Table of Contents

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, 2014

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** *(Address of principal executive offices)*	**37067** *(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 and posted on its corporate web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

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

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

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

As of October 28, 2014, there were outstanding 116,331,829 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, 2014

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

	September 30, 2014	December 31, 2013
ASSETS		
Current assets:		
Cash and cash equivalents	$ 221	$ 373
Patient accounts receivable, net of allowance for doubtful accounts of $3,517 and $2,438 at September 30, 2014 and December 31, 2013, respectively	3,266	2,323
Supplies	553	371
Prepaid income taxes	123	107
Deferred income taxes	318	101
Prepaid expenses and taxes	213	127
Other current assets (including assets of hospitals held for sale of $84 and $40 at September 30, 2014 and December 31, 2013, respectively)	678	345
Total current assets	5,372	3,747
Property and equipment	14,221	10,462
Less accumulated depreciation and amortization	(3,923)	(3,411)
Property and equipment, net	10,298	7,051
Goodwill	8,936	4,424
Other assets, net (including assets of hospitals held for sale of $174 and $94 at September 30, 2014 and December 31, 2013, respectively)	2,618	1,895
Total assets	$ 27,224	$ 17,117
LIABILITIES AND EQUITY		
Current liabilities:		
Current maturities of long-term debt	$ 219	$ 167
Accounts payable	1,060	949
Deferred income taxes	-	3
Accrued interest	164	112
Accrued liabilities (including liabilities of hospitals held for sale of $34 and $24 at September 30, 2014 and December 31, 2013, respectively)	1,737	1,227
Total current liabilities	3,180	2,458
Long-term debt	16,793	9,286
Deferred income taxes	877	906
Other long-term liabilities	1,709	977
Total liabilities	22,559	13,627
Redeemable noncontrolling interests in equity of consolidated subsidiaries	695	358
EQUITY		
Community Health Systems, Inc. stockholders' equity:		
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; 117,257,526 shares issued and 116,281,977 shares outstanding at September 30, 2014, and 95,987,032 shares issued and 95,011,483 shares outstanding at December 31, 2013	1	1
Additional paid-in capital	2,059	1,256
Treasury stock, at cost, 975,549 shares at September 30, 2014 and December 31, 2013	(7)	(7)
Accumulated other comprehensive loss	(48)	(67)
Retained earnings	1,877	1,885
Total Community Health Systems, Inc. stockholders' equity	3,882	3,068
Noncontrolling interests in equity of consolidated subsidiaries	88	64
Total equity	3,970	3,132
Total liabilities and equity	$ 27,224	$ 17,117

See accompanying notes to the condensed consolidated financial statements.

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Operating revenues (net of contractual allowances and discounts)	$ 5,563	$ 3,710	$ 15,984	$ 11,161
Provision for bad debts	768	536	2,225	1,533
Net operating revenues	4,795	3,174	13,759	9,628
Operating costs and expenses:				
Salaries and benefits	2,191	1,514	6,417	4,591
Supplies	733	482	2,104	1,468
Other operating expenses	1,121	705	3,262	2,110
Government settlement and related costs	77	98	77	98
Electronic health records incentive reimbursement	(88)	(65)	(212)	(108)
Rent	110	70	320	208
Depreciation and amortization	280	193	817	574
Amortization of software to be abandoned	-	-	75	-
Total operating costs and expenses	4,424	2,997	12,860	8,941
Income from operations	371	177	899	687
Interest expense, net	250	154	728	464
Loss from early extinguishment of debt	-	-	73	1
Equity in earnings of unconsolidated affiliates	(12)	(12)	(35)	(36)
Impairment of long-lived assets	-	-	24	-
Income from continuing operations before income taxes	133	35	109	258
Provision for income taxes	40	7	16	78
Income from continuing operations	93	28	93	180
Discontinued operations, net of taxes:				
Income (loss) from operations of entities held for sale	1	(6)	(4)	(15)
Impairment of hospitals held for sale	-	-	(22)	-
Income (loss) from discontinued operations, net of taxes	1	(6)	(26)	(15)
Net income	94	22	67	165
Less: Net income attributable to noncontrolling interests	32	18	75	52
Net income (loss) attributable to Community Health Systems, Inc. stockholders	$ 62	$ 4	$ (8)	$ 113
Basic earnings (loss) per share attributable to Community Health Systems, Inc. common stockholders(1):				
Continuing operations	$ 0.54	$ 0.11	$ 0.16	$ 1.39
Discontinued operations	0.01	(0.07)	(0.24)	(0.17)
Net income (loss)	$ 0.54	$ 0.04	$ (0.08)	$ 1.22
Diluted earnings (loss) per share attributable to Community Health Systems, Inc. common stockholders(1):				
Continuing operations	$ 0.53	$ 0.11	$ 0.16	$ 1.37
Discontinued operations	0.01	(0.07)	(0.24)	(0.17)
Net income (loss)	$ 0.54	$ 0.04	$ (0.07)	$ 1.21
Weighted-average number of shares outstanding:				
Basic	113,138,663	93,259,027	110,871,066	92,384,270
Diluted	114,343,778	94,483,596	111,757,390	93,516,158

(1) Total per share amounts may not add due to rounding.
See accompanying notes to the condensed consolidated financial statements.

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net income	$ 94	$ 22	$ 67	$ 165
Other comprehensive income, net of income taxes:				
Net change in fair value of interest rate swaps, net of tax	11	10	20	47
Net change in fair value of available-for-sale securities, net of tax	(5)	1	(2)	3
Amortization and recognition of unrecognized pension cost components, net of tax	1	1	1	2
Other comprehensive income	7	12	19	52
Comprehensive income	101	34	86	217
Less: Comprehensive income attributable to noncontrolling interests	32	18	75	52
Comprehensive income attributable to Community Health Systems, Inc. stockholders	$ 69	$ 16	$ 11	$ 165

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,	
	2014	**2013**
Cash flows from operating activities:		
Net income	$ 67	$ 165
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	897	583
Deferred income taxes	-	-
Government settlement and related costs	77	98
Stock-based compensation expense	36	29
Impairment of long-lived assets and hospitals held for sale	46	-
Loss from early extinguishment of debt	73	1
Excess tax benefit relating to stock-based compensation	(4)	(7)
Other non-cash expenses, net	34	48
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:		
Patient accounts receivable	(299)	(231)
Supplies, prepaid expenses and other current assets	(39)	(60)
Accounts payable, accrued liabilities and income taxes	(189)	(206)
Other	(60)	21
Net cash provided by operating activities	639	441
Cash flows from investing activities:		
Acquisitions of facilities and other related equipment	(3,041)	(34)
Purchases of property and equipment	(560)	(421)
Proceeds from disposition of certain ancillary operations	12	-
Proceeds from sale of property and equipment	40	4
Purchases of available-for-sale securities	(198)	-
Proceeds from sales of available-for-sale securities	191	-
Increase in other investments	(387)	(234)
Net cash used in investing activities	(3,943)	(685)
Cash flows from financing activities:		
Proceeds from exercise of stock options	42	109
Repurchase of restricted stock shares for payroll tax withholding requirements	(11)	(15)
Stock buy-back	-	(27)
Deferred financing costs and other debt-related costs	(272)	(13)
Excess tax benefit relating to stock-based compensation	4	7
Proceeds from noncontrolling investors in joint ventures	10	-
Redemption of noncontrolling investments in joint ventures	(8)	(6)
Distributions to noncontrolling investors in joint ventures	(74)	(60)
Borrowings under credit agreements	8,348	814
Issuance of long-term debt	4,000	-
Proceeds from receivables facility	204	320
Repayments of long-term indebtedness	(9,091)	(1,129)
Net cash provided by financing activities	3,152	-
Net change in cash and cash equivalents	(152)	(244)
Cash and cash equivalents at beginning of period	373	388
Cash and cash equivalents at end of period	$ 221	$ 144
Supplemental disclosure of cash flow information:		
Interest payments	$ (661)	$ (446)
Income tax (paid), net of refunds received	$ 89	$ (72)

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, 2014 and December 31, 2013 and for the three-month and nine-month periods ended September 30, 2014 and September 30, 2013, 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 Health Management Associates, Inc. ("HMA") are included from January 27, 2014, the date of the HMA merger. The results of operations for the three and nine months ended September 30, 2014, are not necessarily indicative of the results to be expected for the full fiscal year ending December 31, 2014. Certain information and disclosures normally included in the notes to 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, 2013, contained in the Company's Annual Report on 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.

During the three months ended March 31, 2014, the Company made the decision to sell several smaller hospitals and entered into definitive agreements to sell two hospitals. During the three months ended June 30, 2014, the Company made the decision to sell an additional hospital. The condensed consolidated statement of income for the three and nine months ended September 30, 2013 has been restated to reclassify the results of operations for these hospitals that were owned or leased in 2013 to discontinued operations. The condensed consolidated balance sheet as of December 31, 2013 has been restated to present these hospitals that were owned or leased in 2013 as held for sale for comparative purposes with the September 30, 2014 presentation.

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, and management services provided, by distinct and indirect subsidiaries of Community Health Systems, Inc.

Allowance for Doubtful Accounts. Accounts receivable are reduced by an allowance for amounts that could become uncollectible in the future. Substantially all of the Company's receivables are related to providing healthcare services to its hospitals' patients.

The Company estimates the allowance for doubtful accounts 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. For all other non-self-pay payor categories, the Company reserves 100% of all accounts aging over 365 days from the date of discharge. The percentage used to reserve for all self-pay accounts is based on the Company's collection history. The Company collects substantially all of its third-party insured receivables, which include receivables from governmental agencies.

Collections are impacted by the economic ability of patients to pay and the effectiveness of the Company's collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect the Company's collection of accounts receivable and the estimates of the collectability of future accounts receivable. The process of estimating the allowance for doubtful accounts requires the Company to estimate the collectability of self-pay accounts receivable, which is primarily based on its collection history, adjusted for expected recoveries and any anticipated changes in collection trends. The Company also continually reviews its overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net revenue less provision for bad debts, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, and the impact of recent acquisitions and dispositions.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), recognized during the three and nine months ended September 30, 2014 and 2013 were as follows (in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Medicare	$ 1,267	$ 895	$ 3,981	$ 2,783
Medicaid	646	387	1,689	1,101
Managed Care and other third-party payors	2,910	1,914	8,159	5,752
Self-pay	740	514	2,155	1,525
Total	$ 5,563	$ 3,710	$15,984	$ 11,161

Electronic Health Records Incentive Reimbursement. The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act ("HITECH"). These provisions were designed to promote the use of electronic health records ("EHR") technology and established the requirements for a Medicare and Medicaid incentive payments program beginning in 2011 for eligible hospitals and professionals that adopt and meaningfully use certified EHR technology. The Company utilizes a gain contingency model to recognize EHR incentive payments. Recognition occurs when the eligible hospitals adopt or demonstrate meaningful use of certified EHR technology for the applicable payment period and have available the Medicare cost report information for the relevant full cost report year used to determine the final incentive payment.

Medicaid EHR incentive payments are calculated based on prior period Medicare cost report information available at the time when eligible hospitals adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. Since the information for the relevant full Medicare cost report year is available at the time of attestation, the incentive income from resolving the gain contingency is recognized when eligible hospitals adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Medicare EHR incentive payments are calculated based on the Medicare cost report information for the full cost report year that began during the federal fiscal year in which meaningful use is demonstrated. Since the necessary information is only available at the end of the relevant full Medicare cost report year and after the cost report is settled, the incentive income from resolving the gain contingency is recognized when eligible hospitals demonstrate meaningful use of certified EHR technology and the information for the applicable full Medicare cost report year to determine the final incentive payment is available.

In some instances, the Company may receive estimated Medicare EHR incentive payments prior to when the Medicare cost report information used to determine the final incentive payment is available. In these instances, recognition of the gain for EHR incentive payments is deferred until all recognition criteria described above are met.

Eligibility for annual Medicare incentive payments is dependent on providers successfully attesting to the meaningful use of EHR technology. Medicaid incentive payments are available to providers in the first payment year that they adopt, implement or upgrade certified EHR technology; however, providers must demonstrate meaningful use of such technology in any subsequent payment years to qualify for additional incentive payments. Medicaid EHR incentive payments are fully funded by the federal government and administered by the states; however, the states are not required to offer EHR incentive payments to providers.

The Company recognized approximately $88 million and $65 million for the three months ended September 30, 2014 and 2013 respectively, and $212 million and $108 million during the nine months ended September 30, 2014 and 2013, respectively, of incentive reimbursement for HITECH incentives from Medicare and Medicaid related to certain of the Company's hospitals and for certain of the Company's employed physicians that have demonstrated meaningful use of certified EHR technology or have completed attestations to their adoption or implementation of certified EHR technology. These incentive reimbursements are presented as a reduction of operating costs and expenses on the condensed consolidated statements of income. The Company received cash related to the incentive reimbursement for HITECH incentives of approximately $8 million and $23 million for the three months ended September 30, 2014 and 2013, respectively, and $95 million and $105 million for the nine months ended September, 30, 2014 and 2013, respectively. At September 30, 2014, there was no deferred revenue recorded. At September 30, 2013, $53 million was recorded as deferred revenue as all criteria for gain recognition had not been met.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Professional Liability Insurance for the Hospitals Acquired in the HMA Merger. Reserves for self-insured professional liability indemnity claims and related expenses, including attorneys' fees and other related costs of litigation that have been incurred and will be incurred in the future, are determined using actuarially-based techniques and methodologies. The data used to develop such reserves is based on asserted and unasserted claim information that has been accumulated by the Company's incident reporting system, historical loss payment patterns and industry trends. The Company uses a wholly-owned captive insurance subsidiary and a risk retention group subsidiary which were acquired during the HMA merger and are domiciled in the Cayman Islands and South Carolina, respectively, to self-insure a significant portion of its professional liability risks for the hospitals acquired in the HMA merger. Those insurance subsidiaries, which are collectively referred to as the "Insurance Subsidiaries," provide (i) claims-made coverage to all of the hospitals and other healthcare facilities acquired in the HMA merger and (ii) occurrence-basis coverage to most of the physicians employed by the hospitals and other healthcare facilities acquired in the HMA merger. The employed physicians not covered by the Insurance Subsidiaries generally maintain claims-made policies with unrelated third party insurance companies. To mitigate the exposure of the program covering the hospitals and other healthcare facilities acquired in the HMA merger, the Insurance Subsidiaries buy 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 June 1, 2014, the claims-made policy for the hospitals acquired in the HMA merger and the occurrence-based policy for most of the physicians employed by the hospitals and other healthcare facilities acquired in the HMA merger were canceled. Such hospitals and physicians are now covered through the Company's existing professional liability program that is described below.

Professional Liability Insurance for All Other Community Health Systems, Inc. Hospitals. The Company is primarily self-insured for professional liability claims; however, the Company obtains excess insurance that transfers the risk of loss to a third-party insurer for claims in excess of self-insured retentions. The Company's excess insurance is underwritten on a claims-made basis. For claims reported prior to June 1, 2002, substantially all of the Company's 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 are self-insured up to $10 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 the Company 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 and up to $195 million per occurrence and in the aggregate for claims incurred and reported after June 1, 2010. For certain policy years prior to June 1, 2014, if the first aggregate layer of excess coverage becomes fully utilized, then the Company's self-insured retention will increase to $10 million per claim for any subsequent claims in that policy year until the Company's total aggregate coverage is met.

Effective January 1, 2008, the hospitals acquired from Triad Hospitals, Inc. ("Triad") 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 1999 were insured through a wholly-owned insurance subsidiary of HCA Holdings Inc. ("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. After 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.

New Accounting Pronouncements. In May 2014, the Financial Accounting Standards Board issued Accounting Standards Update ("ASU") 2014-09, which outlines a single comprehensive model for recognizing revenue and supersedes most existing revenue recognition guidance, including guidance specific to the healthcare industry. This ASU provides companies the option of applying a full or modified retrospective approach upon adoption. This ASU is effective for fiscal years beginning after December 15, 2016. Early adoption is not permitted. The Company will adopt this ASU on January 1, 2017 and is currently evaluating its plan for adoption and the impact on its revenue recognition policies, procedures and control framework and the resulting impact on its consolidated financial position, results of operations and cash flows.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

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. 2009 Stock Option and Award Plan, amended and restated as of March 19, 2014 (the "2009 Plan").

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, 2014, 5,131,690 shares of unissued common stock were reserved for future grants under the 2009 Plan, which includes the 4,000,000 additional shares reserved for future grants approved by the Company's stockholders on May 20, 2014 in conjunction with the March 19, 2014 amendment of 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,	
	2014	2013	2014	2013
Effect on income from continuing operations before income taxes	$ (13)	$ (10)	$ (36)	$ (29)
Effect on net income	$ (8)	$ (6)	$ (22)	$ (18)

At September 30, 2014, $59 million of unrecognized stock-based compensation expense was expected to be recognized over a weighted-average period of 26 months. Of that amount, less than $1 million related to outstanding unvested stock options was expected to be recognized over a weighted-average period of 5 months and $58 million 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 26 months. There were no modifications to awards during the three or nine months ended September 30, 2014 and 2013.

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, 2014, and changes during each of the three-month periods following December 31, 2013, 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, 2014
Outstanding at December 31, 2013	3,737,545	$ 34.88		
Granted	-	-		
Exercised	(174,462)	35.01		
Forfeited and cancelled	(7,672)	34.61		
Outstanding at March 31, 2014	3,555,411	34.87		
Granted	-	-		
Exercised	(226,961)	37.54		
Forfeited and cancelled	(5,337)	25.71		
Outstanding at June 30, 2014	3,323,113	34.71		
Granted	-	-		
Exercised	(777,918)	35.75		
Forfeited and cancelled	(1,002)	18.99		
Outstanding at September 30, 2014	2,544,193	$ 34.39	3.7 years	$ 52
Exercisable at September 30, 2014	2,449,954	$ 34.93	3.5 years	$ 49

No stock options were granted during the three or nine months ended September 30, 2014 and 2013. The aggregate intrinsic value (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 ($54.79) 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, 2014. This amount changes based on the market value of the Company's common stock. The aggregate intrinsic value of options exercised during the three months ended September 30, 2014 and 2013 was $12 million and $1 million, respectively. The aggregate intrinsic value of options exercised during the nine months ended September 30, 2014 and 2013 was $15 million and $30 million, respectively. 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 its directors and 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 performance objective is not attained, the awards will be forfeited in their entirety. Once the performance objective has been attained, restrictions will lapse in one-third increments on each of the first three anniversaries of the award date. In addition, a restricted stock award grant dated March 1, 2014 has a performance objective that is measured based on the realization of synergies related to the HMA merger over a two-year period. The performance objective may be met in part in the first year or in whole or in part over the two-year period. Depending on the degree of attainment of the performance objective, restrictions may lapse on a portion of the award grant over the first three anniversaries of the award date at a level dependent upon the amount of synergies realized. If the synergies related to the HMA merger do not reach a certain level, then the awards will be forfeited in their entirety. 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 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, 2014, and changes during each of the three-month periods following December 31, 2013, were as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested at December 31, 2013	1,607,489	$ 35.13
Granted	1,943,000	41.19
Vested	(818,877)	34.65
Forfeited	(2,007)	34.82
Unvested at March 31, 2014	2,729,605	39.59
Granted	36,000	38.26
Vested	(4,709)	25.50
Forfeited	-	-
Unvested at June 30, 2014	2,760,896	39.59
Granted	-	-
Vested	(13,853)	39.65
Forfeited	(2,691)	19.60
Unvested at September 30, 2014	2,744,352	39.61

Restricted stock units ("RSUs") have been granted to the Company's outside directors under the 2000 Plan and the 2009 Plan. On February 16, 2012, each of the Company's outside directors received a grant under the 2009 Plan of 6,645 RSUs. On February 27, 2013, each of the Company's outside directors received a grant under the 2009 Plan of 3,596 RSUs. On March 1, 2014, each of the Company's outside directors received a grant under the 2009 Plan of 3,614 RSUs. Vesting of these shares of RSUs occurs in one-third increments on each of the first three anniversaries of the award date.

RSUs outstanding under the 2000 Plan and the 2009 Plan as of September 30, 2014, and changes during each of the three-month periods following December 31, 2013, were as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested at December 31, 2013	55,536	$ 31.33
Granted	21,684	41.51
Vested	(27,858)	30.87
Forfeited	-	-
Unvested at March 31, 2014	49,362	36.07
Granted	-	-
Vested	-	-
Forfeited	-	-
Unvested at June 30, 2014	49,362	36.07
Granted	-	-
Vested	-	-
Forfeited	-	-
Unvested at September 30, 2014	49,362	36.07

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 and Naples, Florida office, which were $89 million and $45 million for the three months ended September 30, 2014 and 2013, respectively, and $248 million and $138 million for the nine months ended September 30, 2014 and 2013, respectively. Included in these amounts is stock-based compensation expense of $13 million and $10 million for the three months ended September 30, 2014 and 2013, respectively, and $36 million and $29 million for the nine months ended September 30, 2014 and 2013, 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 as of the date of acquisition. Any material impact to comparative information for periods after acquisition, but before the period in which adjustments are identified, is reflected in those prior periods as if the adjustments were considered as of the acquisition date. 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.

Approximately $13 million and $5 million of acquisition and related integration costs related to prospective and closed acquisitions were expensed during the three months ended September 30, 2014 and 2013, respectively, and $99 million and $10 million during the nine months ended September 30, 2014 and 2013, respectively, and are included in other operating expenses on the condensed consolidated statements of income.

Effective April 1, 2014, one or more subsidiaries of the Company completed the acquisition of Sharon Regional Health System in Sharon, Pennsylvania. This healthcare system includes Sharon Regional (258 licensed beds) and other outpatient and ancillary services. The total cash consideration paid for long-lived assets and working capital was approximately $67 million and $1 million, respectively, with additional consideration of $8 million assumed in liabilities, for a total consideration of $76 million. Based upon the Company's preliminary purchase price allocation relating to this acquisition as of September 30, 2014, approximately $8 million of goodwill has been recorded. The preliminary allocation of the purchase price has been determined by the Company based on available information and is subject to settling amounts related to purchased working capital and final appraisals of tangible and intangible assets. Adjustments to the purchase price allocation are not expected to be material.

Effective April 1, 2014, one or more subsidiaries of the Company completed the acquisition of a 95% interest in Munroe Regional Medical Center (421 licensed beds) in Ocala, Florida and its other outpatient and ancillary services through a joint venture arrangement with an affiliate of a regional not-for-profit healthcare system, which acquired the remaining 5% interest. The total cash consideration paid for long-lived assets plus prepaid rent on the leased property and working capital was approximately $192 million and $4 million, respectively, with additional consideration of $11 million assumed in liabilities, for a total consideration of $207 million. The value of the noncontrolling interest at acquisition was $10 million. Based upon the Company's preliminary purchase price allocation relating to this acquisition as of September 30, 2014, approximately $17 million of goodwill has been recorded. The preliminary allocation of the purchase price has been determined by the Company based on available information and is subject to final appraisals of tangible and intangible assets. Adjustments to the purchase price allocation are not expected to be material.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

HMA Merger

On January 27, 2014, the Company completed the HMA merger by acquiring all the outstanding shares of HMA's common stock for approximately $7.3 billion, including the assumption of approximately $3.8 billion of existing indebtedness, for consideration for each share of HMA's common stock consisting of $10.50 in cash, 0.06942 of a share of the Company's common stock, and one contingent value right ("CVR"). The CVR entitles the holder to receive a cash payment of up to $1.00 per CVR (subject to downward adjustment but not below zero), subject to the final resolution of certain legal matters pertaining to HMA, as defined in the CVR agreement. HMA owned and operated 71 hospitals in 15 states in non-urban communities located primarily in the southeastern United States. On a combined basis, after taking into account the acquisition, the Company owns and operates 206 hospitals in 29 states.

In connection with the HMA merger, the Company and CHS/Community Health Systems, Inc. ("CHS") entered into a third amendment and restatement of its credit facility, providing for additional financing and recapitalization of certain of the Company's term loans. In addition, the Company and CHS also issued: (i) $1.0 billion aggregate principal amount of 5.125% Senior Secured Notes due 2021 and (ii) $3.0 billion aggregate principal amount of 6.875% Senior Notes due 2022.

The total consideration of the HMA merger has been allocated to the assets acquired and liabilities assumed based upon their respective preliminary fair values. The purchase price represented a premium over the fair value of the net tangible and identifiable intangible assets acquired for reasons such as:

- the expansion of the number of markets in which the Company operates in existing states;
- the extension and strengthening of the Company's hospital and physician networks;
- the centralization of many support functions; and
- the elimination of duplicate corporate functions.

The table below summarizes the calculation of consideration paid and preliminary allocations of the purchase price (including assumed liabilities and long-term debt assumed and repaid at closing) for the HMA merger (in millions):

Cash paid	$ 2,778
Shares issued	736
Contingent value right	17
Total consideration	$ 3,531
Current assets	$ 1,514
Property and equipment	3,241
Goodwill	4,484
Intangible assets	100
Other long-term assets	196
Liabilities	(5,649)
Noncontrolling interests	(355)
Total identifiable net assets	$ 3,531

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The allocation process requires the analysis of acquired fixed assets, contracts, contractual commitments, and legal contingencies to identify and record the fair value of all assets acquired and liabilities assumed. The values of certain assets and liabilities are based on preliminary valuations and estimates and are subject to adjustment as additional information is obtained. Such additional information includes, but is not limited to: valuations and physical counts of property and equipment, valuations of acquired intangible assets, analysis of physician income guarantee contracts, analysis of cost report settlements, valuation of contractual commitments and valuation of deferred tax accounts. Material adjustments to goodwill may result upon the completion of these matters. All goodwill related to HMA is recorded in the hospital operations reporting unit.

Net operating revenues and income from continuing operations before income taxes and allocation of both interest and corporate overhead from hospitals acquired from HMA from the date of acquisition through September 30, 2014 was approximately $3.9 billion and $388 million, respectively. The following unaudited pro forma results of operations of the Company for the nine months ended September 30, 2014 and 2013 assume that the HMA merger occurred at the beginning of the periods presented. The pro forma amounts include certain adjustments, including interest expense, depreciation and taxes. The pro forma amounts for the nine months ended September 30, 2014 were adjusted to exclude approximately $68 million of certain nonrecurring acquisition and related integration costs incurred by the Company. Pro forma amounts for the nine months ended September 30, 2013 were adjusted to include these costs. The pro forma net loss for the nine months ended September 30, 2014 includes a charge for the early extinguishment of debt of $73 million before taxes and $45 million after taxes, or $0.40 per share (diluted). The pro forma net loss for the nine months ended September 30, 2013 includes approximately $112 million before taxes and approximately $70 million after taxes, or $0.63 per share (diluted), in change in control and other related expenses recorded by HMA for amounts triggered by the change in control of the HMA board of directors during the three months ended September 30, 2013. The pro forma results do not include adjustments related to cost savings or other synergies that are anticipated as a result of the HMA merger.

These unaudited pro forma results are not necessarily indicative of the actual results of operations (in millions, except per share data).

	Nine Months Ended September 30,	
	2014	2013
Pro forma net operating revenues	$ 14,135	$ 13,978
Pro forma net loss attributable to Community Health Systems, Inc. stockholders	(4)	(12)
Pro forma net loss per share attributable to Community Health Systems, Inc. common stockholders:		
Basic	$ (0.04)	$ (0.11)
Diluted	$ (0.04)	$ (0.11)

Other Acquisitions

During the nine months ended September 30, 2014, the Company paid approximately $6 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 its hospitals. In connection with these acquisitions, during 2014, the Company allocated approximately $3 million of the consideration paid to property and equipment and net working capital and the remainder, approximately $3 million consisting of intangible assets that do not qualify for separate recognition, to goodwill.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Discontinued Operations

During the nine months ended September 30, 2014, the Company made the decision to sell several smaller hospitals, which are classified as held for sale at September 30, 2014. Two other hospitals are required to be divested by the Federal Trade Commission as a condition of its approval of the HMA merger: Riverview Regional Medical Center (281 licensed beds) located in Gadsden, Alabama, and Carolina Pines Regional Medical Center (116 licensed beds) located in Hartsville, South Carolina (the Company entered into a definitive agreement to sell its ownership interest in Carolina Pines Regional Medical Center in October 2014). In addition, HMA entered into a definitive agreement to sell Williamson Memorial Hospital (76 licensed beds) located in Williamson, West Virginia prior to the HMA merger. The Company entered into a definitive agreement to sell one of its other hospitals and began actively marketing the sale of several other hospitals during the nine months ended September 30, 2014. In connection with management's decision to sell these facilities, the Company has classified the results of operations of the above mentioned hospitals as discontinued operations in the accompanying condensed consolidated statements of income, and classified the above mentioned hospitals as held for sale in the accompanying consolidated balance sheet.

Net operating revenues and income (loss) from discontinued operations for the respective periods are as follows (in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net operating revenues	$ 100	$ 44	$ 280	$ 139
Income (loss) from operations of entities held for sale before income taxes	-	(10)	(4)	(24)
Impairment of hospitals held for sale before income taxes	-	-	(29)	-
Income (loss) from discontinued operations, before taxes	-	(10)	(33)	(24)
Income tax benefit	(1)	(4)	(7)	(9)
Income (loss) from discontinued operations, net of taxes	$ 1	$ (6)	$ (26)	$ (15)

Interest expense was allocated to discontinued operations based on sale proceeds available for debt repayment.

In April 2014, the Financial Accounting Standards Board issued ASU 2014-08, which changes the requirements for reporting discontinued operations. A discontinued operation continues to include a component of an entity or a group of components of an entity, or a business activity. However, in a shift reflecting stakeholder concerns that too many disposals of small groups of assets that are recurring in nature qualified for reporting as discontinued operations, a disposal of a component of an entity or a group of components of an entity will be required to be reported in discontinued operations if the disposal represents a strategic shift that has (or will have) a major effect on an entity's operations and financial results. A business or nonprofit activity that, on acquisition, meets the criteria to be classified as held for sale will still be a discontinued operation. Additional disclosures will be required for significant components of the entity that are disposed of or are held for sale but do not qualify as discontinued operations. This ASU is effective for fiscal years beginning after December 15, 2014 and is to be applied on a prospective basis for disposals or components initially classified as held for sale after that date. The Company will adopt this ASU on January 1, 2015 and is currently evaluating the impact on its consolidated financial position, results of operations and cash flows.

6. INCOME TAXES

The total amount of unrecognized benefit that would affect the effective tax rate, if recognized, was approximately $13 million as of September 30, 2014. A total of approximately $8 million of interest and penalties is included in the amount of the liability for uncertain tax positions at September 30, 2014. It is the Company's policy to recognize interest and penalties related to unrecognized benefits in its condensed consolidated statements of income 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 limitations and settlements with taxing authorities; however, the Company does not anticipate the change will have a material impact on the Company's consolidated results of operations or consolidated financial position.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The Company, or one of its subsidiaries, files income tax returns in the United States federal jurisdiction and various state jurisdictions. The Company has extended the federal statute of limitations through December 31, 2014 for Triad for the tax periods ended December 31, 1999, December 31, 2000, April 30, 2001, June 30, 2001, December 31, 2001, December 31, 2002, December 31, 2003, December 31, 2004, December 31, 2005, December 31, 2006 and July 25, 2007. With few exceptions, the Company is no longer subject to state income tax examinations for years prior to 2010. The Company's federal income tax returns for the 2009 and 2010 tax years are currently under examination by the Internal Revenue Service ("IRS"). The Company believes the results of these examinations will not be material to its consolidated results of operations or consolidated financial position. During the year ended December 31, 2013, the IRS concluded its examination of the federal tax return of Community Health Systems, Inc. for the tax periods ended December 31, 2007 and 2008. The results of these examinations did not have a material effect on the Company's consolidated results of operations or consolidated financial position. The Company has extended the federal statute of limitations through December 31, 2014 for Community Health Systems, Inc. for the tax periods ended December 31, 2007 and 2008, and through June 30, 2015 for the tax periods ended December 31, 2009 and 2010.

The Company has recorded a preliminary purchase price allocation in connection with the HMA merger resulting in goodwill of approximately $4.5 billion, which is not tax deductible for income tax purposes. Goodwill consists of the excess of the purchase price over the fair market value of the acquired assets. The purchase price allocation is preliminary and subject to change as additional information is obtained during the measurement period.

The Company's effective tax rates were 29.8% and 20.0% for the three months ended September 30, 2014 and 2013, respectively, and 14.7% and 30.0% for the nine months ended September 30, 2014 and 2013, respectively. The increase in the Company's effective tax rate for the three months ended September 30, 2014 is primarily impacted by the increase in income from continuing operations before income taxes after adjusting for net income attributable to noncontrolling interests, which increased by a lower percentage and is not tax effected in the statement of income. The decrease in the Company's effective tax rate for the nine months ended September 30, 2014 is primarily impacted by the decrease in income from continuing operations before income taxes after adjusting for the increase in net income attributable to noncontrolling interests, which is not tax effected in the statement of income. Adjusting for this impact, the Company's effective tax rate increased from 37.6% for the nine months ended September 30, 2013, to 47.1% for the nine months ended September 30, 2014, primarily due to the impact of non-deductible costs associated with the HMA merger and an increase in the effective tax rate for certain states.

Cash paid for income taxes, net of refunds received, resulted in a net cash refund of $16 million and net cash paid of $2 million during the three months ended September 30, 2014 and 2013, respectively, and a net cash refund of $89 million and net cash paid of $72 million during the nine months ended September 30, 2014 and 2013, respectively.

7. GOODWILL AND OTHER INTANGIBLE ASSETS

Goodwill

The changes in the carrying amount of goodwill for the nine months ended September 30, 2014 are as follows (in millions):

Balance as of December 31, 2013	$	4,424
Goodwill acquired as part of acquisitions during current year		4,512
Balance as of September 30, 2014	$	8,936

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 and hospital management services operations meet the criteria to be classified as reporting units. At September 30, 2014, the hospital operations reporting unit, the home care agency operations reporting unit, and the hospital management services reporting unit had approximately $8.9 billion, $44 million and $33 million, respectively, of goodwill.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Goodwill is evaluated for impairment at the same time every year 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. There is a two-step method for determining goodwill impairment. Step one is to compare the fair value of the reporting unit with the unit's carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit's goodwill with the carrying value of the reporting unit's goodwill. The Company performed its last annual goodwill evaluation during the fourth quarter of 2013. No impairment was indicated by this evaluation. The next annual goodwill evaluation will be performed during the fourth quarter of 2014.

The Company estimates the fair value of the related reporting units using both a discounted cash flow model as well as an EBITDA 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.

Intangible Assets

Approximately $100 million of intangible assets other than goodwill were acquired during the nine months ended September 30, 2014. These acquired intangibles represent the Company's initial estimate of the fair value of the contract-based intangible assets related to the certificates of need and Medicare licenses obtained in the HMA merger. As previously discussed, this estimated amount is subject to change pending the completion of the valuation and appraisal analysis currently in process. The gross carrying amount of the Company's other intangible assets subject to amortization was $69 million at September 30, 2014 and $51 million at December 31, 2013, and the net carrying amount was $37 million at September 30, 2014 and $21 million at December 31, 2013. The carrying amount of the Company's other intangible assets not subject to amortization was $125 million and $50 million at September 30, 2014 and December 31, 2013, 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, 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 five years. There are no expected residual values related to these intangible assets. Amortization expense on these intangible assets was $5 million and $1 million during the three months ended September 30, 2014 and 2013, respectively, and $8 million and $4 million during the nine months ended September 30, 2014 and 2013, respectively. Amortization expense on intangible assets is estimated to be $3 million for the remainder of 2014, $12 million in 2015, $12 million in 2016, $2 million in 2017, $2 million in 2018, $2 million in 2019 and $4 million thereafter.

The gross carrying amount of capitalized software for internal use was approximately $1.4 billion and $988 million at September 30, 2014 and December 31, 2013, respectively, and the net carrying amount considering accumulated amortization was approximately $787 million and $560 million at September 30, 2014 and December 31, 2013, 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, 2014, there was approximately $67 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 $48 million and $35 million during the three months ended September 30, 2014 and 2013, respectively, and $209 million and $100 million during the nine months ended September 30, 2014 and 2013, respectively. Amortization expense on capitalized internal-use software is estimated to be $49 million for the remainder of 2014, $174 million in 2015, $152 million in 2016, $102 million in 2017, $73 million in 2018, $65 million in 2019 and $172 million thereafter.

In connection with the HMA merger, the Company further analyzed its intangible assets related to internal-use software used in certain of its hospitals for patient and clinical systems, including software required to meet criteria for meaningful use attestation and ICD-10 compliance. This analysis resulted in management reassessing its usage of certain software products and rationalizing that, with the addition of the HMA hospitals in the first quarter of 2014, those software applications were going to be discontinued and replaced with new applications that better integrate meaningful use and ICD-10 compliance, are more cost effective and can be implemented at a greater efficiency of scale over future implementations. During the nine months ended September 30, 2014, the Company recorded an impairment charge of approximately $24 million related to software in-process that has been abandoned and the acceleration of amortization of approximately $75 million.

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 earnings per share for income from continuing operations, discontinued operations and net income (loss) attributable to Community Health Systems, Inc. common stockholders (in millions, except share data):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Numerator:				
Income from continuing operations, net of taxes	$ 93	$ 28	$ 93	$ 180
Less: Income from continuing operations attributable to noncontrolling interests	32	18	75	52
Income from continuing operations attributable to Community Health Systems, Inc. common stockholders — basic and diluted	$ 61	$ 10	$ 18	$ 128
Income (loss) from discontinued operations, net of taxes	$ 1	$ (6)	$ (26)	$ (15)
Less: Loss from discontinued operations attributable to noncontrolling interests	-	-	-	-
Income (loss) from discontinued operations attributable to Community Health Systems, Inc. common stockholders — basic and diluted	$ 1	$ (6)	$ (26)	$ (15)
Denominator:				
Weighted-average number of shares outstanding — basic	113,138,663	93,259,027	110,871,066	92,384,270
Effect of dilutive securities:				
Restricted stock awards	506,345	521,460	292,414	381,893
Employee stock options	679,748	681,991	582,216	733,923
Other equity-based awards	19,022	21,118	11,694	16,072
Weighted-average number of shares outstanding — diluted	114,343,778	94,483,596	111,757,390	93,516,158

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Dilutive securities outstanding not included in the computation of earnings per share because their effect is antidilutive:				
Employee stock options and restricted stock awards	-	-	630,333	-

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

9. STOCKHOLDERS' EQUITY

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, 2014, 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.

Historically, the Company has not paid any cash dividends. In December 2012, the Company declared and paid a special dividend of $0.25 per share to holders of its common stock at the close of business as of December 17, 2012, which totaled approximately $23 million. The Company did not pay a cash dividend in 2013 or in the nine months ended September 30, 2014 and does not anticipate the payment of any other cash dividends in the foreseeable future. The Company's Credit Facility 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. The indentures governing the senior and senior secured notes also limit the Company's ability to pay dividends and/or repurchase stock. As of September 30, 2014, under the most restrictive test under these agreements, the Company has approximately $429 million remaining available with which to pay permitted dividends and/or repurchase shares of stock or its senior and senior secured notes.

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, 2014 (in millions):

		Community Health Systems, Inc. Stockholders						
	Redeemable Noncontrolling Interests	Common Stock	Additional Paid-In Capital	Treasury Stock	Accumulated Other Comprehensive (Loss) Income	Retained Earnings	Noncontrolling Interests	Total Equity
Balance, December 31, 2013	$ 358	$ 1	$ 1,256	$ (7)	$ (67)	$ 1,885	$ 64	$ 3,132
Comprehensive income	59	-	-	-	19	(8)	16	27
Distributions to noncontrolling interests, net of contributions	(52)	-	-	-	-	-	(23)	(23)
Purchase of subsidiary shares from noncontrolling interests	(7)	-	(1)	-	-	-	-	(1)
Other reclassifications of noncontrolling interests	-	-	-	-	-	-	-	-
Noncontrolling interests in acquired entity	335	-	-	-	-	-	31	31
Adjustment to redemption value of redeemable noncontrolling interests	2	-	(2)	-	-	-	-	(2)
Issuance of common stock in connection with the exercise of stock options	-	-	42	-	-	-	-	42
Issuance of shares in exchange for HMA common stock	-	-	736	-	-	-	-	736
Cancellation of restricted stock for tax withholdings on vested shares	-	-	(11)	-	-	-	-	(11)
Excess tax benefit from exercise of stock options	-	-	3	-	-	-	-	3
Share-based compensation	-	-	36	-	-	-	-	36
Balance, September 30, 2014	$ 695	$ 1	$ 2,059	$ (7)	$ (48)	$ 1,877	$ 88	$ 3,970

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

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' equity (in millions):

	Nine Months Ended September 30, 2014
Net loss attributable to Community Health Systems, Inc. stockholders	$ (8)
Transfers to the noncontrolling interests:	
Net decrease in Community Health Systems, Inc. paid-in capital for purchase of subsidiary partnership interests	(1)
Net transfers to the noncontrolling interests	(1)
Change to Community Health Systems, Inc. stockholders' equity from net loss attributable to Community Health Systems, Inc. stockholders and transfers to noncontrolling interests	$ (9)

10. EQUITY INVESTMENTS

As of September 30, 2014, the Company owned equity interests of 27.5% in four hospitals in Las Vegas, Nevada, and 26.1% in one hospital in Las Vegas, Nevada, in which Universal Health Systems, Inc. owns the majority interest, and an equity interest of 38.0% in three hospitals in Macon, Georgia, in which HCA owns the majority interest.

Summarized combined financial information for these unconsolidated entities in which the Company owns an equity interest is as follows (in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Revenues	$ 334	$ 306	$ 1,005	$ 942
Operating costs and expenses	303	284	893	836
Income from continuing operations before taxes	31	22	112	106

The summarized financial information was derived from the unaudited financial information provided to the Company by those unconsolidated entities.

In March 2005, the Company began purchasing items, primarily medical supplies, medical equipment and pharmaceuticals, under an agreement with HealthTrust Purchasing Group, L.P. ("HealthTrust"), a group purchasing organization in which the Company is a noncontrolling partner. As part of the HMA merger, the Company acquired HMA's ownership in HealthTrust. As of September 30, 2014, the Company had a 24.6% ownership interest in HealthTrust.

The Company's investment in all of its unconsolidated affiliates was $459 million and $422 million at September 30, 2014 and December 31, 2013, respectively, and is included in other assets, net in the accompanying condensed consolidated balance sheets. Included in the Company's results of operations is the Company's equity in pre-tax earnings from all of its investments in unconsolidated affiliates, which was $12 million and $12 million for the three months ended September 30, 2014 and 2013, respectively, and $35 million and $36 million for the nine months ended September 30, 2014 and 2013, respectively.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

11. LONG-TERM DEBT

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

	September 30, 2014	December 31, 2013
Credit Facility:		
Term loan A	$ 967	$ 637
Term loan B	-	60
Term loan C	-	3,353
Term loan D	4,567	-
Term loan E	1,664	-
Revolving credit loans	-	-
8% Senior Notes due 2019	2,018	2,020
7 1/8% Senior Notes due 2020	1,200	1,200
5 1/8% Senior Secured Notes due 2018	1,600	1,600
5 1/8% Senior Secured Notes due 2021	1,000	-
6 7/8% Senior Notes due 2022	3,000	-
Receivables Facility	660	500
Capital lease obligations	255	46
Other	81	37
Total debt	17,012	9,453
Less current maturities	(219)	(167)
Total long-term debt	$ 16,793	$ 9,286

Credit Facility

The Company's wholly-owned subsidiary 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. Prior to the HMA merger, this credit facility included a $750 million term loan A facility due October 25, 2016, a term loan B due July 25, 2014, a term loan C due January 25, 2017 and a $750 million revolving credit facility for working capital and general corporate purposes.

In connection with the HMA merger, the Company and CHS entered into a third amendment and restatement of its credit facility (the "Credit Facility"), providing for additional financing and recapitalization of certain of the Company's term loans, including (i) the replacement of the revolving credit facility with a new $1.0 billion revolving facility maturing in 2019 (the "Revolving Facility"), (ii) the addition of a new $1.0 billion Term A facility due 2019 (the "Term A Facility"), (iii) a Term D facility in an aggregate principal amount equal to approximately $4.6 billion due 2021 (which includes certain term C loans that were converted into such Term D facility (collectively, the "Term D Facility")), (iv) the conversion of certain term C loans into Term E Loans and the borrowing of new Term E Loans in an aggregate principal amount of approximately $1.7 billion due 2017 and (v) the addition of flexibility commensurate with the Company's post-acquisition structure. In addition to funding a portion of the consideration in connection with the HMA merger, some of the proceeds of the Term A Facility and Term D Facility were used to refinance the outstanding $637 million existing Term A facility due 2016 and the $60 million of term B loans due 2014, respectively. The Revolving Facility includes a subfacility for letters of credit.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

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 Federal Funds Effective 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. Loans in respect of the Revolving Facility and the Term A Facility will accrue interest at a rate per annum initially 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. In addition, the margin in respect of the Revolving Facility and the Term A Facility will be subject to adjustment determined by reference to a leverage-based pricing grid. Loans in respect of the Term D Facility and the Term E Facility will accrue interest at a rate per annum 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 Borrowings. The Term D Facility will be subject to a 1.00% LIBOR floor and a 2.00% Alternate Base Rate floor.

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, (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) 50%, subject to reduction to a lower percentage based on the Company's leverage ratio (as defined in the Credit Facility generally as the ratio of total debt on the date of determination to the Company's 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 obligor 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.

CHS has agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to Eurodollar rate loans 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 maximum secured net leverage ratio and an interest coverage ratio) and various affirmative covenants.

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 a grace period, (4) bankruptcy 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, (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.

As of September 30, 2014, the availability for additional borrowings under the Credit Facility was approximately $1.0 billion pursuant to the Revolving Facility, of which $83 million was set aside for outstanding letters of credit. CHS has the ability to amend the Credit Facility to provide for one or more tranches of term loans in an aggregate principal amount of $1.5 billion, which CHS has not yet accessed. As of September 30, 2014, the weighted-average interest rate under the Credit Facility, excluding swaps, was 4.4%.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

As of September 30, 2014, the Company had letters of credit issued, primarily in support of potential insurance-related claims and certain bonds, of approximately $83 million.

8% Senior Notes due 2019

On November 22, 2011, CHS completed its offering of $1.0 billion aggregate principal amount of 8% Senior Notes due 2019 (the "8% Senior Notes"), which were issued in a private placement. 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 and related fees and expenses. On March 21, 2012, CHS completed the secondary 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, 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, commencing May 15, 2012. 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.

Except as set forth below, CHS is not entitled to redeem the 8% Senior Notes prior to November 15, 2015.

Prior to November 15, 2014, CHS is entitled, at its option, to redeem a portion of the 8% Senior Notes (not to exceed 35% of the outstanding principal amount) at a redemption price equal to 108% of the principal amount of the notes redeemed plus accrued and unpaid interest, with the proceeds from certain public equity offerings. Prior to November 15, 2015, CHS may redeem some or all of the 8% Senior 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 8% Senior Notes indenture. On and after November 15, 2015, 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 periods set forth below:

Period	Redemption Price
November 15, 2015 to November 14, 2016	104.000 %
November 15, 2016 to November 14, 2017	102.000 %
November 15, 2017 to November 15, 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.

7 1/8% Senior Notes due 2020

On July 18, 2012, CHS completed an underwritten public offering under its automatic shelf registration filed with the SEC of $1.2 billion aggregate principal amount 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 plus accrued interest of CHS' outstanding 8 7/8% Senior Notes, to pay for consents delivered in connection therewith, 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, commencing January 15, 2013. 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.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Except as set forth below, CHS is not entitled to redeem the 7 1/8% Senior Notes prior to July 15, 2016.

Prior to July 15, 2015, CHS is entitled, at its option, to redeem a portion of the 7 1/8% Senior Notes (not to exceed 35% of the outstanding principal amount) at a redemption price equal to 107.125% of the principal amount of the notes redeemed plus accrued and unpaid interest, with the proceeds from certain public equity offerings. Prior to July 15, 2016, CHS may redeem some or all of the 7 1/8% Senior 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 7 1/8% Senior Notes indenture. On and after July 15, 2016, 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 periods set forth below:

Period	Redemption Price
July 15, 2016 to July 14, 2017	103.563%
July 15, 2017 to July 14, 2018	101.781%
July 15, 2018 to July 15, 2020	100.000%

5 1/8% Senior Secured Notes due 2018

On August 17, 2012, CHS completed an underwritten public offering under its automatic shelf registration filed with the SEC of $1.6 billion aggregate principal amount of 5 1/8% Senior Secured Notes due 2018 (the "2018 Senior Secured Notes"). The net proceeds from this issuance, together with available cash on hand, were used to finance the prepayment of $1.6 billion of the outstanding term loans due 2014 under the Credit Facility and related fees and expenses. The 2018 Senior Secured Notes bear interest at 5.125% per annum, payable semiannually in arrears on August 15 and February 15, commencing February 15, 2013. Interest on the 2018 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 2018 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 indenture governing the 2018 Senior Secured Notes on substantially the same assets, subject to certain exceptions, that secure CHS' obligations under the Credit Facility.

Except as set forth below, CHS is not entitled to redeem the 2018 Senior Secured Notes prior to August 15, 2015.

Prior to August 15, 2015, CHS is entitled, at its option, to redeem a portion of the 2018 Senior Secured Notes (not to exceed 35% of the outstanding principal amount) at a redemption price equal to 105.125% of the principal amount of the notes redeemed plus accrued and unpaid interest, with the proceeds from certain public equity offerings. Prior to August 15, 2015, CHS may redeem some or all of the 2018 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 2018 Senior Secured Notes indenture. On and after August 15, 2015, CHS is entitled, at its option, to redeem all or a portion of the 2018 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
August 15, 2015 to August 14, 2016	102.563%
August 15, 2016 to August 14, 2017	101.281%
August 15, 2017 to August 15, 2018	100.000%

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

5 1/8% Senior Secured Notes due 2021

On January 27, 2014, CHS issued $1.0 billion aggregate principal amount of 5 1/8% Senior Secured Notes due 2021 (the "2021 Senior Secured Notes"), which were issued in a private placement. 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, commencing August 1, 2014. 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 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 indenture governing the 2021 Senior Secured Notes, on substantially the same assets, subject to certain exceptions, that secure CHS' obligations under the Credit Facility.

Except as set forth below, CHS is not entitled to redeem the 2021 Senior Secured Notes prior to February 1, 2017.

Prior to February 1, 2017, CHS is entitled, at its option, to redeem a portion of the 2021 Senior Secured Notes (not to exceed 40% of the outstanding principal amount) at a redemption price equal to 105.125% of the principal amount of the notes redeemed plus accrued and unpaid interest, with the proceeds from certain equity offerings. Prior to February 1, 2017, CHS may redeem some or all of the 2021 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 2021 Senior Secured Notes indenture. On and after February 1, 2017, 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, 2017 to January 31, 2018	103.844%
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%

6 7/8% Senior Notes due 2022

On January 27, 2014, CHS issued $3.0 billion aggregate principal amount of 6 7/8% Senior Notes due 2022 (the "6 7/8% Senior Notes"), which were issued in a private placement. 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, commencing August 1, 2014. 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.

Except as set forth below, CHS is not entitled to redeem the 6 7/8% Senior Notes prior to February 1, 2018.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Prior to February 1, 2017, CHS is entitled, at its option, to redeem a portion of the 6 7/8% Senior Notes (not to exceed 40% of the outstanding principal amount) at a redemption price equal to 106.875% of the principal amount of the notes redeemed plus accrued and unpaid interest, with the proceeds from certain public equity offerings. Prior to February 1, 2018, CHS may redeem some or all of the 6 7/8% Senior 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 6 7/8% Senior Notes indenture. On and after February 1, 2018, 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%

Receivables Facility

On March 21, 2012, CHS and certain of its subsidiaries entered into 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, and The Bank of Nova Scotia, as a managing agent. On March 7, 2013, CHS and certain of its subsidiaries amended the Receivables Facility to add an additional managing agent, The Bank of Tokyo-Mitsubishi UFJ, Ltd., to increase the size of the facility from $300 million to $500 million and to extend the scheduled termination date. Additional subsidiaries of the Company also agreed to participate in the Receivables Facility as of that date. On March 31, 2014, CHS and certain of its subsidiaries amended the Receivables Facility to increase the size of the facility from $500 million to $700 million and to extend the scheduled termination date. Additional subsidiaries of the Company also agreed to participate in the Receivables Facility as of that date. The existing and future non-self pay patient-related accounts receivable (the "Receivables") for certain of the Company's hospitals serves as collateral for the outstanding borrowings under the Receivables Facility. The interest rate on the borrowings is based on the commercial paper rate plus an applicable interest rate spread. Unless earlier terminated or subsequently extended pursuant to its terms, the Receivables Facility will expire on March 21, 2016, subject to customary termination events that could cause an early termination date. The Company maintains effective control over the Receivables because, pursuant to the terms of the Receivables Facility, the Receivables are sold from certain of the Company's subsidiaries to CHS, which then sells or contributes the Receivables to a special-purpose entity that is wholly-owned by CHS. The wholly-owned special-purpose entity in turn grants security interests in the Receivables in exchange for borrowings obtained from the group of third-party lenders and banks of up to $700 million outstanding from time to time based on the availability of eligible Receivables and other customary factors. The group of third-party lenders and banks do not have recourse to the Company or its subsidiaries beyond the assets of the wholly-owned special-purpose entity that collateralizes the loan. The Receivables and other assets of the wholly-owned special-purpose entity will be available first and foremost to satisfy the claims of the creditors of such entity. The outstanding borrowings pursuant to the Receivables Facility at September 30, 2014 totaled $660 million and are classified as long-term debt on the condensed consolidated balance sheet. At September 30, 2014, the carrying amount of Receivables included in the Receivables Facility totaled approximately $1.3 billion and is included in patient accounts receivable on the condensed consolidated balance sheet.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Loss from Early Extinguishment of Debt

The financing transactions discussed above resulted in a loss from early extinguishment of debt of $73 million and $1 million for the nine months ended September 30, 2014 and 2013, respectively, and an after-tax loss of $45 million and less than $1 million for the nine months ended September 30, 2014 and 2013, respectively.

Other Debt

As of September 30, 2014, other debt consisted primarily of the mortgage obligation on the Company's corporate headquarters and 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 8 separate interest swap agreements in effect at September 30, 2014, with an aggregate notional amount for currently effective swaps of $1.5 billion, and four forward-starting swap agreements with an aggregate notional amount of $1.0 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. The Company currently pays, on a quarterly basis, interest on the Revolving Facility and the Term A Facility at a rate per annum equal to LIBOR plus 275 basis points. Loans in respect of the Term D Facility and the Term E Facility accrue interest at a rate per annum equal to LIBOR plus 325 basis points. The Term D Facility is also subject to a 100 basis point LIBOR floor and a 200 basis point Alternate Base Rate floor. See Note 12 for additional information regarding these swaps.

The Company paid interest of $308 million and $150 million on borrowings during the three months ended September 30, 2014 and 2013, respectively, and $661 million and $446 million on borrowings during the nine months ended September 30, 2014 and 2013, respectively.

12. 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, 2014 and December 31, 2013, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Company could realize in a current market exchange (in millions):

	September 30, 2014		December 31, 2013	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Assets:				
Cash and cash equivalents	$ 221	$ 221	$ 373	$ 373
Available-for-sale securities	256	256	65	65
Trading securities	52	52	38	38
Liabilities:				
Contingent Value Right (CVR)	9	9	-	-
Credit Facility	7,198	7,168	4,050	4,085
8% Senior Notes	2,018	2,132	2,020	2,172
7 1/8% Senior Notes	1,200	1,276	1,200	1,246
2018 Senior Secured Notes	1,600	1,647	1,600	1,662
2021 Senior Secured Notes	1,000	994	-	-
6 7/8% Senior Notes	3,000	3,143	-	-
Receivables Facility and other debt	741	741	537	537

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

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 13. 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, which are validated 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).

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 information from the Company's bankers regarding relevant pricing for trading activity among the Company's lending institutions.

8% Senior Notes. Estimated fair value is based on the average bid and ask price as quoted by the bank who served as an underwriter in the sale of these notes.

7 1/8% Senior Notes. Estimated fair value is based on the average bid and ask price as quoted by the bank who served as an underwriter in the sale of these notes.

2018 Senior Secured Notes. Estimated fair value is based on the average bid and ask price as quoted by the bank who served as an underwriter in the sale of these notes.

2021 Senior Secured Notes. Estimated fair value is based on the average bid and ask price as quoted by the bank who served as an underwriter in the sale of these notes.

6 7/8% Senior Notes. Estimated fair value is based on the average bid and ask price as quoted by the bank who served as an underwriter in the sale of these notes.

Receivables Facility and other debt. The carrying amount of the Receivables Facility and all other debt 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, 2014 and 2013, 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 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. However, at September 30, 2014, all of the swap agreements entered into by the Company were in a net liability position such that the Company would be required to make the net settlement payments to the counterparties; the Company does not anticipate nonperformance by those 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, 2014:

Swap #	Notional Amount (in millions)	Fixed Interest Rate	Termination Date	Fair Value of Liability (in millions)
1	$ 200	2.693%	October 26, 2014	$ -
2	300	3.447%	August 8, 2016	15
3	200	3.429%	August 19, 2016	10
4	100	3.401%	August 19, 2016	5
5	200	3.500%	August 30, 2016	10
6	100	3.005%	November 30, 2016	5
7	200	2.055%	July 25, 2019	2
8	200	2.059%	July 25, 2019	2
9	200	2.613%	August 30, 2019	1 (1)
10	200	2.515%	August 30, 2019	1 (2)
11	300	2.892%	August 30, 2020	4 (3)
12	300	2.738%	August 30, 2020	2 (4)

(1) This interest rate swap becomes effective August 30, 2015.
(2) This interest rate swap becomes effective August 28, 2015.
(3) This interest rate swap becomes effective August 30, 2015.
(4) This interest rate swap becomes effective August 28, 2015.

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 September 30, 2014 interest rates, approximately $38 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.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

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, 2014 and 2013 (in millions):

Derivatives in Cash Flow Hedging Relationships	Amount of Pre-Tax Gain (Loss) Recognized in OCI (Effective Portion)			
	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Interest rate swaps	$ 2	$ (8)	$ (20)	$ (4)

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 income during the three and nine months ended September 30, 2014 and 2013 (in millions):

Location of Loss Reclassified from AOCL into Income (Effective Portion)	Amount of Pre-Tax Loss Reclassified from AOCL into Income (Effective Portion)			
	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Interest expense, net	$ 15	$ 25	$ 51	$ 79

The fair values of derivative instruments in the condensed consolidated balance sheets as of September 30, 2014 and December 31, 2013 were as follows (in millions):

	Asset Derivatives				Liability Derivatives			
	September 30, 2014		December 31, 2013		September 30, 2014		December 31, 2013	
	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	$ -	Other assets, net	$ -	Other long-term liabilities	$ 57	Other long-term liabilities	$ 88

13. 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).

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

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.

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, 2014 and December 31, 2013 (in millions):

	September 30, 2014	Level 1	Level 2	Level 3
Available-for-sale securities	$ 256	$ 127	$ 129	$ -
Trading securities	52	52	-	-
Total assets	$ 308	$ 179	$ 129	$ -
Contingent Value Right (CVR)	$ 9	$ 9	$ -	$ -
CVR-related legal liability	291	-	-	291
Fair value of interest rate swap agreements	57	-	57	-
Total liabilities	$ 357	$ 9	$ 57	$ 291

	December 31, 2013	Level 1	Level 2	Level 3
Available-for-sale securities	$ 65	$ 65	$ -	$ -
Trading securities	38	38	-	-
Total assets	$ 103	$ 103	$ -	$ -
Fair value of interest rate swap agreements	$ 88	$ -	$ 88	$ -
Total liabilities	$ 88	$ -	$ 88	$ -

Available-for-sale securities and trading securities classified as Level 1 are measured using quoted market prices. Level 2 available-for-sale securities primarily consisted of: (i) bonds and notes issued by the United States government and its agencies, domestic and foreign corporations and foreign governments; and (ii) preferred securities issued by 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.

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, 2014 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 statement of income (loss).

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The CVR-related legal liability represents the Company's estimate of fair value at September 30, 2014 of the liability associated with the legal matters assumed in the HMA merger that were not previously accrued by HMA. In addition, a liability of $42 million is recorded in accrued liabilities in the accompanying condensed consolidated balance sheet in respect of claims that were previously recorded by HMA as a probable contingency. 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 has classified the fair value measurement as a Level 3 measurement in the fair value hierarchy.

The fair value of the CVR-related legal liability will be measured each reporting period using similar measurement techniques, updated for the assumptions and facts existing at that date for each of the underlying legal matters. Changes in the fair value of the CVR related legal liability are recorded in future periods through the statement of income (loss).

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 at September 30, 2014 resulted in a decrease in the fair value of the related liability of $3 million and an after-tax adjustment of $2 million to OCI. The CVA on the Company's interest rate swap agreements at December 31, 2013 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.

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.

14. SEGMENT INFORMATION

The Company operates in two distinct operating segments, represented by hospital operations (which includes its general acute care hospitals and related healthcare entities that provide inpatient and outpatient healthcare services) and home care agency operations (which provide in-home outpatient care).

Only the hospital operations segment meets the criteria as a separate reportable segment. The financial information for the home care agency segment does not meet the quantitative thresholds for a separate identifiable reportable segment and is combined into the corporate and all other reportable segment.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Substantially all of the assets acquired in the HMA merger are recorded as part of the hospital operations segment. The distribution between reportable segments of the Company's net operating revenues and income from continuing operations before income taxes is summarized in the following tables (in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net operating revenues:				
Hospital operations	$ 4,739	$ 3,128	$ 13,580	$ 9,497
Corporate and all other	56	46	179	131
Total	$ 4,795	$ 3,174	$ 13,759	$ 9,628
Income from continuing operations before income taxes:				
Hospital operations	$ 248	$ 95	$ 494	$ 432
Corporate and all other	(115)	(60)	(385)	(174)
Total	$ 133	$ 35	$ 109	$ 258

15. OTHER COMPREHENSIVE INCOME

The following tables present information about items reclassified out of accumulated other comprehensive income (loss) by component for the three and nine months ended September 30, 2014 and 2013 (in millions, net of tax):

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Change in Unrecognized Pension Cost Components	Accumulated Other Comprehensive Income (Loss)
Balance as of June 30, 2014	$ (47)	$ 10	$ (18)	$ (55)
Other comprehensive (loss) income before reclassifications	1	(5)	1	(3)
Amounts reclassified from accumulated other comprehensive income (loss)	10	-	-	10
Net current-period other comprehensive income	11	(5)	1	7
Balance as of September 30, 2014	$ (36)	$ 5	$ (17)	$ (48)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Change in Unrecognized Pension Cost Components	Accumulated Other Comprehensive Income (Loss)
Balance as of December 31, 2013	$ (56)	$ 7	$ (18)	$ (67)
Other comprehensive (loss) income before reclassifications	(13)	(2)		(15)
Amounts reclassified from accumulated other comprehensive income (loss)	33	-	1	34
Net current-period other comprehensive income	20	(2)	1	19
Balance as of September 30, 2014	$ (36)	$ 5	$ (17)	$ (48)

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Change in Unrecognized Pension Cost Components	Accumulated Other Comprehensive Income (Loss)
Balance as of June 30, 2013	$ (79)	$ 7	$ (33)	$ (105)
Other comprehensive income before reclassifications	(6)	1	-	(5)
Amounts reclassified from accumulated other comprehensive income (loss)	16	-	1	17
Net current-period other comprehensive income	10	1	1	12
Balance as of September 30, 2013	$ (69)	$ 8	$ (32)	$ (93)

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Change in Unrecognized Pension Cost Components	Accumulated Other Comprehensive Income (Loss)
Balance as of December 31, 2012	$ (116)	$ 5	$ (34)	$ (145)
Other comprehensive income before reclassifications	(4)	3	-	(1)
Amounts reclassified from accumulated other comprehensive income (loss)	51	-	2	53
Net current-period other comprehensive income	47	3	2	52
Balance as of September 30, 2013	$ (69)	$ 8	$ (32)	$ (93)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

The following tables present a subtotal for each significant reclassification to net income out of accumulated other comprehensive income (loss) and the line item affected in the accompanying condensed consolidated statement of income during the three and nine months ended September 30, 2014 and 2013 (in millions):

	Amount reclassified from AOCL		
Details about accumulated other comprehensive income (loss) components	**Three Months Ended September 30, 2014**	**Nine Months Ended September 30, 2014**	**Affected line item in the statement where net income is presented**
Gains and losses on cash flow hedges			
Interest rate swaps	$ (15)	$ (51)	Interest expense, net
	5	18	Tax benefit
	$ (10)	$ (33)	Net of tax
Amortization of defined benefit pension items			
Prior service costs	$ -	$ (1)	Salaries and benefits
Actuarial losses	-	(1)	Salaries and benefits
	-	(2)	Total before tax
	-	1	Tax benefit
	$ -	$ (1)	Net of tax

	Amount reclassified from AOCL		
Details about accumulated other comprehensive income (loss) components	**Three Months Ended September 30, 2013**	**Nine Months Ended September 30, 2013**	**Affected line item in the statement where net income is presented**
Gains and losses on cash flow hedges			
Interest rate swaps	$ (25)	$ (79)	Interest expense, net
	9	28	Tax benefit
	$ (16)	$ (51)	Net of tax
Amortization of defined benefit pension items			
Prior service costs	$ -	$ -	Salaries and benefits
Actuarial losses	(1)	(3)	Salaries and benefits
	(1)	(3)	Total before tax
	-	1	Tax benefit
	$ (1)	$ (2)	Net of tax

16. CONTINGENCIES

The Company is a party to various legal, regulatory and governmental proceedings incidental to its business. Although the outcome of these proceedings cannot be predicted with certainty, the Company does not believe that any ultimate liability with respect to these proceedings to which the Company is currently a party will have a material adverse effect on the Company's consolidated financial position, cash flows or results of operations.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

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.

HMA Legal Matters and Related CVR

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 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. Based on the 264,544,053 CVRs outstanding, if total HMA Losses do not exceed $18 million, the maximum payment to holders of the CVRs would be approximately $265 million.

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, 2014, the Company had acquired no CVRs.

The following table represents the impact of legal expenses paid or incurred to date and settlements paid or deemed final as of September 30, 2014 on the amounts owed to CVR holders (in millions):

	Deductible	CHS Responsibility at 10%	Reduction to Amount Owed to CVR Holders at 90%	Total Expenses and Settlement Cost
As of January 27, 2014	$ -	$ -	$ -	$ -
Settlements paid	-	-	3	3
Legal expenses incurred and/or paid during the nine months ended September 30, 2014	18	-	1	19
As of September 30, 2014	$ 18	$ -	$ 4	$ 22

Amounts owed to CVR holders are dependent on the ultimate resolution of the HMA Legal Matters and determination of HMA Losses incurred. The settlement of any or all of the claims and expenses incurred on behalf of the Company in defending itself will (subject to the deductible) reduce the amounts owed to the CVR holders.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Underlying the CVR agreement are a number of claims included in the HMA Legal Matters asserted against HMA. The Company has recorded a liability 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." For the estimate of the Company's liabilities associated with the HMA Legal Matters that will be covered by the CVR and were not previously accrued by HMA, the Company recorded a liability of $284 million as part of the acquisition accounting for the HMA merger based on the Company's estimate of fair value of such liabilities. The increase in this liability from the date of acquisition until September 30, 2014 was approximately $7 million and the fair value of $291 million is recorded in other long-term liabilities on the accompanying condensed consolidated balance sheet. The remaining portion of the estimated liability for claims underlying the CVR agreement had been previously recorded by HMA, as a probable contingency, and has been reflected as an acquired liability. This amount is $42 million and is recorded in accrued liabilities on the accompanying condensed consolidated balance sheet. In addition, although legal fees (which are expensed as incurred) associated with the HMA Legal Matters are not taken into account in connection with the $291 million fair value determination or $42 million accrual noted above, such legal fees are taken into account in determining HMA Losses under the CVR agreement. Certain significant HMA Legal Matters underlying these liabilities are discussed in greater detail below.

HMA Matters Recorded at Fair Value

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 recently 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 recently partially 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 June 2, 2014, the court entered a stay of this matter until October 6, 2014, which was subsequently extended until February 27, 2015. The Company intends to defend against the allegations in these matters, but will also be cooperating with the government in the ongoing investigation of these allegations.

During September 2010, HMA received a letter from the Department of Justice ("DOJ") indicating that an investigation was being conducted to determine whether certain HMA hospitals improperly submitted claims for the implantation of implantable cardioverter defibrillators ("ICDs"). The DOJ's investigation covers the period commencing with Medicare's expansion of coverage for ICDs in 2003 to the present. The letter from the DOJ further indicates that the claims submitted by HMA's hospitals for ICDs and related services need to be reviewed to determine if Medicare coverage and payment was appropriate. During 2010, the DOJ sent similar letters and other requests to a large number of unrelated hospitals and hospital operators across the country as part of a nation-wide review of ICD billing under the Medicare program. The Company is cooperating with the DOJ in its ongoing investigation, which could potentially give rise to claims against HMA and/or certain of its subsidiary hospitals under the False Claims Act or other statutes, regulations or laws. Additionally, the Company is conducting an internal review of hospital medical records related to ICDs that are the subject of the DOJ investigation. To date, the DOJ has not asserted any monetary or other claims against HMA or its hospitals in this matter and, at this time, the Company is unable to determine the potential impact, if any, that will result from the final resolution of the investigation.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Probable Contingencies - HMA

OIG Investigation of Certain HMA Hospitals' Relationships with Allegiance

On February 22, 2012 and February 24, 2012, the United States Department of Health and Human Services office of the Inspector General ("OIG") served subpoenas on certain HMA hospitals relating to those hospitals' relationships with Allegiance Health Management, Inc. ("Allegiance"). Allegiance, which is unrelated to HMA, is a post-acute healthcare management company that provides intensive outpatient psychiatric ("IOP") services to patients. The HMA hospitals that were served subpoenas were: (i) Central Mississippi Medical Center in Jackson, Mississippi; (ii) Crossgates River Oaks Hospital in Brandon, Mississippi; (iii) Davis Regional Medical Center in Statesville, North Carolina; (iv) Lake Norman Regional Medical Center in Mooresville, North Carolina; (v) the Medical Center of Southeastern Oklahoma in Durant, Oklahoma; and (vi) Natchez Community Hospital in Natchez, Mississippi. Each of those hospitals has or had a contract with Allegiance. Among other things, the subpoenas seek: (i) documents related to the hospitals' financial relationships with Allegiance; (ii) documents related to patients who received IOP services from Allegiance at the HMA hospitals, including their patient medical records; (iii) documents relating to complaints or concerns regarding Allegiance's IOP services at the HMA hospitals; (iv) documents relating to employees, physicians and therapists who were involved with the IOP services provided by Allegiance at the HMA hospitals; and (v) other documents related to Allegiance, including leases, contracts, policies and procedures, training documents, budgets and financial analyses. The period of time covered by the subpoenas is January 1, 2008 through the date of subpoena compliance. The Company will continue to cooperate with the investigations. Prior to the HMA merger, HMA determined that a liability for this claim was probable and a liability was recorded by HMA during the quarter ended December 31, 2013, which liability was assumed as part of the HMA merger.

Department of Justice Investigation of Kyphoplasty Procedures at Certain HMA Hospitals

Several HMA hospitals received letters during 2009 requesting information in connection with a DOJ investigation relating to kyphoplasty procedures. Kyphoplasty is a minimally invasive spinal procedure used to treat vertebral compression fractures. The DOJ is currently investigating hospitals and hospital operators in multiple states to determine whether certain Medicare claims for kyphoplasty were incorrect when billed as an inpatient service rather than as an outpatient service. The DOJ's investigation originated with a False Claims Act lawsuit against Kyphon, Inc., the company that developed the kyphoplasty procedure. The requested information has been provided to the DOJ and the Company is continuing to cooperate with the investigation. Prior to the HMA merger, HMA determined that a liability for this claim was probable and an incremental liability was recorded by HMA during the quarter ended December 31, 2013, which liability was assumed as part of the HMA merger.

Probable Contingencies - CHS

U.S. ex rel. Baker vs. Community Health Systems, Inc. (United States District Court for the District of New Mexico)

The Company's knowledge of this matter originated in early 2006 with correspondence from the Civil Division of the Department of Justice requesting documents in an investigation it was conducting involving the Company. The inquiry related to the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients. These programs are referred to by different names, including "intergovernmental payments," "upper payment limit programs," and "Medicaid disproportionate share hospital payments." For approximately three years, the Company provided the Department of Justice with requested documents, met with its personnel on numerous occasions and otherwise cooperated in its investigation. During the course of the investigation, the Civil Division notified the Company that it believed that the Company and three of its New Mexico hospitals caused the State of New Mexico to submit improper claims for federal funds, in violation of the Federal False Claims Act. This investigation has culminated in the federal government's intervention in the referenced qui tam lawsuit, which alleges that the Company's New Mexico hospitals "caused to be filed" false claims from the period of August 2000 through June 2011. Two of the Parent Company's subsidiaries are also defendants in this lawsuit. The Company has now reached an agreement in principle to settle this matter. The Company believes a reserve of $75 million is sufficient to cover the claims made in this matter. This reserve does not include the legal fees of the relator's counsel. The Company is discussing with the Office of the Inspector General of the Department of Health and Human Services whether a corporate integrity agreement will be required.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Summary of Recorded Amounts

There are a number of legal 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. Due to the uncertainties and difficulty in predicting the ultimate resolution of these contingencies, the actual amount could differ from the estimated amount; however, the Company does not believe a change in estimate for any of these matters would be material.

The table below presents a reconciliation of the beginning and ending liability balances (in millions) during the nine months ended September 30, 2014 with respect to the Company's fair value determination in connection with HMA Legal Matters that were not previously accrued by HMA, the estimated liability in connection with HMA Legal Matters that were previously recorded by HMA as a probable contingency, and the remaining contingencies of the Company in respect of which an accrual has been recorded. These accruals do not include the Company's estimated legal fees associated with such matters, which are expensed as incurred.

	CVR Related Liability at Fair Value	CVR Related Liability for Probable Contingencies	Other Probable Contingencies
Balance as of December 31, 2013	$ -	$ -	$ 119
Assumed liabilities for HMA contingencies	284	42	16
Expense	10	-	78
Cash payments	(3)	-	(105)
Balance as of September 30, 2014	**$ 291**	**$ 42**	**$ 108**

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 $10 million and $2 million for the three months ended September 30, 2014 and 2013, respectively, and $24 million and $7 million for the nine months ended September 30, 2014 and 2013, respectively, and are included in other operating expenses in the accompanying condensed consolidated statements of income.

Matters for which an Outcome Cannot be Assessed

For all of the legal matters below, 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. Because the matters below are at a preliminary stage and other factors, there are not sufficient facts available to make these assessments.

Implantable Cardioverter Defibrillators ("ICDs"). The Company was first made aware of this investigation in September 2010, when the Company received a letter from the Civil Division of the United States Department of Justice. The letter advised the Company that an investigation was being conducted to determine whether certain hospitals have improperly submitted claims for payment for ICDs. The period of time covered by the investigation was 2003 to 2010. The Company continues to fully cooperate with the government in this investigation and has provided requested records and documents. On August 30, 2012, the Department of Justice issued a document entitled, "Medical Review Guidelines/Resolution Model," which sets out, for the purposes of this investigation, the patient conditions and criteria for the medical necessity of the implantation of ICDs in Medicare beneficiaries and how the Department of Justice will enforce the repayment obligations of hospitals. The Company is in the process of reviewing its medical records in light of the guidance contained in this document.

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. The Company's motion to dismiss this case has been fully briefed and is pending before the court. The Company believes this consolidated matter is without merit and will vigorously defend this case.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Shareholder Derivative Actions. Three purported shareholder derivative actions have also been filed in the United States District Court for the Middle District of Tennessee; Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund v. Wayne T. Smith, et al., filed May 24, 2011; Roofers Local No. 149 Pension Fund v. Wayne T. Smith, et al., filed June 21, 2011; and Lambert Sweat v. Wayne T. Smith, et al., filed October 5, 2011. These three cases allege breach of fiduciary duty arising out of allegedly improper inpatient admission practices, mismanagement, waste and unjust enrichment. These cases have been consolidated into a single, consolidated action. The plaintiffs filed an operative amended derivative complaint in these three consolidated actions on March 15, 2012. The Company's motion to dismiss was argued on June 13, 2013. On September 27, 2013, the court issued an order granting in part and denying in part the Company's motion to dismiss. On October 14, 2013, the Company filed for a Motion for Reconsideration of the Order Granting in Part and Denying in Part the Motion to Dismiss, a Motion to Stay Discovery, and an unopposed Motion for Extension of Time to File an Answer. The Company's motion to stay was denied and its motion for reconsideration is still pending. The Company believes all of the plaintiffs' claims are without merit and will vigorously defend them.

17. SUBSEQUENT EVENTS

The Company evaluated all material events occurring subsequent to the balance sheet date for events requiring disclosure or recognition in the condensed consolidated financial statements.

On October 1, 2014, one or more subsidiaries of the Company completed the acquisition of Natchez Regional Medical Center (179 licensed beds) in Natchez, Mississippi. The total cash consideration paid at closing for long-lived assets was $10 million. As part of the closing, the Company also paid $8 million as a prepayment for future property taxes that will be applied to the tax liability for the next 17 years.

On October 13, 2014, the Company executed a definitive agreement to sell its ownership interest in Carolina Pines Regional Medical Center (116 licensed beds) in Hartsville, South Carolina and related outpatient services to Capella Healthcare. This hospital is required to be divested by the Federal Trade Commission as a condition of its approval of the HMA merger.

Pursuant to registration rights agreements entered into at the time of the issuance of the 2021 Senior Secured Notes and the 6 7/8% Senior Notes, as a result of exchange offers made by CHS, substantially all of the 2021 Senior Secured Notes and 6 7/8% Senior Notes issued in January 2014 were exchanged in October 2014 for new notes having terms substantially identical in all material respects to the 2021 Senior Secured Notes and the 6 7/8% Senior Notes (except that the exchange notes were issued under a registration statement pursuant to the 1933 Act).

On October 29, 2014, the Company received notice of the approval by the federal government for the settlement of the claim for the rural floor budget neutrality adjustment related to the former HMA hospitals. The Company will receive approximately $36 million, net of attorneys' fees, which will be recognized in net operating revenues during the three months ending December 31, 2014.

Effective November 1, 2014, the Company entered into and closed on a restructuring agreement related to the joint venture between an affiliate of the Company and an affiliate of Novant Health, Inc. ("Novant"), the non-profit joint venture partner. Through this joint venture, Novant owned an indirect noncontrolling interest in Lake Norman Regional Medical Center ("Lake Norman"), one of the former HMA hospitals. The HMA merger triggered a change in control provision in the operating agreement of this joint venture, requiring the Company to purchase the 30% noncontrolling interest in Lake Norman held by Novant for the higher of fair value or $150 million. As part of the restructuring agreement, on November 3, 2014, the Company paid Novant (1) $150 million for its 30% noncontrolling interest in Lake Norman, (2) approximately $4 million to acquire Upstate Carolina Medical Center (125 licensed beds) in Gaffney, South Carolina, and (3) approximately $5 million to settle prior claims with Novant. The amounts paid to Novant to acquire the noncontrolling interest in Lake Norman and to settle prior claims were recognized as part of the opening balance sheet in the purchase accounting for HMA.

On November 3, 2014, the Company sold Special Care Hospital (67 licensed beds) located in Nanticoke, Pennsylvania, which is a long-term acute care hospital, to Post Acute Medical, LLC for approximately $3 million in cash.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

18. SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION

The Senior Notes due 2019, 2020 and 2022, which are senior unsecured obligations of CHS, and the 5 1/8% Senior Secured Notes due 2018 and 2021 (collectively, "the Notes") are guaranteed on a senior basis by the Company and by certain of its existing and subsequently acquired or organized 100% owned domestic subsidiaries. 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' equity. 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.

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 Receivables Facility that is further discussed in Note 11. 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, the Company sells and/or repurchases noncontrolling interests in consolidated subsidiaries, which may change subsidiaries between guarantors and non-guarantors. Amounts for prior periods are revised to reflect the status of guarantors or non-guarantors as of September 30, 2014.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Balance Sheet
September 30, 2014

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)			
ASSETS						
Current assets:						
Cash and cash equivalents	$ -	$ -	$ 64	$ 157	$ -	$ 221
Patient accounts receivable, net of allowance for doubtful accounts	-	-	1,186	2,080	-	3,266
Supplies	-	-	374	179	-	553
Prepaid income taxes	123	-	-	-	-	123
Deferred income taxes	318	-	-	-	-	318
Prepaid expenses and taxes	-	-	160	53	-	213
Other current assets	-	-	314	364	-	678
Total current assets	441	-	2,098	2,833	-	5,372
Intercompany receivable	1,129	16,418	3,010	7,880	(28,437)	-
Property and equipment, net	-	-	6,639	3,659	-	10,298
Goodwill	-	-	5,459	3,477	-	8,936
Other assets, net	-	310	1,821	1,115	(628)	2,618
Net investment in subsidiaries	3,205	18,082	7,187	-	(28,474)	-
Total assets	$ 4,775	$ 34,810	$ 26,214	$ 18,964	$ (57,539)	$ 27,224
LIABILITIES AND EQUITY						
Current liabilities:						
Current maturities of long-term debt	$ -	$ 154	$ 57	$ 8	$ -	$ 219
Accounts payable	-	-	791	269	-	1,060
Deferred income taxes	-	-	-	-	-	-
Accrued interest	-	162	1	1	-	164
Accrued liabilities	5	-	1,193	539	-	1,737
Total current liabilities	5	316	2,042	817	-	3,180
Long-term debt	-	15,861	161	771	-	16,793
Intercompany payable	-	14,610	19,250	15,382	(49,242)	-
Deferred income taxes	877	-	-	-	-	877
Other long-term liabilities	11	818	1,148	360	(628)	1,709
Total liabilities	893	31,605	22,601	17,330	(49,870)	22,559
Redeemable noncontrolling interests in equity of consolidated subsidiaries	-	-	-	695	-	695
Equity:						
Community Health Systems, Inc. stockholders' equity:						
Preferred stock	-	-	-	-	-	-
Common stock	1	-	-	-	-	1
Additional paid-in capital	2,059	1,172	1,318	683	(3,173)	2,059
Treasury stock, at cost	(7)	-	-	-	-	(7)
Accumulated other comprehensive (loss) income	(48)	(48)	(15)	3	60	(48)
Retained earnings	1,877	2,081	2,310	165	(4,556)	1,877
Total Community Health Systems, Inc. stockholders' equity	3,882	3,205	3,613	851	(7,669)	3,882
Noncontrolling interests in equity of consolidated subsidiaries	-	-	-	88	-	88
Total equity	3,882	3,205	3,613	939	(7,669)	3,970
Total liabilities and equity	$ 4,775	$ 34,810	$ 26,214	$ 18,964	$ (57,539)	$ 27,224

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Balance Sheet
December 31, 2013

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)			
ASSETS						
Current assets:						
Cash and cash equivalents	$ -	$ -	$ 238	$ 135	$ -	$ 373
Patient accounts receivable, net of allowance for doubtful accounts	-	-	866	1,457	-	2,323
Supplies	-	-	256	115	-	371
Prepaid income taxes	107	-	-	-	-	107
Deferred income taxes	101	-	-	-	-	101
Prepaid expenses and taxes	-	-	98	29	-	127
Other current assets	-	-	262	83	-	345
Total current assets	208	-	1,720	1,819	-	3,747
Intercompany receivable	579	9,541	4,534	3,810	(18,464)	-
Property and equipment, net	-	-	4,657	2,394	-	7,051
Goodwill	-	-	2,530	1,894	-	4,424
Other assets, net	-	144	1,454	828	(531)	1,895
Net investment in subsidiaries	3,194	9,335	4,030	-	(16,559)	-
Total assets	$ 3,981	$ 19,020	$ 18,925	$ 10,745	$ (35,554)	$ 17,117
LIABILITIES AND EQUITY						
Current liabilities:						
Current maturities of long-term debt	$ -	$ 152	$ 13	$ 2	$ -	$ 167
Accounts payable	-	-	734	215	-	949
Deferred income taxes	3	-	-	-	-	3
Accrued interest	-	111	-	1	-	112
Accrued liabilities	4	-	871	352	-	1,227
Total current liabilities	7	263	1,618	570	-	2,458
Long-term debt	-	8,718	51	517	-	9,286
Intercompany payable	-	6,226	13,060	8,266	(27,552)	-
Deferred income taxes	906	-	-	-	-	906
Other long-term liabilities	-	619	671	218	(531)	977
Total liabilities	913	15,826	15,400	9,571	(28,083)	13,627
Redeemable noncontrolling interests in equity of consolidated subsidiaries	-	-	-	358	-	358
Equity:						
Community Health Systems, Inc. stockholders' equity:						
Preferred stock	-	-	-	-	-	-
Common stock	1	-	-	-	-	1
Additional paid-in capital	1,256	1,175	1,274	595	(3,044)	1,256
Treasury stock, at cost	(7)	-	-	-	-	(7)
Accumulated other comprehensive (loss) income	(67)	(67)	(11)	-	78	(67)
Retained earnings	1,885	2,086	2,262	157	(4,505)	1,885
Total Community Health Systems, Inc. stockholders' equity	3,068	3,194	3,525	752	(7,471)	3,068
Noncontrolling interests in equity of consolidated subsidiaries	-	-	-	64	-	64
Total equity	3,068	3,194	3,525	816	(7,471)	3,132
Total liabilities and equity	$ 3,981	$ 19,020	$ 18,925	$ 10,745	$ (35,554)	$ 17,117

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Income
Three Months Ended September 30, 2014

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Operating revenues (net of contractual allowances and discounts)	$ -	$ (5)	$ 3,418	$ 2,150	$ -	$ 5,563
Provision for bad debts	-	-	460	308	-	768
Net operating revenues	-	(5)	2,958	1,842	-	4,795
Operating costs and expenses:						
Salaries and benefits	-	-	1,207	984	-	2,191
Supplies	-	-	469	264	-	733
Other operating expenses	-	-	724	397	-	1,121
Government settlement and related costs reserve	-	-	77	-	-	77
Electronic health records incentive reimbursement	-	-	(63)	(25)	-	(88)
Rent	-	-	57	53	-	110
Depreciation and amortization			187	93		280
Amortization of software to be abandoned	-	-	-	-	-	-
Total operating costs and expenses	-	-	2,658	1,766	-	4,424
Income from operations	-	(5)	300	76	-	371
Interest expense, net	-	13	219	18	-	250
Loss from early extinguishment of debt	-	-	-	-	-	-
Equity in earnings of unconsolidated affiliates	(62)	(66)	(33)	-	149	(12)
Impairment of long-lived assets	-	-	-	-	-	-
Income from continuing operations before income taxes	62	48	114	58	(149)	133
Provision for (benefit from) income taxes	-	(14)	44	10	-	40
Income from continuing operations	62	62	70	48	(149)	93
Discontinued operations, net of taxes:						
(Loss) income from operations of entities held for sale	-	-	(6)	7	-	1
Impairment of hospitals held for sale	-	-	-	-	-	-
(Loss) income from discontinued operations, net of taxes	-	-	(6)	7	-	1
Net (loss) income	62	62	64	55	(149)	94
Less: Net income attributable to noncontrolling interests	-	-	-	32	-	32
Net income (loss) attributable to Community Health Systems, Inc. stockholders	$ 62	$ 62	$ 64	$ 23	$ (149)	$ 62

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Income
Three Months Ended September 30, 2013

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)			
Operating revenues (net of contractual allowances and discounts)	$ -	$ (4)	$ 2,367	$ 1,347	$ -	$ 3,710
Provision for bad debts	-	-	350	186	-	536
Net operating revenues	-	(4)	2,017	1,161	-	3,174
Operating costs and expenses:						
Salaries and benefits	-	-	891	623	-	1,514
Supplies	-	-	313	169	-	482
Other operating expenses	-	-	457	248	-	705
Government settlement and related costs reserve	-	-	98	-	-	98
Electronic health records incentive reimbursement	-	-	(49)	(16)	-	(65)
Rent	-	-	40	30	-	70
Depreciation and amortization	-	-	132	61	-	193
Total operating costs and expenses	-	-	1,882	1,115	-	2,997
Income from operations	-	(4)	135	46	-	177
Interest expense, net	-	(1)	135	20	-	154
Loss from early extinguishment of debt	-	-	-	-	-	-
Equity in earnings of unconsolidated affiliates	(4)	(78)	(14)	-	84	(12)
Impairment of long-lived assets	-	-	-	-	-	-
Income from continuing operations before income taxes	4	75	14	26	(84)	35
Provision for (benefit from) income taxes	-	71	(67)	3	-	7
Income from continuing operations	4	4	81	23	(84)	28
Discontinued operations, net of taxes:						
(Loss) income from operations of entities held for sale	-	-	(6)	-	-	(6)
Impairment of hospitals held for sale	-	-	-	-	-	-
(Loss) income from discontinued operations, net of taxes	-	-	(6)	-	-	(6)
Net (loss) income	4	4	75	23	(84)	22
Less: Net income attributable to noncontrolling interests	-	-	-	18	-	18
Net income (loss) attributable to Community Health Systems, Inc. stockholders	$ 4	$ 4	$ 75	$ 5	$ (84)	$ 4

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Loss
Nine Months Ended September 30, 2014

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Operating revenues (net of contractual allowances and discounts)	$ -	$ (13)	$ 9,937	$ 6,060	$ -	$ 15,984
Provision for bad debts	-	-	1,398	827	-	2,225
Net operating revenues	-	(13)	8,539	5,233	-	13,759
Operating costs and expenses:						
Salaries and benefits	-	-	3,601	2,816	-	6,417
Supplies	-	-	1,368	736	-	2,104
Other operating expenses	-	-	2,095	1,167	-	3,262
Government settlement and related costs	-	-	77	-	-	77
Electronic health records incentive reimbursement	-	-	(147)	(65)	-	(212)
Rent	-	-	170	150	-	320
Depreciation and amortization			574	243		817
Amortization of software to be abandoned	-	-	45	30	-	75
Total operating costs and expenses	-	-	7,783	5,077	-	12,860
Income from operations	-	(13)	756	156	-	899
Interest expense, net	-	84	596	48	-	728
Loss from early extinguishment of debt	-	73	-	-	-	73
Equity in earnings of unconsolidated affiliates	8	(96)	(44)	-	97	(35)
Impairment of long-lived assets	-	-	24	-	-	24
(Loss) income from continuing operations before income taxes	(8)	(74)	180	108	(97)	109
Provision for (benefit from) income taxes	-	(66)	69	13	-	16
(Loss) income from continuing operations	(8)	(8)	111	95	(97)	93
Discontinued operations, net of taxes:						
(Loss) income from operations of entities held for sale	-	-	(20)	16	-	(4)
Impairment of hospitals held for sale	-	-	-	(22)	-	(22)
(Loss) income from discontinued operations, net of taxes	-	-	(20)	(6)	-	(26)
Net (loss) income	(8)	(8)	91	89	(97)	67
Less: Net income attributable to noncontrolling interests	-	-	-	75	-	75
Net (loss) income attributable to Community Health Systems, Inc. stockholders	$ (8)	$ (8)	$ 91	$ 14	$ (97)	$ (8)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Income
Nine Months Ended September 30, 2013

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Operating revenues (net of contractual allowances and discounts)	$ -	$ (11)	$ 7,148	$ 4,024	$ -	$ 11,161
Provision for bad debts	-	-	1,057	476	-	1,533
Net operating revenues	-	(11)	6,091	3,548	-	9,628
Operating costs and expenses:						
Salaries and benefits	-	-	2,691	1,900	-	4,591
Supplies	-	-	957	511	-	1,468
Other operating expenses	-	-	1,350	760	-	2,110
Government settlement and related costs	-	-	98	-	-	98
Electronic health records incentive reimbursement	-	-	(76)	(32)	-	(108)
Rent	-	-	119	89	-	208
Depreciation and amortization	-	-	388	186	-	574
Total operating costs and expenses	-	-	5,527	3,414	-	8,941
Income from operations	-	(11)	564	134	-	687
Interest expense, net	-	2	403	59	-	464
Loss from early extinguishment of debt	-	1	-	-	-	1
Equity in earnings of unconsolidated affiliates	(113)	(194)	(46)	-	317	(36)
Impairment of long-lived assets	-	-	-	-	-	-
Income from continuing operations before income taxes	113	180	207	75	(317)	258
Provision for (benefit from) income taxes	-	67	2	9	-	78
Income from continuing operations	113	113	205	66	(317)	180
Discontinued operations, net of taxes:						
(Loss) income from operations of entities held for sale	-	-	(17)	2	-	(15)
Impairment of hospitals held for sale	-	-	-	-	-	-
(Loss) income from discontinued operations, net of taxes	-	-	(17)	2	-	(15)
Net (loss) income	113	113	188	68	(317)	165
Less: Net income attributable to noncontrolling interests	-	-	-	52	-	52
Net income (loss) attributable to Community Health Systems, Inc. stockholders	$ 113	$ 113	$ 188	$ 16	$ (317)	$ 113

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) – (Continued)

Condensed Consolidating Statement of Comprehensive Income
Three Months Ended September 30, 2014

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net income	$ 62	$ 62	$ 64	$ 55	$ (149)	$ 94
Other comprehensive income, net of taxes						
Net change in fair value of interest rate swaps, net of tax	11	11	-	-	(11)	11
Net change in fair value of available-for-sale securities, net of tax	(5)	(5)	(5)	-	10	(5)
Amortization and recognition of unrecognized pension cost components, net of tax	1	1	1	-	(2)	1
Other comprehensive income	7	7	(4)	-	(3)	7
Comprehensive income	69	69	60	55	(152)	101
Less: Comprehensive income attributable to noncontrolling interests	-	-	-	32	-	32
Comprehensive income attributable to Community Health Systems, Inc. stockholders	$ 69	$ 69	$ 60	$ 23	$ (152)	$ 69

Condensed Consolidating Statement of Comprehensive Income
Three Months Ended September 30, 2013

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net income	$ 4	$ 4	$ 75	$ 23	$ (84)	$ 22
Other comprehensive income, net of taxes						
Net change in fair value of interest rate swaps, net of tax	10	10	-	-	(10)	10
Net change in fair value of available-for-sale securities, net of tax	1	1	1	-	(2)	1
Amortization and recognition of unrecognized pension cost components, net of tax	1	1	1	-	(2)	1
Other comprehensive income	12	12	2	-	(14)	12
Comprehensive income	16	16	77	23	(98)	34
Less: Comprehensive income attributable to noncontrolling interests	-	-	-	18	-	18
Comprehensive income attributable to Community Health Systems, Inc. stockholders	$ 16	$ 16	$ 77	$ 5	$ (98)	$ 16

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, 2014

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)			
Net (loss) income	$ (8)	$ (8)	$ 91	$ 89	$ (97)	$ 67
Other comprehensive income, net of income taxes:						
Net change in fair value of interest rate swaps, net of tax	20	20	-	-	(20)	20
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	19	19	(1)	-	(18)	19
Comprehensive income	11	11	90	89	(115)	86
Less: Comprehensive income attributable to noncontrolling interests	-	-	-	75	-	75
Comprehensive income attributable to Community Health Systems, Inc. stockholders	$ 11	$ 11	$ 90	$ 14	$ (115)	$ 11

Condensed Consolidating Statement of Comprehensive Income
Nine Months Ended September 30, 2013

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)			
Net income	$ 113	$ 113	$ 188	$ 68	$ (317)	$ 165
Other comprehensive income, net of income taxes:						
Net change in fair value of interest rate swaps, net of tax	47	47	-	-	(47)	47
Net change in fair value of available-for-sale securities, net of tax	3	3	3	-	(6)	3
Amortization and recognition of unrecognized pension cost components, net of tax	2	2	2	-	(4)	2
Other comprehensive income	52	52	5	-	(57)	52
Comprehensive income	165	165	193	68	(374)	217
Less: Comprehensive income attributable to noncontrolling interests	-	-	-	52	-	52
Comprehensive income attributable to Community Health Systems, Inc. stockholders	$ 165	$ 165	$ 193	$ 16	$ (374)	$ 165

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, 2014

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net cash (used in) provided by operating activities	$ 96	$ 144	$ 657	$ (258)	$ -	$ 639
Cash flows from investing activities:						
Acquisitions of facilities and other related equipment	-	-	(2,840)	(201)	-	(3,041)
Purchases of property and equipment	-	-	(390)	(170)	-	(560)
Proceeds from disposition of ancillary operations	-	-	-	12	-	12
Proceeds from sale of property and equipment	-	-	33	7	-	40
Purchases of available-for-sale securities	-	-	(23)	(175)	-	(198)
Proceeds from sales of available-for-sale securities	-	-	24	167	-	191
Increase in other investments	-	-	(284)	(103)	-	(387)
Net cash used in investing activities	-	-	(3,480)	(463)	-	(3,943)
Cash flows from financing activities:						
Proceeds from exercise of stock options	42	-	-	-	-	42
Repurchase of restricted stock shares for payroll tax withholding requirements	(11)	-	-	-	-	(11)
Stock buy-back	-	-	-	-	-	-
Deferred financing costs and other-debt related costs	-	(272)	-	-	-	(272)
Excess tax benefit relating to stock-based compensation	4	-	-	-	-	4
Proceeds from noncontrolling investors in joint ventures	-	-	-	10	-	10
Redemption of noncontrolling investments in joint ventures	-	-	-	(8)	-	(8)
Distributions to noncontrolling investors in joint ventures	-	-	-	(74)	-	(74)
Changes in intercompany balances with affiliates, net	(131)	(3,195)	2,665	661	-	-
Borrowings under credit agreements	-	8,307	38	3	-	8,348
Issuance of long-term debt	-	4,000	-	-	-	4,000
Proceeds from receivables facility	-	-	-	204	-	204
Repayments of long-term indebtedness	-	(8,984)	(54)	(53)	-	(9,091)
Net cash provided by (used in) financing activities	(96)	(144)	2,649	743	-	3,152
Net change in cash and cash equivalents	-	-	(174)	22	-	(152)
Cash and cash equivalents at beginning of period	-	-	238	135	-	373
Cash and cash equivalents at end of period	$ -	$ -	$ 64	$ 157	$ -	$ 221

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, 2013

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net cash (used in) provided by operating activities	$ (81)	$ 6	$ 495	$ 21	$ -	$ 441
Cash flows from investing activities:						
Acquisitions of facilities and other related equipment	-	-	(9)	(25)	-	(34)
Purchases of property and equipment	-	-	(356)	(65)	-	(421)
Proceeds from sale of property and equipment	-	-	1	3	-	4
Purchases of available-for-sale securities	-	-	-	-	-	-
Proceeds from sales of available-for-sale securities	-	-	-	-	-	-
Increase in other investments	-	-	(191)	(43)	-	(234)
Net cash used in investing activities	-	-	(555)	(130)	-	(685)
Cash flows from financing activities:						
Proceeds from exercise of stock options	109	-	-	-	-	109
Repurchase of restricted stock shares for payroll tax withholding requirements	(15)	-	-	-	-	(15)
Stock buy-back	(27)	-	-	-	-	(27)
Deferred financing costs and other-debt related costs	-	(13)	-	-	-	(13)
Excess tax benefit relating to stock-based compensation	7	-	-	-	-	7
Proceeds from noncontrolling investors in joint ventures	-	-	-	-	-	-
Redemption of noncontrolling investments in joint ventures	-	-	-	(6)	-	(6)
Distributions to noncontrolling investors in joint ventures	-	-	-	(60)	-	(60)
Changes in intercompany balances with affiliates, net	7	183	(196)	6	-	-
Borrowings under credit agreements	-	792	21	1	-	814
Issuance of long-term debt	-	-	-	-	-	-
Proceeds from receivables facility	-	-	-	320	-	320
Repayments of long-term indebtedness	-	(968)	(20)	(141)	-	(1,129)
Net cash provided by (used in) financing activities	81	(6)	(195)	120	-	-
Net change in cash and cash equivalents	-	-	(255)	11	-	(244)
Cash and cash equivalents at beginning of period	-	-	272	116	-	388
Cash and cash equivalents at end of period	$ -	$ -	$ 17	$ 127	$ -	$ 144

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

You should read this discussion together with our unaudited 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, and management services provided, by distinct and indirect subsidiaries of Community Health Systems, Inc.

Executive Overview

We are one of the largest publicly-traded operators of hospitals in the United States in terms of number of facilities and net operating revenues. We provide healthcare services through the hospitals that we own and operate 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 other outpatient services to patients in the communities in which we are located. As of September 30, 2014, we owned or leased 196 hospitals included in continuing operations, comprised of 192 general acute care hospitals and four stand-alone rehabilitation or psychiatric hospitals. In addition to our hospitals and related businesses, we own and operate home care agencies, located primarily in markets where we also operate a hospital. Also, through our wholly-owned subsidiary, Quorum Health Resources, LLC, or QHR, we provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. For the hospitals and home care agencies that we own and operate, we are paid for our services by governmental agencies, private insurers and directly by the patients we serve. For our management and consulting services, we are paid by the non-affiliated hospitals utilizing our services.

On January 27, 2014, we and one of our wholly-owned subsidiaries completed the acquisition of Health Management Associates, Inc., or HMA, by acquiring all the outstanding shares of common stock of HMA, or HMA common stock, for approximately $7.3 billion, including the assumption of approximately $3.8 billion of indebtedness, consisting of a combination of cash and Parent Company common stock. Each share of HMA common stock issued and outstanding immediately prior to the effective time of the HMA merger was converted into the right to receive $10.50 in cash, 0.06942 of a share of the Parent Company's common stock, and one contingent value right, or CVR, which entitles the holder of each CVR to receive a cash payment of $1.00 per share, following and conditioned upon the final resolution of certain legal matters involving HMA, subject to downward adjustments relating to the amount of certain losses arising out of or relating to such legal matters. At the time of the completion of the HMA merger, HMA owned and operated 71 hospitals in 15 states in non-urban communities located primarily in the southeastern United States. During the three months ended September 30, 2014 and 2013, we recognized approximately $11 million and $4 million of acquisition and integration expenses related to the HMA merger, respectively. During the nine months ended September 30, 2014 and 2013, we recognized approximately $89 million and $5 million of acquisition and integration expenses related to the HMA merger, respectively.

In connection with the HMA merger, the Parent Company and CHS/Community Health Systems, Inc., or CHS, entered into a third amendment and restatement of its credit facility, or Credit Facility, providing for additional financing and recapitalization of certain of our term loans. In addition, we also issued: (i) $1.0 billion aggregate principal amount of 5.125% Senior Secured Notes due 2021 and (ii) $3.0 billion aggregate principal amount of 6.875% Senior Notes due 2022.

We believe the HMA merger has benefited us since it has expanded the number of markets we serve and reduced our concentration of credit risk and other risks in any one state. We have also achieved synergies, and believe that we will achieve additional synergies, from eliminating duplicate corporate functions and centralizing many support functions, which we believe will allow us to improve HMA's margins. We believe this merger has extended and strengthened our hospital and physician networks.

Operating results and statistical data for the three and nine-month periods ended September 30, 2014, include comparative information for the operations of the acquired HMA hospitals from January 27, 2014, the date of the HMA merger. Throughout this executive overview and management's discussion and analysis, same-store operating results and statistical data for both the three and nine months ended September 30, 2014 and 2013 is hereinafter defined to include the hospitals acquired in the HMA merger. For the hospitals acquired in the HMA merger, this same-store information reflects the periods from February through September 2014 and 2013 for the nine-month comparisons and from July through September 2014 and 2013 for the three-month comparisons, in each case as if they were owned during both comparable periods. For all hospitals owned throughout both periods, the same-store operating results and statistical data reflects the indicated three-month and nine-month periods. In addition, the same-store comparisons exclude our hospitals that have previously been classified as discontinued operations for accounting purposes.

In addition, during the nine months ended September 30, 2014, we completed the acquisition of a hospital in Sharon, Pennsylvania as well as a hospital in Ocala, Florida with the hospital in Ocala, Florida being acquired through a long-term prepaid lease executed in conjunction with a joint venture arrangement with an affiliate of a regional not-for-profit healthcare system.

Our net operating revenues for the three months ended September 30, 2014, increased approximately $1.6 billion to approximately $4.8 billion compared to approximately $3.2 billion for the three months ended September 30, 2013. We had income from continuing operations before noncontrolling interests of $93 million during the three months ended September 30, 2014, compared to income of $28 million for the three months ended September 30, 2013. Income from continuing operations before noncontrolling interests for the three months ended September 30, 2014 included an after-tax charge of $2 million for acquisition and integration expenses from the HMA merger, an after-tax charge of $5 million for legal expenses related to the HMA legal proceedings underlying the CVR agreement and an after-tax charge of $47 million for the government settlement and related costs in connection with the agreement in principle to settle claims at our New Mexico hospitals as discussed further below under Part II, Item 1, Legal Proceedings. Included in income from continuing operations for the three months ended September 30, 2013, is a $61 million after-tax charge for the government settlement and related costs reserve. Consolidated inpatient admissions for the three months ended September 30, 2014, increased 49.0%, compared to the three months ended September 30, 2013, and consolidated adjusted admissions for the three months ended September 30, 2014 increased 53.2%, compared to the three months ended September 30, 2013. These increases were primarily due to the HMA merger during 2014. Same-store inpatient admissions for the three months ended September 30, 2014, decreased 3.9%, compared to the three months ended September 30, 2013, and same-store adjusted admissions remained flat for the three months ended September 30, 2014, compared to the three months ended September 30, 2013.

Our net operating revenues for the nine months ended September 30, 2014, increased approximately $4.2 billion to approximately $13.8 billion compared to approximately $9.6 billion for the nine months ended September 30, 2013. We had income from continuing operations before noncontrolling interests of $93 million during the nine months ended September 30, 2014, compared to income of $180 million for the nine months ended September 30, 2013. Income from continuing operations before noncontrolling interests for the nine months ended September 30, 2014 included an after-tax charge of $45 million for loss from early extinguishment of debt, $42 million after-tax expense for acquisition and integration expenses from the HMA merger, an after-tax charge of $47 million for the acceleration of amortization on software to be abandoned, an after-tax charge of $15 million for impairment of software costs taken out of service, an after-tax charge of $13 million for the HMA legal proceedings underlying the CVR agreement and an after-tax charge of $47 million for the government settlement and related costs in connection with the agreement in principle to settle claims at our New Mexico hospitals. Consolidated inpatient admissions for the nine months ended September 30, 2014, increased 40.2%, compared to the nine months ended September 30, 2013, and consolidated adjusted admissions for the nine months ended September 30, 2014 increased 44.4%, compared to the nine months ended September 30, 2013. These increases were primarily due to the HMA merger during 2014. Same-store inpatient admissions for the nine months ended September 30, 2014, decreased 5.5%, compared to the nine months ended September 30, 2013, and same-store adjusted admissions for the nine months ended September 30, 2014 decreased 2.1%, compared to the nine months ended September 30, 2013.

Self-pay revenues represented approximately 13.3% and 13.9% of our net operating revenues, net of contractual allowances and discounts (but before provision for bad debts), for the three months ended September 30, 2014 and 2013, respectively, and 13.5% and 13.7% for the nine months ended September 30, 2014 and 2013, respectively. The amount of foregone revenue related to providing charity care services as a percentage of net operating revenues was approximately 2.8% and 6.4% for the three months ended September 30, 2014 and 2013, respectively, and 3.1% and 6.2% for the nine months ended September 30, 2014 and 2013, respectively. Direct and indirect costs incurred by us in providing charity care services were approximately 0.4% and 0.9% of net operating revenues for the three months ended September 30, 2014 and 2013, respectively, and 0.5% and 0.9% for the nine months ended September 30, 2014 and 2013, respectively.

The Patient Protection and Affordable Care Act of 2010, or the Reform Legislation, mandates that substantially all U.S. citizens maintain medical insurance coverage, which has begun to increase the number of persons with access to health insurance in the United States. The Reform Legislation expands health insurance coverage through a combination of public program expansion and private sector health insurance reforms.

Based on the Congressional Budget Office projections issued in April 2014, the Reform Legislation could result in 12 million and 25 million formerly uninsured Americans gaining insurance coverage by the end of 2014 and 2016, respectively. In an April 2014 report, the CBO projects, by the end of 2016, a 45% reduction in the number of nonelderly Americans who remain uninsured due to the effects on insurance coverage from the Reform Legislation. The 28 states in which we operate hospitals that are included in continuing operations include nine of the 10 states with the highest percentage of nonelderly uninsured people from among the state's nonelderly population. More broadly, the 28 states in which we operate hospitals that are included in continuing operations include 25 of the 30 states with the highest percentage of nonelderly uninsured people from among the state's nonelderly population.

As a result of a 2012 Supreme Court decision, states may opt out of the Medicaid coverage expansion provisions of the Reform Legislation without losing existing federal Medicaid funding. Some states have opted not to expand their Medicaid programs, but could decide at a later date to expand their Medicaid programs. In states that do not expand their Medicaid programs, the number of uninsured patients at our hospitals will likely decline by a smaller margin as compared to our expectations when the Reform Legislation was first adopted. Of the 28 states in which we operate hospitals that are included in continuing operations, 12 states are expanding their Medicaid programs. At this time, the other 16 states are not expanding Medicaid coverage. Florida, Indiana, Tennessee and Texas, where we operated a significant number of hospitals as of September 30, 2014, are four of the states that have not expanded Medicaid coverage. Three of the states in which we operate that have not expanded Medicaid, Indiana, Missouri and Utah, are evaluating options such as waiver plans to operate an alternative Medicaid expansion plan.

We believe our hospitals are well positioned to participate in the provider networks of various QHPs offering plan options on the health insurance exchanges. As of September 30, 2014, 194 of our 196 hospitals in continuing operations participated in a health insurance exchange agreement, 90% of our hospitals possessed two or more contracts, 87% of our hospitals had a contract with the first or second lowest cost bronze plans (QHPs with a 60% actuarial value), and 90% of our hospitals had a contract with the first or second lowest cost silver plans (QHPs with a 70% actuarial value). Most of our exchange reimbursement arrangements reflect a slight discount to that of commercial rates.

The Reform Legislation also makes a number of other 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 which began October 1, 2011, and a reduction to the Medicare and Medicaid disproportionate share payments, that could adversely impact the reimbursement received under these programs.

Also included in the Reform Legislation are provisions aimed at reducing fraud, waste and abuse in the healthcare industry. These provisions allocate significant additional resources to federal enforcement agencies and expand the use of private contractors to recover potentially inappropriate Medicare and Medicaid payments. The Reform Legislation amends several existing federal laws, including the Medicare Anti-Kickback Statute and the False Claims Act, making it easier for government agencies and private plaintiffs to prevail in lawsuits brought against healthcare providers. These amendments also make it easier for potentially severe fines and penalties to be imposed on healthcare providers accused of violating applicable laws and regulations.

We believe the expansion of private sector and Medicaid coverage will, over time, increase our reimbursement related to providing services to individuals who were previously uninsured, which should reduce our expense from uncollectible accounts receivable. The various provisions in the Reform Legislation that directly or indirectly affect reimbursement are scheduled to take effect over a number of years. Over time, we believe the net impact of the overall changes as a result of the Reform Legislation will have a positive effect on our net operating revenues. In addition, we believe that the Reform Legislation has had a positive impact on net operating revenues during 2014 as the result of the expansion of private sector and Medicaid coverage that has already resulted from the Reform Legislation. Other provisions of the Reform Legislation, such as requirements related to employee health insurance coverage, should increase our operating costs. Because of the many variables involved, including clarifications and modifications resulting from the rule-making process, the development of agency guidance and future judicial interpretations, whether and how many states decide to expand or not to expand Medicaid coverage, the number of uninsured who elect to purchase health insurance coverage, budgetary issues at federal and state levels, and the potential for delays in the implementation of some of the provisions of the Reform Legislation, we may not be able to fully realize the positive impact the Reform Legislation may otherwise have on our business, results of operations, cash flow, capital resources and liquidity. Furthermore, we cannot predict whether we will be able to modify certain aspects of our operations to offset any potential adverse consequences from the Reform Legislation.

In a number of markets, we have partnered with local physicians in the ownership of our facilities. Such investments have been permitted under an exception to the federal physician self-referral law, or Stark Law, that allows physicians to invest in an entire hospital (as opposed to individual hospital departments). The Reform Legislation changed the "whole hospital" exception to the Stark Law. The Reform Legislation permits existing physician investments in a whole hospital to continue under a "grandfather" clause if the arrangement satisfies certain requirements and restrictions, but physicians are now prohibited, from the time the Reform Legislation became effective, from increasing the aggregate percentage of their ownership in the hospital. The Reform Legislation also restricts the ability of existing physician-owned hospitals to expand the capacity of their facilities.

In addition, the American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act, or HITECH. These provisions were designed to promote the use of electronic health records, or EHR, technology and established the requirements for a Medicare and Medicaid incentive payments program beginning in 2011 for eligible hospitals and professionals that adopt and meaningfully use certified EHR technology. These payments are intended to incentivize the meaningful use of EHR. Rules adopted in July 2010 by the Department of Health and Human Services established an initial set of standards and certification criteria. Our hospital facilities have been implementing EHR technology on a facility-by-facility basis since 2011. We anticipate recognizing 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 will 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. Beginning in 2015, 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 penalties. For eligible hospitals, the penalty would be a reduced market basket update to the inpatient prospective payment system standardized amount in 2015 and each subsequent fiscal year. For eligible professionals, the penalty would be a 1% per year cumulative reduction applied to the Medicare physician fee schedule amount for covered professional services, subject to a cap of 5%.

Although we believe that our hospital facilities will be in compliance with the meaningful use standards by 2015, there can be no assurance that all of our facilities will be or will remain in compliance and therefore not subject to the penalty provisions of HITECH. We recognized approximately $88 million and $65 million during the three months ended September 30, 2014 and 2013, respectively, and $212 million and $108 million for the nine months ended September 30, 2014 and 2013, respectively, of incentive reimbursement for HITECH incentive reimbursements from Medicare and Medicaid related to certain of our hospitals and for certain of our employed physicians, which are presented as a reduction of operating expenses.

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 and into the foreseeable future. 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. Furthermore, we continue to benefit from synergies from our acquisitions and will continue to strive to improve operating efficiencies and procedures in order to improve our profitability at all of our hospitals.

Sources of Revenue

The following table presents the approximate percentages of operating revenues, net of contractual allowances and discounts (but before provision for bad debts), by payor source for the periods indicated. The data for the periods presented are not strictly comparable due to the effect that hospital acquisitions have had on these statistics.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Medicare	22.8 %	24.1 %	24.9%	24.9 %
Medicaid	11.6	10.4	10.6	9.9
Managed Care and other third-party payors	52.3	51.6	51.0	51.5
Self-pay	13.3	13.9	13.5	13.7
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 Reform Legislation, currently in effect, has increased and should continue to increase the number of insured patients, which, in turn, has reduced and should continue to reduce revenues from self-pay patients and reduce our provision for bad debts. The Reform Legislation, however, 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 Reform Legislation 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 income (loss) by an insignificant amount in each of the three-month and nine-month periods ended September 30, 2014 and 2013.

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 22, 2014, the Centers for Medicare and Medicaid Services, or CMS, issued the final rule to adjust this index by 2.9% for hospital inpatient acute care services that are reimbursed under the prospective payment system. The final rule also made other payment adjustments that, coupled with the 0.5% multifactor productivity reduction and a 0.2% reduction to hospital inpatient rates implemented pursuant to the Reform Legislation, yielded an estimated net 0.6% decrease in reimbursement for hospital inpatient acute care services beginning October 1, 2014. CMS also implemented new admission and medical review criteria for inpatient services commonly known as the "two midnight rule." Under the rule, Medicare beneficiaries are only to be admitted as inpatients when there is a reasonable expectation that the hospital care is medically necessary and will be required across two midnights, absent unusual circumstances. Compliance with the two midnight rule was required beginning October 1, 2013 and will become subject to Recovery Audit Contractor audits beginning April 1, 2015. 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. After these supplemental programs are signed into law, we recognize 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 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 occurs during the summer months. Accordingly, eliminating the effect of new acquisitions, our net operating revenues and earnings are historically highest during the first quarter and lowest during the third quarter. Same-store operating results include the hospitals acquired in the HMA merger. For the hospitals acquired in the HMA merger, this same-store information reflects the periods from February through September 2014 and 2013 for the nine-month comparisons and from July through September 2014 and 2013 for the three-month comparisons, in each case as if they were owned during both comparable periods. For all hospitals owned throughout both periods, the same-store information reflects the indicated three-month and nine-month periods.

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
	(Expressed as a percentage of net operating revenues)			
Consolidated (a):				
Net operating revenues	100.0 %	100.0 %	100.0 %	100.0 %
Operating expenses (b)	(86.5)	(88.3)	(87.0)	(86.9)
Depreciation and amortization	(5.8)	(6.1)	(6.5)	(6.0)
Income from operations	7.7	5.6	6.5	7.1
Interest expense, net	(5.2)	(4.9)	(5.3)	(4.8)
Loss from early extinguishment of debt	-	-	(0.5)	-
Equity in earnings of unconsolidated affiliates	0.3	0.4	0.3	0.4
Impairment of long-lived assets	-	-	(0.2)	-
Income from continuing operations before income taxes	2.8	1.1	0.8	2.7
Provision for income taxes	(0.8)	(0.2)	(0.1)	(0.8)
Income from continuing operations	2.0	0.9	0.7	1.9
Income (loss) from discontinued operations, net of taxes	-	(0.2)	(0.2)	(0.2)
Net income	2.0	0.7	0.5	1.7
Less: Net income attributable to noncontrolling interests	(0.7)	(0.6)	(0.5)	(0.5)
Net income (loss) attributable to Community Health Systems, Inc. stockholders	1.3 %	0.1 %	- %	1.2 %

	Three Months Ended September 30, 2014	Nine Months Ended September 30, 2014
Percentage increase (decrease) from same period prior year (a):		
Net operating revenues	51.1 %	42.9 %
Admissions	49.0	40.2
Adjusted admissions (c)	53.2	44.4
Average length of stay	-	-
Net income (loss) attributable to Community Health Systems, Inc. (d)	1,450.0	(107.1)
Same-store percentage increase (decrease) from same period prior year (a)(e):		
Net operating revenues	2.8 %	(0.2)%
Admissions	(3.9)	(5.5)
Adjusted admissions (c)	-	(2.1)

(a) We have restated our prior period financial statements and statistical results to reflect the reclassification as discontinued operations for the hospitals held for sale at September 30, 2014.

(b) Operating expenses include salaries and benefits, supplies, other operating expenses, government settlement and related costs, electronic health records incentive reimbursement and rent.

(c) 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.

(d) Includes loss from discontinued operations.

(e) Includes former HMA hospitals for the months of February through September 2014 and 2013 with respect to the above nine-month comparisons and the months of July through September 2014 and 2013 with respect to the above three-month comparisons. For all hospitals owned throughout both periods, the same-store operating results and statistical data reflects the indicated three-month and nine-month periods.

Three Months Ended September 30, 2014 Compared to Three Months Ended September 30, 2013

Net operating revenues increased $1.6 billion to approximately $4.8 billion for the three months ended September 30, 2014, from approximately $3.2 billion for the three months ended September 30, 2013. During the three months ended September 30, 2014, net operating revenues from hospitals acquired in 2014 contributed approximately $1.5 billion and net operating revenues from hospitals owned throughout both periods contributed approximately $0.1 billion to this increase. On a same-store basis, net operating revenues increased 2.8% during the three months ended September 30, 2014. On a consolidated basis, inpatient admissions increased by 49.0% and adjusted admissions increased by 53.2% during the three months ended September 30, 2014. These increases were primarily due to the HMA merger during 2014. On a same-store basis, inpatient admissions decreased by 3.9% and adjusted admissions remained flat during the three months ended September 30, 2014. The increase in same-store net operating revenues was attributable to favorable changes in payor mix with corresponding reductions in charity care and self-pay discounts as a percentage of revenue, offset by the decline in inpatient admissions.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, decreased from 88.3% for the three months ended September 30, 2013 to 86.5% for the three months ended September 30, 2014 primarily due to the changes in operating expenses described below. Salaries and benefits, as a percentage of net operating revenues, decreased from 47.7% for the three months ended September 30, 2013 to 45.7% for the three months ended September 30, 2014. This decrease in salaries and benefits, as a percentage of net operating revenues, was primarily due to elimination of certain of HMA's corporate overhead costs and productivity improvement from integrating HMA into our operations. Supplies, as a percentage of net operating revenues, increased from 15.2% for the three months ended September 30, 2013 to 15.3% for the three months ended September 30, 2014. Other operating expenses, as a percentage of net operating revenues, increased from 22.1% for the three months ended September 30, 2013 to 23.4% for the three months ended September 30, 2014. This increase in other operating expenses, as a percentage of net operating revenues, was primarily due to increases in expenses related to achieving meaningful use compliance and acquisition and integration-related expenses, primarily related to the HMA merger. Government settlement and related costs, as a percentage of net revenues, decreased from 3.1% for the three months ended September 30, 2013 to 1.6% for the three months ended September 30, 2014. Rent, as a percentage of net operating revenues, increased from 2.2% for the three months ended September 30, 2013 to 2.3% for the three months ended September 30, 2014.

Electronic health records incentive reimbursements represent those incentives under the HITECH Act for which the recognition criterion has been met. We recognized approximately $88 million and $65 million of incentive reimbursements, or 1.8% and 2.0% of net operating revenues, for the three months ended September 30, 2014 and 2013, respectively. We received cash payments of $8 million and $23 million for these incentives during the three months ended September 30, 2014 and 2013, respectively. At September 30, 2014, there was no deferred revenue recorded. At September 30, 2013, $53 million was recorded as deferred revenue as all criteria for gain recognition had not been met. Operating expenses, including depreciation and amortization, incurred related to the installation and adoption of electronic health records as a percentage of net operating revenues were 1.0% and 0.8% for the three months ended September 30, 2014 and 2013, respectively, of which depreciation and amortization represented 0.6% and 0.5% of net operating revenues for the three months ended September 30, 2014 and 2013, respectively.

Depreciation and amortization, as a percentage of net operating revenues, decreased from 6.1% for the three months ended September 30, 2013 to 5.8% for the three months ended September 30, 2014. This decrease was due primarily to the impairment and acceleration of depreciation of certain software assets in prior quarters, which reduced the depreciable asset base, as well as a dilutive effect of lower depreciation as a percent of net operating revenues for the acquired and revalued assets of HMA.

Interest expense, net, increased by $96 million from $154 million for the three months ended September 30, 2013, to $250 million for the three months ended September 30, 2014. An increase in our average outstanding debt during 2014, primarily due to the additional debt incurred to acquire HMA, resulted in an increase in interest expense of $110 million. This increase in interest expense was partially offset by a $14 million decrease in interest rates during 2014, compared to 2013, primarily resulting from the expiration of our interest rate swaps during 2014.

Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, decreased from 0.4% for the three months ended September 30, 2013 to 0.3% for the three months ended September 30, 2014.

The net results of the above mentioned changes resulted in income from continuing operations before income taxes increasing $98 million from $35 million for the three months ended September 30, 2013 to $133 million for the three months ended September 30, 2014.

Provision for income taxes from continuing operations increased from $7 million for the three months ended September 30, 2013 to $40 million for the three months ended September 30, 2014 due to the increase in income from continuing operations before income taxes. Our effective tax rates were 29.8% and 20.0% for the three months ended September 30, 2014 and 2013, respectively. The increase in our effective tax rate is primarily impacted by the increase in income from continuing operations before income taxes after adjusting for net income attributable to noncontrolling interests, which increased by a lower percentage and is not tax effected in the statement of income.

Income from continuing operations, as a percentage of net operating revenues, increased from 0.9% for the three months ended September 30, 2013 to 2.0% for the three months ended September 30, 2014.

Net income, as a percentage of net operating revenues, increased from 0.7% for the three months ended September 30, 2013 to 2.0% for the three months ended September 30, 2014.

Net income attributable to noncontrolling interests, as a percentage of net operating revenues, increased from 0.6% for the three months ended September 30, 2013 to 0.7% for the three months ended September 30, 2014.

Net income attributable to Community Health Systems, Inc. was $62 million for the three months ended September 30, 2014, compared to $4 million for the three months ended September 30, 2013. This increase for the three months ended September 30, 2014 was primarily attributable to an increase in operating margins due to decreased operating expenses as discussed above.

Nine Months Ended September 30, 2014 Compared to Nine Months Ended September 30, 2013

Net operating revenues increased approximately $4.2 billion to approximately $13.8 billion for the nine months ended September 30, 2014, from approximately $9.6 billion for the nine months ended September 30, 2013. Net operating revenues from hospitals acquired in 2014 contributed $4.4 billion to this increase, offset by a decrease of $0.2 billion in net operating revenues from hospitals owned throughout both periods. On a same-store basis, net operating revenues decreased 0.2% during the nine months ended September 30, 2014. On a consolidated basis, inpatient admissions increased by 40.2% and adjusted admissions increased by 44.4% during the nine months ended September 30, 2014. These increases were primarily due to the HMA merger during 2014. On a same-store basis, inpatient admissions decreased by 5.5% and adjusted admissions decreased by 2.1% during the nine months ended September 30, 2014. The increase in same-store net operating revenues was attributable to favorable changes in payor mix with corresponding reductions in charity care and self-pay discounts as a percentage of revenue, offset by the decline in inpatient admissions.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, increased from 86.9% for the nine months ended September 30, 2013 to 87.0% for the nine months ended September 30, 2014 primarily due to the changes in operating expenses described below. Salaries and benefits, as a percentage of net operating revenues, decreased from 47.7% for the nine months ended September 30, 2013 to 46.6% for the nine months ended September 30, 2014. This decrease in salaries and benefits, as a percentage of net operating revenues, was primarily due to productivity improvement from integrating HMA into our operations. Supplies, as a percentage of net operating revenues, increased from 15.2% for the nine months ended September 30, 2013 to 15.3% for the nine months ended September 30, 2014. Other operating expenses, as a percentage of net operating revenues, increased from 21.9% for the nine months ended September 30, 2013 to 23.7% for the nine months ended September 30, 2014. This increase in other operating expenses, as a percentage of net operating revenues, was primarily due to increases in expenses related to achieving meaningful use compliance and acquisition and integration-related expenses, primarily related to the HMA merger. Government settlement and related costs, as a percentage of net revenues, decreased from 1.0% for the nine months ended September 30, 2013 to 0.6% for the nine months ended September 30, 2014. Rent, as a percentage of net operating revenues, increased from 2.2% for the nine months ended September 30, 2013 to 2.3% for the nine months ended September 30, 2014.

Electronic health records incentive reimbursements represent those incentives under the HITECH Act for which the recognition criterion has been met. We recognized approximately $212 million and $108 million of incentive reimbursements, or 1.5% and 1.1% of net operating revenues, for the nine months ended September 30, 2014 and 2013, respectively. We received cash payments of $95 million and $105 million for these incentives during the nine months ended September 30, 2014 and 2013, respectively. At September 30, 2014, there was no deferred revenue recorded. At September 30, 2013, $53 million was recorded as deferred revenue as all criteria for gain recognition had not been met. Operating expenses, including depreciation and amortization, incurred related to the installation and adoption of electronic health records as a percentage of net operating revenues were 1.1% and 0.8% for the nine months ended September 30, 2014 and 2013, respectively, of which depreciation and amortization represented 0.5% of net operating revenues for both of the nine-month periods ended September 30, 2014 and 2013.

Depreciation and amortization, including $75 million of amortization of software to be abandoned, as a percentage of net operating revenues, increased from 6.0% for the nine months ended September 30, 2013 to 6.5% for the nine months ended September 30, 2014. This increase was due primarily to the shortening of the remaining useful life of software, which was previously in use with an abandonment date of July 1, 2014.

Interest expense, net, increased by $264 million from $464 million for the nine months ended September 30, 2013, to $728 million for the nine months ended September 30, 2014. An increase in our average outstanding debt during 2014, primarily due to the additional debt incurred to acquire HMA, resulted in an increase in interest expense of $285 million. In addition, an increase in interest expense of $1 million occurred as a result of less interest being capitalized during 2014, as compared to 2013, because the prior year period had more major construction projects. These increases in interest expense were partially offset by a decrease in interest rates during 2014, compared to 2013, which resulted in a decrease in interest expense of $22 million.

The loss from early extinguishment of debt of $73 million was recognized during the nine months ended September 30, 2014 after the repayment of the outstanding term loans under the Credit Facility. The loss from early extinguishment of debt of $1 million was recognized during the nine months ended September 30, 2013 after the repayment of $207 million of the outstanding term loans under the Credit Facility.

Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, decreased from 0.4% for the nine months ended September 30, 2013 to 0.3% for the nine months ended September 30, 2014.

In connection with the HMA merger, we further analyzed our intangible assets related to internal-use software used in certain of our hospitals for patient and clinical systems, including software required to meet criteria for meaningful use attestation and ICD-10 compliance. This analysis resulted in management reassessing its usage of certain software products and rationalizing that, with the addition of the HMA hospitals in the first quarter of 2014, those software applications were going to be discontinued and replaced with new applications that better integrate meaningful use and ICD-10 compliance, are more cost effective and can be implemented at a greater efficiency of scale over future implementations. Because of this decision by management of the Company, an impairment charge of approximately $24 million was recorded during the nine months ended September 30, 2014.

The net results of the above mentioned changes resulted in income from continuing operations before income taxes decreasing $149 million from $258 million for the nine months ended September 30, 2013 to $109 million for the nine months ended September 30, 2014.

Provision for income taxes from continuing operations decreased from $78 million for the nine months ended September 30, 2013 to $16 million for the nine months ended September 30, 2014 due to the decrease in income from continuing operations before income taxes. Our effective tax rates were 14.7% and 30.0% for the nine months ended September 30, 2014 and 2013, respectively. The decrease in our effective tax rate for the nine months ended September 30, 2014 is primarily impacted by the decrease in income from continuing operations before income taxes after adjusting for the increase in net income attributable to noncontrolling interests, which is not tax effected in the statement of income. Adjusting for this impact, our effective tax rate increased from 37.6% for the nine months ended September 30, 2013, to 47.1% for the nine months ended September 30, 2014, primarily due to the impact of non-deductible costs associated with the HMA merger and an increase in the effective tax rate for certain states.

Income from continuing operations, as a percentage of net operating revenues, decreased from 1.9% for the nine months ended September 30, 2013 to 0.7% for the nine months ended September 30, 2014.

Net income, as a percentage of net operating revenues, decreased from 1.7% for the nine months ended September 30, 2013 to 0.5% for the nine months ended September 30, 2014.

Net income attributable to noncontrolling interests, as a percentage of net operating revenues, remained consistent at 0.5% for both of the nine-month periods ended September 30, 2014 and 2013.

Net income attributable to Community Health Systems, Inc. was $113 million for the nine months ended September 30, 2013, compared to a net loss of $8 million for the nine months ended September 30, 2014, a decrease of 107.1%. This decrease for the nine months ended September 30, 2014 was primarily attributable to an increase in operating expenses, including depreciation and amortization, as a percentage of net operating revenues, which were impacted by lower volumes during the nine months, government settlement and related costs, loss from early extinguishment of debt and impairment of long-lived assets, as discussed above.

Liquidity and Capital Resources

Net cash provided by operating activities increased $198 million, from approximately $441 million for the nine months ended September 30, 2013 to approximately $639 million for the nine months ended September 30, 2014. The increase in cash provided by operating activities is a result of the net impact of the decline in net income of $98 million, offset by a $314 million increase to depreciation and amortization and an increase of $93 million in the non-cash charges to income primarily for loss from early extinguishment of debt, the impairment of long-lived assets and hospitals held for sale, and the charge in connection with the agreement in principle to settle claims at our New Mexico hospitals and related costs. Cash from operating activities also had a decline in working capital items of approximately $111 million, net of the effect of acquired balances from the HMA merger. Total cash paid for interest during the nine months ended September 30, 2014 was approximately $661 million and approximately $89 million was received as net refunds for income taxes. Included in net cash provided by operating activities for the nine months ended September 30, 2014 is $95 million of cash received for HITECH incentive reimbursements, compared to $105 million for the nine months ended September 30, 2013.

The cash used in investing activities increased $3.3 billion, from approximately $685 million for the nine months ended September 30, 2013 to approximately $3.9 billion for the nine months ended September 30, 2014. The increase in cash used in investing activities was due to an increase in cash paid for acquisitions of facilities and other related equipment of $3.0 billion as a result of the acquisition of HMA (which owned and operated 71 hospitals at the time of the completion of the HMA merger) and two additional hospitals in the current period compared to no hospital acquisitions in the first nine months of 2013, an increase in the cash used for the purchase of property and equipment of $139 million, the net impact of the purchases and sales of available-for-sale securities of $7 million and an increase in cash used for other investments of $153 million. These increases were offset by an increase in the proceeds from sale of property and equipment of $36 million and the proceeds from disposition of ancillary operations of $12 million. Included in cash outflows for other investments for the nine months ended September 30, 2014 is approximately $227 million of capital expenditures related to the purchase and implementation of certified EHR technology, including implementation of Cerner software at several hospital locations. The remaining cash outflows for other investments consists primarily of purchases and development of other internal-use software and payments made under non-employee physician recruiting agreements of $160 million. We anticipate being able to fund future routine capital expenditures with cash flows generated from operations.

Our net cash provided by financing activities was $3.2 billion for the nine months ended September 30, 2014, compared to a nominal amount of net cash used in financing activities for the nine months ended September 30, 2013. The increase in cash provided by financing activities, in comparison to the prior year, is primarily due to an increase in borrowings of our long-term debt, net of repayments, and the issuance of long-term debt, which was partially offset by payments for deferred financing costs and other debt-related costs, a decrease in proceeds from the receivables facility, and a decrease in proceeds from the exercise of stock options.

Capital Expenditures

Cash expenditures for purchases of facilities and other related equipment were $3.0 billion for the nine months ended September 30, 2014, compared to $34 million for the nine months ended September 30, 2013. The expenditures during the nine months ended September 30, 2014 were primarily related to the purchase price paid by us in the acquisition of HMA (which owned and operated 71 hospitals at the time of the completion of the HMA merger), the acquisition of two additional hospitals, and the purchase of several surgery centers, physician practices and other ancillary services. The expenditures during the nine months ended September 30, 2013 were for the purchase of surgery centers and other physician practices.

Excluding the cost to construct replacement hospitals, our cash expenditures for routine capital for the nine months ended September 30, 2014 totaled $479 million, compared to $379 million for the nine months ended September 30, 2013. These capital expenditures related primarily to the purchase of additional equipment, minor renovations and information systems infrastructure. Costs to construct replacement hospitals for the nine months ended September 30, 2014 totaled $81 million, compared to $42 million for the nine months ended September 30, 2013. The costs to construct replacement hospitals for the nine months ended September 30, 2014 and 2013 represent planning and construction costs for the two replacement hospitals discussed below.

Pursuant to a hospital purchase agreement in effect as of September 30, 2014, we have committed to build a replacement facility in York, Pennsylvania by July 2017. Construction costs, including equipment costs, for the York replacement facility are currently estimated to be approximately $100 million. In addition, in October 2008, after the purchase of the noncontrolling owner's interest in our Birmingham, Alabama facility, we initiated the purchase of a site, which includes a partially constructed hospital structure, for a potential replacement to our existing Birmingham facility. In September 2010, we received approval of our request for a certificate of need, or CON, from the Alabama Certificate of Need Review Board. This CON was challenged in the Alabama state circuit and appellate courts, but the CON was upheld by the Supreme Court of Alabama in May 2013, eliminating any further appeals. Our estimated construction costs, including the acquisition of the site and equipment costs, are approximately $280 million for the Birmingham replacement facility.

Capital Resources

Net working capital was approximately $2.2 billion at September 30, 2014, compared to $1.3 billion at December 31, 2013, an increase of $903 million, primarily due to the net working capital acquired from the HMA merger with the remainder primarily attributable to an increase in accounts receivable and a decrease in accounts payable due to timing of collections and payments.

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. Prior to the HMA merger, this credit facility included a $750 million term loan A facility due October 25, 2016, a term loan B due July 25, 2014, a term loan C due January 25, 2017 and a $750 million revolving credit facility for working capital and general corporate purposes.

In connection with the HMA merger on January 27, 2014, CHS entered into a third amendment and restatement, or the Amendment, of its existing credit agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010 and as of February 2, 2012, among the Parent Company, CHS, the lenders party thereto and Credit Suisse AG, as administrative agent and collateral agent. The Amendment provides for (i) the replacement of the revolving credit facility with a new $1.0 billion revolving facility maturing in 2019, or the Revolving Facility, (ii) the addition of a new $1.0 billion Term A facility due 2019, or the Term A Facility, (iii) a Term D facility in an aggregate principal amount equal to $4.6 billion due 2021 (which includes certain term C loans that were converted into such Term D facility (collectively, the Term D Facility), (iv) the conversion of certain term C loans into Term E Loans and the borrowing of new Term E Loans in an aggregate principal amount of $1.7 billion and (v) the addition of flexibility commensurate with our post-acquisition structure. In addition to funding a portion of the consideration in connection with the HMA merger, some of the proceeds of the Term A Facility and Term D Facility were used to refinance the outstanding $637 million existing Term A facility due 2016 and the $60 million of term B loans due 2014, respectively. The Revolving Facility also 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 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 Federal Funds Effective Rate (as defined) plus 0.5% 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. Loans in respect of the Revolving Facility and the Term A Facility will accrue interest at a rate per annum initially 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. In addition, the margin in respect of the Revolving Facility and the Term A Facility will be subject to adjustment determined by reference to a leverage-based pricing grid. Loans in respect of the Term D Facility and the Term E Facility will accrue interest at a rate per annum 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 Borrowings. The Term D Facility will be subject to a 1.00% LIBOR floor and a 2.00% Alternate Base Rate floor.

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, (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) 50%, subject to reduction to a lower percentage based on our leverage ratio (as defined in the Credit Facility generally as the ratio of total debt on the date of determination to our 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 obligor under the Credit Facility is 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.

We have agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to Eurodollar rate loans 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 exception, 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 secured net leverage ratio and an interest coverage ratio) and various affirmative covenants.

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 a grace period, (4) bankruptcy 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, (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.

As of September 30, 2014, the availability for additional borrowings under our Credit Facility was $1.0 billion pursuant to the Revolving Facility, of which $83 million was set aside for outstanding letters of credit. We believe that these funds, along with internally generated cash and continued access to the bank credit and capital markets, will be sufficient to finance future acquisitions, capital expenditures and working capital requirements through the next 12 months and into the foreseeable future.

In connection with the consummation of the HMA merger, CHS issued: (i) $1.0 billion aggregate principal amount of 5.125% Senior Secured Notes due 2021, or the 2021 Senior Secured Notes, pursuant to an indenture, as supplemented, dated as of January 27, 2014, collectively, the Secured Indenture, by and among CHS, the Parent Company, the other guarantors from time to time party thereto, Regions Bank, as trustee, and Credit Suisse AG, as collateral agent, or the Collateral Agent and (ii) $3.0 billion aggregate principal amount of 6.875% Senior Notes due 2022, or the 6 7⁄8% Senior Notes, pursuant to an indenture, as supplemented, dated as of January 27, 2014, collectively, the Unsecured Indenture, by and among CHS, the Parent Company, the other guarantors from time to time party thereto, and Regions Bank, as trustee, or the Unsecured Indenture.

The 2021 Senior Secured Notes are senior secured obligations of CHS and are guaranteed on a senior secured basis by us, CHS and certain of CHS's subsidiaries. The 2021 Senior Secured Notes mature on August 1, 2021, and bear interest at a rate of 5.125% per annum, payable semi-annually in arrears in cash on February 1 and August 1 of each year, beginning on August 1, 2014. CHS is entitled to redeem some or all of the 2021 Senior Secured Notes at any time on or after February 1, 2017 at the redemption prices set forth in the Secured Indenture, plus accrued and unpaid interest, if any. In addition, prior to February 1, 2017, CHS may redeem some or all of the 2021 Senior Secured Notes at a price equal to 100% of the principal amount thereof, plus accrued and unpaid interest, if any, plus a "make-whole" premium, as set forth in the Secured Indenture. CHS is entitled to redeem up to 40% of the aggregate principal amount of the 2021 Senior Secured Notes until February 1, 2017 with the net proceeds from certain equity offerings at the redemption price set forth in the Secured Indenture. The Secured Indenture also contains covenants that, among other things, subject to various qualifications and exceptions, limit the ability of CHS and certain of CHS's subsidiaries to: incur or guarantee additional indebtedness; pay dividends or make other restricted payments; make certain investments; create or incur certain liens; sell assets and subsidiary stock; transfer all or substantially all of their assets or enter into merger or consolidation transactions; and enter into transactions with affiliates.

The 6 7/8% Senior Notes are senior unsecured obligations of CHS and are guaranteed on a senior basis by the Parent Company, CHS and certain of CHS's subsidiaries. The 6 7/8% Senior Notes mature on February 1, 2022, and bear interest at a rate of 6.875% per annum, payable semi-annually in arrears in cash on February 1 and August 1 of each year, beginning on August 1, 2014. CHS is entitled to redeem some or all of the 6 7/8% Senior Notes at any time on or after February 1, 2018 at the redemption prices set forth in the Unsecured Indenture, plus accrued and unpaid interest, if any. In addition, prior to February 1, 2018, CHS may redeem some or all of the 6 7/8% Senior Notes at a price equal to 100% of the principal amount thereof, plus accrued and unpaid interest, if any, plus a "make-whole" premium, as set forth in the Unsecured Indenture. CHS is entitled to redeem up to 40% of the aggregate principal amount of the 6 7/8% Senior Notes until February 1, 2017 with the net proceeds from certain equity offerings at the redemption price set forth in the Unsecured Indenture. The Unsecured Indenture also contains covenants that, among other things, subject to various qualifications and exceptions, limit the ability of CHS, and certain of its subsidiaries to: incur or guarantee additional indebtedness; pay dividends or make other restricted payments; make certain investments; create or incur certain liens; sell assets and subsidiary stock; transfer all or substantially all of their assets or enter into merger or consolidation transactions; and enter into transactions with affiliates.

On March 21, 2012, CHS completed the secondary offering of $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, to pay related fees and expenses and for general corporate purposes. On March 21, 2012, CHS completed the cash tender offer for $850 million of the then $1.8 billion aggregate outstanding principal amount of 8 7/8% Senior Notes.

On July 18, 2012, CHS completed an underwritten public offering under our automatic shelf registration filed with the SEC of $1.2 billion aggregate principal amount of 7 1/8% Senior Notes due 2020. The net proceeds of the offering were used to finance the purchase or redemption of the then outstanding $934 million principal amount plus accrued interest of the 8 7/8% Senior Notes, to pay for consents delivered in connection therewith, to pay related fees and expenses, and for general corporate purposes.

On August 17, 2012, CHS completed an underwritten public offering under our automatic shelf registration filed with the SEC of $1.6 billion aggregate principal amount of 5 1/8% Senior Secured Notes due 2018. The 5 1/8% 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 indenture governing the 5 1/8% Senior Secured Notes on substantially the same assets, subject to certain exceptions, that secure CHS' obligations under the Credit Facility. The net proceeds of the offering, together with available cash on hand, were used to finance the prepayment of $1.6 billion of the outstanding term loans due 2014 under the Credit Facility and related fees and expenses.

On March 21, 2012, through certain of its subsidiaries, CHS entered into 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, and The Bank of Nova Scotia, as a managing agent. On March 7, 2013, CHS and certain of its subsidiaries amended the Receivables Facility to add an additional managing agent, The Bank of Tokyo-Mitsubishi UFJ, Ltd., to increase the size of the facility from $300 million to $500 million and to extend the scheduled termination date. Additional subsidiaries also agreed to participate in the Receivables Facility as of that date. On March 31, 2014, CHS and certain of its subsidiaries amended the Receivables Facility to increase the size of the facility from $500 million to $700 million and to extend the scheduled termination date. Additional subsidiaries also agreed to participate in the Receivables Facility as of that date. The existing and future non-self pay patient-related accounts receivable, or the Receivables, for certain hospitals of CHS and its subsidiaries serve as collateral for the outstanding borrowings under the Receivables Facility. The interest rate on the borrowings is based on the commercial paper rate plus an applicable interest rate spread. Unless earlier terminated or subsequently extended pursuant to its terms, the Receivables Facility will expire on March 21, 2016, subject to customary termination events that could cause an early termination date. CHS maintains effective control over the Receivables because, pursuant to the terms of the Receivables Facility, the Receivables are sold from certain of CHS' subsidiaries to CHS, and CHS then sells or contributes the Receivables to a special-purpose entity that is wholly-owned by CHS. The wholly-owned special-purpose entity in turn grants security interests in the Receivables in exchange for borrowings obtained from the group of third-party lenders and banks of up to $700 million outstanding from time to time based on the availability of eligible Receivables and other customary factors. The group of third-party lenders and banks do not have recourse to CHS or its subsidiaries beyond the assets of the wholly-owned special-purpose entity that collateralizes the loan. The Receivables and other assets of the wholly-owned special-purpose entity will be available first and foremost to satisfy the claims of the creditors of such entity. The outstanding borrowings pursuant to the Receivables Facility at September 30, 2014 totaled $660 million and are classified as long-term debt on the condensed consolidated balance sheet. At September 30, 2014, the carrying amount of Receivables included in the Receivables Facility totaled approximately $1.3 billion and is included in patient accounts receivable on the condensed consolidated balance sheet.

As of September 30, 2014, we are currently a party to the following interest rate swap agreements to limit the effect of changes in interest rates on approximately 19.1% 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. We currently pay, on a quarterly basis, interest on the Revolving Facility and the Term A Facility at a rate per annum equal to LIBOR plus 275 basis points. Loans in respect of the Term D Facility and the Term E Facility accrue interest at a rate per annum equal to LIBOR plus 325 basis points. The Term D Facility is also subject to a 100 basis point LIBOR floor and a 200 basis point Alternate Base Rate floor.

Swap #	Notional Amount (in millions)	Fixed Interest Rate	Termination Date	Fair Value of Liability (in millions)
1	$ 200	2.693 %	October 26, 2014	$ -
2	300	3.447 %	August 8, 2016	15
3	200	3.429 %	August 19, 2016	10
4	100	3.401 %	August 19, 2016	5
5	200	3.500 %	August 30, 2016	10
6	100	3.005 %	November 30, 2016	5
7	200	2.055 %	July 25, 2019	2
8	200	2.059 %	July 25, 2019	2
9	200	2.613 %	August 30, 2019	1 (1)
10	200	2.515 %	August 30, 2019	1 (2)
11	300	2.892 %	August 30, 2020	4 (3)
12	300	2.738 %	August 30, 2020	2 (4)

(1) This interest rate swap becomes effective August 30, 2015.
(2) This interest rate swap becomes effective August 28, 2015.
(3) This interest rate swap becomes effective August 30, 2015.
(4) This interest rate swap becomes effective August 28, 2015.

The swaps that were in effect prior to the HMA merger remain in effect after the refinancing for the HMA merger and will continue to be used to limit the effects of changes in interest rates on portions of our amended credit facility.

The Credit Facility and/or the Notes contain various covenants that limit our ability to take certain actions including; among other things, 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 investments;
- redeem debt that is junior in right of payment to the Notes;
- create liens without securing the Notes;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- enter into agreements that restrict dividends from subsidiaries;
- merge, consolidate, sell or otherwise dispose of substantial portions of our assets;
- enter into transactions with affiliates and
- guarantee certain obligations.

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 Notes. Upon the occurrence of an event of default under our Credit Facility or the Notes, all amounts outstanding under our Credit Facility and the 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 $1.0 billion (consisting of a $1.0 billion Revolving Facility, of which $83 million is set aside for outstanding letters of credit) and our ability to amend the Credit Facility to provide for one or more tranches of term loans in an aggregate principal amount of $1.5 billion, and our continued access to the bank credit and capital markets will be sufficient to finance acquisitions, capital expenditures and working capital requirements through the next 12 months. We believe these same sources of cash, borrowings under our Credit Facility as well as access to bank credit and capital markets will be available to us beyond the next 12 months and into the foreseeable future.

On May 24, 2012, we filed a universal automatic shelf registration statement on Form S-3ASR, as amended on June 7, 2012, that will permit us, from time to time, in one or more public offerings, to offer debt securities, common stock, preferred stock, warrants, depositary shares, or any combination of such securities. The shelf registration statement will also permit our subsidiary, CHS, to offer debt securities that would be guaranteed by us, from time to time in one or more public offerings. The terms of any such future offerings would be established at the time of the offering.

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, 2014:

	Nine Months Ended September 30, 2014
Ratio of earnings to fixed charges (1)	1.11 x

(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 12.1 filed as part of this Report for the calculation of this ratio.

Off-balance Sheet Arrangements

Our consolidated operating results for the nine months ended September 30, 2014 and 2013, included $86 million and $85 million, respectively, of net operating revenues generated from two hospitals operated by us under operating lease arrangements at September 30, 2014. In addition, income from continuing operations with respect to these operating lease arrangements included $8 million for both of the nine-month periods ended September 30, 2014 and 2013. In accordance with accounting principles generally accepted in the United States of America, or U.S. GAAP, the respective assets and the future lease obligations under these arrangements are not recorded on our condensed consolidated balance sheet. Lease costs under these arrangements are included in rent expense and totaled approximately $5 million for both of the nine-month periods ended September 30, 2014 and 2013. The current terms of these operating leases expire between December 2020 and June 2022, not including lease extension options. If we allow these leases to expire, we would no longer generate revenues nor incur expenses from these hospitals.

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.

Noncontrolling Interests

We have sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. In conjunction with the HMA merger, we acquired 29 hospitals containing minority ownership interests ranging from less than 1% to 40%. We do not believe the minority ownership interests acquired in the HMA merger are material to our financial position or results of operations. As of September 30, 2014, we have hospitals in 37 of the markets we serve, with noncontrolling physician ownership interests ranging from less than 1% to 40%, including two hospitals that also have a non-profit entity as a partner. In addition, we have 14 other hospitals with noncontrolling interests owned by non-profit entities. Redeemable noncontrolling interests in equity of consolidated subsidiaries was $695 million and $358 million as of September 30, 2014 and December 31, 2013, respectively, and noncontrolling interests in equity of consolidated subsidiaries was $88 million and $64 million as of September 30, 2014 and December 31, 2013, respectively. The amount of net income attributable to noncontrolling interests was $32 million and $18 million for the three months ended September 30, 2014 and 2013, respectively, and $75 million and $52 million for the nine months ended September 30, 2014 and 2013, respectively. As a result of the change in the Stark Law “whole hospital” exception included in the Reform Legislation, we are not permitted to introduce physician ownership at any of our wholly-owned hospital facilities or increase the aggregate percentage of physician ownership in any of our existing hospital joint ventures in excess of the aggregate physician ownership level held at the time of the adoption of the Reform Legislation.

Reimbursement, Legislative and Regulatory Changes

Ongoing legislative and regulatory efforts could reduce or otherwise adversely affect the payments we receive from Medicare and Medicaid. Within the statutory framework of the Medicare and Medicaid programs, including programs currently unaffected by the Reform Legislation, 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 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 as a result of the Reform Legislation.

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.

Third-party Reimbursement

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 automatically calculated and recorded through our internally developed "automated contractual allowance system." Within the automated system, actual Medicare DRG data and 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 we deduct from gross revenues to arrive at 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 and historical paid claims data. 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, 2014 from our estimated reimbursement percentage, net loss for the nine months ended September 30, 2014 would have changed by approximately $63 million, and net accounts receivable at September 30, 2014 would have changed by $118 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 income (loss) by an insignificant amount in each of the three-month and nine-month periods ended September 30, 2014 and 2013.

Allowance for Doubtful Accounts

Substantially all of our accounts receivable are related to providing healthcare services to our hospitals' patients. 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. At the point of service, for patients required to make a co-payment, we generally collect less than 15% of the related revenue. 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 the allowance for doubtful accounts 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. For all other non-self-pay payor categories, we reserve 100% of all accounts aging over 365 days from the date of discharge. 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.

Collections are impacted by the economic ability of patients to pay and the effectiveness of our collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect our collection of accounts receivable. The process of estimating the allowance for doubtful accounts requires us to estimate the collectability of self-pay accounts receivable, which is primarily based on our collection history, adjusted for expected recoveries and any anticipated changes in collection trends. Significant change in payor mix, business office operations, economic conditions, trends in federal and state governmental healthcare coverage or other third-party payors could affect our estimates of accounts receivable collectability. If the actual collection percentage differed by 1% at September 30, 2014 from our estimated collection percentage as a result of a change in expected recoveries, net loss for the nine months ended September 30, 2014 would have changed by $37 million, and net accounts receivable at September 30, 2014 would have changed by $69 million. We also continually review our overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net revenue less provision for bad debts, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding 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 $3.8 billion and $3.0 billion at September 30, 2014 and December 31, 2013, respectively, 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 gross accounts receivable or our allowance for doubtful accounts. Collections on amounts previously written-off are recognized as a reduction to bad debt expense when received. However, we take into consideration estimated collections of these future amounts written-off in evaluating the reasonableness of our allowance for doubtful accounts.

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

Patient accounts receivable from our hospitals represent approximately 95% of our total consolidated accounts receivable.

Days revenue outstanding was 62 days at September 30, 2014 and 67 days at December 31, 2013. Our target range for days revenue outstanding is from 53 to 63 days.

Total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) was approximately $17.9 billion as of September 30, 2014 and approximately $10.9 billion as of December 31, 2013.

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

	September 30, 2014	December 31, 2013
Insured receivables	62.4 %	59.8 %
Self-pay receivables	37.6	40.2
Total	100.0 %	100.0 %

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 at the same time every year 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. There is a two-step method for determining goodwill impairment. Step one is to compare the fair value of the reporting unit with the unit's carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit's goodwill with the carrying value of the reporting unit's goodwill. We performed our last annual goodwill evaluation during the fourth quarter of 2013. No impairment was indicated by this evaluation. The next annual goodwill evaluation will be performed during the fourth quarter of 2014.

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

Professional Liability Insurance for the Hospitals Acquired in the HMA Merger. Reserves for self-insured professional liability indemnity claims and related expenses, including attorneys' fees and other related costs of litigation that have been incurred and will be incurred in the future, are determined using actuarially-based techniques and methodologies. The data used to develop such reserves is based on asserted and unasserted claim information that has been accumulated by our incident reporting system, historical loss payment patterns and industry trends. Such long-term liabilities have been discounted to their estimated present values. Management selects a discount rate that represents a risk-free interest rate correlating to the period when the claims are projected to be paid. We use a wholly-owned captive insurance subsidiary and a risk retention group subsidiary which were acquired during the HMA merger and are domiciled in the Cayman Islands and South Carolina, respectively, to self-insure a significant portion of our professional liability risks for the hospitals acquired in the HMA merger. Those insurance subsidiaries, which are collectively referred to as the "Insurance Subsidiaries," provide (i) claims-made coverage to all of the hospitals and other healthcare facilities acquired in the HMA merger and (ii) occurrence-basis coverage to most of the physicians employed by the hospitals and other healthcare facilities acquired in the HMA merger. The employed physicians not covered by the Insurance Subsidiaries generally maintain claims-made policies with unrelated third party insurance companies. To mitigate the exposure of the program covering the hospitals and other healthcare facilities acquired in the HMA merger, the Insurance Subsidiaries buy 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 June 1, 2014, the claims-made policy for the hospitals acquired in the HMA merger and the occurrence-based policy for most of the physicians employed by the hospitals and other healthcare facilities acquired in the HMA merger were canceled. Such hospitals and physicians are now covered through the Company's existing professional liability program that is described below.

Professional Liability Insurance for All Other Community Health Systems Hospitals. 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 approximately a 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 1.6%, 1.2% and 1.2% in 2013, 2012 and 2011, 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 income.

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 four and five 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 less than 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 Triad Hospitals, Inc., or Triad, 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 are self-insured up to $10 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 incurred and reported after January 1, 2008 and up to $195 million per occurrence and in the aggregate for claims reported after June 1, 2010. 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.

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 Holdings, Inc., or 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 have been no significant changes in our estimate of the reserve for professional liability claims during the three and nine months ended September 30, 2014.

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 $13 million as of September 30, 2014. A total of approximately $8 million of interest and penalties is included in the amount of liability for uncertain tax positions at September 30, 2014. It is our policy to recognize interest and penalties related to unrecognized benefits in our condensed consolidated statements of income 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 limitations and settlements with taxing authorities; however, we do not anticipate the change will have a material impact on our consolidated results of operations or consolidated financial position.

We, or one or more of our subsidiaries, file income tax returns in the United States federal jurisdiction and various state jurisdictions. We have extended the federal statute of limitations through December 31, 2013 for Triad for the tax periods ended December 31, 1999, December 31, 2000, April 30, 2001, June 30, 2001, December 31, 2001, December 31, 2002, December 31, 2003, December 31, 2004, December 31, 2005, December 31, 2006 and July 25, 2007. With few exceptions, we are no longer subject to state income tax examinations for years prior to 2009. Our federal income tax returns for the 2009 and 2010 tax years are currently under examination by the Internal Revenue Service, or IRS. We believe the results of these examinations will not be material to our consolidated results of operations or consolidated financial position. During the year ended December 31, 2013, the IRS concluded its examination of the federal tax return of Community Health Systems, Inc. for the tax periods ended December 31, 2007 and 2008. The results of these examinations did not have a material effect on our consolidated results of operations or consolidated financial position. We have extended the federal statute of limitations through December 31, 2014 for Community Health Systems, Inc. for the tax periods ended December 31, 2007 and 2008, and through June 30, 2015 for the tax periods ended December 31, 2009 and 2010.

Recent Accounting Pronouncements

In April 2014, the Financial Accounting Standards Board issued Accounting Standards Update, or ASU, 2014-08, which changes the requirements for reporting discontinued operations. A discontinued operation continues to include a component of an entity or a group of components of an entity, or a business activity. However, in a shift reflecting stakeholder concerns that too many disposals of small groups of assets that are recurring in nature qualified for reporting as discontinued operations, a disposal of a component of an entity or a group of components of an entity will be required to be reported in discontinued operations if the disposal represents a strategic shift that has (or will have) a major effect on an entity's operations and financial results. A business or nonprofit activity that, on acquisition, meets the criteria to be classified as held for sale will still be a discontinued operation. Additional disclosures will be required for significant components of the entity that are disposed of or are held for sale but do not qualify as discontinued operations. This ASU is effective for fiscal years beginning after December 15, 2014 and is to be applied on a prospective basis for disposals or components initially classified as held for sale after that date. We will adopt this ASU on January 1, 2015 and are currently evaluating the impact on our consolidated financial position, results of operations and cash flows.

In May 2014, the Financial Accounting Standards Board issued ASU 2014-09, which outlines a single comprehensive model for recognizing revenue and supersedes most existing revenue recognition guidance, including guidance specific to the healthcare industry. This ASU provides companies the option of applying a full or modified retrospective approach upon adoption. This ASU is effective for fiscal years beginning after December 15, 2016. Early adoption is not permitted. We will adopt this ASU on January 1, 2017 and are currently evaluating our plan for adoption and the impact on our revenue recognition policies, procedures and control framework and the resulting impact on our consolidated financial position, results of operations and cash flows.

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 the following:

- general economic and business conditions, both nationally and in the regions in which we operate,
- implementation and effect of adopted and potential federal and state healthcare reform legislation and other federal, state or local laws or regulations affecting the healthcare industry,
- the extent to which states support increases, decreases or changes in Medicaid programs, implement healthcare exchanges or alter the provision of healthcare to state residents through regulation or otherwise,
- risks associated with our substantial indebtedness, leverage and debt service obligations,

- 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 managed care provider arrangements and the terms of these arrangements,
- changes in, or the failure to comply with, managed care provider contracts, which could result in, among other things, disputes and changes in reimbursements, both prospectively and retroactively,
- changes in inpatient or outpatient Medicare and Medicaid payment levels,
- 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,
- the efforts of insurers, healthcare providers and others to contain healthcare costs,
- our ongoing ability to demonstrate meaningful use of certified electronic health record technology and recognize income for the related Medicare or Medicaid incentive payments,
- increases in wages as a result of inflation or competition for highly technical positions and rising supply 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 additional acquisitions or replacement facilities or other capital expenditures,
- our ability to successfully make acquisitions or complete divestitures,
- our ability to successfully integrate any acquired hospitals, including those of HMA, or to recognize expected synergies from acquisitions,
- the impact of the acquisition of HMA on third-party relationships,
- the impact of seasonal severe weather conditions,
- 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, including Ebola,
- the impact of the external, criminal cyber-attack suffered by us in the second quarter of 2014, including potential reputational damage, the outcome of our investigation and any potential governmental inquiries, the outcome of litigation filed against us in connection with this cyber-attack, and the extent of remediation costs and additional operating or other expenses that we may continue to incur, and
- the other risk factors set forth in our annual report on Form 10-K for the year ended December 31, 2013 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 the control of the Company. Accordingly, the Company cannot give any assurance that its expectations will in fact occur and cautions 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. The Company undertakes 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 described under the heading "Liquidity and Capital Resources" in Part I, Item 2 of this Quarterly Report on Form 10-Q. 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 interest rate swap agreements expire throughout the year, we will become more subject to variable interest rates during 2014.

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 $16 million and $5 million for the three months ended September 30, 2014 and 2013, respectively, and $42 million and $14 million for the nine months ended September 30, 2014 and 2013, 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, or the Exchange Act), 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 disclosed by the Company in the reports that it files or submits under the Exchange Act is 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 disclosed by the Company in the reports that it files or submits under the Exchange Act is accumulated and communicated to management, including our Chief Executive Officer and Chief Financial Officer, to allow timely decisions regarding required disclosure.

Following the completion of the HMA merger on January 27, 2014, we have been in the process of analyzing the systems of disclosure controls and procedures and internal controls over financial reporting of the HMA hospitals and other operations, and have been integrating them within our broader framework of controls. Since the SEC's rules allow us to exclude these acquired hospitals and operations from our internal controls assessment and evaluation of disclosure controls that are subsumed by such internal controls in respect of periods ending on or prior to the first anniversary of the HMA merger, we have excluded HMA's operations from our evaluation of such disclosure controls, and changes in our internal controls, for the period covered by this report. We plan to complete this evaluation and integration within the required SEC time frame and report any changes in internal controls in our first annual report in which our assessment of internal controls with respect to the acquired operations of HMA is included.

There are no changes in our internal control over financial reporting that occurred during the quarter ended September 30, 2014 that have materially affected or are reasonably likely to materially affect our internal control 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 and the Department of Justice regarding various Medicare and Medicaid issues. In addition to the subpoenas discussed below, we are currently responding to subpoenas and administrative demands concerning certain cardiology procedures, medical records and policies at a New Mexico hospital, a civil investigative demand concerning cardiology devices at a Pennsylvania hospital, a request for medical records at an Arizona hospital regarding transfers to a higher level of care and a request for medical records concerning dialysis treatment at a Virginia hospital. In addition, we are subject to other claims and lawsuits arising in the ordinary course of our business. Some pending or threatened proceedings against us may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. 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. Also, 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, these matters may be relevant to security holders. Certain of the matters are also discussed under Footnote 16 "Contingencies."

Community Health Systems, Inc. Legal Proceedings

U.S. ex rel. Baker vs. Community Health Systems, Inc. (United States District Court for the District of New Mexico)

Our knowledge of this matter originated in early 2006 with correspondence from the Civil Division of the Department of Justice requesting documents in an investigation it was conducting involving the Company. The inquiry related to the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients. These programs are referred to by different names, including "intergovernmental payments," "upper payment limit programs," and "Medicaid disproportionate share hospital payments." For approximately three years, we provided the Department of Justice with requested documents, met with its personnel on numerous occasions and otherwise cooperated in its investigation. During the course of the investigation, the Civil Division notified us that it believed that we and three of our New Mexico hospitals caused the State of New Mexico to submit improper claims for federal funds, in violation of the Federal False Claims Act. This investigation has culminated in the federal government's intervention in the referenced qui tam lawsuit, which alleges that our New Mexico hospitals "caused to be filed" false claims from the period of August 2000 through June 2011. Two of the Parent Company's subsidiaries are also defendants in this lawsuit. We have now reached an agreement in principle to settle this matter. We believe a reserve of $75 million is sufficient to cover the claims made in this matter. This reserve does not include the legal fees of the relator's counsel. We are discussing with the Office of the Inspector General of the Department of Health and Human Services whether a corporate integrity agreement will be required.

Multi-provider National Department of Justice Investigations

Kyphoplasty. Kyphoplasty is a surgical spine procedure that returns a compromised vertebra (either from trauma or osteoporotic disease process) to its previous height, reducing or eliminating severe pain. We were first made aware of this investigation in June 2008, when two of our hospitals received document request letters from the United States Attorney's Office for the Western District of New York. Subsequently, additional hospitals (a total of five) also received requests for documents and/or medical records. The investigation covers the period of January 1, 2002 through June 9, 2008. This investigation is part of a national investigation and is related to a qui tam settlement between the same United States Attorney's office and the manufacturer and distributor of the Kyphon product, which is used in performing the kyphoplasty procedure. We are cooperating with the investigation and we are continuing to evaluate and discuss this matter with the federal government.

Implantable Cardioverter Defibrillators (ICDs). We were first made aware of this investigation in September 2010, when we received a letter from the Civil Division of the United States Department of Justice. The letter advised us that an investigation was being conducted to determine whether certain hospitals have improperly submitted claims for payment for ICDs. The period of time covered by the investigation was 2003 to 2010. We continue to fully cooperate with the government in this investigation and have provided requested records and documents. On August 30, 2012, the Department of Justice issued a document entitled, "Medical Review Guidelines/Resolution Model," which sets out, for the purposes of this investigation, the patient conditions and criteria for the medical necessity of the implantation of ICDs in Medicare beneficiaries and how the Department of Justice will enforce the repayment obligations of hospitals. We are in the process of reviewing our medical records in light of the guidance contained in this document.

Department of Justice Settlement – ED Short Stay Admissions. On August 4, 2014, we announced that we had entered into a civil settlement agreement with the U.S. Department of Justice, other federal agencies and identified relators that concluded previously announced investigations and litigation related to short stay admissions through emergency departments at certain of our affiliated hospitals. The settlement concluded the government's review into whether these 119 hospitals billed Medicare, Medicaid and TRICARE for certain inpatient admissions from January 2005 to December 2010 that the government contended should have been billed as outpatient or observation cases. Under the terms of the settlement agreement, there was no finding of improper conduct by us or our affiliated hospitals, and we denied any wrongdoing. We have paid approximately $88 million in resolution of all federal government claims, including Medicare, TRICARE and the federal share of the Medicaid claims, and an additional approximately $1 million to the states for their portions of the Medicaid claims. The settlement also covered the dismissal of specified litigation.

Further, the settlement resolved the government's investigation into a hospital affiliated with us in Laredo, Texas. The government's review in Laredo centered on whether the hospital submitted claims for inpatient procedures that should have been billed as outpatient procedures as well as the financial relationship between the hospital and a member of its medical staff. The hospital has paid $9 million to resolve this investigation.

As part of the settlement, we entered into a five-year Corporation Integrity Agreement, or CIA, with the Office of Inspector General of the U.S. Department of Health and Human Services. The CIA will be incorporated into our existing and comprehensive compliance program. The CIA establishes general and specialized training requirements and mandates that we retain independent review organizations to review the adequacy of our claims for inpatient services furnished to federal health care program beneficiaries. The CIA also includes Laredo-specific reviews of physician financial relationships.

The settlement will also result in the unsealing and dismissal of qui tam actions filed in Illinois, Tennessee, North Carolina and Texas, as well as the previously unsealed case in Indiana. Two of these cases also name HMA as defendants and were partially unsealed in December 2013 when the government intervened in those and six other cases pending against HMA. Certain of the relators' claims for attorneys' fees remain to be resolved. We previously established a $102 million reserve to cover these settlements and related legal costs of which approximately $98 million has been paid as summarized above.

SEC Subpoena. In May 2011, we received a subpoena from the SEC requesting documents related to or requested in connection with the various inquiries, lawsuits and investigations regarding, generally, emergency room admissions or observation practices at our hospitals. The subpoena also requested documents relied upon by us in responding to the Tenet litigation, as well as other communications about the Tenet litigation. On October 22, 2014, we were notified that the SEC had closed its investigation.

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. Our motion to dismiss this case has been fully briefed and is pending before the court. We believe this consolidated matter is without merit and will vigorously defend this case.

Shareholder Derivative Actions. Three purported shareholder derivative actions have also been filed in the United States District Court for the Middle District of Tennessee; Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund v. Wayne T. Smith, et al., filed May 24, 2011; Roofers Local No. 149 Pension Fund v. Wayne T. Smith, et al., filed June 21, 2011; and Lambert Sweat v. Wayne T. Smith, et al., filed October 5, 2011. These three cases allege breach of fiduciary duty arising out of allegedly improper inpatient admission practices, mismanagement, waste and unjust enrichment. These cases have been consolidated into a single, consolidated action. The plaintiffs filed an operative amended derivative complaint in these three consolidated actions on March 15, 2012. Our motion to dismiss was argued on June 13, 2013. On September 27, 2013, the court issued an order granting in part and denying in part our motion to dismiss. On October 14, 2013, we filed for a Motion for Reconsideration of the Order Granting in Part and Denying in Part the Motion to Dismiss, a Motion to Stay Discovery, and an unopposed Motion for Extension of Time to File an Answer. Our motion to stay was denied and our motion for reconsideration is still pending. We believe all of the plaintiffs' claims are without merit and will vigorously defend them.

Other Government Investigations

Easton, Pennsylvania – Urologist. On June 13, 2011, our hospital in Easton, Pennsylvania received a document subpoena from the Philadelphia office of the United States Department of Justice. The documents requested included medical records for certain urological procedures performed by a non-employed physician who is no longer on the medical staff and other records concerning the hospital's relationship with the physician. Certain procedures performed by the physician had been previously reviewed and appropriate repayments had been made. We are cooperating fully with the government in this investigation.

Hattiesburg, Mississippi – Allegiance Health Management, Inc. On February 23, 2012, our hospital in Hattiesburg, Mississippi received a document subpoena from OIG relating to its relationship with Allegiance Health Management, Inc., or Allegiance, a company that provides intensive outpatient psychiatric, or IOP, services to its patients. The subpoena seeks information concerning the hospital's financial relationship with Allegiance, medical records of patients receiving IOP services, and other documents relating to Allegiance such as agreements, policies and procedures, audits, complaints, budgets, financial analyses and identities of those delivering services. We are cooperating fully with this investigation.

Qui Tam Cases – Government Declined Intervention

On June 2, 2011, an order was entered unsealing a relator's qui tam complaint in the matter of *U.S. ex rel. Wood M. Deming, MD, individually and on behalf of Regional Cardiology Consultants, PC v. Jackson-Madison County General Hospital, an Affiliate of West Tennessee Healthcare, Regional Hospital of Jackson, a Division of Community Health Systems Professional Services Corporation, James Moss, individually, Timothy Puthoff, individually, Joel Perchik, MD, individually, and Elie H. Korban, MD, individually*. The action is pending in the Western District of Tennessee, Jackson Division. Regional Hospital of Jackson is an affiliated hospital and Mr. Puthoff is a former chief executive officer there. The Order recited that the United States had elected to intervene to a limited degree only concerning the claims against Dr. Korban for false and fraudulent billing for allegedly unnecessary stent procedures and for causing the submission of false claims by the hospitals. On July 28, 2011, we were served by the relator. On June 12, 2013, the government and Dr. Korban filed an advisory that they had reached a "handshake" settlement of all claims pled by the government. On December 17, 2013, the government filed a notice of settlement with Dr. Korban. A scheduling order has been entered with a trial date of September 28, 2015. We believe the claims against our hospital are without merit and we are vigorously defending this case.

On August 8, 2012, an order was entered unsealing a relator's qui tam complaint in the matter of *U.S. and N.M. ex rel. Sally Hansen v. Mimbres Memorial Hospital, et al*. This action is pending in the United States District Court for New Mexico. This case cites alleged quality control failures as violations of the Clinical Laboratory Improvement Amendments of 1988 as the basis for a False Claims Act suit. Both the U.S. government and the New Mexico state government declined to intervene in this case. We filed a motion to dismiss and the relator filed an amended complaint. Both the U.S. government and the New Mexico state government have now declined to intervene on this amended complaint. On June 12, 2013, we filed a motion to dismiss the amended complaint. The relator also voluntarily dismissed Community Health Systems, Inc., without prejudice. Our motion to dismiss was granted on November 21, 2013 and relator's motion for reconsideration of that decision was denied on January 24, 2014. On February 21, 2014, relator filed a notice of appeal to the Tenth Circuit Court of Appeals. We believe the claim against our hospital is without merit and we are vigorously defending this case.

On December 20, 2013, we became aware of a case styled U.S. ex rel. Macler v. Pinnacle Partners in Medicine, et. al (including our affiliated facility, Pottstown Memorial Medical Center, Pottstown, Pennsylvania), filed on April 17, 2013 in the Eastern District of Pennsylvania. The complaint alleges that certain patients did not receive a post-anesthesia visit as required by the Medicare Conditions of Participation and Pennsylvania law. The Department of Justice has declined to intervene in this case and the case was unsealed on or about December 19, 2013. We previously had not been aware of this case nor had any knowledge of any government investigation of the allegations. We were never served with a complaint and on September 8, 2014 the court dismissed this matter.

On February 4, 2014, a redacted case then styled (Sealed Party) v. Pottstown Hospital Co., LLC d/b/a Pottstown Memorial Medical Center and Community Health Systems, Inc. was filed in the Eastern District of Pennsylvania. On May 6, 2014, the district court ordered the seal lifted. The relator is Alan E. Cooper, M.D. The complaint alleges the hospital traded on call agreements for referrals. There is no indication that the Department of Justice has intervened in this matter. This matter was previously reported in prior filings in the Legal Proceedings section as subpoenas to two Pennsylvania hospitals and one of our subsidiaries concerning on call agreements and physician directorships. On June 5, 2014, we filed motions to dismiss the complaint and on June 30, 2014 the relator filed his response. Oral argument occurred on October 15, 2014 and the matter was taken under advisement and discovery was stayed. We anticipate that we will vigorously defend this matter if it is pursued by the government or the relator.

On July 15, 2014, we became aware of a previously unknown qui tam styled U.S. ex rel. McFeeters v. Northwest Hospital, LLC d/b/a Northwest Medical Center and Community Health Systems, Inc. pending in the Middle District of Tennessee and originally filed on May 16, 2013. On July 10, 2014, the United States filed its Notice of Election to Decline Intervention. The complaint alleges the hospital misbilled physical therapy treatment time units. On September 10, 2014, we filed a motion to dismiss and on October 1, 2014 the relator filed an amended complaint. We will be filing a renewed motion to dismiss. We will vigorously defend this matter.

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; a response was filed on May 21, 2012. At a hearing on July 27, 2012, the court dismissed Community Health Systems, Inc. from this case and subsequently certified the 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. We are vigorously defending this action.

Eliel Ntakirutimana, M.D. and Anesthesia Healthcare Partners of Laredo, P.A., Jose Berlioz, M.D. and Jose Berlioz, M.D., P.A. d/b/a Safari Pediatrics v. Laredo Texas Hospital Company, L.P. d/b/a Laredo Medical Center, CHS/Community Health Systems, Inc., Webb Hospital Corporation, Community Health Systems Professional Services Corporation, Community Health Systems, Inc., Abraham "Abe" Martinez, Argelia "Argie" Martinez, Michael Portacci, Wayne Smith, Timothy P. Adams, and Timothy Schmidt. On December 28, 2012, two physicians and each of their professional associations, who previously contracted as independent contractors with Laredo Medical Center under contracts that could be terminated without cause upon certain written notice, filed a first amended complaint. The first amended complaint alleged claims for breaches of contracts, unjust enrichment, violation of the Texas Theft Liability Act, negligence, breach of fiduciary duty, knowing participation in breach of fiduciary duty, defamation and business disparagement, R.I.C.O., economic duress/coercion, tortious interference with contracts or prospective business relations, conspiracy, respondent superior, actual and apparent authority, ratification, vice-principal liability, and joint enterprise liability. The first amended complaint, in part, alleges facts concerning payments made by Dr. Eliel Ntakirutimana to former Laredo Medical Center CEO, Abe Martinez, who is also a defendant in the suit. On October 23, 2013, an Order staying the case until further notice was entered.

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 in 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 continue to work 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 the Company regarding remediation efforts. We are providing appropriate notification to affected patients and regulatory agencies as required by federal and state law. We are offering identity theft protection services to individuals affected by this attack.

We have incurred certain expenses to remediate and investigate this matter, and expect to continue to incur expenses of this nature in the foreseeable future. In addition, multiple purported class action lawsuits have been filed against the Company. (Denise B. Alverson, v. Community Health Systems, Inc., Community Health Systems Professional Services Corporation, Riverview Regional Medical Center, LLC, Gadsden Regional Medical Center, LLC, Foley Hospital Corporation and Anniston HMA, LLC, (USDC, N.D., AL); Mary Martin Glah and Charles William Stonestreet, et al. v. Community Health Systems, Inc., Community Health Systems Professional Services Corporation, et al., (USDC, S.D. WV); Roman v. Community Health Systems, Inc. and Community Health Systems Professional Services Corporation, (USDC, M.D. PA); Braquelle Lawson, et al. v. Community Health Systems, Inc., Community Health Systems Professional Services Corporation, River Oaks Hospital, LLC, Vicksburg Healthcare, LLC D/B/A River Region Health System, Brandon HMA, LLC D/B/A Crossgates River Oaks Hospital, LLC, Madison HMA, LLC D/B/A Madison River Oaks Hospital, Central Mississippi Medical Center, and Natchez Community Hospital, LLC, (USDC, S.D. MS); Briana Brito v. Community Health Systems, Inc., Community Health Systems Professional Services Corporation, Alta Vista Regional Hospital, Carlsbad Medical Center, Eastern NM Med Center, Mimbres Memorial Hospital, Mountainview Regional Medical Center, Lea Regional Medical Center, (NM State Court, 4th Jud. Dist. San Miguel County NM).) These lawsuits allege that sensitive information was unprotected and inadequately encrypted by the Company. The plaintiffs claim breach of contract and other theories of recovery, and are seeking damages, as well as restitution for any identity theft. At this time, we are unable to predict the outcome of this litigation or determine the potential impact, if any, that could result from this litigation, but we intend to vigorously defend these lawsuits. This matter may subject the Company to additional litigation, potential governmental inquiries, potential reputational damage, and additional remediation, operating and other expenses.

Certain Legal Proceedings Related to HMA

Medicare/Medicaid Billing Lawsuits

On January 11, 2010, HMA and one of its subsidiaries were named in a qui tam lawsuit entitled United States of America ex rel. J. Michael Mastej v. Health Management Associates, Inc. et al. in the U.S. District Court for the Middle District of Florida, Tampa Division. The plaintiff's complaint alleged that, among other things, the defendants erroneously submitted claims to Medicare and that those claims were falsely certified to be in compliance with Section 1877 of the Social Security Act of 1935 (commonly known as the "Stark law") and the Anti-Kickback Statute. The plaintiff's complaint further alleged that the defendants' conduct violated the False Claims Act. The plaintiff seeks recovery of all Medicare and Medicaid reimbursement that the defendants received as a result of the alleged false certifications and treble damages under the False Claims Act, as well as a civil penalty for each Medicare and Medicaid claim supported by such alleged false certifications. On August 18, 2010, the plaintiff filed a first amended complaint that was similar to the original complaint. On February 23, 2011, the case was transferred to the U.S. District Court for the Middle District of Florida, Fort Myers Division. On May 5, 2011, the plaintiff filed a second amended complaint, which was similar to the first amended complaint. On May 17, 2011, the defendants moved to dismiss the second amended complaint for failure to state a claim with the particularity required and failure to state a claim upon which relief can be granted. On January 26, 2012, the United States gave notice of its decision not to intervene in this lawsuit. On February 16, 2012, the court granted the defendants' motion to dismiss, without prejudice. The court's order permitted the plaintiff to file an amended complaint. On March 8, 2012, the plaintiff filed a third amended complaint, which was similar to the first amended complaint and the second amended complaint. On March 26, 2012, the defendants moved to dismiss the third amended complaint on the same bases set forth in earlier motions to dismiss. On March 19, 2013, the U.S. District Court for the Middle District of Florida, Tampa Division, dismissed the third amended complaint with prejudice. On March 28, 2013, the United States of America filed a motion to clarify that the dismissal with prejudice did not relate to the United States. On April 4, 2013, the defendants filed an opposition to the United States' motion for clarification. The Government's motion remains pending at this time. On April 16, 2013, the plaintiff filed a motion for relief from judgment and for leave to amend the complaint, and a proposed fourth amended complaint. On April 18, 2013, the plaintiff filed a notice of appeal. On May 2, 2013, the defendants filed an opposition to the plaintiff's motion for relief from judgment and for leave to amend the complaint for the fourth time. On July 10,

2013, the court denied plaintiff's motion for relief from judgment and for leave to amend the complaint for the fourth time. The case was appealed by Mastej to the Eleventh Circuit Court of Appeals and on October 30, 2014 the appellate court affirmed the dismissal of part of the case and reversed the dismissal of part of the case. The case will be returned to the district court for further proceedings. We intend to vigorously defend HMA and its subsidiary against the allegations in this matter.

On July 31, 2013, a qui tam lawsuit captioned United States ex rel. Williams v. Health Management Associates, Inc. was unsealed in the U.S. District Court for the Middle District of Georgia. The complaint alleges that HMA and Walton Regional Medical Center, as well as Tenet Healthcare Corp. and several of its hospitals, engaged in a kickback scheme with Clinica de la Mama, a prenatal clinic, whereby Clinica de la Mama would provide translation and eligibility services in exchange for the referral of Medicaid patients to the defendant hospitals. The State of Georgia filed a similar complaint alleging that these referrals violated the Georgia False Medical Claims Act, the Georgia Medical Assistance Act, and various state laws. HMA has moved to dismiss the relater and State complaints, and its motion is currently pending before the Court. On March 18, 2014, the United States filed a complaint in intervention alleging that the relationship between Clinica de la Mama and Walton violated the federal False Claims Act and common law unjust enrichment and payment by mistake. On June 24, 2014, our motion to dismiss was denied. We deny the allegations in these complaints and intend to defend against these claims.

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 recently 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 recently partially 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 June 2, 2014, the court entered a stay of this matter until October 6, 2014, which was subsequently extended until February 27, 2015. We intend to defend against the allegations in these matters, but will also be cooperating with the government in the ongoing investigation of these allegations.

Several HMA hospitals received letters during 2009 requesting information in connection with a DOJ investigation relating to kyphoplasty procedures. Kyphoplasty is a minimally invasive spinal procedure used to treat vertebral compression fractures. The DOJ is currently investigating hospitals and hospital operators in multiple states to determine whether certain Medicare claims for kyphoplasty were incorrect when billed as an inpatient service rather than as an outpatient service. The DOJ's investigation originated with a False Claims Act lawsuit against Kyphon, Inc., the company that developed the kyphoplasty procedure. The requested information has been provided to the DOJ and we are cooperating with the investigation. Prior to the HMA merger, HMA determined that a liability for this claim was probable and an incremental liability was recorded by HMA during the quarter ended December 31, 2013, which was assumed as part of the HMA merger.

During September 2010, HMA received a letter from the DOJ indicating that an investigation was being conducted to determine whether certain HMA hospitals improperly submitted claims for the implantation of ICDs. The DOJ's investigation covers the period commencing with Medicare's expansion of coverage for ICDs in 2003 to the present. The letter from the DOJ further indicates that the claims submitted by HMA's hospitals for ICDs and related services need to be reviewed to determine if Medicare coverage and payment was appropriate. During 2010, the DOJ sent similar letters and other requests to a large number of unrelated hospitals and hospital operators across the country as part of a nation-wide review of ICD billing under the Medicare program. We are cooperating with the DOJ in its ongoing investigation, which could potentially give rise to claims against HMA and/or certain of its subsidiary hospitals under the False Claims Act or other statutes, regulations or laws. Additionally, we are conducting an internal review of hospital medical records related to ICDs that are the subject of the DOJ investigation. To date, the DOJ has not asserted any monetary or other claims against HMA or its hospitals in this matter and, at this time, we are unable to determine the potential impact, if any, that will result from the final resolution of the investigation.

On February 22, 2012 and February 24, 2012, OIG served subpoenas on certain HMA hospitals relating to those hospitals' relationships with Allegiance. Allegiance, which is unrelated to HMA, is a post-acute healthcare management company that provides IOP services to patients. The HMA hospitals that were served subpoenas were: (i) Central Mississippi Medical Center in Jackson, Mississippi; (ii) Crossgates River Oaks Hospital in Brandon, Mississippi; (iii) Davis Regional Medical Center in Statesville, North Carolina; (iv) Lake Norman Regional Medical Center in Mooresville, North Carolina; (v) the Medical Center of Southeastern Oklahoma in Durant, Oklahoma; and (vi) Natchez Community Hospital in Natchez, Mississippi. Each of those hospitals has or had a contract with Allegiance. Among other things, the subpoenas seek: (i) documents related to the hospitals' financial relationships with Allegiance; (ii) documents related to patients who received IOP services from Allegiance at the HMA hospitals, including their patient medical records; (iii) documents relating to complaints or concerns regarding Allegiance's IOP services at the HMA hospitals; (iv) documents relating to employees, physicians and therapists who were involved with the IOP services provided by Allegiance at the HMA hospitals; and (v) other documents related to Allegiance, including leases, contracts, policies and procedures, training documents, budgets and financial analyses. The period of time covered by the subpoenas is January 1, 2008 through the date of subpoena compliance. We intend to cooperate with the investigations. Prior to the HMA merger, HMA determined that a liability for this claim was probable and a liability was recorded by HMA during the quarter ended December 31, 2013, which was assumed as part of the HMA merger.

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.

Class Action and Derivative Action Lawsuits

On April 30, 2012, two class action lawsuits that were brought against HMA and certain of its then executive officers, one of whom was at that time also a director, were consolidated in the U.S. District Court for the Middle District of Florida under the caption In Re: Health Management Associates, Inc., et al. and three pension fund plaintiffs were appointed as lead plaintiffs. On July 30, 2012, the lead plaintiffs filed an amended consolidated complaint purportedly on behalf of stockholders who purchased HMA's common stock during the period from July 27, 2009, through January 9, 2012. The amended consolidated complaint (i) alleges that HMA made false and misleading statements in certain public disclosures regarding its business and financial results and (ii) asserts claims for violations of Sections 10(b) and 20(a) of the Securities Exchange Act of 1934, as amended. Among other things, the plaintiffs claim that HMA inflated its earnings by engaging in fraudulent Medicare billing practices that entailed admitting patients to observation status when they should not have been admitted at all and to inpatient status when they should have been admitted to observation status. The plaintiffs seek unspecified monetary damages. On October 22, 2012, the defendants moved to dismiss the plaintiffs' amended consolidated complaint for failure to state a claim or plead facts required by the Private Securities Litigation Reform Act. The plaintiffs filed an unopposed stipulation and proposed order to suspend briefing on the defendants' motion to dismiss because they intended to seek leave of court to file a proposed second amended consolidated complaint. On December 15, 2012, the court entered an order approving the stipulation and providing a schedule for briefing with respect to the proposed amended pleadings. On February 25, 2013, the plaintiffs filed a second amended consolidated complaint, which asserted substantially the same claims as the amended consolidated complaint. As of August 15, 2013, the defendants' motion to dismiss the second amended complaint for failure to state a claim and plead facts required by the Private Securities Litigation Reform Act was fully briefed and awaiting the Court's decision. On May 22, 2014, the court granted the motion to dismiss and on June 20, 2014 the plaintiffs appealed to the Eleventh

Circuit. We intend to vigorously defend against the allegations in this lawsuit. We are unable to predict the outcome or determine the potential impact, if any, that could result from its final resolution.

Wrongful Termination Lawsuits

Meyer v. Health Management Associates, Inc. In October 2011, a wrongful termination action was commenced against HMA by Paul Meyer, HMA's former Director of Compliance in the Circuit Court in Broward County, Florida. In the lawsuit, the plaintiff seeks unspecified compensatory and punitive damages. HMA has asserted that Mr. Meyer was terminated after insubordinately refusing to cooperate with HMA's efforts to comply with its obligations under a government subpoena by refusing to return documents belonging to HMA that were in his possession. HMA has filed a counterclaim against Mr. Meyer for breach of contract, conversion and breach of duty of loyalty. On September 16, 2014, we reached an out of court resolution of this matter.

William J. Shoen vs. Health Management Associates, Inc. Schoen, former Chairman of the Board of HMA, filed suit against HMA on June 27, 2014 alleging breach of contract for a lump sum termination payment, certain airplane usage rights and underpayment of his SERP. He also seeks declaratory judgment that he and his spouse are entitled to lifetime health insurance benefits. On July 25, 2014, the matter was removed to the United States District Court for the Middle District of Florida. On September 22, 2014, we filed a motion to dismiss this matter, which has not yet been set for argument. We will vigorously defend this matter.

Jeffery D. Hamby, M.D. v. EmCare Physician Providers, Inc., Health Management Associates, Inc., Joni Carmack, M.D. and Michael Wheelis, M.D. Circuit Court Crawford County, Arkansas. Hamby, who worked in the emergency department at HMA affiliate Summit Medical Center (AK) and was employed by independent contractor EmCare, filed suit alleging wrongful termination by EmCare at the behest of HMA. On January 13, 2014, the court granted HMA's motion to dismiss which dismissal Hamby has now appealed. We will continue to vigorously defend this matter.

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 and Sarbanes-Oxley independence requirements, the Audit and Compliance Committee is comprised entirely of individuals who are independent of Company management, and all three members of the Audit and Compliance Committee are "audit committee financial experts" as defined in the Exchange Act.

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.

For the past several years, our Board of Directors has met monthly to review the status of the lawsuits and investigations relating to allegations of improper billing for inpatient care at our hospitals and to oversee management in connection with our investigation and defense of these matters. Following the consummation of the HMA merger, these meetings have been expanded to include the review and oversight of the legal proceedings related to HMA that are covered by the CVR. The independent members of our Board of Directors remain fully engaged in the oversight of these matters.

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m 1A. ***Risk Factors***

In addition to the risk factors disclosed under Item 1A to Part 1 of our Annual Report for the fiscal year ended December 31, 2013, the following risk factors should be read carefully in connection with evaluating our business and the forward-looking information contained within our Annual Report on Form 10-K and our Quarterly Reports on Form 10-Q. Other than the updates to our risk factors presented below, there have been no material changes in the risk factors previously disclosed in our Annual Report on Form 10-K.

A cyber security attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, or other common law theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

We rely extensively on our computer systems to manage clinical and financial data, communicate with our patients, payors, vendors and other third parties and summarize and analyze operating results. In addition, we have made significant investments in technology to adopt and utilize electronic health records and to become meaningful users of health information technology pursuant to the American Recovery and Reinvestment Act of 2009. During the second quarter of 2014, our computer network was the target of an external, criminal cyber attack resulting in the attacker successfully copying and transferring certain data outside the Company. This data included certain non-medical patient identification data (such as patient names, addresses, birthdates, telephone numbers and social security numbers) considered protected under the Health Insurance Portability and Accountability Act (HIPAA) but did not include patient credit card, medical or clinical information. We have incurred certain expenses to remediate and investigate this matter and expect to continue to incur expenses of this nature in the foreseeable future. We also have been subject to multiple purported class action lawsuits in connection with this matter. This cyber attack may subject the Company to additional litigation, potential governmental inquiries and potential reputation damages.

In addition, there can be no assurance that we will not be subject to additional cybersecurity attacks in the future that bypass our security measures, result in loss of protected health information or other data subject to privacy laws or disrupt our IT systems or business. As a result, cybersecurity and the continued development and enhancement of our controls, processes and practices designed to protect our systems, computers, software, data and networks from attack, damage or unauthorized access remain a priority for us. As cyber threats continue to evolve, we may be required to expend significant additional resources to continue to modify or enhance our protective measures or to investigate and remediate any information security vulnerabilities. If we are subject to additional cyber attacks or security breaches in the future, this could have an adverse impact on our business, financial condition or results of operations.

A pandemic, epidemic or outbreak of a contagious disease, such as the Ebola virus, in the markets that we operate or impacting our facilities could adversely impact our business.

An epidemic of the Ebola virus is ongoing in parts of West Africa, and the World Health Organization has declared it a global health emergency. If a pandemic or other public health crisis were to affect our markets, our business could be adversely affected. Such a crisis could diminish the public trust in healthcare facilities, especially hospitals that fail to accurately or timely diagnose, or are treating (or have treated) patients affected by contagious diseases. If any of our facilities were involved in treating patients from such a contagious disease, other patients might cancel elective procedures or fail to seek needed care at our facilities. Further, a pandemic might adversely impact our business by disrupting or delaying production and delivery of materials and products in the supply chain or by causing staffing shortages in our facilities. Although we have disaster plans in place and operate pursuant to infectious disease protocols, the potential impact of a pandemic, epidemic or outbreak of a contagious disease, such as the Ebola virus, with respect to our markets or our facilities is difficult to predict and could adversely impact our business.

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

Historically, we have not paid any cash dividends. In December 2012, we declared and paid a special dividend of $0.25 per share to holders of our common stock at the close of business as of December 17, 2012, which totaled approximately $23 million. We have not paid any dividends since this time, and we do not anticipate paying any other cash dividends in the foreseeable future. Our Credit Facility 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. The indentures governing our senior and senior secured notes also limit our ability to pay dividends and/or repurchase stock. As of September 30, 2014, under the most restrictive test under these agreements, we have approximately $429 million available with which to pay permitted dividends and/or repurchase shares of our stock or our Notes.

Item 3.
Defaults Upon Senior Securities

None.

Item 4. ***Mine Safety Disclosures***

Not applicable.

Item 5. ***Other Information***

None.

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tem 6. ***Exhibits***

No.	Description
10.1	Fourth Amendment, dated August 29, 2014, to the Receivables Loan Agreement among CHS Receivables Funding, LLC, the lenders party thereto, the managing agents party thereto, Crédit Agricole Corporate and Investment Bank, as Administrative Agent, and Community Health Systems Professional Services Corporation, as Collection Agent, all dated as of March 21, 2012
12.1	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, dated July 28, 2014, 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

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GNATURES

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

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/ W. Larry Cash
W. Larry Cash
President of Financial Services, Chief
Financial Officer and Director
(principal financial officer)

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

Date: November 4, 2014

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101.PRE	XBRL Taxonomy Extension Presentation Linkbase

Exhibit 10.1

FOURTH AMENDMENT TO RECEIVABLES LOAN AGREEMENT

This **FOURTH AMENDMENT TO RECEIVABLES LOAN AGREEMENT** is made as of August 29, 2014 (this "Amendment"), among CHS RECEIVABLES FUNDING, LLC, a Delaware limited liability company ("Receivables Funding"), as Borrower, THE BANK OF NOVA SCOTIA ("Scotia"), as a Committed Lender and as a Managing Agent, CRÉDIT AGRICOLE CORPORATE AND INVESTMENT BANK ("CA-CIB"), as a Committed Lender, as a Managing Agent and as Administrative Agent, THE BANK OF TOKYO-MITSUBISHI UFJ, LTD. ("BTMU"), as a Committed Lender and as a Managing Agent, ATLANTIC ASSET SECURITIZATION LLC ("Atlantic"), as a Conduit Lender, LIBERTY STREET FUNDING LLC ("Liberty Street"), as a Conduit Lender, VICTORY RECEIVABLES CORPORATION ("Victory"), as a Conduit Lender, and COMMUNITY HEALTH SYSTEMS PROFESSIONAL SERVICES CORPORATION ("Professional Services"), a Delaware corporation, as Collection Agent under the Receivables Loan Agreement, and is acknowledged and agreed by Receivables Funding, as the Company, Professional Services, as Collection Agent under each of the Contribution Agreement and the Sale Agreement, and as Authorized Representative (as defined in the Sale Agreement, the "Authorized Representative"), CHS/COMMUNITY HEALTH SYSTEMS, INC., a Delaware corporation ("CHS"), as Transferor, as Buyer and individually (as the provider of a performance undertaking), and EACH OF THE OTHER PERSONS IDENTIFIED AS ORIGINATORS ON THE SIGNATURE PAGES HERETO AFFILIATED WITH CHS/COMMUNITY HEALTH SYSTEMS, INC., as Originators. All capitalized terms used herein without reference shall have the meanings assigned to such terms in the Receivables Loan Agreement (as defined below) after giving effect to this Amendment.

WHEREAS, Receivables Funding, as Borrower, Scotia, as a Committed Lender and as a Managing Agent, CA-CIB, as a Committed Lender, as a Managing Agent and as Administrative Agent, BTMU, as a Committed Lender and as a Managing Agent, the other Lenders party thereto and Professional Services, as Collection Agent, have entered into the Receivables Loan Agreement, dated as of March 21, 2012 (as amended, restated, supplemented or otherwise modified prior to the date hereof, the "Receivables Loan Agreement");

WHEREAS, CHS, as Transferor, Receivables Funding, as the Company, and Professional Services, as Collection Agent thereunder, have entered into the Receivables Purchase and Contribution Agreement, dated as of March 21, 2012 (as amended, restated, supplemented or otherwise modified prior to the date hereof, the "Contribution Agreement");

WHEREAS, the Originators, Professional Services, as Collection Agent and Authorized Representative thereunder, and CHS, as Buyer, have entered into the Receivables Sale Agreement, dated as of March 21, 2012 (as amended, restated, supplemented or otherwise modified prior to the date hereof, the "Sale Agreement");

WHEREAS, the parties hereto desire to amend certain provisions of the Receivables Loan Agreement pursuant to Section 10.01 of the Receivables Loan Agreement and take the other actions set forth herein, and have agreed to do so subject to the terms and conditions of this Amendment.

NOW, THEREFORE, in consideration of the agreements hereinafter set forth,

and for other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the parties hereto agree as follows:

SECTION 1. Amendments to Receivables Loan Agreement. Subject to all of the terms and conditions set forth in this Amendment:

(a) Section 1.01 of the Receivables Loan Agreement is amended as by inserting the following definitions in the appropriate alphabetical order:

"Specified Defaulted Receivables" means a Receivable:

(a) as to which, as of the date that is 150 days after the Last Service Date, the amount paid thereon is less than the Expected Net Value of such Receivable (other than as a result of a miscalculation by the Collection Agent of Contractual Allowances) and which is between 151 days and 180 days from the Last Service Date,

(b) as to which the Obligor thereof is currently the subject of an Insolvency Proceeding, or

(c) which, consistent with the Credit and Collection Policy, has been or should be written off the Borrower's or an Originator's books as uncollectible.

"Trigger Temporary Relief Period" means the period comprised of the six consecutive Collection Periods from August 2014 through and including January 2015.

(b) The definition of "Default Ratio" in Section 1.01 of the Receivables Loan Agreement is hereby amended and restated in its entirety to read as follows:

"Default Ratio" means, in respect of any Collection Period, the ratio (expressed as a percentage) computed as of the Determination Date, by dividing

(a) the aggregate Expected Net Value of all Receivables that were Specified Defaulted Receivables as of the last day of such Collection Period by

(b) the aggregate Expected Net Value of all Receivables as of the last day of such Collection Period.

(c) The definition of "Temporary Relief Period" in Section 1.01 of the Receivables Loan Agreement is hereby amended and restated in its entirety to read as follows:

"HHS Temporary Relief Period" means, solely to the extent that the HHS Compliance Date occurs on or before October 1, 2014, the following periods: (i) with respect to the Default Ratio for a single Collection Period, the period comprised of the five consecutive Collection Periods from February 2015 through and including June 2015, (ii) with respect to the Delinquency Ratio for a single Collection Period, the period comprised of the five consecutive Collection Periods

from February 2015 through and including June 2015, (iii) with respect to the Payment Denial Rate for a single Collection Period, the period comprised of the four consecutive Collection Periods from April 2015 through and including July 2015, (iv) with respect to the average of the Default Ratio for a Collection Period and the two prior Collection Periods, the period comprised of the five consecutive Collection Periods from March 2015 through and including July 2015, (v) with respect to the average of the Delinquency Ratio for a Collection Period and the two prior Collection Periods, the period comprised of the five consecutive Collection Periods from March 2015 through and including July 2015, and (vi) with respect to the DSO for a single Collection Period, the period comprised of the three consecutive Collection Periods from February 2015 through and including April 2015; *provided*, that if the HHS Compliance Date occurs after October 1, 2014, the "HHS Temporary Relief Period" hereunder shall consist of such periods, if any, and pursuant to such terms as the Administrative Agent and the Managing Agents each agrees in writing in its respective sole discretion.

(d) Clause (h) of Section 7.01 of the Receivables Loan Agreement is hereby amended and restated in its entirety to read as follows:

(h) As of the last day of any Collection Period, (i) the Default Ratio (x) for any Collection Period occurring during the Trigger Temporary Relief Period shall exceed 2.25%, (y) for any Collection Period occurring during the HHS Temporary Relief Period shall exceed 2.50% and (z) for all other Collection Periods shall exceed 2.00%, (ii) the Delinquency Ratio (x) for any Collection Period occurring during the Trigger Temporary Relief Period shall exceed 4.00%, (y) for any Collection Period occurring during the HHS Temporary Relief Period shall exceed 5.75% and (z) for all other Collection Periods, shall exceed 3.50%, (iii) the Payment Denial Rate (x) for any Collection Period occurring during the HHS Temporary Relief Period shall exceed 1.50% and (y) for all other Collection Periods shall exceed 1.25%, (iv) the average of the Default Ratio for each of such Collection Period and the two prior Collection Periods (x) for any Collection Period occurring during the Trigger Temporary Relief Period shall exceed 2.15%, (y) for any Collection Period occurring during the HHS Temporary Relief Period shall exceed 2.65% and (z) for all other Collection Periods shall exceed 1.90%, or (v) the average of the Delinquency Ratio for each of such Collection Period and the two prior Collection Periods (x) for any Collection Period occurring during the Trigger Temporary Relief Period shall exceed 3.75%, (y) for any Collection Period occurring during the HHS Temporary Relief Period shall exceed 5.25% and (z) for all other Collection Periods shall exceed 3.25%; or

(e) Clause (i) of Section 7.01 of the Receivables Loan Agreement is hereby amended and restated in its entirety to read as follows:

(i) The DSO reported on any Monthly Report shall exceed, (x) if with respect to a Collection Period occurring during the HHS Temporary Relief Period, 60 days and (y) if with respect to a Collection Period occurring at any other time, 55 days; or

SECTION 2. Conditions to Effectiveness. This Amendment shall become effective upon the date (the "Amendment Effective Date") on which the following conditions have been satisfied (in form and substance reasonably acceptable to the Administrative Agent):

(a) The Administrative Agent shall have received counterparts of this Amendment duly executed by each of the Borrower, the Collection Agent, the Managing Agents, the Committed Lenders, the Conduit Lenders and the Administrative Agent and counterparts evidencing acknowledgment and agreement duly executed by each of the Company, the Collection Agent (as Collection Agent under each of the Contribution Agreement and the Sale Agreement), the Authorized Representative, the Transferor, the Buyer, CHS individually and the Originators.

(b) All fees and expenses required to be paid prior to an Advance under the Receivables Loan Agreement (as amended by this Amendment) pursuant to (i) the Receivables Loan Agreement (as amended by this Amendment) and (ii) the Fee Letter shall have been paid.

(c) Each Managing Agent and the Administrative Agent shall have completed satisfactory due diligence and obtained the requisite credit approvals.

SECTION 3. Representations and Warranties.

(a) Each of the Borrower and the Collection Agent represents and warrants as of the date hereof that (i) it has taken all necessary action to authorize the execution, delivery and performance of this Amendment and the performance of the Receivables Loan Agreement and the other Facility Documents, each as amended hereby, as applicable, and (ii) no consent, approval, authorization or order of, or filing, registration or qualification with, any court or governmental authority or third party is required in connection with the execution, delivery or performance by such Person of this Amendment other than such as has been met or obtained and are in full force and effect.

(b) Each of the Borrower and the Collection Agent represents and warrants as of the date hereof that each of this Amendment and each Facility Document (as amended by this Amendment or otherwise as of the date hereof, as applicable) constitutes such Person's legal, valid and binding obligation, enforceable against such person in accordance with its terms, except as such enforceability may be subject to (A) bankruptcy, insolvency, reorganization, fraudulent conveyance or transfer, moratorium or similar laws affecting creditors' rights generally and (B) general principles of equity (regardless of whether such enforceability is considered in a proceeding at law or in equity).

(c) The Borrower hereby makes each of the representations and warranties contained in Sections 4.01 and 4.03 of the Receivables Loan Agreement as of the date hereof, in each case after giving effect to this Amendment, except for those representations and warranties that refer to specific dates, which are made as of the dates indicated therein.

(d) The Collection Agent hereby makes each of the representations and warranties contained in Section 4.02 of the Receivables Loan Agreement as of the date hereof, in each case after giving effect to this Amendment, except for those representations and warranties that refer to specific dates, which are made as of the dates indicated therein.

(e) Each of the Borrower and the Collection Agent further represents and warrants that, both before and after giving effect to this Amendment, no event has occurred and is continuing which constitutes an Event of Default, or would, with the passage of time or the giving of notice, constitute an Event of Default.

SECTION 4. Facility Document. This Amendment shall constitute a Facility Document under the terms of the Receivables Loan Agreement as amended hereby.

SECTION 5. Further Assurances. The Borrower and the Collection Agent agree to promptly take such action, upon the reasonable request of the Administrative Agent, as is necessary to carry out the intent of this Amendment.

SECTION 6. Confirmation of Agreement. On and after the date hereof, all references to the Receivables Loan Agreement in the Facility Documents and the other documents and instruments delivered pursuant to or in connection with such Facility Documents shall mean the Receivables Loan Agreement as amended by this Amendment, and as hereafter modified, amended or restated in accordance with its terms. Except as herein expressly amended, the Receivables Loan Agreement is ratified and confirmed in all respects and shall remain in full force and effect in accordance with its terms.

SECTION 7. Confirmation of Undertaking. CHS, as undertaking party under the Collection Agent Performance Undertaking, dated as of March 21, 2012 (as amended, restated, supplemented or otherwise modified prior to the date hereof, the "Performance Undertaking"), in favor of CA-CIB as administrative agent on behalf of the Lenders, hereby consents to the amendments to the Receivables Loan Agreement set forth in Section 3 of this Amendment, and hereby confirms and agrees that, notwithstanding the effectiveness of this Amendment, the Performance Undertaking heretofore executed and delivered by it is, and shall continue to be, in full force and effect in accordance with its terms and shall apply to the Receivables Loan Agreement (as amended by this Amendment), Contribution Agreement and Sale Agreement and the Performance Undertaking is hereby so ratified and confirmed.

SECTION 8. GOVERNING LAW. THIS AMENDMENT SHALL, IN ACCORDANCE WITH SECTION 5-1401 OF THE GENERAL OBLIGATIONS LAW OF THE STATE OF NEW YORK, BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK. EACH OF THE PARTIES HERETO HEREBY SUBMITS TO THE EXCLUSIVE JURISDICTION OF THE STATE AND FEDERAL COURTS OF THE UNITED STATES AND THE NON-EXCLUSIVE JURISDICTION OF THE STATE AND FEDERAL COURTS SITTING IN NEW YORK COUNTY, NEW YORK IN ANY ACTION OR PROCEEDING ARISING OUT OF OR RELATING TO THIS AMENDMENT, ANY OTHER FACILITY DOCUMENT, ANY OTHER DOCUMENT DELIVERED PURSUANT HERETO OR THERETO, OR THE TRANSACTIONS CONTEMPLATED HEREBY OR THEREBY. EACH OF THE PARTIES HERETO HEREBY WAIVES ANY OBJECTION BASED ON FORUM NON CONVENIENS THE MAINTENANCE OF ANY SUCH ACTION OR PROCEEDING AND CONSENTS TO THE GRANTING OF SUCH LEGAL OR EQUITABLE RELIEF AS IS DEEMED APPROPRIATE BY SUCH COURT.

SECTION 9. Execution in Counterparts. This Amendment may be executed in any number of counterparts and by different parties hereto in separate counterparts, each of which when so executed shall be deemed to be an original and all of which when taken together shall constitute one and the same agreement. Delivery of an executed counterpart of a signature page to this Amendment by facsimile or by electronic mail in portable document format (pdf) shall be effective as delivery of a manually executed counterpart of this Amendment.

SECTION 10. Severability of Provisions. Any provision of this Amendment which is prohibited or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such prohibition or unenforceability without invalidating the remaining provisions hereof or affecting the validity or enforceability of such provision in any other jurisdiction.

SECTION 11. Headings. Section headings used herein are for convenience of reference only, are not part of this Amendment and shall not affect the construction of, or be taken into consideration in interpreting, this Amendment.

[Signature Pages Follow]

IN WITNESS WHEREOF, this Amendment has been duly executed as of the date first written above.

CHS RECEIVABLES FUNDING, LLC,
as Borrower

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

CHS Receivables Funding, LLC
4000 Meridian Boulevard
Franklin, Tennessee 37067
Attention: Rachel A. Seifert
Telephone No: (615) 465-7000
Facsimile No: (615) 373-9704
Email: rachel_seifert@chs.net

COMMUNITY HEALTH SYSTEMS
PROFESSIONAL SERVICES CORPORATION,
as Collection Agent under the Receivables Loan Agreement

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

Community Health Systems Professional Services Corporation
4000 Meridian Boulevard
Franklin, Tennessee 37067
Attention: Rachel A. Seifert
Telephone No: (615) 465-7000
Facsimile No: (615) 373-9704
Email: rachel_seifert@chs.net

CRÉDIT AGRICOLE CORPORATE AND
INVESTMENT BANK, as Administrative Agent,
as a Managing Agent and as a Committed Lender

By: /s/ Sam Pilcer
Name: Sam Pilcer
Title: Managing Director

By: /s/ Michael Regan
Name: Michael Regan
Title: Managing Director

Crédit Agricole CIB
1301 Avenue of the Americas
New York, NY 10019
Attention: Sunny Gulrajani
Telephone No: (212) 261-7845
Facsimile No: (917) 849-5584
Email: sunny.gulrajani@ca-cib.com

ATLANTIC ASSET SECURITIZATION LLC,
as a Conduit Lender

By: CRÉDIT AGRICOLE CORPORATE AND
INVESTMENT BANK, as attorney-in-fact

By: /s/ Sam Pilcer
Name: Sam Pilcer
Title: Managing Director

By: /s/ Michael Regan
Name: Michael Regan
Title: Managing Director

Atlantic Asset Securitization
c/o Crédit Agricole CIB
1301 Avenue of the Americas
New York, NY 10019
Attention: Sunny Gulrajani
Telephone No: (212) 261-7845
Facsimile No: (917) 849-5584
Email: sunny.gulrajani@ca-cib.com

THE BANK OF NOVA SCOTIA, as a Managing Agent and as a Committed Lender

By: /s/ John Frazell
Name: John Frazell
Title: Director

LIBERTY STREET FUNDING LLC,
as a Conduit Lender

By: /s/ Frank B. Bilotta
Name: Frank B. Bilotta
Title: Vice President

THE BANK OF TOKYO-MITSUBISHI UFJ, LTD.,
as a Managing Agent

By: /s/ Christopher Pohl
Name: Christopher Pohl
Title: Managing Director

THE BANK OF TOKYO-MITSUBISHI UFJ, LTD.,
as a Committed Lender

By: /s/ Jaime Sussman
Name: Jaime Sussman
Title: Vice President

VICTORY RECEIVABLES CORPORATION,
as a Conduit Lender

By: /s/ David V. DeAngelis
Name: David V. DeAngelis
Title: Vice President

ACKNOWLEDGED AND AGREED:

CHS RECEIVABLES FUNDING, LLC,
as Company

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

CHS Receivables Funding, LLC
4000 Meridian Boulevard
Franklin, Tennessee 37067
Attention: Rachel A. Seifert
Telephone No: (615) 465-7000
Facsimile No: (615) 373-9704
Email: rachel_seifert@chs.net

COMMUNITY HEALTH SYSTEMS
PROFESSIONAL SERVICES CORPORATION,
as Collection Agent under each of the Contribution Agreement and the Sale Agreement and as Authorized Representative

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

Community Health Systems Professional Services Corporation
4000 Meridian Boulevard
Franklin, Tennessee 37067
Attention: Rachel A. Seifert
Telephone No: (615) 465-7000
Facsimile No: (615) 373-9704
Email: rachel_seifert@chs.net

ACKNOWLEDGED AND AGREED:

CHS/COMMUNITY HEALTH SYSTEMS, INC.,
as Transferor, as Buyer and individually

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

ACKNOWLEDGED AND AGREED:

ORIGINATORS:

AFFINITY HOSPITAL, LLC
BERWICK HOSPITAL COMPANY, LLC
BLUEFIELD HOSPITAL COMPANY, LLC
BLUFFTON HEALTH SYSTEM LLC
BULLHEAD CITY HOSPITAL CORPORATION
CARLSBAD MEDICAL CENTER, LLC
CLEVELAND TENNESSEE HOSPITAL COMPANY, LLC
COATESVILLE HOSPITAL CORPORATION
CRESTVIEW HOSPITAL CORPORATION
DEACONESS HEALTH SYSTEM, LLC
DHSC, LLC
DUKES HEALTH SYSTEM, LLC
DYERSBURG HOSPITAL CORPORATION
EMPORIA HOSPITAL CORPORATION
FOLEY HOSPITAL CORPORATION
FRANKLIN HOSPITAL CORPORATION
GADSDEN REGIONAL MEDICAL CENTER, LLC
GALESBURG HOSPITAL CORPORATION
GRANBURY HOSPITAL CORPORATION
GRANITE CITY ILLINOIS HOSPITAL COMPANY, LLC
GREENBRIER VMC, LLC
HOSPITAL OF MORRISTOWN, INC.
JACKSON, TENNESSEE HOSPITAL COMPANY, LLC
JOURDANTON HOSPITAL CORPORATION
KAY COUNTY OKLAHOMA HOSPITAL COMPANY, LLC

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

ORIGINATORS (CONT.):

LAKE WALES HOSPITAL CORPORATION
LANCASTER HOSPITAL CORPORATION
LAS CRUCES MEDICAL CENTER, LLC
LEA REGIONAL HOSPITAL, LLC
MARTIN HOSPITAL CORPORATION
MARY BLACK HEALTH SYSTEM LLC
MCKENZIE-WILLAMETTE REGIONAL MEDICAL CENTER ASSOCIATES, LLC
MCNAIRY HOSPITAL CORPORATION
MCSA, L.L.C.
MOBERLY HOSPITAL COMPANY, LLC
NATIONAL HEALTHCARE OF LEESVILLE, INC.
NATIONAL HEALTHCARE OF MT. VERNON, INC.
NORTHAMPTON HOSPITAL COMPANY, LLC
NORTHWEST HOSPITAL, LLC
ORO VALLEY HOSPITAL, LLC
PAYSON HOSPITAL CORPORATION
PETERSBURG HOSPITAL COMPANY, LLC
PHOENIXVILLE HOSPITAL COMPANY, LLC
POTTSTOWN HOSPITAL COMPANY, LLC
PORTER HOSPITAL, LLC
QHG OF ENTERPRISE, INC.
QHG OF SOUTH CAROLINA, INC.
ROSWELL HOSPITAL CORPORATION
RUSTON LOUISIANA HOSPITAL COMPANY, LLC

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

ORIGINATORS (CONT.):

SAN MIGUEL HOSPITAL CORPORATION
SCRANTON HOSPITAL COMPANY, LLC
SHELBYVILLE HOSPITAL CORPORATION
SILOAM SPRINGS ARKANSAS HOSPITAL COMPANY, LLC
SPOKANE VALLEY WASHINGTON HOSPITAL COMPANY, LLC
SPOKANE WASHINGTON HOSPITAL COMPANY, LLC
ST. JOSEPH HEALTH SYSTEM LLC
TOMBALL TEXAS HOSPITAL COMPANY, LLC
TOOELE HOSPITAL CORPORATION
WARREN OHIO HOSPITAL COMPANY, LLC
WARREN OHIO REHAB HOSPITAL COMPANY, LLC
WARSAW HEALTH SYSTEM LLC
WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC
WEATHERFORD TEXAS HOSPITAL COMPANY, LLC
WESLEY HEALTH SYSTEM, LLC
WEST GROVE HOSPITAL COMPANY, LLC
WILKES-BARRE HOSPITAL COMPANY, LLC
WOMEN & CHILDREN'S HOSPITAL, LLC
YOUNGSTOWN OHIO HOSPITAL COMPANY, LLC

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

ORIGINATORS (CONT.):

ANNA HOSPITAL CORPORATION
AUGUSTA HOSPITAL, LLC
BIG BEND HOSPITAL CORPORATION
BIG SPRING HOSPITAL CORPORATION
BLUE RIDGE GEORGIA HOSPITAL COMPANY, LLC
CENTRE HOSPITAL CORPORATION
CLINTON HOSPITAL CORPORATION
DEMING HOSPITAL CORPORATION
EVANSTON HOSPITAL CORPORATION
FALLBROOK HOSPITAL CORPORATION
FORREST CITY ARKANSAS HOSPITAL COMPANY, LLC
FORT PAYNE HOSPITAL CORPORATION
GREENVILLE HOSPITAL CORPORATION
HOSPITAL OF BARSTOW, INC.
HOSPITAL OF FULTON, INC.
HOSPITAL OF LOUISA, INC.
KIRKSVILLE MISSOURI HOSPITAL COMPANY, LLC
LEXINGTON HOSPITAL CORPORATION
LUTHERAN MUSCULOSKELETAL CENTER, LLC
MARION HOSPITAL CORPORATION
MCKENZIE TENNESSEE HOSPITAL COMPANY, LLC
MMC OF NEVADA, LLC
NATIONAL HEALTHCARE OF NEWPORT, INC.
OAK HILL HOSPITAL CORPORATION
PHILLIPS HOSPITAL CORPORATION

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

ORIGINATORS (CONT.):

RED BUD ILLINOIS HOSPITAL COMPANY, LLC
SALEM HOSPITAL CORPORATION
SCRANTON QUINCY HOSPITAL COMPANY, LLC
SUNBURY HOSPITAL COMPANY, LLC
WATSONVILLE HOSPITAL CORPORATION
WILLIAMSTON HOSPITAL CORPORATION
WOODWARD HEALTH SYSTEM, LLC

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

ORIGINATORS (CONT.):

BROWNWOOD HOSPITAL, L.P.
By: Brownwood Medical Center, LLC
Its: General Partner

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

COLLEGE STATION HOSPITAL, L.P.
By: College Station Medical Center, LLC
Its: General Partner

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

IOM HEALTH SYSTEM, L.P.
By: Lutheran Health Network Investors, LLC
Its: General Partner

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

ORIGINATORS (CONT.):

LAREDO TEXAS HOSPITAL COMPANY, L.P.
By: Webb Hospital Corporation
Its: General Partner

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

LONGVIEW MEDICAL CENTER, L.P.
By: Regional Hospital of Longview, LLC
Its: General Partner

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

NAVARRO HOSPITAL, L.P.
By: Navarro Regional, LLC
Its: General Partner

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

ORIGINATORS (CONT.):

PINEY WOODS HEALTHCARE SYSTEM, L.P.
By: Woodland Heights Medical Center, LLC
Its: General Partner

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

REHAB HOSPITAL OF FORT WAYNE GENERAL PARTNERSHIP
By: Lutheran Health Network Investors, LLC
Its: General Partner

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

SAN ANGELO HOSPITAL, L.P.
By: San Angelo Community Medical Center, LLC
Its: General Partner

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

VICTORIA OF TEXAS, L.P.
By: Detar Hospital, LLC
Its: General Partner

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

ORIGINATORS (CONT.):

ARMC, L.P.
By: Triad-ARMC, LLC
Its: General Partner

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

CRESTWOOD HEALTHCARE, L.P.
By: Crestwood Hospital, LLC
Its: General Partner

By: /s/ James W. Doucette
Name: James W. Doucette
Title: Senior Vice President and Treasurer

Exhibit 12.1

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

	Nine Months Ended September 30, 2014
Earnings	
Income from continuing operations before provision for income taxes	$ 109
Income from equity investees	(35)
Distributed income from equity investees	21
Interest and amortization of deferred finance costs	728
Amortization of capitalized interest	4
Implicit rental interest expense	80
Total Earnings	$ 907
Fixed Charges	
Interest and amortization of deferred finance costs	$ 728
Capitalized interest	7
Implicit rental interest expense	80
Total Fixed Charges	$ 815
Ratio of Earnings to Fixed Charges	**1.11 x**

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

Exhibit 31.1

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 quarterly 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 quarterly report;

3. Based on my knowledge, the financial statements, and other financial information included in this quarterly 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 quarterly 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 quarterly report is being prepared;

b) designed such internal control 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.

Date: November 4, 2014

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

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

Exhibit 31.2

I, W. Larry Cash, certify that:

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

2. Based on my knowledge, this quarterly 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 quarterly report;

3. Based on my knowledge, the financial statements, and other financial information included in this quarterly 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 quarterly 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 quarterly report is being prepared;

b) designed such internal control 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.

Date: November 4, 2014

/s/ W. Larry Cash
W. Larry Cash
President of Financial Services,
Chief Financial Officer and Director

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, 2014, 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

November 4, 2014

A signed original of this written statement required by Section 906 has been provided to Community Health Systems, Inc. and will be retained by Community Health Systems, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

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, 2014, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, W. Larry Cash, President of Financial Services, Chief Financial Officer and Director 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/ W. Larry Cash
W. Larry Cash
President of Financial Services, Chief Financial Officer and Director

November 4, 2014

A signed original of this written statement required by Section 906 has been provided to Community Health Systems, Inc. and will be retained by Community Health Systems, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

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

I. PREAMBLE

Community Health Systems, Inc. hereby enters into this 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). 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 CIA shall be five 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 involving CHSI's Laredo Medical Center ("LMC") that:

    a. involves, directly or indirectly, the offer, payment, solicitation, or receipt of anything of value; and is between LMC and any actual or potential source of health care business or referrals to LMC or any actual or potential recipient of health care business or referrals from LMC. 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 LMC refers an individual for the furnishing or arranging for the furnishing of any item or service, or (2) from whom LMC 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 LMC 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 LMC for designated health services (as defined at 42 U.S.C. § 1395nn(h)(6)).

7. "Focus Arrangements" means every Arrangement involving CHSI's LMC that:

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

b. is between LMC 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 LMC 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 LMC.

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;

iii. 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 LMC 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, LMC 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. *Inpatient Medical Necessity and Appropriateness Review.* The IRO shall review CHSI Covered Facilities coding, billing, and claims submission to the Federal health care programs and the reimbursement received (Inpatient Medical Necessity and Appropriateness Review) and shall prepare an Inpatient Medical Necessity and Appropriateness 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 of LMC arrangements 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 Inpatient Medical Necessity and Appropriateness 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 Inpatient Medical Necessity and Appropriateness Review, Arrangements Review, or Unallowable Cost Review fails to conform to the requirements of this CIA; or (b) the IRO's findings or Inpatient Medical Necessity and Appropriateness Review, Arrangements Review, or Unallowable Cost Review results are inaccurate, OIG may, at its sole discretion, conduct its own review to determine whether the Inpatient Medical Necessity and Appropriateness Review, Arrangements Review, or Unallowable Cost Review complied with the requirements of the CIA and/or the findings or Inpatient Medical Necessity and Appropriateness 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 Inpatient Medical Necessity and Appropriateness Review, Arrangements Review, or Unallowable Cost Review submissions or findings; (b) present any additional information to clarify the results of the Inpatient Medical Necessity and Appropriateness Review, Arrangements Review, or Unallowable Cost Review or to correct the inaccuracy of the Inpatient Medical Necessity and Appropriateness 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 Inpatient Medical Necessity and Appropriateness 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 five 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;

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:

Andrea E. Bosshart
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 Inpatient Medical Necessity and Appropriateness 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/ Andrea Bosshart	July 23, 2014
Andrea Bosshart Sr. Vice President, Corporate Compliance and Privacy Officer	DATE
/s/ Richard Sauber	July 23, 2014
Richard Sauber, Esq. Counsel for CHSI	DATE

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

/s/ Robert K. DeConti	July 28, 2014
ROBERT K. DECONTI Assistant Inspector General for Legal Affairs Office of Inspector General U. S. Department of Health and Human Services	DATE
/s/ Felicia E. Heimer	July 24, 2014
FELICIA E. HEIMER Senior Counsel Office of Inspector General U.S. Department of Health and Human Services	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 that possesses the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO shall conduct the review in a professionally independent and objective fashion, as set forth in Paragraph D. 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.

2. If CHSI engages a new IRO during the term of the CIA, this IRO shall 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 Inpatient Medical Necessity and Appropriateness Review, and Unallowable Cost Review who have expertise in the billing, coding, reporting, and other requirements governing inpatient admissions of Federal health care program beneficiaries, and in the general requirements of the Federal health care programs from which CHSI seeks reimbursement;

2. assign individuals to design and select the Inpatient Medical Necessity and Appropriateness Review sample who are knowledgeable about the appropriate statistical sampling techniques;

3. assign individuals to conduct the coding review portions of the Inpatient Medical Necessity and Appropriateness Review who have a nationally recognized coding certification and who have maintained this certification (e.g., completed applicable continuing education requirements); and

4. assign individuals to conduct the Arrangements Review who are knowledgeable in the requirements of the Anti-Kickback Statute and Stark Law and the regulations and other guidance documents related to these statutes; and

5. 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 Inpatient Medical Necessity and Appropriateness Review and Unallowable Cost review in accordance with the specific requirements of the CIA;

2. follow all applicable Federal health care program rules and reimbursement guidelines in making assessments in the Inpatient Medical Necessity and Appropriateness Review;

3. if in doubt of the application of a particular Federal health care program policy or regulation, request clarification from the appropriate authority (e.g., Medicare contractor);

4. perform each Arrangements Review in accordance with the specific requirements of the CIA;

5. respond to all OIG inquires in a prompt, objective, and factual manner; and

6. prepare timely, clear, well-written reports that include all the information required by Appendix B and Appendix C to the CIA.

D. IRO Independence and Objectivity

The IRO must perform the Inpatient Medical Necessity and Appropriateness Review and Arrangements Review in a professionally independent and objective fashion, as defined in the most recent Government Auditing Standards issued by the United States Government Accountability Office.

E. IRO Removal/Termination

1. *Provider 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 its reasons for termination or the reason for 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 the IRO does not possess the qualifications described in Paragraph B, is not independent and objective as set forth in Paragraph D, or has failed to carry out its responsibilities as described in Paragraph C, OIG may, at its sole discretion, require CHSI to engage a new IRO in accordance with Paragraph A of this Appendix. CHSI must engage a new IRO within 60 days of termination of the IRO.

Prior to requiring CHSI to engage a new IRO, OIG shall notify CHSI of its intent to do so and provide a written explanation of why OIG believes such a step is necessary. To resolve any concerns raised by OIG, CHSI may present additional information regarding the IRO's qualifications, independence or performance of its responsibilities. OIG will attempt in good faith to resolve any differences regarding the IRO with CHSI prior to requiring CHSI to terminate the IRO. However, 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

INPATIENT MEDICAL NECESSITY AND APPROPRIATENESS REVIEW

A. Inpatient Medical Necessity and Appropriateness Review. The IRO shall perform the Inpatient Medical Necessity and Appropriateness Review annually to cover each of the five Reporting Periods. The IRO shall perform all components of each Inpatient Medical Necessity and Appropriateness Review. The Inpatient Medical Necessity and Appropriateness Review shall be conducted at 7.5% of CHSI's Covered Facilities for each Reporting Period. Each Inpatient Medical Necessity and Appropriateness Review shall consist of all the following. The IRO shall evaluate and analyze CHSI's inpatient admissions, relevant length of stays, associated billing, and claims submissions to Federal health care programs and the reimbursement received, and determine if such admissions and lengths of stays (as identified in Section A.2.b of Appendix B) were medically necessary and appropriate under the applicable Federal health care program rules and regulations governing inpatient admission, treatment, discharge, billing, and reimbursement. The Inpatient Medical Necessity and Appropriateness Review shall include a Discovery Sample and, if necessary, a Full Sample for each CHSI Covered Facility reviewed. The review shall be performed as follows:

1. *Selection of CHSI Covered Facilities To Be Reviewed*. Within 60 days after the end of each Reporting Period, CHSI shall provide OIG and the IRO with the following information for each CHSI Covered Facility for the prior fiscal year: (1) Total dollar amount of Paid Claims for inpatient discharges; and (2) the percentage of Federal health care program reimbursement received by the CHSI Covered Facility compared to the Covered Facility's total revenue. In addition, within 60 days after the end of each Reporting Period, the IRO shall provide OIG with its recommendations of the Covered Facilities to be reviewed for the Reporting Period. Within 30 days after OIG receives the IRO's recommendations, OIG will notify CHSI and the IRO if the recommendations are unacceptable and provide a final list of Covered Facilities to be reviewed and the schedule of reviews. Absent notification from OIG that the recommendations are unacceptable, the IRO may proceed with the Inpatient Medical Necessity and Appropriateness Review.

2. *Definitions*. For the purposes of the Inpatient Medical Necessity and Appropriateness 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 any Federal health care program requirements, as determined by the IRO

in connection with the Inpatient Medical Necessity and Appropriateness Reviews performed under this Appendix B, and which shall include any extrapolated Overpayments determined in accordance with Section A.3 and A.4 of this Appendix B.

b. Paid Claim: A claim submitted by CHSI and for which CHSI has received reimbursement from the Medicare program, limited to the following categories of claims:

i. "Zero-day" inpatient admissions, i.e., claims bearing the same calendar date for both the admission and the discharge date; and

ii. "One-day" inpatient admissions, i.e., claims bearing an admission date followed by a discharge date one calendar day later.

c. Population: The Population shall be defined as all Paid Claims during the 12-month period covered by the Inpatient Medical Necessity and Appropriateness Review.

d. Error Rate: The Error Rate shall be the percentage of net Overpayments identified in the sample. The net Overpayments shall be calculated by subtracting all underpayments identified in the sample from all gross Overpayments identified in the sample. (Note: Any potential cost settlements or other supplemental payments should not be included in the net Overpayment calculation. Rather, only underpayments identified as part of the Discovery Sample shall be included as part of the net Overpayment calculation.)

The Error Rate is calculated by dividing the net Overpayment identified in the sample by the total dollar amount associated with the Paid Claims in the sample.

3. *Discovery Sample.* The IRO shall randomly select and review a sample of 50 Paid Claims (each constituting a "Discovery Sample") at each CHSI Covered 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 billing and coding, regulations and guidance to determine whether the claim was correctly coded, submitted, and reimbursed.

If the Error Rate (as defined above) for any Discovery Sample for any CHSI Covered Facility is less than 5%, no additional sampling is required, nor is the Systems Review required. (Note: The guidelines listed above do not imply that this is an acceptable error rate. Accordingly, CHSI should, as appropriate, further analyze any errors identified in the Discovery Sample. CHSI recognizes that OIG or other HHS component, in its discretion and as authorized by statute, regulation, or other appropriate authority may also analyze or review Paid Claims included, or errors identified, in the Discovery Sample or any other segment of the universe.)

4. *Full Sample*. If the Discovery Sample at any CHSI Covered Facility selected for review indicates that the Error Rate is 5% or greater, the IRO shall select an additional sample of Paid Claims from that CHSI Covered Facility (Full Sample) using commonly accepted sampling methods. The Paid Claims selected for any Full Sample shall be reviewed based on supporting documentation available at CHSI or under CHSI's control and applicable billing and coding regulations and guidance to determine whether the claim was correctly coded, submitted, and reimbursed. For purposes of calculating the size of any Full Sample, the Discovery Sample may serve as the probe sample, if statistically appropriate. Additionally, the IRO may use the Paid Claims sampled as part of the Discovery Sample, and the corresponding findings for those Paid Claims, as part of its Full Sample, if: (1) statistically appropriate and (2) the IRO selects the Full Sample Paid Claims using the seed number generated by the Discovery Sample. The findings of the Full Sample shall be used by the IRO to estimate the actual Overpayment in the Population with a 90% confidence level and with a maximum relative precision of 25% of the point estimate. OIG, in its sole discretion, may refer the findings of the Full Sample (and any related workpapers) received from CHSI to the appropriate Federal health care program payor (e.g., Medicare contractor), for appropriate follow-up by that payor.

5. *Systems Review*. If CHSI's Discovery Sample at any CHSI Covered Facility Selected for review identifies an Error Rate of 5% or greater, CHSI's IRO shall also conduct a Systems Review. The Systems Review shall consist of the following:

a. a review of CHSI's admissions, utilization review, billing and coding systems and processes relating to claims submitted to Federal health care programs (the processes and systems used to decide the appropriate level of care, utilization review processes and systems, the operation of the billing system, the process by which claims are coded, safeguards to ensure proper coding, claims submission and billing; and procedures to identify and correct inaccurate coding and billing);

b. for each claim in the Discovery Sample and Full Sample that resulted in an Overpayment, the IRO shall review the system(s) and process(es) that generated the 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 claim.

6. *Other Requirements*

a. Supplemental Materials. The IRO shall request all documentation and materials required for its review of the Paid Claims selected as part of the Discovery Sample or Full Sample (if applicable), and CHSI shall furnish such documentation and materials to the IRO prior to the IRO initiating its review of the Discovery Sample or Full Sample (if applicable). If the IRO accepts any supplemental documentation or materials from CHSI after the IRO has completed its initial review of the Discovery Sample or Full Sample (if applicable) (Supplemental Materials), the IRO shall identify in the Inpatient Medical Necessity and Appropriateness 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 Inpatient Medical Necessity and Appropriateness 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 sufficient to support the Paid Claim 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 all samples (Discovery Sample(s) and Full Sample(s)) discussed in this Appendix, the Paid Claims selected in each first sample 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 Discovery Sample or Full Sample).

7. *Repayment of Identified Overpayments.* CHSI shall repay within 60 days any Overpayment(s) identified in the Discovery Sample(s), regardless of the Error Rate, and (if applicable) the Full Sample(s), including the IRO's estimate of the actual Overpayment in the Population as determined in accordance with Section A.3 and A.4 above, in accordance with payor refund policies. CHSI shall make available to OIG all documentation that reflects the refund of the Overpayment(s) to the payor.

B. Inpatient Medical Necessity and Appropriateness Review Report. The IRO shall prepare an Inpatient Medical Necessity and Appropriateness Review Report as described in this Appendix for each Inpatient Medical Necessity and Appropriateness Review performed. The following information shall be included in the Inpatient Medical Necessity and Appropriateness Review Report for each Discovery Sample and Full Sample (if applicable).

1. *Inpatient Medical Necessity and Appropriateness Review Methodology*

a. Inpatient Medical Necessity and Appropriateness Review Population. A description of the Population subject to the Inpatient Medical Necessity and Appropriateness Review.

b. Inpatient Medical Necessity and Appropriateness Review Objective. A clear statement of the objective intended to be achieved by the Inpatient Medical Necessity and Appropriateness Review.

c. Source of Data. A description of the specific documentation relied upon by the IRO when performing the Inpatient Medical Necessity and Appropriateness 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 Inpatient Medical Necessity and Appropriateness Review was conducted and what was evaluated.

e. Supplemental Materials. A description of any Supplemental Materials as required by Section A.6.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 copy of the statistical software printout(s) estimating how many Paid Claims are to be included in the Full Sample, if applicable.

   c. A description or identification of the statistical sampling software package used to select the sample and determine the Full Sample size, if applicable.

3. *Inpatient Medical Necessity and Appropriateness Review Findings*

   a. Narrative Results

      i. A description of CHSI's admission, utilization review, billing and coding system(s), including the identification, by position description, of the personnel involved in level of care decisions, utilization review, coding and billing.

      ii. A narrative explanation of the IRO's findings and supporting rationale (including reasons for errors, patterns noted, etc.) regarding the Inpatient Medical Necessity and Appropriateness Review, including the results of the Discovery Sample(s), and the results of the Full Sample(s) (if any).

   b. Quantitative Results

      i. Total number and percentage of instances in which the IRO determined that the Paid Claims submitted by CHSI (Claim Submitted) differed from what should have been the correct claim (Correct Claim), regardless of the effect on the payment.

      ii. Total number and percentage of instances in which the Claim Submitted differed from the Correct Claim and in which such difference resulted in an Overpayment to CHSI.

      iii. Total dollar amount of all Overpayments in the Discovery Sample and the Full Sample (if applicable).

iv. Total dollar amount of Paid Claims included in the Discovery Sample and the Full Sample and the net Overpayment associated with the Discovery Sample and the Full Sample.

v. Error Rate in the Discovery Sample and the Full Sample.

vi. A spreadsheet of the Inpatient Medical Necessity and Appropriateness 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.

vii. If a Full Sample is performed, the methodology used by the IRO to estimate the actual Overpayment in the Population and the amount of such Overpayment.

c. Recommendations. The IRO's report shall include any recommendations for improvements to CHSI's billing and coding system based on the findings of the Inpatient Medical Necessity and Appropriateness Review.

4. *Systems Review Findings*. The IRO shall prepare a Systems Review Report based on the Systems Review performed (if applicable) that shall include the IRO's observations, findings, and recommendations regarding:

a. the strengths and weaknesses in CHSI's admissions systems and processes;

b. the strengths and weaknesses in CHSI's utilization review systems and processes;

c. the strengths and weaknesses in CHSI's billing systems and processes;

d. the strengths and weaknesses in CHSI's coding systems and processes; and

e. possible improvements to CHSI's admissions, utilization review, billing, and coding systems and processes to address the specific problems or weaknesses that resulted in the identified Overpayments.

5. *Credentials*. The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Inpatient Medical Necessity and Appropriateness Review and (2) performed the Inpatient Medical Necessity and Appropriateness 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 and fourth Reporting Periods. 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 and fourth Reporting Periods. The Arrangements Transactions Review shall be performed annually and shall cover each of the five Reporting Periods.

A. 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.

B. 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 A.1-9 above;

3. findings and supporting rationale regarding weaknesses in CHSI's systems, processes, policies, and procedures relating to Arrangements described in Section A.1-9 above; and

4. recommendations to improve CHSI's systems, policies, processes, or procedures relating to Arrangements described in Section A.1-9 above.

C. 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.

D. 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.