COMMUNITY HEALTH SYSTEMS INC
Form 10-K
February 23, 2012

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the year ended December 31, 2011

OR

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

For the transition period from to

Commission file number 001-15925

COMMUNITY HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**13-3893191**
(State of incorporation)	**(IRS Employer Identification No.)**
4000 Meridian Boulevard	
Franklin, Tennessee	**37067**
(Address of principal executive offices)	**(Zip Code)**

Registrant s telephone number, including area code:

(615) 465-7000

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	**Name of Each Exchange on Which Registered**
Common Stock, $.01 par value	New York Stock Exchange

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. YES x NO ¨

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. YES ¨ NO x

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of the registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of the Form 10-K or any amendment to the Form 10-K. x

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

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

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). YES ¨ NO x

The aggregate market value of the voting stock held by non-affiliates of the Registrant was $2,368,591,590. Market value is determined by reference to the closing price on June 30, 2011 of the Registrant s Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2011) have any non-voting common stock outstanding. As of February 15, 2012, there were 91,546,078 shares of common stock, par value $.01 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required for Part III of this annual report is incorporated by reference to portions of the Registrant s definitive proxy statement for its 2012 annual meeting of stockholders to be filed with the Securities and Exchange Commission within 120 days after the end of the Registrant s fiscal year ended December 31, 2011.

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PART I

Item 1. *Business of Community Health Systems, Inc.*

Overview of Our Company

We are one of the largest publicly-traded operators of hospitals in the United States in terms of number of facilities and net operating revenues. We were originally founded in 1986 and were reincorporated in 1996 as a Delaware corporation. We provide healthcare services through the hospitals that we own and operate in non-urban and selected urban markets throughout the United States. As of December 31, 2011, we owned or leased 131 hospitals, including four stand-alone rehabilitation or psychiatric hospitals. These hospitals are geographically diversified across 29 states, with an aggregate of 19,695 licensed beds. We generate revenues by providing a broad range of general and specialized hospital healthcare services to patients in the communities in which we are located. Services provided by our hospitals include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric and rehabilitation services. As an integral part of providing these services, we also employ approximately 2,000 physicians and an additional 500 licensed healthcare practitioners, and provide additional outpatient services at urgent care centers, occupational medicine clinics, imaging centers, cancer centers, ambulatory surgery centers and home health and hospice agencies. Through our management and operation of these businesses, we provide standardization and centralization of operations across key business areas; strategic assistance to expand and improve services and facilities; implementation of patient safety and quality of care improvement programs; and assistance in the recruitment of additional physicians and licensed healthcare practitioners to the markets in which our hospitals are located. In a number of our markets, we have partnered with local physicians or not-for-profit providers, or both, in the ownership of our facilities. In addition to our hospitals and related businesses, we also own and operate 63 licensed home care agencies and 30 licensed hospice agencies, located primarily in markets where we also operate a hospital. Also, through our wholly-owned subsidiary, Quorum Health Resources, LLC, or QHR, we provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. The home care agencies and the hospital management services businesses constitute operating segments, but are not considered reportable segments since they do not meet the quantitative thresholds for a separate identifiable reportable segment. The financial information for our reportable operating segments is presented in Note 14 of the Notes to our Consolidated Financial Statements included under Item 8 of this Report.

Our strategy has also included growth by acquisition. We generally target hospitals in growing, non-urban and selected urban healthcare markets for acquisition because of their favorable demographic and economic trends and competitive conditions. Because non-urban service areas have smaller populations, there are generally fewer hospitals and other healthcare service providers in these communities and generally a lower level of managed care presence in these markets. We believe that smaller populations support less direct competition for hospital-based services and these communities generally view the local hospital as an integral part of the community. We believe opportunities exist for skilled, disciplined operators in selected urban markets to create networks between urban hospitals and non-urban hospitals while improving physician alignment in those markets and making it more attractive to managed care.

Throughout this Form 10-K, we refer to Community Health Systems, Inc., or the Parent Company, and its consolidated subsidiaries in a simplified manner and on a collective basis, using words like we and our. This drafting style is suggested by the Securities and Exchange Commission, or SEC, and is not meant to indicate that the publicly-traded Parent Company or any other 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.

Available Information

Our website address is www.chs.net and the investor relations section of our website is located at www.chs.net/investor/index.html. We make available free of charge, through the investor relations section of our website, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K as well as amendments to those reports, as soon as reasonably practical after they are filed with the SEC. Our filings are also available to the public at the website maintained by the SEC, www.sec.gov.

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We also make available free of charge, through the investor relations section of our website, our Governance Principles, our Code of Conduct and the charters of our Audit and Compliance Committee, Compensation Committee and Governance and Nominating Committee.

We have included the Chief Executive Officer and the Chief Financial Officer certifications regarding the public disclosure required by Sections 302 and 906 of the Sarbanes-Oxley Act of 2002 as Exhibits 31.1, 31.2, 32.1 and 32.2 of this report.

Our Business Strategy

With the objective of increasing shareholder value and improving care, the key elements of our business strategy are to:

- increase revenue at our facilities,
- improve profitability,
- improve patient safety and quality of care and
- grow through selective acquisitions.

Increase Revenue at Our Facilities

Overview. We seek to increase revenue at our facilities by providing a broader range of services in a more attractive care setting, as well as by supporting and recruiting physicians. We identify the healthcare needs of the community by analyzing demographic data and patient referral trends. We also work with local hospital boards, management teams and medical staffs to determine the number and type of additional physician specialties needed. Our initiatives to increase revenue include:

- recruiting and/or employing additional primary care physicians and specialists,
- expanding the breadth of services offered at our hospitals and in the communities in which we operate through targeted capital expenditures and physician alignment to support the addition of more complex services, including orthopedics, cardiovascular services and urology and
- providing the capital to invest in technology and the physical plant at our facilities, particularly in our emergency rooms, surgery departments, critical care departments and diagnostic services.

We believe that appropriate capital investments in our facilities, combined with the development of our service capabilities, will reduce the migration of patients to competing providers while providing an attractive return on investment.

Our industry is highly regulated by the government and other third parties who provide payment for the services we provide to patients. Accordingly, we seek to review all initiatives to increase revenue through our corporate-wide voluntary compliance program in an effort to ensure compliance with laws and regulation.

Physician Recruiting. The primary method of adding or expanding medical services is the recruitment of new physicians into the community. A core group of primary care physicians is necessary as an initial contact point for all local healthcare. The addition of specialists who offer services, including general surgery, obstetrics and gynecology, cardiovascular services, orthopedics and urology, completes the full range of

medical and surgical services required to meet a community s core healthcare needs. At the time we acquire a hospital and from time to time thereafter, we identify the healthcare needs of the community by analyzing demographic data and patient referral trends. As a result of this analysis, we are able to determine what we believe to be the optimum mix of primary care physicians and specialists. We employ recruiters at the corporate level to support the local hospital managers in their recruitment efforts. We have increased the number of physicians affiliated with us through our

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recruiting efforts, net of turnover, by approximately 869 in 2011, 935 in 2010 and 772 in 2009. The percentage of recruited or other physicians commencing practice with us that were specialists was over 50% in 2011. Additionally, in response to the recent trend in physicians seeking employment, we have begun employing more physicians, including, in some instances, acquiring physician practices. However, most of the physicians in our communities remain in private practice and are not our employees. We believe we have been successful in recruiting physicians because of the practice opportunities afforded physicians in our markets, as well as lower managed care penetration as compared to larger urban areas.

Emergency Room Initiatives. Approximately 60% of our patients initiate their encounter with our hospitals through the emergency room. Accordingly, we believe that making sure that this experience is as satisfying and efficient for the patient as it reasonably can be, but at the same time seeking to ensure that a safe and high quality service is provided to each patient, will in turn result in an optimized revenue stream and provide growth in services performed by our hospitals. We take numerous steps to seek to achieve these intertwined objectives, including:

- Improving safety, service, satisfaction and waiting times initiatives include rounding on patients while in the emergency room, applying quality monitoring tools in evaluating the care provided, implementing a five-level triage system and fast-tracking patients with non-emergency conditions, post-discharge calls to patients and monitoring practitioner utilization rates and practices,

- Raise community awareness of the services offered and the efforts to improve service and quality through marketing campaigns and

- Improving patient flow by renovating and expanding our emergency room facilities 13 such projects have been undertaken in the past three years, including four in 2011.

One of our emergency room initiatives that spans our efforts across all three of these areas is the use of specialized emergency room information management software. Such software is designed to collect information to monitor the patients experience and care provided; assist nurses, physicians and other clinicians in communicating with each other about the clinical condition of the patients and provide consistent discharge instructions to patients. We believe that these information management systems enable our hospitals and their medical staffs to also monitor and seek to improve aggregate performance and patient outcomes. In addition, these information management systems are integral to our efforts to achieve meaningful use of electronic health records and qualify for and retain payments under the Health Information Technology for Economic and Clinical Health Act, or HITECH Act.

Expansion of Services. In an effort to better meet the healthcare needs of the communities we serve and to capture a greater portion of the healthcare spending in our markets, we have added a broad range of services to our facilities and, in certain markets, acquired physician practices to broaden our service offerings. These services range from various types of diagnostic equipment capabilities to additional and renovated emergency rooms, surgical and critical care suites and specialty services. For example, we spent approximately $203.7 million on 48 major construction projects that were completed in 2011. The 2011 projects included new emergency rooms, cardiac cathertization laboratories, intensive care units, hospital additions and surgical suites. These projects improved various diagnostic and other inpatient and outpatient service capabilities. We continue to believe that appropriate capital investments in our facilities, combined with the development of our service capabilities, will reduce the migration of patients to competing providers while providing an attractive return on investment. We also employ a small group of clinical consultants at our corporate headquarters to assist the hospitals in their development of surgery, emergency, critical care, cardiovascular and hospitalist services. In addition to spending capital on expanding services at our existing hospitals, we also build replacement facilities in certain markets to better meet the healthcare needs in those communities. In 2011, we spent $162.9 million on construction projects related to three replacement hospitals that we are required to build pursuant to either a hospital purchase agreement or an amendment to a lease agreement. In addition, in September 2010, we received approval of our request for a certificate of need, or CON, from the Alabama Certificate of Need Review Board for the construction of a replacement hospital in Birmingham, Alabama. This CON remains subject to an appeal process. The total cost of these four replacement hospitals is estimated to be $597.2 million.

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Managed Care Strategy. Managed care has seen growth across the U.S. as health plans expand service areas and membership in an attempt to control rising medical costs. As we service primarily non-urban markets, we do not have significant relationships with individual managed care organizations, including Medicare Advantage. We have responded with a proactive and carefully considered strategy developed specifically for each of our facilities. Our experienced corporate managed care department reviews and approves all managed care contracts, which are organized and monitored using a central database. The primary mission of this department is to select and evaluate appropriate managed care opportunities, manage existing reimbursement arrangements and negotiate increases. Generally, we do not intend to enter into capitated or risk sharing contracts. However, some purchased hospitals have risk sharing contracts at the time we acquire them. We seek to discontinue these contracts to eliminate risk retention related to payment for patient care. We do not believe that we have, at the present time, any risk sharing contracts that would have a material impact on our results of operations.

Improve Profitability

Overview. To improve efficiencies and increase operating margins, we implement cost containment programs and adhere to operating philosophies that include:

- standardizing and centralizing our methods of operation and management,
- improving patient safety and optimizing resource allocation through our case and resource management program, which assists in improving clinical care and containing costs,
- monitoring and enhancing productivity of our human resources,
- capitalizing on purchasing efficiencies through the use of company-wide standardized purchasing contracts and terminating or renegotiating specified vendor contracts and
- installing a standardized management information system, resulting in more streamlined clinical operations and more efficient billing and collection procedures.

In addition, each of our hospital management teams is supported by our centralized operational, reimbursement, regulatory and compliance expertise, as well as by our senior management team, a seasoned group of executives with an average of over 25 years of experience in the healthcare industry.

Standardization and Centralization. Our standardization and centralization initiatives encompass nearly every aspect of our business, from developing standard policies and procedures with respect to patient accounting and physician practice management to implementing standard processes to initiate, evaluate and complete construction projects. Our standardization and centralization initiatives are a key element in improving our operating results.

- *Billing and Collections.* We have adopted standard policies and procedures with respect to billing and collections. We have also automated and standardized various components of the collection cycle, including statement and collection letters and the movement of accounts through the collection cycle. Upon completion of an acquisition, our management information systems team converts the hospital s existing information system to our standardized system. This enables us to quickly implement our business controls and cost containment initiatives.

Physician Support. We support our newly recruited physicians to enhance their transition into our communities. All newly recruited physicians who enter into contracts with us are required to attend a three-day introductory seminar that covers issues involved in starting up a practice. We have also implemented physician practice management seminars, webinars and other training. We host these seminars monthly.

Procurement and Materials Management. We have standardized and centralized our operations with respect to medical supplies, equipment and pharmaceuticals used in our hospitals. We have a participation agreement with HealthTrust Purchasing Group, L.P., or HealthTrust, a group purchasing organization, or GPO. HealthTrust contracts with certain vendors who supply a substantial portion of our medical supplies, equipment and pharmaceuticals. Our agreement with HealthTrust extends to January 2013, with automatic renewal terms of one year unless either party terminates by giving notice of non-renewal.

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Facilities Management. We have standardized interiors, lighting and furniture programs. We have also implemented a standard process to initiate, evaluate and complete construction projects. Our corporate staff monitors all construction projects, and reviews and pays all construction project invoices. Our initiatives in this area have reduced our construction costs while maintaining the same level of quality and have shortened the time it takes us to complete these projects.

Other Initiatives. We have also improved margins by implementing standard programs with respect to ancillary services in areas, including emergency rooms, pharmacy, laboratory, imaging, home care, skilled nursing, centralized outpatient scheduling and health information management. We have improved quality and reduced costs associated with these services by improving contract terms and standardizing information systems. We work to identify and communicate best practices and monitor these improvements throughout the Company.

Internal Controls Over Financial Reporting. We have centralized many of our significant internal controls over financial reporting and standardized those other controls that are performed at our hospital locations. We continuously monitor compliance with and evaluate the effectiveness of our internal controls over financial reporting.

Case and Resource Management. The primary goal of our case management program is to ensure the delivery of safe, high quality care in an efficient and cost effective manner. The program focuses on:

- appropriate management of length of stay consistent with national standards and benchmarks;
- reducing unnecessary utilization;
- discharge planning;
- developing and implementing operational best practices; and
- compliance with all regulatory standards.

Our case management program integrates the functions of utilization review, discharge planning, assessment of medical necessity and resource management. Patients are assessed upon presentation to the hospital with ongoing reviews throughout their course of care. Industry standard criteria are utilized in patient assessments, and discharge plans are adjusted according to patient needs. Cases are monitored to prevent delays in service or unnecessary utilization of resources. When a patient is ready for discharge, a case manager works with the patient s attending physician to evaluate and coordinate the patient s needs for continued care in the post-acute setting. Each hospital has the support of a physician advisor to act as a liaison to the medical staff and assist with all the activities of the program.

Improve Patient Safety and Quality of Care

Each of our hospitals has a board of trustees, which includes members of the hospital s medical staff. The board of trustees establishes policies concerning the hospital s medical, professional, and ethical practices, monitors these practices, and is responsible for ensuring that these practices conform to legally required standards. We maintain quality assurance programs to support and monitor quality of care standards and to meet Medicare and Medicaid accreditation and regulatory requirements. Patient care evaluations and other quality of care assessment activities are reviewed and monitored continuously.

We have implemented various programs to support our hospitals in an effort to ensure continuous improvement in patient safety and the quality of care provided. We have developed training programs for all senior hospital management, chief nursing officers, quality directors, physicians and other clinical staff. We share information among our hospital management to implement best practices and assist in complying with

regulatory requirements.

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We have standardized our process for documenting compliance with accreditation requirements. All hospitals conduct patient, physician and staff satisfaction surveys to help identify methods of improving patient safety and the quality of care.

To ensure the experience of our emergency room patients meets our service and quality expectations, we have implemented a program to contact selected patients as a follow-up to the services they received. We verify that patients were able to obtain any prescriptions and outpatient appointments recommended at discharge. We also ensure that their symptoms have abated and that they understood the discharge instructions given at the hospital. Through this program, we placed in excess of one million follow-up calls in 2011.

In 2011, we established a component patient safety organization, or PSO, which was listed by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality on January 11, 2012. We believe we are the first for-profit hospital company to form a component PSO and that it will assist us in improving patient safety at our hospitals.

Grow Through Selective Acquisitions

Acquisition Criteria. Each year we intend to acquire, on a selective basis, approximately two to four hospitals that fit our acquisition criteria. Generally, we pursue acquisition candidates that:

- have a service area population between 20,000 and 400,000 with a stable or growing population base,
- are the sole or primary provider of acute care services in the community,
- are located in an area with the potential for service expansion,
- are not located in an area that is dependent upon a single employer or industry and
- have financial performance that we believe will benefit from our management s operating skills.

Occasionally, we have pursued acquisition opportunities outside of our specified criteria when such opportunities have had uniquely favorable characteristics. In addition, in recent years, we have been successful in acquiring a few multi-hospital systems. In 2009, we acquired a total of three hospitals-two hospitals located in Wilkes-Barre, Pennsylvania and one hospital in Siloam Springs, Arkansas-and purchased the remaining equity in a hospital located in El Dorado, Arkansas in which we previously had a noncontrolling interest. In 2010, we acquired five hospitals located in Marion, South Carolina; Youngstown, Ohio; Warren, Ohio and Bluefield, West Virginia and in 2011, we acquired four hospitals located in Scranton, Pennsylvania; Tunkhannock, Pennsylvania; Nanticoke, Pennsylvania and Tomball, Texas. We believe that our access to capital, reputation for providing quality care and ability to recruit physicians makes us an attractive partner for these communities.

Disciplined Acquisition Approach. We believe that we have been disciplined in our approach to acquisitions. We have a dedicated team of internal and external professionals who complete a thorough review of the hospital s financial and operating performance, the demographics and service needs of the market and the physical condition of the facilities. Based on our historical experience, we then build a pro forma financial model that reflects what we believe can be accomplished under our ownership. Whether we buy or lease the existing facility or agree to construct a replacement hospital, we believe we have been disciplined in our approach to pricing. We typically begin the acquisition process by entering into a non-binding letter of intent with an acquisition candidate. After we complete business and financial due diligence and financial modeling, we decide whether or not to enter into a definitive agreement. Once an acquisition is completed, we have an organized and systematic approach to transitioning and integrating the new hospital into our system of hospitals.

Acquisition Efforts. Most of our acquisition targets are municipal or other not-for-profit hospitals. We believe that our access to capital, ability to recruit physicians and reputation for providing quality care make us an attractive partner for these communities. In addition, we have found that communities located in states where we already operate a hospital are more receptive to our acquiring their hospitals, because they are aware of

our operating track record with respect to our other hospitals within the state.

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At the time we acquire a hospital, we may commit to an amount of capital expenditures, such as a replacement facility, renovations, or equipment over a specified period of time. As obligations under two hospital purchase agreements in effect as of December 31, 2011, we are required to build a replacement facility in Valparaiso, Indiana by April 2011 and in Siloam Springs, Arkansas by February 2013. Due to delays in receiving government approved building and zoning permits, the replacement facility in Valparaiso, Indiana is not expected to be completed until the fourth quarter of 2012. These delays did not result in any penalties under the terms of the purchase agreement and we do not expect such delays to result in any significant increase in the costs to construct the replacement facility. Also, as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location by November 2012. Estimated construction costs, including equipment costs, are approximately $317.2 million for these three replacement facilities, of which approximately $210.3 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 for our existing Birmingham facility. In September 2010, we received approval of our request for a CON from the Alabama Certificate of Need Review Board; however, this CON 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, of which approximately $3.5 million has been incurred to date. Under other purchase agreements in effect as of December 31, 2011, we have committed to spend $652.5 million, generally over a five to seven year period after acquisition, for costs such as capital improvements, equipment, selected leases and physician recruiting. Through December 31, 2011, we have incurred approximately $247.8 million related to these commitments.

Industry Overview

The Centers for Medicare and Medicaid Services, or CMS, reported that in 2010 total U.S. healthcare expenditures grew by 3.9% to approximately $2.6 trillion. CMS also projected total U.S. healthcare spending to grow by 4.8% in 2011 and by an average of 5.8% annually from 2010 through 2020. By these estimates, healthcare expenditures will account for approximately $4.6 trillion, or 19.8% of the total U.S. gross domestic product, by 2020.

Hospital services, the market in which we operate, is the largest single category of healthcare at 31.4% of total healthcare spending in 2010, or approximately $814.0 billion, as reported by CMS. CMS projects the hospital services category to grow by at least 4.7% per year through 2020. It expects growth in hospital healthcare spending to continue due to the aging of the U.S. population and consumer demand for expanded medical services. As hospitals remain the primary setting for healthcare delivery, CMS expects hospital services to remain the largest category of healthcare spending.

U.S. Hospital Industry. The U.S. hospital industry is broadly defined to include acute care, rehabilitation and psychiatric facilities that are either public (government owned and operated), not-for-profit private (religious or secular), or for-profit institutions (investor owned). According to the American Hospital Association, there are approximately 5,000 inpatient hospitals in the U.S. which are not-for-profit owned, investor owned, or state or local government owned. Of these hospitals, approximately 40% are located in non-urban communities. We believe that a majority of these hospitals are owned by not-for-profit or governmental entities. These facilities offer a broad range of healthcare services, including internal medicine, general surgery, cardiology, oncology, orthopedics, OB/GYN and emergency services. In addition, hospitals also offer other ancillary services, including psychiatric, diagnostic, rehabilitation, home care and outpatient surgery services.

Urban vs. Non-Urban Hospitals

According to the U.S. Census Bureau, 21% of the U.S. population lives in communities designated as non-urban. In these non-urban communities, hospitals are typically the primary source of healthcare. In many cases a single hospital is the only provider of general healthcare services in these communities.

Factors Affecting Performance. Among the many factors that can influence a hospital s financial and operating performance are:

- facility size and location,

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- facility ownership structure (i.e., tax-exempt or investor owned),
- a facility s ability to participate in group purchasing organizations and
- facility payor mix.

Patients needing the most complex care are more often served by the larger and/or more specialized urban hospitals. We believe opportunities exist in selected urban markets to create networks between urban hospitals and non-urban hospitals in order to expand the breadth of services offered in the non-urban hospitals while improving physician alignment in those markets and making it more attractive to managed care.

Hospital Industry Trends

Demographic Trends. According to the U.S. Census Bureau, there are presently approximately 40.3 million Americans aged 65 or older in the U.S. who comprise approximately 13.0% of the total U.S. population. By the year 2030, the number of Americans aged 65 or older is expected to climb to 72.1 million, or 19.3% of the total population. Due to the increasing life expectancy of Americans, the number of people aged 85 years and older is also expected to increase from 5.8 million to 8.7 million by the year 2030. This increase in life expectancy will increase demand for healthcare services and, as importantly, the demand for innovative, more sophisticated means of delivering those services. Hospitals, as the largest category of care in the healthcare market, will be among the main beneficiaries of this increase in demand. Based on data compiled for us, the populations of the service areas where our hospitals are located grew by 24.0% from 1990 to 2010 and are expected to grow by 3.9% from 2010 to 2015. The number of people aged 65 or older in these service areas grew by 27.4% from 1990 to 2010 and is expected to grow by 14.9% from 2010 to 2015.

Consolidation. In addition to our own acquisitions in recent years, consolidation activity in the hospital industry, primarily through mergers and acquisitions involving both for-profit and not-for-profit hospital systems, is continuing. Reasons for this activity include:

- excess capacity of available capital,
- valuation levels,
- financial performance issues, including challenges associated with changes in reimbursement and collectability of self-pay revenue,
- the desire to enhance the local availability of healthcare in the community,
- the need and ability to recruit primary care physicians and specialists,
- the need to achieve general economies of scale and to gain access to standardized and centralized functions, including favorable supply agreements and access to malpractice coverage and
- regulatory changes.

The healthcare industry is also undergoing consolidation, first, in anticipation of, and second, in reaction to, efforts to reform the payment system. Hospital systems are acquiring physician practices and other outpatient and sub-acute providers to position themselves for readmission, bundling and other payment restructuring. Similarly, payors are consolidating and acquiring disease management service providers in an effort

to offer more competitive programs.

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Selected Operating Data

The following table sets forth operating statistics for our hospitals for each of the years presented, which are included in our continuing operations. Statistics for 2011 include a full year of operations for 127 hospitals and partial periods for four hospitals acquired during the year. Statistics for 2010 include a full year of operations for 122 hospitals and partial periods for five hospitals acquired during the year. Statistics for 2009 include a full year of operations for 118 hospitals and partial periods for three hospitals acquired during the year and one hospital in which we previously had a noncontrolling interest and purchased the remaining interest during the year. Statistics for hospitals which have been sold are excluded from all periods presented.

	Year Ended December 31,		
	2011	2010	2009
	(Dollars in thousands)		
Consolidated Data			
Number of hospitals (at end of period)	131	127	122
Licensed beds (at end of period)(1)	19,695	19,004	17,557
Beds in service (at end of period)(2)	16,832	16,264	15,539
Admissions(3)	675,050	678,284	675,902
Adjusted admissions(4)	1,330,988	1,277,235	1,242,647
Patient days(5)	2,970,044	2,891,699	2,874,125
Average length of stay (days)(6)	4.4	4.3	4.3
Occupancy rate (beds in service)(7)	49.1%	50.2%	51.3%
Net operating revenues	$ 13,626,168	$ 12,623,274	$ 11,742,454
Net inpatient revenues as a % of total net operating revenues	46.1%	49.3%	50.4%
Net outpatient revenues as a % of total net operating revenues	51.9%	48.5%	47.3%
Net income attributable to Community Health Systems, Inc.	$ 201,948	$ 279,983	$ 243,150
Net income attributable to Community Health Systems, Inc. as a % of total net operating revenues	1.5%	2.2%	2.1%
Liquidity Data			
Adjusted EBITDA(8)	$ 1,836,650	$ 1,761,484	$ 1,652,405
Adjusted EBITDA as a % of total net operating revenues(8)	13.5%	14.0%	14.1%
Net cash flows provided by operating activities	$ 1,261,908	$ 1,188,730	$ 1,076,429
Net cash flows provided by operating activities as a % of total net operating revenues	9.3%	9.4%	9.2%
Net cash flows used in investing activities	$ (1,195,775)	$ (1,044,310)	$ (867,182)
Net cash flows used in financing activities	$ (235,437)	$ (189,792)	$ (85,361)

See pages 10 and 11 for footnotes.

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	Year Ended December 31, 2011	2010	(Decrease) Increase
	(Dollars in thousands)		
Same-Store Data(9)			
Admissions(3)	640,302	678,284	(5.6)%
Adjusted admissions(4)	1,267,860	1,277,235	(0.7)%
Patient days(5)	2,806,139	2,891,699	
Average length of stay (days)(6)	4.4	4.3	
Occupancy rate (beds in service)(7)	48.9%	50.2%	
Net operating revenues	$ 13,083,230	$ 12,618,026	3.7%
Income from operations	$ 1,188,176	$ 1,131,850	5.0%
Income from operations as a % of net operating revenues	9.1%	9.0%	
Depreciation and amortization	$ 633,417	$ 594,997	
Equity in earnings of unconsolidated affiliates	$ 49,507	$ 45,380	

(1) Licensed beds are the number of beds for which the appropriate state agency licenses a facility regardless of whether the beds are actually available for patient use.
(2) Beds in service are the number of beds that are readily available for patient use.
(3) Admissions represent the number of patients admitted for inpatient treatment.
(4) 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.
(5) Patient days represent the total number of days of care provided to inpatients.
(6) Average length of stay (days) represents the average number of days inpatients stay in our hospitals.
(7) We calculated occupancy rate percentages by dividing the average daily number of inpatients by the weighted-average number of beds in service.
(8) EBITDA consists of net income attributable to Community Health Systems, Inc. before interest, income taxes, depreciation and amortization. Adjusted EBITDA is EBITDA adjusted to exclude discontinued operations, gain/loss from early extinguishment of debt and net income attributable to noncontrolling interests. We have from time to time sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. We believe that it is useful to present adjusted EBITDA because it excludes the portion of EBITDA attributable to these third-party interests and clarifies for investors our portion of EBITDA generated by continuing operations. We use adjusted EBITDA as a measure of liquidity. We have included this measure because we believe it provides investors with additional information about our ability to incur and service debt and make capital expenditures. Adjusted EBITDA is the basis for a key component in the determination of our compliance with some of the covenants under our senior secured credit facility, as well as to determine the interest rate and commitment fee payable under the senior secured credit facility (although adjusted EBITDA does not include all of the adjustments described in the senior secured credit facility).

Adjusted EBITDA is not a measurement of financial performance or liquidity under generally accepted accounting principles. It should not be considered in isolation or as a substitute for net income, operating income, cash flows from operating, investing or financing activities, or any other measure calculated in accordance with generally accepted accounting principles. The items excluded from adjusted EBITDA are significant components in understanding and evaluating financial performance and liquidity. Our calculation of adjusted EBITDA may not be comparable to similarly titled measures reported by other companies.

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The following table reconciles adjusted EBITDA, as defined, to our net cash provided by operating activities as derived directly from our Consolidated Financial Statements for the years ended December 31, 2011, 2010 and 2009 (in thousands):

	Year Ended December 31,		
	2011	2010	2009
Adjusted EBITDA	$ 1,836,650	$ 1,761,484	$ 1,652,405
Interest expense, net	(644,410)	(647,593)	(643,608)
Provision for income taxes	(137,653)	(163,681)	(141,851)
Deferred income taxes	107,032	97,370	34,268
(Loss) income from operations of hospitals sold	(7,769)	(6,772)	971
Depreciation and amortization of discontinued operations	4,991	14,842	15,500
Stock compensation expense	42,542	38,779	44,501
(Excess tax benefit) income tax payable increase relating to stock-based compensation	(5,290)	(10,219)	3,472
Other non-cash expenses, net	28,716	12,503	22,870
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	(138,332)	(27,049)	58,390
Supplies, prepaid expenses and other current assets	(42,858)	(39,904)	(34,535)
Accounts payable, accrued liabilities and income taxes	246,110	161,952	86,098
Other	(27,821)	(2,982)	(22,052)
Net cash provided by operating activities	$ 1,261,908	$ 1,188,730	$ 1,076,429

(9) Includes acquired hospitals to the extent we operated them during comparable periods in both years.

Sources of Revenue

We receive payment for healthcare services provided by our hospitals from:

- the federal Medicare program,
- state Medicaid or similar programs,
- healthcare insurance carriers, health maintenance organizations or HMOs, preferred provider organizations or PPOs, and other managed care programs and
- patients directly.

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

	Year Ended December 31,		
Net Operating Revenues by Payor Source	**2011**	**2010**	**2009**
Medicare	26.8%	27.4%	27.4%
Medicaid	9.7%	10.7%	9.8%
Managed Care and other third-party payors	51.5%	50.4%	51.6%
Self-pay	12.0%	11.5%	11.2%
Total	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, we expect the Reform Legislation (as defined below) to increase the number of insured patients, which should reduce revenues from self-pay patients and reduce our provision for bad debts. The Reform Legislation, however, imposes significant reductions in amounts the government pays Medicare managed care plans. 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.

Medicare is a federal program that provides medical insurance benefits to persons age 65 and over, some disabled persons, and persons with end-stage renal disease. Medicaid is a federal-state funded program, administered by the states, which provides medical benefits to individuals who are unable to afford healthcare. All of our hospitals are certified as providers of Medicare and Medicaid services. Amounts received under the Medicare and Medicaid programs are generally significantly less than a hospital s customary charges for the services provided. Since a substantial portion of our revenue comes from patients under Medicare and Medicaid programs, our ability to operate our business successfully in the future will depend in large measure on our ability to adapt to changes in these programs.

In addition to government programs, we are paid by private payors, which include insurance companies, HMOs, PPOs, other managed care companies, employers and by patients directly. Blue Cross payors are included in the Managed Care and other third-party payors line in the above table. Patients are generally not responsible for any difference between customary hospital charges and amounts paid for hospital services by Medicare and Medicaid programs, insurance companies, HMOs, PPOs and other managed care companies, but are responsible for services not covered by these programs or plans, as well as for deductibles and co-insurance obligations of their coverage. The amount of these deductibles and co-insurance obligations has increased in recent years. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government or business payors. To further reduce their healthcare costs, an increasing number of insurance companies, HMOs, PPOs and other managed care companies are negotiating discounted fee structures or fixed amounts for hospital services performed, rather than paying healthcare providers the amounts billed. We negotiate discounts with managed care companies, which are typically smaller than discounts under governmental programs. If an increased number of insurance companies, HMOs, PPOs and other managed care companies succeed in negotiating discounted fee structures or fixed amounts, our results of operations may be negatively affected. For more information on the payment programs on which our revenues depend, see Payment on page 19.

As of December 31, 2011, Indiana, Texas and Pennsylvania represented our only areas of geographic concentration. Net operating revenues as a percentage of consolidated net operating revenues generated in Indiana were 10.3% in 2011, 10.6% in 2010 and 11.2% in 2009. Net operating revenues as a percentage of consolidated net operating revenues generated in Texas were 13.1% in 2011, 13.0% in 2010 and 13.2% in 2009. Net operating revenues as a percentage of consolidated net operating revenues generated in Pennsylvania were 11.5% in 2011, 10.3% in 2010 and 10.2% in 2009.

Hospital revenues depend upon inpatient occupancy levels, the volume of outpatient procedures and the charges or negotiated payment rates for hospital services provided. Charges and payment rates for routine inpatient services vary significantly depending on the type of service performed and the geographic location of the hospital. In recent years, we have experienced a significant increase in revenue received from outpatient services. We attribute this increase to:

- advances in technology, which have permitted us to provide more services on an outpatient basis and

- pressure from Medicare or Medicaid programs, insurance companies and managed care plans to reduce hospital stays and to reduce costs by having services provided on an outpatient rather than on an inpatient basis.

Government Regulation

Overview. The healthcare industry is required to comply with extensive government regulation at the federal, state and local levels. Under these regulations, hospitals must meet requirements to be certified as hospitals and qualified to participate in government programs, including the Medicare and Medicaid programs. These requirements relate to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, hospital use, rate-setting, compliance with building codes and environmental protection laws. There are also extensive regulations governing a hospital s participation in these government programs. If we fail to comply with applicable laws and regulations, we can be subject to criminal penalties and civil sanctions, our hospitals can lose their licenses and we could lose our ability to participate in these government programs. In addition, government regulations may change. If that happens, we may have to make changes in our facilities, equipment, personnel and services so that our hospitals remain certified as hospitals and qualified to participate in these programs. We believe that our hospitals are in substantial compliance with current federal, state and local regulations and standards.

Hospitals are subject to periodic inspection by federal, state and local authorities to determine their compliance with applicable regulations and requirements necessary for licensing and certification. All of our hospitals are licensed under appropriate state laws and are qualified to participate in Medicare and Medicaid programs. In addition, most of our hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations. This accreditation indicates that a hospital satisfies the applicable health and administrative standards to participate in Medicare and Medicaid programs.

Healthcare Reform. The American Recovery and Reinvestment Act of 2009, or ARRA, was signed into law on February 17, 2009, providing for a temporary increase in the federal matching assistance percentage (FMAP), a temporary increase in federal Medicaid Disproportionate Share Hospital, or DSH, allotments, subsidization of health insurance premiums (COBRA) for up to nine months, and grants and loans for infrastructure and incentive payments for providers who adopt and use health information technology. This act also provides penalties by reducing reimbursement from Medicare in the form of reductions to scheduled market basket increases beginning in federal fiscal year 2015 if eligible hospitals and professionals fail to demonstrate meaningful use of electronic health record technology.

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 two healthcare acts, referred to collectively as the Reform Legislation, include a mandate that requires substantially all U.S. 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 which began October 1, 2011, and a reduction to the Medicare and Medicaid disproportionate share payments, that could adversely impact the reimbursement received under these programs. 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 Medicare Anti-Kickback Statute and the False Claims Act, making it easier for government agencies and private plaintiffs to prevail in lawsuits brought against healthcare providers. These amendments also make it easier for potentially severe fines and penalties to be imposed on healthcare providers accused of violating applicable laws and regulations.

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 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.

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, twenty-six state attorneys general have jointly filed a challenge to certain aspects of the Reform Legislation. Currently, rulings in four separate federal Courts of Appeals have led to a split among the federal Circuit Courts regarding the constitutionality of the Reform Legislation. The Fourth Circuit, Sixth Circuit and the Court of Appeals for the D.C. Circuit have ruled in favor of the Reform Legislation while the Eleventh Circuit ruled the individual mandate within the Reform Legislation unconstitutional. The United States Supreme Court granted certiorari on or about November 14, 2011 to hear the appeal of the Eleventh Circuit s ruling, with oral argument set for March 26 through 28, 2012. The Supreme Court will hear oral argument on four issues: (1) does the Anti-Injunction Act bar a legal challenge to the individual mandate aspect of the Reform Legislation until that mandate takes effect in 2014; (2) is the individual mandate aspect of the Reform Legislation constitutional; (3) if not, is the individual mandate aspect of the Reform Legislation severable from the Reform Legislation as a whole such that it may be stricken without nullifying the Reform Legislation in its entirety and (4) can the states be compelled by the federal government to expand their Medicaid expenditures or risk losing federal funding if they refuse. 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 Supreme Court case. 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.

Fraud and Abuse Laws. Participation in the Medicare program is heavily regulated by federal statute and regulation. If a hospital fails substantially to comply with the requirements for participating in the Medicare program, the hospital s participation in the Medicare program may be terminated and/or civil or criminal penalties may be imposed. For example, a hospital may lose its ability to participate in the Medicare program if it performs any of the following acts:

making claims to Medicare for services not provided or misrepresenting actual services provided in order to obtain higher payments,

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paying money to induce the referral of patients where services are reimbursable under a federal health program or

paying money to limit or reduce the services provided to Medicare beneficiaries.

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of the fraud and abuse laws. Under HIPAA, any person or entity that knowingly and willfully defrauds or attempts to defraud a healthcare benefit program, including private healthcare plans, may be subject to fines, imprisonment or both. Additionally, any person or entity that knowingly and willfully falsifies or conceals a material fact or makes any material false or fraudulent statements in connection with the delivery or payment of healthcare services by a healthcare benefit plan is subject to a fine, imprisonment or both.

Another law regulating the healthcare industry is a section of the Social Security Act, known as the anti-kickback statute. This law prohibits some business practices and relationships under Medicare, Medicaid and other federal healthcare programs. These practices include the payment, receipt, offer, or solicitation of remuneration of any kind in exchange for items or services that are reimbursed under most federal or state healthcare programs. Violations of the anti-kickback statute may be punished by criminal and civil fines, exclusion from federal healthcare programs and damages up to three times the total dollar amount involved.

The Office of Inspector General of the Department of Health and Human Services, or OIG, is responsible for identifying and investigating fraud and abuse activities in federal healthcare programs. As part of its duties, the OIG provides guidance to healthcare providers by identifying types of activities that could violate the anti-kickback statute. The OIG also publishes regulations outlining activities and business relationships that would be deemed not to violate the anti-kickback statute. These regulations are known as safe harbor regulations. However, the failure of a particular activity to comply with the safe harbor regulations does not necessarily mean that the activity violates the anti-kickback statute.

The OIG has identified the following incentive arrangements as potential violations of the anti-kickback statute:

payment of any incentive by the hospital when a physician refers a patient to the hospital,

use of free or significantly discounted office space or equipment for physicians in facilities usually located close to the hospital,

provision of free or significantly discounted billing, nursing, or other staff services,

free training for a physician s office staff, including management and laboratory techniques (but excluding compliance training),

guarantees which provide that if the physician s income fails to reach a predetermined level, the hospital will pay any portion of the remainder,

low-interest or interest-free loans, or loans which may be forgiven if a physician refers patients to the hospital,

payment of the costs of a physician s travel and expenses for conferences,

payment of services which require few, if any, substantive duties by the physician, or payment for services in excess of the fair market value of the services rendered or

purchasing goods or services from physicians at prices in excess of their fair market value.

We have a variety of financial relationships with physicians who refer patients to our hospitals. Physicians own interests in a number of our facilities. Physicians may also own our stock. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases, management agreements and professional service agreements. We provide financial incentives to recruit physicians to relocate to communities served by our hospitals. These incentives include relocation, reimbursement for certain direct expenses, income guarantees and, in some cases, loans. Although we believe that we have structured our

arrangements with physicians in light of the safe harbor rules, we cannot assure you that regulatory authorities will not determine otherwise. If that happens, we could be subject to criminal and civil penalties and/or exclusion from participating in Medicare, Medicaid, or other government healthcare programs.

The Social Security Act also includes a provision commonly known as the Stark Law. This law prohibits physicians from referring Medicare patients to healthcare entities in which they or any of their immediate family members have ownership interests or other financial arrangements. These types of referrals are commonly known as self referrals. Sanctions for violating the Stark Law include denial of payment, civil money penalties, assessments equal to twice the dollar value of each service and exclusion from government payor programs. There are ownership and compensation arrangement exceptions to the self-referral prohibition. One exception allows a physician to make a referral to a hospital if the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. Another exception allows a physician to refer patients to a healthcare entity in which the physician has an ownership interest if the entity is located in a rural area, as defined in the statute. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases and recruitment agreements. From time to time, the federal government has issued regulations which interpret the provisions included in the Stark Law. The Reform Legislation changed the whole hospital exception to the Stark Law. The Reform Legislation permitted 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 restricted the ability of existing physician-owned hospitals to expand the capacity of their aggregate licensed beds, operating rooms and procedure rooms. The whole hospital exception, as amended, also contains additional disclosure requirements. For example, a grandfathered physician-owned hospital is required to submit an annual report to the Department of Health and Human Services, or the DHHS, listing each investor in the hospital, including all physician owners. In addition, grandfathered physician-owned hospitals must have procedures in place that require each referring physician owner to disclose to patients, with enough notice for the patient to make a meaningful decision regarding receipt of care, the physician s ownership interest and, if applicable, any ownership interest held by the treating physician. A grandfathered physician-owned hospital also must disclose on its web site and in any public advertising the fact that it has physician ownership. The Reform Legislation required grandfathered physician-owned hospitals to comply with these new requirements by September 23, 2011, and requires audits of the hospitals compliance beginning no later than May 1, 2012.

Sanctions for violating the Stark Law include denial of payment, civil monetary penalties of up to $15,000 per claim submitted and exclusion from federal healthcare programs. The statute also provides for a penalty of up to $100,000 for a scheme intended to circumvent the Stark Law prohibitions.

In addition to the restrictions and disclosure requirements applicable to physician-owned hospitals under the Stark Law, CMS regulations require physician-owned hospitals and their physician owners to disclose certain ownership information to patients. Physician-owned hospitals that receive referrals from physician owners must disclose in writing to patients that such hospitals are owned by physicians and that patients may receive a list of the hospitals physician investors upon request. Additionally, a physician-owned hospital must require all physician owners who are members of the hospital s medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose in writing to all patients whom they refer to the hospital their (or an immediate family member s) ownership interest in the hospital. A hospital is considered to be physician-owned if any physician, or an immediate family member of a physician, holds debt, stock or other types of investment in the hospital or in any owner of the hospital, excluding physician ownership through publicly-traded securities that meet certain conditions. If a hospital fails to comply with these regulations, the hospital could lose its Medicare provider agreement and be unable to participate in Medicare.

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Evolving interpretations of current, or the adoption of new, federal or state laws or regulations could affect many of the arrangements entered into by each of our hospitals. In addition, law enforcement authorities, including the OIG, the courts and Congress are increasing scrutiny of arrangements between healthcare providers and potential referral sources to ensure that the arrangements are not designed as a mechanism to improperly pay for patient referrals and/or other business. Investigators also have demonstrated a willingness to look behind the formalities of a business transaction to determine the underlying purpose of payments between healthcare providers and potential referral sources.

Many states in which we operate have also adopted laws that prohibit payments to physicians in exchange for referrals similar to the federal anti-kickback statute or that otherwise prohibit fraud and abuse activities. Many states have also passed self-referral legislation similar to the Stark Law, prohibiting the referral of patients to entities with which the physician has a financial relationship. Often these state laws are broad in scope and may apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties, as well as loss of licensure. Little precedent exists for the interpretation or enforcement of these state laws.

Our operations could be adversely affected by the failure of our arrangements to comply with the anti-kickback statute, the Stark Law, billing laws and regulations, current state laws or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may affect our operations. We are continuing to enter into new financial arrangements with physicians and other providers in a manner structured to comply in all material respects with these laws. We cannot assure you, however, that governmental officials responsible for enforcing these laws or whistleblowers will not assert that we are in violation of them or that such statutes or regulations ultimately will be interpreted by the courts in a manner consistent with our interpretation.

We strive to comply with the Stark Law and regulations; however, the government may interpret the law and regulations differently. If we are found to have violated the Stark Law or regulations, we could be subject to significant sanctions, including damages, penalties and exclusion from federal healthcare programs.

Federal False Claims Act and Similar State Laws. Another trend affecting the healthcare industry today is the increased use of the federal False Claims Act, or FCA, and, in particular, actions being brought by individuals on the government s behalf under the FCA s qui tam or whistleblower provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. If the government intervenes in the action and prevails, the party filing the initial complaint may share in any settlement or judgment. If the government does not intervene in the action, the whistleblower plaintiff may pursue the action independently and may receive a larger share of any settlement or judgment. When a private party brings a qui tam action under the FCA, the defendant generally will not be made aware of the lawsuit until the government commences its own investigation or makes a determination whether it will intervene. Further, every entity that receives at least $5 million annually in Medicaid payments must have written policies for all employees, contractors or agents providing detailed information about false claims, false statements and whistleblower protections under certain federal laws, including the FCA, and similar state laws.

When a defendant is determined by a court of law to be liable under the FCA, the defendant must pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim. Settlements entered into prior to litigation usually involve a less severe calculation of damages. There are many potential bases for liability under the FCA. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The FCA broadly defines the term knowingly. Although simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity can constitute knowingly submitting a false claim and result in liability. In some cases, whistleblowers, the federal government and courts have taken the position that providers who allegedly have violated other statutes, such as the anti-kickback statute or the Stark Law, have thereby submitted false claims under the FCA. The Reform Legislation clarifies this issue with respect to the anti-kickback statute by providing that submission of a claim for an item or service generated in violation of the anti-kickback statute constitutes a false or fraudulent claim under the FCA. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Reform Legislation, the

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FCA is implicated by the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later. Further, the FCA will cover payments involving federal funds in connection with the new health insurance exchanges to be created pursuant to the Reform Legislation. Even if the FCA is not implicated and a mistake is made in the submission of claims, substantial financial liability can arise with respect to any overpayments. There is a notable gap in the time periods for which overpayments may be recouped by the government but for which corrected claims can be submitted.

A number of states, including states in which we operate, have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court. The Deficit Reduction Act of 2005 created an incentive for states to enact false claims laws that are comparable to the FCA. From time to time, companies in the healthcare industry, including ours, may be subject to actions under the FCA or similar state laws.

Corporate Practice of Medicine; Fee-Splitting. Some states have laws that prohibit unlicensed persons or business entities, including corporations, from employing physicians. Some states also have adopted laws that prohibit direct or indirect payments or fee-splitting arrangements between physicians and unlicensed persons or business entities. Possible sanctions for violations of these restrictions include loss of a physician s license, civil and criminal penalties and rescission of business arrangements. These laws vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. We structure our arrangements with healthcare providers to comply with the relevant state law. However, we cannot be assured that governmental officials responsible for enforcing these laws will not assert that we, or transactions in which we are involved, are in violation of these laws. These laws may also be interpreted by the courts in a manner inconsistent with our interpretations.

Emergency Medical Treatment and Active Labor Act. The Emergency Medical Treatment and Active Labor Act imposes requirements as to the care that must be provided to anyone who comes to facilities providing emergency medical services seeking care before they may be transferred to another facility or otherwise denied care. Sanctions for failing to fulfill these requirements include exclusion from participation in Medicare and Medicaid programs and civil money penalties. In addition, the law creates private civil remedies which enable an individual who suffers personal harm as a direct result of a violation of the law to sue the offending hospital for damages and equitable relief. A medical facility that suffers a financial loss as a direct result of another participating hospital s violation of the law also has a similar right. Although we believe that our practices are in compliance with the law, we can give no assurance that governmental officials responsible for enforcing the law or others will not assert we are in violation of these laws.

Conversion Legislation. Many states, including some where we have hospitals and others where we may in the future acquire hospitals, have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In other states that do not have specific legislation, the attorneys general have demonstrated an interest in these transactions under their general obligations to protect charitable assets from waste. These legislative and administrative efforts primarily focus on the appropriate valuation of the assets divested and the use of the proceeds of the sale by the not-for-profit seller. While these reviews and, in some instances, approval processes can add additional time to the closing of a hospital acquisition, we have not had any significant difficulties or delays in completing the process. There can be no assurance, however, that future actions on the state level will not seriously delay or even prevent our ability to acquire hospitals. If these activities are widespread, they could limit our ability to acquire hospitals.

Certificates of Need. The construction of new facilities, the acquisition of existing facilities and the addition of new services at our facilities may be subject to state laws that require prior approval by state regulatory agencies. These CON laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. As of December 31, 2011, we operated 57 hospitals in 16 states that have adopted CON laws for acute care facilities. If we fail to obtain necessary state approval, we will not be able to expand our facilities, complete acquisitions or add new services in these states. Violation of these state laws may result in the imposition of civil sanctions or the revocation of a hospital s licenses.

HIPAA Administrative Simplification and Privacy and Security Requirements. HIPAA requires the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. The

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DHHS has established electronic data transmission standards that all healthcare providers must use when submitting or receiving certain healthcare transactions electronically. In addition, HIPAA requires that each provider use a National Provider Identifier. In January 2009, CMS published a final rule making changes to the formats used for certain electronic transactions and requiring the use of updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets. Although use of the ICD-10 code sets is not mandatory until October 1, 2013, we will be modifying our payment systems and processes to prepare for their implementation. Use of the ICD-10 code sets will require significant changes; however, we believe that the cost of compliance with these regulations has not had and is not expected to have a material adverse effect on our business, financial position or results of operations. The Reform Legislation requires the DHHS to adopt standards for additional electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction.

As required by HIPAA, the DHHS has issued privacy and security regulations that extensively regulate the use and disclosure of individually identifiable health-related information and require healthcare providers to implement administrative, physical and technical practices to protect the security of individually identifiable health information that is electronically maintained or transmitted. ARRA broadens the scope of the HIPAA privacy and security regulations. In addition, ARRA extends the application of certain provisions of the security and privacy regulations to business associates (entities that handle identifiable health-related information on behalf of covered entities) and subjects business associates to civil and criminal penalties for violation of the regulations. On July 14, 2010, the DHHS issued a proposed rule that would implement these ARRA provisions. If finalized, these changes would likely require amendments to existing agreements with business associates and would subject business associates and their subcontractors to direct liability under the HIPAA privacy and security regulations. We have developed and utilize a HIPAA compliance plan as part of our effort to comply with HIPAA privacy and security requirements. The privacy regulations and security regulations have and will continue to impose significant costs on our facilities in order to comply with these standards.

As required by ARRA, the DHHS published an interim final rule on August 24, 2009, that requires covered entities to report breaches of unsecured protected health information to affected individuals without unreasonable delay, but not to exceed 60 days of discovery of the breach by the covered entity or its agents. Notification must also be made to the DHHS and, in certain situations involving large breaches, to the media. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information.

Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties, and ARRA has strengthened the enforcement provisions of HIPAA, which may result in increased enforcement activity. Under ARRA, the DHHS is required to conduct periodic compliance audits of covered entities and their business associates. ARRA broadens the applicability of the criminal penalty provisions to employees of covered entities and requires the DHHS to impose penalties for violations resulting from willful neglect. ARRA significantly increases the amount of the civil penalties, with penalties of up to $50,000 per violation for a maximum civil penalty of $1,500,000 in a calendar year for violations of the same requirement. Further, ARRA authorizes state attorneys general to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. Our facilities also are subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties.

Payment

Medicare. Under the Medicare program, we are paid for inpatient and outpatient services performed by our hospitals.

Payments for inpatient acute services are generally made pursuant to a prospective payment system, commonly known as PPS. Under PPS, our hospitals are paid a predetermined amount for each hospital discharge based on the patient s diagnosis. Specifically, each discharge is assigned to a diagnosis-related group, commonly known as a DRG, based upon the patient s condition and treatment during the relevant inpatient stay. Commencing with the federal fiscal year 2009 (i.e., the federal fiscal year beginning October 1, 2008), each DRG is assigned a payment rate using 100% of the national average cost per case and 100% of the severity adjusted DRG weights. DRG payments are based on national averages and not on charges or costs specific to a hospital. Severity adjusted DRGs

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more accurately reflect the costs a hospital incurs for caring for a patient and account more fully for the severity of each patient s condition. However, DRG payments are adjusted by a predetermined geographic adjustment factor assigned to the geographic area in which the hospital is located. While a hospital generally does not receive payment in addition to a DRG payment, hospitals may qualify for an outlier payment when the relevant patient s treatment costs are extraordinarily high and exceed a specified regulatory threshold.

The DRG payment rates are adjusted by an update factor on October 1 of each year, the beginning of the federal fiscal year. The index used to adjust the DRG payment rates, known as the market basket index, gives consideration to the inflation experienced by hospitals in purchasing goods and services. DRG payment rates were increased by the full market basket index, for the federal fiscal years 2012, 2011, 2010 and 2009, by 3.0%, 2.6%, 2.1% and 3.6%, respectively. In addition, the DRG payment rates were reduced by 0.25% on April 1, 2010 and by 0.25% on October 1, 2010, as mandated by the Reform Legislation. The DRG payment rates were also reduced by 2.9% for federal fiscal year 2011 for behavioral changes in coding practices related to MS-DRG. In addition, for federal fiscal year 2012, the DRG payment rates were reduced by 1% for the multi-factor productivity adjustment; reduced by 0.1% in accordance with the Reform Legislation; reduced by 2% for documentation and coding; and increased by 1.1% as a result of the decision in Cape Cod Hospital v. Sebelius. The Deficit Reduction Act of 2005 imposed a two percentage point reduction to the market basket index beginning October 1, 2007, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement. Future legislation may decrease the rate of increase for DRG payments or even decrease such payment rates, but we are not able to predict the amount of any reduction or the effect that any reduction will have on us.

In addition, hospitals may qualify for Medicare disproportionate share payments when their percentage of low income patients exceeds specified regulatory thresholds. A majority of our hospitals qualify to receive Medicare disproportionate share payments. For the majority of our hospitals that qualify to receive Medicare disproportionate share payments, these payments were increased by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 effective April 1, 2004. These Medicare disproportionate share payments as a percentage of net operating revenues were 1.5%, 1.6% and 1.6% for the years ended December 31, 2011, 2010 and 2009, respectively.

Beginning August 1, 2000, we began receiving Medicare reimbursement for outpatient services through a PPS. Under the Balanced Budget Refinement Act of 1999, non-urban hospitals with 100 beds or less were held harmless. The Medicare Improvements for Patients and Providers Act extended the hold harmless provision for non-urban hospitals with 100 beds or less, including non-urban sole community hospitals, through December 31, 2009, at 85% of the hold harmless amount. Of our 125 hospitals at December 31, 2009, 44 qualified for this relief. The Reform Legislation extended the hold harmless provision for non-urban hospitals with 100 beds or less, including non-urban sole community hospitals, through December 31, 2010. Of our 130 hospitals at December 31, 2010, 46 qualified for this relief. The Medicare and Medicaid Extenders Act of 2010 extended the hold harmless provision for non-urban hospitals with 100 beds or less, including non-urban sole community hospitals, through December 31, 2011. Of our 131 hospitals at December 31, 2011, 45 qualified for this relief. The outpatient conversion factor was increased 3.6% effective January 1, 2009; however, coupled with adjustments to other variables with outpatient PPS, an approximate 3.5% to 3.9% net increase in outpatient payments occurred. The outpatient conversion factor was increased 2.1% effective January 1, 2010; however, coupled with adjustments to other variables with outpatient PPS, an approximate 1.8% to 2.2% net increase in outpatient payments occurred. The outpatient conversion factor was increased 2.35% effective January 1, 2011; however, coupled with adjustments to other variables with outpatient PPS, an approximate 2.1% to 2.5% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.0 % effective January 1, 2012; however, coupled with adjustments to other variables with outpatient PPS, an approximate 2.1% to 2.5% net increase in outpatient payments is expected to occur. The Medicare Improvements and Extension Act of the Tax Relief and Health Care Act of 2006 imposed a two percentage point reduction to the market basket index beginning January 1, 2009, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement.

The DHHS established a PPS for home health services (i.e., home care) effective October 1, 2000. The home health agency PPS per episodic payment rate increased by 2.9% on January 1, 2009; however, coupled with adjustments to other variables with home health agency PPS, an approximate 0.2% net increase in home health agency payments occurred. The home health agency PPS per episodic payment rate increased 2.0% on January 1, 2010; however, coupled with adjustments to other variables with home health agency PPS, an approximate 2.3% net

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increase in home health agency payments occurred. The home health agency PPS per episodic payment rate increased 1.1% on January 1, 2011; however, coupled with adjustments to other variables with home health agency PPS, an approximate 4.9% net decrease in home health agency payments occurred. The home health agency PPS per episodic payment rate increased 2.4% on January 1, 2012; however, coupled with adjustments to other variables with home health agency PPS, an approximate 2.31% net decrease in home health agency payments is expected to occur. The Reform Legislation increases the home health agency PPS per episodic payment rate by 3.0% for home health services provided to patients in rural areas on or after April 1, 2010 through December 31, 2016. The Deficit Reduction Act of 2005 imposed a two percentage point reduction to the market basket index beginning January 1, 2007, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement.

Medicaid. Most state Medicaid payments are made under a PPS or under programs which negotiate payment levels with individual hospitals. Medicaid is currently funded jointly by state and federal government. The federal government and many states are currently considering significantly reducing Medicaid funding, while at the same time expanding Medicaid benefits. 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. We can provide no assurance that reductions to Medicaid fundings will not have a material adverse effect on our consolidated results of operations.

Annual Cost Reports. Hospitals participating in the Medicare and some Medicaid programs, whether paid on a reasonable cost basis or under a PPS, are required to meet specified financial reporting requirements. Federal and, where applicable, state regulations require submission of annual cost reports identifying medical costs and expenses associated with the services provided by each hospital to Medicare beneficiaries and Medicaid recipients.

Annual cost reports required under the Medicare and some Medicaid programs are subject to routine governmental audits. These audits may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. Finalization of these audits often takes several years. Providers can appeal any final determination made in connection with an audit. DRG outlier payments have been and continue to be the subject of CMS audit and adjustment. The DHHS OIG is also actively engaged in audits and investigations into alleged abuses of the DRG outlier payment system.

Commercial Insurance and Managed Care Companies. Our hospitals provide services to individuals covered by private healthcare insurance or by health plans administered by managed care companies. These payors pay our hospitals or in some cases reimburse their policyholders based upon the hospital s established charges and the coverage provided in the insurance policy. They try to limit the costs of hospital services by negotiating discounts, including PPS, which would reduce payments by commercial insurers or health plans to our hospitals. Commercial insurers and Managed Care companies also seek to reduce payments to hospitals by establishing payment rules that in effect recharacterize the services ordered by physicians. For example, some payors vigorously review each patient s length of stay in the hospital and recharacterize as outpatient all in-patient stays of less than a particular duration (e.g. 24 hours). Reductions in payments for services provided by our hospitals to individuals covered by these payors could adversely affect us.

Supply Contracts

In March 2005, we began purchasing items, primarily medical supplies, medical equipment and pharmaceuticals, under an agreement with HealthTrust, a GPO in which we are a noncontrolling partner. Triad Hospitals, Inc., or Triad, was also a noncontrolling partner in HealthTrust and we acquired Triad s ownership interest and contractual rights when we acquired Triad. As of December 31, 2011, we have a 17.6% ownership interest in HealthTrust. By participating in this organization, we are able to procure items at competitively priced rates for our hospitals. There can be no assurance that our arrangement with HealthTrust will continue to provide the discounts that we have historically received.

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Competition

The hospital industry is highly competitive. An important part of our business strategy is to continue to acquire hospitals in non-urban markets and selected urban markets. However, other for-profit hospital companies and not-for-profit hospital systems generally attempt to acquire the same type of hospitals as we do. In addition, some hospitals are sold through an auction process, which may result in higher purchase prices than we believe are reasonable.

In addition to the competition we face for acquisitions, we must also compete with other hospitals and healthcare providers for patients. The competition among hospitals and other healthcare providers for patients has intensified in recent years. Our hospitals are located in non-urban and selected urban service areas. Those hospitals in non-urban service areas face no direct competition because there are no other hospitals in their primary service areas. However, these hospitals do face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in those service areas may travel to these other hospitals for a variety of reasons, including the need for services we do not offer or physician referrals. Patients who are required to seek services from these other hospitals may subsequently shift their preferences to those hospitals for services we do provide. Those hospitals in selected urban service areas may face competition from hospitals that are more established than our hospitals. Certain of these competing facilities offer services, including extensive medical research and medical education programs, which are not offered by our facilities. In addition, in certain markets where we operate, there are large teaching hospitals that provide highly specialized facilities, equipment and services that may not be available at our hospitals.

Some of our hospitals operate in primary service areas where they compete with another hospital. Some of these competing hospitals use equipment and services more specialized than those available at our hospitals and/or are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. These hospitals do not pay income or property taxes, and can make capital expenditures without paying sales tax. We also face competition from other specialized care providers, including outpatient surgery, orthopedic, oncology and diagnostic centers.

The number and quality of the physicians on a hospital s staff is an important factor in a hospital s competitive position. Physicians decide whether a patient is admitted to the hospital and the procedures to be performed. Admitting physicians may be on the medical staffs of other hospitals in addition to those of our hospitals. We attempt to attract our physicians patients to our hospitals by offering quality services and facilities, convenient locations and state-of-the-art equipment.

Compliance Program

We take an operations team approach to compliance and utilize corporate experts for program design efforts and facility leaders for employee-level implementation. We believe compliance is another area that demonstrates our utilization of standardization and centralization techniques and initiatives which yield efficiencies and consistency throughout our facilities. We recognize that our compliance with applicable laws and regulations depends on individual employee actions as well as company operations. Our approach focuses on integrating compliance responsibilities with operational functions. This approach is intended to reinforce our company-wide commitment to operate strictly in accordance with the laws and regulations that govern our business.

Our company-wide compliance program has been in place since 1997. Currently, the program s elements include leadership, management and oversight at the highest levels, a Code of Conduct, risk area specific policies and procedures, employee education and training, an internal system for reporting concerns, auditing and monitoring programs and a means for enforcing the program s policies.

Since its initial adoption, the compliance program continues to be expanded and developed to meet the industry s expectations and our needs. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring activities, have been prepared and implemented to address the functional and operational aspects of our business. Included within these functional areas are materials and activities for business sub-units, including laboratory, radiology, pharmacy, emergency, surgery, observation, home care, skilled nursing and clinics. Specific areas identified through regulatory interpretation and enforcement activities have also been

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addressed in our program. Claims preparation and submission, including coding, billing and cost reports, comprise the bulk of these areas. Financial arrangements with physicians and other referral sources, including compliance with the federal anti-kickback statute and the Stark Law, emergency department treatment and transfer requirements and other patient disposition issues, are also the focus of policy and training, standardized documentation requirements and review and audit. Another focus of the program is the interpretation and implementation of the HIPAA standards for privacy and security.

We have a Code of Conduct which applies to all directors, officers, employees and consultants, and a confidential disclosure program to enhance the statement of ethical responsibility expected of our employees and business associates who work in the accounting, financial reporting and asset management areas of our Company. Our Code of Conduct is posted on our website at www.chs.net/company_overview/code_conduct.html.

Employees

At December 31, 2011, we employed approximately 66,000 full-time employees and 22,000 part-time employees. We have approximately 8,000 employees who are union members. We currently believe that our labor relations are good.

Professional Liability Claims

As part of our business of owning and operating hospitals, we are subject to legal actions alleging liability on our part. To cover claims arising out of the operations of hospitals, we maintain professional malpractice liability insurance and general liability insurance on a claims made basis in excess of those amounts for which we are self-insured, in amounts we believe to be sufficient for our operations. We also maintain umbrella liability coverage for claims which, due to their nature or amount, are not covered by our other insurance policies. However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. For a further discussion of our insurance coverage, see our discussion of professional liability claims in Management s Discussion and Analysis of Financial Condition and Results of Operations in Item 7 of this Report.

Environmental Matters

We are subject to various federal, state and local laws and regulations governing the use, discharge and disposal of hazardous materials, including medical waste products. Compliance with these laws and regulations is not expected to have a material adverse effect on us. It is possible, however, that environmental issues may arise in the future which we cannot now predict.

We are insured for damages of personal property or environmental injury arising out of environmental impairment for both above ground and underground storage tank issues under one insurance policy for all of our hospitals. Our policy coverage is $5 million per occurrence with a $50,000 deductible and a $20 million annual aggregate. This policy also provides pollution legal liability coverage.

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

The following risk factors could materially and adversely affect our future operating results and could cause actual results to differ materially from those predicted in the forward-looking statements we make about our business.

Our level of indebtedness could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry and prevent us from meeting our obligations under the agreements relating to our indebtedness.

We are significantly leveraged. The table below shows our level of indebtedness and other information as of December 31, 2011. In connection with the consummation of our acquisition of Triad in July 2007, approximately $7.2 billion of senior secured financing under a new credit facility, or the Credit Facility, was obtained by our wholly-owned subsidiary, CHS/Community Health Systems, Inc., or CHS. CHS also issued 8.875% senior notes, or the 8 7/8% Senior Notes, having an aggregate principal amount of approximately $3.0 billion. Both the indebtedness under the Credit Facility and the 8 7/8% Senior Notes are senior obligations of CHS and are guaranteed on a senior basis by us and by certain of our domestic subsidiaries. We used the net proceeds from the 8 7/8% Senior Notes offering and the net proceeds of the approximately $6.1 billion term loans under the Credit Facility to pay the consideration under the merger agreement with Triad, to refinance certain of our existing indebtedness and the indebtedness of Triad, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. As of December 31, 2011, a $750 million revolving credit facility was available to us for working capital and general corporate purposes under the Credit Facility, with $37.7 million of the revolving credit facility being set aside for outstanding letters of credit and $30.0 million outstanding at December 31, 2011. On November 5, 2010, we entered into an amendment and restatement of our existing Credit Facility, which extended by two and a half years, until January 25, 2017, the maturity date of $1.5 billion of our existing term loans under the Credit Facility. In addition, effective February 2, 2012, we completed an additional amendment and restatement of the Credit Facility, which extended by two and a half years the maturity date of an additional $1.6 billion of our existing non-extended term loans under the Credit Facility, until January 25, 2017 (subject to customary acceleration events) or, if more than $50 million of our 8 7/8% Senior Notes are outstanding on April 15, 2015, to April 15, 2015. The remaining approximately $2.9 billion in term loans mature in 2014. On November 22, 2011, CHS completed its offering of $1.0 billion aggregate principal amount of 8% Senior Notes, or the 8% Senior Notes, which were issued in a private placement. The net proceeds from this issuance, together with available cash on hand, were used to finance the purchase of up to $1.0 billion aggregate principal amount of outstanding 8 7/8% Senior Notes and related fees and expenses. The 8% Senior Notes are unsecured senior obligations of CHS and are guaranteed on a senior basis by us and by certain of our domestic subsidiaries. With the exception of some small principal payments of our term loans under our Credit Facility, representing less than 1% of the outstanding balance each year through 2013, approximately $2.9 billion of term loans under our Credit Facility mature in 2014, our 8 7/8% Senior Notes are due in 2015, the remaining $3.1 billion in term loans mature in 2017 and our 8% Senior Notes are due in 2019.

	December 31, 2011 ($ in millions)
Senior secured credit facility term loans	$ 5,949.4
Revolving credit facility	30.0
8 7/8% Senior Notes	1,777.6
8% Senior Notes	1,000.0
Other	89.5
Total debt	$ 8,846.5
Community Health Systems, Inc. stockholders equity	$ 2,397.1

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As of December 31, 2011, our approximately $4.9 billion notional amount of interest rate swap agreements represented approximately 82% of our variable rate debt. On a prospective basis, a 1% change in interest rates on the remaining unhedged variable rate debt existing as of December 31, 2011, would result in interest expense fluctuating approximately $11.0 million per year.

The Credit Facility and/or both of the 8 $^{7}/8$% Senior Notes and the 8% Senior Notes, or collectively known as the Senior Notes, contain various covenants that limit our ability to take certain actions, including our ability to:

- incur, assume or guarantee additional indebtedness,
- issue redeemable stock and preferred stock,
- repurchase capital stock,
- make restricted payments, including paying dividends and making investments,
- redeem debt that is junior in right of payment to the Senior Notes,
- create liens,
- sell or otherwise dispose of assets, including capital stock of subsidiaries,
- enter into agreements that restrict dividends from subsidiaries,
- merge, consolidate, sell or otherwise dispose of substantial portions of our assets,
- enter into transactions with affiliates and
- guarantee certain obligations.

In addition, our Credit Facility contains restrictive covenants and requires us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet these 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.

The counterparty to the interest rate swap agreements exposes us to credit risk in the event of non-performance. However, at December 31, 2011, we do not anticipate non-performance by the counterparty due to the net settlement feature of the agreements and our liability position with respect to each of our counterparties.

A breach of any of these covenants could result in a default under our Credit Facility and/or the Senior Notes. Upon the occurrence of an event of default under our Credit Facility or the Senior Notes, all amounts outstanding under our Credit Facility and the Senior Notes may become

immediately due and payable and all commitments under the Credit Facility to extend further credit may be terminated.

Our leverage could have important consequences for you, including the following:

- it may limit our ability to obtain additional debt or equity financing for working capital, capital expenditures, debt service requirements, acquisitions and general corporate or other purposes,

- a substantial portion of our cash flows from operations will be dedicated to the payment of principal and interest on our indebtedness and will not be available for other purposes, including our operations, capital expenditures and future business opportunities,

- the debt service requirements of our indebtedness could make it more difficult for us to satisfy our financial obligations,

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some of our borrowings, including borrowings under our Credit Facility, are at variable rates of interest, exposing us to the risk of increased interest rates,

it may limit our ability to adjust to changing market conditions and place us at a competitive disadvantage compared to our competitors that have less debt and

we may be vulnerable in a downturn in general economic conditions or in our business, or we may be unable to carry out capital spending that is important to our growth.

The ratio of earnings to fixed charges is a measure of our ability to meet our fixed obligations related to our indebtedness. The following table shows the ratio of earnings to fixed charges for the periods indicated:

	Year Ended December 31,				
	2007	2008	2009	2010	2011
Ratio of earnings to fixed charges(1)	1.21x	1.47x	1.60x	1.69x	1.61x

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

Despite current indebtedness levels, we may be able to incur substantially more debt. This could further exacerbate the risks described above.

We may be able to incur substantial additional indebtedness in the future. The terms of the indentures governing the Senior Notes do not fully prohibit us from doing so. For example, under the indentures for the 8 7/8% Senior Notes and the 8% Senior Notes, we may incur up to approximately $7.8 billion pursuant to a credit facility or a qualified receivables transaction, less certain amounts repaid with the proceeds of asset dispositions. As of December 31, 2011, our Credit Facility provided for commitments of up to approximately $6.7 billion in the aggregate. Additionally, our Credit Facility also gives us the ability to provide for one or more additional tranches of term loans in the aggregate principal amount of up to $1.0 billion without the consent of the existing lenders if specified criteria are satisfied and for up to $300 million of borrowing capacity from receivable transactions (including securitizations). If new debt is added to our current debt levels, the related risks that we now face could be further exacerbated.

If competition decreases our ability to acquire additional hospitals on favorable terms, we may be unable to execute our acquisition strategy.

An important part of our business strategy is to acquire two to four hospitals each year. However, not-for-profit hospital systems and other for-profit hospital companies generally attempt to acquire the same type of hospital as we do. Some of these other purchasers have greater financial resources than us. Our principal competitors for acquisitions have included Health Management Associates, Inc. and LifePoint Hospitals, Inc. On some occasions, we also compete with HCA Holdings Inc., Universal Health Services, Inc., other non-public, for-profit hospitals and local market hospitals. In addition, some hospitals are sold through an auction process, which may result in higher purchase prices than we believe are reasonable. Therefore, we may not be able to acquire additional hospitals on terms favorable to us.

If we fail to improve the operations of acquired hospitals, we may be unable to achieve our growth strategy.

Many of the hospitals we have acquired had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced temporary delays in improving the operating margins or effectively integrating the operations of these acquired hospitals. In the future, if we are unable to improve the operating margins of acquired hospitals, operate them profitably, or effectively integrate their operations, we may be unable to achieve our growth strategy.

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If we acquire hospitals with unknown or contingent liabilities, we could become liable for material obligations.

Hospitals that we acquire may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. Although we generally seek indemnification from prospective sellers covering these matters, we may nevertheless have material liabilities for past activities of acquired hospitals.

State efforts to regulate the construction, acquisition or expansion of hospitals could prevent us from acquiring additional hospitals, renovating our facilities or expanding the breadth of services we offer.

Some states require prior approval for the construction or acquisition of healthcare facilities and for the expansion of healthcare facilities and services. In giving approval, these states consider the need for additional or expanded healthcare facilities or services. In some states in which we operate, we are required to obtain CONs for capital expenditures exceeding a prescribed amount, changes in bed capacity or services and some other matters. Other states may adopt similar legislation. We may not be able to obtain the required CONs or other prior approvals for additional or expanded facilities in the future. In addition, at the time we acquire a hospital, we may agree to replace or expand the facility we are acquiring. If we are not able to obtain required prior approvals, we would not be able to replace or expand the facility and expand the breadth of services we offer. Furthermore, if a CON or other prior approval, upon which we relied to invest in construction of a replacement or expanded facility, were to be revoked or lost through an appeal process, then we may not be able to recover the value of our investment.

State efforts to regulate the sale of hospitals operated by not-for-profit entities could prevent us from acquiring additional hospitals and executing our business strategy.

Many states, including some where we have hospitals and others where we may in the future acquire hospitals, have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In other states that do not have specific legislation, the attorneys general have demonstrated an interest in these transactions under their general obligations to protect the use of charitable assets. These legislative and administrative efforts focus primarily on the appropriate valuation of the assets divested and the use of the proceeds of the sale by the non-profit seller. While these review and, in some instances, approval processes can add additional time to the closing of a hospital acquisition, we have not had any significant difficulties or delays in completing acquisitions. However, future actions on the state level could seriously delay or even prevent our ability to acquire hospitals.

If we are unable to effectively compete for patients, local residents could use other hospitals.

The hospital industry is highly competitive. In addition to the competition we face for acquisitions and physicians, we must also compete with other hospitals and healthcare providers for patients. The competition among hospitals and other healthcare providers for patients has intensified in recent years. The majority of our hospitals are located in non-urban service areas. In over 60% of our markets, we are the sole provider of general acute care health services. In most of our other markets, the primary competitor is a not-for-profit hospital. These not-for-profit hospitals generally differ in each jurisdiction. However, our hospitals face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in our primary service areas may travel to these other hospitals for a variety of reasons. These reasons include physician referrals or the need for services we do not offer. Patients who seek services from these other hospitals may subsequently shift their preferences to those hospitals for the services we provide.

Some of our hospitals operate in primary service areas where they compete with one other hospital; 25 of our hospitals compete with more than one other hospital in their respective primary service areas. Some of these competing hospitals use equipment and services more specialized than those available at our hospitals. In addition, some competing hospitals are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. These hospitals do not pay income or property taxes, and can make capital expenditures without paying sales tax. We also face competition from other specialized care providers, including outpatient surgery, orthopedic, oncology and diagnostic centers.

We expect that these competitive trends will continue. Our inability to compete effectively with other hospitals and other healthcare providers could cause local residents to use other hospitals.

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The failure to obtain our medical supplies at favorable prices could cause our operating results to decline.

We have a participation agreement with HealthTrust, a GPO. This agreement extends to January 2013, with automatic renewal terms of one year, unless either party terminates by giving notice of non-renewal. GPOs attempt to obtain favorable pricing on medical supplies with manufacturers and vendors who sometimes negotiate exclusive supply arrangements in exchange for the discounts they give. To the extent these exclusive supply arrangements are challenged or deemed unenforceable, we could incur higher costs for our medical supplies obtained through HealthTrust. These higher costs could cause our operating results to decline.

There can be no assurance that our arrangement with HealthTrust will provide the discounts we expect to achieve.

If the fair value of our reporting units declines, a material non-cash charge to earnings from impairment of our goodwill could result.

At December 31, 2011, we had approximately $4.3 billion of goodwill recorded on our books. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. If the carrying value of our goodwill is impaired, we may incur a material non-cash charge to earnings.

A significant decline in operating results or other indicators of impairment at one or more of our facilities could result in a material, non-cash charge to earnings to impair the value of long-lived assets.

Our operations are capital intensive and require significant investment in long-lived assets, such as property, equipment and other long-lived intangible assets, including capitalized internal-use software. If one of our facilities experiences declining operating results or is adversely impacted by one or more of these risk factors, we may not be able to recover the carrying value of those assets through our future operating cash flows. On an ongoing basis, we evaluate whether changes in future undiscounted cash flows reflect an impairment in the fair value of our long-lived assets. If the carrying value of those assets is impaired, we may incur a material non-cash charge to earnings.

Risks related to our industry

We are subject to uncertainties regarding healthcare reform.

In recent years, Congress and some state legislatures have introduced an increasing number of proposals to make major changes in the healthcare system, including an increased emphasis on the linkage between quality of care criteria and payment levels such as the submission of patient quality data to the Secretary of Health and Human Services. In addition, CMS conducts ongoing reviews of certain state reimbursement programs.

ARRA was signed into law on February 17, 2009, providing for a temporary increase in the federal matching assistance percentage (FMAP), a temporary increase in federal Medicaid DSH allotments, subsidization of health insurance premiums (COBRA) for up to nine months and grants and loans for infrastructure and incentive payments for providers who adopt and use health information technology. This act also provides penalties by reducing reimbursement from Medicare in the form of reductions to scheduled market basket increases beginning in federal fiscal year 2015 if eligible hospitals and professionals fail to demonstrate meaningful use of electronic health record technology.

PPACA was signed into law on March 23, 2010. In addition, the Reconciliation Act, which contains a number of amendments to PPACA, was signed into law on March 30, 2010. These two healthcare acts, referred to collectively as the Reform Legislation, include a mandate that requires substantially all U.S. 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 which began October 1, 2011, and a reduction to the Medicare and Medicaid disproportionate share payments, that could adversely impact the reimbursement received under these programs. 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.

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

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 have been made and the hospital has a Medicare provider agreement as of a specific date.

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. In particular, the Supreme Court of the United States has accepted an appeal of one of the many cases challenging various aspects, including constitutionality of the Reform Legislation. 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.

If federal or state healthcare programs or managed care companies reduce the payments we receive as reimbursement for services we provide, our net operating revenues may decline.

In 2011, 36.5% of our net operating revenues came from the Medicare and Medicaid programs. Federal healthcare expenditures continue to increase and state governments continue to face budgetary shortfalls as a result of the current economic downturn and accelerating Medicaid enrollment. As a result, federal and state governments have made, and continue to make, significant changes in the Medicare and Medicaid programs. Some of these changes have decreased, or could decrease, the amount of money we receive for our services relating to these programs.

In addition, insurance and managed care companies and other third parties from whom we receive payment for our services increasingly are attempting to control healthcare costs by requiring that hospitals discount payments for their services in exchange for exclusive or preferred participation in their benefit plans. We believe that this trend may continue and our inability to negotiate increased reimbursement rates or maintain existing rates may reduce the payments we receive for our services.

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.

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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 Item 3 of this Report.

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.

A shortage of qualified nurses could limit our ability to grow and deliver hospital healthcare services in a cost-effective manner.

Hospitals are currently experiencing a shortage of nursing professionals, a trend which we expect to continue for some time. If the supply of qualified nurses declines in the markets in which our hospitals operate, it may result in increased labor expenses and lower operating margins at those hospitals. In addition, in some markets like California, there are requirements to maintain specified nurse-staffing levels. To the extent we cannot meet those levels, the healthcare services that we provide in these markets may be reduced.

If we become subject to significant legal actions, we could be subject to substantial uninsured liabilities or increased insurance costs.

In recent years, physicians, hospitals and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability, or related legal theories. Even in states that have imposed caps on damages, litigants are seeking recoveries under new theories of liability that might not be subject to the caps on damages. Many of these actions involve large claims and significant defense costs. To protect us from the cost of these claims, we maintain claims made professional malpractice liability insurance and general liability insurance coverage in excess of those amounts for which we are self-insured. This insurance coverage is in amounts that we believe to be sufficient for our operations. However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. As a percentage of net operating revenues, our expense related to malpractice and other professional liability claims, including the cost of excess insurance, increased in 2009 by 0.2%, decreased in 2010 by 0.2% and decreased in 2011 by 0.2%. If these costs rise rapidly, our profitability could decline. For a further discussion of our insurance coverage, see our discussion of professional liability claims in Management s Discussion and Analysis of Financial Condition and Results of Operations in Item 7 of this Report.

If we experience growth in self-pay volume and revenues, our financial condition or results of operations could be adversely affected.

Like others in the hospital industry, we have experienced an increase in our provision for bad debts as a percentage of net operating revenues due to a growth in self-pay volume and revenues. Although we continue to seek ways of improving point of service collection efforts and implementing appropriate payment plans with our patients, if we experience growth in self-pay volume and revenues, our results of operations could be adversely affected. Further, our ability to improve collections for self-pay patients may be limited by statutory, regulatory and investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

Currently, the global economies, and in particular the United States, are experiencing a period of economic uncertainty and the related financial markets are experiencing a high degree of volatility. This current financial turmoil is adversely affecting the banking system and financial markets and resulting in a tightening in the credit

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markets, a low level of liquidity in many financial markets and extreme volatility in fixed income, credit, currency and equity markets. This uncertainty poses a risk as it could potentially lead to higher levels of uninsured patients, result in higher levels of patients covered by lower paying government programs and/or result in fiscal uncertainties at both government payors and private insurers.

If our implementation of electronic health record systems is not effective or exceeds our budget and timeline, our consolidated results of operations could be adversely affected.

ARRA created an incentive payment program for eligible hospitals and healthcare professionals to adopt and meaningfully use certified electronic health records, or EHR, technology. The implementation of EHR that meets the meaningful use criteria requires a significant capital investment, and our current plan to implement EHR anticipates maximizing the incentive payment program created by ARRA. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. As additional incentive, beginning in federal fiscal year 2015, if eligible hospitals and professionals fail to demonstrate meaningful use of certified EHR technology, they will be penalized with reduced reimbursement from Medicare in the form of reductions to scheduled market basket increases. If we fail to implement EHR systems effectively and in a timely manner, there could be a material adverse effect on our consolidated financial position and consolidated results of operations.

This Report includes forward-looking statements which could differ from actual future results.

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 si 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,

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- 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 or complete divestitures,
- 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 1B. ***Unresolved Staff Comments***

None

Item 2. ***Properties***

Corporate Headquarters

We own our corporate headquarters building located in Franklin, Tennessee.

Hospitals

Our hospitals are general care hospitals offering a wide range of inpatient and outpatient medical services. These services generally include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric and rehabilitation services. In addition, some of our hospitals provide skilled nursing and home care services based on individual community needs.

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For each of our hospitals owned or leased as of December 31, 2011, the following table shows its location, the date of its acquisition or lease inception and the number of licensed beds:

Hospital	City	Licensed Beds(1)	Date of Acquisition/ Lease Inception	Ownership Type
Alabama				
LV Stabler Memorial Hospital	Greenville	72	October, 1994	Owned
South Baldwin Regional Medical Center	Foley	112	June, 2000	Leased
Cherokee Medical Center	Centre	60	April, 2006	Owned
Dekalb Regional Medical Center	Fort Payne	134	April, 2006	Owned
Trinity Medical Center	Birmingham	534	July, 2007	Owned
Flowers Hospital	Dothan	235	July, 2007	Owned
Medical Center Enterprise	Enterprise	131	July, 2007	Owned
Gadsden Regional Medical Center	Gadsden	346	July, 2007	Owned
Crestwood Medical Center	Huntsville	150	July, 2007	Owned
Alaska				
Mat-Su Regional Medical Center	Palmer	74	July, 2007	Owned
Arizona				
Payson Regional Medical Center	Payson	44	August, 1997	Leased
Western Arizona Regional Medical Center	Bullhead City	139	July, 2000	Owned
Northwest Medical Center	Tucson	300	July, 2007	Owned
Northwest Medical Center Oro Valley	Oro Valley	144	July, 2007	Owned
Arkansas				
Harris Hospital	Newport	133	October, 1994	Owned
Helena Regional Medical Center	Helena	155	March, 2002	Leased
Forrest City Medical Center	Forrest City	118	March, 2006	Leased
Northwest Medical Center Bentonville	Bentonville	128	July, 2007	Owned
Northwest Medical Center Springdale	Springdale	222	July, 2007	Owned
Willow Creek Women s Hospital	Johnson	64	July, 2007	Owned
Siloam Springs Memorial Hospital	Siloam Springs	73	February, 2009	Leased
Medical Center of South Arkansas	El Dorado	166	April, 2009	Leased
California				
Barstow Community Hospital	Barstow	56	January, 1993	Leased
Fallbrook Hospital	Fallbrook	47	November, 1998	Operated (2)
Watsonville Community Hospital	Watsonville	106	September, 1998	Owned
Florida				
Lake Wales Medical Center	Lake Wales	160	December, 2002	Owned
North Okaloosa Medical Center	Crestview	110	March, 1996	Owned
Georgia				
Fannin Regional Hospital	Blue Ridge	50	January, 1986	Owned
Trinity Hospital of Augusta	Augusta	231	July, 2007	Leased

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Hospital	City	Licensed Beds(1)	Date of Acquisition/ Lease Inception	Ownership Type
Illinois				
Crossroads Community Hospital	Mt. Vernon	57	October, 1994	Owned
Gateway Regional Medical Center	Granite City	367	January, 2002	Owned
Heartland Regional Medical Center	Marion	92	October, 1996	Owned
Red Bud Regional Hospital	Red Bud	31	September, 2001	Owned
Galesburg Cottage Hospital	Galesburg	173	July, 2004	Owned
Vista Medical Center East	Waukegan	336	July, 2006	Owned
Vista Medical Center West (psychiatric and rehabilitation beds)	Waukegan	71	July, 2006	Owned
Union County Hospital	Anna	25	November, 2006	Leased
Indiana				
Porter Hospital	Valparaiso	301	May, 2007	Owned
Bluffton Regional Medical Center	Bluffton	79	July, 2007	Owned
Dupont Hospital	Fort Wayne	131	July, 2007	Owned
Lutheran Hospital	Fort Wayne	396	July, 2007	Owned
Lutheran Musculoskeletal Center	Fort Wayne	39	July, 2007	Owned
Lutheran Rehabilitation Hospital (rehabilitation)	Fort Wayne	36	July, 2007	Owned
St. Joseph s Hospital	Fort Wayne	191	July, 2007	Owned
Dukes Memorial Hospital	Peru	25	July, 2007	Owned
Kosciusko Community Hospital	Warsaw	72	July, 2007	Owned
Kentucky				
Parkway Regional Hospital	Fulton	70	May, 1992	Owned
Three Rivers Medical Center	Louisa	90	May, 1993	Owned
Kentucky River Medical Center	Jackson	55	August, 1995	Leased
Louisiana				
Byrd Regional Hospital	Leesville	60	October, 1994	Owned
Northern Louisiana Medical Center	Ruston	159	April, 2007	Owned
Women & Children s Hospital	Lake Charles	88	July, 2007	Owned
Mississippi				
Wesley Medical Center	Hattiesburg	211	July, 2007	Owned
River Region Health System	Vicksburg	341	July, 2007	Owned
Missouri				
Moberly Regional Medical Center	Moberly	101	November, 1993	Owned
Northeast Regional Medical Center	Kirksville	115	December, 2000	Leased
Nevada				
Mesa View Regional Hospital	Mesquite	25	July, 2007	Owned
New Jersey				
Memorial Hospital of Salem County	Salem	140	September, 2002	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/ Lease Inception	Ownership Type
New Mexico				
Mimbres Memorial Hospital	Deming	49	March, 1996	Owned
Eastern New Mexico Medical Center	Roswell	162	April, 1998	Owned
Alta Vista Regional Hospital	Las Vegas	54	April, 2000	Owned
Carlsbad Medical Center	Carlsbad	115	July, 2007	Owned
Lea Regional Medical Center	Hobbs	201	July, 2007	Owned
Mountain View Regional Medical Center	Las Cruces	168	July, 2007	Owned
North Carolina				
Martin General Hospital	Williamston	49	November, 1998	Leased
Ohio				
Affinity Medical Center	Massillon	266	July, 2007	Owned
Northside Medical Center	Youngstown	355	October, 2010	Owned
Trumbull Memorial Hospital	Warren	311	October, 2010	Owned
Hillside Rehabilitation Hospital (rehabilitation)	Warren	69	October, 2010	Owned
Oklahoma				
Ponca City Medical Center	Ponca City	140	May, 2006	Owned
Deaconess Hospital	Oklahoma City	291	July, 2007	Owned
Woodward Regional Hospital	Woodward	87	July, 2007	Leased
Oregon				
McKenzie-Willamette Medical Center	Springfield	113	July, 2007	Owned
Pennsylvania				
Berwick Hospital	Berwick	101	March, 1999	Owned
Brandywine Hospital	Coatesville	236	June, 2001	Owned
Jennersville Regional Hospital	West Grove	59	October, 2001	Owned
Easton Hospital	Easton	254	October, 2001	Owned
Lock Haven Hospital	Lock Haven	47	August, 2002	Owned
Pottstown Memorial Medical Center	Pottstown	226	July, 2003	Owned
Phoenixville Hospital	Phoenixville	137	August, 2004	Owned
Chestnut Hill Hospital	Philadelphia	160	February, 2005	Owned
Sunbury Community Hospital	Sunbury	89	October, 2005	Owned
Wilkes-Barre General Hospital	Wilkes-Barre	412	April, 2009	Owned
First Hospital Wyoming Valley (psychiatric)	Wilkes-Barre	135	April, 2009	Owned
Regional Hospital of Scranton	Scranton	230	May, 2011	Owned
Special Care Hospital	Nanticoke	67	May, 2011	Leased
Tyler Memorial Hospital	Tunkhannock	48	May, 2011	Owned
South Carolina				
Marlboro Park Hospital	Bennettsville	102	August, 1996	Leased
Chesterfield General Hospital	Cheraw	59	August, 1996	Leased
Springs Memorial Hospital	Lancaster	231	November, 1994	Owned
Carolinas Hospital System Florence	Florence	420	July, 2007	Owned
Mary Black Memorial Hospital	Spartanburg	209	July, 2007	Owned
Marion Regional Hospital	Mullins	124	July, 2010	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/ Lease Inception	Ownership Type
Tennessee				
Lakeway Regional Hospital	Morristown	135	May, 1993	Owned
Regional Hospital of Jackson	Jackson	152	January, 2003	Owned
Dyersburg Regional Medical Center	Dyersburg	225	January, 2003	Owned
Haywood Park Community Hospital	Brownsville	62	January, 2003	Owned
Henderson County Community Hospital	Lexington	45	January, 2003	Owned
McKenzie Regional Hospital	McKenzie	45	January, 2003	Owned
McNairy Regional Hospital	Selmer	45	January, 2003	Owned
Volunteer Community Hospital	Martin	100	January, 2003	Owned
Heritage Medical Center	Shelbyville	60	July, 2005	Owned
Sky Ridge Medical Center	Cleveland	351	October, 2005	Owned
Gateway Medical Center	Clarksville	270	July, 2007	Owned
Texas				
Big Bend Regional Medical Center	Alpine	25	October, 1999	Owned
Scenic Mountain Medical Center	Big Spring	150	October, 1994	Owned
Hill Regional Hospital	Hillsboro	92	October, 1994	Leased
Lake Granbury Medical Center	Granbury	83	January, 1997	Leased
South Texas Regional Medical Center	Jourdanton	67	November, 2001	Owned
Laredo Medical Center	Laredo	326	October, 2003	Owned
Weatherford Regional Medical Center	Weatherford	99	November, 2006	Leased
Abilene Regional Medical Center	Abilene	231	July, 2007	Owned
Brownwood Regional Medical Center	Brownwood	194	July, 2007	Owned
College Station Medical Center	College Station	166	July, 2007	Owned
Navarro Regional Hospital	Corsicana	162	July, 2007	Owned
Longview Regional Medical Center	Longview	131	July, 2007	Owned
Woodland Heights Medical Center	Lufkin	149	July, 2007	Owned
San Angelo Community Medical Center	San Angelo	171	July, 2007	Owned
DeTar Healthcare System	Victoria	308	July, 2007	Owned
Cedar Park Regional Medical Center	Cedar Park	77	December, 2007	Owned
Tomball Regional Hospital	Tomball	358	October, 2011	Owned
Utah				
Mountain West Medical Center	Tooele	44	October, 2000	Owned
Virginia				
Southern Virginia Regional Medical Center	Emporia	80	March, 1999	Owned
Southampton Memorial Hospital	Franklin	105	March, 2000	Owned
Southside Regional Medical Center	Petersburg	300	August, 2003	Owned
Washington				
Deaconess Medical Center	Spokane	388	October, 2008	Owned
Valley Hospital and Medical Center	Spokane Valley	123	October, 2008	Owned
West Virginia				
Plateau Medical Center	Oak Hill	25	July, 2002	Owned
Greenbrier Valley Medical Center	Ronceverte	122	July, 2007	Owned
Bluefield Regional Medical Center	Bluefield	240	October, 2010	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/ Lease Inception	Ownership Type
Wyoming				
Evanston Regional Hospital	Evanston	42	November, 1999	Owned
Total Licensed Beds at December 31, 2011		19,695		

(1) Licensed beds are the number of beds for which the appropriate state agency licenses a facility regardless of whether the beds are actually available for patient use.

(2) We operate this hospital under a lease-leaseback and operating agreement. We recognize all operating statistics, revenues and expenses associated with this hospital in our consolidated financial statements.

The real property of substantially all of our wholly-owned hospitals is encumbered by mortgages under the Credit Facility.

The following table lists the hospitals owned by joint venture entities in which we do not have a consolidating ownership interest, along with our percentage ownership interest in the joint venture entity as of December 31, 2011. Information on licensed beds was provided by the majority owner and manager of each joint venture. A subsidiary of HCA is the majority owner of Macon Healthcare LLC, and a subsidiary of UHS is the majority owner of Summerlin Hospital Medical Center LLC and Valley Health System LLC.

Joint Venture	Facility Name	City	State	Licensed Beds
Macon Healthcare LLC	Coliseum Medical Center (38%)	Macon	GA	250
Macon Healthcare LLC	Coliseum Psychiatric Center (38%)	Macon	GA	60
Macon Healthcare LLC	Coliseum Northside Hospital (38%)	Macon	GA	103
Summerlin Hospital Medical Center LLC	Summerlin Hospital Medical Center (26.1%)	Las Vegas	NV	454
Valley Health System LLC	Desert Springs Hospital (27.5%)	Las Vegas	NV	293
Valley Health System LLC	Valley Hospital Medical Center (27.5%)	Las Vegas	NV	404
Valley Health System LLC	Spring Valley Hospital Medical Center (27.5%)	Las Vegas	NV	231
Valley Health System LLC	Centennial Hills Hospital Medical Center (27.5%)	Las Vegas	NV	171

Item 3. ***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: DME vendor relationships and patient choice discharge instructions at our Washington hospitals, operations of a cardiovascular surgery department at our Oregon hospital and lab operations at a New Mexico 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.

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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 closed. The deadline for filing of Motions for Summary Judgment is March 27, 2012 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. On December 5, 2011, the court entered an order approving the suggested damages methodology. We are vigorously defending this action.

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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. We continue to cooperate fully with this investigation.

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 this investigation.

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 all documentation and reports requested. 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 (including production of documents and interviews with witnesses) 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.

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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. On November 1, 2011, the court denied the motion to transfer the matter and extended the stay until April 30, 2012. 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.

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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. On December 28, 2011, the court consolidated all three shareholder cases for pretrial purposes, selected NYC Funds as lead plaintiffs, and selected NYC Funds counsel as lead plaintiffs counsel. The parties are in the process of negotiating operative dates for these consolidated shareholder federal securities actions, including dates for the filing of an operative consolidated complaint and related briefing. Three purported shareholder derivative actions have also been filed in the United States District Court for the Middle District of Tennessee; Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund v. Wayne T. Smith, 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 28, 2011, the court ordered that the Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund action and the Roofers Local No. 149 Pension Fund action be consolidated for pretrial purposes, and appointed the derivative plaintiffs lead counsel. On November 29, 2011, the court ordered that the Lambert Sweat action be consolidated with the Plumbers and Roofers consolidated derivative actions. Plaintiffs are expected to file an operative amended derivative complaint in these three consolidated actions on or about March 15, 2012. 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. On January 26, 2012, the relator was granted unopposed leave to file an amended complaint. 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.

On February 2, 2012, an order was entered unsealing a relator s qui tam complaint in the matter of Pamela Gronemeyer ex rel. United States of America v. Crossroads Community Hospital. The action is pending in the United States District Court, Southern District of Illinois. Crossroads Community Hospital is an affiliated hospital. The order recited that the United States had declined to intervene in this matter. We had previously disclosed this matter in the context of our response to a subpoena concerning blood administration practices at an affiliated Illinois hospital. We believe the claim against our hospital is without merit and we will vigorously defend this case.

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

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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 (on February 15, 2012, we received a follow-up letter from CtW Investment Group that discusses the inherent limitations in using only publicly available data and points out that other factors can affect admission and length of stay patterns; the letter also concludes that CtW Investment Group is now satisfied with the commitment of the Company, its management and its Board of Directors to acting in accordance with their respective duties and obligations);

- 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 fails to account for patients who are treated and discharged promptly (i.e., neither admitted as inpatients nor placed in observation), 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, on average, monthly to review the status of the lawsuits and investigations relating to allegations of improper billing for inpatient care at our hospitals and to oversee management in connection with our investigation and defense of these matters. 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. 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.

The independent members of our Board of Directors remain fully engaged in the oversight 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.

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Triad Hospitals, Inc. Legal Proceedings

In a case styled U.S. ex rel. Bartlett vs. Quorum Health Resources, LLC, 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 4. ***Mine Safety Disclosures***
Not applicable.

PART II

Item 5. ***Market for Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***
We completed an initial public offering of our common stock on June 14, 2000. Our common stock began trading on June 9, 2000 and is listed on the New York Stock Exchange under the symbol CYH. At February 15, 2012, there were approximately 47 record holders of our common stock. The following table sets forth, for the periods indicated, the high and low sale prices per share of our common stock as reported by the New York Stock Exchange.

	High	Low
Year Ended December 31, 2010		
First Quarter	$ 40.84	$ 31.00
Second Quarter	42.30	33.21
Third Quarter	34.11	25.63
Fourth Quarter	38.00	29.08
Year Ended December 31, 2011		
First Quarter	$ 42.50	$ 34.62
Second Quarter	41.09	22.33
Third Quarter	27.63	15.91
Fourth Quarter	21.92	14.61

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Stock Performance Graph

The following graph sets forth the cumulative return of our common stock during the five year period ended December 31, 2011, as compared to the cumulative return of the Standard & Poor s 500 Stock Index (S&P 500) and the cumulative return of the Dow Jones Healthcare Index. The graph assumes an initial investment of $100 in our common stock and in each of the foregoing indices and the reinvestment of dividends where applicable.

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 initial 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 indentures governing our Senior Notes also limit our ability to pay dividends and/or repurchase stock. As of December 31, 2011, under the most restrictive test under these agreements, we have approximately $30.1 million remaining available with which to pay permitted dividends and/or make stock and Senior Notes repurchases.

On December 14, 2011, we adopted a new open market repurchase program for up to 4,000,000 shares of our common stock, not to exceed $100 million in repurchases. The new repurchase program will conclude at the earliest of three years, when the maximum number of shares has been repurchased, or when the maximum dollar amount has been expended. Through December 31, 2011, no shares have been purchased and retired under this program.

On September 15, 2010, we commenced an 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 December 31, 2011, we did not repurchase any shares under this program. During the year ended December 31, 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 December 31, 2011 is 3,921,138 shares at a weighted-average price of $25.39 per share.

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Item 6. ***Selected Financial Data***

The following table summarizes specified selected financial data and should be read in conjunction with our related Consolidated Financial Statements and accompanying Notes to Consolidated Financial Statements. The amounts shown below have been adjusted for discontinued operations.

Community Health Systems, Inc.

Five Year Summary of Selected Financial Data

	Year Ended December 31,				
	2011	**2010**	**2009**	**2008**	**2007[1]**
	(in thousands, except share and per share data)				
Consolidated Statement of Income Data					
Net operating revenues	$ 13,626,168	$ 12,623,374	$ 11,742,454	$ 10,563,460	$ 6,915,234
Income from operations	1,134,485	1,121,044	1,064,831	970,086	470,598
Income from continuing operations	335,894	355,213	305,811	238,386	70,351
Net income	277,623	348,441	306,377	252,734	44,691
Net income attributable to noncontrolling interests	75,675	68,458	63,227	34,430	14,402
Net income attributable to Community Health Systems, Inc	201,948	279,983	243,150	218,304	30,289
Basic earnings per share attributable to Community Health Systems, Inc. common stockholders (2):					
Continuing operations	$ 2.89	$ 3.13	$ 2.68	$ 2.18	$ 0.61
Discontinued operations	(0.65)	(0.07)		0.16	(0.29)
Net income	$ 2.24	$ 3.05	$ 2.68	$ 2.34	$ 0.32
Diluted earnings per share attributable to Community Health Systems, Inc. common stockholders (2):					
Continuing operations	$ 2.87	$ 3.08	$ 2.65	$ 2.16	$ 0.60
Discontinued operations	(0.64)	(0.07)		0.16	(0.28)
Net income	$ 2.23	$ 3.01	$ 2.66	$ 2.32	$ 0.32
Weighted-average number of shares outstanding					
Basic	89,966,933	91,718,791	90,614,886	93,371,782	93,517,337
Diluted (3)	90,666,348	92,946,048	91,517,274	94,288,829	94,642,294
Consolidated Balance Sheet Data					
Cash and cash equivalents	$ 129,865	$ 299,169	$ 344,541	$ 220,655	$ 133,574
Total assets	15,208,840	14,698,123	14,021,472	13,818,254	13,493,644
Long-term obligations	10,437,513	10,418,234	10,179,402	10,287,535	9,974,516
Redeemable noncontrolling interests in equity of consolidated subsidiaries	395,743	387,472	368,857	348,816	346,999
Community Health Systems, Inc. stockholders equity	2,397,096	2,189,464	1,950,635	1,611,029	1,687,293
Noncontrolling interests in equity of consolidated subsidiaries	67,349	60,913	64,782	61,457	51,419

(1) Includes the results of operations of the former Triad hospitals from July 25, 2007, the date of acquisition.
(2) Total per share amounts may not add due to rounding.
(3) See Note 12 to the Consolidated Financial Statements, included in Item 8 of this Form 10-K.

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Item 7. ***Management s Discussion and Analysis of Financial Condition and Results of Operations***

You should read this discussion together with our Consolidated Financial Statements and the accompanying Notes to Consolidated Financial Statements and Selected Financial Data included elsewhere in this Form 10-K.

Executive Overview

We are one of the largest publicly-traded operators of hospitals in the United States in terms of number of facilities and net operating revenues. We provide healthcare services through the hospitals that we own and operate in non-urban and selected urban markets. We generate revenue primarily by providing a broad range of general hospital healthcare services to patients in the communities in which we are located. We currently own and operate 133 hospitals comprised of 129 general acute care hospitals and four stand-alone rehabilitation or psychiatric hospitals. 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.

In 2011, we continued the execution of our acquisition strategy by acquiring a total of four hospitals located in Scranton, Pennsylvania; Tunkhannock, Pennsylvania; Nanticoke, Pennsylvania and Tomball, Texas. In 2010, we acquired a total of five hospitals located in Marion, South Carolina; Youngstown and Warren, Ohio and Bluefield, West Virginia.

Additionally, during 2011, we sold three hospitals and a multi-specialty physician clinic. Accordingly, the related results of operations, impairment of long-lived assets held for sale and the loss on sale of these entities have been classified as discontinued operations in the consolidated statements of income for all years presented.

During 2011, we experienced same-store decreases of 5.6% in inpatient admissions and 0.7% in adjusted admissions, when compared to the year ended December 31, 2010. Same-store outpatient surgeries increased 4.0% in 2011, when compared to the year ended December 31, 2010. Contributing to the decrease in inpatient admissions were decreases in admissions from women s services including obstetrics and gynecology, reductions in one day stay inpatient admissions from the emergency room, reductions in surgical inpatient admissions, reductions due to certain service closures in a few of our hospitals and reductions due to competition and weather. Offsetting these decreases, we experienced increases in outpatient surgical visits and outpatient registrations and had an increase in the average acuity of inpatient admissions. Our net operating revenues for the year ended December 31, 2011 increased to approximately $13.6 billion, as compared to approximately $12.6 billion for the year ended December 31, 2010. The loss on early extinguishment of debt decreased income from continuing operations, before noncontrolling interests for the year ended December 31, 2011, resulting in a decrease of 5.4% over the year ended December 31, 2010. The loss on early extinguishment of debt related to the purchase of $1.0 billion aggregate principal amount of the 8 $^{7}/8$% Senior Notes with proceeds from the sale of $1.0 billion aggregate principal amount of the 8% Senior Notes. Excluding the loss on early extinguishment of debt, our income from continuing operations, before noncontrolling interests, for the year ended December 31, 2011 increased 6.4% compared to the year ended December 31, 2010. This increase is due primarily to higher revenues from an increase in outpatient services, which offset the decrease in inpatient admissions, an increase in average acuity of inpatient admissions and the elimination of certain unprofitable services in a few of our hospitals. It also reflects our ability to reduce supply expense as a percentage of net operating revenues, although our expense savings were partially offset by expenses related to the Tenet lawsuit, shareholder lawsuits and government investigations.

Self-pay revenues represented approximately 12.0% of our net operating revenues in 2011 compared to 11.5% in 2010. The amount of foregone revenue related to providing charity care services as a percentage of net operating revenues was approximately 4.8% and 4.1% in 2011 and 2010, respectively. Direct and indirect costs incurred by us in providing charity care services were approximately 0.9% and 0.8% of net operating revenues in 2011 and 2010, respectively.

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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 two 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.

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, twenty-six state attorneys general have jointly filed a challenge to certain aspects of the Reform Legislation. Currently, rulings in four separate federal Courts of Appeals have led to a split among the federal Circuit Courts regarding the constitutionality of the Reform Legislation. The Fourth Circuit, Sixth Circuit and the Court of Appeals for the D.C. Circuit have ruled in favor of the Reform Legislation while the Eleventh Circuit ruled the individual mandate within the Reform Legislation unconstitutional. The United States Supreme Court granted certiorari on or about November 14, 2011 to hear the appeal of the Eleventh Circuit s ruling, with oral argument set for March 26 through 28, 2012. The Supreme Court will hear oral argument on four issues: (1) does the Anti-Injunction Act bar a legal challenge to the individual mandate aspect of the Reform Legislation until that mandate takes effect in 2014; (2) is the individual mandate aspect of the Reform Legislation constitutional; (3) if not, is the individual mandate aspect of the Reform Legislation severable from the Reform Legislation as a whole such that it may be stricken without nullifying the Reform Legislation in its entirety and (4) can the states be compelled by the federal government to expand their Medicaid expenditures or risk losing federal funding if they refuse. 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 Supreme Court case. 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

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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 costs 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 incentive reimbursement related to the Medicare or Medicaid incentives as we are able to implement the certified EHR technology, meet the defined meaningful use criteria, and information from completed cost report periods is available from which to calculate the incentive reimbursement. The timing of recognizing incentive reimbursement will not correlate with the timing of recognizing operating expenses and incurring capital costs in connection with the implementation of EHR technology which may result in material period-to-period changes in our future results of operations. 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 year ended December 31, 2011, we recognized approximately $63.4 million of HITECH incentive reimbursements from Medicaid, which are presented as a reduction of operating expenses.

Effective January 1, 2012, we completed the acquisition of Moses Taylor Healthcare System, located in northeast Pennsylvania. This healthcare system includes Moses Taylor Hospital in Scranton, Pennsylvania (217 licensed beds) and Mid-Valley Hospital in Peckville, Pennsylvania (25 licensed beds). The total cash consideration paid at closing for long-lived assets was approximately $152.0 million and for preliminary net working capital was approximately $10.0 million. We have signed definitive agreements for the acquisition of two hospitals, located in York, Pennsylvania and Blue Island, Illinois, which are scheduled to close in 2012.

In addition, effective February 2, 2012, we completed an amendment and restatement of our existing Credit Facility. The amendment extended by two and a half years the maturity date of $1.6 billion of our existing non-extended term loans under the Credit Facility to January 25, 2017 (subject to customary acceleration events) or, if more than $50 million of our 8 $^{7}/_{8}$% Senior Notes are outstanding on April 15, 2015, to April 15, 2015. The amendment also increased the pricing on the newly extended term loans by 125 basis points and amended certain covenants and certain other terms and conditions of the Credit Facility.

As a result of our current levels of cash, available borrowing capacity, long-term outlook on our debt repayments, the refinancing of our term loans and our continued projection of our ability to generate cash flows, we 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 our acquisitions and will continue to strive to improve operating efficiencies and procedures in order to improve our profitability at all of our hospitals.

Acquisitions and Divestitures

Effective October 22, 2011, we sold Cleveland Regional Medical Center, located in Cleveland, Texas, and other related healthcare assets affiliated with the hospital to New Directions Health Systems, LLC for approximately $0.9 million in cash. The carrying amount of the net assets sold in this transaction, including an allocation of reporting unit goodwill, was approximately $14.2 million.

Effective October 1, 2011, we completed the acquisition of Tomball Regional Hospital (358 licensed beds) located in Tomball, Texas. The total cash consideration paid for fixed assets and working capital was approximately $192.0 million and $17.5 million, respectively, with additional consideration of $15.8 million assumed in liabilities, for a total consideration of $225.3 million. Based upon our preliminary purchase price allocation relating to this acquisition as of December 31, 2011, approximately $30.8 million of goodwill has been recorded. The preliminary allocation of the purchase price has been determined by us based on available information and is subject to settling amounts related to purchased working capital and final appraisals of tangible and intangible assets. Adjustments to the purchase price allocation are not expected to be material.

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Effective September 1, 2011, we sold Southcrest Hospital, located in Tulsa, Oklahoma, Claremore Regional Hospital, located in Claremore, Oklahoma, and other related healthcare assets affiliated with those hospitals to Hillcrest Healthcare System, part of Ardent Health Services, for approximately $154.2 million in cash. The carrying amount of the net assets sold in this transaction, including an allocation of reporting unit goodwill, was approximately $193.0 million.

Effective May 1, 2011, we completed the acquisition of Mercy Health Partners based in Scranton, Pennsylvania, which is a healthcare system comprised of two acute care hospitals, a long-term acute care facility and other healthcare providers. This healthcare system includes Regional Hospital of Scranton (198 licensed beds) located in Scranton, Pennsylvania, and Tyler Memorial Hospital (48 licensed beds) located in Tunkhannock, Pennsylvania. This healthcare system also includes a long-term acute care facility, Special Care Hospital (67 licensed beds) located in Nanticoke, Pennsylvania, as well as several outpatient clinics and other ancillary facilities. The total cash consideration paid for fixed assets was approximately $150.8 million, with additional consideration of $12.3 million assumed in liabilities as well as a credit applied at closing of $2.1 million for negative acquired working capital, for a total consideration of $161.0 million. Based upon our final purchase price allocation relating to this acquisition as of December 31, 2011, approximately $43.1 million of goodwill has been recorded.

Effective February 1, 2011, we sold Willamette Community Medical Group, which is a physician clinic operating as Oregon Medical Group, or OMG, located in Springfield, Oregon, to Oregon Healthcare Resources, LLC, for $14.6 million in cash; this business had a carrying amount of net assets, including an allocation of reporting unit goodwill, of $19.7 million.

Additionally, during 2011, we paid approximately $57.9 million to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by our hospitals. In connection with these acquisitions, we allocated approximately $13.1 million of the consideration paid to property and equipment, $2.9 million to net working capital, $1.6 million to other intangible assets and the remainder, approximately $40.3 million consisting of intangible assets that do not qualify for separate recognition, was allocated to goodwill. These acquisition transactions were accounted for as purchase business combinations.

Sources of Revenue

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 years presented are not strictly comparable due to the effect that hospital acquisitions have had on these statistics.

	Year Ended December 31,		
Net Operating Revenues by Payor Source	**2011**	**2010**	**2009**
Medicare	26.8%	27.4%	27.4%
Medicaid	9.7%	10.7%	9.8%
Managed Care and other third-party payors	51.5%	50.4%	51.6%
Self-pay	12.0%	11.5%	11.2%
Total	100.0%	100.0%	100.0%

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

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income by an insignificant amount in each of the years ended December 31, 2011, 2010 and 2009. 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 Centers for Medicare and Medicaid Services, or CMS, and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Similar programs are also being considered by other states. After these supplemental programs are signed into law, we recognize revenue and related expenses in the period in which amounts are estimable and collection is reasonably assured. Reimbursement under these programs is reflected in net operating revenues and included as Medicaid revenue in the table above, and fees, taxes or other program related costs are reflected in other operating 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.

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.

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

	Year Ended December 31,		
	2011	2010	2009
	(Expressed as a percentage of net operating revenues)		
Consolidated			
Net operating revenues	100.0%	100.0%	100.0%
Operating expenses (a)	(86.9)	(86.4)	(86.2)
Depreciation and amortization	(4.8)	(4.7)	(4.7)
Income from operations	8.3	8.9	9.1
Interest expense, net	(4.7)	(5.2)	(5.5)
Loss (gain) from early extinguishment of debt (b)	(0.5)		
Equity in earnings of unconsolidated affiliates	0.4	0.4	0.3
Impairment of long-lived and other assets			(0.1)
Income from continuing operations before income taxes	3.5	4.1	3.8
Provision for income taxes	(1.0)	(1.3)	(1.2)
Income from continuing operations	2.5	2.8	2.6
(Loss) income from discontinued operations, net of taxes	(0.5)	(0.1)	
Net income	2.0	2.7	2.6
Less: Net income attributable to noncontrolling interests	(0.5)	(0.5)	(0.5)
Net income attributable to Community Health Systems, Inc.	1.5%	2.2%	2.1%

	Year Ended December 31,	
	2011	2010
	(Expressed in percentages)	
Percentage increase (decrease) from same period prior year:		
Net operating revenues	7.9%	7.5%
Admissions	(0.5)	0.4
Adjusted admissions(c)	4.2	2.8
Average length of stay	2.3	0.0
Net income attributable to Community Health Systems, Inc. (d)	(27.9)	15.1
Same-store percentage increase (decrease) from same period prior year(e):		
Net operating revenues	3.7%	4.1%
Admissions	(5.6)	(2.4)
Adjusted admissions(c)	(0.7)	(0.3)

(a) Operating expenses include salaries and benefits, provision for bad debts, supplies, other operating expenses, electronic health records incentive reimbursement and rent.
(b) Both the gain from early extinguishment of debt and income from discontinued operations were less than 0.1% for the year ended December 31, 2009.
(c) Adjusted admissions is a general measure of combined inpatient and outpatient volume. We computed adjusted admissions by multiplying admissions by gross patient revenues and then dividing that number by gross inpatient revenues.
(d) Includes income from discontinued operations, if any.
(e) Includes acquired hospitals to the extent we operated them in both years.

Year Ended December 31, 2011 Compared to Year Ended December 31, 2010

Net operating revenues increased by 7.9% to approximately $13.6 billion in 2011, from approximately $12.6 billion in 2010. Growth from hospitals owned throughout both periods contributed $465 million of that increase and $538 million was contributed by hospitals acquired in 2011 and 2010. On a same-store basis, net operating revenues increased 3.7%. 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.

On a consolidated basis, inpatient admissions decreased by 0.5% and adjusted admissions increased by 4.2%. On a same-store basis, inpatient admissions decreased by 5.6% and adjusted admissions decreased by 0.7% during the year ended December 31, 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 and reductions due to competition, weather and certain service closures in a few of our hospitals during the year ended December 31, 2011, as compared to the year ended December 31, 2010. The reductions in surgical inpatient admissions were offset with a corresponding increase in outpatient surgical visits.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, increased from 86.4% in 2010 to 86.9% in 2011. Salaries and benefits, as a percentage of net operating revenues, increased from 40.3% in 2010 to 40.9% in 2011 as a result of recent acquisitions and an increase in the number of employed physicians. Provision for bad debts, as a percentage of net revenues, increased from 12.1% in 2010 to 12.6% in 2011. This increase in the provision for bad debts primarily represents an increase in self-pay revenues as a percentage of our total net operating revenues. The increase does not reflect a further deterioration in our ability to collect self-pay accounts receivable, as our collection trends have remained relatively consistent over the prior period. Supplies, as a percentage of net operating revenues, decreased from 13.8% in 2010 to 13.5% in 2011. This decrease in supplies expenses is due primarily to greater utilization of and improved pricing under our purchasing program. Other operating expenses, as a percentage of net operating revenues, increased from 18.2% in 2010 to 18.5% in 2011. Rent, as a percentage of net operating revenues, decreased from 2.0% in 2010 to 1.9% in 2011.

Electronic health records incentive reimbursements represent those incentives under the HITECH Act for which the recognition criterion has been met. For the year ended December 31, 2011, we have recognized approximately $63.4 million of incentive reimbursements, or 0.5% of net operating revenues. Of these incentives, we had received payments of $28.9 million through December 31, 2011. Operating expenses incurred related to the installation and adoption of electronic health records, including depreciation and amortization, totaled approximately 0.2% of net operating revenues in 2011, of which depreciation and amortization represented less than 0.1% of net operating revenues.

Depreciation and amortization, as a percentage of net operating revenues, increased from 4.7% in 2010 to 4.8% in 2011.

Interest expense, net, decreased by $3.2 million from $647.6 million in 2010, to $644.4 million in 2011. A decrease in our average outstanding debt during 2011, compared to 2010, resulted in a decrease in interest expense of $1.3 million. Additionally, interest expense decreased by $9.7 million as a result of more interest being capitalized during 2011, as compared to 2010, as the current year period had more major construction projects.

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These increases were offset by an increase in interest rates during 2011, including the pricing increase on $1.5 billion of our existing term loans under the amended Credit Facility beginning November 5, 2010, compared to 2010, resulting in an increase in interest expense of $7.8 million. Interest savings in 2012 from replacing $1.0 billion aggregate principal amount of our 8 $^{7}/8$% Senior Notes with our 8% Senior Notes will be more than offset by the higher interest rate on the $1.6 billion of extended term loans under the second amendment and restatement of the Credit Facility that was effective on February 2, 2012.

Loss from early extinguishment of debt was recognized after the purchase of up to $1.0 billion aggregate principal amount of CHS outstanding 8 $^{7}/8$% Senior Notes due 2015.

Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, remained consistent at 0.4% for 2010 and 2011.

The net results of the above mentioned changes resulted in income from continuing operations before income taxes decreasing $45.4 million from $518.9 million in 2010 to $473.5 million for 2011.

Provision for income taxes from continuing operations decreased from $163.7 million in 2010 to $137.7 million in 2011 due to the decrease in income from continuing operations before income taxes. Our effective tax rates were 29.1% and 31.6% for the years ended December 31, 2011 and 2010, respectively. The decrease in our effective tax rate is primarily related to the release of uncertain tax positions and an increase in federal tax credits.

Income from continuing operations, as a percentage of net operating revenues, decreased from 2.8% in 2010 to 2.5% in 2011. The decrease is primarily due to the loss from early extinguishment of debt discussed above.

Net income, as a percentage of net operating revenues, decreased from 2.7% in 2010 to 2.0% in 2011. The decrease is primarily due to the loss from early extinguishment of debt and loss from discontinued operations.

Net income attributable to noncontrolling interests as a percentage of net operating revenues remained consistent at 0.5% for the years ended December 31, 2011 and 2010.

Net income attributable to Community Health Systems, Inc. was $201.9 million in 2011 compared to $280.0 million in 2010, a decrease of 27.9%. The decrease in net income attributable to Community Health Systems, Inc. is reflective of the loss from early extinguishment of debt and loss from discontinued operations.

Year Ended December 31, 2010 Compared to Year Ended December 31, 2009

Net operating revenues increased by 7.5% to approximately $12.6 billion in 2010, from approximately $11.7 billion in 2009. Growth from hospitals owned throughout both periods contributed $478 million of that increase and $404 million was contributed by hospitals acquired in 2010 and 2009. On a same-store basis, net operating revenues increased 4.1%. The increased net operating revenues contributed by hospitals that we owned throughout both periods were primarily attributable to general rate and reimbursement increases.

On a consolidated basis, inpatient admissions increased by 0.4% and adjusted admissions increased by 2.8%. On a same-store basis, inpatient admissions decreased by 2.4% during the year ended December 31, 2010. This decrease in inpatient admissions was due primarily to a decrease in admissions from a less severe flu season as compared to the prior year period, lower birth rates coinciding with the downturn in the economy, reductions in one day stays and certain service closures during the year ended December 31, 2010, as compared to the year ended December 31, 2009.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, increased from 86.2% in 2009 to 86.4% in 2010. Salaries and benefits, as a percentage of net operating revenues, increased from 40.0% in 2009 to 40.3% in 2010 as a result 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 revenues, increased from 12.0% in 2009 to 12.1% in 2010, which is reflective of stabilization in the economy and unemployment rates. Supplies, as a percentage of net operating revenues, decreased from 14.0% in 2009 to 13.8% in 2010. This decrease in supplies expenses is due primarily to greater

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utilization of and improved pricing under our purchasing program. Other operating expenses, as a percentage of net operating revenues, remained consistent at 18.2% for 2009 and 2010. Rent, as a percentage of net operating revenues, remained consistent at 2.0% for 2009 and 2010.

Depreciation and amortization remained consistent at 4.7% of net operating revenues for 2009 and 2010.

Interest expense, net, increased by $4.0 million from $643.6 million in 2009, to $647.6 million in 2010. An increase in interest rates during 2010, including the pricing increase on $1.5 billion of our existing term loans under the amended Credit Facility beginning November 5, 2010, compared to 2009, resulted in an increase in interest expense of $5.9 million. Additionally, interest expense increased by $5.3 million as a result of less interest being capitalized during 2010, as compared to 2009, as the current year period had fewer major construction projects. These increases were offset by a decrease in interest expense of $7.2 million due to a decrease in our average outstanding debt during 2010, compared to 2009.

Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, increased from 0.3% in 2009 to 0.4% in 2010.

Impairment of long-lived and other assets of $12.5 million in 2009 resulted from our assessment of the recoverability of these assets. No impairment of long-lived and other assets was recognized in 2010.

The net results of the above mentioned changes resulted in income from continuing operations before income taxes increasing $71.2 million from $447.7 million in 2009 to $518.9 million for 2010.

Provision for income taxes from continuing operations increased from $141.9 million in 2009 to $163.7 million in 2010 due to the increase in income from continuing operations before income taxes. Our effective tax rates were 31.6% and 31.7% for the years ended December 31, 2010 and 2009, respectively. The decrease in our effective tax rate is primarily a result of a decrease in our effective state tax rate.

Income from continuing operations, as a percentage of net operating revenues, increased from 2.6% in 2009 to 2.8% in 2010. The increase is primarily due to the decrease in interest expense as a percentage of net operating revenues, discussed above.

Net income, as a percentage of net operating revenues, increased from 2.6% in 2009 to 2.7% in 2010. The increase is primarily due to the decrease in interest expense as a percentage of net operating revenues, discussed above.

Net income attributable to noncontrolling interests as a percentage of net operating revenues remained consistent at 0.5% for the years ended December 31, 2010 and 2009.

Net income attributable to Community Health Systems, Inc. was $280.0 million in 2010 compared to $243.2 million in 2009, an increase of 15.1%. The increase in net income attributable to Community Health Systems, Inc. is reflective of the increase in net operating revenues while maintaining substantially the same profit margin levels as discussed above.

Liquidity and Capital Resources

2011 Compared to 2010

Net cash provided by operating activities increased $73.2 million, from approximately $1.2 billion for the year ended December 31, 2010 to approximately $1.3 billion for the year ended December 31, 2011. Net income, adjusted for non-cash expenses of depreciation and amortization expense of $47.8 million, impairment of hospitals sold of $47.9 million, loss on early extinguishment of debt of $66.0 million and all other non-cash charges of $9.4 million, resulted in an increase in cash flows from operating activities of $100.3 million. In addition, an increase in cash flows from accounts payable, accrued liabilities and income taxes, primarily as a result of the timing of payments, increased cash flows from operating activities by $112.0 million. These increases in cash flows were offset by a decrease in cash flows from supplies, prepaid expenses and other current assets of $3.0 million, a

decrease in cash flows generated from the change in all other assets and liabilities of $24.8 million, and decreases in cash generated from accounts receivable of $111.3 million, primarily a result of delays in payment from the Illinois Medicaid program, which contributed to our three-day decline in account receivable days outstanding in 2011 compared to a two-day improvement in 2010.

The cash used in investing activities increased $151.5 million, from approximately $1.0 billion for the year ended December 31, 2010 to approximately $1.2 billion for the year ended December 31, 2011. The increase in cash used in investing activities, in comparison to the prior year, is primarily attributable to an increase in cash paid for acquisitions of facilities and other related equipment of $167.1 million, an increase in the cash used for the purchase of property and equipment of $109.3 million and an increase in cash used for the acquisition of software, primarily related to electronic health records, resulting in an increase in other investments of $51.3 million. These increases in cash used in investing activities were offset by an increase in the amount of the proceeds from the sale of property and equipment of $2.8 million and the proceeds of $173.4 million from the sale of three hospitals in 2011. There were no hospital divestitures in 2010. We anticipate being able to fund future routine capital expenditures with cash flows generated from operations.

In 2011, our net cash used in financing activities increased $45.6 million from $189.8 million in 2010 to $235.4 million in 2011. The increase in cash used in financing activities, in comparison to the prior year, is primarily due to an increase in deferred financing costs of $6.0 million associated with the issuance of our 8% Senior Notes, a reduction in the proceeds from the exercise of stock options of $38.0 million, an increase in the repurchase of restricted stock shares for payroll tax withholding requirements of $13.3 million and a reduction in the proceeds from noncontrolling investors in joint ventures of $6.0 million as the Reform Legislation significantly limits the selling of noncontrolling interests to physician investors. The net increase in all other financing activities was $22.5 million. This included an increase in borrowings under our Credit Facility and the issuance of our 8% Senior Notes, but was mostly offset by repayments of our long-term debt. These increases were offset by a decrease in the repurchases of our common stock of $28.2 million and a reduction in the distributions to noncontrolling investors in joint ventures of $12.0 million.

In 2011, we used $85.7 million for the repurchase and retirement of 3,469,866 shares of our outstanding common stock on the open market. We believed this to be a prudent use of cash as a result of our low market valuation when compared with historical valuations of both our stock and other healthcare providers stock. 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 the initial 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 indentures governing our Senior Notes also limit our ability to pay dividends and/or repurchase stock. As of December 31, 2011, under the most restrictive test under these agreements, we have approximately $30.1 million remaining available with which to pay permitted dividends and/or make stock and Senior Notes repurchases.

In 2011, we successfully continued efforts commenced in 2010 to access the capital markets and extend the maturities of our long-term indebtedness. Our current debt structure was put into place in connection with our acquisition of Triad in 2007 and the then balance of our $6.1 billion Credit Facility term loans was to mature on July 25, 2014; the approximately $3.0 billion aggregate principal amount of 8 7/8% Senior Notes were due July 25, 2015. In November 2011, we completed an offering of $1.0 billion aggregate principal amount of 8% Senior Notes (due 2019), the proceeds of which were used, together with available cash on hand, to finance the repurchase of up to $1.0 billion aggregate principal amount of our 8 7/8% Senior Notes. Subsequent to year end, on February 2, 2012, we completed an amendment and extension of our Credit Facility to extend the maturity date of $1.6 billion of our existing term loans under the Credit Facility by two and a half years, to January 25, 2017, the same maturity date as the November 2010 amendment and extension of $1.5 billion in principal amount of our existing term loans (and at the same increased pricing by 125 basis points). We believe that we will continue to be able to extend the maturities on the unextended portions of our existing Credit Facility (now, approximately $2.9 billion), albeit at higher interest rates, and that we should be able to replace our remaining 8 7/8% Senior Notes (approximately $1.8 billion in principal amount) at lower interest rates. The table below sets forth addition detail about our upcoming cash obligations and a further discussion of our existing Credit Facility is set out under the section Capital Resources in Item 7 of this Report. We do not anticipate the need to use funds currently available under our Credit Facility for purposes of funding our operations, although these funds could be used for the purpose of making further acquisitions or for restructuring our existing debt. Furthermore, we anticipate we will remain in compliance with our debt covenants through the next 12 months and beyond into the foreseeable future.

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As described in Notes 6, 9 and 15 of the Notes to Consolidated Financial Statements, at December 31, 2011, we had certain cash obligations, which are due as follows (in thousands):

	Total	2012	2013 - 2015	2016 - 2017	2018 and thereafter
Long-term debt(1)	$ 6,020,525	$ 59,698	$ 4,515,632	$ 1,441,327	$ 3,868
8 7/8% Senior Notes	1,777,617		1,777,617		
8% Senior Notes	1,000,000				1,000,000
Interest on Credit Facility and Senior Notes(2)	1,778,254	427,151	1,019,699	221,404	110,000
Capital lease obligations, including interest	91,419	8,386	19,931	11,127	51,975
Total long-term debt	10,667,815	495,235	7,332,879	1,673,858	1,165,843
Operating leases	793,855	176,403	370,766	122,479	124,207
Replacement facilities and other capital commitments(3)	511,692	226,683	254,194	4,509	26,306
Open purchase orders(4)	354,745	354,745			
Liability for uncertain tax positions, including interest and penalties	1,028				1,028
Total	$ 12,329,135	$ 1,253,066	$ 7,957,839	$ 1,800,846	$ 1,317,384

(1) Subsequent to December 31, 2011, we completed an amendment and restatement of our existing Credit Facility. The amendment, effective February 2, 2012, extended by two and a half years the maturity date of $1.6 billion of the existing non-extended term loans under the Credit Facility to January 25, 2017 (subject to customary acceleration events) or, if more than $50 million of our 8 7/8% Senior Notes are outstanding on April 15, 2015, to April 15, 2015.

(2) Estimate of interest payments assumes the interest rates at December 31, 2011 remain constant during the period presented for the Credit Facility, which is variable rate debt. The interest rate used to calculate interest payments for the Credit Facility was the London Interbank Offered Rate, or LIBOR, as of December 31, 2011 plus the applicable spread. The 8 7/8% Senior Notes are fixed at an interest rate of 8.875% per annum. The 8% Senior Notes are fixed at an interest rate of 8% per annum.

(3) Pursuant to hospital purchase agreements in effect as of December 31, 2011, and where final CON approval has been obtained, we have commitments to build the following replacement facilities and the following capital commitments. 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 purchase 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 $317.2 million of which approximately $210.3 million has been incurred to date. In addition, under other purchase agreements, we have committed to spend approximately $652.5 million for costs such as capital improvements, equipment, selected leases and physician recruiting. These commitments are required to be fulfilled generally over a five to seven year period after acquisition. Through December 31, 2011, we have incurred approximately $247.8 million related to these commitments.

(4) Open purchase orders represent our commitment for items ordered but not yet received.

At December 31, 2011, we had issued letters of credit primarily in support of potential insurance related claims and specified outstanding bonds of approximately $37.7 million.

Our debt as a percentage of total capitalization decreased from 80% at December 31, 2010 to 79% at December 31, 2011.

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2010 Compared to 2009

Net cash provided by operating activities increased $112.3 million, from approximately $1.1 billion for the year ended December 31, 2009 to approximately $1.2 billion for the year ended December 31, 2010. The increase is primarily due to an increase in cash flows from net income of $42.1 million, an increase in non-cash depreciation and amortization expense of $43.3 million, an increase in other non-cash expenses of $22.8 million, an increase in cash flows from accounts payable, accrued liabilities and income taxes of $75.9 million, primarily as a result of the timing of payments, and an increase in cash flows generated from the change in all other assets and liabilities of $19.0 million. These increases in cash flows were offset by decreases in cash flows from supplies, prepaid expenses and other current assets of $5.4 million and decreases in cash generated from accounts receivable of $85.4 million, primarily a result of our two-day improvement in account receivable days outstanding in 2010 compared to a five-day improvement in 2009.

The cash used in investing activities increased $177.1 million, from $867.2 million for the year ended December 31, 2009 to approximately $1.0 billion for the year ended December 31, 2010. The increase in cash used in investing activities, in comparison to the prior year, is primarily attributable to an increase in the cash used for the purchase of property and equipment of $90.5 million, a reduction in the amount of proceeds from the disposition of hospitals and other ancillary operations of $89.5 million due to the sale of one hospital in 2009 and no hospital divestitures in 2010, and a net increase in other non-operating assets of $17.0 million. These increases in cash used in investing activities were offset by a reduction in acquisitions of facilities and other related equipment of $15.5 million and an increase in the amount of the proceeds from the sale of property and equipment of $4.4 million. We anticipate being able to fund future routine capital expenditures with cash flows generated from operations.

In 2010, our net cash used in financing activities increased $104.4 million from $85.4 million in 2009 to $189.8 million in 2010. The increase in cash used in financing activities, in comparison to the prior year, is primarily due to repurchases of our common stock of $114.0 million, an increase in deferred financing costs of $13.2 million associated with the amendment and extension of a portion of the Credit Facility, and a reduction in the proceeds from noncontrolling investors in joint ventures of $22.6 million, as the Reform Legislation significantly limits the selling of noncontrolling interests to physician investors. These increases were offset by an increase in the proceeds from the exercise of stock options of $44.2 million and an increase in the excess tax benefit relating to stock-based compensation of $13.7 million. The net increase in all other financing activities was $12.5 million. This included an increase in borrowings under our Credit Facility, but was mostly offset by repayments of our long-term debt.

Capital Expenditures

Cash expenditures for purchases of facilities were $415.4 million in 2011, $248.3 million in 2010 and $263.8 million in 2009. Our expenditures in 2011 included $357.3 million for the purchase of four hospitals, $56.7 million for the purchase of clinics, surgery centers and physician practices and $1.4 million for the settlement of acquired working capital. Our expenditures in 2010 included $181.1 million for the purchase of five hospitals and $67.2 million for the purchase of clinics, surgery centers and physician practices. Our expenditures in 2009 included $182.2 million for the purchase of three hospitals and the remaining equity in a hospital in which we previously had a noncontrolling interest, $72.3 million for the purchase of clinics, surgery centers and physician practices, and $9.3 million for the settlement of acquired working capital.

Excluding the cost to construct replacement hospitals, our cash expenditures for routine capital for 2011 totaled $611.7 million compared to $631.7 million in 2010, and $572.1 million in 2009. These capital expenditures related primarily to the purchase of additional equipment, minor renovations and information systems infrastructure. Costs to construct replacement hospitals totaled $165.0 million in 2011, $35.7 million in 2010 and $4.8 million in 2009. The costs to construct replacement hospitals for the year ended December 31, 2011 represent both planning and construction costs for the four replacement hospitals discussed below. The costs to construct replacement hospitals for the year ended December 31, 2010 represent both planning and construction costs for the four replacement hospitals. The costs to construct replacement hospitals for the year ended December 31, 2009 represent planning costs for future construction projects since there were no replacement hospitals under construction at year ended December 31, 2009.

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Pursuant to hospital purchase agreements in effect as of December 31, 2011, and where final CON 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 applicable purchase 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 $317.2 million, of which approximately $210.3 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 CON from the Alabama Certificate of Need Review Board; however, this CON 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. We expect total capital expenditures of approximately $800 million to $900 million in 2012 (which includes amounts which are required to be expended pursuant to the terms of hospital purchase agreements), including approximately $640 million to $720 million for renovation and equipment cost and approximately $160 million to $180 million for construction and equipment cost of the replacement hospitals.

Capital Resources

Net working capital was approximately $935.0 million at December 31, 2011, compared to $1.229 billion at December 31, 2010, a decrease of $294.2 million. Contributing to the decrease in net working capital were decreases in cash of approximately $170.3 million, prepaid taxes of approximately $17.1 million, deferred tax assets of approximately $26.0 million and increases in accounts payable of approximately $211.1 million and employee compensation liabilities of approximately $15.6 million. These decreases in working capital were offset by increases in patient accounts receivable of approximately $103.2 million, supplies of approximately $8.3 million, net working capital acquired as part of our business acquisitions of approximately $7.3 million and decreases in deferred tax liabilities of approximately $8.9 million and accrued interest of $36.3 million. All other changes in working capital items decreased net working capital by approximately $18.1 million.

In connection with the consummation of the Triad acquisition in July 2007, we obtained approximately $7.2 billion of senior secured financing under the 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 had been 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 extended by two and a half years, until January 25, 2017, the maturity date of $1.5 billion of our existing term loans under the Credit Facility and increased the pricing on these term loans to LIBOR plus 350 basis points. If more than $50 million of our 8 $^{7}/8$% Senior 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 amendment also increased our ability to issue additional indebtedness under the uncommitted incremental facility to $1.0 billion from $600 million, permitted us to issue Term A term loans under the incremental facility and provided up to $2.0 billion of borrowing capacity from receivable transactions, an increase of $0.5 billion, of which approximately $1.7 billion would be required to be used for repayment of our existing term loans. In addition, effective February 2, 2012, we completed an additional amendment and restatement of the Credit Facility, which extended by two and a half years, until January 25, 2017, the maturity date of an additional $1.6 billion of our existing non-extended term loans under the Credit Facility and increased the pricing on the newly extended term loans by 125 basis points. The maturity date of the balance of the term loans of approximately $2.9 billion remained unchanged at July 25, 2014.

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. 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 rate 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 exception, to, among other things, (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of our businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change our fiscal year. We and our subsidiaries are also required to comply with specified financial covenants (consisting of a leverage ratio and an interest coverage ratio) and various affirmative covenants.

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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 December 31, 2011, the availability for additional borrowings under our Credit Facility was approximately $750 million pursuant to the revolving credit facility, of which $37.7 million was set aside for outstanding letters of credit and $30.0 million was outstanding at December 31, 2011. 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.

On November 22, 2011, CHS completed its offering of $1.0 billion aggregate principal amount of 8% Senior Notes, which were issued in a private placement. The net proceeds from this issuance, together with available cash on hand, were used to finance the purchase of up to $1.0 billion aggregate principal amount of CHS outstanding 8 7/8% Senior Notes and related fees and expenses. This resulted in a loss from early extinguishment of debt of $66.0 million with an after-tax impact of $42.0 million recorded in continuing operations for the year ended December 31, 2011.

As of December 31, 2011, we are currently a party to the following interest rate swap agreements to limit the effect of changes in interest rates on approximately 82% 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.

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Swap #	Notional Amount (in 000 s)	Fixed Interest Rate	Termination Date	Fair Value of Liability (in 000 s)
1	100,000	3.8470%	January 4, 2012	30
2	100,000	3.8510%	January 4, 2012	30
3	100,000	3.8560%	January 4, 2012	30
4	200,000	3.7260%	January 8, 2012	152
5	200,000	3.5065%	January 16, 2012	281
6	250,000	5.0185%	May 30, 2012	4,509
7	150,000	5.0250%	May 30, 2012	2,709
8	200,000	4.6845%	September 11, 2012	5,574
9	100,000	3.3520%	October 23, 2012	2,161
10	125,000	4.3745%	November 23, 2012	4,104
11	75,000	4.3800%	November 23, 2012	2,466
12	150,000	5.0200%	November 30, 2012	5,900
13	200,000	2.2420%	February 28, 2013	3,550
14	100,000	5.0230%	May 30, 2013	5,952
15	300,000	5.2420%	August 6, 2013	21,085
16	100,000	5.0380%	August 30, 2013	6,967
17	50,000	3.5860%	October 23, 2013	2,505
18	50,000	3.5240%	October 23, 2013	2,451
19	100,000	5.0500%	November 30, 2013	7,948
20	200,000	2.0700%	December 19, 2013	5,080
21	100,000	5.2310%	July 25, 2014	10,706
22	100,000	5.2310%	July 25, 2014	10,707
23	200,000	5.1600%	July 25, 2014	21,073
24	75,000	5.0405%	July 25, 2014	7,685
25	125,000	5.0215%	July 25, 2014	12,752
26	100,000	2.6210%	July 25, 2014	4,436
27	100,000	3.1100%	July 25, 2014	5,612
28	100,000	3.2580%	July 25, 2014	5,968
29	200,000	2.6930%	October 26, 2014	9,916
30	300,000	3.4470%	August 8, 2016	27,728
31	200,000	3.4285%	August 19, 2016	18,401
32	100,000	3.4010%	August 19, 2016	9,099
33	200,000	3.5000%	August 30, 2016	19,048
34	100,000	3.0050%	November 30, 2016	7,613

The Credit Facility and/or the Senior 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;

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- make restricted payments, including paying dividends and making investments;
- redeem debt that is junior in right of payment to the Senior Notes;
- create liens without securing the Senior Notes;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- enter into agreements that restrict dividends from subsidiaries;
- merge, consolidate, sell or otherwise dispose of substantial portions of our assets;
- enter into transactions with affiliates; and
- guarantee certain obligations.

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

We believe that internally generated cash flows, availability for additional borrowings under our Credit Facility of $750 million (consisting of a $750 million revolving credit facility, of which $37.7 million is set aside for outstanding letters of credit and $30 million outstanding at December 31, 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.

Off-balance sheet arrangements

Our consolidated operating results for the years ended December 31, 2011 and 2010, included $248.4 million and $245.4 million, respectively, of net operating revenues and $16.4 million and $26.6 million, respectively, of income from continuing 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 in our consolidated balance sheet. Lease costs under these arrangements are included in rent expense and totaled approximately $11.9 million and $12.4 million for the years ended December 31, 2011 and 2010, respectively. The current terms of these operating leases expire between January 2013 and June 2022, not including lease extension options. If we allow these leases to expire, we would no longer generate revenues nor incur expenses from these hospitals.

In the past, we have utilized operating leases as a financing tool for obtaining the operations of specified hospitals without acquiring, through ownership, the related assets of the hospital and without a significant outlay of cash at the front end of the lease. We utilize the same operating strategies to improve operations at those hospitals held under operating leases as we do at those hospitals that we own. We have not entered into any operating leases for hospital operations since December 2000.

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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 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 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.

As described more fully in Note 15 of the Notes to Consolidated Financial Statements, at December 31, 2011, we have certain cash obligations for replacement facilities and other construction commitments of $511.7 million and open purchase orders for $354.7 million.

Noncontrolling Interests

We have sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. As of December 31, 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. During 2010 (prior to the enactment of the Reform Legislation), we sold noncontrolling interests in two of our hospitals and additional noncontrolling interests in hospitals with existing physician ownership, for total consideration of $7.2 million. During 2009, we sold noncontrolling interests in six of our hospitals, including additional noncontrolling interests in hospitals with existing physician ownership, for total consideration of $19.3 million. Effective June 1, 2009, we acquired from Akron General Medical Center the remaining 20% noncontrolling interest in Massillon Community Health System, LLC not then owned by us. This entity indirectly owns and operates Affinity Medical Center of Massillon, Ohio. The purchase price for this noncontrolling interest was $1.1 million in cash. Affinity Medical Center is now wholly-owned by us. Redeemable noncontrolling interests in equity of consolidated subsidiaries was $395.7 million and $387.5 million as of December 31, 2011 and 2010, respectively, and noncontrolling interests in equity of consolidated subsidiaries was $67.3 million and $60.9 million as of December 31, 2011 and 2010, respectively, and the amount of net income attributable to noncontrolling interests was $75.7 million, $68.5 million and $63.2 million for the years ended December 31, 2011, 2010 and 2009, 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.

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.

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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. For a detailed discussion on the application of these and other accounting policies, see Note 1 in the Notes to the Consolidated Financial Statements included under Item 8 of this Report.

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 December 31, 2011 from our estimated reimbursement percentage, net income for the year ended December 31, 2011 would have changed by approximately $35.0 million, and net accounts receivable at December 31, 2011 would have changed by $55.6 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 years ended December 31, 2011, 2010 and 2009.

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

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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 at December 31, 2011 differed by 1% from our estimated collection percentage as a result of a change in expected recoveries, net income for the year ended December 31, 2011 would have changed by $19.5 million, and net accounts receivable at December 31, 2011 would have changed by $31.0 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 December 31, 2011 and 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 49 days at December 31, 2011 and 46 days at December 31, 2010. Our target range for days revenue outstanding is from 46 to 56 days.

Total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) was approximately $8.3 billion as of December 31, 2011 and approximately $7.2 billion as of December 31, 2010.

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

	December 31,	
	2011	2010
Insured receivables	63.7%	63.9%
Self-pay receivables	36.3%	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 December 31, 2011 and 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 December 31, 2011 and 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.

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Professional Liability Claims

As part of our business of owning and operating hospitals, we are subject to legal actions alleging liability on our part. We accrue for losses resulting from such liability claims, as well as loss adjustment expenses that are out-of-pocket and directly related to such liability claims. These direct out-of-pocket expenses include fees of outside counsel and experts. We do not accrue for costs that are part of our corporate overhead, such as the costs of our in-house legal and risk management departments. The losses resulting from professional liability claims primarily consist of estimates for known claims, as well as estimates for incurred but not reported claims. The estimates are based on specific claim facts, our historical claim reporting and payment patterns, the nature and level of our hospital operations and actuarially determined projections. The actuarially determined projections are based on our actual claim data, including historic reporting and payment patterns which have been gathered over approximately a 20-year period. As discussed below, since we purchase excess insurance on a claims-made basis that transfers risk to third party insurers, the liability we accrue does include an amount for the losses covered by our excess insurance. We also record a receivable for the expected reimbursement of losses covered by 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 1.2%, 1.3% and 1.4% in 2011, 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 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.

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The following table presents the amounts of our accrual for professional liability claims and approximate amounts of our activity for each of the respective years (excludes premiums for excess insurance coverage) (in thousands):

	Year Ended December 31,		
	2011	2010	2009
Accrual for professional liability claims, beginning of year	$ 489,207	$ 431,225	$ 350,579
Impact from adopting ASU 2010-24	42,171		
Expense (income) related to:			
Current accident year	145,396	141,923	136,424
Prior accident years	(30,698)	(10,583)	(6,702)
(Income) expense from discounting	(2,393)	(2,678)	11,515
Total incurred loss and loss expense (1)	112,305	128,662	141,237
Paid claims and expenses related to:			
Current accident year	(468)	(1,980)	(1,387)
Prior accident years	(75,430)	(68,700)	(59,204)
Total paid claims and expenses	(75,898)	(70,680)	(60,591)
Accrual for professional liability claims, end of year	$ 567,785	$ 489,207	$ 431,225

(1) Total expense, including premiums for insured coverage, was $150.2 million in 2011, $164.2 million in 2010 and $176.4 million in 2009. The increase in current accident year claims expense in each year from 2009 to 2011 is consistent with the increase in net operating revenues during these periods. Income/expense related to prior accident years reflects changes in estimates resulting from the filing of claims for prior year incidents, claim settlements, updates from litigation and our ongoing investigation of open claims. Expense/income from discounting reflects the changes in the weighted-average risk-free interest rate used and timing of estimated payments for discounting in each year.

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

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 $0.8 million as of December 31, 2011. During the year ended December 31, 2011, we decreased liabilities for uncertain tax positions by $5.4 million, including the favorable resolution of an issue on appeal with the IRS related to its tax examination of Triad tax returns, and decreased interest and penalties by approximately $1.1 million. A total of approximately $0.3 million of interest and penalties is included in the amount of liability for uncertain tax positions at December 31, 2011. It is our policy to recognize interest and penalties related to unrecognized benefits in our consolidated statements of income as income tax expense. During the year ended December 31, 2011, we released $2.3 million for income taxes and $0.7 million for accrued interest of our liability for uncertain tax positions, as a result of the expiration of the statute of limitations pertaining to tax positions taken in prior years.

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

We, or one or more of our subsidiaries, file income tax returns in the United States federal jurisdiction and various state jurisdictions. We have extended the federal statute of limitations 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 consolidated statement of income for the year ended December 31, 2011. With few exceptions, we are no longer subject to state income tax examinations for years prior to 2008 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. In connection with our 2007 and 2008 IRS examinations, the IRS has taken exception to the timing of our malpractice expense deductions. Management believes that our deduction timing is appropriate, and will work to resolve this item over the next 24 months. If management is unable to sustain the current timing of our deduction, then it would be subject to interest and penalty costs. Management does not consider this matter to have met the recognition criteria to be considered an uncertain tax position for which a reserve is necessary.

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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 prospectively by us on January 1, 2011. The adoption of this ASU increased other current assets by $5.3 million, other assets, net by $36.9 million and long-term liabilities by $42.2 million in the consolidated balance sheet at December 31, 2011 and had no impact to the consolidated statement of income for the year ended December 31, 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 $125.7 million, $105.5 million and $104.0 million for the years ended December 31, 2011, 2010 and 2009, 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 June 2011, the FASB issued ASU 2011-05, which eliminates the option to present components of other comprehensive income as part of the statement of changes in stockholders equity. Instead, ASU 2011-05 requires that all nonowner changes in stockholders equity be presented either in a single continuous statement of comprehensive income or in two separate but consecutive statements. In December 2011, the FASB issued ASU 2011-12, which amends ASU 2011-05 to defer the requirement to measure and present reclassification adjustments from accumulated other comprehensive income to net income by income statement line item in net income and also in other comprehensive income. ASU 2011-05, as amended by ASU 2011-12, is required to be applied retrospectively and is effective for fiscal years beginning after December 15, 2011, and will be adopted by us in the first quarter of 2012. The adoption of ASU 2011-05, as amended by ASU 2011-12, will not impact our consolidated financial position, results of operations or cash flows, although it will change the presentation of our other comprehensive income for all periods presented.

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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 such 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 collectability 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 all periods presented in this annual report as if the ASU was early adopted in 2011 are as follows (in thousands):

	Year Ended December 31,		
	2011	**2010**	**2009**
Net operating revenues (net of contractual allowances and discounts)	$ 13,626,168	$ 12,623,274	$ 11,742,454
Provision for bad debts	(1,719,956)	(1,530,852)	(1,408,953)
Net operating revenues, less provision for bad debts	$ 11,906,212	$ 11,092,422	$ 10,333,501

In September 2011, the FASB issued ASU 2011-08, which simplifies 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. ASU 2011-08 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 ASU 2011-08 is not expected to impact our consolidated financial position, results of operations or cash flows.

Item 7A. ***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. We utilize risk management procedures and controls in executing derivative financial instrument transactions. We do not execute transactions or hold derivative financial instruments for trading purposes. Derivative financial instruments related to interest rate sensitivity of debt obligations are used with the goal of mitigating a portion of the exposure when it is cost effective to do so. As interest rate swap agreements expire throughout the year we will become more subject to variable interest rates during 2012.

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 $7.2 million in 2011, $6.8 million in 2010 and $2.5 million in 2009.

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Item 8. ***Financial Statements and Supplementary Data***

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of

Community Health Systems, Inc.

Franklin, Tennessee

We have audited the accompanying consolidated balance sheets of Community Health Systems, Inc. and subsidiaries (the Company) as of December 31, 2011 and 2010, and the related consolidated statements of income, stockholders equity, and cash flows for each of the three years in the period ended December 31, 2011. These financial statements are the responsibility of the Company s management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Community Health Systems, Inc. and subsidiaries as of December 31, 2011 and 2010, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2011, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company s internal control over financial reporting as of December 31, 2011, based on the criteria established in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 22, 2012 expressed an unqualified opinion on the Company s internal control over financial reporting.

/s/ Deloitte & Touche LLP

Nashville, Tennessee

February 22, 2012

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2011	2010	2009
	(In thousands, except share and per share data)		
Net operating revenues	$ 13,626,168	$ 12,623,274	$ 11,742,454
Operating costs and expenses:			
Salaries and benefits	5,577,925	5,093,767	4,701,231
Provision for bad debts	1,719,956	1,530,852	1,408,953
Supplies	1,834,106	1,738,088	1,649,779
Other operating expenses	2,515,638	2,296,063	2,129,081
Electronic health records incentive reimbursement	(63,397)		
Rent	254,781	248,463	237,536
Depreciation and amortization	652,674	594,997	551,043
Total operating costs and expenses	12,491,683	11,502,230	10,677,623
Income from operations	1,134,485	1,121,044	1,064,831
Interest expense, net of interest income of $4,650, $1,757 and $3,561 in 2011, 2010, and 2009, respectively	644,410	647,593	643,608
Loss (gain) from early extinguishment of debt	66,019		(2,385)
Equity in earnings of unconsolidated affiliates	(49,491)	(45,443)	(36,531)
Impairment of long-lived and other assets			12,477
Income from continuing operations before income taxes	473,547	518,894	447,662
Provision for income taxes	137,653	163,681	141,851
Income from continuing operations	335,894	355,213	305,811
Discontinued operations, net of taxes:			
(Loss) income from operations of entities sold	(7,769)	(6,772)	971
Impairment of hospitals sold	(47,930)		
Loss on sale, net	(2,572)		(405)
(Loss) income from discontinued operations	(58,271)	(6,772)	566
Net income	277,623	348,441	306,377
Less: Net income attributable to noncontrolling interests	75,675	68,458	63,227
Net income attributable to Community Health Systems, Inc.	$ 201,948	$ 279,983	$ 243,150
Basic earnings per share attributable to Community Health Systems, Inc. common stockholders(1):			
Continuing operations	$ 2.89	$ 3.13	$ 2.68
Discontinued operations	(0.65)	(0.07)	
Net income	$ 2.24	$ 3.05	$ 2.68

Diluted earnings per share attributable to Community Health Systems, Inc. common stockholders(1):			
Continuing operations	$ 2.87	$ 3.08	$ 2.65
Discontinued operations	(0.64)	(0.07)	
Net income	$ 2.23	$ 3.01	$ 2.66
Weighted-average number of shares outstanding:			
Basic	89,966,933	91,718,791	90,614,886
Diluted	90,666,348	92,946,048	91,517,274

(1) Total per share amounts may not add due to rounding.

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2011	2010
	(In thousands, except share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 129,865	$ 299,169
Patient accounts receivable, net of allowance for doubtful accounts of $1,891,334 and $1,639,198 at December 31, 2011 and December 31, 2010, respectively	1,834,167	1,714,542
Supplies	346,611	329,114
Prepaid income taxes	101,389	118,464
Deferred income taxes	89,797	115,819
Prepaid expenses and taxes	112,613	100,754
Other current assets	231,647	193,331
Total current assets	2,846,089	2,871,193
Property and equipment:		
Land and improvements	591,457	538,496
Buildings and improvements	5,715,066	5,108,711
Equipment and fixtures	3,063,005	2,735,915
	9,369,528	8,383,122
Less accumulated depreciation and amortization	(2,513,552)	(2,058,685)
Property and equipment, net	6,855,976	6,324,437
Goodwill	4,264,845	4,150,247
Other assets, net of accumulated amortization of $313,028 and $258,547 at December 31, 2011 and December 31, 2010, respectively (including long-lived assets of hospitals held for sale of $0 and $182,688 at December 31, 2011 and 2010, respectively)	1,241,930	1,352,246
Total assets	$ 15,208,840	$ 14,698,123
LIABILITIES AND EQUITY		
Current liabilities:		
Current maturities of long-term debt	$ 63,706	$ 63,139
Accounts payable	748,997	526,338
Deferred income taxes		8,882
Accrued liabilities:		
Employee compensation	620,508	596,026
Interest	110,121	146,415
Other	367,807	301,240
Total current liabilities	1,911,139	1,642,040

Long-term debt	8,782,798	8,808,382
Deferred income taxes	704,725	608,177
Other long-term liabilities	949,990	1,001,675
Total liabilities	12,348,652	12,060,274
Redeemable noncontrolling interests in equity of consolidated subsidiaries	395,743	387,472
Commitments and contingencies (Note 15)		
EQUITY		
Community Health Systems, Inc. stockholders equity		
Preferred stock, $.01 par value per share, 100,000,000 shares authorized; none issued		
Common stock, $.01 par value per share, 300,000,000 shares authorized; 91,547,079 shares issued and 90,571,530 shares outstanding at December 31, 2011 and 93,644,862 shares issued and 92,669,313 shares outstanding at December 31, 2010	915	936
Additional paid-in capital	1,086,008	1,126,751
Treasury stock, at cost, 975,549 shares at December 31, 2011 and December 31, 2010	(6,678)	(6,678)
Accumulated other comprehensive loss	(184,479)	(230,927)
Retained earnings	1,501,330	1,299,382
Total Community Health Systems, Inc. stockholders equity	2,397,096	2,189,464
Noncontrolling interests in equity of consolidated subsidiaries	67,349	60,913
Total equity	2,464,445	2,250,377
Total liabilities and equity	$ 15,208,840	$ 14,698,123

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS EQUITY

		Community Health Systems, Inc. Stockholders								
	Redeemable Noncontrolling Interests	Common Stock Shares	Common Stock Amount	Additional Paid-in Capital	Treasury Stock Shares	Treasury Stock Amount	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Noncontrolling Interests	Total
				(In thousands, except share data)						
BALANCE, December 31, 2008	$ 348,816	92,483,166	$ 925	$ 1,136,108	(975,549)	$ (6,678)	$ (295,575)	$ 776,249	$ 61,457	$ 1,672,486
Comprehensive income (loss):										
Net income	46,716							243,150	16,511	259,661
Net change in fair value of interest rate swaps, net of tax of $42,876							76,225			76,225
Net change in fair value of available-for-sale securities							412			412
Amortization and recognition of unrecognized pension cost components, net of tax benefit of $3,262							(2,447)			(2,447)
Total comprehensive income	46,716						74,190	243,150	16,511	333,851
Distributions to noncontrolling interests, net of contributions	(27,072)								(13,582)	(13,582)
Purchase of subsidiary shares from noncontrolling interests	(5,439)			3,106					396	3,502
Sale of less-than-wholly-owned subsidiaries	(21,691)									
Adjustment to redemption value of redeemable noncontrolling interests	27,527			(27,527)						(27,527)
Issuance of common stock in connection with the exercise of stock options		680,898	7	12,760						12,767
Cancellation of restricted stock for tax withholdings on vested shares		(328,470)	(3)	(7,117)						(7,120)
Income tax payable increase from exercise				(3,472)						(3,472)

of stock options										
Share-based compensation		1,177,943	11	44,501						44,512
BALANCE, December 31, 2009	368,857	94,013,537	940	1,158,359	(975,549)	(6,678)	(221,385)	1,019,399	64,782	2,015,417
Comprehensive income (loss):										
Net income	50,292							279,983	18,166	298,149
Net change in fair value of interest rate swaps, net of tax benefit of $8,818							(15,676)			(15,676)
Net change in fair value of available-for-sale securities							3,716			3,716
Amortization and recognition of unrecognized pension cost components, net of tax of $1,142							2,418			2,418
Total comprehensive income (loss)	50,292						(9,542)	279,983	18,166	288,607
Distributions to noncontrolling interests, net of contributions	(40,068)								(20,046)	(20,046)
Purchase of subsidiary shares from noncontrolling interests	(3,754)			(3,529)						(3,529)
Other reclassifications of noncontrolling interests	1,989								(1,989)	(1,989)
Adjustment to redemption value of redeemable noncontrolling interests	10,156			(10,156)						(10,156)
Issuance of common stock in connection with the exercise of stock options		2,194,862	22	56,916						56,938
Cancellation of restricted stock for tax withholdings on vested shares		(295,171)	(3)	(9,876)						(9,879)
Repurchases of common stock		(3,415,800)	(34)	(113,961)						(113,995)
Excess tax benefit from exercise of stock options				10,219						10,219
Share-based compensation		1,147,434	11	38,779						38,790
BALANCE, December 31, 2010	387,472	93,644,862	936	1,126,751	(975,549)	(6,678)	(230,927)	1,299,382	60,913	2,250,377
Comprehensive income (loss):										
Net income	54,251							201,948	21,424	223,372
							55,145			55,145

Net change in fair value of interest rate swaps, net of tax of $31,154										
Net change in fair value of available-for-sale securities							(960)			(960)
Amortization and recognition of unrecognized pension cost components, net of tax benefit of $4,754							(7,737)			(7,737)
Total comprehensive income	54,251						46,448	201,948	21,424	269,820
Distributions to noncontrolling interests, net of contributions	(39,816)								(15,049)	(15,049)
Purchase of subsidiary shares from noncontrolling interests	(7,426)			(4,556)					(1,040)	(5,596)
Other reclassifications of noncontrolling interests	(2,099)								1,101	1,101
Adjustment to redemption value of redeemable noncontrolling interests	3,361			(3,361)						(3,361)
Issuance of common stock in connection with the exercise of stock options		623,341	6	18,910						18,916
Cancellation of restricted stock for tax withholdings on vested shares		(346,419)	(3)	(13,311)						(13,314)
Repurchases of common stock		(3,469,099)	(35)	(85,790)						(85,825)
Excess tax benefit from exercise of stock options				4,823						4,823
Share-based compensation		1,094,394	11	42,542						42,553
BALANCE, December 31, 2011	$ 395,743	91,547,079	$ 915	$ 1,086,008	(975,549)	$ (6,678)	$ (184,479)	$ 1,501,330	$ 67,349	$ 2,464,445

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2011	**2010**	**2009**
		(In thousands)	
Cash flows from operating activities:			
Net income	$ 277,623	$ 348,441	$ 306,377
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	657,665	609,839	566,543
Deferred income taxes	107,032	97,370	34,268
Stock-based compensation expense	42,542	38,779	44,501
Loss on sale, net	2,572		405
Impairment of hospitals sold and other long-lived assets	47,930		12,477
Loss (gain) on early extinguishment of debt	66,019		(2,385)
(Excess tax benefit) income tax payable increase relating to stock-based compensation expense	(5,290)	(10,219)	3,472
Other non-cash expenses, net	28,716	12,503	22,870
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	(138,332)	(27,049)	58,390
Supplies, prepaid expenses and other current assets	(42,858)	(39,904)	(34,535)
Accounts payable, accrued liabilities and income taxes	246,110	161,952	86,098
Other	(27,821)	(2,982)	(22,052)
Net cash provided by operating activities	1,261,908	1,188,730	1,076,429
Cash flows from investing activities:			
Acquisitions of facilities and other related equipment	(415,360)	(248,251)	(263,773)
Purchases of property and equipment	(776,713)	(667,378)	(576,888)
Proceeds from disposition of hospitals and other ancillary operations	173,387		89,514
Proceeds from sale of property and equipment	11,160	8,401	4,019
Increase in other investments	(188,249)	(137,082)	(120,054)
Net cash used in investing activities	(1,195,775)	(1,044,310)	(867,182)
Cash flows from financing activities:			
Proceeds from exercise of stock options	18,910	56,916	12,759
Repurchase of restricted stock shares for payroll tax withholding requirements	(13,311)		
Deferred financing costs	(19,352)	(13,260)	(82)
Excess tax benefit (income tax payable increase) relating to stock-based compensation	5,290	10,219	(3,472)
Stock buy-back	(85,790)	(113,961)	
Proceeds from noncontrolling investors in joint ventures	1,229	7,201	29,838
Redemption of noncontrolling investments in joint ventures	(13,022)	(7,318)	(7,268)
Distributions to noncontrolling investors in joint ventures	(56,094)	(68,113)	(58,963)
Borrowings under credit agreement	578,236		200,000
Issuance of long-term debt	1,000,000		
Repayments of long-term indebtedness	(1,651,533)	(61,476)	(258,173)
Net cash used in financing activities	(235,437)	(189,792)	(85,361)

Net change in cash and cash equivalents	(169,304)	(45,372)	123,886
Cash and cash equivalents at beginning of period	299,169	344,541	220,655
Cash and cash equivalents at end of period	$ 129,865	$ 299,169	$ 344,541
Supplemental disclosure of cash flow information:			
Interest payments	$ 680,704	$ 650,712	$ 656,997
Income taxes paid, net	$ 26,463	$ 128,186	$ 57,299

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Business and Summary of Significant Accounting Policies

Business. Community Health Systems, Inc. is a holding company and operates no business in its own name. On a consolidated basis, Community Health Systems, Inc. and its subsidiaries (collectively the Company) own, lease and operate acute care hospitals in non-urban and selected urban markets. As of December 31, 2011, the Company owned or leased 131 hospitals, including four stand-alone rehabilitation or psychiatric hospitals, licensed for 19,695 beds in 29 states. Throughout these notes to the consolidated financial statements, Community Health Systems, Inc. (the Parent) and its consolidated subsidiaries are referred to on a collective basis as the Company. This drafting style is not meant to indicate that the publicly-traded Parent or any subsidiary of the Parent owns or operates any asset, business, or property. The hospitals, operations and businesses described in this filing are owned and operated, and management services provided, by distinct and indirect subsidiaries of Community Health Systems, Inc.

As of December 31, 2011, Indiana, Texas and Pennsylvania represent the only areas of geographic concentration. Net operating revenues generated by the Company s hospitals in Indiana, as a percentage of consolidated net operating revenues, were 10.3% in 2011, 10.6% in 2010 and 11.2% in 2009. Net operating revenues generated by the Company s hospitals in Texas, as a percentage of consolidated net operating revenues, were 13.1% in 2011, 13.0% in 2010 and 13.2% in 2009. Net operating revenues generated by the Company s hospitals in Pennsylvania, as a percentage of consolidated net operating revenues, were 11.5% in 2011, 10.3% in 2010 and 10.2% in 2009.

Use of Estimates. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates under different assumptions or conditions.

Principles of Consolidation. The consolidated financial statements include the accounts of the Parent, its subsidiaries, all of which are controlled by the Parent through majority voting control, and variable interest entities for which the Company is the primary beneficiary. All significant intercompany accounts, profits and transactions have been eliminated. Noncontrolling interests in less-than-wholly-owned consolidated subsidiaries of the Parent are presented as a component of total equity to distinguish between the interests of the Parent and the interests of the noncontrolling owners. Revenues, expenses and income from continuing operations from these subsidiaries are included in the consolidated amounts as presented on the consolidated statements of income, along with a net income measure that separately presents the amounts attributable to the controlling interests and the amounts attributable to the noncontrolling interests for each of the periods presented. Noncontrolling interests that are redeemable or may become redeemable at a fixed or determinable price at the option of the holder or upon the occurrence of an event outside of the control of the Company are presented in mezzanine equity on the consolidated balance sheets.

Cost of Revenue. Substantially all of the Company s operating expenses are cost of revenue items. Operating costs that could be classified as general and administrative by the Company would include the Company s corporate office costs at its Franklin, Tennessee office, which were $183.4 million, $155.4 million and $157.9 million for the years ended December 31, 2011, 2010 and 2009, respectively. Included in these amounts is stock-based compensation of $42.5 million, $38.8 million and $44.5 million for the years ended December 31, 2011, 2010 and 2009, respectively.

Cash Equivalents. The Company considers highly liquid investments with original maturities of three months or less to be cash equivalents.

Supplies. Supplies, principally medical supplies, are stated at the lower of cost (first-in, first-out basis) or market.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Marketable Securities. The Company s marketable securities are classified as trading or available-for-sale. Available-for-sale securities are carried at fair value as determined by quoted market prices, with unrealized gains and losses reported as a separate component of stockholders equity. Trading securities are reported at fair value with unrealized gains and losses included in earnings. Interest and dividends on securities classified as available-for-sale or trading are included in net operating revenues and were not material in all periods presented. Accumulated other comprehensive income (loss) included an unrealized loss of $1.0 million and an unrealized gain of $3.7 million at December 31, 2011 and 2010, respectively, related to these available-for-sale securities.

Property and Equipment. Property and equipment are recorded at cost. Depreciation is recognized using the straight-line method over the estimated useful lives of the land and improvements (2 to 15 years; weighted-average useful life is 14 years), buildings and improvements (5 to 40 years; weighted-average useful life is 24 years) and equipment and fixtures (4 to 18 years; weighted-average useful life is 8 years). Costs capitalized as construction in progress were $397.2 million and $221.2 million at December 31, 2011 and 2010, respectively. Expenditures for renovations and other significant improvements are capitalized; however, maintenance and repairs which do not improve or extend the useful lives of the respective assets are charged to operations as incurred. Interest capitalized related to construction in progress was $21.4 million, $11.9 million and $16.7 million for the years ended December 31, 2011, 2010 and 2009, respectively. Purchases of property and equipment accrued in accounts payable and not yet paid were $94.2 million and $59.5 million at December 31, 2011 and 2010, respectively.

The Company also leases certain facilities and equipment under capital leases (see Note 9). Such assets are amortized on a straight-line basis over the lesser of the term of the lease or the remaining useful lives of the applicable assets.

Goodwill. Goodwill represents the excess of the fair value of the consideration conveyed in the acquisition over the fair value of net assets acquired. Goodwill arising from business combinations is not amortized. Goodwill is required to be evaluated for impairment at the same time every year and when an event occurs or circumstances change such that it is reasonably possible that an impairment may exist. The Company has selected September 30 as its annual testing date.

Other Assets. Other assets primarily consist of costs associated with the issuance of debt, which are included in interest expense over the life of the related debt using the effective interest method, and costs to recruit physicians to the Company s markets, which are deferred and expensed over the term of the respective physician recruitment contract, which is generally three years, and included in amortization expense. Other assets also include capitalized internal-use software costs, which are expensed over the expected useful life, which is generally three years for routine software and eight years for major software projects, and included in amortization expense.

Third-Party Reimbursement. Net patient service revenue is reported at the estimated net realizable amount from patients, third-party payors and others for services rendered. Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems, provisions of cost-reimbursement and other payment methods. Approximately 36.5%, 38.1% and 37.2% of net operating revenues for the years ended December 31, 2011, 2010 and 2009, respectively, are related to services rendered to patients covered by the Medicare and Medicaid programs. Revenues from Medicare outlier payments are included in the amounts received from Medicare and were approximately 0.42%, 0.43% and 0.43% of net operating revenues for the years ended December 31, 2011, 2010 and 2009, respectively. In addition, the Company is reimbursed by non-governmental payors using a variety of payment methodologies. Amounts received by the Company for treatment of patients covered by such programs are generally less than the standard billing rates. The differences between the estimated program reimbursement rates and the standard billing rates are accounted for as contractual adjustments, which are deducted from gross revenues to arrive at net operating revenues. These net operating revenues are an estimate of the net realizable amount due from these payors. The process of estimating contractual allowances requires the Company 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 the Company receives could be different from the amounts it estimates and records. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. Adjustments to previous program reimbursement estimates are accounted for as contractual allowance adjustments and reported 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 years ended December 31, 2011, 2010 and 2009.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Amounts due to third-party payors were $66.0 million and $80.5 million as of December 31, 2011 and 2010, respectively, and are included in accrued liabilities-other in the accompanying consolidated balance sheets. Amounts due from third-party payors were $86.5 million and $118.7 million as of December 31, 2011 and 2010, respectively, and are included in other current assets in the accompanying consolidated balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 2006.

Net Operating Revenues. Net operating revenues are recorded net of provisions for contractual allowance of approximately $42.4 billion, $35.8 billion and $30.8 billion in 2011, 2010 and 2009, respectively. Net operating revenues are recognized when services are provided and are reported at the estimated net realizable amount from patients, third-party payors and others for services rendered. Also included in the provision for contractual allowance shown above is the value of administrative and other discounts provided to self-pay patients eliminated from net operating revenues which was $852.4 million, $689.4 million and $531.9 million for the years ended December 31, 2011, 2010 and 2009, respectively. In the ordinary course of business, the Company renders services to patients who are financially unable to pay for hospital care. Also, included in the provision for contractual allowance shown above is the value (at the Company s 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 the Company s charity care policy. The value of these services was $651.1 million, $512.4 million and $451.0 million for the years ended December 31, 2011, 2010 and 2009, respectively. The estimated cost incurred by the Company to provide these services to patients who are unable to pay was approximately $125.7 million, $105.5 million and $104.0 million for the years ended December 31, 2011, 2010 and 2009, 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 the Company s charity care policy and that do not otherwise qualify for reimbursement from a governmental program.

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 Centers for Medicare and Medicaid Services 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, the Company recognizes revenue and related expenses in the period in which amounts are estimable and collection is reasonably assured. Reimbursement under these programs is reflected in net operating revenues and fees, taxes or other program-related costs are reflected in other operating costs and expenses.

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

The Company estimates the allowance for doubtful accounts by reserving a percentage of all self-pay accounts receivable without regard to aging category, based on collection history, adjusted for expected recoveries and, if present, anticipated changes in trends. For all other non-self-pay payor categories, the Company reserves 100% of all accounts aging over 365 days from the date of discharge. The percentage used to reserve for all self-pay accounts is based on the Company s collection history. The Company collects substantially all of its third-party insured receivables, which include receivables from governmental agencies.

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

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Physician Income Guarantees. The Company enters into physician recruiting agreements under which it supplements physician income to a minimum amount over a period of time, typically one year, while the physicians establish themselves in the community. As part of the agreements, the physicians are committed to practice in the community for a period of time, typically three years, which extends beyond their income guarantee period. The Company records an asset and liability for the estimated fair value of minimum revenue guarantees on new agreements. Adjustments to the ultimate value of the guarantee paid to physicians are recognized in the period that the change in estimate is identified. The Company amortizes an asset over the life of the agreement. As of December 31, 2011 and 2010, the unamortized portion of these physician income guarantees was $33.0 million and $37.2 million, respectively.

Concentrations of Credit Risk. The Company grants unsecured credit to its patients, most of whom reside in the service area of the Company s facilities and are insured under third-party payor agreements. Because of the economic diversity of the Company s facilities and non-governmental third-party payors, Medicare represents the only significant concentration of credit risk from payors. Accounts receivable, net of contractual allowances, from Medicare were $250.8 million and $270.8 million as of December 31, 2011 and 2010, respectively, representing 6.7% and 8.1% of consolidated net accounts receivable, before allowance for doubtful accounts, as of December 31, 2011 and 2010, respectively.

Professional Liability Claims. The Company accrues for estimated losses resulting from professional liability. The accrual, which includes an estimate for incurred but not reported claims, is based on historical loss patterns and actuarially-determined projections and is discounted to its net present value. To the extent that subsequent claims information varies from management s estimates, the liability is adjusted when such information becomes available.

Accounting for the 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, the Company projects 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.

Income Taxes. The Company accounts for income taxes under the asset and liability method, in which deferred income tax assets and liabilities are recognized for the tax consequences of temporary differences by applying enacted statutory tax rates applicable to future years to differences between the financial statement carrying amounts and the tax bases of existing assets and liabilities. The effect on deferred taxes of a change in tax rates is recognized in the consolidated statement of income during the period in which the tax rate change becomes law.

Comprehensive Income (Loss). Comprehensive income (loss) is the change in equity of a business enterprise during a period from transactions and other events and circumstances from non-owner sources.

Accumulated Other Comprehensive Income (Loss) consisted of the following (in thousands):

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Change in Unrecognized Pension Cost Components	Accumulated Other Comprehensive Income (Loss)
Balance as of December 31, 2009	$ (202,260)	$ (1,180)	$ (17,945)	$ (221,385)
2010 Activity, net of tax	(15,676)	3,716	2,418	(9,542)

Balance as of December 31, 2010	(217,936)	2,536	(15,527)	(230,927)
2011 Activity, net of tax	55,145	(960)	(7,737)	46,448
Balance as of December 31, 2011	$ (162,791)	$ 1,576	$ (23,264)	$ (184,479)

Segment Reporting. A public company is required to report annual and interim financial and descriptive information about its reportable operating segments. Operating segments, as defined, are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

decision maker in deciding how to allocate resources and in assessing performance. Aggregation of similar operating segments into a single reportable operating segment is permitted if the businesses have similar economic characteristics and meet the criteria established by U.S. GAAP.

The Company operates in three distinct operating segments, represented by the hospital operations (which includes the Company s acute care hospitals and related healthcare entities that provide inpatient and outpatient healthcare services), the home care agencies operations (which provide in-home outpatient care), and the hospital management services business (which provides executive management and consulting services to non-affiliated general acute care hospitals). U.S. GAAP requires (1) that financial information be disclosed for operating segments that meet a 10% quantitative threshold of the consolidated totals of net revenue, profit or loss, or total assets; and (2) that the individual reportable segments disclosed contribute at least 75% of total consolidated net revenue. Based on these measures, only the hospital operations segment meets the criteria as a separate reportable segment. Financial information for the home care agencies and hospital management services segments do not meet the quantitative thresholds and are therefore combined with corporate into the all other reportable segment.

Derivative Instruments and Hedging Activities. The Company records derivative instruments on the consolidated balance sheet as either an asset or liability measured at its fair value. Changes in a derivative s fair value are recorded each period in earnings or other comprehensive income (OCI), depending on whether the derivative is designated and is effective as a hedged transaction, and on the type of hedge transaction. Changes in the fair value of derivative instruments recorded to OCI are reclassified to earnings in the period affected by the underlying hedged item. Any portion of the fair value of a derivative instrument determined to be ineffective under the standard is recognized in current earnings.

The Company has entered into several interest rate swap agreements. See Note 7 for further discussion about the swap transactions.

New Accounting Pronouncements. In August 2010, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (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 prospectively by the Company on January 1, 2011. The adoption of this ASU increased other current assets by $5.3 million, other assets, net by $36.9 million and long-term liabilities by $42.2 million in the consolidated balance sheet at December 31, 2011 and had no impact to the consolidated statement of income for the year ended December 31, 2011.

In June 2011, the FASB issued ASU 2011-05, which eliminates the option to present components of other comprehensive income as part of the statement of changes in stockholders equity. Instead, ASU 2011-05 requires that all nonowner changes in stockholders equity be presented either in a single continuous statement of comprehensive income or in two separate but consecutive statements. In December 2011, the FASB issued ASU 2011-12, which amends ASU 2011-05 to defer the requirement to measure and present reclassification adjustments from accumulated other comprehensive income to net income by income statement line item in net income and also in other comprehensive income. ASU 2011-05, as amended by ASU 2011-12, is required to be applied retrospectively and is effective for fiscal years beginning after December 15, 2011, and will be adopted by the Company in the first quarter of 2012. The adoption of ASU 2011-05, as amended by ASU 2011-12, will not impact the Company s consolidated financial position, results of operations or cash flows, although it will change the presentation of the Company s other comprehensive income for all periods presented.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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 such 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 the Company s policy for recognizing revenue and bad debt expense for patient service transactions and quantitative information about the effects of changes in the assessment of collectability of patient service revenue. This ASU is effective for fiscal years beginning after December 15, 2011, and will be adopted by the Company in the first quarter of 2012. Upon adoption, the Company s 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 all periods presented in this annual report as if the ASU was early adopted in 2011 are as follows (in thousands):

	Year Ended December 31,		
	2011	**2010**	**2009**
Net operating revenues (net of contractual allowances and discounts)	$ 13,626,168	$ 12,623,274	$ 11,742,454
Provision for bad debts	(1,719,956)	(1,530,852)	(1,408,953)
Net operating revenues, less provision for bad debts	$ 11,906,212	$ 11,092,422	$ 10,333,501

In September 2011, the FASB issued ASU 2011-08, which simplifies 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. ASU 2011-08 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 the Company in 2012. The adoption of ASU 2011-08 is not expected to impact the Company s consolidated financial position, results of operations or cash flows.

2. Accounting for Stock-Based Compensation

Stock-based compensation awards are granted under the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan, amended and restated as of March 24, 2009 (the 2000 Plan), and the Community Health Systems, Inc. 2009 Stock Option and Award Plan, amended and restated as of March 18, 2011 (the 2009 Plan).

The 2000 Plan allows for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code (IRC), as well as stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Prior to being amended in 2009, the 2000 Plan also allowed for the grant of phantom stock. Persons eligible to receive grants under the 2000 Plan include the Company s directors, officers, employees and consultants. To date, all options granted under the 2000 Plan have been nonqualified stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date. Options granted prior to 2005 have a 10-year contractual term, options granted in 2005 through 2007 have an eight-year contractual term and options granted in 2008 or later have a 10-year contractual term. As of December 31, 2011, 332,747 shares of unissued common stock were reserved for future grants under the 2000 Plan.

The 2009 Plan provides for the grant of incentive stock options intended to qualify under Section 422 of the IRC and for the grant of stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Persons eligible to receive grants under the 2009 Plan include the Company s directors, officers, employees and consultants. To date, all options granted under the 2009 Plan have been nonqualified stock options for tax purposes. Options granted in 2011 have a 10-year contractual term. As of December 31, 2011, 2,773,489 shares of unissued common stock were reserved for future grants under the 2009 Plan.

The exercise price of all options granted is equal to the fair value of the Company s common stock on the option grant date.

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

	Year Ended December 31,		
	2011	2010	2009
Effect on income from continuing operations before income taxes	$ (42,542)	$ (38,779)	$ (44,501)
Effect on net income	$ (27,014)	$ (24,625)	$ (26,986)

At December 31, 2011, $59.0 million of unrecognized stock-based compensation expense was expected to be recognized over a weighted-average period of 22 months. Of that amount, $13.1 million relates to outstanding unvested stock options expected to be recognized over a weighted-average period of 22 months and $45.9 million relates to outstanding unvested restricted stock, restricted stock units and phantom shares expected to be recognized over a weighted-average period of 22 months. There were no modifications to awards during the years ended December 31, 2011, 2010 and 2009.

The fair value of stock options was estimated using the Black-Scholes option pricing model with the following assumptions during the years ended December 31, 2011, 2010 and 2009:

	Year Ended December 31,		
	2011	2010	2009
Expected volatility	33.8%	33.7%	40.7%
Expected dividends	0	0	0
Expected term	4 years	3.1 years	4 years
Risk-free interest rate	1.63%	1.41%	1.64%

In determining the expected term, the Company examined concentrations of option holdings and historical patterns of option exercises and forfeitures, as well as forward-looking factors, in an effort to determine if there were any discernable employee populations. From this analysis, the Company identified two primary employee populations, one consisting of certain senior executives and the other consisting of substantially all other recipients.

The expected volatility rate was estimated based on historical volatility. In determining expected volatility, the Company also reviewed the market-based implied volatility of actively traded options of its common stock and determined that historical volatility utilized to estimate the expected volatility rate did not differ significantly from the implied volatility.

The expected term computation is based on historical exercise and cancellation patterns and forward-looking factors, where present, for each population identified. The risk-free interest rate is based on the U.S. Treasury yield curve in effect at the time of the grant. The pre-vesting forfeiture rate is based on historical rates and forward-looking factors for each population identified. The Company adjusts the estimated forfeiture rate to its actual experience.

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Options outstanding and exercisable under the 2000 Plan and 2009 Plan as of December 31, 2011, and changes during each of the years in the three-year period ended December 31, 2011 were as follows (in thousands, except share and per share data):

	Shares	Weighted - Average Exercise Price	Weighted - Average Remaining Contractual Term	Aggregate Intrinsic Value as of December 31, 2011
Outstanding at December 31, 2008	8,764,084	$ 30.97		
Granted	1,313,000	19.43		
Exercised	(680,898)	18.74		
Forfeited and cancelled	(442,105)	31.27		
Outstanding at December 31, 2009	8,954,081	30.19		
Granted	1,447,500	33.89		
Exercised	(2,194,862)	25.88		
Forfeited and cancelled	(372,387)	29.80		
Outstanding at December 31, 2010	7,834,332	32.08		
Granted	1,505,000	35.87		
Exercised	(623,341)	30.34		
Forfeited and cancelled	(326,849)	33.69		
Outstanding at December 31, 2011	8,389,142	$ 32.83	5.3 years	$ 120
Exercisable at December 31, 2011	5,884,262	$ 32.74	3.9 years	$ 74

The weighted-average grant date fair value of stock options granted during the years ended December 31, 2011, 2010 and 2009, was $10.07, $8.47 and $6.61, respectively. The aggregate intrinsic value (the number of in-the-money stock options multiplied by the difference between the Company s closing stock price on the last trading day of the reporting period ($17.45) and the exercise price of the respective stock options) in the table above represents the amount that would have been received by the option holders had all option holders exercised their options on December 31, 2011. This amount changes based on the market value of the Company s common stock. The aggregate intrinsic value of options exercised during the years ended December 31, 2011, 2010 and 2009 was $6.1 million, $28.9 million and $7.6 million, respectively. The aggregate intrinsic value of options vested and expected to vest approximates that of the outstanding options.

The Company has also awarded restricted stock under the 2000 Plan and the 2009 Plan to its directors and employees of certain subsidiaries. The restrictions on these shares generally lapse in one-third increments on each of the first three anniversaries of the award date. Certain of the restricted stock awards granted to the Company s senior executives contain a performance objective that must be met in addition to any vesting requirements. If the performance objective is not attained, the awards will be forfeited in their entirety. Once the performance objective has been attained, restrictions will lapse in one-third increments on each of the first three anniversaries of the award date. Notwithstanding the above-mentioned performance objectives and vesting requirements, the restrictions will lapse earlier in the event of death, disability or termination of employment by the Company for any reason other than for cause of the holder of the restricted stock, or change in control of the

Company. Restricted stock awards subject to performance standards are not considered outstanding for purposes of determining earnings per share until the performance objectives have been satisfied.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Restricted stock outstanding under the 2000 Plan and the 2009 Plan as of December 31, 2011, and changes during each of the years in the three-year period ended December 31, 2011 was as follows:

	Shares	Weighted - Average Grant Date Fair Value
Unvested at December 31, 2008	1,684,207	$ 35.57
Granted	1,188,814	18.45
Vested	(965,478)	37.08
Forfeited	(10,002)	32.52
Unvested at December 31, 2009	1,897,541	24.09
Granted	1,099,000	33.83
Vested	(860,749)	27.04
Forfeited	(10,501)	27.84
Unvested at December 31, 2010	2,125,291	27.92
Granted	1,109,949	37.57
Vested	(1,009,959)	27.40
Forfeited	(17,669)	35.68
Unvested at December 31, 2011	2,207,612	32.95

Phantom stock and restricted stock units (RSUs) have been granted to the Company s outside directors under the 2000 Plan and the 2009 Plan. On February 25, 2009, each of the Company s outside directors received a grant under the 2000 Plan of 7,151 shares of phantom stock. On May 19, 2009, the newly elected outside director received a grant under the 2000 Plan of 7,151 RSUs. On February 24, 2010, six of the Company s seven outside directors each received a grant under the 2000 Plan of 4,130 RSUs and one outside director, who did not stand for reelection in 2010, did not receive such a grant. On February 23, 2011, each of the Company s outside directors received a grant under the 2009 Plan of 3,688 RSUs. Vesting of these shares of phantom stock and RSUs occurs in one-third increments on each of the first three anniversaries of the award date.

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Phantom stock and RSUs outstanding as of December 31, 2011, and changes during each of the years in the three-year period ended December 31, 2011 were as follows:

	Shares	Weighted - Average Grant Date Fair Value
Unvested at December 31, 2008		$
Phantom Stock Granted February 25, 2009	42,906	18.18
RSUs Granted May 19, 2009	7,151	25.27
Vested		
Forfeited		
Unvested at December 31, 2009	50,057	19.19
RSUs Granted February 24, 2010	24,780	33.90
Vested	(21,449)	18.97
Forfeited		
Unvested at December 31, 2010	53,388	26.11
RSUs Granted February 23, 2011	22,128	37.96
Vested	(22,560)	24.68
Forfeited		
Unvested at December 31, 2011	52,956	31.67

Under the Directors Fees Deferral Plan, the Company s outside directors may elect to receive share equivalent units in lieu of cash for their directors fees. These share equivalent units are held in the plan until the director electing to receive the share equivalent units retires or otherwise terminates his/her directorship with the Company. Share equivalent units are converted to shares of common stock of the Company at the time of distribution based on the closing market price of the Company s common stock on that date. The following table represents the amount of directors fees which were deferred during each of the respective periods, and the number of share equivalent units into which such directors fees would have converted had each of the directors who had deferred such fees retired or terminated his/her directorship with the Company as of the end of the respective periods (in thousands, except share equivalent units):

	Year Ended December 31,		
	2011	2010	2009
Directors fees earned and deferred into plan	$ 220	$ 180	$ 80

Share equivalent units	9,974	5,207	3,284

At December 31, 2011, a total of 28,775 share equivalent units were deferred in the plan with an aggregate fair value of $0.5 million, based on the closing market price of the Company s common stock at December 31, 2011 of $17.45.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

3. Acquisitions and Divestitures

Acquisitions

The Company accounts for all transactions that represent business combinations after January 1, 2009 using the acquisition method of accounting, where the identifiable assets acquired, the liabilities assumed and any noncontrolling interest in the acquired entity are recognized and measured at their fair values on the date the Company obtains control in the acquiree. Such fair values that are not finalized for reporting periods following the acquisition date are estimated and recorded as provisional amounts. Adjustments to these provisional amounts during the measurement period (defined as the date through which all information required to identify and measure the consideration transferred, the assets acquired, the liabilities assumed and any noncontrolling interests has been obtained, limited to one year from the acquisition date) are recorded as of the date of acquisition. Any material impact to comparative information for periods after acquisition, but before the period in which adjustments are identified, is reflected in those prior periods as if the adjustments were considered as of the acquisition date. Goodwill is determined as the excess of the fair value of the consideration conveyed in the acquisition over the fair value of the net assets acquired.

Effective October 1, 2011, one or more subsidiaries of the Company completed the acquisition of Tomball Regional Hospital (358 licensed beds) located in Tomball, Texas. The total cash consideration paid for fixed assets and working capital was approximately $192.0 million and $17.5 million, respectively, with additional consideration of $15.8 million assumed in liabilities, for a total consideration of $225.3 million. Based upon the Company s preliminary purchase price allocation relating to this acquisition as of December 31, 2011, approximately $30.8 million of goodwill has been recorded. The preliminary allocation of the purchase price has been determined by the Company based on available information and is subject to settling amounts related to purchased working capital and final appraisals of tangible and intangible assets. Adjustments to the purchase price allocation are not expected to be material.

Effective May 1, 2011, one or more subsidiaries of the Company completed the acquisition of Mercy Health Partners based in Scranton, Pennsylvania, which is a healthcare system comprised of two acute care hospitals, a long-term acute care facility and other healthcare providers. This healthcare system includes Regional Hospital of Scranton (198 licensed beds) located in Scranton, Pennsylvania, and Tyler Memorial Hospital (48 licensed beds) located in Tunkhannock, Pennsylvania. This healthcare system also includes a long-term acute care facility, Special Care Hospital (67 licensed beds) located in Nanticoke, Pennsylvania, as well as several outpatient clinics and other ancillary facilities. The total cash consideration paid for fixed assets was approximately $150.8 million, with additional consideration of $12.3 million assumed in liabilities as well as a credit applied at closing of $2.1 million for negative acquired working capital, for a total consideration of $161.0 million. Based upon the Company s final purchase price allocation relating to this acquisition, as of December 31, 2011 approximately $43.1 million of goodwill has been recorded.

Effective October 1, 2010, one or more subsidiaries of the Company completed the acquisition of Forum Health based in Youngstown, Ohio, a healthcare system of two acute care hospitals, a rehabilitation hospital and other healthcare providers. This healthcare system includes Northside Medical Center (355 licensed beds) located in Youngstown, Ohio, and Trumbull Memorial Hospital (311 licensed beds) located in Warren, Ohio. This healthcare system also includes Hillside Rehabilitation Hospital (69 licensed beds) located in Warren, Ohio, as well as several outpatient clinics and other ancillary facilities. The total cash consideration paid for fixed assets and working capital was approximately $93.4 million and $27.8 million, respectively, with additional consideration of $40.3 million assumed in liabilities, for a total consideration of $161.5 million. Based upon the Company s final purchase price allocation relating to this acquisition, as of December 31, 2011 approximately $8.1 million of goodwill has been recorded.

Effective October 1, 2010, one or more subsidiaries of the Company completed the acquisition of Bluefield Regional Medical Center (240 licensed beds) located in Bluefield, West Virginia. The total cash consideration paid for fixed assets was approximately $35.4 million, with additional consideration of $8.9 million assumed in liabilities as well as a credit applied at closing of $1.8 million for negative acquired working capital, for a total consideration of $42.5 million. Based upon the Company s final purchase price allocation relating to this acquisition, as of December 31, 2011 approximately $2.4 million of goodwill has been recorded.

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Effective July 7, 2010, one or more subsidiaries of the Company completed the acquisition of Marion Regional Healthcare System located in Marion, South Carolina. This healthcare system includes Marion Regional Hospital (124 licensed beds), an acute care hospital, along with a related skilled nursing facility and other ancillary services. The total cash consideration paid for fixed assets and working capital was approximately $18.6 million and $5.8 million, respectively, with additional consideration of $3.9 million assumed in liabilities, for a total consideration of $28.3 million. Based upon the Company s final purchase price allocation relating to this acquisition, as of December 31, 2011 no goodwill has been recorded.

On December 31, 2009, one or more subsidiaries of the Company completed an affiliation transaction providing $54.2 million of financing to Rockwood Clinic, P.S., a multi-specialty clinic with 32 locations across the inland northwest region of eastern Washington and western Idaho. This transaction was accounted for as a purchase business combination.

Effective June 1, 2009, one or more subsidiaries of the Company acquired from Akron General Medical Center the remaining 20% noncontrolling interest in Massillon Community Health System, LLC not then owned by a subsidiary of the Company. This entity indirectly owns and operates Affinity Medical Center of Massillon, Ohio. The purchase price for this noncontrolling interest was $1.1 million in cash. Affinity Medical Center is now wholly-owned by these subsidiaries of the Company.

Effective April 30, 2009, one or more subsidiaries of the Company acquired Wyoming Valley Health Care System in Wilkes-Barre, Pennsylvania. This healthcare system includes Wilkes-Barre General Hospital (392 licensed beds), an acute care hospital located in Wilkes-Barre, Pennsylvania, and First Hospital Wyoming Valley, a behavioral health facility located in Kingston, Pennsylvania, as well as other outpatient and ancillary services. The total consideration for fixed assets and working capital of Wyoming Valley Health Care System was approximately $133.7 million and $30.0 million, respectively, with additional consideration of $25.4 million assumed in liabilities and net of $14.2 million of cash in acquired bank accounts, for a total consideration of $174.9 million. Based upon the Company s final purchase price allocation relating to this acquisition, as of December 31, 2011 no goodwill has been recorded.

Effective April 1, 2009, one or more subsidiaries of the Company acquired from Share Foundation the remaining 50% equity interest in MCSA L.L.C., an entity in which one or more subsidiaries of the Company previously had a 50% unconsolidated noncontrolling interest. One or more subsidiaries of the Company provided MCSA L.L.C. certain management services. This acquisition resulted in these subsidiaries of the Company owning a 100% equity interest in that entity. MCSA L.L.C. owns and operates Medical Center of South Arkansas (166 licensed beds) in El Dorado, Arkansas. The purchase price was $26.0 million in cash. As of the acquisition date, one or more subsidiaries of the Company had a liability to MCSA L.L.C. of $14.1 million, as a result of a cash management agreement previously entered into with the hospital. Upon completion of the acquisition, this liability was eliminated in consolidation.

Effective February 1, 2009, one or more subsidiaries of the Company completed the acquisition of Siloam Springs Memorial Hospital (73 licensed beds), located in Siloam Springs, Arkansas, from the City of Siloam Springs. The total consideration for this hospital consisted of approximately $0.1 million paid in cash for working capital and approximately $1.0 million of assumed liabilities. In connection with this acquisition, a subsidiary of the Company entered into a lease agreement for the existing hospital and agreed to build a replacement facility at this location, with construction required to commence by February 2011 and be completed by February 2013. As security for this obligation, a subsidiary of the Company deposited $1.6 million into an escrow account at closing and agreed to deposit an additional $1.6 million by February 1, 2010, which the Company s subsidiary deposited in January 2010. If the construction of the replacement facility is not completed within the agreed time frame, the escrow balance will be remitted to the City of Siloam Springs. If the construction of the replacement facility is completed by February 2013 as planned, the escrow balance will be returned to the Company s subsidiary.

Approximately $16.0 million, $8.9 million and $6.7 million of acquisition costs related to prospective and closed acquisitions were expensed during the years ended December 31, 2011, 2010 and 2009, respectively.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

The table below summarizes the allocations of the purchase price (including assumed liabilities) for the above acquisition transactions (in thousands):

	2011	2010
Current assets	$ 26,017	$ 46,842
Property and equipment	280,639	169,209
Goodwill	73,923	10,537
Intangible assets	2,260	1,730
Other long-term assets	3,497	
Liabilities	28,089	51,124

The operating results of the foregoing transactions have been included in the consolidated statements of income from their respective dates of acquisition, including net operating revenues of $169.7 million for the year ended December 31, 2011 from hospital acquisitions that closed during 2011 and net operating revenues of $139.0 million for the year ended December 31, 2010 from hospital acquisitions that closed during 2010. The following pro forma combined summary of operations of the Company gives effect to using historical information of the operations of the acquisitions in 2011 and 2010 discussed above as if the transactions had occurred as of January 1, 2010 (in thousands, except per share data):

	Year Ended December 31,	
	2011	2010
	(Unaudited)	
Pro forma net operating revenues	$ 13,904,851	$ 13,364,916
Pro forma net income	173,697	259,978
Pro forma net income per share:		
Basic	$ 1.93	$ 2.83
Diluted	$ 1.92	$ 2.80

Pro forma adjustments to net income include adjustments to depreciation and amortization expense, net of the related tax effect, based on the estimated fair value assigned to the long-lived assets acquired, and to interest expense, net of the related tax effect, assuming the increase in long-term debt used to fund the acquisitions had occurred as of January 1, 2010. These pro forma results are not necessarily indicative of the actual results of operations.

Additionally, during 2011, the Company paid approximately $57.9 million to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by its hospitals. In connection with these acquisitions, the Company allocated approximately $13.1 million of the consideration paid to property and equipment, $2.9 million to net working capital, $1.6 million to other intangible assets and the remainder, approximately $40.3 million consisting of intangible assets that do not qualify for separate recognition, was allocated to goodwill. These acquisition transactions were accounted for as purchase business combinations.

During 2010, the Company paid approximately $67.4 million to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by its hospitals. In connection with these acquisitions, the Company allocated approximately $35.6 million of the consideration paid to property and equipment and the remainder, approximately $35.4 million consisting of intangible assets that do not qualify for separate recognition, was allocated to goodwill. These acquisition transactions were accounted for as purchase business combinations.

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Discontinued Operations

Effective February 1, 2011, the Company sold Willamette Community Medical Group, which is a physician clinic operating as Oregon Medical Group, located in Springfield, Oregon, to Oregon Healthcare Resources, LLC, for $14.6 million in cash; this business had a carrying amount of net assets, including an allocation of reporting unit goodwill, of $19.7 million.

Effective September 1, 2011, the Company sold Southcrest Hospital, located in Tulsa, Oklahoma, Claremore Regional Hospital, located in Claremore, Oklahoma, and other related healthcare assets affiliated with those hospitals to Hillcrest Healthcare System, part of Ardent Health Services, for approximately $154.2 million in cash. The carrying amount of the net assets sold in this transaction, including an allocation of reporting unit goodwill, was approximately $193.0 million.

Effective October 22, 2011, the Company sold Cleveland Regional Medical Center, located in Cleveland, Texas, and other related healthcare assets affiliated with the hospital to New Directions Health Systems, LLC for approximately $0.9 million in cash. The carrying amount of the net assets sold in this transaction, including an allocation of reporting unit goodwill, was approximately $14.2 million.

Effective March 31, 2009, the Company, through its subsidiaries Triad-Denton Hospital LLC and Triad-Denton Hospital LP, completed the settlement of pending litigation, which resulted in the sale of its ownership interest in a partnership, which owned and operated Presbyterian Hospital of Denton (255 licensed beds) in Denton, Texas, to Texas Health Resources for $103.0 million in cash. Also as part of the settlement, these subsidiaries transferred certain hospital related assets to Texas Health Resources.

In connection with management s decision to sell the previously mentioned facilities, the Company has classified the results of operations of the above mentioned hospitals as discontinued operations in the accompanying consolidated statements of income. As of December 31, 2011, no hospitals are held for sale.

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

	Year Ended December 31,		
	2011	2010	2009
Net operating revenues	$ 190,791	$ 363,226	$ 407,272
(Loss) income from operations of entities sold before income taxes	(12,390)	(10,460)	1,492
Impairment of hospitals sold	(51,695)		
Loss on sale, net	(4,301)		(644)
(Loss) income from discontinued operations before income taxes	(68,386)	(10,460)	848
(Benefit from) provision for income taxes	(10,115)	(3,688)	282
(Loss) income from discontinued operations, net of taxes	$ (58,271)	$ (6,772)	$ 566

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

The long-lived assets and allocated goodwill at December 31, 2010 of the hospitals and physician clinic sold during the year ended December 31, 2011 totaled approximately $182.7 million, and are included in the accompanying consolidated balance sheet in other assets, net.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

4. Goodwill and Other Intangible Assets

The changes in the carrying amount of goodwill are as follows (in thousands):

	Year Ended December 31,	
	2011	**2010**
Balance, beginning of year	$ 4,150,247	$ 4,157,927
Goodwill acquired as part of acquisitions during the year	114,473	45,975
Consideration adjustments and purchase price allocation adjustments for prior year s acquisitions	125	(3,997)
Goodwill related to the hospital operations reporting unit assigned to the disposal group classified as held for sale in 2011		(49,658)
Balance, end of year	$ 4,264,845	$ 4,150,247

Goodwill is allocated to each identified reporting unit, which is defined as an operating segment or one level below the operating segment (referred to as a component of the entity). Management has determined that the Company s operating segments meet the criteria to be classified as reporting units. At December 31, 2011, the hospital operations reporting unit, the home care agency operations reporting unit and the hospital management services reporting unit had approximately $4.2 billion, $40.5 million and $33.3 million, respectively, of goodwill. At December 31, 2010, the hospital operations reporting unit, the home care agency operations reporting unit and the hospital management services reporting unit had approximately $4.1 billion, $35.9 million and $33.3 million, respectively, of goodwill.

Goodwill is evaluated for impairment at the same time every year and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. There is a two-step method for determining goodwill impairment. Step one is to compare the fair value of the reporting unit with the unit s carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit s goodwill with the carrying value of the reporting unit s goodwill. The Company has selected September 30 as its annual testing date. The Company performed its last annual goodwill evaluation as of September 30, 2011, which evaluation took place during the fourth quarter of 2011. No impairment was indicated by this evaluation.

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

Approximately $3.8 million of intangible assets other than goodwill were acquired during the year ended December 31, 2011. The gross carrying amount of the Company s other intangible assets subject to amortization was $60.0 million and $60.5 million at December 31, 2011 and 2010, respectively, and the net carrying amount was $30.6 million and $36.1 million at December 31, 2011 and 2010, respectively. The carrying amount of the Company s other intangible assets not subject to amortization was $46.9 million and $44.4 million at December 31, 2011 and 2010. Other intangible assets are included in other assets, net on the Company s consolidated balance sheets. Substantially all of the Company s intangible assets are contract-based intangible assets related to operating licenses, management contracts, or non-compete agreements entered into in connection with prior acquisitions.

The weighted-average amortization period for the intangible assets subject to amortization is approximately nine years. There are no expected residual values related to these intangible assets. Amortization expense on these intangible assets was $8.1 million, $12.2 million and $13.0 million during the years ended December 31, 2011, 2010 and 2009, respectively. Amortization expense on intangible assets is estimated to be $7.4 million in 2012, $4.7 million in 2013, $2.9 million in 2014, $2.5 million in 2015, $2.3 million in 2016 and $10.8 million thereafter.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

The gross carrying amount of capitalized software for internal use was approximately $451.0 million and $356.5 million at December 31, 2011 and 2010, respectively, and the net carrying amount considering accumulated amortization was approximately $241.3 million and $209.4 million at December 31, 2011 and 2010, respectively. The estimated amortization period for capitalized internal-use software is generally three years, except for capitalized costs related to significant system conversions, which is generally eight years. There is no expected residual value for capitalized internal-use software. At December 31, 2011, there was approximately $109.3 million of capitalized costs for internal-use software that will begin amortization once the software project is complete and ready for its intended use. Amortization expense for capitalized internal-use software was $70.5 million, $48.2 million and $32.5 million during the years ended December 31, 2011, 2010 and 2009, respectively. Amortization expense for capitalized internal-use software is estimated to be $81.0 million in 2012, $70.8 million in 2013, $35.1 million in 2014, $17.3 million in 2015, $15.4 million in 2016 and $21.7 million thereafter.

5. Income Taxes

The provision for income taxes for income from continuing operations consists of the following (in thousands):

	Year Ended December 31,		
	2011	**2010**	**2009**
Current:			
Federal	$ 23,020	$ 54,986	$ 93,543
State	7,601	11,208	13,577
	30,621	66,194	107,120
Deferred:			
Federal	105,771	92,628	16,012
State	1,261	4,859	18,719
	107,032	97,487	34,731
Total provision for income taxes for income from continuing operations	$ 137,653	$ 163,681	$ 141,851

The following table reconciles the differences between the statutory federal income tax rate and the effective tax rate (dollars in thousands):

	Year Ended December 31,					
	2011		**2010**		**2009**	
	Amount	**%**	**Amount**	**%**	**Amount**	**%**
Provision for income taxes at statutory federal rate	$ 165,741	35.0%	$ 181,474	35.0%	$ 156,682	35.0%
State income taxes, net of federal income tax benefit	8,212	1.7	8,847	1.7	9,080	2.0

Release of unrecognized tax benefit	(6,509)	(1.3)				
Net income attributable to noncontrolling interests	(26,486)	(5.6)	(23,960)	(4.6)	(22,006)	(4.9)
Change in valuation allowance		0.0	(910)	(0.2)	1,113	0.3
Federal and state tax credits	(3,788)	(0.8)	(2,246)	(0.4)	(4,241)	(0.9)
Deferred tax revaluation					(2,996)	(0.7)
Other	483	0.1	476	0.1	4,219	0.9
Provision for income taxes and effective tax rate for income from continuing operations	$ 137,653	29.1%	$ 163,681	31.6%	$ 141,851	31.7%

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Deferred income taxes are based on the estimated future tax effects of differences between the financial statement and tax bases of assets and liabilities under the provisions of the enacted tax laws. Deferred income taxes as of December 31, 2011 and 2010 consist of (in thousands):

	December 31,			
	2011		2010	
	Assets	Liabilities	Assets	Liabilities
Net operating loss and credit carryforwards	$ 140,825	$	$ 131,093	$
Property and equipment		727,366		685,089
Self-insurance liabilities	113,640		91,246	
Intangibles		201,396		169,860
Investments in unconsolidated affiliates		62,112		48,353
Other liabilities		22,050		27,045
Long-term debt and interest		24,115		29,191
Accounts receivable	11,435		60,026	
Accrued expenses	49,575		53,842	
Other comprehensive income	128,170		156,597	
Stock-based compensation	28,894		25,472	
Deferred compensation	42,668		41,703	
Other	57,158		24,963	
	572,365	1,037,039	584,942	959,538
Valuation allowance	(150,254)		(126,644)	
Total deferred income taxes	$ 422,111	$ 1,037,039	$ 458,298	$ 959,538

The Company s deferred tax assets and liabilities have been adjusted in 2010 for the effects of its filed 2009 tax return, having the effect of increasing total deferred tax assets by $12.5 million, increasing total deferred tax liabilities by $11.4 million, and decreasing prepaid income taxes by $1.1 million. The effects of the adjustments did not impact income tax expense, and their effects on previously issued consolidated financial statements were not material.

The Company believes that the net deferred tax assets will ultimately be realized, except as noted below. Its conclusion is based on its estimate of future taxable income and the expected timing of temporary difference reversals. The Company has state net operating loss carry forwards of approximately $3.3 billion, which expire from 2012 to 2031. The Company also has unrecognized deferred tax assets primarily related to interest expense that are included in other comprehensive income. If recognized, additional state net operating losses will be created which the Company does not expect to be able to utilize prior to the expiration of the carryforward period. A valuation allowance of approximately $24.9 million has been recognized for those items. With respect to the deferred tax liability pertaining to intangibles, as included above, goodwill purchased in connection with certain of the Company s business acquisitions is amortizable for income tax reporting purposes. However, for financial reporting purposes, there is no corresponding amortization allowed with respect to such purchased goodwill.

The valuation allowance increased by $23.6 million during the year ended December 31, 2011 and increased by $11.5 million during the year ended December 31, 2010. In addition to amounts previously discussed, the change in valuation allowance relates to a redetermination of the amount of, and realizability of, net operating losses in certain state income tax jurisdictions.

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The total amount of unrecognized benefit that would impact the effective tax rate, if recognized, was approximately $0.8 million as of December 31, 2011. A total of approximately $0.3 million of interest and penalties is included in the amount of liability for uncertain tax positions at December 31, 2011. During the year ended December 31, 2011, the Company decreased liabilities for uncertain tax positions by $5.4 million, including the favorable resolution of an issue on appeal with the IRS related to its tax examination of Triad tax returns, and decreased interest and penalties by approximately $1.1 million. It is the Company s policy to recognize interest and penalties related to unrecognized benefits in its consolidated statements of income as income tax expense. During the year ended December 31, 2011, the Company released $2.3 million for income taxes and $0.7 million for accrued interest of its liability for uncertain tax positions, as a result of the expiration of the statute of limitations pertaining to tax positions taken in prior years.

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

The following is a tabular reconciliation of the total amount of unrecognized tax benefit for the years ended December 31, 2011, 2010 and 2009 (in thousands):

	Year Ended December 31,		
	2011	2010	2009
Unrecognized tax benefit, beginning of year	$ 7,458	$ 9,234	$ 15,630
Gross (decreases) increases purchase business combination			(4,173)
Gross increases tax positions in prior period	349	70	
Reductions tax positions in prior period	(3,469)	(1,833)	
Lapse of statute of limitations	(3,575)		(663)
Settlements	(134)	(13)	(1,560)
Unrecognized tax benefit, end of year	$ 629	$ 7,458	$ 9,234

The Company, or one of its subsidiaries, files income tax returns in the United States federal jurisdiction and various state jurisdictions. The Company has extended the federal statute of limitations 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, the Company reached a favorable resolution of an issue on appeal with the IRS related to its examination of Triad s tax returns. As a result, the Company recognized a tax benefit of $4.0 million, which is reflected in the accompanying consolidated statement of income for the year ended December 31, 2011. With few exceptions, the Company is no longer subject to state income tax examinations for years prior to 2008 and federal income tax examinations with respect to Community Health Systems, Inc. federal returns for years prior to 2007. The Company s federal income tax returns for the 2007 and 2008 tax years are currently under examination by the IRS. The Company believes the results of this examination will not be material to its consolidated results of operations or consolidated financial position. In connection with the Company s 2007 and 2008 IRS examinations, the IRS has taken exception to the timing of the Company s malpractice expense deductions. Management believes that the Company s deduction timing is appropriate, and will work to resolve this item over the next 24 months. If management is unable to sustain the current timing of the Company s deduction, then it would be subject to interest and penalty costs. Management does not consider this matter to have met the recognition criteria to be considered an uncertain tax position for which a reserve is necessary.

The Company paid income taxes, net of refunds received, of $26.5 million, $128.2 million and $57.3 million during the years ended December 31, 2011, 2010 and 2009.

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6. Long-Term Debt

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

	December 31,	
	2011	2010
Credit Facility:		
Term loans	$ 5,949,383	$ 5,999,337
Revolving credit loans	30,000	
8 7/8% Senior Notes due 2015	1,777,617	2,784,331
8% Senior Notes due 2019	1,000,000	
Capital lease obligations (see Note 9)	48,361	51,731
Other	41,143	36,122
Total debt	8,846,504	8,871,521
Less current maturities	(63,706)	(63,139)
Total long-term debt	$ 8,782,798	$ 8,808,382

Credit Facility

In connection with the consummation of the acquisition of Triad in July 2007, the Company s wholly-owned subsidiary CHS/Community Health Systems, Inc. (CHS) obtained approximately $7.2 billion of senior secured financing under a new credit facility (the Credit Facility) with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent, and issued approximately $3.0 billion aggregate principal amount of 8 7/8% senior notes due 2015 (the 8 7/8% Senior Notes). The Company used the net proceeds of $3.0 billion from the 8 7/8% Senior Notes offering and the net proceeds of approximately $6.1 billion of term loans under the Credit Facility to acquire the outstanding shares of Triad, to refinance certain of Triad s indebtedness and the Company s indebtedness, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. Specifically, the Company repaid its outstanding debt under the previously outstanding credit facility, the 6.50% senior subordinated notes due 2012 and certain of Triad s existing indebtedness.

The Credit Facility consisted of an approximately $6.1 billion funded term loan facility with a maturity of seven years, a $400 million delayed draw term loan facility with a maturity of seven years and a $750 million revolving credit facility with a maturity of six years. As of December 31, 2007, the $400 million delayed draw term loan facility had been reduced to $300 million at the request of CHS. During the fourth quarter of 2008, $100 million of the delayed draw term loan was drawn by CHS, reducing the delayed draw term loan availability to $200 million at December 31, 2008. In January 2009, CHS 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, CHS entered into an amendment and restatement of its existing Credit Facility. The amendment extended 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 increased the pricing on these term loans to LIBOR plus 350 basis points. If more than $50 million of the 8 7/8% Senior 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 amendment also increases CHS s ability to issue additional indebtedness under the uncommitted incremental facility to $1.0 billion from $600 million, permits CHS 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. In addition, effective February 2, 2012, the Company completed an additional amendment and restatement of the Credit Facility, which extended by two and a half years, until January 25, 2017, the maturity

date of an additional $1.6 billion of the existing non-extended term loans under the Credit Facility and increased the pricing on the newly extended term loans by 125 basis points. The maturity date of the balance of the term loans of approximately $2.9 billion remained unchanged at July 25, 2014.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

The term loan facility must be prepaid in an amount equal to (1) 100% of the net cash proceeds of certain asset sales and dispositions by the Company and its subsidiaries, subject to certain exceptions and reinvestment rights, (2) 100% of the net cash proceeds of issuances of certain debt obligations or receivables based financing by the Company and its subsidiaries, subject to certain exceptions, and (3) 50%, subject to reduction to a lower percentage based on the Company s leverage ratio (as defined in the Credit Facility generally as the ratio of total debt on the date of determination to the Company s EBITDA, as defined, for the four quarters most recently ended prior to such date), of excess cash flow (as defined) for any year, 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. All of the obligations under the Credit Facility are unconditionally guaranteed by the Company 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 the Company, CHS and each subsidiary guarantor, including equity interests held by the Company, CHS or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries.

The loans under the Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at CHS s 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 London Interbank Offered Rate (LIBOR) on such day for a three-month interest period commencing on the second business day after such day plus 1%, or (b) 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 is 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 is 1.25% for Alternate Base Rate revolving loans and 2.25% for Eurodollar revolving loans, in each case subject to reduction based on the Company s leverage ratio. Loans under the swingline subfacility bear interest at the rate applicable to Alternate Base Rate loans under the revolving credit facility.

CHS has agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to Eurodollar rate loans under the revolving 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. CHS was initially obligated to pay commitment fees of 0.50% per annum (subject to reduction based upon the Company s 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, CHS was also obligated to pay commitment fees of 0.50% per annum for the first nine months after the closing of the Credit Facility, 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 paid 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, CHS no longer pays any commitment fees for the delayed draw term loan facility. CHS paid arrangement fees on the closing of the Credit Facility and pays an annual administrative agent fee.

The Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting the Company s and its subsidiaries ability, subject to certain exceptions, to, among other things (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of the Company s businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change the Company s fiscal year. The Company is also required to comply with specified financial covenants (consisting of a leverage ratio and an interest coverage ratio) and various affirmative covenants.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Events of default under the Credit Facility include, but are not limited to, (1) CHS s 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.

On April 2, 2009, the Company paid down $110.4 million of its term loans under the Credit Facility. Of this amount, $85.0 million was paid down as required under the terms of the Credit Facility with the net proceeds received from the sale of the ownership interest in the partnership that owned and operated Presbyterian Hospital of Denton. This resulted in a loss from early extinguishment of debt of $1.1 million with an after-tax impact of $0.7 million recorded in discontinued operations for the year ended December 31, 2009. The remaining $25.4 million was paid on the term loans as required under the terms of the Credit Facility with the net proceeds received from the sale of various other assets. This resulted in a loss from early extinguishment of debt of $0.3 million with an after-tax impact of $0.2 million recorded in continuing operations for the year ended December 31, 2009.

As of December 31, 2011, a $750 million revolving credit facility was available to the Company for working capital and general corporate purposes under the Credit Facility, with $37.7 million of the revolving credit facility being set aside for outstanding letters of credit and $30.0 million outstanding at December 31, 2011. CHS has the ability to amend the Credit Facility to provide for one or more tranches of term loans in an aggregate principal amount of $1.0 billion, which CHS has not yet accessed. CHS also has the ability to add up to $300 million of borrowing capacity from receivable transactions (including securitizations) under the Credit Facility, which has not yet been accessed. As of December 31, 2011, the weighted-average interest rate under the Credit Facility, excluding swaps, was 3.5%.

The term loans are scheduled to be paid with principal payments for future years as follows (in thousands):

Year	Amount
2012	$ 49,874
2013	49,874
2014	4,413,385
2015	15,000
2016	15,000
Thereafter	1,406,250
Total	$ 5,949,383

As of December 31, 2011 and 2010, the Company had letters of credit issued, primarily in support of potential insurance-related claims and certain bonds, of approximately $37.7 million and $81.9 million, respectively.

8 7/8% Senior Notes due 2015

The 8 7/8% Senior Notes were issued by CHS in connection with the Triad acquisition in the principal amount of approximately $3.0 billion. The 8 7/8% Senior Notes will mature on July 15, 2015. The 8 7/8% Senior Notes bear interest at the rate of 8.875% per annum, payable semiannually in arrears on January 15 and July 15, commencing January 15, 2008. Interest on the 8 7/8% Senior Notes accrues from the date of original

issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

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On and after July 15, 2011, CHS is entitled, at its option, to redeem all or a portion of the 8 7/8% Senior Notes upon not less than 30 nor more than 60 days notice, at the redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the 12-month period commencing on July 15 of the years set forth below:

Period	Redemption Price
2012	102.219%
2013 and thereafter	100.000%

Pursuant to a registration rights agreement entered into at the time of the issuance of the 8 7/8% Senior Notes, as a result of an exchange offer made by CHS, substantially all of the 8 7/8% Senior Notes issued in July 2007 were exchanged in November 2007 for new notes (the Exchange Notes) having terms substantially identical in all material respects to the 8 7/8% Senior Notes (except that the Exchange Notes were issued under a registration statement pursuant to the 1933 Act). References to the 8 7/8% Senior Notes shall also be deemed to include the Exchange Notes unless the context provides otherwise.

On December 7, 2011, CHS completed the cash tender offer for $1.0 billion of the $2.8 billion aggregate principal amount of 8 7/8% Senior Notes due 2015. This resulted in a loss from early extinguishment of debt of $66.0 million with an after-tax impact of $42.0 million recorded in continuing operations for the year ended December 31, 2011.

8% Senior Notes due 2019

On November 22, 2011, CHS completed its offering of $1.0 billion aggregate principal amount of 8% Senior Notes due 2019 (the 8% Senior Notes), which were issued in a private placement. The net proceeds from this issuance, together with available cash on hand, were used to finance the purchase of $1.0 billion aggregate principal amount of CHS outstanding 8 7/8% Senior Notes due 2015 and related fees and expenses. The 8% Senior Notes bear interest at 8% per annum, payable semiannually in arrears on May 15 and November 15, commencing May 15, 2012. Interest on the 8% Senior Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

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

On and after November 15, 2015, CHS is entitled, at its option, to redeem all or a portion of the 8% Senior Notes upon not less than 30 nor more than 60 days notice, at the redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the 12-month period commencing on November 15 of the years set forth below:

Period	Redemption Price
2015	104.000%

2016	102.000%
2017 and thereafter	100.000%

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In addition, any time prior to November 15, 2014, CHS is entitled, at its option, on one or more occasions to redeem the 8% Senior Notes (which include additional 8% Senior Notes, if any) in an aggregate principal amount not to exceed 35% of the aggregate principal amount of the 8% Senior Notes (which includes additional 8% Senior Notes, if any) originally issued at a redemption price (expressed as a percentage of principal amount) of 108.000%, plus accrued and unpaid interest to the redemption date, with the Net Cash Proceeds (as defined in the indenture governing the 8% Senior Notes) from one or more Public Equity Offerings (as defined in the indenture governing the 8% Senior Notes) (provided that if the Public Equity Offering is an offering by the Company, a portion of the Net Cash Proceeds thereof equal to the amount required to redeem any such 8% Senior Notes is contributed to the equity capital of CHS); provided, however, that:

1) at least 65% of such aggregate principal amount of 8% Senior Notes originally issued remains outstanding immediately after the occurrence of each such redemption (other than the 8% Senior Notes held, directly or indirectly, by the Company or its subsidiaries); and

2) each such redemption occurs within 180 days after the date of the related Public Equity Offering.

CHS is entitled, at its option, to redeem the 8% Senior Notes, in whole or in part, at any time prior to November 15, 2015, upon not less than 30 or more than 60 days notice, at a redemption price equal to 100% of the principal amount of 8% Senior Notes redeemed plus the Applicable Premium (as defined), and accrued and unpaid interest, if any, as of the applicable redemption date.

Other Debt. As of December 31, 2011, other debt consisted primarily of the mortgage obligation on the Company s corporate headquarters and other obligations maturing in various installments through 2020.

To limit the effect of changes in interest rates on a portion of the Company s long-term borrowings, the Company is a party to 34 separate interest swap agreements in effect at December 31, 2011, with an aggregate notional amount of approximately $4.9 billion. On each of these swaps, the Company receives a variable rate of interest based on the three-month LIBOR in exchange for the payment of a fixed rate of interest. The Company currently pays, on a quarterly basis, a margin above LIBOR of 225 basis points for the outstanding balance of revolver loans and term loans due in 2014 and 350 basis points for term loans due in 2017 under the Credit Facility. See Note 7 for additional information regarding these swaps.

As of December 31, 2011, the scheduled maturities of long-term debt outstanding, including capital lease obligations for each of the next five years and thereafter are as follows (in thousands):

Year	Amount
2012	$ 63,706
2013	87,993
2014	4,417,745
2015	1,796,304
2016	18,644
Thereafter	2,462,112
Total	$ 8,846,504

The Company paid interest of $680.7 million, $650.7 million and $657.0 million on borrowings during the years ended December 31, 2011, 2010 and 2009, respectively.

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7. Fair Values of Financial Instruments

The fair value of financial instruments has been estimated by the Company using available market information as of December 31, 2011 and 2010, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Company could realize in a current market exchange (in thousands):

	December 31,			
	2011		2010	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Assets:				
Cash and cash equivalents	$ 129,865	$ 129,865	$ 299,169	$ 299,169
Available-for-sale securities	31,582	31,582	31,570	31,570
Trading securities	30,486	30,486	35,092	35,092
Liabilities:				
Credit Facility	5,979,383	5,780,877	5,999,337	5,882,124
8 7/8 % Senior Notes	1,777,617	1,842,322	2,784,331	2,923,548
8% Senior Notes	1,000,000	995,000		
Other debt	41,143	41,143	36,122	36,122

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

Available-for-sale securities. Estimated fair value is based on closing price as quoted in public markets.

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

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

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

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

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Other debt. The carrying amount of all other debt approximates fair value due to the nature of these obligations.

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

The Company assesses the effectiveness of its hedge instruments on a quarterly basis. For the years ended December 31, 2011 and 2010, the Company completed an assessment of the cash flow hedge instruments and determined the hedges to be highly effective. The Company has also determined that the ineffective portion of the hedges do not have a material effect on the Company s consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements expose the Company to credit risk in the event of nonperformance. However, at December 31, 2011, each swap agreement entered into by the Company was in a net liability position so that the Company would be required to make the net settlement payments to the counterparties; the Company does not anticipate nonperformance by those counterparties. The Company does not hold or issue derivative financial instruments for trading purposes.

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Interest rate swaps consisted of the following at December 31, 2011:

Swap #	Notional Amount (in 000 s)	Fixed Interest Rate	Termination Date	Fair Value of Liability (in 000 s)
1	100,000	3.8470%	January 4, 2012	30
2	100,000	3.8510%	January 4, 2012	30
3	100,000	3.8560%	January 4, 2012	30
4	200,000	3.7260%	January 8, 2012	152
5	200,000	3.5065%	January 16, 2012	281
6	250,000	5.0185%	May 30, 2012	4,509
7	150,000	5.0250%	May 30, 2012	2,709
8	200,000	4.6845%	September 11, 2012	5,574
9	100,000	3.3520%	October 23, 2012	2,161
10	125,000	4.3745%	November 23, 2012	4,104
11	75,000	4.3800%	November 23, 2012	2,466
12	150,000	5.0200%	November 30, 2012	5,900
13	200,000	2.2420%	February 28, 2013	3,550
14	100,000			