Eaton Corp plc
Form 4
January 25, 2013

FORM 4

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

STATEMENT OF CHANGES IN BENEFICIAL OWNERSHIP OF SECURITIES

Filed pursuant to Section 16(a) of the Securities Exchange Act of 1934, Section 17(a) of the Public Utility Holding Company Act of 1935 or Section 30(h) of the Investment Company Act of 1940

OMB APPROVAL

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Check this box if no longer subject to Section 16. Form 4 or Form 5 obligations may continue. *See* Instruction 1(b).

(Print or Type Responses)

1. Name and Address of Reporting Person *
PAGE GREGORY R

(Last) (First) (Middle)

EATON CENTER, 1111 SUPERIOR AVENUE

(Street)

CLEVELAND, OH 44114

(City) (State) (Zip)

2. Issuer Name **and** Ticker or Trading Symbol
Eaton Corp plc [ETN]

3. Date of Earliest Transaction (Month/Day/Year)
01/23/2013

4. If Amendment, Date Original Filed(Month/Day/Year)

5. Relationship of Reporting Person(s) to Issuer

(Check all applicable)

__X__ Director _____ 10% Owner
_____ Officer (give title below) _____ Other (specify below)

6. Individual or Joint/Group Filing(Check Applicable Line)
_X_ Form filed by One Reporting Person
___ Form filed by More than One Reporting Person

Table I - Non-Derivative Securities Acquired, Disposed of, or Beneficially Owned

1.Title of Security (Instr. 3)	2. Transaction Date (Month/Day/Year)	2A. Deemed Execution Date, if any (Month/Day/Year)	3. Transaction Code (Instr. 8)		4. Securities Acquired (A) or Disposed of (D) (Instr. 3, 4 and 5)			5. Amount of Securities Beneficially Owned Following Reported Transaction(s) (Instr. 3 and 4)	6. Ownership Form: Direct (D) or Indirect (I) (Instr. 4)	7. Nature of Indirect Beneficial Ownership (Instr. 4)
			Code	V	Amount	(A) or (D)	Price			

Reminder: Report on a separate line for each class of securities beneficially owned directly or indirectly.

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SEC 1474 (9-02)

Table II - Derivative Securities Acquired, Disposed of, or Beneficially Owned
(*e.g.*, puts, calls, warrants, options, convertible securities)

1. Title of Derivative Security	2. Conversion or Exercise	3. Transaction Date (Month/Day/Year)	3A. Deemed Execution Date, if any	4. Transaction Code	5. Number of Derivative Securities	6. Date Exercisable and Expiration Date (Month/Day/Year)	7. Title and Amount of Underlying Securities	8. Pri Deriv Secur

(Instr. 3)	Price of Derivative Security	(Month/Day/Year)	(Instr. 8)	Acquired (A) or Disposed of (D) (Instr. 3, 4, and 5)				(Instr. 3 and 4)				(Instr
			Code	V	(A)	(D)	Date Exercisable	Expiration Date	Title	Amount or Number of Shares		
Restricted Stock Units	$ 0	01/23/2013	A		2,338		(1)	(1)	Ordinary Shares	2,338		$

Reporting Owners

Reporting Owner Name / Address	Relationships			
	Director	10% Owner	Officer	Other
PAGE GREGORY R EATON CENTER 1111 SUPERIOR AVENUE CLEVELAND, OH 44114	X			

Signatures

/s/Elizabeth K. Riotte, as Attorney-in-Fact	01/25/2013
**Signature of Reporting Person	Date

Explanation of Responses:

***** If the form is filed by more than one reporting person, *see* Instruction 4(b)(v).

****** Intentional misstatements or omissions of facts constitute Federal Criminal Violations. *See* 18 U.S.C. 1001 and 15 U.S.C. 78ff(a).

(1) These restricted stock units vest in their entirety upon the reporting person's retirement from the Eaton Corporation plc Board of Directors.

Note: File three copies of this Form, one of which must be manually signed. If space is insufficient, *see* Instruction 6 for procedure.
Potential persons who are to respond to the collection of information contained in this form are not required to respond unless the form displays a currently valid OMB number. > 97,810 190,082

Depreciation and amortization

287,240 193,806 481,046

Total operating costs and expenses			
	5,306,669	4,063,720	9,370,389

Income from operations

616,953 236,539 853,492

Interest expense, net

65,799 378,598 41,531 485,928

Equity in earnings of unconsolidated affiliates

(171,017) (182,668) (118,116) 433,456 (38,345)

Explanation of Responses:

Income from continuing operations before income taxes

171,017 116,869 356,471 195,008 (433,456) 405,909

Provision for (benefit from) income taxes

(54,148) 128,686 51,092 125,630

Income from continuing operations

171,017 171,017 227,785 143,916 (433,456) 280,279

Discontinued operations, net of taxes:

Income (loss) from operations of entities sold and held for sale

(1,278) (3,268) (4,546)

Impairment of hospitals sold and held for sale

(47,930) (47,930)

Loss on sale

(3,300) (3,300)

Explanation of Responses:

Loss from discontinued operations, net of taxes

(49,208) (6,568) (55,776)

Net income

171,017 171,017 178,577 137,348 (433,456) 224,503

Explanation of Responses:

Less: Net income attributable to noncontrolling interests						
	53,486	53,486				
Net income attributable to Community Health Systems, Inc.						
	$171,017	$171,017	$178,577	$83,862	$(433,456)	$171,017

Explanation of Responses: 9

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

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

Condensed Consolidating Statement of Income

Nine Months Ended September 30, 2010

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net operating revenues	$	$	$ 5,362,911	$ 3,946,170	$	$ 9,309,081
Operating costs and expenses:						
Salaries and benefits			2,028,716	1,716,627		3,745,343
Provision for bad debts			668,161	452,854		1,121,015
Supplies			728,225	558,900		1,287,125
Other operating expenses			930,729	762,501		1,693,230
Rent			87,669	97,412		185,081
Depreciation and amortization			257,392	183,579		440,971
Total operating costs and expenses			4,700,892	3,771,873		8,472,765
Income from operations			662,019	174,297		836,316
Interest expense, net		88,079	358,942	36,029		483,050
Equity in earnings of unconsolidated affiliates	(210,473)	(245,197)	(88,435)		510,997	(33,108)
Income from continuing operations before income taxes	210,473	157,118	391,512	138,268	(510,997)	386,374
Provision for (benefit from) income taxes		(53,355)	144,076	34,908		125,629
Income from continuing operations	210,473	210,473	247,436	103,360	(510,997)	260,745
Discontinued operations, net of taxes:						
Income (loss) from operations of entities sold and held for sale			(2,901)	(1,652)		(4,553)
Impairment of hospitals sold and held for sale						
Loss on sale						
Loss from discontinued operations, net of taxes			(2,901)	(1,652)		(4,553)
Net income	210,473	210,473	244,535	101,708	(510,997)	256,192
Less: Net income attributable to noncontrolling interests				45,719		45,719
Net income attributable to Community Health Systems, Inc.	$ 210,473	$ 210,473	$ 244,535	$ 55,989	$ (510,997)	$ 210,473

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, 2011

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Cash flows from operating activities:						
Net cash (used in) provided by operating activities	$ (23,970)	$ (120,269)	$ 595,670	$ 368,804	$	$ 820,235
Cash flows from investing activities:						
Acquisitions of facilities and other related equipment			(163,397)	(46,054)		(209,451)
Purchases of property and equipment			(295,298)	(237,547)		(532,845)
Proceeds from disposition of hospitals and other ancillary operations				172,578		172,578
Proceeds from sale of property and equipment			1,269	7,982		9,251
Increase in other non-operating assets			(90,009)	(40,971)		(130,980)
Net cash used in investing activities			(547,435)	(144,012)		(691,447)
Cash flows from financing activities:						
Proceeds from exercise of stock options	18,880					18,880
Deferred financing costs		(100)				(100)
Excess tax benefit relating to stock-based compensation	4,616					4,616
Stock buy-back	(85,790)					(85,790)
Proceeds from noncontrolling investors in joint ventures				1,229		1,229
Redemption of noncontrolling investments in joint ventures				(4,784)		(4,784)
Distributions to noncontrolling investors in joint ventures				(49,928)		(49,928)
Changes in intercompany balances with affiliates, net	86,264	157,854	(90,312)	(153,806)		
Borrowings under credit agreement		83,000				83,000
Repayments of long-term indebtedness		(120,485)	(7,222)	(1,061)		(128,768)
Net cash provided by (used in) financing activities	23,970	120,269	(97,534)	(208,350)		(161,645)
Net change in cash and cash equivalents			(49,299)	16,442		(32,857)
Cash and cash equivalents at beginning of period			212,992	86,177		299,169
Cash and cash equivalents at end of period	$	$	$ 163,693	$ 102,619	$	$ 266,312

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, 2010

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Cash flows from operating activities:						
Net cash (used in) provided by operating activities	$ (150,750)	$ (101,498)	$ 804,039	$ 346,586	$	$ 898,377
Cash flows from investing activities:						
Acquisitions of facilities and other related equipment			(39,140)	(28,401)		(67,541)
Purchases of property and equipment			(211,023)	(170,830)		(381,853)
Proceeds from disposition of hospitals and other ancillary operations						
Proceeds from sale of property and equipment			2,398	447		2,845
Increase in other non-operating assets			(64,177)	(34,325)		(98,502)
Net cash used in investing activities			(311,942)	(233,109)		(545,051)
Cash flows from financing activities:						
Proceeds from exercise of stock options	53,839					53,839
Deferred financing costs						
Excess tax benefit relating to stock-based compensation	10,109					10,109
Stock buy-back	(107,932)					(107,932)
Proceeds from noncontrolling investors in joint ventures				5,155		5,155
Redemption of noncontrolling investments in joint ventures				(2,467)		(2,467)
Distributions to noncontrolling investors in joint ventures				(41,870)		(41,870)
Changes in intercompany balances with affiliates, net	194,734	134,102	(246,860)	(81,976)		
Borrowings under credit agreement						
Repayments of long-term indebtedness		(32,604)	(12,788)	(1,560)		(46,952)
Net cash provided by (used in) financing activities	150,750	101,498	(259,648)	(122,718)		(130,118)
Net change in cash and cash equivalents			232,449	(9,241)		223,208
Cash and cash equivalents at beginning of period			238,709	105,832		344,541
Cash and cash equivalents at end of period	$	$	$ 471,158	$ 96,591	$	$ 567,749

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 accompanying notes included herein.

Throughout this Quarterly Report on Form 10-Q, Community Health Systems, Inc., the parent company, and its consolidated subsidiaries are referred to on a collective basis using words like we, our, us and the Company . This drafting style is not meant to indicate that the publicly-traded parent company or any 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. We provide healthcare services through the hospitals that we own and operate in non-urban and selected urban markets. We generate revenue primarily by providing a broad range of general hospital healthcare services to patients in the communities in which we are located. At September 30, 2011, we owned and operated 131 hospitals comprised of 127 general acute care hospitals and four stand-alone rehabilitation or psychiatric hospitals, including one hospital held for sale. In addition, we own and operate home care agencies, located primarily in markets where we also operate a hospital, and 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. During the three months ended March 31, 2011, we sold a multi-specialty physician clinic and identified a hospital as held for sale. In June 2011, we entered into a definitive agreement to sell two additional hospitals. During the three months ended September 30, 2011, we sold two of the three hospitals that were held for sale. We closed on the sale of the remaining hospital held for sale on October 22, 2011. Accordingly, the related results of operations, impairment of long-lived assets held for sale and the loss on sale have been classified as discontinued operations in the condensed consolidated statements of income for the three-month and nine-month periods ended September 30, 2011 and 2010. In addition, in October 2011, we acquired Tomball Regional Hospital, a 358 licensed bed facility located in Tomball, Texas.

Our net operating revenues for the three months ended September 30, 2011 increased to approximately $3.4 billion, as compared to approximately $3.2 billion for the three months ended September 30, 2010. Income from continuing operations, before noncontrolling interests, for the three months ended September 30, 2011 increased 8.9% over the three months ended September 30, 2010 to $95.8 million compared to $88.0 million. This increase in income from continuing operations during the three months ended September 30, 2011, as compared to the three months ended September 30, 2010, is due primarily to higher revenues from an increase in outpatient services, offsetting a decrease in inpatient admissions, an increase in average acuity of inpatient admissions, the recognition of HITECH incentives and the elimination of certain unprofitable services in a few of our hospitals. It also reflects our ability to realize reductions in supplies expense, purchased services and other operating expenses as a percentage of net operating revenues, combined with reductions in interest expense and income taxes, partially offset by expenses related to the Tenet lawsuit, shareholder lawsuits and governmental investigations. Total inpatient admissions for the three months ended September 30, 2011 decreased 0.7%, compared to the three months ended September 30, 2010, and adjusted admissions for the three months ended September 30, 2011 increased 4.9%, compared to the three months ended September 30, 2010. On a same-store basis, admissions decreased 7.0% and adjusted admissions decreased 1.1%, compared with the three months ended September 30, 2010.

Our net operating revenues for the nine months ended September 30, 2011 increased to approximately $10.2 billion, as compared to approximately $9.3 billion for the nine months ended September 30, 2010. Income from continuing operations, before noncontrolling interests, for the nine months ended September 30, 2011 increased 7.5% over the nine months ended September 30, 2010 to $280.3 million compared to $260.7 million. This increase in income from continuing operations during the nine months ended September 30, 2011, as compared to the nine months ended September 30, 2010, is due primarily to higher revenues from an increase in outpatient services, offsetting a decrease in inpatient admissions, an increase in average acuity of inpatient admissions, the recognition of HITECH incentives and the elimination of certain unprofitable services in a few of our hospitals. It also reflects our ability to reduce supplies expense as a percentage of net operating revenues, partially offset by expenses related to the Tenet lawsuit, shareholder lawsuits and government investigations. Our successful physician recruiting efforts continue to be a key driver in the

execution of our operating strategies. Total inpatient admissions for the nine months ended September 30, 2011 increased 0.5%, compared to the nine months ended September 30, 2010, and adjusted admissions for the nine months ended September 30, 2011 increased 5.0%, compared to the nine months ended September 30, 2010. On a same-store basis, admissions decreased 5.2% and adjusted admissions decreased 0.5%, compared to the nine months ended September 30, 2010.

Self-pay revenues represented approximately 12.3% and 11.7% of our net operating revenues for the three months ended September 30, 2011 and 2010, respectively, and approximately 12.2% and 11.6% of our net operating revenues for the nine months ended September 30, 2011 and 2010, respectively. The amount of foregone revenue related to providing charity care services as a percentage of net operating revenues was approximately 4.4% and 4.3% for the three months ended September 30, 2011 and 2010, respectively, and approximately 4.4% and 4.1% of our net operating revenues for the nine months ended September 30, 2011 and 2010, respectively. Direct and indirect costs incurred by us in providing charity care services were approximately 0.8% and 0.9% of net operating revenues for the three months ended September 30, 2011 and 2010, respectively, and 0.9% and 0.8% of net operating revenues for the nine months ended September 30, 2011 and 2010, respectively.

On July 19, 2011, we announced that one or more of our subsidiaries has executed a definitive agreement to acquire substantially all of the assets of Moses Taylor Health Care System, located in northeast Pennsylvania. The system includes Moses Taylor Hospital (217 licensed beds) in Scranton and Mid-Valley Hospital (25 licensed beds) in Peckville. The transaction, subject to customary federal and state regulatory approvals, is expected to be completed in the first quarter of 2012.

The Patient Protection and Affordable Care Act, or PPACA, was signed into law on March 23, 2010. In addition, the Health Care and Education Affordability Reconciliation Act of 2010, or Reconciliation Act, which contains a number of amendments to PPACA, was signed into law on March 30, 2010. These healthcare acts, referred to collectively as the Reform Legislation, include a mandate that requires substantially all United States citizens to maintain medical insurance coverage which will ultimately increase the number of persons with access to health insurance in the United States. The Reform Legislation should result in a reduction in uninsured patients, which should reduce our expense from uncollectible accounts receivable; however, this legislation 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, and a reduction to the Medicare and Medicaid disproportionate share payments, that could adversely impact the reimbursement received under these programs. The various provisions in the Reform Legislation that directly or indirectly affect reimbursement are scheduled to take effect over a number of years, and we cannot predict their impact at this time. Other provisions of the Reform Legislation, such as requirements related to employee health insurance coverage, should increase our operating costs.

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 federal 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.

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 physician self-referral law, or the Stark Law, that allows physicians to invest in an entire hospital (as opposed to individual hospital departments). The Reform Legislation changes 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 became 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. Physician investments in hospitals that are under development are protected by the grandfather clause only if the physician investments were made prior to the time the Reform Legislation became effective and the hospital has a Medicare provider agreement with an effective date on or prior to December 31, 2010.

The impact of the Reform Legislation on each of our hospitals will vary depending on payor mix and a variety of other factors. We anticipate that many of the provisions in the Reform Legislation will be subject to further clarification and modification through the rule-making process, the development of agency guidance and judicial interpretations. Moreover, a number of state attorneys general are challenging the legality of certain aspects of the Reform Legislation. Currently, rulings in five separate Federal District Courts, regarding the constitutionality of the Reform Legislation, have been split, with three courts ruling in favor of the legislation and two courts ruling that part or all of the Reform Legislation was unconstitutional. These decisions are in the process of being appealed to

the United States Supreme Court. We cannot predict the impact the Reform Legislation may have on our business, results of operations, cash flow, capital resources and liquidity or the ultimate outcome of the judicial rulings. 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 addition to the Reform Legislation, 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 increase the use of electronic health records, or EHR, technology and establish the requirements for a Medicare and Medicaid incentive payments program beginning in 2011 for eligible hospitals and providers that adopt and meaningfully use certified EHR technology. These incentive payments are intended to offset a portion of the cost incurred to implement and qualify as a meaningful user 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 begun to implement EHR technology on a facility-by-facility basis beginning in 2011. We anticipate recognizing revenues related to the Medicare or Medicaid incentives as we are able to implement the certified EHR technology and meet the defined meaningful use criteria. However, there can be no assurance that we will ultimately qualify for these incentive payments and should we qualify, the amounts received may vary from estimates as they are dependent on the availability of federal funding for both Medicare and Medicaid incentive payments, timing of the approval of state Medicaid incentive plans by the Centers for Medicare and Medicaid Services, or CMS, and the timing of our ability to implement and demonstrate meaningful use of the EHR technology. The timing of recognizing revenue from the incentive payments 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. Hospitals that do not qualify as a meaningful user of EHR technology by 2015 are subject to a reduced market basket update to the inpatient prospective payment system standardized amount in 2015 and each subsequent fiscal year. Although we believe that our hospital facilities will be in compliance with the EHR standards by 2015, there can be no assurance that all of our facilities will be in compliance and therefore not subject to the penalty provisions of HITECH. During the three-month and nine-month periods ended September 30, 2011, we recognized approximately $40.2 million of revenue for HITECH incentives from Medicare and Medicaid related to certain of our hospitals that have demonstrated meaningful use of certified EHR technology or have completed attestations to their adoption or implementation of certified EHR technology. Such revenues are included with net operating revenues on the condensed consolidated statement of income.

As a result of our current levels of cash, available borrowing capacity, long-term outlook on our debt repayments and our continued projection of our ability to generate cash flows, we do not anticipate a significant impact on our ability 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 the acquisition of Triad Hospitals, Inc., or Triad, as well as our more recent 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 Consolidated Net Operating Revenues

The following table presents the approximate percentages of net operating revenues derived from Medicare, Medicaid, managed care, self-pay and other sources 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,	
	2011	2010	2011	2010
Medicare	26.0%	27.1%	26.8%	27.5%
Medicaid	9.5%	11.2%	9.7%	10.7%
Managed Care and other third-party payors	52.2%	50.0%	51.3%	50.2%
Self-pay	12.3%	11.7%	12.2%	11.6%
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 net 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 will increase the number of insured patients which should reduce revenues from self-pay patients and reduce the provision for bad debts. The Reform Legislation, however, imposes significant reductions in amounts the government pays Medicare Managed Care plans. Other provisions in the Reform Legislation impose minimum medical-loss ratios and require insurers to meet specific benefit requirements. In addition, specified managed care programs, insurance companies, and employers are actively negotiating the amounts paid to hospitals. The trend toward increased enrollment in managed care may adversely affect our net 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 treatment of patients covered by these programs 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 by an insignificant amount in each of the three-month and nine-month periods ended September 30, 2011 and 2010. In the future, we expect the percentage of revenues received from the Medicare program to increase due to the general aging of the population.

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 revenues in the table above, and fees, taxes or other program related costs are reflected in other operating costs and expenses.

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 18, 2011, CMS issued the final rule to adjust this index by 3.0% 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 0.1% reduction to hospital inpatient rates implemented pursuant to the Reform Legislation, yielded a net 1.1% increase in reimbursement for hospital inpatient acute care services beginning October 1, 2011. Reductions in the rate of increase or overall reductions in Medicare reimbursement may cause a decline in the growth of our net operating revenues. In addition, specified managed care programs, insurance companies and employers are actively negotiating the amounts paid to hospitals. The trend toward increased enrollment in managed care may adversely affect our net operating revenue growth.

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.

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
	(Expressed as a percentage of net operating revenues)			
Consolidated				
Net operating revenues	100.0%	100.0%	100.0%	100.0%
Operating expenses (a)	(87.0)	(86.3)	(87.0)	(86.3)
Depreciation and amortization	(4.7)	(4.7)	(4.7)	(4.8)
Income from operations	8.3	9.0	8.3	8.9
Interest expense, net	(4.6)	(5.1)	(4.7)	(5.1)
Equity in earnings of unconsolidated affiliates	0.2	0.3	0.4	0.4
Income from continuing operations before income taxes	3.9	4.2	4.0	4.2
Provision for income taxes	(1.1)	(1.4)	(1.3)	(1.4)
Income from continuing operations	2.8	2.8	2.7	2.8
Loss from discontinued operations, net of taxes	(0.1)	(0.1)	(0.5)	
Net income	2.7	2.7	2.2	2.8
Less: Net income attributable to noncontrolling interests	(0.5)	(0.5)	(0.5)	(0.5)
Net income attributable to Community Health Systems, Inc.	2.2%	2.2%	1.7%	2.3%

	Three Months Ended September 30, 2011	Nine Months Ended September 30, 2011
Percentage increase (decrease) from same period prior year:		
Net operating revenues	8.7%	9.8%
Admissions	(0.7)	0.5
Adjusted admissions (b)	4.9	5.0
Average length of stay	4.8	2.3
Net income attributable to Community Health Systems, Inc. (c)	5.5	(18.7)
Same-store percentage increase (decrease) from same period prior year (d):		
Net operating revenues	3.8%	5.0%
Admissions	(7.0)	(5.2)
Adjusted admissions (b)	(1.1)	(0.5)

(a) Operating expenses include salaries and benefits, provision for bad debts, supplies, rent and other operating expenses.
(b) Adjusted admissions is a general measure of combined inpatient and outpatient volume. We computed adjusted admissions by multiplying admissions by gross patient revenues and then dividing that number by gross inpatient revenues.
(c) Includes loss from discontinued operations.
(d) Includes acquired hospitals to the extent we operated them in both periods.

Three Months Ended September 30, 2011 Compared to Three Months Ended September 30, 2010

Net operating revenues increased $276.2 million to approximately $3.4 billion for the three months ended September 30, 2011, from approximately $3.2 billion for the three months ended September 30, 2010. Hospitals owned throughout both periods contributed $120.8 million of that increase and hospitals acquired in 2011 and 2010 contributed $155.4 million. On a same-store basis, net operating revenues increased 3.8%. The increased net operating revenues contributed by hospitals that we owned throughout both periods were primarily attributable to general rate and reimbursement increases including revenues from states with provider assessment programs and HITECH incentives.

On a consolidated basis, inpatient admissions decreased by 0.7% and adjusted admissions increased by 4.9% during the three months ended September 30, 2011. On a same-store basis, inpatient admissions decreased by 7.0% during the three months ended September 30, 2011. This decrease in same-store inpatient admissions was due primarily to a decrease in admissions from women s services including obstetrics and gynecology, reductions in one day stays from the emergency room, reductions in surgical inpatient admissions with a corresponding increase in outpatient surgical visits and reductions due to competition, weather and certain service closures in a few of our hospitals during the three months ended September 30, 2011, as compared to the three months ended September 30, 2010.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, increased 0.7% to 87.0% for the three months ended September 30, 2011, compared to 86.3% for the three months ended September 30, 2010. Salaries and benefits, as a percentage of net operating revenues, increased 0.4% to 40.5% for the three months ended September 30, 2011, compared to 40.1% for the three months ended September 30, 2010. This increase is due primarily to the impact of recent acquisitions and an increase in the number of employed physicians, which offset efficiencies gained at hospitals owned throughout both periods. Provision for bad debts as a percentage of net operating revenues, increased 0.8% to 13.1% for the three months ended September 30, 2011, compared to 12.3% for the three months ended September 30, 2010. This increase is due primarily to the increase in self-pay revenues as a percentage of total net operating revenues. Supplies, as a percentage of net operating revenues, decreased 0.3% to 13.4% for the three months ended September 30, 2011, as compared to 13.7% for the three months ended September 30, 2010. This decrease is due primarily to lower implant costs, medical supply costs, drug costs, pacemaker costs and an improvement in vendor rebates. Other operating expenses, as a percentage of net operating revenues, decreased 0.1% to 18.1% for the three months ended September 30, 2011, as compared to 18.2% for the three months ended September 30, 2010. This decrease is due primarily to decreases in other operating expenses, partially offset by increased legal expenses and other costs relating to the Tenet lawsuit, shareholder lawsuits and the governmental investigations discussed in more detail in Legal Proceedings in Part II, Item 1 of this Form 10-Q. Rent, as a percentage of net operating revenues, decreased 0.1% to 1.9% for the three months ended September 30, 2011, as compared to 2.0% for the three months ended September 30, 2010. Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, decreased 0.1% to 0.2% for the three months ended September 30, 2011, compared to 0.3% for the three months ended September 30, 2010.

Depreciation and amortization, as a percentage of net operating revenues, remained consistent at 4.7% for each of the three-month periods ended September 30, 2011 and 2010.

Interest expense, net, decreased by $3.4 million from $162.9 million for the three months ended September 30, 2010 to $159.5 million for the three months ended September 30, 2011. A decrease in our average outstanding debt during the three months ended September 30, 2011, compared to September 30, 2010, resulted in a decrease in interest expense of $0.7 million. Additionally, interest expense decreased by $4.1 million as a result of more interest being capitalized during the three months ended September 30, 2011, as compared to the three months ended September 30, 2010, as the current year period had more major construction projects. These decreases were partially offset by an increase in interest rates during the three months ended September 30, 2011, compared to the three months ended September 30, 2010, which resulted in an increase in interest expense of $1.4 million.

The net of the above mentioned changes resulted in income from continuing operations before income taxes increasing $1.2 million from $131.3 million for the three months ended September 30, 2010 to $132.5 million for the three months ended September 30, 2011.

Provision for income taxes decreased from $43.3 million for the three months ended September 30, 2010 to $36.7 million for the three months ended September 30, 2011, due primarily to a benefit of $6.9 million recognized related to a settlement with the Internal Revenue Service, or IRS, which is comprised of $4.0 million related to a tax issue on appeal and $2.9 million related to various tax issues agreed upon at the examination level. Our effective tax rate decreased from 33.0% for the three months ended September 30, 2010 to 27.7% for the three months ended September 30, 2011.

Income from continuing operations, as a percentage of net operating revenues, remained consistent at 2.8% for both of the three-month periods ended September 30, 2011 and 2010. Net income, as a percentage of net operating revenues, remained consistent at 2.7% for both of the three-month periods ended September 30, 2011 and 2010.

Net income attributable to noncontrolling interests as a percentage of net operating revenues, remained consistent at 0.5% for both of the three-month periods ended September 30, 2011 and 2010.

Net income attributable to Community Health Systems, Inc. was $74.3 million for the three months ended September 30, 2011, compared to $70.4 million for the three months ended September 30, 2010, representing an increase of 5.5%. The increase in net income is primarily due to reductions in interest expense and provision for income taxes, partially offset by the increases in operating costs and expenses.

Nine months Ended September 30, 2011 Compared to Nine months Ended September 30, 2010

Net operating revenues increased $914.8 million to approximately $10.2 billion for the nine months ended September 30, 2011, from approximately $9.3 billion for the nine months ended September 30, 2010. Hospitals owned throughout both periods contributed $464.9 million of that increase and hospitals acquired in 2011 and 2010 along with the final settlement of a rate-related reimbursement dispute contributed $449.9 million. On a same-store basis, net operating revenues increased 5.0%. The increased net operating revenues contributed by hospitals that we owned throughout both periods were primarily attributable to general rate and reimbursement increases including revenues from states with provider assessment programs and HITECH incentives.

On a consolidated basis, inpatient admissions increased by 0.5% and adjusted admissions increased by 5.0% during the nine months ended September 30, 2011. This increase in inpatient and adjusted admissions was due primarily to acquisitions during the past twelve months. On a same-store basis, inpatient admissions decreased by 5.2% during the nine months ended September 30, 2011. This decrease in same-store inpatient admissions was due primarily to a decrease in admissions from women s services including obstetrics and gynecology, reductions in one day stays from the emergency room, reductions in surgical inpatient admissions with a corresponding increase in outpatient surgical visits and reductions due to competition, weather and certain service closures in a few of our hospitals during the nine months ended September 30, 2011, as compared to the nine months ended September 30, 2010.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, increased 0.7% to 87.0% for the nine months ended September 30, 2011, compared to 86.3% for the nine months ended September 30, 2010. Salaries and benefits, as a percentage of net operating revenues, increased 0.5% to 40.7% for the nine months ended September 30, 2011, compared to 40.2% for the nine months ended September 30, 2010. This increase is due primarily to the impact of recent acquisitions and an increase in the number of employed physicians, which offset efficiencies gained at hospitals owned throughout both periods. Provision for bad debts as a percentage of net operating revenues, increased 0.6% to 12.6% for the nine months ended September 30, 2011, compared to 12.0% for the nine months ended September 30, 2010. This increase is due primarily to the increase in self-pay revenues as a percentage of total net operating revenues. Supplies, as a percentage of net operating revenues, decreased 0.4% to 13.4% for the nine months ended September 30, 2011, as compared to 13.8% for the nine months ended September 30, 2010. This decrease is due primarily to lower implant costs, medical supply costs, drug costs, pacemaker costs and an improvement in vendor rebates. Other operating expenses, as a percentage of net operating revenues, increased 0.1% to 18.4% for the nine months ended September 30, 2011, as compared to 18.3% for the nine months ended September 30, 2010. This increase is due primarily to an increase in provider taxes from states with provider assessment programs and increased legal expenses and other costs relating to the Tenet lawsuit, shareholder lawsuits and the governmental investigations discussed in more detail in Legal Proceedings in Part II, Item 1 of this Form 10-Q. Rent, as a percentage of net operating revenues, decreased 0.1% to 1.9% for the nine months ended September 30, 2011, as compared to 2.0% for the nine months ended September 30, 2010. Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, remained consistent at 0.4% for each of the nine-month periods ended September 30, 2011 and 2010.

Depreciation and amortization, as a percentage of net operating revenues, decreased 0.1% to 4.7% for the nine months ended September 30, 2011, as compared to 4.8% for the nine months ended September 30, 2010.

Interest expense, net, increased by $2.9 million from $483.0 million for the nine months ended September 30, 2010 to $485.9 million for the nine months ended September 30, 2011. An increase in interest rates during the nine months ended September 30, 2011, compared to the nine months ended September 30, 2010, resulted in an increase in interest expense of $13.0 million. These increases were partially offset by a decrease in interest expense of $2.1 million due to a decrease in our average outstanding debt during the nine months ended September 30, 2011, compared to the nine months ended September 30, 2010. Additionally, interest expense decreased by $8.0 million as a result of more interest being capitalized during the nine months ended September 30, 2011, as compared to the nine months ended September 30, 2010, as the current year period had more major construction projects.

The net of the above mentioned changes resulted in income from continuing operations before income taxes increasing $19.5 million from $386.4 million for the nine months ended September 30, 2010 to $405.9 million for the nine months ended September 30, 2011.

Provision for income taxes remained consistent at $125.6 million for both of the nine-month periods ended September 30, 2011 and 2010. Our effective tax rates were 31.0% and 32.5% for the nine months ended September 30, 2011 and 2010, respectively. Our effective tax rate decreased due primarily to a benefit of $6.9 million recognized in the third quarter of 2011 related to a settlement with the IRS, which is comprised of $4.0 million related to a tax issue on appeal and $2.9 million related to various tax issues agreed upon at the examination level.

Income from continuing operations, as a percentage of net operating revenues, decreased from 2.8% for the nine months ended September 30, 2010 to 2.7% for the nine months ended September 30, 2011. Net income, as a percentage of net operating revenues, decreased from 2.8% for the nine months ended September 30, 2010 to 2.2% for the nine months ended September 30, 2011. The decrease in net income, as a percentage of net operating revenues, is primarily due to the loss on discontinued operations from the loss on sale, impairment of hospitals held for sale and loss from operations of entities sold and held for sale.

Net income attributable to noncontrolling interests as a percentage of net operating revenues, remained consistent at 0.5% for each of the nine-month periods ended September 30, 2011 and 2010.

Net income attributable to Community Health Systems, Inc. was $171.0 million for the nine months ended September 30, 2011, compared to $210.5 million for the nine months ended September 30, 2010, representing a decrease of 18.7%. The decrease in net income is primarily due to the loss on discontinued operations from the loss on sale, impairment of hospitals held for sale and loss from operations of entities sold and held for sale.

Liquidity and Capital Resources

Net cash provided by operating activities decreased $78.2 million, from $898.4 million for the nine months ended September 30, 2010 to $820.2 million for the nine months ended September 30, 2011. The decrease in cash provided by operating activities, in comparison to the prior year period, is primarily due to a decrease in net income of $31.7 million, a decrease in cash flow from the change in accounts receivable of $65.2 million, a decrease in cash flow from the change in supplies, prepaid expenses and other current assets of $36.2 million, a decrease in cash flow from the change in accounts payable, accrued liabilities and income taxes of $26.5 million, due primarily to the timing of payroll payments during the periods which offset income tax refunds received during the year, and a decrease in cash flow from the change in other assets and liabilities of $16.7 million. These decreases in cash flows were partially offset by an increase in depreciation and amortization expense of $33.7 million, impairment of hospitals held for sale and sold of $47.9 million and an increase in all other non-cash expenses of $16.5 million.

The cash used in investing activities was $691.4 million for the nine months ended September 30, 2011, compared to $545.1 million for the nine months ended September 30, 2010. The increase in cash used in investing activities, in comparison to the prior year period, is primarily due to an increase in cash used for acquisition of facilities and other related equipment of $141.9 million, an increase in cash used for purchasing property and equipment of $151.0 million and an increase in cash used for other assets, which consists primarily of purchases and development of internal-use software and payments made under non-employee physician recruiting agreements, of $32.4 million. Other changes in cash used in investing activities were an increase in proceeds from the disposition of hospitals and other ancillary operations of $172.6 million and an increase in proceeds received from the sale of property and equipment of $6.4 million.

The cash used in financing activities was $161.6 million for the nine months ended September 30, 2011, compared to $130.1 million for the nine months ended September 30, 2010. The increase in cash used in financing activities, in comparison to the prior year period, is due primarily to a decrease in proceeds from the exercise of stock options and an increase in cash used to purchase outstanding shares under our open market repurchase program.

Capital Expenditures

Cash expenditures related to purchases of facilities were $209.5 million for the nine months ended September 30, 2011, compared to $67.5 million for the nine months ended September 30, 2010. The expenditures during the nine months ended September 30, 2011 were for the purchase of three hospitals in Pennsylvania, surgery centers and physician practices and the settlement of working capital items from 2010 acquisitions. The expenditures during the nine months ended September 30, 2010 were for the purchase of a healthcare system in Marion, South Carolina, the purchase of surgery centers and physician practices, and the settlement of working capital items from a 2009 acquisition.

Excluding the cost to construct replacement hospitals, our cash expenditures for routine capital for the nine months ended September 30, 2011 totaled $406.5 million, compared to $366.8 million for the nine months ended September 30, 2010. 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, 2011 totaled $126.3 million, compared to $15.1 million for the nine months ended September 30, 2010. The costs to construct replacement hospitals for the nine months ended September 30, 2011 represented both planning and construction costs for the four replacement hospitals discussed below. The costs to construct replacement hospitals for the nine months ended September 30, 2010 represented planning costs for future construction projects since there were no replacement hospitals under construction.

Pursuant to purchase agreements in effect as of September 30, 2011 and where certificate of need approval has been obtained, we have commitments to build the following three replacement facilities: As required by an amendment to our lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location by November 2012. As part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana by April 2011; however, due to delays in receiving government approved building and zoning permits, completion is not expected until the fourth quarter of 2012. These delays did not result in any penalties under the terms of the agreement and we do not expect such delays to result in any significant increase in the costs to construct the replacement facility. As part of an acquisition in 2009, we agreed to build a replacement hospital in Siloam Springs, Arkansas by February 2013. Construction costs, including equipment costs, for these three replacement facilities are currently estimated to be approximately $318.5 million, of which approximately $172.4 million has been incurred to date. 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 from the Alabama Certificate of Need Review Board; however, this certificate of need remains subject to an appeal process. Our estimated construction costs, including the acquisition of the site and equipment costs, are approximately $280.0 million for the Birmingham replacement facility.

Capital Resources

Net working capital was approximately $1.133 billion at September 30, 2011, compared to approximately $1.229 billion at December 31, 2010. The decrease in net working capital is primarily due to the use of free cash flow and cash on hand to complete acquisitions of a hospital system and several physician practices, repurchase outstanding shares under our repurchase program, and make repayments of certain long-term indebtedness.

In connection with the consummation of the Triad acquisition in July 2007, we obtained approximately $7.2 billion of senior secured financing under a Credit Facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The Credit Facility consisted of an approximately $6.1 billion funded term loan facility with a maturity of seven years, a $300 million delayed draw term loan facility (reduced by us from $400 million) with a maturity of seven years and a $750 million revolving credit facility with a maturity of six years. During the fourth quarter of 2008, $100 million of the delayed draw term loan was drawn down by us, reducing the delayed draw term loan availability to $200 million at December 31, 2008. In January 2009, we drew down the remaining $200 million of the delayed draw term loan. The revolving credit facility also includes a subfacility for letters of credit and a swingline subfacility. The Credit Facility requires quarterly amortization payments of each term loan facility equal to 0.25% of the outstanding amount of the term loans. On November 5, 2010, we entered into an amendment and restatement of our existing Credit Facility. The amendment extends by two and a half years, until January 25, 2017, the maturity date of $1.5 billion of the existing term loans under the Credit Facility and increases the pricing on these term loans to London Interbank Offered Rate, or LIBOR, plus 350 basis points. If more than $50 million of our Notes remain outstanding on April 15, 2015, without having been refinanced, then the maturity date for the extended term loans will be accelerated to April 15, 2015. The maturity date of the balance of the term loans of approximately $4.5 billion remains unchanged at July 25, 2014. The amendment also increases our ability to issue additional indebtedness under the uncommitted incremental facility to $1.0 billion from $600 million, permits us to issue Term A term loans under the incremental facility, and provides up to $2.0 billion of borrowing capacity from receivable transactions, an increase of $0.5 billion, of which $1.7 billion would be required to be used for repayment of existing term loans.

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, commencing in 2008, 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/Community Health Systems, Inc., or CHS, a wholly-owned subsidiary of Community Health Systems, Inc. All of our obligations under the Credit Facility are unconditionally guaranteed by Community Health Systems, Inc. and certain 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.

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 one-half of 1.0% or (3) the adjusted LIBOR on such day for a three-month interest period commencing on the second business day after such day plus 1%, or (b) a reserve adjusted LIBOR for dollars (Eurodollar rate) (as defined). The applicable percentage for Alternate Base Rate loans is 1.25% for term loans due 2014 and 2.25% for term loans due 2017. The applicable percentage for Eurodollar rate loans is 2.25% for term loans due 2014 and 3.5% for term loans due 2017. The applicable percentage for revolving loans was initially 1.25% for Alternate Base Rate revolving loans and 2.25% for Eurodollar revolving loans, in each case subject to reduction based on our leverage ratio. Loans under the swingline subfacility bear interest at the rate applicable to Alternate Base Rate loans under the revolving credit facility.

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 credit 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 were initially obligated to pay commitment fees of 0.50% per annum (subject to reduction based upon our leverage ratio), on the unused portion of the revolving credit facility. For purposes of this calculation, swingline loans are not treated as usage of the revolving credit facility. With respect to the delayed draw term loan facility, we were also obligated to pay commitment fees of 0.50% per annum for the first nine months after the close of the Credit Facility and 0.75% per annum for the next three months after such nine-month period and thereafter 1.0% per annum. In each case, the commitment fee was based on the unused amount of the delayed draw term loan facility. After the draw down of the remaining $200 million of the delayed draw term loan in January 2009, we no longer pay any commitment fees for the delayed draw term loan facility. We also paid arrangement fees on the closing of the Credit Facility and pay an annual administrative agent fee.

The Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting our and our subsidiaries ability, subject to certain exceptions, to, among other things, (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of our businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change our fiscal year. We and our subsidiaries are also required to comply with specified financial covenants (consisting of a 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, 2011, the availability for additional borrowings under our Credit Facility was approximately $750 million pursuant to the revolving credit facility, of which $38.0 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.

As of September 30, 2011, we are a party to the following interest rate swap agreements to limit the effect of changes in interest rates on approximately 90% 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, a margin above LIBOR of 225 basis points for revolving credit and term loans due 2014 and 350 basis points for term loans due 2017 under the Credit Facility.

Swap #	Notional Amount (in 000 s)	Fixed Interest Rate	Termination Date	Fair Value (in 000 s)
1	$ 100,000	3.0230%	October 23, 2011	$ 176
2	200,000	4.4815%	October 26, 2011	582
3	200,000	4.0840%	December 3, 2011	1,339
4	100,000	3.8470%	January 4, 2012	901
5	100,000	3.8510%	January 4, 2012	902
6	100,000	3.8560%	January 4, 2012	904
7	200,000	3.7260%	January 8, 2012	1,827
8	200,000	3.5065%	January 16, 2012	1,836
9	250,000	5.0185%	May 30, 2012	7,447
10	150,000	5.0250%	May 30, 2012	4,475
11	200,000	4.6845%	September 11, 2012	7,784
12	100,000	3.3520%	October 23, 2012	2,952
13	125,000	4.3745%	November 23, 2012	5,406
14	75,000	4.3800%	November 23, 2012	3,248
15	150,000	5.0200%	November 30, 2012	7,696
16	200,000	2.2420%	February 28, 2013	4,674
17	100,000	5.0230%	May 30, 2013	7,170
18	300,000	5.2420%	August 6, 2013	24,883
19	100,000	5.0380%	August 30, 2013	8,183
20	50,000	3.5860%	October 23, 2013	2,945
21	50,000	3.5240%	October 23, 2013	2,885
22	100,000	5.0500%	November 30, 2013	9,125
23	200,000	2.0700%	December 19, 2013	6,161
24	100,000	5.2310%	July 25, 2014	11,766
25	100,000	5.2310%	July 25, 2014	11,769
26	200,000	5.1600%	July 25, 2014	23,172
27	75,000	5.0405%	July 25, 2014	8,453
28	125,000	5.0215%	July 25, 2014	14,027
29	100,000	2.6210%	July 25, 2014	5,005
30	100,000	3.1100%	July 25, 2014	6,275
31	100,000	3.2580%	July 25, 2014	6,658
32	200,000	2.6930%	October 26, 2014	10,589 (1)
33	300,000	3.4470%	August 8, 2016	27,835
34	200,000	3.4285%	August 19, 2016	18,452
35	100,000	3.4010%	August 19, 2016	9,132
36	200,000	3.5000%	August 30, 2016	19,124
37	100,000	3.0050%	November 30, 2016	7,508

(1) This interest rate swap becomes effective October 26, 2011, concurrent with the termination of swap #2.

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. We were in compliance with all financial ratios and other financial condition tests at September 30, 2011, and expect to remain in compliance in the future. Our ability to meet these restrictive 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 due and payable and all commitments under the Credit Facility to extend further credit may be terminated.

We believe that internally generated cash, availability for additional borrowings under our Credit Facility of $750 million (consisting of a $750 million revolving credit facility, of which $38.0 million is set aside for outstanding letters of credit as of September 30, 2011) and our ability to amend the Credit Facility to provide for one or more tranches of term loans in an aggregate principal amount of $1.0 billion, our ability to add up to $300 million of borrowing capacity from receivable transactions (including securitizations) 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 December 22, 2008, we filed a universal automatic shelf registration statement on Form S-3ASR 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 for the nine months ended September 30, 2011 is as follows:

	Nine months Ended September 30, 2011
Ratio of earnings to fixed charges (1)	1.70x

(1) There are no shares of preferred stock outstanding.

Off-balance Sheet Arrangements

Our consolidated operating results for the nine months ended September 30, 2011 and 2010, included $191.3 million and $184.5 million, respectively, of net operating revenues and $14.6 million and $19.8 million, respectively, of income from operations generated from five hospitals operated by us under operating lease arrangements. 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 $8.9 million and $9.3 million for the nine months ended September 30, 2011 and 2010, respectively. The current terms of these operating leases expire between June 2012 and December 2020, not including lease extension options. If we allow these leases to expire, we would no longer generate revenue 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.

During the year ended December 31, 2010, we entered into an agreement with the lessor of Cleveland Regional Medical Center, or Cleveland Regional, our leased facility in Cleveland, TX, to exchange our ownership interest in certain real estate at Hill Regional Medical Center, or Hill Regional, in Hillsboro, TX for the lessor s ownership interest in the real estate at Cleveland Regional. The related lease agreement was amended to incorporate Hill Regional as a leased asset with no change to the remaining lease term or payment schedule. No monetary consideration was exchanged in this transaction, and the transaction qualifies as a non-taxable, like-kind exchange under the regulations in Section 1031 of the Internal Revenue Code. The assets of Cleveland Regional were recorded in the condensed consolidated balance sheet at fair value on the date of this transaction; however, as a result of our continuing involvement in the Hill Regional assets, the exchange with the lessor does not qualify for sale treatment under U.S. GAAP. Accordingly, the transaction has been accounted for as a financing obligation and the assets of Hill Regional will remain on the condensed consolidated balance sheet as assets recorded under a financing obligation. Starting in the fourth quarter of 2010, future payments under the lease are amortized against the financing obligation rather than recorded as rent expense.

Noncontrolling Interests

We have sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. As of September 30, 2011, we have hospitals in 24 of the markets we serve, with noncontrolling physician ownership interests ranging from less than 1% to 40%, including one hospital that also had a non-profit entity as a partner. In addition, we have three other hospitals with noncontrolling interests owned by non-profit entities. Redeemable noncontrolling interests in equity of consolidated subsidiaries was $383.7 million and $387.5 million as of September 30, 2011 and December 31, 2010, respectively. Noncontrolling interests in equity of consolidated subsidiaries was $61.0 million and $60.9 million as of September 30, 2011 and December 31, 2010, respectively. The amount of net income attributable to noncontrolling interests was $18.3 million and $14.5 million for the three months ended September 30, 2011 and 2010, respectively, and $53.5 million and $45.7 million for the nine months ended September 30, 2011 and 2010, respectively. As a result of the change in the Stark Law whole hospital exception included in the Reform Legislation, we will not introduce physician ownership at any of our wholly-owned facilities or increase the aggregate percentage of physician ownership in any of our existing joint ventures.

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Explanation of Responses:

Reimbursement, Legislative and Regulatory Changes

The Reform Legislation was enacted in the context of other ongoing legislative and regulatory efforts, which would 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 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 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 net operating revenues. 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, 2011 from our estimated reimbursement percentage, net income for the nine months ended September 30, 2011 would have changed by approximately $33.4 million, and net accounts receivable at September 30, 2011 would have changed by $53.0 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 by an insignificant amount in each of the three-month and nine-month periods ended September 30, 2011 and 2010.

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, if present, 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, if available, 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, 2011 from our estimated collection percentage as a result of a change in expected recoveries, net income for the nine months ended September 30, 2011 would have changed by $19.1 million, and net accounts receivable at September 30, 2011 would have changed by $30.4 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 $2.2 billion and $2.1 billion at September 30, 2011 and December 31, 2010, 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 47 days and 46 days at September 30, 2011 and December 31, 2010, respectively. Our target range for days revenue outstanding is 46 to 56 days.

Total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) was approximately $8.0 billion and $7.2 billion as of September 30, 2011 and December 31, 2010, respectively.

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

	September 30, 2011	December 31, 2010
Insured receivables	63.0%	63.9%
Self-pay receivables	37.0%	36.1%
Total	100.0%	100.0%

For the hospital segment, the combined total of the allowance for doubtful accounts for self-pay accounts receivable and related allowances for other self-pay discounts and contractuals, as a percentage of gross self-pay receivables, was approximately 84% at both September 30, 2011 and December 31, 2010. If the receivables that have been written-off, but where collections are still being pursued by outside collection agencies, were included in both the allowances and gross self-pay receivables specified above, the percentage of combined allowances to total self-pay receivables would have been approximately 91% at both September 30, 2011 and December 31, 2010.

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 have selected September 30 as our annual testing date. Based on the results of our most recent annual impairment test, we have concluded that we do not have any reporting units that are at risk of failing step one of the goodwill impairment test.

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 Insurance Claims

As part of our business of owning and operating hospitals, we are subject to legal actions alleging liability on our part. We accrue for losses resulting from such liability claims, as well as loss adjustment expenses that are out-of-pocket and directly related to such liability claims. These direct out-of-pocket expenses include fees of outside counsel and experts. We do not accrue for costs that are part of our corporate overhead, such as the costs of our in-house legal and risk management departments. The losses resulting from professional liability claims primarily consist of estimates for known claims, as well as estimates for incurred but not reported claims. The estimates are based on specific claim facts, our historical claim reporting and payment patterns, the nature and level of our hospital operations, and actuarially determined projections. The actuarially determined projections are based on our actual claim data, including historic reporting and payment patterns which have been gathered over approximately a 20-year period. As discussed below, although 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 1.3% and 1.4% in 2010 and 2009, 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 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 $0.5 million per occurrence self-insured retention and for claims reported from June 1, 2002 through June 1, 2003, these self-insured retentions were $2.0 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 are self-insured up to $5 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 and up to $145 million per occurrence and in the aggregate for claims incurred and reported after January 1, 2008. For certain policy years, if the first aggregate layer of excess coverage becomes fully utilized, then the self-insured retention could 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 are 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 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, 2011.

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 $3.7 million as of September 30, 2011. During the three months ended September 30, 2011, we decreased liabilities for uncertain tax positions by $4.0 million as a result of a favorable resolution of an issue on appeal with the IRS related to its examination of Triad tax returns. For the nine months ended September 30, 2011, we decreased liabilities for uncertain tax positions by $3.4 million and decreased interest and penalties by approximately $0.4 million. A total of approximately $1.0 million of interest and penalties is included in the amount of liability for uncertain tax positions at September 30, 2011. It is our policy to recognize interest and penalties related to unrecognized benefits in our condensed consolidated statements of income as income tax expense.

We believe it is reasonably possible that approximately $2.1 million of our current unrecognized tax benefit may be recognized within the next 12 months as a result of a lapse of the statute of limitations and settlements with taxing authorities.

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 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 and December 31, 2003. The IRS has concluded its examination of the federal tax return of Triad for the tax periods ended December 31, 2004, December 31, 2005, December 31, 2006 and July 25, 2007. In September 2011, we reached a favorable resolution of an issue on appeal with the IRS related to its examination of Triad s tax returns. As a result, we recognized a tax benefit of $4.0 million, which is reflected in the accompanying condensed consolidated statement of income for the three months ended September 30, 2011. With few exceptions, we are no longer subject to state income tax examinations for years prior to 2007 and federal income tax examinations with respect to Community Health Systems, Inc. federal returns for years prior to 2007. Our federal income tax returns for the 2007 and 2008 tax years are currently under examination by the IRS. We believe the results of this examination will not be material to our consolidated results of operations or consolidated financial position.

Recent Accounting Pronouncements

In August 2010, the Financial Accounting Standards Board, or FASB, issued Accounting Standards Update, or ASU, 2010-24, which provides clarification to companies in the healthcare industry on the accounting for professional liability insurance. This ASU states that receivables related to insurance recoveries should not be netted against the related claim liability and such claim liabilities should be determined without considering insurance recoveries. This ASU is effective for fiscal years beginning after December 15, 2010 and was adopted by us on January 1, 2011. The adoption of this ASU increased other current assets by $6.2 million, other assets, net by $34.6 million and long-term liabilities by $40.8 million in the condensed consolidated balance sheet at September 30, 2011 and had no impact to the condensed consolidated statement of income for the three and nine months ended September 30, 2011.

In August 2010, the FASB issued ASU 2010-23, which requires a company in the healthcare industry to use its direct and indirect costs of providing charity care as the measurement basis for charity care disclosures. This ASU also requires additional disclosures of the method used to determine such costs. We adopted this ASU on January 1, 2011. In the ordinary course of business, we render services to patients who are financially unable to pay for hospital care. Included in the provision for contractual allowances is the value (at our standard charges) of these services to patients who are unable to pay that is eliminated from net operating revenues when it is determined they qualify under our charity care policy. The estimated cost incurred by us to provide these services to patients who are unable to pay was approximately $28.8 million and $27.7 million for the three months ended September 30, 2011 and 2010, respectively, and $88.3 million and $78.5 million for the nine months ended September 30, 2011 and 2010, respectively. The estimated cost of these charity care services was determined using a ratio of cost to gross charges and applying that ratio to the gross charges associated with providing care to charity patients for the period. Gross charges associated with providing care to charity patients includes only the related charges for those patients who are financially unable to pay and qualify under our charity care policy and that do not otherwise qualify for reimbursement from a governmental program.

In July 2011, the FASB issued ASU 2011-07, which requires healthcare organizations that perform services for patients for which the ultimate collection of all or a portion of the amounts billed or billable cannot be determined at the time services are rendered to present all bad debt expense associated with patient service revenue as an offset to the patient service revenue line item in the statement of operations. The ASU also requires qualitative disclosures about our policy for recognizing revenue and bad debt expense

for patient service transactions and quantitative information about the effects of changes in the assessment of collectibility of patient service revenue. This ASU is effective for fiscal years beginning after December 15, 2011, and will be adopted by us in the first quarter of 2012. Upon adoption, our provision for bad debts will be presented as a reduction of patient service revenue after contractual adjustments and discounts. The changes in net revenue for the three and nine months ended September 30, 2011 and 2010 as if the ASU had been early adopted for 2011 are as follows (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
Net operating revenues (net of contractual allowances and discounts)	$ 3,436,000	$ 3,159,823	$ 10,223,881	$ 9,309,081
Provision for bad debts	(450,296)	(387,512)	(1,283,267)	(1,121,015)
Net operating revenues, less provision for bad debts	$ 2,985,704	$ 2,772,311	$ 8,940,614	$ 8,188,066

In September 2011, the FASB issued ASU 2011-08, which modifies how entities test goodwill for impairment. Previous guidance required an entity to perform a two-step goodwill impairment test at least annually by comparing the fair value of a reporting unit with its carrying amount, including goodwill, and recording an impairment loss if the fair value is less than the carrying amount. This ASU allows an entity to first assess qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If an entity determines after that assessment that it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step impairment test is not required. This ASU is required to be applied to interim and annual goodwill impairment tests performed for fiscal years beginning after December 15, 2011, and will be adopted by us in 2012. The adoption of this ASU is not expected to impact our consolidated financial position, results of operations or 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 sim 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 legislation;
- 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 could result in disputes and changes in reimbursement that could be applied retroactively;

changes in inpatient or outpatient Medicare and Medicaid payment levels;

increases in the amount and risk of collectability of patient accounts receivable;

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, without significant 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;

our ability to successfully acquire additional hospitals and complete the sale of hospitals held for sale;

our ability to successfully integrate any acquired hospitals or to recognize expected synergies from such acquisitions;

our ability to obtain adequate levels of general and professional liability insurance; and

timeliness of reimbursement payments received under government programs.

Although we believe that these statements are based upon reasonable assumptions, we can give no assurance that our goals will be achieved. Given these uncertainties, prospective investors are cautioned not to place undue reliance on these forward-looking statements. These forward-looking statements are made as of the date of this filing. We assume no obligation to update or revise them or provide reasons why actual results may differ.

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 Item 2. We do not anticipate any material changes in our primary market risk exposures in 2011. 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.

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 $1.6 million and $1.7 million for the three months ended September 30, 2011 and 2010, respectively, and approximately $4.8 million and $5.2 million for the nine months ended September 30, 2011 and 2010, 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 included in this report has been recorded, processed, summarized and reported within the time periods specified in the Commission s rules and forms and to ensure that the information required to be included in this report was accumulated and communicated to management, including our Chief Executive Officer and Chief Financial Officer, to allow timely decisions regarding required disclosure.

There have been no changes in our internal control over financial reporting during the quarter ended September 30, 2011, 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 various inquiries or subpoenas from state regulators, 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 for matters such as: blood administration practices of a single physician at an Illinois hospital, DME vendor relationships and patient choice discharge instructions at our Washington hospitals, and operations of a cardiovascular surgery department at our Oregon hospital. In addition, we are subject to other claims and lawsuits arising in the ordinary course of our business. We are not aware of any pending or threatened litigation that is not covered by insurance policies or reserved for in our financial statements or which we believe would have a material adverse impact on us; however, 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.

Community Health Systems, Inc. Legal Proceedings

On February 10, 2006, we received a letter 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. The February 2006 letter focused on our hospitals in three states: Arkansas, New Mexico, and South Carolina. On August 31, 2006, we received a follow up letter from the Department of Justice requesting additional documents relating to the programs in New Mexico and the payments to our three hospitals in that state. Through the beginning of 2009, 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 these three New Mexico hospitals caused the State of New Mexico to submit improper claims for federal funds, in violation of the Federal False Claims Act. At one point, the Civil Division calculated that the three hospitals received ineligible federal participation payments from August 2000 to June 2006 of approximately $27.5 million and said that if it proceeded to trial, it would seek treble damages plus an appropriate penalty for each of the violations of the Federal False Claims Act. This investigation has culminated in the federal government s intervention in a qui tam lawsuit styled U.S. ex rel. Baker vs. Community Health Systems, Inc., pending in the United States District Court for the District of New Mexico. The federal government filed its complaint in intervention on June 30, 2009. The relator filed a second amended complaint on July 1, 2009. Both of these complaints expand the time period during which alleged improper payments were made. We filed motions to dismiss all of the federal government s and the relator s claims on August 28, 2009. On March 19, 2010, the court granted in part and denied in part our motion to dismiss as to the relator s complaint. On July 7, 2010, the court denied our motion to dismiss the federal government s complaint in intervention. On July 21, 2010, we filed our answer and pretrial discovery began. On June 2, 2011, the relator filed a Third Amended Complaint adding subsidiaries Community Health Systems Professional Services Corporation and CHS/Community Health Systems, Inc. as defendants. On June 6, 2011, the government filed its First Amended Complaint in intervention adding Community Health Systems Professional Services Corporation as a defendant. Discovery is continuing. The discovery deadline is currently set for October 31, 2011, the deadline for filing of Motions for Summary Judgment is November 21, 2011 and there is currently no trial date set. We are vigorously defending this action.

On June 12, 2008, two of our hospitals received letters from the United States Attorney s Office for the Western District of New York requesting documents in an investigation it was conducting into billing practices with respect to kyphoplasty procedures performed during the period January 1, 2002 through June 9, 2008. On September 16, 2008, one of our hospitals in South Carolina also received an inquiry. Kyphoplasty is a surgical spine procedure that returns a compromised vertebrae (either from trauma or osteoporotic disease process) to its previous height, reducing or eliminating severe pain. We have been informed that similar investigations have been initiated at unaffiliated facilities in Alabama, South Carolina, Indiana and other states. We believe that this investigation 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.

On April 19, 2009, we were served in Roswell, New Mexico with an answer and counterclaim in the case of Roswell Hospital Corporation d/b/a Eastern New Mexico Medical Center vs. Patrick Sisneros and Tammie McClain (sued as Jane Doe Sisneros). The case was originally filed as a collection matter. The counterclaim was filed as a putative class action and alleged theories of breach of contract, unjust enrichment, misrepresentation, prima facie tort, Fair Trade Practices Act and violation of the New Mexico RICO statute. On May 7, 2009, the hospital filed a notice of removal to federal court. On July 27, 2009, the case was remanded to state court for lack of a federal question. A motion to dismiss and a motion to dismiss misjoined counterclaim plaintiffs were filed on October 20, 2009. These motions were denied. Extensive discovery has been conducted. A motion for class certification for all uninsured patients was heard on March 3 through March 5, 2010 and on April 13, 2010, the state district court judge certified the case as a class action. Numerous hearings have been conducted to assess the sufficiency of the methodology used to determine class damages. We are vigorously defending this action.

On December 7, 2009, we received a document subpoena from the United States Department of Health and Human Services, Office of the Inspector General, or OIG, requesting documents related to our hospital in Laredo, Texas. The categories of documents requested included case management, resource management, admission criteria, patient medical records, coding, billing, compliance, the Joint Commission accreditation, physician documentation, payments to referral sources, transactions involving physicians, disproportionate share hospital status, and audits by the hospital s Quality Improvement organization. On January 22, 2010, we received a request for information or assistance from the OIG s Office of Investigation requesting patient medical records from Laredo Medical Center in Laredo, Texas for certain Medicaid patients with an extended length of stay. Additional requests for records have also been received, including a request containing follow-up questions received on January 5, 2011. On May 16, 2011, we received a subpoena dated May 10, 2011 from the Houston Office of the United States Department of Health and Human Services, OIG, requesting 71 patient medical records from our hospital in Shelbyville, Tennessee, and directing the return of the records to the Assistant United States Attorney handling the Laredo investigation. We are unaware of any connection between these two facilities other than they are both affiliated with us. We continue to cooperate fully with these investigations.

On September 20, 2010, we received a letter from the United States Department of Justice, Civil Division, advising us that an investigation is being conducted to determine whether certain hospitals have improperly submitted claims for payment for implantable cardioverter defibrillators, or ICD. The period of time covered by the investigation is 2003 to the present. The letter states that the Department of Justice s data indicates that many of our hospitals have claims that need to be reviewed to determine if Medicare payment was appropriate. We understand that the Department of Justice has submitted similar requests to many other hospitals and hospital systems across the country as well as to the ICD manufacturers themselves. We continue to fully cooperate with the government in this investigation and have provided requested records and documents.

On November 15, 2010, we were served with substantially identical Civil Investigative Demands (CIDs) from the Office of Attorney General, State of Texas for all 18 of our affiliated Texas hospitals. The subject of the requests appears to concern emergency department procedures and billing. We have complied with these requests and are providing documentation and reports regarding the Pro-MED System. We are continuing to cooperate with the government in this investigation.

On April 8, 2011, we received a document subpoena, dated March 31, 2011, from the United States Department of Health and Human Services, OIG, in connection with an investigation of possible improper claims submitted to Medicare and Medicaid. The subpoena, issued from the OIG s Chicago, Illinois office, requested documents from all of our hospitals and appears to concern emergency department processes and procedures, including our hospitals use of the Pro-MED Clinical Information System, which is a third-party software system that assists with the management of patient care and provides operational support and data collection for emergency department management and has the ability to track discharge, transfer and admission recommendations of emergency department physicians. The subpoena also requested other information about our relationships with emergency department physicians, including financial arrangements. The subpoena s requests were very similar to those contained in the Civil Investigative Demands received by our Texas hospitals from the Office of the Attorney General of the State of Texas on November 15, 2010 (described above). We are continuing to cooperate with the government in this investigation.

On April 11, 2011, Tenet Healthcare Corporation, or Tenet, filed suit against the Company, Wayne T. Smith and W. Larry Cash in the United States District Court for the Northern District of Texas. The suit alleged we committed violations of certain federal securities laws by making certain statements in various proxy materials filed with the Securities and Exchange Commission, or SEC, in connection with our offer to purchase Tenet. Tenet alleged that we engaged in a practice to under-utilize observation status and over-utilize inpatient admission status and asserts that by doing so, we created undisclosed financial and legal liability to federal, state and private payors. The suit seeks declaratory and injunctive relief and Tenet s costs. On April 19, 2011, we filed a motion to dismiss the complaint. On April 28, 2011, we responded to the allegations during our earnings release conference call (see our Form 8-K furnished on April 28, 2011). On May 16, 2011, Tenet filed an amended complaint. On June 29, 2011, we filed a motion to dismiss the amended complaint. A hearing on our motion to dismiss occurred on September 8, 2011. The Court took this matter under advisement. We will continue to vigorously defend this suit.

On April 22, 2011, a joint motion was filed by the relator and the United States Department of Justice in the case styled United States ex rel. and Reuille vs. Community Health Systems Professional Services Corporation and Lutheran Musculoskeletal Center, LLC d/b/a Lutheran Hospital, in the United States District Court for the Northern District of Indiana, Fort Wayne Division. The lawsuit was originally filed under seal on January 7, 2009. The suit is brought under the False Claims Act and alleges that Lutheran Hospital of Indiana billed the Medicare program for (a) false 23 hour observation after outpatient surgeries and procedures, and (b) intentional assignment of inpatient status to one-day stays for cases that do not meet Medicare criteria for inpatient intensity of service or severity of illness. The relator had worked in the case management department of Lutheran Hospital of Indiana but was reassigned to another department in the fall of 2006. This facility was acquired by us as part of the July 25, 2007 merger transaction with Triad Hospitals, Inc. The complaint also includes allegations of age discrimination in Ms. Reuille s 2006 reassignment and retaliation in connection with her resignation on October 1, 2008. We had cooperated fully with the government in its investigation of this matter, but had been unaware of the exact nature of the allegations in the complaint. On December 27, 2010, the government filed a notice that it declined to intervene in this suit. The motion contained additional information about how the government intended to proceed with an investigation regarding allegations of improper billing for inpatient care at other hospitals associated with Community Health Systems, Inc. . . . asserted in other qui tam complaints in other jurisdictions. The motion stated that the Department of Justice has consolidated its investigations of the Company and other related entities and that the Civil Division of the Department of Justice, multiple United States Attorneys offices, and the Office of Inspector General for the Department of Health and Human Services, or HHS, are now closely coordinating their investigation of these overlapping allegations. The Attorney General of Texas has initiated an investigation; the United States intends to work cooperatively with Texas and any other States investigating these allegations. The motion also stated that the Office of Audit Services for the Office of Investigations for HHS has been engaged to conduct a national audit of certain of our Medicare claims. The government confirmed that it considers the allegations made in the complaint styled Tenet Healthcare Corporation vs. Community Health Systems, Inc., et al. filed in the United States District Court for the Northern District of Texas, Dallas Division on April 11, 2011 to be related to the allegations in the qui tam and to what the government is now describing as a consolidated investigation. Because qui tam suits are filed under seal, no one but the relator and the government knows that the suit has been filed or what allegations are being made by the relator on behalf of the government. Initially, the government has 60 days to make a determination about whether to intervene in a case and to act as the plaintiff or to decline to intervene and allow the relator to act as the plaintiff in the suit, but extensions of time are frequently granted to allow the government additional time to investigate the allegations. Even if, in the course of an investigation, the court partially unseals a complaint to allow the government and a defendant to work to a resolution of the complaint s allegations, the defendant is prohibited from revealing to anyone even that the partial unsealing has occurred. As the investigation proceeds, we may learn of additional qui tam suits filed against us or our affiliated hospitals or related entities, or that contact letters, document requests, or medical record requests we have received in the past from various governmental agencies are generated from qui tam cases filed under seal. The motion filed on April 22, 2011 concluded by requesting a stay of the litigation in the Reuille case for 180 days, and on April 25, 2011, the court granted the motion. Our management company subsidiary, Community Health Systems Professional Services Corporation, the defendant in the Reuille case, consented to the request for the stay. On October 19, 2011, the government filed an application to transfer the Reuille case to the Middle District of Tennessee or for an extension of the stay for an additional 180 days. We agreed that a stay for an additional, but shorter period of time, 90 days, was appropriate, but did not consent to the transfer of the case. Our response setting forth our legal arguments was filed on October 24, 2011. We are cooperating fully with the government in its investigations.

On May 13, 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. As with all government investigations, we are cooperating fully with the SEC.

Three purported class action shareholder federal securities 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., Wayne T. Smith and W. Larry Cash, filed May 5, 2011; De Zheng v. Community Health Systems, Inc., Wayne T. Smith and W. Larry Cash, filed May 12, 2011; and Minneapolis Firefighters Relief Association v. Community Health Systems, Inc., Wayne T. Smith, W. Larry Cash and Thomas Mark Buford, filed June 2, 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. On September 20, 2011, all three were assigned to the same judge as related cases. Three 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, W. Larry Cash, T. Mark Buford, John A. Clerico, James S. Ely III, John A. Fry, William Norris Jennings, Julia B. North and H. Mitchell Watson, Jr., filed May 24, 2011, Roofers Local No. 149 Pension Fund v. Wayne T. Smith, W. Larry Cash, John A. Clerico, James S. Ely, III, John A. Fry, William Norris Jennings, Julia B. North and H. Mitchell Watson, Jr., filed June 21, 2011, and Lambert Sweat v. Wayne T. Smith, W. Larry Cash, T. Mark Buford, John A. Clerico, James S. Ely, III, John A. Fry, William Norris Jennings, Julia B. North, H. Mitchell Watson, Jr. and Community Health Systems, Inc., 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. On September 20, 2011, all three of these cases were assigned to the same judge as related cases. We believe all of these matters are without merit and will vigorously defend them.

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. The United States expressly declined to intervene in all other claims against all other named defendants. On July 28, 2011, we were served by the relator. On September 7, 2011, we filed our answer. We believe the claims against our hospital are without merit and we will vigorously defend this case.

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.

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. All significant legal proceedings and allegations of financial statement fraud, error, or misstatement are promptly referred 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 included significant policy and guidance revisions, training and education, and auditing. With respect to Medicare inpatient admissions, improvements in case management, including updating of inpatient medical necessity criteria, heightened focus on correct use of observation status, and new policies requiring unambiguous signed physician orders prior to billing, were all adopted in 2009 and 2010. These activities were communicated to and discussed with the Audit and Compliance Committee.

With respect to the various assertions of third parties about the Audit and Compliance Committee s oversight:

- The September 2010 allegation made by CtW Investment Group (that a high percentage of our hospitals had a high percentage of Medicare short-stay inpatient admissions, which could signal billing improprieties) was promptly referred to the Audit and Compliance Committee and an investigation was authorized and initiated with outside counsel and consultants in December 2010;

- Prior to the receipt of the civil investigative demands in Texas in November 2010, no concerns had been raised that the Pro-MED emergency department management system inappropriately caused physicians or hospitals to order tests or admit patients, and we continue to dispute that it does so; and

The purported observation rate metric, which served as a basis for allegations contained in Tenet s lawsuit, is not generally accepted in the industry and we continue to dispute the validity of the metric in the manner used by Tenet or that the metric is a meaningful indicator of incorrect billing practices.

Since the filing of the Tenet lawsuit on April 11, 2011, our Audit and Compliance Committee and/or Board of Directors has met more than ten (10) times 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. At many of those meetings, the independent members of the Board of Directors have met in separate session, first with outside counsel handling the investigations and lawsuits, and then alone, to discuss their duties and oversight of these matters. At this time, the independent members of the Board of Directors have determined that (a) the Audit and Compliance Committee is the correct and most capable group of directors to oversee these matters and, given the independence and authority of the Audit and Compliance Committee, there is no need to form a further special committee to oversee these matters, and (b) outside counsel is handling the investigation and defense of these matters in the best interests of us and our stockholders and there is no need to engage separate counsel in connection with the investigation of these matters.

We intend to provide additional updates about these matters as we are able to do so (taking into account any potential impact on these matters) through appropriate, widely-disseminated means.

Triad Hospitals, Inc. Legal Proceedings

In a case styled U.S. ex rel. Bartlett vs. Quorum Health Resources, Inc., et al., pending in the Western District of Pennsylvania, Johnstown Division, the relator alleges in his second amended complaint, filed in January 2006 (the first amended complaint having been dismissed), that QHR conspired with an unaffiliated hospital to pay illegal remuneration in violation of the federal anti-kickback statute and the Stark Law, thus causing false claims to be filed. A renewed motion to dismiss was filed in March 2006 asserting that the second amended complaint did not cure the defects contained in the first amended complaint. In September 2006, the hospital and one of the other defendants affiliated with the hospital filed for protection under Chapter 11 of the federal bankruptcy code, which imposed an automatic stay on proceedings in the case. Relators entered into a settlement agreement with the hospital, subject to confirmation of the hospital s reorganization plan. The District Court conducted a status conference on January 30, 2009 and later convened another conference on March 30, 2009 and heard arguments on whether to proceed with a motion to dismiss, but did not make a ruling. The government and relator have reached a settlement with the hospital. On March 22, 2011, the court denied all other defendants motions to dismiss. Initial written discovery is underway. We believe this case is without merit and will continue to vigorously defend it.

Item 1A. ***Risk Factors***

Our most recent Annual Report on Form 10-K includes a listing of risk factors to be considered by investors in our securities. Appearing below is an update to one of the risk factors in the Form 10-K.

If we fail to comply with extensive laws and government regulations, including fraud and abuse laws, we could suffer penalties or be required to make significant changes to our operations.

The healthcare industry is required to comply with many laws and regulations at the federal, state, and local government levels. These laws and regulations require that hospitals meet various requirements, including those relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, compliance with building codes, environmental protection and privacy. These laws include, in part, the Health Insurance Portability and Accountability Act of 1996 and a section of the Social Security Act, known as the anti-kickback statute. If we fail to comply with applicable laws and regulations, including fraud and abuse laws, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in the Medicare, Medicaid, and other federal and state healthcare programs.

In addition, there are heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment. Recent enforcement actions have focused on financial arrangements between hospitals and physicians, billing for services without adequately documenting the medical necessity for such services, and billing for services outside the coverage guidelines for such services. Specific to our hospitals, we have received inquiries and subpoenas from various governmental agencies regarding these and other matters, and we are also subject to various claims and lawsuits relating to such matters. For a further discussion of these matters, see Legal Proceedings in Part II, Item 1 of this Form 10-Q.

In the future, different interpretations or enforcement of these laws and regulations could subject our current practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs, and operating expenses.

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

The following table contains information about our purchases of common stock during the three months ended September 30, 2011.

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans(a)	Maximum Number of Shares That May Yet Be Purchased Under the Plans or Programs(a)
July 1, 2011 - July 31, 2011		$		1,785,162
August 1, 2011 - August 31, 2011	839,000	24.21	839,000	946,162
September 1, 2011 - September 30, 2011	867,300	17.76	867,300	78,862
Total	1,706,300	$ 20.93	1,706,300	78,862

(a) On September 15, 2010, we commenced a new open market repurchase program for up to 4,000,000 shares of our common stock, not to exceed $100 million in repurchases. This program will conclude at the earliest of three years from the commencement date, when the maximum number of shares has been repurchased or when the maximum dollar amount has been expended. During the three months ended September 30, 2011, we repurchased and retired 1,706,300 shares at a weighted-average price of $20.93 per share. During the nine months ended September 30, 2011, we repurchased and retired 3,469,866 shares at a weighted-average price of $24.68 per share. The cumulative number of shares that have been repurchased and retired under this program through September 30, 2011 are 3,921,138 shares at a weighted-average price of $25.39.

We have not paid any cash dividends since our inception, and do not anticipate the payment of 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 $50 million in the aggregate after November 5, 2010, the date of our amendment and restatement of our Credit Facility. In addition, our Credit Facility allows us to repurchase stock in an amount not to exceed the aggregate amount of proceeds from the exercise of stock options. The indenture governing our Notes also limits our ability to pay dividends and/or repurchase stock. As of September 30, 2011, under the most restrictive test under these agreements, we have approximately $30.0 million remaining available with which to pay permitted dividends and/or make stock and Note repurchases.

Item 3. ***Defaults Upon Senior Securities***

None

Item 4. ***(Removed and Reserved)***

Item 5. ***Other Information***

None

Item 6. ***Exhibits***

No.	Description
4.1	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc. s 8 7/8% Senior Notes due 2015, dated as of September 1, 2011, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association
4.2	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc. s 8 7/8% Senior Notes due 2015, dated as of September 30, 2011, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association
10.1	Amendment No. 1, dated as of September 13, 2011, to the CHS/Community Health Systems, Inc. Amended and Restated Supplemental Executive Retirement Plan, as amended and restated on January 1, 2009
12	Computation of Ratio of Earnings to Fixed Charges
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
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101.INS	XBRL Instance Document*
101.SCH	XBRL Schema Document*
101.CAL	XBRL Calculation Linkbase Document*
101.DEF	XBRL Definition Linkbase Document*
101.LAB	XBRL Label Linkbase Document*
101.PRE	XBRL Presentation Linkbase Document*

Indicates a management contract or compensatory plan or arrangement.

* Pursuant to applicable securities laws and regulations, we are deemed to have complied with the reporting obligation relating to the submission of interactive data files in such exhibits and are not subject to liability under any anti-fraud provisions of the federal securities laws as long as we have made a good faith attempt to comply with the submission requirements and promptly amend the interactive data files after becoming aware that the interactive data files fail to comply with the submission requirements. Users of this data are advised pursuant to Rule 406T of Regulation S-T that this interactive data file is deemed not filed or part of a registration statement or prospectus for purposes of sections 11 or 12 of the Securities Act of 1933, is deemed not filed for purposes of section 18 of the Securities Exchange Act of 1934, and otherwise is not subject to liability under these sections.

SIGNATURES

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

COMMUNITY HEALTH SYSTEMS, INC.

(Registrant)

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

By: /s/ W. Larry Cash
W. Larry Cash
Executive Vice President, Chief Financial Officer and Director
(principal financial officer)

By: /s/ T. Mark Buford
T. Mark Buford
Senior Vice President and Chief Accounting Officer
(principal accounting officer)

Date: October 28, 2011

Index to Exhibits

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