from all parties to Focus Arrangements;

3. CHSI's systems, policies, processes, and procedures for tracking service and activity logs to ensure that parties to the Focus Arrangement are performing the services required under the applicable Focus Arrangement(s) (if applicable);

4. CHSI's systems, policies, processes, and procedures for monitoring the use of leased space, medical supplies, medical devices, equipment, or other patient care items to ensure that such use is consistent with the terms of the applicable Focus Arrangement(s) (if applicable);

5. CHSI's systems, policies, processes, and procedures for initiating arrangements, including those policies that identify the individuals with authority to initiate an Arrangement and that specify the business need or business rationale required to initiate an Arrangement;

6. CHSI's systems, policies, processes, and procedures for the internal review and approval of all Arrangements, including those policies that identify the individuals required to approve each type or category of Arrangement entered into by CHSI, the internal controls designed to ensure that all required approvals are obtained, and the processes for ensuring that all Focus Arrangements are subject to a legal review by counsel with expertise in the Anti-Kickback Statute and Stark Law;

7. the Compliance Officer's annual review of and reporting to the Compliance Committee on the Focus Arrangements Tracking System, CHSI's internal review and approval process, and other Arrangements systems, process, policies, and procedures;

8. CHSI's systems, policies, processes, and procedures for implementing effective responses when suspected violations of the Anti-Kickback Statute and Stark Law are discovered, including disclosing Reportable Events and quantifying and repaying Overpayments when appropriate; and

9. CHSI's systems, policies, processes, and procedures for ensuring that all new and renewed Focus Arrangements comply with the Focus Arrangements Requirements set forth in Section III.D.2 of the CIA.

C. Arrangements Systems Review Report. The IRO shall prepare a report based upon each Arrangements Systems Review performed. The Arrangements Systems Review Report shall include the following information:

1. a description of the documentation (including policies) reviewed and personnel interviewed;

2. a detailed description of CHSI's systems, policies, processes, and procedures relating to the items identified in Section B.1-9 above;

3. findings and supporting rationale regarding weaknesses in CHSI's systems, processes, policies, and procedures relating to Arrangements described in Section B.1-9 above; and

4. recommendations to improve CHSI's systems, policies, processes, or procedures relating to Arrangements described in Section B.1-9 above.

D. Arrangements Transactions Review. The Arrangements Transactions Review shall consist of a review by the IRO of 25 randomly selected Focus Arrangements that were entered into or renewed by CHSI during the Reporting Period. The IRO shall assess whether CHSI has complied with the Focus Arrangements Procedures and the Focus Arrangements Requirements described in Sections III.D.1 and III.D.2 of the CIA, with respect to the selected Focus Arrangements.

The IRO's assessment with respect to each Focus Arrangement that is subject to review shall include:

1. verifying that the Focus Arrangement is maintained in CHSI's centralized tracking system in a manner that permits the IRO to identify the parties to the Focus Arrangement and the relevant terms of the Focus Arrangement (i.e., the items/services/equipment/space to be provided, the amount of compensation, the effective date, the expiration date, etc.)

2. verifying that the Focus Arrangement was subject to the internal review and approval process (including both a legal and business review) and obtained the necessary approvals and that such review and approval is appropriately documented;

3. verifying that the remuneration related to the Focus Arrangement is properly tracked;

4. verifying that the service and activity logs are properly completed and reviewed (if applicable);

5. verifying that leased space, medical supplies, medical devices, and equipment, and other patient care items are properly monitored (if applicable); and

6. verifying that the Focus Arrangement satisfies the Focus

Arrangements Requirements of Section III.D.2 of the CIA.

E. Arrangements Transaction Review Report. The IRO shall prepare a report based on each Arrangements Transactions Review performed. The Arrangements Transaction Review Report shall include the following information:

1. *Review Methodology*

a. Review Protocol: A detailed narrative description of the procedures performed and a description of the sampling unit and universe utilized in performing the procedures for the sample reviewed.

b. Sources of Data: A full description of the documentation and other information, if applicable, relied upon by the IRO in performing the Arrangements Transaction Review.

c. Supplemental Materials. The IRO shall request all documentation and materials required for its review of the Focus Arrangements selected as part of the Arrangements Transaction Review and CHSI shall furnish such documentation and materials to the IRO, prior to the IRO initiating its review of the Focus Arrangements. If the IRO accepts any supplemental documentation or materials from CHSI after the IRO has completed its initial review of the Focus Arrangements (Supplemental Materials), the IRO shall identify in the Arrangements Transaction Review Report the Supplemental Materials, the date the Supplemental Materials were accepted, and the relative weight the IRO gave to the Supplemental Materials in its review. In addition, the IRO shall include a narrative in the Arrangements Transaction Review Report describing the process by which the Supplemental Materials were accepted and the IRO's reasons for accepting the Supplemental Materials.

2. *Review Findings*. The IRO's findings with respect to whether CHSI has complied with the Focus Arrangements Procedures and Focus Arrangements Requirements with respect to each of the randomly selected Focus

Arrangements reviewed by the IRO. In addition, the Arrangements Transactions Review Report shall include observations, findings and recommendations on possible improvements to CHSI's policies, procedures, and systems in place to ensure that all Focus Arrangements comply with the Focus Arrangements Procedures and Focus Arrangements Requirements.