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

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the year ended December 31, 2012

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 ☒ 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 ☒

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

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

Indicate by check mark 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. ☒

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

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

The aggregate market value of the voting stock held by non-affiliates of the Registrant was $2,549,100,980. Market value is determined by reference to the closing price on June 30, 2012 of the Registrant's Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2012) have any non-voting common stock outstanding. As of February 20, 2013, there were 92,163,048 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 2013 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, 2012.

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COMMUNITY HEALTH SYSTEMS, INC.
Year ended December 31, 2012

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, 2012, we owned or leased 135 hospitals, comprised of 131 general acute care hospitals and four stand-alone rehabilitation or psychiatric hospitals. These hospitals are geographically diversified across 29 states, with an aggregate of 20,334 licensed beds. We generate revenues by providing a broad range of general and specialized hospital healthcare services and other outpatient services to patients in the communities in which we are located. Services provided through our hospitals and affiliated businesses include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric and rehabilitation services. We also provide additional outpatient services at urgent care centers, occupational medicine clinics, imaging centers, cancer centers, ambulatory surgery centers and home health and hospice agencies. An integral part of providing these services is our relationship and network of affiliated physicians at our hospitals and affiliated businesses. We employ approximately 2,500 physicians and an additional 600 licensed healthcare practitioners. 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 64 licensed home care agencies and 31 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 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. In recent years, our acquisition strategy has also included acquiring selective physician practices and physician-owned ancillary service providers. Such acquisitions are executed in markets where we already have a hospital presence and provide an opportunity to increase the number of affiliated physicians or expand the range of specialized healthcare services provided by our hospitals.

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,” “our,” “us” and the “Company.” This drafting style is suggested by the Securities and Exchange Commission, or SEC, and is not meant to indicate that the publicly-traded Parent Company or any 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.

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

Our objective is to increase shareholder value by providing high-quality patient care using cost effective and efficient operations while pursuing selective growth opportunities. The key elements of our business strategy to achieve this objective 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, recruiting and employing 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,
- 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 and
- executing select managed care contracts through a centrally managed review process.

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.

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. Additionally, in response to the recent trend in physicians seeking employment, we have begun employing more physicians, including, in many instances, acquiring physician practices. We have increased the number of physicians affiliated with us through our recruiting and employment efforts, net of turnover, by approximately 1,147 in 2012, 869 in 2011 and 935 in 2010. The percentage of recruited or other physicians commencing practice with us that were specialists was over 50% in 2012. 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.

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 $197.3 million on 45 major construction projects that were completed in 2012. The 2012 projects included new emergency rooms, cardiac catheterization 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 2012, we spent $96.0 million on construction projects related to three replacement hospitals that we were required to build pursuant to either a hospital purchase agreement or an amendment to a lease agreement. All three of these hospitals were completed and opened in 2012. As part of an acquisition in 2012, we agreed to build a replacement hospital in York, Pennsylvania by July 2017. No capital was spent on this project in 2012. 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 was challenged in the Alabama state circuit and appellate courts but has recently been upheld, with issuance subject to the final resolution of the appeal process. The total cost of these remaining two replacement hospitals is estimated to be $380.0 million.

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 standardized management information systems, 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 2014, with automatic renewal terms of one year unless either party terminates by giving notice of non-renewal.
- *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 with comparison to regional and national benchmarks when available.

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 high reliability/safety and quality 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. We have standardized many of our processes for documenting compliance with accreditation requirements and clinical practices proven to lead to improved patient outcomes. 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 2012.

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 our PSO 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 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 multi-hospital systems in larger metropolitan areas. We believe the acquisition of certain hospitals located in select urban or other geographic regions can provide additional opportunities for increased services and leveraging of our existing presence in some regions as well as reduced costs through shared resources.

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. In 2012, we acquired four hospitals located in Scranton, Pennsylvania; Peckville, Pennsylvania; Blue Island, Illinois and York, Pennsylvania and a large physician practice located in Longview, 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.

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. Pursuant to a hospital purchase agreement in effect as of December 31, 2012, we are required to build a replacement facility in York, Pennsylvania by July 2017. Estimated construction costs, including equipment costs, are approximately $100.0 million for this replacement facility. No capital was spent on this project in 2012. 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. This CON was challenged in the Alabama state circuit and appellate courts but has recently been upheld, with issuance subject to the final resolution of the 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 $3.6 million has been incurred to date. Under other purchase agreements in effect as of December 31, 2012, we have committed to spend $493.5 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, 2012, we have incurred approximately $254.0 million related to these commitments.

Industry Overview

The Centers for Medicare and Medicaid Services, or CMS, reported that in 2011 total U.S. healthcare expenditures grew by 3.9% to approximately $2.7 trillion. CMS also projected total U.S. healthcare spending to grow by 4.2% in 2012 and by an average of 5.7% annually from 2011 through 2021. By these estimates, healthcare expenditures will account for approximately $4.8 trillion, or 19.6% of the total U.S. gross domestic product, by 2021.

Hospital services, the market within the healthcare industry in which we operate, is the largest single category of healthcare at 31.5% of total healthcare spending in 2011, or approximately $850.6 billion, as reported by CMS. CMS projects the hospital services category to grow by at least 4.1% per year through 2021. 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, 19.3% 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,
- 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 2.5% from 2006 to 2011 and are expected to grow by 3.8% from 2011 to 2016. The number of people aged 65 or older in these service areas grew by 7.6% from 2006 to 2011 and is expected to grow by 16.5% from 2011 to 2016. People aged 65 or older comprised 13.9% of the total population in our service areas in 2011, yet they could comprise 15.6% of the total population in our service areas by 2016.

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:

- ample supply 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 in anticipation of and 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.

Trends in Payment for Healthcare Services. As discussed in more detail in the Government Regulation section, the impact of health care reform legislation, combined with the growing financial and economic pressures on the healthcare industry, has resulted in challenges to current and future reimbursement trends. Because of higher healthcare costs and expanded coverage for uninsured patients, the healthcare industry must face the risk that higher deductibles and co-payment requirements for insured patients will increase, resulting in the potential for greater write-offs of uncollectible amounts from those patients.

Shift to Outpatient Services. Because of the growing availability of stand-alone outpatient healthcare facilities and the increase in the services that are able to be provided at these locations, many individuals are seeking a broader range of services at outpatient facilities. This trend has contributed to an increase in outpatient services while inhibiting the growth of inpatient admissions.

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 2012 include a full year of operations for 131 hospitals and partial periods for four hospitals acquired during the year. 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 hospitals which have been sold are excluded from all periods presented.

	Year Ended December 31,		
	2012	2011	2010
	(Dollars in thousands)		
Consolidated Data			
Number of hospitals (at end of period)	135	131	127
Licensed beds (at end of period)(1)	20,334	19,695	19,004
Beds in service (at end of period)(2)	17,265	16,832	16,264
Admissions(3)	701,837	675,050	678,284
Adjusted admissions(4)	1,418,472	1,330,988	1,277,235
Patient days(5)	3,058,931	2,970,044	2,891,699
Average length of stay (days)(6)	4.4	4.4	4.3
Occupancy rate (beds in service)(7)	48.6%	49.1%	50.2%
Net operating revenues	$13,028,985	$11,906,212	$11,092,422
Net inpatient revenues as a % of operating revenues before provision for bad debt	44.7%	46.1%	49.3%
Net outpatient revenues as a % of operating revenues before provision for bad debt	53.4%	51.9%	48.5%
Net income attributable to Community Health Systems, Inc.	$ 265,640	$ 201,948	$ 279,983
Net income attributable to Community Health Systems, Inc. as a % of net operating revenues	2.0%	1.7%	2.5%
Liquidity Data			
Adjusted EBITDA(8)	$ 1,977,715	$ 1,836,650	$ 1,761,484
Adjusted EBITDA as a % of net operating revenues(8)	15.2%	15.4%	15.9%
Net cash flows provided by operating activities	$ 1,280,120	$ 1,261,908	$ 1,188,730
Net cash flows provided by operating activities as a % of net operating revenues	9.8%	10.6%	10.7%
Net cash flows used in investing activities	$ (1,383,202)	$ (1,195,775)	$ (1,044,310)
Net cash flows provided by (used in) financing activities	$ 361,030	$ (235,437)	$ (189,792)

	Year Ended December 31,		(Decrease) Increase
	2012	2011	
	(Dollars in thousands)		
Same-Store Data(9)			
Admissions(3)	668,679	675,050	(0.9)%
Adjusted admissions(4)	1,351,043	1,330,988	1.5%
Patient days(5)	2,902,418	2,970,044	
Average length of stay (days)(6)	4.3	4.4	
Occupancy rate (beds in service)(7)	48.3%	49.1%	
Net operating revenues	$12,438,580	$11,893,095	4.6%
Income from operations	$ 1,198,243	$ 1,164,545	2.9%
Income from operations as a % of net operating revenues	9.6%	9.8%	
Depreciation and amortization	$ 703,236	$ 652,674	
Equity in earnings of unconsolidated affiliates	$ 42,210	$ 49,491	

(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, impairment of long-lived assets, 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.

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, 2012, 2011 and 2010 (in thousands):

	Year Ended December 31,		
	2012	2011	2010
Adjusted EBITDA	$1,977,715	$1,836,650	$1,761,484
Interest expense, net	(622,933)	(644,410)	(647,593)
Provision for income taxes	(157,502)	(137,653)	(163,681)
Deferred income taxes	53,407	107,032	97,370
Loss from operations of hospitals sold	(466)	(7,769)	(6,772)
Depreciation and amortization of discontinued operations	—	4,991	14,842
Stock-based compensation expense	40,896	42,542	38,779
Excess tax benefit relating to stock-based compensation	(3,973)	(5,290)	(10,219)
Other non-cash expenses, net	33,251	28,716	12,503
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	(204,151)	(138,332)	(27,049)
Supplies, prepaid expenses and other current assets	(99,799)	(42,858)	(39,904)
Accounts payable, accrued liabilities and income taxes	246,301	246,110	161,952
Other	17,374	(27,821)	(2,982)
Net cash provided by operating activities	$1,280,120	$1,261,908	$1,188,730

(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.

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

	Year Ended December 31,		
	2012	2011	2010
Medicare	26.0%(1)	26.8%	27.4%
Medicaid	9.8%	9.7%	10.7%
Managed Care and other third-party payors	51.2%	51.5%	50.4%
Self-pay	13.0%	12.0%	11.5%
Total	100.0%	100.0%	100.0%

(1) Excludes the $84.3 million reimbursement settlement and payment update as discussed below.

As shown above, we receive a substantial portion of our revenues from the Medicare and Medicaid programs. Included in Managed Care and other third-party payors is operating revenues from insurance companies with which we have insurance provider contracts, Medicare managed care, insurance companies for which we do not have insurance provider contracts, workers' compensation carriers and non-patient service revenue, such as rental income and cafeteria sales. In the future, we generally expect revenues received from the Medicare and Medicaid programs to increase due to the general aging of the population. In addition, as discussed below, the Reform Legislation should increase the number of insured patients, which, in turn, 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. The trend toward increased enrollment in Medicare managed care may adversely affect our operating revenue growth. Other provisions in the Reform Legislation impose minimum medical-loss ratios and require insurers to meet specific benefit requirements. Furthermore, in the normal course of business, managed care programs, insurance companies and employers actively negotiate the amounts paid to hospitals. 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 and 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 20.

As of December 31, 2012, Indiana, Texas and Pennsylvania represented our only areas of geographic concentration. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated in Indiana, as a percentage of consolidated operating revenues, were 10.5% in 2012, 10.3% in 2011 and 10.6% in 2010. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated in Texas, as a percentage of consolidated operating revenues, were 14.4% in 2012, 13.1% in 2011 and 13.0% in 2010. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated in Pennsylvania, as a percentage of consolidated operating revenues, were 12.6% in 2012, 11.5% in 2011 and 10.3% in 2010.

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, as originally enacted, is expected to expand health insurance coverage through a combination of public program expansion and private sector health insurance reforms. We believe the expansion of private sector and Medicaid coverage will, over time, increase our reimbursement related to providing services to individuals who were previously uninsured, which should reduce our expense from uncollectible accounts receivable. The Reform Legislation also makes a number of other changes to Medicare and Medicaid, such as reductions to the Medicare annual market basket update for federal

fiscal years 2010 through 2019, a productivity offset to the Medicare market basket update which began October 1, 2011, and a reduction to the Medicare and Medicaid disproportionate share payments, that could adversely impact the reimbursement received under these programs. The various provisions in the Reform Legislation that directly or indirectly affect reimbursement are scheduled to take effect over a number of years. Over time, we believe the net impact of the overall changes as a result of the Reform Legislation will have a positive effect on our net operating revenues. 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.

On June 28, 2012, the Supreme Court of the United States largely upheld the constitutionality of the Reform Legislation, though it overturned an aspect of the legislation that would have permitted the Federal government to withhold all Medicaid funding from a state if that state did not expand Medicaid coverage to the extent required by the Reform Legislation. The Supreme Court's ruling instead held that only new incremental funding could be withheld from a state in such a situation. As a result, states will face less severe financial consequences if they refuse to expand Medicaid coverage to individuals with incomes below certain thresholds. Since the Supreme Court's ruling, some states have suggested that, for budgetary and other reasons, they would not expand their Medicaid programs. If states refuse to expand their Medicaid programs, the number of uninsured patients at our hospitals will decline by a smaller margin as compared to our expectations when the Reform Legislation was first adopted. In response to the Supreme Court ruling, the previous estimates of the reduction in uninsured individuals as a result of the Reform Legislation have been revised, with approximately 27 million additional individuals expected to have health insurance coverage by 2017. Because of the many variables involved, including clarifications and modifications resulting from the rule-making process, the development of agency guidance and future judicial interpretations, whether and how many states decide to expand or not to expand Medicaid coverage, the number of uninsured who elect to purchase health insurance coverage, and budgetary issues at federal and state levels, we may not be able to realize the positive impact the Reform Legislation may have on our business, results of operations, cash flow, capital resources and liquidity. Furthermore, we cannot predict whether we will be able to modify certain aspects of our operations to offset any potential adverse consequences from the Reform Legislation.

In a number of markets, we have partnered with local physicians in the ownership of our facilities. Such investments have been permitted under an exception to the 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 are now prohibited, from the time the Reform Legislation became effective, from increasing the aggregate percentage of their ownership in the hospital. The Reform Legislation also restricts the ability of existing physician-owned hospitals to expand the capacity of their facilities.

In addition to the Reform Legislation, the American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act, or HITECH. These provisions were designed to increase the use of electronic health records, or EHR, technology and establish the requirements for a Medicare and Medicaid incentive payments program beginning in 2011 for eligible hospitals and providers that adopt and meaningfully use certified EHR technology. These incentive payments are intended to offset a portion of the 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.

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,
- 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 required 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.

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 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, 2012, we operated 58 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 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. Use of the ICD-10 code sets is mandatory on October 1, 2014, so we are 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 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 2013, 2012, 2011, and 2010, by 2.6%, 3.0%, 2.6%, and 2.1%, 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 documentation and coding practices related to the Medicare severity diagnosis-related group known as "MS-DRG", system. 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. In addition, for federal fiscal year 2013, the DRG payment rates were increased by 2.9% to restore the one-time recoupment adjustment made to the national standardized amount for federal fiscal year 2012 and reduced by 1.9% for documentation and coding; reduced by 0.7% for the multi-factor productivity adjustment; and reduced by 0.1% in accordance with the

Reform Legislation. The rates are also adjusted for readmission reduction factors and value-based purchasing factors for federal fiscal year 2014. For behavioral changes in coding practices related to MS-DRGs, the American Taxpayer Relief Act of 2012 provides for an approximate 2% reduction to Medicare inpatient PPS DRG rates for federal fiscal year 2014. 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 operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), were 1.3%, 1.5% and 1.7% for the years ended December 31, 2012, 2011 and 2010, respectively. Effective at the beginning of federal fiscal year 2014, Medicare disproportionate share payments will be reduced by 75% in accordance with the Reform Legislation. The funds from the 75% Medicare disproportionate share reduction are reduced as the U.S. uninsured population declines and are then returned to hospitals depending on the amount of uncompensated care they provide. The funds from the 75% Medicare disproportionate share reduction will continue to be reduced over time as the uninsured population decreases. At this time, we cannot predict an impact for this change. Hospitals may also qualify for Medicaid disproportionate share payments when they qualify under the state established guidelines. These Medicaid disproportionate share payments as a percentage of operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), were 0.4%, 0.5% and 0.4% for the years ended December 31, 2012, 2011 and 2010, 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, at 85% of the hold harmless amount. 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, at 85% of the hold harmless amount. Of our 131 hospitals at December 31, 2011, 45 qualified for this relief. The Middle Class Tax Relief and Job Creation Act extended the hold harmless provision for non-urban hospitals with 100 beds or less, including non-urban sole community hospitals, through December 31, 2012, at 85% of the hold harmless amount. Of our 135 hospitals at December 31, 2012, 46 qualified for this relief. 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 occurred. The outpatient conversion factor was increased 2.6% effective January 1, 2013; however, coupled with adjustments to other variables with outpatient PPS, an approximate 1.6% to 2.0% 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 2.0% on January 1, 2010; however, coupled with adjustments to other variables with home health agency PPS, an approximate 2.3% net 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 occurred. The home health agency PPS per episodic payment rate increased by 2.3% on January 1, 2013; however, coupled with adjustments to other variables with home health agency PPS, an approximate 0.01% 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.

The Medicare reimbursement discussed above could be reduced in 2013 due to federal legislation that requires across-the-board spending cuts to the federal budget, also known as sequestration. These sequestration cuts include reductions in payments for Medicare and other federally funded healthcare programs, including TRICARE. Such cuts were originally identified to go into effect on January 1, 2013 as part of the Budget Control Act of 2011, which was passed as the result of attempts by the government to reduce the federal budget deficit. The passage of the American Taxpayer Relief Act of 2012 delayed the effective date of the sequestration until March 1, 2013, with the sequester-related Medicare reimbursement cuts occurring sometime after April 1, 2013. We cannot determine at this time whether the sequester-related cuts to reimbursement will be postponed further, amended, or eliminated entirely. If the sequestration cuts occur as currently scheduled, they could have a material impact on our net operating revenues and cash flows.

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. As of December 31, 2012, we have a 17.4% 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.

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 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, 2012, we employed approximately 72,000 full-time employees and 24,000 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.

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. Our wholly-owned subsidiary CHS/Community Health Systems, Inc., or CHS, has obtained senior secured financing under a credit facility, or Credit Facility, with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The table below shows our level of indebtedness and other information as of December 31, 2012. As of December 31, 2012, a $750 million revolving credit facility was available to us for working capital and general corporate purposes under the Credit Facility, with $37.8 million of the revolving credit facility being set aside for outstanding letters of credit. 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 (subject to customary acceleration events), 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 term loans due 2014 under the Credit Facility, until January 25, 2017 (subject to customary acceleration events). On March 6, 2012, we obtained a new $750 million incremental term loan A facility, or the Incremental Term Loan, with a maturity date of October 25, 2016, subject to customary acceleration events and to earlier maturity if the repayment, extension or refinancing with longer maturity debt of substantially all of our outstanding term loans maturing on July 25, 2014 and the now fully redeemed 8⅞% Senior Notes due 2015, or the 8⅞% Senior Notes, does not occur by April 25, 2014. The proceeds of the Incremental Term Loan were used to prepay the same amount of the existing term loans due July 25, 2017 under the Credit Facility. On August 22, 2012, we entered into a loan modification agreement with respect to the Credit Facility to extend approximately $340 million of the term loans due 2014 to match the maturity date and interest rate margins of the term loans due January 25, 2017. After the prepayment of $1.6 billion of the term loans due 2014 from the issuance of the 5⅛% Senior Secured Notes discussed below, the remaining approximately $266.1 million 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 due 2019, 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 CHS' then outstanding 8⅞% 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. On March 21, 2012, CHS completed its offering of $1.0 billion aggregate principal amount of additional 8% Senior Notes. The net proceeds from this issuance, together with available cash on hand, were used to finance the purchase of approximately $850 million aggregate principal amount of the then

outstanding 8⅞% Senior Notes, to pay related fees and expenses and for general corporate purposes. On July 18, 2012, CHS completed its offering of $1.2 billion aggregate principal amount of 7⅛% Senior Notes due 2020, or the 7⅛% Senior Notes. A portion of the net proceeds from this issuance were used to purchase approximately $639.7 million principal amount (out of the then approximately $934.3 million total aggregate principal amount outstanding) of 8⅞% Senior Notes that were validly tendered and not validly withdrawn in the cash tender offer commenced on July 3, 2012, to pay for consents delivered in connection therewith and to pay related fees and expenses. On August 17, 2012, pursuant to our redemption option, we redeemed the remaining $294.6 million principal outstanding of the 8⅞% Senior Notes. The 8% Senior Notes and the 7⅛% Senior Notes are its unsecured senior obligations and are guaranteed on a senior basis by us and by certain of our domestic subsidiaries. On August 17, 2012, CHS completed its offering of $1.6 billion aggregate principal amount of 5⅛% Senior Secured Notes due 2018, or the 5⅛% Senior Secured Notes. The net proceeds from this issuance, together with available cash on hand, were used to finance the prepayment of $1.6 billion of the then outstanding term loans due 2014 under the Credit Facility and related fees and expenses.

On March 21, 2012, we entered into an accounts receivable loan agreement, or the Receivables Facility, with a group of lenders and banks with a maximum borrowing capacity of $300 million and with an expiration date of March 21, 2014. The existing and future patient-related accounts receivable for certain of the Company's hospitals serve as collateral for the outstanding borrowings under the Receivables Facility. The outstanding borrowings at December 31, 2012, pursuant to the Receivables Facility totaled $300.0 million.

With the exception of some small principal payments of our term loans under our Credit Facility, approximately $266.1 million of term loans under our Credit Facility mature in 2014, the remaining $3.4 billion in term loans mature in 2017, our 5⅛% Senior Secured Notes are due in 2018, our 8% Senior Notes are due in 2019 and our 7⅛% Senior Notes are due 2020. The remaining $712.5 million in term loans under the incremental term loan A facility mature in 2016 and require quarterly amortization payments of 1⅔% per quarter in 2012, 2.5% per quarter during 2013 and 2014, 3.75% per quarter during 2015 and 15% per quarter during 2016 through the maturity date, in each case, subject to customary adjustments for prepayments, with the balance payable in full on the maturity date.

	December 31, 2012
	($ in millions)
Senior secured credit facility term loans	$4,331.6
8% Senior Notes	2,022.8
7⅛% Senior Notes	1,200.0
5⅛% Senior Secured Notes	1,600.0
Receivables Facility	300.0
Other	86.9
Total debt	$9,541.3
Community Health Systems, Inc. stockholders' equity	$2,731.2

As of December 31, 2012, our approximately $3.1 billion notional amount of interest rate swap agreements represented approximately 67% 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, 2012, would result in interest expense fluctuating approximately $15.3 million per year.

The Credit Facility and/or the 8% Senior Notes, the 7⅛% Senior Notes and the 5⅛% Senior Secured Notes, or collectively known as the 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 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, 2012, 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 Notes. Upon the occurrence of an event of default under our Credit Facility or the Notes, all amounts outstanding under our Credit Facility and the Notes may become immediately due and payable and all commitments under the Credit Facility to extend further credit may be terminated.

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,
- 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,				
	2008	2009	2010	2011	2012
Ratio of earnings to fixed charges(1)	1.47x	1.60x	1.69x	1.61x	1.66x

(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 Notes do not fully prohibit us from doing so. For example, under the indentures for the 8% Senior Notes, the 7⅛% Senior Notes and the 5⅛% Senior Secured Notes, we may incur up to approximately $5.0 billion pursuant to a credit facility and $300 million for a qualified receivables transaction, less certain amounts repaid with the proceeds of asset dispositions. As of December 31, 2012, our Credit Facility and Receivables Facility provided for commitments of up to approximately $5.3 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. 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.

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 nearly 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; 26 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.

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 2014, 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, 2012, we had approximately $4.4 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.

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, as originally enacted, is expected to expand health insurance coverage through a combination of public program expansion and private sector health insurance reforms. We believe the expansion of private sector and Medicaid coverage will, over time, increase our reimbursement related to providing services to individuals who were previously uninsured, which should reduce our expense from uncollectible accounts receivable. The Reform Legislation also makes a number of other changes to Medicare and Medicaid, such as reductions to the Medicare annual market basket update for federal fiscal years 2010 through 2019, a productivity offset to the Medicare market basket update which began October 1, 2011, and a reduction to the Medicare and Medicaid disproportionate share payments, that could adversely impact the reimbursement received under these programs. The various provisions in the Reform Legislation that directly or indirectly affect reimbursement are scheduled to take effect over a number of years. Over time, we believe the net impact of the overall changes as a result of the Reform Legislation will have a positive effect on our net operating revenues. 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.

On June 28, 2012, the Supreme Court of the United States largely upheld the constitutionality of the Reform Legislation, though it overturned an aspect of the legislation that would have permitted the Federal government to withhold all Medicaid funding from a state if that state did not expand Medicaid coverage to the extent required by the Reform Legislation. The Supreme Court's ruling instead held that only new incremental funding could be withheld from a state in such a situation. As a result, states will face less severe financial consequences if they refuse to expand Medicaid coverage to individuals with incomes below certain thresholds. Since the Supreme Court's ruling, some states have suggested that, for budgetary and other reasons, they would not expand their Medicaid programs. If states refuse to expand their Medicaid programs, the number of uninsured patients at our hospitals will decline by a smaller margin as compared to our expectations when the Reform Legislation was first adopted. In response to the Supreme Court ruling, the previous estimates of the reduction in uninsured individuals as a result of the Reform Legislation have been revised, with approximately 27 million additional individuals expected to have health insurance coverage by 2017. Because of the many variables involved, including clarifications and modifications resulting from the rule-making process, the development of agency guidance and future judicial interpretations, whether and how many states decide to expand or not to expand Medicaid coverage, the number of uninsured who elect to purchase health insurance coverage, and budgetary issues at federal and state levels, we may not be able to realize the positive impact the Reform Legislation may have on our business, results of operations, cash flow, capital resources and liquidity. Furthermore, we cannot predict whether we will be able to modify certain aspects of our operations to offset any potential adverse consequences from the Reform Legislation.

In a number of markets, we have partnered with local physicians in the ownership of our facilities. Such investments have been permitted under an exception to the 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 are now prohibited, from the time the Reform Legislation became effective, from increasing the aggregate percentage of their ownership in the hospital. The Reform Legislation also restricts the ability of existing physician-owned hospitals to expand the capacity of their facilities.

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 2012, 35.8% of our operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), 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.

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.

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, was relatively unchanged in 2012, and decreased by 0.2% and 0.3% in 2011 and 2010, respectively. 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 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 there are delays in regulatory updates by governmental entities to federal and state healthcare programs, we may experience increased volatility in our operating results as such delays may result in a timing difference between when such program revenues are earned and when they become known or estimable for purposes of accounting recognition.

We derive a significant amount of our net operating revenues from governmental health care programs, primarily from the Medicare and Medicaid programs. The reimbursements due to us from those programs are subject to legislative and regulatory changes that can have a significant impact on our operating results. When delays occur in the passage of regulations or legislation, there is the potential for material increases or decreases in operating revenues to be recognized in periods subsequent to when such related services were performed, resulting in the potential for a material effect on our consolidated financial position and consolidated results of operations.

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 similar expressions are forward-looking statements. These statements involve known and unknown risks, uncertainties and other factors that may cause our actual results and performance to be materially different from any future results or performance expressed or implied by these forward-looking statements. These factors include the following:

- general economic and business conditions, both nationally and in the regions in which we operate,
- implementation and effect of adopted and potential federal and state healthcare 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, which could result in, among other things, disputes and changes in reimbursements, both prospectively and retroactively,
- changes in inpatient or outpatient Medicare and Medicaid payment levels,
- increases in the amount and risk of collectability of patient accounts receivable,
- increases in wages as a result of inflation or competition for highly technical positions and rising supply costs due to market pressure from pharmaceutical companies and new product releases,
- liabilities and other claims asserted against us, including self-insured malpractice claims,
- competition,
- our ability to attract and retain, at reasonable employment costs, qualified personnel, key management, physicians, nurses and other healthcare workers,
- trends toward treatment of patients in less acute or specialty healthcare settings, including ambulatory surgery centers or specialty hospitals,
- changes in medical or other technology,
- changes in accounting principles generally accepted in the United States of America, or 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.

For each of our hospitals owned or leased as of December 31, 2012, 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 Health System				
Northwest Medical Center — Bentonville	Bentonville	128	July, 2007	Owned
Northwest Medical Center — Springdale	Springdale	222	July, 2007	Owned
Northwest Medical Center — Willow Creek Women's Hospital	Johnson	64	July, 2007	Owned
Siloam Springs Regional Hospital	Siloam Springs	73	February, 2009	Owned
Medical Center of South Arkansas	El Dorado	166	April, 2009	Leased
California				
Barstow Community Hospital	Barstow	30	January, 1993	Owned
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
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
MetroSouth Medical Center	Blue Island	330	March, 2012	Owned
Vista Medical Center East	Waukegan	336	July, 2006	Owned

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
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
Lutheran Health Network				
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
New Mexico				
Mimbres Memorial Hospital	Deming	25	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
Valleycare System of Ohio				
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

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
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	Owned
Oregon				
McKenzie-Willamette Medical Center	Springfield	113	July, 2007	Owned
Pennsylvania				
Commonwealth Health Network				
Berwick Hospital	Berwick	101	March, 1999	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
Moses Taylor Hospital	Scranton	217	January, 2012	Owned
Mid-Valley Hospital	Peckville	25	January, 2012	Owned
Brandywine Hospital	Coatesville	246	June, 2001	Owned
Chestnut Hill Hospital	Philadelphia	135	February, 2005	Owned
Easton Hospital	Easton	254	October, 2001	Owned
Jennersville Regional Hospital	West Grove	62	October, 2001	Owned
Lock Haven Hospital	Lock Haven	47	August, 2002	Owned
Pottstown Memorial Medical Center	Pottstown	224	July, 2003	Owned
Phoenixville Hospital	Phoenixville	137	August, 2004	Owned
Sunbury Community Hospital	Sunbury	89	October, 2005	Owned
Memorial Hospital	York	100	July, 2012	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
Mary Black Memorial Hospital	Spartanburg	207	July, 2007	Owned
Carolinas Hospital System — Florence	Florence	420	July, 2007	Owned
Carolinas Hospital System — Marion	Mullins	124	July, 2010	Owned
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	116	October, 1994	Leased
Lake Granbury Medical Center	Granbury	83	January, 1997	Leased

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
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	167	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	85	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				
Rockwood Health System				
Deaconess Hospital	Spokane	388	October, 2008	Owned
Valley Hospital	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
Wyoming				
Evanston Regional Hospital	Evanston	42	November, 1999	Owned
Total Licensed Beds at December 31, 2012		20,334		

(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, 2012. 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	320
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 and administrative demands concerning certain cardiology procedures, medical records and policies 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 consolidated 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. Also, from time to time, we detect issues of non-compliance with Federal healthcare laws pertaining to claims submission and reimbursement practices and/or financial relationships with physicians. We avail ourselves of various mechanisms to address potential overpayments arising out of these issues, including repayment of claims, rebilling of claims, and participation in voluntary disclosure protocols offered by the Centers for Medicare and Medicaid Services and the Office of the Inspector General. Participating in voluntary repayments and voluntary disclosure protocols can have the potential for significant settlement obligations or even enforcement action, however, we are not aware of any such exposures that have not been reserved for in our consolidated financial statements or which we believe would have a material adverse impact on us.

The following items have been previously disclosed in our annual and/or quarterly reports, however, the narrative descriptions have been reorganized and revised to shorten and better summarize the disclosures.

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

Our knowledge of this matter originated in early 2006 with correspondence from the Civil Division of the Department of Justice requesting documents in an investigation it was conducting involving the Company. The inquiry related to the way in which different state Medicaid programs apply to the federal government for

matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients. These programs are referred to by different names, including "intergovernmental payments," "upper payment limit programs," and "Medicaid disproportionate share hospital payments." For approximately three years, we provided the Department of Justice with requested documents, met with its personnel on numerous occasions and otherwise cooperated in its investigation. During the course of the investigation, the Civil Division notified us that it believed that we and three of our New Mexico hospitals caused the State of New Mexico to submit improper claims for federal funds, in violation of the Federal False Claims Act. This investigation has culminated in the federal government's intervention in the referenced qui tam lawsuit, which alleges that our New Mexico hospitals "caused to be filed" false claims from the period of August 2000 through June 2011. Two of our parent company's subsidiaries are also defendants in this lawsuit. We continue to vigorously defend this action. The current posture of this case is that discovery is closed and both parties' motions for summary judgment have been on file for approximately 11 months. There is currently no hearing date on these motions and no trial date has been set.

Multi-provider National Department of Justice Investigations

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

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

Laredo, Texas Department of Justice Investigation

In December 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. In January 2010, we received a "request for information or assistance" from the OIG's Office of Investigation requesting patient medical records from this facility for certain Medicaid patients with an extended lengths of stay. We continue to cooperate fully with this investigation.

Department of Justice Investigation of Medicare Short-Stay Admissions from Emergency Departments

In April 2011, we received a document subpoena 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 was directed to all of our hospitals and requested documents concerning emergency

department processes and procedures, including our hospitals' use of the Pro-MED Clinical Information System, a third-party software system that assists with the management of patient care and provides operational support and data collection for emergency department management. The subpoena also sought information about our relationships with emergency department physicians, including financial arrangements. This investigation is being led by the Department of Justice. We are continuing to cooperate with the government with the ongoing document production, as well as conducting a joint medical necessity review of a sampling of medical records at a small number of hospitals.

The following matters, although initiated independently of the Department of Justice's April 2011 subpoena, are factually related in some manner to that subpoena and are grouped here for clarity.

Texas Attorney General Investigation of Emergency Department Procedures and Billing. In November 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 concerns emergency department procedures and billing. We have complied with these requests and provided all documentation and reports requested. We continue to cooperate fully with this investigation.

United States ex rel. and Reuille vs. Community Health Systems Professional Services Corporation and Lutheran Musculoskeletal Center, LLC d/b/a Lutheran Hospital (United States District Court for the Northern District of Indiana, Fort Wayne Division). This lawsuit was originally filed under seal in January 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. In December 2010, the government filed a notice that it declined to intervene in this suit. On April 22, 2011, a joint motion was filed by the relator and the Department of Justice to extend the period of time for the relator to serve us in the case to allow the government more time to decide if it will intervene in the case. The motion to stay was granted, as have subsequent joint motions, and the stay is currently continued until April 29, 2013. The original motion and subsequent filings gave insight to the fact that there are other qui tam complaints in other jurisdictions and that the government was consolidating its investigations and working cooperatively with other investigative bodies (including the Attorney General of the State of Texas). The government also 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 government's consolidated investigation. We are cooperating fully with the government in its investigations.

Shelbyville, Tennessee OIG Subpoena. In May 2011, we received a subpoena 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. We provided the requested records and have met with the government regarding this matter. We continue to cooperate fully with this investigation.

SEC Subpoena. In May 2011, we received a subpoena from the SEC requesting documents related to or requested in connection with the various inquiries, lawsuits and investigations regarding, generally, emergency room admissions or observation practices at our hospitals. The subpoena also requested documents relied upon by us in responding to the Tenet litigation, as well as other communications about the Tenet litigation. As with all government investigations, we are cooperating fully with the SEC.

Class Action Shareholder Federal Securities Cases. Three purported class action cases have been filed in the United States District Court for the Middle District of Tennessee; namely, Norfolk County Retirement System v. Community Health Systems, Inc., et al., filed May 5, 2011; De Zheng v. Community Health Systems, Inc., et al., filed May 12, 2011; and Minneapolis Firefighters Relief Association v. Community Health Systems, Inc., et al., filed June 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. In December 2011, the cases were consolidated for pretrial purposes and NYC Funds and its counsel were selected as lead plaintiffs/lead plaintiffs' counsel. Our motion to dismiss this case has been fully briefed and is pending before the court. We believe this consolidated matter is without merit and will vigorously defend this case.

Shareholder Derivative Actions. Three purported shareholder derivative actions have also been filed in the United States District Court for the Middle District of Tennessee; Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund v. Wayne T. Smith, et al., filed May 24, 2011; Roofers Local No. 149 Pension Fund v. Wayne T. Smith, et al., filed June 21, 2011; and Lambert Sweat v. Wayne T. Smith, et al., filed October 5, 2011. These three cases allege breach of fiduciary duty arising out of allegedly improper inpatient admission practices, mismanagement, waste and unjust enrichment. These cases have been consolidated into a single, consolidated action. The plaintiffs filed an operative amended derivative complaint in these three consolidated actions on March 15, 2012. Our motion to dismiss has been fully briefed and is pending before the court. We believe all of these matters are without merit and will vigorously defend them.

Other Government Investigations

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

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

Qui Tam Cases — Government Declined Intervention

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

On February 2, 2012, an order was entered unsealing a relator's qui tam complaint in the matter of *U.S. ex rel. Pamela Gronemeyer 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. The allegations in this case pertain to blood administration practices at an affiliated Illinois hospital. We were served in this case on April 18, 2012. In an amended filing in November 2012, the relator dropped her qui tam claims and is proceeding on a wrongful

(retaliatory) termination claim only, even though she was never an employee of the hospital. We have filed a motion to dismiss this case. We believe the claim against our hospital is without merit and we are vigorously defending this case. Due to the change in character of this case, we will no longer refer to it in our reports.

On August 8, 2012, an order was entered unsealing a relator's qui tam complaint in the matter of *U.S. and N.M. ex rel. Sally Hansen v. Mimbres Memorial Hospital, et al*. This action is pending in the United States District Court for New Mexico. This case cites alleged quality control failures as violations of the Clinical Laboratory Improvement Amendments of 1988 as the basis for a False Claims Act suit. Both the U.S. government and the New Mexico state government declined to intervene in this case. We have filed a motion to dismiss this case. We believe the claim against our hospital is without merit and we are vigorously defending this case.

Commercial Litigation and Other Lawsuits

Managed Care Solutions, Inc. v. Community Health Systems, Inc. (United States District Court for the Southern District of Florida). This suit was filed on February 4, 2010. Plaintiff contracted with two affiliated hospitals to provide services collecting receivables from third-party payors. Plaintiff sought to extend the contract to additional facilities at which it never provided any services and claimed $435 million in damages. A motion for summary judgment was filed on February 17, 2012. On June 4, 2012, the District Court affirmed the recommendation of the Magistrate Judge limiting the Plaintiff's claims to only two hospitals. The Court has continued the trial until July 2013 and our renewed motion for summary judgment has been fully briefed and is waiting disposition. We will continue to vigorously defend this action.

Becker v. Community Health Systems, Inc. d/b/a Community Health Systems Professional Services Corporation d/b/a Community Health Systems d/b/a Community Health Systems PSC, Inc. d/b/a Rockwood Clinic P.S. and Rockwood Clinic, P.S. (Superior Court, Spokane, Washington). This suit was filed on February 29, 2012, by a former chief financial officer at Rockwood Clinic in Spokane, Washington. Becker claims he was wrongfully terminated for allegedly refusing to certify a budget for Rockwood Clinic in 2012. On February 29, 2012, he also filed an administrative complaint with the Department of Labor, Occupational Safety and Health Administration alleging that he is a whistleblower under Sarbanes-Oxley; a response was filed on May 21, 2012. At a hearing on July 27, 2012, the court dismissed Community Health Systems, Inc. from this case and has subsequently certified the case for an interlocutory appeal of the denial to dismiss his employer and the management company. We are vigorously defending this action.

Management of Significant Legal Proceedings

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

In addition, the Audit and Compliance Committee and the other independent members of the Board of Directors oversee the functions of the voluntary compliance program, including its auditing and monitoring functions and confidential disclosure program. In recent years, the voluntary compliance program has addressed the potential for a variety of billing errors that might be the subject of audits and payment denials by the CMS Recovery Audit Contractors' permanent project, including MS-DRG coding, outpatient hospital and physician

coding and billing, and medical necessity for services (including a focus on hospital stays of very short duration). Efforts by management, through the voluntary compliance program, to identify and limit risk from these government audits have included significant policy and guidance revisions, training and education, and auditing.

Since April 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 our Board of Directors remain fully engaged in the oversight of these matters.

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 20, 2013, there were approximately 45 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.

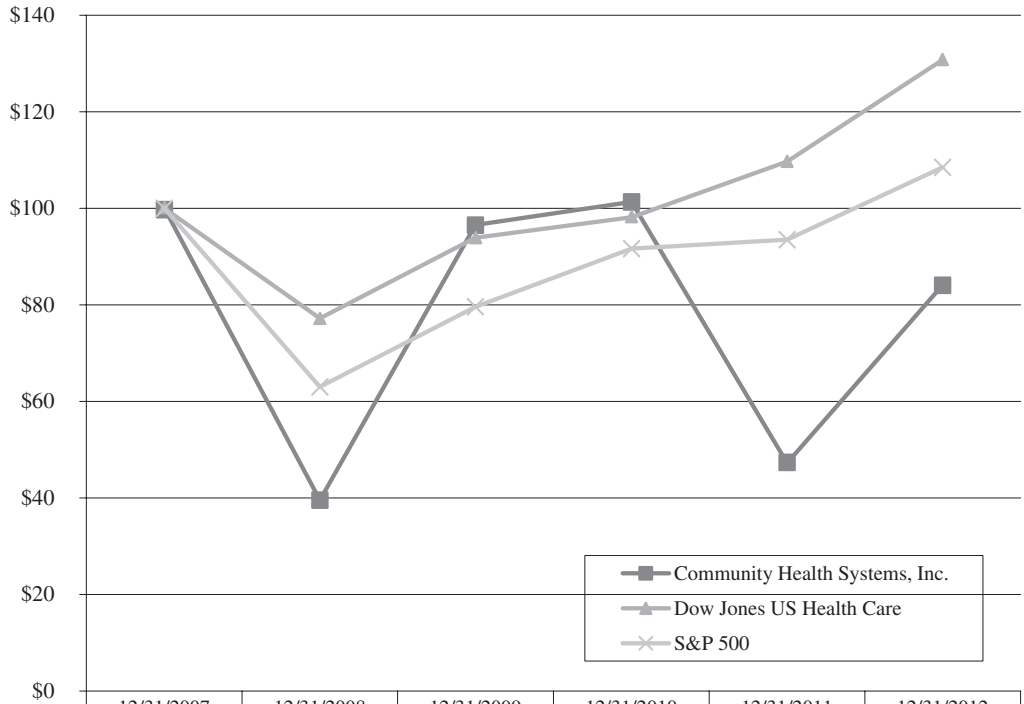
	High	Low
Year Ended December 31, 2011		
First Quarter	$42.50	$34.62
Second Quarter	41.09	22.33
Third Quarter	27.63	15.91
Fourth Quarter	21.92	14.61
Year Ended December 31, 2012		
First Quarter	$25.74	$16.37
Second Quarter	28.79	20.71
Third Quarter	29.59	22.51
Fourth Quarter	32.70	26.33

Stock Performance Graph

The following graph sets forth the cumulative return of our common stock during the five year period ended December 31, 2012, 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.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN*

Among Community Health Systems, Inc., the S&P 500 Index, and the Dow Jones US Health Care Index



	12/31/2007	12/31/2008	12/31/2009	12/31/2010	12/31/2011	12/31/2012
Community Health Systems, Inc.	$100.00	$39.56	$96.58	$101.38	$47.34	$84.10
S&P 500	$100.00	$63.00	$79.67	$91.67	$93.61	$108.59
Dow Jones US Health Care	$100.00	$77.20	$93.96	$98.20	$109.74	$130.87

Historically, we have not paid any cash dividends. In December 2012, we declared and paid a special dividend of $0.25 per share to holders of our common stock at the close of business as of December 17, 2012, which totaled approximately $23.0 million. In the foreseeable future, we do not anticipate the payment of any other cash dividends. Our Credit Facility limits our ability to pay dividends and/or repurchase stock to an amount not to exceed $150 million in the aggregate plus the aggregate amount of proceeds from the exercise of stock options. The indentures governing our 8% Senior Notes due 2019, our 7⅛% Senior Notes due 2020 and our 5⅛% Senior Secured Notes due 2018 also limit our ability to pay dividends and/or repurchase stock. As of December 31, 2012, under the most restrictive test under these agreements, we have approximately $178.1 million available with which to pay permitted dividends and/or repurchase shares of stock or our Notes.

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, 2012, 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 year ended December 31, 2012, 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, 2012 is 3,921,138 shares at a weighted-average price of $25.39 per share.

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,				
	2012	2011	2010	2009	2008
	(in thousands, except share and per share data)				
Consolidated Statement of Income Data					
Net operating revenues	$13,028,985	$11,906,212	$11,092,422	$10,333,501	$ 9,398,781
Income from operations	1,210,124	1,134,485	1,121,044	1,064,831	970,086
Income from continuing operations	346,269	335,894	355,213	305,811	238,386
Net income	345,803	277,623	348,441	306,377	252,734
Net income attributable to noncontrolling interests	80,163	75,675	68,458	63,227	34,430
Net income attributable to Community Health Systems, Inc.	265,640	201,948	279,983	243,150	218,304
Basic earnings per share attributable to Community Health Systems, Inc. common stockholders(1):					
Continuing operations	$ 2.98	$ 2.89	$ 3.13	$ 2.68	$ 2.18
Discontinued operations	(0.01)	(0.65)	(0.07)	—	0.16
Net income	$ 2.98	$ 2.24	$ 3.05	$ 2.68	$ 2.34
Diluted earnings per share attributable to Community Health Systems, Inc. common stockholders(1):					
Continuing operations	$ 2.96	$ 2.87	$ 3.08	$ 2.65	$ 2.16
Discontinued operations	0.01	(0.64)	(0.07)	—	0.16
Net income	$ 2.96	$ 2.23	$ 3.01	$ 2.66	$ 2.32
Weighted-average number of shares outstanding:					
Basic	89,242,949	89,966,933	91,718,791	90,614,886	93,371,782
Diluted(2)	89,806,937	90,666,348	92,946,048	91,517,274	94,288,829
Consolidated Balance Sheet Data					
Cash and cash equivalents	$ 387,813	$ 129,865	$ 299,169	$ 344,541	$ 220,655
Total assets	16,606,335	15,208,840	14,698,123	14,021,472	13,818,254
Long-term obligations	11,298,928	10,437,513	10,418,234	10,179,402	10,287,535
Redeemable noncontrolling interests in equity of consolidated subsidiaries	367,666	395,743	387,472	368,857	348,816
Community Health Systems, Inc. stockholders' equity	2,731,207	2,397,096	2,189,464	1,950,635	1,611,029
Noncontrolling interests in equity of consolidated subsidiaries	65,314	67,349	60,913	64,782	61,457

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

(2) See Note 12 to the Consolidated Financial Statements, included in Item 8 of this Form 10-K.

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 revenues by providing a broad range of general and specialized hospital and other outpatient healthcare services to patients in the communities in which we are located. As of December 31, 2012, we owned or leased 135 hospitals comprised of 131 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.

As further discussed in Recent Accounting Pronouncements, during the first quarter of 2012 we adopted the provisions of Accounting Standards Update, or ASU, No. 2011-07 of the Financial Accounting Standards Board, or FASB, which requires us to present revenues net of the provision for bad debts. Prior to the adoption of this ASU, our provision for bad debts was presented as a component of operating expenses. For all periods presented in this annual report, revenues and any related financial ratios or metrics have been updated to reflect the change in the presentation of net operating revenues. The adoption of this standard did not impact our financial position, results of operations or cash flows.

During the year ended December 31, 2012, we continued the execution of our acquisition strategy by acquiring four hospitals located in Scranton, Pennsylvania; Peckville, Pennsylvania; York, Pennsylvania; and Blue Island, Illinois and a large physician practice located in Longview, Texas.

During the year ended December 31, 2012, we also closed several financing arrangements that extend the maturity date of a significant portion of our outstanding indebtedness. As further discussed in the Liquidity and Capital Resources section, we entered into additional amendments and a modification of our Credit Facility that extend by two and a half years, until January 25, 2017, the maturity date of approximately $1.9 billion of our term loans due 2014. We obtained a new $750 million senior secured revolving credit facility and a new $750 million incremental term loan A facility, both with a maturity date of October 25, 2016, subject to certain acceleration clauses, the net proceeds of which were used to repay the same amount of existing borrowings under the previous revolving credit facility and term loans under the Credit Facility. We also completed through various offerings the issuance of $2.2 billion of senior notes and $1.6 billion of senior secured notes, the net proceeds of which were used to finance the purchase and redemption of all our outstanding $8^{7}/_{8}\%$ Senior Notes due 2015, to prepay $1.6 billion of the outstanding term loans due 2014 under the Credit Facility, to pay related fees and expenses and for general corporate purposes. Compared to our debt maturities at December 31, 2011, the net effect of these financing transactions extended the maturity of approximately $6.0 billion of our outstanding long-term debt previously due in 2014 and 2015 to various maturities ranging from 2016 to 2020.

Our net operating revenues for the year ended December 31, 2012 increased to approximately $13.0 billion, as compared to approximately $11.9 billion for the year ended December 31, 2011. Income from continuing operations, before noncontrolling interests, for the year ended December 31, 2012 increased 3.1% over the year ended December 31, 2011 to $346.3 million compared to $335.9 million. Included in income from continuing operations for the year ended December 31, 2012, is a $47.9 million after-tax benefit from the resolution of an industry-wide governmental settlement and a payment update related to prior periods, a $20.2 million after-tax

charge for certain legal and regulatory matters, a $71.8 million after-tax loss from the early extinguishment of debt and a $6.2 million after-tax impairment charge for long-lived assets. For the year ended December 31, 2011, income from continuing operations included a $42.0 million after-tax loss from the early extinguishment of debt. Excluding the effect of these one-time items, the increase in income from continuing operations during the year ended December 31, 2012, as compared to the year ended December 31, 2011, is due primarily to increased revenues at our same-store hospitals, income from electronic health records incentive reimbursements and reductions in interest expense. Total inpatient admissions for the year ended December 31, 2012 increased 4.0%, compared to the year ended December 31, 2011, and adjusted admissions for the year ended December 31, 2012 increased 6.6%, compared to the year ended December 31, 2011. On a same-store basis, admissions decreased 0.9% and adjusted admissions increased 1.5%, compared with the year ended December 31, 2011.

Self-pay revenues represented approximately 13.0% of our net operating revenues, net of contractual allowances and discounts (but before provision for bad debts), in 2012 compared to 12.0% in 2011. The amount of foregone revenue related to providing charity care services as a percentage of net operating revenues was approximately 5.3% and 5.5% in 2012 and 2011, respectively. Direct and indirect costs incurred by us in providing charity care services were approximately 1.0% and 1.1% of net operating revenues in 2012 and 2011, respectively.

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, as originally enacted, is expected to expand health insurance coverage through a combination of public program expansion and private sector health insurance reforms. We believe the expansion of private sector and Medicaid coverage will, over time, increase our reimbursement related to providing services to individuals who were previously uninsured, which should reduce our expense from uncollectible accounts receivable. The Reform Legislation also makes a number of other changes to Medicare and Medicaid, such as reductions to the Medicare annual market basket update for federal fiscal years 2010 through 2019, a productivity offset to the Medicare market basket update which began October 1, 2011, and a reduction to the Medicare and Medicaid disproportionate share payments, that could adversely impact the reimbursement received under these programs. The various provisions in the Reform Legislation that directly or indirectly affect reimbursement are scheduled to take effect over a number of years. Over time, we believe the net impact of the overall changes as a result of the Reform Legislation will have a positive effect on our net operating revenues. 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.

On June 28, 2012, the Supreme Court of the United States largely upheld the constitutionality of the Reform Legislation, though it overturned an aspect of the legislation that would have permitted the Federal government to withhold all Medicaid funding from a state if that state did not expand Medicaid coverage to the extent required by the Reform Legislation. The Supreme Court's ruling instead held that only new incremental funding could be withheld from a state in such a situation. As a result, states will face less severe financial consequences if they refuse to expand Medicaid coverage to individuals with incomes below certain thresholds. Since the Supreme Court's ruling, some states have suggested that, for budgetary and other reasons, they would not expand their Medicaid programs. If states refuse to expand their Medicaid programs, the number of uninsured patients at

our hospitals will decline by a smaller margin as compared to our expectations when the Reform Legislation was first adopted. In response to the Supreme Court ruling, the previous estimates of the reduction in uninsured individuals as a result of the Reform Legislation have been revised, with approximately 27 million additional individuals expected to have health insurance coverage by 2017. Because of the many variables involved, including clarifications and modifications resulting from the rule-making process, the development of agency guidance and future judicial interpretations, whether and how many states decide to expand or not to expand Medicaid coverage, the number of uninsured who elect to purchase health insurance coverage, and budgetary issues at federal and state levels, we may not be able to realize the positive impact the Reform Legislation may have on our business, results of operations, cash flow, capital resources and liquidity. Furthermore, we cannot predict whether we will be able to modify certain aspects of our operations to offset any potential adverse consequences from the Reform Legislation.

In a number of markets, we have partnered with local physicians in the ownership of our facilities. Such investments have been permitted under an exception to the 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 are now prohibited, from the time the Reform Legislation became effective, from increasing the aggregate percentage of their ownership in the hospital. The Reform Legislation also restricts the ability of existing physician-owned hospitals to expand the capacity of their facilities.

In addition to the Reform Legislation, the American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act, or HITECH. These provisions were designed to increase the use of electronic health records, or EHR, technology and establish the requirements for a Medicare and Medicaid incentive payments program beginning in 2011 for eligible hospitals and providers that adopt and meaningfully use certified EHR technology. These incentive payments are intended to offset a portion of the 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. We recognized approximately $126.7 million and $63.4 million during the years ended December 31, 2012 and 2011, respectively, of incentive reimbursement for HITECH incentive reimbursements from Medicare and Medicaid related to certain of our hospitals and for certain of our employed physicians, which are presented as a reduction of operating expenses.

As a result of our current levels of cash, available borrowing capacity, long-term outlook on our debt repayments, the refinancing of our term loans and our continued projection of our ability to generate cash flows, we 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 July 1, 2012, we completed the acquisition of Memorial Health Systems in York, Pennsylvania. This healthcare system includes Memorial Hospital (100 licensed beds), the Surgical Center of York, and other outpatient and ancillary services. As part of this purchase agreement, we agreed to spend at least $75.0 million to build a replacement hospital within five years of the closing date. The total cash consideration paid for fixed assets and working capital was approximately $45.0 million and $2.6 million, respectively, with additional consideration of $12.5 million assumed in liabilities, for a total consideration of $60.1 million. Based upon our preliminary purchase price allocation relating to this acquisition as of December 31, 2012, approximately $9.9 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.

Effective March 5, 2012, we completed a merger with Diagnostic Clinic of Longview, P.A., which is a multi-specialty clinic serving residents of Longview, Texas and surrounding East Texas communities. This merger was accounted for as a purchase business combination. The total cash consideration paid for the business, including net working capital, was approximately $52.3 million, with additional consideration of $6.9 million assumed in liabilities, for a total consideration of $59.2 million. Based upon our preliminary purchase price allocation relating to this acquisition as of December 31, 2012, approximately $41.8 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. Adjustments to the purchase price allocation are not expected to be material.

Effective March 1, 2012, we completed the acquisition of MetroSouth Medical Center (330 licensed beds) located in Blue Island, Illinois. The total cash consideration paid for fixed assets was approximately $39.3 million with additional consideration of $5.8 million assumed in liabilities as well as a credit applied at closing of $0.9 million for negative acquired working capital, for a total consideration of $44.2 million. Based upon our preliminary purchase price allocation relating to this acquisition as of December 31, 2012, no 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.

Effective January 1, 2012, we completed the acquisition of Moses Taylor Healthcare System based in Scranton, Pennsylvania, which is a healthcare system comprised of two acute care hospitals and other healthcare providers. This healthcare system includes Moses Taylor Hospital (217 licensed beds) located in Scranton, Pennsylvania, and Mid-Valley Hospital (25 licensed beds) located in Peckville, Pennsylvania. The total cash consideration paid for fixed assets and working capital was approximately $151.1 million and $13.1 million, respectively, with additional consideration of $9.4 million assumed in liabilities, for a total consideration of $173.6 million. Based upon our final purchase price allocation relating to this acquisition as of December 31, 2012, approximately $54.6 million of goodwill has been recorded.

Additionally, during 2012, we paid approximately $41.5 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 assumed approximately $2.0 million in net working capital liabilities and allocated approximately $10.2 million of the consideration paid to property and equipment and the remainder, approximately $33.3 million consisting of intangible assets that do not qualify for separate recognition, to goodwill. These acquisition transactions were accounted for as purchase business combinations.

Sources of Revenue

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

	Year Ended December 31,		
	2012	2011	2010
Medicare	26.0%(1)	26.8%	27.4%
Medicaid	9.8%	9.7%	10.7%
Managed Care and other third-party payors	51.2%	51.5%	50.4%
Self-pay	13.0%	12.0%	11.5%
Total	100.0%	100.0%	100.0%

(1) Excludes the $84.3 million reimbursement settlement and payment update as discussed below.

As shown above, we receive a substantial portion of our revenues from the Medicare and Medicaid programs. Included in Managed Care and other third-party payors is operating revenues from insurance companies with which we have insurance provider contracts, Medicare managed care, insurance companies for which we do not have insurance provider contracts, workers' compensation carriers and non-patient service revenue, such as rental income and cafeteria sales. In the future, we generally expect revenues received from the Medicare and Medicaid programs to increase due to the general aging of the population. In addition, the Reform Legislation, currently in effect, should increase the number of insured patients, which, in turn, 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. The trend toward increased enrollment in Medicare managed care may adversely affect our operating revenue growth. Other provisions in the Reform Legislation impose minimum medical-loss ratios and require insurers to meet specific benefit requirements. Furthermore, in the normal course of business, managed care programs, insurance companies and employers actively negotiate the amounts paid to hospitals. There can be no assurance that we will retain our existing reimbursement arrangements or that these third-party payors will not attempt to further reduce the rates they pay for our services.

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-based reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. During the year ended December 31, 2012, we recognized a net after-tax benefit of $46.0 million from the resolution of an industry-wide governmental settlement and a payment update related to prior periods. Other than these items, 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, 2012, 2011 and 2010.

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 31, 2012, CMS issued the final rule to adjust this index by 2.6% 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 0.7% multifactor productivity reduction and a 0.1% reduction to hospital inpatient rates implemented pursuant to the Reform Legislation, yielded an estimated net 2.3% increase in reimbursement for hospital inpatient acute care services beginning October 1, 2012. Reductions in the rate of increase or overall reductions in Medicare reimbursement may cause a decline in the growth of our net operating revenues.

Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from 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.

In addition, specified managed care programs, insurance companies and employers are actively negotiating the amounts paid to hospitals. The trend toward increased enrollment in managed care may adversely affect our net operating revenue growth.

Results of Operations

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

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

	Year Ended December 31,		
	2012	2011	2010
	(Expressed as a percentage of net operating revenues)		
Consolidated			
Net operating revenues	100.0%	100.0%	100.0%
Operating expenses(a)	(85.1)	(85.0)	(84.5)
Depreciation and amortization	(5.6)	(5.5)	(5.4)
Income from operations	9.3	9.5	10.1
Interest expense, net	(4.7)	(5.4)	(5.8)
Loss from early extinguishment of debt	(0.9)	(0.5)	—
Equity in earnings of unconsolidated affiliates	0.3	0.4	0.4
Impairment of long-lived assets	(0.1)	—	—
Income from continuing operations before income taxes	3.9	4.0	4.7
Provision for income taxes	(1.2)	(1.2)	(1.5)
Income from continuing operations	2.7	2.8	3.2
Loss from discontinued operations, net of taxes	—	(0.5)	(0.1)
Net income	2.7	2.3	3.1
Less: Net income attributable to noncontrolling interests	(0.7)	(0.6)	(0.6)
Net income attributable to Community Health Systems, Inc.	2.0%	1.7%	2.5%

	Year Ended December 31,	
	2012	2011
	(Expressed in percentages)	
Percentage increase (decrease) from same period prior year:		
Net operating revenues	9.4%	7.3%
Admissions	4.0	(0.5)
Adjusted admissions(b)	6.6	4.2
Average length of stay	—	2.3
Net income attributable to Community Health Systems, Inc.(c)	31.5	(27.9)
Same-store percentage increase (decrease) from same period prior year(d):		
Net operating revenues	4.6%	2.9%
Admissions	(0.9)	(5.6)
Adjusted admissions(b)	1.5	(0.7)

(a) Operating expenses include salaries and benefits, supplies, other operating expenses, electronic health records incentive reimbursement and rent.

(b) Adjusted admissions is a general measure of combined inpatient and outpatient volume. We computed adjusted admissions by multiplying admissions by gross patient revenues and then dividing that number by gross inpatient revenues.

(c) Includes loss from discontinued operations.

(d) Includes acquired hospitals to the extent we operated them in both years.

Year Ended December 31, 2012 Compared to Year Ended December 31, 2011

Net operating revenues increased by 9.4% to approximately $13.0 billion in 2012, from approximately $11.9 billion in 2011. Growth from hospitals owned throughout both periods contributed $545.5 million of that increase and $493.0 million was contributed by hospitals acquired in 2012 and 2011. On a same-store basis, net operating revenues increased 4.6%. 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. Included in net operating revenues on a non-same store basis is approximately $105.3 million of net operating revenues from an industry-wide settlement with the United States Department of Health and Human Services and CMS, based on a claim that acute-care hospitals in the U.S. were underpaid from the Medicare inpatient prospective payment system in federal fiscal years 1999 through 2011. The underpayments resulted from calculations related to the rural floor budget neutrality adjustments implemented in connection with the Balanced Budget Act of 1997. Also included is an unfavorable adjustment of approximately $21.0 million, related to the revised Supplemental Security Income ratios issued for federal fiscal years 2006 through 2009 utilized for calculating Medicare Disproportionate Share Hospital reimbursements.

On a consolidated basis, inpatient admissions increased by 4.0% and adjusted admissions increased by 6.6%. On a same-store basis, inpatient admissions decreased by 0.9% and adjusted admissions increased by 1.5% during the year ended December 31, 2012. This decrease in same-store inpatient admissions was due primarily to a decrease in admissions from women's services including obstetrics and gynecology, fewer flu and respiratory-related admissions and reductions due to competition in a few of our hospitals during the year ended December 31, 2012, as compared to the year ended December 31, 2011. 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 85.0% in 2011 to 85.1% in 2012. Salaries and benefits, as a percentage of net operating revenues, remained consistent at 46.9% for the years ended December 31, 2012 and 2011. Supplies, as a percentage of net operating revenues, decreased from 15.4% in 2011 to 15.1% in 2012. This decrease is due primarily to lower

drug, implant and food costs. Other operating expenses, as a percentage of net operating revenues, increased from 21.1% in 2011 to 22.0% in 2012. This increase is due primarily to an increase in costs associated with provider taxes from states with provider assessment programs. Rent, as a percentage of net operating revenues, remained consistent at 2.1% for the years ended December 31, 2012 and 2011.

Electronic health records incentive reimbursements represent those incentives under the HITECH Act for which the recognition criterion has been met. We have recognized approximately $126.7 million and $63.4 million of incentive reimbursements, or 1.0% and 0.5% of net operating revenues, for the years ended December 31, 2012 and 2011, respectively. We received cash payments of $141.0 million and $37.4 million for these incentives, of which $33.3 million and $8.5 million was recorded as deferred revenue as all criteria for gain recognition had not been met, during the years ended December 31, 2012 and 2011, respectively. Operating expenses incurred related to the installation and adoption of electronic health records, including depreciation and amortization, totaled approximately 0.6% of net operating revenues, of which depreciation and amortization represented 0.3% of net operating revenues for the year ended December 31, 2012. 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, of which depreciation and amortization represented less than 0.1% of net operating revenues for the year ended December 31, 2011.

Depreciation and amortization, as a percentage of net operating revenues, increased from 5.5% in 2011 to 5.6% in 2012.

Interest expense, net, decreased by $21.5 million from $644.4 million in 2011, to $622.9 million in 2012. A decrease in interest rates during 2012, compared to 2011, resulted in a decrease in interest expense of $59.4 million. Additionally, interest expense decreased by $2.9 million as a result of more interest being capitalized during 2012, as compared to 2011, as the current year period had more major construction projects. These decreases were partially offset by both an increase in interest expense of $39.0 million due to an increase in our average outstanding debt during 2012, compared to 2011, and an increase in interest expense of $1.8 million due to one additional day of interest expense since 2012 was a leap year.

The loss from early extinguishment of debt of $115.5 million was recognized after the purchase and redemption of the $8^{7}/_{8}$% Senior Notes due 2015 and the repayment of existing term loans and revolving credit facility under the Credit Facility as further discussed in Liquidity and Capital Resources.

Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, decreased from 0.4% in 2011 to 0.3% in 2012.

An impairment of $10.0 million was recorded on certain long-lived assets at three of our small hospitals. No impairment charge was recorded for 2011.

The net results of the above mentioned changes resulted in income from continuing operations before income taxes increasing $30.3 million from $473.5 million in 2011 to $503.8 million for 2012.

Provision for income taxes from continuing operations increased from $137.7 million in 2011 to $157.5 million in 2012 due to the increase in income from continuing operations before income taxes. Our effective tax rates were 31.3% and 29.1% for the years ended December 31, 2012 and 2011, respectively. The increase in our effective tax rate is primarily related to a release of uncertain tax positions in 2011 and a decrease in federal tax credits in 2012.

Income from continuing operations, as a percentage of net operating revenues, decreased from 2.8% in 2011 to 2.7% in 2012.

Net income, as a percentage of net operating revenues, increased from 2.3% in 2011 to 2.7% in 2012. The increase is primarily due to the increase in net operating revenues, income from electronic health records incentive reimbursement and a decrease in interest expense, offset by the loss from early extinguishment of debt as discussed above.

Net income attributable to noncontrolling interests as a percentage of net operating revenues increased from 0.6% in 2011 to 0.7% in 2012.

Net income attributable to Community Health Systems, Inc. was $265.6 million in 2012 compared to $201.9 million in 2011, an increase of 31.5%. The increase in net income attributable to Community Health Systems, Inc. is primarily due to the increase in net operating revenues, income from electronic health records incentive reimbursement and a decrease in interest expense, offset by the loss from early extinguishment of debt as discussed above.

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

Net operating revenues increased by 7.3% to approximately $11.9 billion in 2011, from approximately $11.1 billion in 2010. Growth from hospitals owned throughout both periods contributed $323 million of that increase and $490 million was contributed by hospitals acquired in 2011 and 2010. On a same-store basis, net operating revenues increased 2.9%. 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 84.5% in 2010 to 85.0% in 2011. Salaries and benefits, as a percentage of net operating revenues, increased from 45.9% in 2010 to 46.9% in 2011 as a result of recent acquisitions and an increase in the number of employed physicians. Supplies, as a percentage of net operating revenues, decreased from 15.7% in 2010 to 15.4% 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 20.7% in 2010 to 21.1% in 2011. Rent, as a percentage of net operating revenues, decreased from 2.2% in 2010 to 2.1% 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 cash payments of $37.4 million, of which $8.5 million was recorded as deferred revenue as all criteria for gain recognition had not been met during the year ended 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 5.4% in 2010 to 5.5% 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. 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 8⅞% 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 8⅞% 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 3.2% in 2010 to 2.8% 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 3.1% in 2010 to 2.3% 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 0.6% 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.

Liquidity and Capital Resources

2012 Compared to 2011

Net cash provided by operating activities increased $18.2 million, from approximately $1.262 billion for the year ended December 31, 2011 to approximately $1.280 billion for the year ended December 31, 2012. The increase in cash provided by operating activities is due primarily to an increase in net income of $68.2 million, an increase in depreciation and amortization expense of $67.9 million, loss from early extinguishment of debt of $49.4 million, impairment of long-lived assets of $10.0 million, an increase in all other non-cash expenses of $1.5 million, and an increase in cash flow from the change in other assets and liabilities of $45.2 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 $0.2 million. These increases in cash flows were offset by a decrease in cash flows from supplies, prepaid expenses and other current assets of $56.9 million, a decrease in deferred taxes of $53.6 million, a decrease due to the non-recurring impairment of hospitals sold in 2011 of $47.9 million and decreases in cash generated from accounts receivable of $65.8 million, primarily from growth in accounts receivable at hospitals acquired in 2012 due to delays in billing and collection arising from system conversions. Included in net cash provided by operating activities for the year ended December 31, 2012 is $141.0 million of cash received for HITECH incentive reimbursements, compared to $37.4 million for the year ended December 31, 2011.

The cash used in investing activities increased $187.4 million, from approximately $1.2 billion for the year ended December 31, 2011 to approximately $1.4 billion for the year ended December 31, 2012. The increase in cash used in investing activities was due to a decrease in the amount of the proceeds from the sale of property and equipment of $5.3 million and the decrease in proceeds from the sale of three hospitals in 2011 of $173.4 million. There were no hospital divestitures in 2012. Additionally, the increase in cash used in investing activities was due to an increase in cash used for other investments of $109.6 million. Included in cash outflows for other investments for the year ended December 31, 2012 is approximately $127.0 million of capital expenditures related to the purchase and implementation of certified EHR technology. The remaining cash outflows for other investments consists primarily of purchases and development of other internal-use software and payments made under non-employee physician recruiting agreements of $148.5 million and an increase in available-for-sale securities of $22.5 million. These increases in cash outflows were partially offset by a decrease in cash paid for acquisitions of facilities and other related equipment of $93.0 million and a decrease in the cash used for the purchase of property and equipment of $7.9 million. We anticipate being able to fund future routine capital expenditures with cash flows generated from operations.

Our net cash provided by financing activities was $361.0 million for the year ended December 31, 2012, compared to net cash used in financing activities $235.4 million for the year ended December 31, 2011. The increase in cash provided by financing activities, in comparison to the prior year, is primarily due to an increase in borrowings under our Credit Facility, proceeds from the Receivables Facility and the issuance of our 8% Senior Notes, our 7 ⅛% Senior Notes and our 5 ⅛% Senior Secured Notes totaling $6.6 billion, but was mostly offset by an increase in the repayments of our long-term debt of $5.9 billion. Additionally, a reduction in the repurchase of our common stock of $85.8 million increased cash provided by financing activities. These increases were also partially offset by an increase in deferred financing costs of $121.9 million associated with the amendments of our Credit Facility and the issuance of our 8% Senior Notes, our 7 ⅛% Senior Notes and our 5 ⅛% Senior Secured Notes, the special dividend to stockholders of $22.5 million and an increase in the redemption of noncontrolling investments in joint ventures of $31.3 million. The net decrease in all other financing activities was $8.2 million.

Historically, we have not paid any cash dividends. In December 2012, we declared and paid a special dividend of $0.25 per share to holders of our common stock at the close of business on December 17, 2012, which totaled approximately $23.0 million. In the foreseeable future, we do not anticipate the payment of any other cash dividends. Our Credit Facility limits our ability to pay dividends and/or repurchase stock to an amount not to exceed $150 million in the aggregate plus the aggregate amount of proceeds from the exercise of stock options. The indentures governing our 8% Senior Notes due 2019, our 7 ⅛% Senior Notes due 2020 and our 5 ⅛% Senior Secured Notes due 2018 also limit our ability to pay dividends and/or repurchase stock. As of December 31, 2012, under the most restrictive test under these agreements, we have approximately $178.1 million available with which to pay permitted dividends and/or repurchase shares of stock or our Notes.

In 2012, we successfully continued efforts commenced in 2011 to access the capital markets and extend the maturities of our long-term indebtedness. Our Credit Facility term loans were scheduled to mature on July 25, 2014 and the approximately $3.0 billion aggregate principal amount of 8 ⅞% Senior Notes were due July 25, 2015. During 2012, we closed several financing arrangements that extend the maturity date of a significant portion of our outstanding indebtedness. We entered into additional amendments and a modification of our Credit Facility that extend by two and a half years, until January 25, 2017, the maturity date of approximately $1.9 billion of our term loans due 2014. We obtained a new $750 million senior secured revolving credit facility and a new $750 million incremental term loan A facility, both with a maturity date of October 25, 2016, subject to certain acceleration clauses, the net proceeds of which were used to repay the same amount of existing borrowings under the previous revolving credit facility and term loans under the Credit Facility. We also completed through various offerings the issuance of $2.2 billion of senior notes and $1.6 billion of senior secured notes, the net proceeds of which were used to finance the purchase and redemption of all our outstanding 8 ⅞% Senior Notes, to prepay $1.6 billion of the then outstanding term loans due 2014 under the Credit Facility, to pay related fees and expenses and for general corporate purposes. Compared to our debt maturities at December 31,

2011, the net effect of these financing transactions extended the maturity of approximately $6.0 billion of our outstanding long-term debt previously due in 2014 and 2015 to various maturities ranging from 2016 to 2020. The table below sets forth additional 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.

As described in Notes 6, 9 and 15 of the Notes to Consolidated Financial Statements, at December 31, 2012, we had certain cash obligations, which are due as follows (in thousands):

	Total	2013	2014-2016	2017-2018	2019 and thereafter
Long-term debt	$ 4,370,524	$ 85,280	$ 996,599	$3,285,210	$ 3,435
8% Senior Notes	2,000,000	—	—	—	2,000,000
7 1/8% Senior Notes	1,200,000	—	—	—	1,200,000
5 1/8% Senior Secured Notes	1,600,000	—	—	1,600,000	—
Receivables Facility	300,000	—	300,000	—	—
Interest on Credit Facility, Senior Notes and Receivables Facility(1)	2,819,198	483,129	1,404,083	639,715	292,271
Capital lease obligations, including interest	87,163	8,795	20,293	11,126	46,949
Total long-term debt	12,376,885	577,204	2,720,975	5,536,051	3,542,655
Operating leases	786,560	185,532	381,071	109,408	110,549
Replacement facilities and other capital commitments(2)	339,531	97,225	224,920	4,234	13,152
Open purchase orders(3)	348,552	348,552	—	—	—
Liability for uncertain tax positions, including interest and penalties	1,156	481	—	—	675
Total	$13,852,684	$1,208,994	$3,326,966	$5,649,693	$3,667,031

(1) Estimate of interest payments assumes the interest rates at December 31, 2012 remain constant during the period presented for the Credit Facility and the Receivables Facility, which are 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, 2012 plus the applicable spread. The 8% Senior Notes are fixed at an interest rate of 8% per annum. The 7 1/8% Senior Notes are fixed at an interest rate of 7.125% per annum. The 5 1/8% Senior Secured Notes are fixed at an interest rate of 5.125% per annum.

(2) Pursuant to hospital purchase agreements in effect as of December 31, 2012, and where final CON approval has been obtained, we have commitments to build one replacement facility and the following capital commitments. As part of an acquisition in 2012, we agreed to build a replacement hospital in York, Pennsylvania, by July 2017. Construction costs, including equipment costs, for this replacement facility is currently estimated to be approximately $100.0 million. No capital has been spent on this replacement facility. In addition, under other purchase agreements, we have committed to spend approximately $493.5 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, 2012, we have incurred approximately $254.0 million related to these commitments.

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

At December 31, 2012, we had issued letters of credit primarily in support of potential insurance related claims and specified outstanding bonds of approximately $37.8 million.

Our debt as a percentage of total capitalization decreased from 78% at December 31, 2011 to 77% at December 31, 2012.

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 $37.2 million, resulted in an increase in cash flows from operating activities of $128.1 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 $84.2 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.

Capital Expenditures

Cash expenditures for purchases of facilities were $322.3 million in 2012, $415.4 million in 2011 and $248.3 million in 2010. Our expenditures in 2012 included $238.8 million for the purchase of three hospitals in Pennsylvania and one hospital in Illinois, $91.5 million for surgery centers and other physician practices, including a large physician practice in Texas, partially offset by $8.0 million of cash received for the settlement of working capital items from a prior divestiture and return of a deposit made at acquisition related to building a replacement hospital. 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.

Excluding the cost to construct replacement hospitals, our cash expenditures for routine capital for 2012 totaled $672.7 million compared to $611.7 million in 2011, and $631.7 million in 2010. These capital expenditures related primarily to the purchase of additional equipment, minor renovations and information systems infrastructure. Costs to construct replacement hospitals totaled $96.1 million in 2012, $165.0 million in 2011 and $35.7 million in 2010. The costs to construct replacement hospitals for the year ended December 31, 2012 represent both planning and construction costs for four replacement hospitals discussed below. The costs to construct replacement hospitals for the years ended December 31, 2011 and 2010 represent both planning and construction costs for four replacement hospitals.

Pursuant to hospital purchase agreements in effect as of December 31, 2012, and where final CON approval has been obtained, we committed to build the following 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. This replacement hospital was completed in September 2012 and occupied in October 2012. As part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana, which opened in August 2012. As part of an acquisition in 2009, we agreed to build a replacement hospital in Siloam Springs, Arkansas, which opened in April 2012. As part of an acquisition in 2012, we agreed to build a replacement hospital in York, Pennsylvania, by July 2017. Construction costs, including equipment costs, for the York replacement facility is currently estimated to be approximately $100.0 million. No capital was spent on this project in 2012. In addition, in October 2008, after the purchase of the noncontrolling owner's interest in our Birmingham, Alabama facility, we initiated the purchase of a site, which includes a partially constructed hospital structure, for a potential replacement to our existing Birmingham facility. In September 2010, we received approval of our request for a certificate of need from the Alabama Certificate of Need Review Board. This CON was challenged in the Alabama state circuit and appellate courts but has recently been upheld, with issuance subject to the final resolution of the 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 $800.0 million to $900.0 million in 2013 (which includes amounts that are required to be expended pursuant to the terms of hospital purchase agreements), including approximately $725.0 million to $820.0 million for renovation and equipment cost and approximately $75.0 million to $80.0 million for construction and equipment cost of the replacement hospitals.

Capital Resources

Net working capital was approximately $1.3 billion at December 31, 2012, compared to $935.0 million at December 31, 2011, an increase of $341.0 million. Contributing to the increase in net working capital were increases in cash of approximately $256.5 million, patient accounts receivable of approximately $211.6 million, supplies of approximately $11.7 million, deferred tax assets of approximately $27.3 million, prepaid expenses of approximately $11.7 million, other current assets of approximately $70.0 million and net working capital acquired as part of our business acquisitions of approximately $10.4 million. These increases in working capital were partially offset by increases in current maturities of long-term debt of approximately $24.6 million, accounts payable of approximately $68.6 million, employee compensation liabilities of approximately $78.0 million, other current liabilities of approximately $34.9 million, accrued interest of approximately $0.6 million and decreases in prepaid income taxes of approximately $51.5 million.

We obtained senior secured financing under the Credit Facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. A $750 million revolving credit facility was available to us for working capital and general corporate purposes under the Credit Facility. 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. 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 loan A 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. On February 2, 2012, we completed a second amendment and restatement of the Credit Facility to extend an additional $1.6 billion of our term loans due 2014 under the Credit Facility to match the maturity date and interest rate margins of the term loans due January 25, 2017. On August 3, 2012, we entered into Amendment No. 1 to the Credit Facility to provide increased flexibility for refinancing and repayment of the term loans due 2014 and amend certain other terms. On August 22, 2012, we entered into a loan modification agreement with respect to the Credit Facility to extend approximately $340 million of the term loans due 2014 to match the maturity date and interest rate margins of the term loans due January 25, 2017. On November 27, 2012, we entered into Amendment No. 2 to the Credit Facility to provide increased flexibility for us to make investments and restricted payments, incur debt related to acquisitions, amend certain other terms of the Credit Facility, including the maximum leverage ratio and interest coverage ratio financial coverage levels, and add a one year 1% prepayment premium payable in connection with a repricing of the term loans due in 2017. The extended term loans are subject to customary acceleration events and earlier maturity if the repayment, extension or refinancing with longer maturity on substantially all of the outstanding term loans maturing July 25, 2014 does not occur by April 15, 2015. The July 25, 2014 maturity date of the balance of the remaining non-extended term loans at December 31, 2012 of approximately $266.1 million remains unchanged.

Effective March 6, 2012, we obtained a new $750 million senior secured revolving credit facility, or the Replacement Revolver Facility, and a new $750 million incremental term loan A facility, or the Incremental Term Loan. The Replacement Revolver Facility replaced in full the existing revolving credit facility under the Credit Facility. The net proceeds of the Incremental Term Loan were used to repay the same amount of the existing term loans under the Credit Facility. Both the Replacement Revolver Facility and the Incremental Term Loan have a maturity date of October 25, 2016, subject to customary acceleration events and to earlier maturity if the repayment, extension or refinancing with longer maturity debt of substantially all of the then outstanding term loans maturing July 25, 2014 and the now fully redeemed 8⅞% Senior Notes does not occur by April 25, 2014. The pricing on each of the Replacement Revolver Facility and the Incremental Term Loan is initially LIBOR plus a margin of 250 basis points, subject to adjustment based on our leverage ratio. The Incremental Term Loan amortizes at 5% in year one, 10% in years two and three, 15% in year four and 60% in year five.

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 of its existing and subsequently acquired or organized domestic subsidiaries. All obligations under the Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of Community Health Systems, Inc., CHS and each subsidiary guarantor, including equity interests held by us or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries.

The loans under the Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at our option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus 0.5% or (3) the adjusted LIBOR rate on such day for a three-month interest period commencing on the second business day after such day plus 1%, or (b) 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 2.50% 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 and Incremental Term Loans is 1.50% for Alternate Base Rate loans and 2.50% for Eurodollar 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 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 are 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.

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.

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, 2012, the availability for additional borrowings under our Credit Facility was approximately $750 million pursuant to the revolving credit facility, of which $37.8 million was set aside for outstanding letters of credit at December 31, 2012. 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' then outstanding 8⅞% Senior Notes and related fees and expenses.

On March 21, 2012, CHS completed the secondary offering of $1.0 billion aggregate principal amount of 8% Senior Notes, which were issued in a private placement (at a premium of 102.5%). The net proceeds from this issuance were used to finance the purchase of approximately $850 million aggregate principal amount of

CHS' then outstanding 8⅞% Senior Notes, to pay related fees and expenses and for general corporate purposes. On March 21, 2012, CHS completed the cash tender offer for $850 million of the then $1.8 billion aggregate outstanding principal amount of 8⅞% Senior Notes.

On July 18, 2012, CHS completed an underwritten public offering under our automatic shelf registration filed with the SEC for $1.2 billion aggregate principal amount of 7⅛% Senior Notes due 2020. The net proceeds of the offering were used to finance the purchase or redemption of the then outstanding $934.3 million principal amount plus accrued interest of the 8⅞% Senior Notes, to pay for consents delivered in connection therewith, to pay related fees and expenses, and for general corporate purposes.

On August 17, 2012, CHS completed an underwritten public offering under our automatic shelf registration filed with the SEC for $1.6 billion aggregate principal amount of 5⅛% Senior Secured Notes due 2018. The 5⅛% Senior Secured Notes are secured by a first-priority lien subject to a shared lien of equal priority with certain other obligations, including obligations under the Credit Facility, and subject to prior ranking liens permitted by the indenture governing the 5⅛% Senior Secured Notes on substantially the same assets, subject to certain exceptions, that secure CHS' obligations under the Credit Facility. The net proceeds of the offering, together with available cash on hand, were used to finance the prepayment of $1.6 billion of the outstanding term loans due 2014 under the Credit Facility and related fees and expenses.

On March 21, 2012, through certain of our subsidiaries, we entered into an accounts receivable loan agreement, or the Receivables Facility, with a group of lenders and banks, Credit Agricolé Corporate and Investment Bank, as a managing agent and as the administrative agent, and The Bank of Nova Scotia, as a managing agent. The existing and future patient-related accounts receivable, or the Receivables, for certain of our hospitals serve as collateral for the outstanding borrowings under the Receivables Facility. The interest rate on the borrowings is based on the commercial paper rate plus an applicable interest rate spread. Unless earlier terminated or subsequently extended pursuant to its terms, the Receivables Facility will expire on March 21, 2014, subject to customary termination events that could cause an early termination date. We maintain effective control over the Receivables because, pursuant to the terms of the Receivables Facility, the Receivables are sold from certain of our subsidiaries to us, and we then sell or contribute the Receivables to a special-purpose entity that is wholly-owned by us. The wholly-owned special-purpose entity in turn grants security interests in the Receivables in exchange for borrowings obtained from the group of third-party lenders and banks of up to $300 million outstanding from time to time based on the availability of eligible Receivables and other customary factors. The group of third-party lenders and banks do not have recourse to us or our subsidiaries beyond the assets of the wholly-owned special-purpose entity that collateralizes the loan. The Receivables and other assets of the wholly-owned special-purpose entity will be available first and foremost to satisfy the claims of the creditors of such entity. The outstanding borrowings pursuant to the Receivables Facility at December 31, 2012 totaled $300.0 million and are classified as long-term debt on the consolidated balance sheet. At December 31, 2012, the carrying amount of Receivables included in the Receivables Facility totaled approximately $927.8 million and are included in patient accounts receivable on the consolidated balance sheet.

As of December 31, 2012, we are currently a party to the following interest rate swap agreements to limit the effect of changes in interest rates on approximately 67% 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, 250 basis points for the Replacement Revolver Facility and the Incremental Term Loan and 350 basis points for term loans due 2017 under the Credit Facility.

Swap #	Notional Amount (in 000's)	Fixed Interest Rate	Termination Date	Fair Value of Liability (in 000's)
1	$200,000	2.242%	February 28, 2013	$ 621
2	100,000	5.023%	May 30, 2013	1,947
3	300,000	5.242%	August 6, 2013	8,885
4	100,000	5.038%	August 30, 2013	3,151
5	50,000	3.586%	October 23, 2013	1,333
6	50,000	3.524%	October 23, 2013	1,308
7	100,000	5.050%	November 30, 2013	4,339
8	200,000	2.070%	December 19, 2013	3,400
9	100,000	5.231%	July 25, 2014	7,650
10	100,000	5.231%	July 25, 2014	7,650
11	200,000	5.160%	July 25, 2014	15,078
12	75,000	5.041%	July 25, 2014	5,514
13	125,000	5.022%	July 25, 2014	9,153
14	100,000	2.621%	July 25, 2014	3,560
15	100,000	3.110%	July 25, 2014	4,326
16	100,000	3.258%	July 25, 2014	4,558
17	200,000	2.693%	October 26, 2014	8,484
18	300,000	3.447%	August 8, 2016	30,395
19	200,000	3.429%	August 19, 2016	20,257
20	100,000	3.401%	August 19, 2016	10,033
21	200,000	3.500%	August 30, 2016	20,889
22	100,000	3.005%	November 30, 2016	9,069

The Credit Facility and/or the Notes contain various covenants that limit our ability to take certain actions including; among other things, our ability to:

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

In addition, our Credit Facility contains restrictive covenants and requires us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet these restricted covenants and financial ratios and tests can be affected by events beyond our control, and we cannot assure you that we will meet those tests. A

breach of any of these covenants could result in a default under our Credit Facility and/or the Notes. Upon the occurrence of an event of default under our Credit Facility or the Notes, all amounts outstanding under our Credit Facility and the Notes may become immediately due and payable and all commitments under the Credit Facility to extend further credit may be terminated.

We believe that internally generated cash flows, availability for additional borrowings under our Credit Facility of $750 million (consisting of a $750 million revolving credit facility, of which $37.8 million is set aside for outstanding letters of credit at December 31, 2012) 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, and our continued access to the bank credit and capital markets will be sufficient to finance acquisitions, capital expenditures and working capital requirements through the next 12 months. We believe these same sources of cash, borrowings under our Credit Facility as well as access to bank credit and capital markets will be available to us beyond the next 12 months and into the foreseeable future.

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

Off-balance Sheet Arrangements

Our consolidated operating results for the years ended December 31, 2012 and 2011, included $217.3 million and $202.7 million, respectively, of net operating revenues and $22.6 million and $16.4 million, respectively, of income from continuing operations, generated from five hospitals operated by us under operating lease arrangements. In accordance with U.S. GAAP, the respective assets and the future lease obligations under these arrangements are not recorded on our consolidated balance sheet. Lease costs under these arrangements are included in rent expense and totaled approximately $11.5 million and $11.9 million for the years ended December 31, 2012 and 2011, respectively. The current terms of these operating leases expire between May 2015 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. The operating lease at our Barstow, California location terminated on November 30, 2012 in conjunction with the opening of the replacement facility that we constructed, which was a requirement of the operating lease agreement. The 11 months of operating results for the Barstow location for the year ended December 31, 2012 are included in the above amounts.

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.

As described more fully in Note 15 of the Notes to Consolidated Financial Statements, at December 31, 2012, we have certain cash obligations for replacement facilities and other construction commitments of $339.5 million and open purchase orders for $348.6 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, 2012, we have hospitals in 21 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 the three months ended March 31, 2012, one of our

subsidiaries purchased the outstanding partnership interests not already owned by us that were held by physician investors in the limited partnership that owns and operates Longview Regional Medical Center in Longview, Texas. The purchase price for these partnership interests was $28.8 million. After acquiring these partnership interests, one or more of our subsidiaries collectively own 100% of the outstanding equity of the limited partnership that owns and operates this hospital. 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. Redeemable noncontrolling interests in equity of consolidated subsidiaries was $367.7 million and $395.7 million as of December 31, 2012 and 2011, respectively, and noncontrolling interests in equity of consolidated subsidiaries was $65.3 million and $67.3 million as of December 31, 2012 and 2011, respectively, and the amount of net income attributable to noncontrolling interests was $80.2 million, $75.7 million and $68.5 million for the years ended December 31, 2012, 2011 and 2010, respectively. As a result of the change in the Stark Law "whole hospital" exception included in the Reform Legislation, we are not permitted to introduce physician ownership at any of our wholly-owned 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.

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 operating revenues (net of contractual allowances and discounts). The process of estimating contractual allowances requires us to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification and historical paid claims data. Due to the complexities involved in these estimates, actual payments we receive could be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs and managed care contracts differed by 1% at December 31, 2012 from our estimated reimbursement percentage, net income for the year ended December 31, 2012 would have changed by approximately $38.4 million, and net accounts receivable at December 31, 2012 would have changed by $61.8 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. During the year ended December 31, 2012, we recognized a net after-tax benefit of $46.0 million from the resolution of an industry-wide governmental settlement and a payment update related to prior periods. Other than these items, 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, 2012, 2011 and 2010.

Allowance for Doubtful Accounts

Substantially all of our accounts receivable are related to providing healthcare services to our hospitals' patients. Collection of these accounts receivable is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and outstanding patient balances for which the primary insurance payor has paid some but not all of the outstanding balance, with the remaining outstanding balance (generally deductibles and co-payments) owed by the patient. At the point of service, for patients required to make a co-payment, we generally collect less than 15% of the related revenue. For all procedures scheduled in advance, our policy is to verify insurance coverage prior to the date of the procedure. Insurance coverage is not verified in advance of procedures for walk-in and emergency room patients.

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

Collections are impacted by the economic ability of patients to pay and the effectiveness of our collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect our collection of accounts receivable. The process of estimating the allowance for doubtful accounts requires us to estimate the collectability of self-pay accounts receivable, which is primarily based on our collection history, adjusted for expected recoveries and, if available,

anticipated changes in collection trends. Significant change in payor mix, business office operations, economic conditions, trends in federal and state governmental healthcare coverage or other third-party payors could affect our estimates of accounts receivable collectability. If the actual collection percentage differed by 1% at December 31, 2012 from our estimated collection percentage as a result of a change in expected recoveries, net income for the year ended December 31, 2012 would have changed by $23.4 million, and net accounts receivable at December 31, 2012 would have changed by $37.7 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 $2.4 billion and $2.2 billion at December 31, 2012 and 2011, 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 58 days at December 31, 2012 and 56 days at December 31, 2011. Our target range for days revenue outstanding is from 53 to 63 days.

Total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) was approximately $9.6 billion as of December 31, 2012 and approximately $8.3 billion as of December 31, 2011.

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,	
	2012	2011
Insured receivables	61.5%	63.7%
Self-pay receivables	38.5%	36.3%
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, 2012 and 2011. 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 90% and 91% at December 31, 2012 and 2011, respectively.

Goodwill and Other Intangibles

Goodwill represents the excess of the fair value of the consideration conveyed in the acquisition over the fair value of net assets acquired. Goodwill is evaluated for impairment at the same time every year and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. There is a two-step method for determining goodwill impairment. Step one is to compare the

fair value of the reporting unit with the unit's carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit's goodwill with the carrying value of the reporting unit's goodwill. We performed our last annual goodwill evaluation during the fourth quarter of 2012. No impairment was indicated by this evaluation. The next annual goodwill evaluation will be performed during the fourth quarter of 2013.

Impairment or Disposal of Long-Lived Assets

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

Professional Liability Claims

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

The net present value of the projected payments was discounted using a weighted-average risk-free rate of 1.2%, 1.2% and 1.3% in 2012, 2011 and 2010, 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, Inc., or Triad, hospitals versus claims relating to our other hospitals. Several actuarial

methods are used against this data to produce estimates of ultimate paid losses and reserves for incurred but not reported claims. Each of these methods uses our company-specific historical claims data and other information. This company-specific data includes information regarding our business, including historical paid losses and loss adjustment expenses, historical and current case loss reserves, actual and projected hospital statistical data, a variety of hospital census information, employed physician information, professional liability retentions for each policy year, geographic information and other data.

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

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,		
	2012	2011	2010
Accrual for professional liability claims, beginning of year	$567,785	$489,207	$431,225
Liability for insured claims(1)	23,695	42,171	—
Expense (income) related to:			
Current accident year	143,110	145,396	141,923
Prior accident years	(28,652)	(30,698)	(10,583)
(Income) expense from discounting	461	(2,393)	(2,678)
Total incurred loss and loss expense(2)	114,919	112,305	128,662
Paid claims and expenses related to:			
Current accident year	(447)	(468)	(1,980)
Prior accident years	(84,215)	(75,430)	(68,700)
Total paid claims and expenses	(84,662)	(75,898)	(70,680)
Accrual for professional liability claims, end of year	$621,737	$567,785	$489,207

(1) The liability for insured claims is recorded on the consolidated balance sheet with a corresponding insurance recovery receivable.

(2) Total expense, including premiums for insured coverage, was $155.0 million in 2012, $150.2 million in 2011 and $164.2 million in 2010.

The impact of risk management patient safety quality programs and initiatives implemented at our hospitals, as well as decreasing obstetric admissions and a slightly lower same-store acuity case mix, resulted in the current accident year expense decreasing slightly, as a percentage of net operating revenues, for each year presented. 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, up to $145 million per occurrence and in the aggregate for claims incurred and reported after January 1, 2008 and up to $195 million per occurrence and in the aggregate for claims reported after June 1, 2010. For certain policy years, if the first aggregate layer of excess coverage becomes fully utilized, then the self-insured retention could increase to $10 million per claim for any subsequent claims in that policy year until our total aggregate coverage is met.

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

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 $0.9 million as of December 31, 2012. During the year ended December 31, 2012, we increased interest and penalties by approximately $0.1 million. A total of approximately $0.5 million of interest and penalties is included in the amount of liability for uncertain tax positions at December 31, 2012. It is our policy to recognize interest and penalties related to unrecognized benefits in our consolidated statements of income as income tax expense.

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, December 31, 2003 and December 31, 2004. The Internal Revenue Service, or 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. With few exceptions, we are no longer subject to state income tax examinations for years prior to 2009 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, 2008, 2009 and 2010 tax years are currently under examination by the IRS. We anticipate reaching a resolution on the 2007 and 2008 year examinations within the next six months. We believe the results of these examinations will not be material to our consolidated results of operations or consolidated financial position.

Recent Accounting Pronouncements

In July 2011, the FASB issued ASU 2011-07, which requires healthcare organizations that perform services for patients for which the ultimate collection of all or a portion of the amounts billed or billable cannot be determined at the time services are rendered to present all bad debt expense associated with patient service revenue as an offset to the patient service revenue line item in the statement of operations. The ASU also requires qualitative disclosures about our policy for recognizing revenue and bad debt expense for patient service transactions and quantitative information about the effects of changes in the assessment of collectibility of patient service revenue. This ASU is effective for fiscal years beginning after December 15, 2011, and was adopted by us on January 1, 2012. Upon adoption, our provision for bad debts was presented as a reduction of operating revenue after contractual adjustments and discounts for all periods presented.

In September 2011, the FASB issued ASU 2011-08, which modifies how entities test goodwill for impairment. Previous guidance required an entity to perform a two-step goodwill impairment test at least annually by comparing the fair value of a reporting unit with its carrying amount, including goodwill, and recording an impairment loss if the fair value is less than the carrying amount. This ASU allows an entity to first assess qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If an entity determines after that assessment that it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step impairment test is not required. This ASU is required to be applied to interim and annual goodwill impairment tests performed for fiscal years beginning after December 15, 2011, and was adopted by us on January 1, 2012. The adoption of this ASU did not impact our consolidated financial position, results of operations or cash flows.

In July 2012, the FASB issued ASU 2012-02, which modifies how entities test indefinite-lived intangible assets other than goodwill for impairment. Previous guidance required an entity to perform an impairment test on indefinite-lived intangible assets other than goodwill at least annually by comparing the fair value of the asset with its carrying amount, and recording an impairment loss for any excess if the carrying amount exceeds the fair value. 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 the intangible asset 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 an intangible asset is less than its carrying amount, then calculating the fair value of the intangible asset is not required. This ASU is required to be applied to interim and annual intangible asset impairment tests performed for fiscal years beginning after September 15, 2012, with early adoption permitted, and was adopted by us in July 2012. The adoption of this ASU did not impact our consolidated financial position, results of operations or cash flows.

In February 2013, the FASB issued ASU 2013-02, which requires additional disclosures on the effect of significant reclassifications out of accumulated other comprehensive income. The ASU requires a company that reports other comprehensive income to present (either on the face of the statement where net income is presented or in the notes) the effects on the line items of net income of significant amounts reclassified out of accumulated other comprehensive income. For other amounts that are not required to be reclassified in their entirety to net income in the same reporting period, an entity is required to cross-reference to other required disclosures that provide additional details about those amounts. This ASU is effective for fiscal years beginning after December 15, 2012, and will be adopted by us on January 1, 2013. As it only requires additional disclosure, the adoption of this ASU will not 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" in Item 2. We utilize risk management procedures and controls in executing derivative financial instrument transactions. We do not execute transactions or hold derivative financial instruments for trading purposes. Derivative financial instruments related to interest rate sensitivity of debt obligations are used with the goal of mitigating a portion of the exposure when it is cost effective to do so. As interest rate swap agreements expire throughout the year, we will become more subject to variable interest rates during 2013.

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 $18.3 million in 2012, $7.2 million in 2011 and $6.8 million in 2010.

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

Index to Financial Statements

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, 2012 and 2011, and the related consolidated statements of income, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2012. 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, 2012 and 2011, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2012, 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, 2012, 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 27, 2013 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ Deloitte & Touche LLP
Nashville, Tennessee
February 27, 2013

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2012	2011	2010
	(in thousands, except share and per share data)		
Operating revenues (net of contractual allowances and discounts)	$14,988,179	$13,626,168	$12,623,274
Provision for bad debts	1,959,194	1,719,956	1,530,852
Net operating revenues	13,028,985	11,906,212	11,092,422
Operating costs and expenses:			
Salaries and benefits	6,103,931	5,577,925	5,093,767
Supplies	1,973,491	1,834,106	1,738,088
Other operating expenses	2,869,786	2,515,638	2,296,063
Electronic health records incentive reimbursement	(126,734)	(63,397)	—
Rent	272,829	254,781	248,463
Depreciation and amortization	725,558	652,674	594,997
Total operating costs and expenses	11,818,861	10,771,727	9,971,378
Income from operations	1,210,124	1,134,485	1,121,044
Interest expense, net of interest income of $3,031, $4,650 and $1,757 in 2012, 2011, and 2010, respectively	622,933	644,410	647,593
Loss from early extinguishment of debt	115,453	66,019	—
Equity in earnings of unconsolidated affiliates	(42,033)	(49,491)	(45,443)
Impairment of long-lived assets	10,000	—	—
Income from continuing operations before income taxes	503,771	473,547	518,894
Provision for income taxes	157,502	137,653	163,681
Income from continuing operations	346,269	335,894	355,213
Discontinued operations, net of taxes:			
Loss from operations of entities sold	(466)	(7,769)	(6,772)
Impairment of hospitals sold	—	(47,930)	—
Loss on sale, net	—	(2,572)	—
Loss from discontinued operations, net of taxes	(466)	(58,271)	(6,772)
Net income	345,803	277,623	348,441
Less: Net income attributable to noncontrolling interests	80,163	75,675	68,458
Net income attributable to Community Health Systems, Inc. stockholders	$ 265,640	$ 201,948	$ 279,983
Basic earnings (loss) per share attributable to Community Health Systems, Inc. common stockholders(1):			
Continuing operations	$ 2.98	$ 2.89	$ 3.13
Discontinued operations	(0.01)	(0.65)	(0.07)
Net income	$ 2.98	$ 2.24	$ 3.05
Diluted earnings (loss) per share attributable to Community Health Systems, Inc. common stockholders(1):			
Continuing operations	$ 2.96	$ 2.87	$ 3.08
Discontinued operations	(0.01)	(0.64)	(0.07)
Net income	$ 2.96	$ 2.23	$ 3.01
Weighted-average number of shares outstanding:			
Basic	89,242,949	89,966,933	91,718,791
Diluted	89,806,937	90,666,348	92,946,048

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

See notes to the consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31,		
	2012	2011	2010
		(In thousands)	
Net income	$345,803	$277,623	$348,441
Other comprehensive income (loss), net of income taxes:			
Net change in fair value of interest rate swaps, net of tax of $26,219, $31,154 and $(8,818) for the years ended December 31, 2012, 2011 and 2010, respectively	46,409	55,145	(15,676)
Net change in fair value of available-for-sale securities	3,012	(960)	3,716
Amortization and recognition of unrecognized pension cost components, net of tax of $(3,310), $(4,754) and $1,142 for the years ended December 31, 2012, 2011 and 2010, respectively	(10,252)	(7,737)	2,418
Other comprehensive income (loss)	39,169	46,448	(9,542)
Comprehensive income	384,972	324,071	338,899
Less: Comprehensive income attributable to noncontrolling interests	80,163	75,675	68,458
Comprehensive income attributable to Community Health Systems, Inc. stockholders	$304,809	$248,396	$270,441

See notes to the consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

	December 31, 2012	December 31, 2011
	(in thousands, except share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 387,813	$ 129,865
Patient accounts receivable, net of allowance for doubtful accounts of $2,201,875 and $1,891,334 at December 31, 2012 and 2011, respectively	2,067,379	1,834,167
Supplies	368,172	346,611
Prepaid income taxes	49,888	101,389
Deferred income taxes	117,045	89,797
Prepaid expenses and taxes	126,561	112,613
Other current assets	302,284	231,647
Total current assets	3,419,142	2,846,089
Property and equipment:		
Land and improvements	614,964	591,457
Buildings and improvements	6,086,169	5,715,066
Equipment and fixtures	3,444,275	3,063,005
Property and equipment, gross	10,145,408	9,369,528
Less accumulated depreciation and amortization	(2,993,535)	(2,513,552)
Property and equipment, net	7,151,873	6,855,976
Goodwill	4,408,138	4,264,845
Other assets, net of accumulated amortization of $394,827 and $313,028 at December 31, 2012 and 2011, respectively	1,627,182	1,241,930
Total assets	$16,606,335	$15,208,840
LIABILITIES AND EQUITY		
Current liabilities:		
Current maturities of long-term debt	$ 89,911	$ 63,706
Accounts payable	825,914	748,997
Accrued liabilities:		
Employee compensation	713,685	620,508
Interest	110,702	110,121
Other	403,008	367,807
Total current liabilities	2,143,220	1,911,139
Long-term debt	9,451,394	8,782,798
Deferred income taxes	808,489	704,725
Other long-term liabilities	1,039,045	949,990
Total liabilities	13,442,148	12,348,652
Redeemable noncontrolling interests in equity of consolidated subsidiaries	367,666	395,743
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; 92,925,715 shares issued and 91,950,166 shares outstanding at December 31, 2012, and 91,547,079 shares issued and 90,571,530 shares outstanding at December 31, 2011	929	915
Additional paid-in capital	1,138,274	1,086,008
Treasury stock, at cost, 975,549 shares at December 31, 2012 and 2011	(6,678)	(6,678)
Accumulated other comprehensive loss	(145,310)	(184,479)
Retained earnings	1,743,992	1,501,330
Total Community Health Systems, Inc. stockholders' equity	2,731,207	2,397,096
Noncontrolling interests in equity of consolidated subsidiaries	65,314	67,349
Total equity	2,796,521	2,464,445
Total liabilities and equity	$16,606,335	$15,208,840

See notes to the consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Redeemable Noncontrolling Interests	Community Health Systems, Inc. Stockholders								
		Common Stock		Additional Paid-in Capital	Treasury Stock		Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Noncontrolling Interests	Total
		Shares	Amount		Shares	Amount				
		(In thousands, except share data)								
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)	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
Stock-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	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
Stock-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

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY — (Continued)

	Redeemable Noncontrolling Interests	Community Health Systems, Inc. Stockholders							Noncontrolling Interests	Total
		Common Stock		Additional Paid-in Capital	Treasury Stock		Accumulated Other Comprehensive Income (Loss)	Retained Earnings		
		Shares	Amount		Shares	Amount				
		(In thousands, except share data)								
Comprehensive income	56,235	—	—	—	—	—	39,169	265,640	23,928	328,737
Distributions to noncontrolling interests, net of contributions	(43,613)	—	—	—	—	—	—	—	(24,196)	(24,196)
Purchase of subsidiary shares from noncontrolling interests	(21,607)	—	—	(21,537)	—	—	—	—	(1,143)	(22,680)
Other reclassifications of noncontrolling interests	718	—	—	—	—	—	—	—	(624)	(624)
Adjustment to redemption value of redeemable noncontrolling interests	(19,810)	—	—	19,810	—	—	—	—	—	19,810
Issuance of common stock in connection with the exercise of stock options	—	1,054,075	11	20,858	—	—	—	—	—	20,869
Cancellation of restricted stock for tax withholdings on vested shares	—	(371,946)	(4)	(9,314)	—	—	—	—	—	(9,318)
Net distribution to shareholders	—	—	—	443	—	—	—	(22,978)	—	(22,535)
Excess tax benefit from exercise of stock options	—	—	—	1,110	—	—	—	—	—	1,110
Stock-based compensation	—	696,507	7	40,896	—	—	—	—	—	40,903
Balance, December 31, 2012	$367,666	92,925,715	$929	$1,138,274	(975,549)	$(6,678)	$(145,310)	$1,743,992	$ 65,314	$2,796,521

See notes to the consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2012	2011	2010
		(In thousands)	
Cash flows from operating activities:			
Net income	$ 345,803	$ 277,623	$ 348,441
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	725,558	657,665	609,839
Deferred income taxes	53,407	107,032	97,370
Stock-based compensation expense	40,896	42,542	38,779
Loss on sale, net	—	2,572	—
Impairment of hospitals sold	—	47,930	—
Impairment of long-lived assets	10,000	—	—
Loss from early extinguishment of debt	115,453	66,019	—
Excess tax benefit relating to stock-based compensation	(3,973)	(5,290)	(10,219)
Other non-cash expenses, net	33,251	28,716	12,503
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	(204,151)	(138,332)	(27,049)
Supplies, prepaid expenses and other current assets	(99,799)	(42,858)	(39,904)
Accounts payable, accrued liabilities and income taxes	246,301	246,110	161,952
Other	17,374	(27,821)	(2,982)
Net cash provided by operating activities	1,280,120	1,261,908	1,188,730
Cash flows from investing activities:			
Acquisitions of facilities and other related equipment	(322,315)	(415,360)	(248,251)
Purchases of property and equipment	(768,790)	(776,713)	(667,378)
Proceeds from disposition of hospitals and other ancillary operations	—	173,387	—
Proceeds from sale of property and equipment	5,897	11,160	8,401
Increase in other investments	(297,994)	(188,249)	(137,082)
Net cash used in investing activities	(1,383,202)	(1,195,775)	(1,044,310)
Cash flows from financing activities:			
Proceeds from exercise of stock options	20,858	18,910	56,916
Repurchase of restricted stock shares for payroll tax withholding requirements	(9,314)	(13,311)	—
Payment of special dividend to stockholders	(22,535)	—	—
Deferred financing costs	(141,219)	(19,352)	(13,260)
Excess tax benefit relating to stock-based compensation	3,973	5,290	10,219
Stock buy-back	—	(85,790)	(113,961)
Proceeds from noncontrolling investors in joint ventures	535	1,229	7,201
Redemption of noncontrolling investments in joint ventures	(44,287)	(13,022)	(7,318)
Distributions to noncontrolling investors in joint ventures	(68,344)	(56,094)	(68,113)
Borrowings under credit agreements	3,975,866	578,236	—
Issuance of long-term debt	3,825,000	1,000,000	—
Proceeds from receivables facility	350,000	—	—
Repayments of long-term indebtedness	(7,529,503)	(1,651,533)	(61,476)
Net cash provided by (used in) financing activities	361,030	(235,437)	(189,792)
Net change in cash and cash equivalents	257,948	(169,304)	(45,372)
Cash and cash equivalents at beginning of period	129,865	299,169	344,541
Cash and cash equivalents at end of period	$ 387,813	$ 129,865	$ 299,169
Supplemental disclosure of cash flow information:			
Interest payments	$ 594,292	$ 680,704	$ 650,712
Income taxes paid, net	$ 55,551	$ 26,463	$ 128,186

See notes to the consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION AND 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, 2012, the Company owned or leased 135 hospitals, including four stand-alone rehabilitation or psychiatric hospitals, licensed for 20,334 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, 2012, Indiana, Texas and Pennsylvania represent the only areas of geographic concentration. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by the Company's hospitals in Indiana, as a percentage of consolidated operating revenues, were 10.5% in 2012, 10.3% in 2011 and 10.6% in 2010. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by the Company's hospitals in Texas, as a percentage of consolidated operating revenues, were 14.4% in 2012, 13.1% in 2011 and 13.0% in 2010. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by the Company's hospitals in Pennsylvania, as a percentage of consolidated operating revenues, were 12.6% in 2012, 11.5% in 2011 and 10.3% in 2010.

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 $214.8 million, $183.4 million and $155.4 million for the years ended December 31, 2012, 2011 and 2010, respectively. Included in these amounts is stock-based compensation of $40.9 million, $42.5 million and $38.8 million for the years ended December 31, 2012, 2011 and 2010, 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.

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. Other comprehensive income (loss) included an unrealized gain of $3.0 million, an unrealized loss of $1.0 million and an unrealized gain of $3.7 million during the years ended December 31, 2012, 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 50 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 $173.4 million and $397.2 million at December 31, 2012 and 2011, 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 $23.9 million, $21.4 million and $11.9 million for the years ended December 31, 2012, 2011 and 2010, respectively. Purchases of property and equipment accrued in accounts payable and not yet paid were $50.2 million and $94.2 million at December 31, 2012 and 2011, 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 performs its annual testing of impairment for goodwill in the fourth quarter of each year.

Other Assets. Other assets 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 to ten 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. 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 36.1%, 36.5% and 38.1% of operating revenues,

net of contractual allowances and discounts (but before the provision for bad debts), for the years ended December 31, 2012, 2011 and 2010, 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 0.45%, 0.42% and 0.43% of operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), for the years ended December 31, 2012, 2011 and 2010, 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 operating revenues (net of contractual allowances and discounts). 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.

Included in net operating revenues for the year ended December 31, 2012 is approximately $105.3 million of net operating revenues from an industry-wide settlement with the United States Department of Health and Human Services and Centers for Medicare and Medicaid Services, based on a claim that acute-care hospitals in the U.S. were underpaid from the Medicare inpatient prospective payment system in federal fiscal years 1999 through 2011. The underpayments resulted from calculations related to the rural floor budget neutrality adjustments implemented in connection with the Balanced Budget Act of 1997. Also included in net operating revenues for the year ended December 31, 2012 is an unfavorable adjustment of approximately $21.0 million related to the revised Supplemental Security Income ratios issued for federal fiscal years 2006 through 2009 utilized for calculating Medicare Disproportionate Share Hospital reimbursements. Other than these items, 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, 2012, 2011 and 2010.

Amounts due to third-party payors were $80.5 million and $66.0 million as of December 31, 2012 and 2011, respectively, and are included in accrued liabilities-other in the accompanying consolidated balance sheets. Amounts due from third-party payors were $119.2 million and $86.5 million as of December 31, 2012 and 2011, 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 $49.3 billion, $42.4 billion and $35.8 billion in 2012, 2011 and 2010, 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 $1.2 billion, $852.4 million and $689.4 million for the years ended December 31, 2012, 2011 and 2010, respectively.

In the ordinary course of business, the Company renders services to patients who are financially unable to pay for hospital care. The Company's policy is to not pursue collections for such amounts, therefore, the related

charges for those patients who are financially unable to pay and that otherwise do not qualify for reimbursement from a governmental program are not reported in net operating revenues or in the provision for bad debts, and are thus classified as charity care. The Company determines amounts that qualify for charity care primarily based on the patient's household income relative to the federal poverty level guidelines, as established by the federal government.

Included in the provision for contractual allowance shown above is $692.4 million, $651.1 million and $512.4 million for the years ended December 31, 2012, 2011 and 2010, respectively, representing the value (at the Company's standard charges) of these charity care services that are excluded from net operating revenues.

The estimated cost incurred by the Company to provide these charity care services to patients who are unable to pay was approximately $125.4 million, $125.7 million and $105.5 million for the years ended December 31, 2012, 2011 and 2010, respectively. The estimated cost of these charity care services was determined using a ratio of cost to gross charges and applying that ratio to the gross charges associated with providing care to charity patients for the period.

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 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 expenses.

Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), recognized during the years ended December 31, 2012, 2011 and 2010, is as follows (in thousands):

	Year Ended December 31,		
	2012	2011	2010
Medicare	$ 3,955,235	$ 3,654,247	$ 3,464,117
Medicaid	1,455,650	1,318,756	1,345,315
Managed Care and other third-party payors	7,629,416	7,014,519	6,359,322
Self-pay	1,947,878	1,638,646	1,454,520
Total	$14,988,179	$13,626,168	$12,623,274

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.

Electronic Health Records Incentive Reimbursement. The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act ("HITECH"). These provisions were designed to increase the use of electronic health records ("EHR") technology and establish the requirements for a Medicare and Medicaid incentive payments program beginning in 2011 for eligible hospitals and providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are available to providers that adopt, implement or upgrade certified EHR technology; but providers must demonstrate meaningful use of such technology in subsequent years to qualify for additional incentive payments. Medicaid EHR incentive payments are fully funded by the federal government and administered by the states; however, the states are not required to offer EHR incentive payments to providers.

The Company recognized approximately $126.7 million and $63.4 million during the years ended December 31, 2012 and 2011, respectively, of incentive reimbursement for HITECH incentives from Medicare and Medicaid related to certain of the Company's hospitals and for certain of the Company's employed physicians that have demonstrated meaningful use of certified EHR technology or have completed attestations to their adoption or implementation of certified EHR technology. These incentive reimbursements are presented as a reduction of operating costs and expenses on the consolidated statements of income. The Company received cash related to the incentive reimbursement for HITECH incentives of approximately $141.0 million and $37.4 million, of which $33.3 million and $8.5 million was recorded as deferred revenue as all criteria for gain recognition had not been met, for the years ended December 31, 2012 and 2011, respectively. No incentive reimbursement was recognized and no cash was received for the year ended December 31, 2010 related to HITECH incentives from Medicare and Medicaid.

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, 2012 and 2011, the unamortized portion of these physician income guarantees was $30.1 million and $33.0 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 $315.5 million and $250.8 million as of December 31, 2012 and 2011, respectively, representing 7.4% and 6.7% of consolidated net accounts receivable, before allowance for doubtful accounts, as of December 31, 2012 and 2011, 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.

During the year ended December 31, 2012, the Company recorded a pretax impairment charge of $10.0 million to reduce the carrying value of certain long-lived assets at three of its smaller hospitals to their estimated fair value. The impairment was identified because of declining operating results and projections of future cash flows at these hospitals caused by competitive and operational challenges specific to the markets in which these hospitals operate. The impairment did not have a significant impact on the Company's consolidated financial position, results of operations, or cash flows as of and for the year ended December 31, 2012. There were no impairments of long-lived assets in 2011 or 2010.

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, 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)
2012 activity, net of tax	46,409	3,012	(10,252)	39,169
Balance as of December 31, 2012 . . .	$(116,382)	$4,588	$(33,516)	$(145,310)

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 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 February 2013, the Financial Accounting Standards Board issued Accounting Standards Update ("ASU") 2013-02, which requires additional disclosures on the effect of significant reclassifications out of accumulated other comprehensive income. The ASU requires a company that reports other comprehensive income to present (either on the face of the statement where net income is presented or in the notes) the effects on the line items of net income of significant amounts reclassified out of accumulated other comprehensive income. For other amounts that are not required to be reclassified in their entirety to net income in the same reporting period, an entity is required to cross-reference to other required disclosures that provide additional details about those amounts. This ASU is effective for fiscal years beginning after December 15, 2012, and will be adopted by the Company on January 1, 2013. As it only requires additional disclosure, the adoption of this ASU will not 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 (the "IRC"), as well as stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Prior to being amended in 2009, the 2000 Plan also allowed for the grant of phantom stock. Persons eligible to receive grants under the 2000 Plan include the Company's directors, officers, employees and consultants. 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, 2012, 799,129 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. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date. Options granted in 2011 or later have a 10-year contractual term. As of December 31, 2012, 1,511,339 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.

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,		
	2012	2011	2010
Effect on income from continuing operations before income taxes	$(40,896)	$(42,542)	$(38,779)
Effect on net income	$(25,683)	$(27,014)	$(24,625)

At December 31, 2012, $35.2 million of unrecognized stock-based compensation expense was expected to be recognized over a weighted-average period of 17 months. Of that amount, $7.0 million related to outstanding unvested stock options was expected to be recognized over a weighted-average period of 17 months and $28.2 million related to outstanding unvested restricted stock and restricted stock units was expected to be recognized over a weighted-average period of 17 months. There were no modifications to awards during the years ended December 31, 2012, 2011 and 2010.

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, 2012, 2011 and 2010:

	Year Ended December 31,		
	2012	2011	2010
Expected volatility	57.8%	33.8%	33.7%
Expected dividends	—	—	—
Expected term	4.1 years	4 years	3.1 years
Risk-free interest rate	0.66%	1.63%	1.41%

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 discernible employee populations. From this analysis, the Company identified two primary employee populations, one consisting of certain senior executives and the other one 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.

Options outstanding and exercisable under the 2000 Plan and the 2009 Plan as of December 31, 2012, and changes during each of the years in the three-year period ended December 31, 2012, 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, 2012
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		
Granted	253,500	21.16		
Exercised	(1,050,772)	19.85		
Forfeited and cancelled	(487,757)	34.12		
Outstanding at December 31, 2012	7,104,113	$34.25	4.6 years	$10,504
Exercisable at December 31, 2012	5,663,196	$34.64	3.8 years	$ 6,947

The weighted-average grant date fair value of stock options granted during the years ended December 31, 2012, 2011 and 2010, was $9.20, $10.07, and $8.47, 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 ($30.74) 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, 2012. 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, 2012, 2011 and 2010 was $9.4 million, $6.1 million and $28.9 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.

Restricted stock outstanding under the 2000 Plan and the 2009 Plan as of December 31, 2012, and changes during each of the years in the three-year period ended December 31, 2012, were as follows:

	Shares	Weighted - Average Grant Date Fair Value
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
Granted	680,500	21.20
Vested	(1,118,213)	29.67
Forfeited	(25,335)	30.94
Unvested at December 31, 2012	1,744,564	30.50

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 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. On February 16, 2012, each of the Company's outside directors received a grant under the 2009 Plan of 6,645 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. As of December 31, 2012, all phantom stock has vested and there is no phantom stock outstanding.

Restricted stock units and phantom stock outstanding under the 2000 Plan and the 2009 Plan as of December 31, 2012, and changes during each of the years in the three-year period ended December 31, 2012, were as follows:

	Shares	Weighted - Average Grant Date Fair Value
Unvested at December 31, 2009	50,057	$19.19
RSUs Granted	24,780	33.90
Vested	(21,449)	18.97
Forfeited	—	—
Unvested at December 31, 2010	53,388	26.11
RSUs Granted	22,128	37.96
Vested	(22,560)	24.68
Forfeited	—	—
Unvested at December 31, 2011	52,956	31.67
RSUs Granted	39,870	21.07
Vested	(29,940)	27.95
Forfeited	—	—
Unvested at December 31, 2012	62,886	26.72

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,		
	2012	2011	2010
Directors' fees earned and deferred into plan	$ 110	$ 220	$ 180
Share equivalent units	4,056	9,974	5,207

At December 31, 2012, a total of 28,069 share equivalent units were deferred in the plan with an aggregate fair value of $0.9 million, based on the closing market price of the Company's common stock at December 31, 2012 of $30.74.

3. ACQUISITIONS AND DIVESTITURES

Acquisitions

The Company accounts for all transactions that represent business combinations using the acquisition method of accounting, where the identifiable assets acquired, the liabilities assumed and any noncontrolling

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

Effective July 1, 2012, one or more subsidiaries of the Company completed the acquisition of Memorial Health Systems in York, Pennsylvania. This healthcare system includes Memorial Hospital (100 licensed beds), the Surgical Center of York, and other outpatient and ancillary services. As part of this purchase agreement, the Company has agreed to spend at least $75.0 million to build a replacement hospital within five years of the closing date. The total cash consideration paid for fixed assets and working capital was approximately $45.0 million and $2.6 million, respectively, with additional consideration of $12.5 million assumed in liabilities, for a total consideration of $60.1 million. Based upon the Company's preliminary purchase price allocation relating to this acquisition as of December 31, 2012, approximately $9.9 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 March 5, 2012, one or more subsidiaries of the Company completed a merger with Diagnostic Clinic of Longview, P.A., which is a multi-specialty clinic serving residents of Longview, Texas and surrounding East Texas communities. This merger was accounted for as a purchase business combination. The total cash consideration paid for the business, including net working capital, was approximately $52.3 million, with additional consideration of $6.9 million assumed in liabilities, for a total consideration of $59.2 million. Based upon the Company's preliminary purchase price allocation relating to this acquisition as of December 31, 2012, approximately $41.8 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. Adjustments to the purchase price allocation are not expected to be material.

Effective March 1, 2012, one or more subsidiaries of the Company completed the acquisition of MetroSouth Medical Center (330 licensed beds) located in Blue Island, Illinois. The total cash consideration paid for fixed assets was approximately $39.3 million with additional consideration of $5.8 million assumed in liabilities as well as a credit applied at closing of $0.9 million for negative acquired working capital, for a total consideration of $44.2 million. Based upon the Company's preliminary purchase price allocation relating to this acquisition as of December 31, 2012, no 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 January 1, 2012, one or more subsidiaries of the Company completed the acquisition of Moses Taylor Healthcare System based in Scranton, Pennsylvania, which is a healthcare system comprised of two acute care hospitals and other healthcare providers. This healthcare system includes Moses Taylor Hospital (217 licensed beds) located in Scranton, Pennsylvania, and Mid-Valley Hospital (25 licensed beds) located in Peckville, Pennsylvania. The total cash consideration paid for fixed assets and working capital was approximately $151.1 million and $13.1 million, respectively, with additional consideration of $9.4 million

assumed in liabilities, for a total consideration of $173.6 million. Based upon the Company's final purchase price allocation relating to this acquisition as of December 31, 2012, approximately $54.6 million of goodwill has been recorded.

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 $15.9 million assumed in liabilities, for a total consideration of $225.4 million. Based upon the Company's final purchase price allocation relating to this acquisition, as of December 31, 2012, approximately $32.4 million of goodwill has been recorded.

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, 2012, 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, 2012 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, 2012 approximately $2.4 million of goodwill has been recorded.

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, 2012 no goodwill has been recorded.

Approximately $9.9 million, $16.0 million and $8.9 million of acquisition costs related to prospective and closed acquisitions were expensed during the years ended December 31, 2012, 2011 and 2010, respectively, and are included in other operating expenses on the consolidated statements of income.

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

	2012	2011
Current assets	$ 46,207	$ 26,017
Property and equipment	178,836	280,639
Goodwill	106,269	73,923
Intangible assets	2,522	2,260
Other long-term assets	490	3,497
Liabilities	34,463	28,089

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 $337.0 million for the year ended December 31, 2012 from hospital acquisitions that closed during 2012 and net operating revenues of $169.7 million for the year ended December 31, 2011 from hospital acquisitions that closed during 2011. The following pro forma combined summary of operations of the Company gives effect to using historical information of the operations of the acquisitions in 2012 and 2011 discussed above as if the transactions had occurred as of January 1, 2011 (in thousands, except per share data):

	Year Ended December 31,	
	2012	2011
	(Unaudited)	
Pro forma net operating revenues	$13,120,413	$12,581,713
Pro forma net income	258,019	163,463
Pro forma net income per share:		
Basic	$ 2.89	$ 1.82
Diluted	$ 2.87	$ 1.80

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, 2011. These pro forma results are not necessarily indicative of the actual results of operations.

Additionally, during the years ended December 31, 2012, 2011 and 2010, the Company paid approximately $41.5 million, $57.9 million and $67.4 million, respectively, to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by its hospitals. In connection with these acquisitions, during 2012, the Company assumed approximately $2.0 million in net working capital liabilities and allocated approximately $10.2 million of the consideration paid to property and equipment and the remainder, approximately $33.3 million consisting of intangible assets that do not qualify for separate recognition, to goodwill. During 2011, 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, to goodwill. During 2010, 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, to goodwill. These acquisition transactions during the years ended December 31, 2012, 2011 and 2010 were accounted for as purchase business combinations.

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.

The Company has classified the results of operations for Oregon Medical Group, SouthCrest Hospital, Claremore Regional Hospital and Cleveland Regional Hospital as discontinued operations in the accompanying consolidated statements of income for the years ended December 31, 2012, 2011 and 2010. As of December 31, 2012, no hospitals are held for sale.

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

	Year Ended December 31,		
	2012	2011	2010
Net operating revenues	$ —	$144,546	$305,562
Loss from operations of entities sold before income taxes	(729)	(12,390)	(10,460)
Impairment of hospitals sold	—	(51,695)	—
Loss on sale, net	—	(4,301)	—
Loss from discontinued operations, before taxes	(729)	(68,386)	(10,460)
Income tax benefit	(263)	(10,115)	(3,688)
Loss from discontinued operations, net of taxes	$ (466)	$ (58,271)	$ (6,772)

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

4. GOODWILL AND OTHER INTANGIBLE ASSETS

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

	Year ended December 31,	
	2012	2011
Balance, beginning of year	$4,264,845	$4,150,247
Goodwill acquired as part of acquisitions during the year	141,277	114,473
Consideration adjustments and purchase price allocation adjustments for prior year's acquisitions	2,016	125
Balance, end of year	$4,408,138	$4,264,845

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, 2012, the hospital operations reporting unit, the home care agency operations reporting unit, and the hospital management services reporting unit had approximately $4.3 billion, $40.5 million and $33.3 million, respectively, of goodwill. 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.

Goodwill is evaluated for impairment at the same time every year and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. There is a two-step method for determining goodwill impairment. Step one is to compare the fair value of the reporting unit with the unit's carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit's goodwill with the carrying value of the reporting unit's goodwill. The Company performed its last annual goodwill evaluation during the fourth quarter of 2012. No impairment was indicated by this evaluation. The next annual goodwill evaluation will be performed during the fourth quarter of 2013.

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 $2.7 million of intangible assets other than goodwill were acquired during the year ended December 31, 2012. The gross carrying amount of the Company's other intangible assets subject to amortization was $61.9 million at December 31, 2012 and $60.0 million at December 31, 2011, and the net carrying amount was $26.3 million at December 31, 2012 and $30.6 million at December 31, 2011. The carrying amount of the Company's other intangible assets not subject to amortization was $48.1 million and $46.9 million at December 31, 2012 and 2011, respectively. 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 eight years. There are no expected residual values related to these intangible assets. Amortization expense on these intangible assets was $7.5 million, $8.1 million and $12.2 million during the years ended December 31, 2012, 2011 and 2010, respectively. Amortization expense on intangible assets is estimated to be $6.0 million in 2013, $3.9 million in 2014, $3.2 million in 2015, $2.4 million in 2016, $2.1 million in 2017 and $8.7 million thereafter.

The gross carrying amount of capitalized software for internal use was approximately $654.4 million and $451.0 million at December 31, 2012 and 2011, respectively, and the net carrying amount considering accumulated amortization was approximately $354.4 million and $241.3 million at December 31, 2012 and 2011, respectively. The estimated amortization period for capitalized internal-use software is generally three years, except for capitalized costs related to significant system conversions, which is generally eight to ten years. There is no expected residual value for capitalized internal-use software. At December 31, 2012, there was approximately $161.3 million of capitalized costs for internal-use software that is currently in the development stage and will begin amortization once the software project is complete and ready for its intended use. Amortization expense on capitalized internal-use software was $100.7 million, $70.5 million and $48.2 million during the years ended December 31, 2012, 2011 and 2010, respectively. Amortization expense on capitalized internal-use software is estimated to be $107.3 million in 2013, $89.4 million in 2014, $44.9 million in 2015, $29.8 million in 2016, $25.6 million in 2017 and $57.4 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,		
	2012	2011	2010
Current:			
Federal	$ 94,080	$ 23,020	$ 54,986
State	10,015	7,601	11,208
	104,095	30,621	66,194
Deferred:			
Federal	56,487	105,771	92,628
State	(3,080)	1,261	4,859
	53,407	107,032	97,487
Total provision for income taxes for income from continuing operations	$157,502	$137,653	$163,681

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,					
	2012		2011		2010	
	Amount	%	Amount	%	Amount	%
Provision for income taxes at statutory federal rate	$176,320	35.0%	$165,741	35.0%	$181,474	35.0%
State income taxes, net of federal income tax benefit	12,293	2.4	8,212	1.7	8,847	1.7
Release of unrecognized tax benefit	—	—	(6,509)	(1.3)	—	—
Net income attributable to noncontrolling interests	(28,057)	(5.6)	(26,486)	(5.6)	(23,960)	(4.6)
Change in valuation allowance	(1,233)	(0.2)	—	—	(910)	(0.2)
Federal and state tax credits	(2,185)	(0.4)	(3,788)	(0.8)	(2,246)	(0.4)
Other	364	0.1	483	0.1	476	0.1
Provision for income taxes and effective tax rate for income from continuing operations	$157,502	31.3%	$137,653	29.1%	$163,681	31.6%

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, 2012 and 2011 consist of (in thousands):

	December 31,			
	2012		2011	
	Assets	Liabilities	Assets	Liabilities
Net operating loss and credit carryforwards	$ 170,521	$ —	$ 140,825	$ —
Property and equipment	—	762,387	—	727,366
Self-insurance liabilities	124,842	—	113,640	—
Intangibles	—	222,392	—	201,396
Investments in unconsolidated affiliates	—	64,170	—	62,112
Other liabilities	—	22,468	—	22,050
Long-term debt and interest	—	28,920	—	24,115
Accounts receivable	—	38,503	11,435	—
Accrued expenses	55,203	—	49,575	—
Other comprehensive income	102,242	—	128,170	—
Stock-based compensation	31,504	—	28,894	—
Deferred compensation	58,509	—	42,668	—
Other	65,887	—	57,158	—
	608,708	1,138,840	572,365	1,037,039
Valuation allowance	(161,312)	—	(150,254)	—
Total deferred income taxes	$ 447,396	$1,138,840	$ 422,111	$1,037,039

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 $3.5 billion, which expire from 2013 to 2032. 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 $17.4 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 $11.1 million during the year ended December 31, 2012 and increased by $23.6 million during the year ended December 31, 2011. 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 and credits in certain income tax jurisdictions.

The total amount of unrecognized benefit that would impact the effective tax rate, if recognized, was approximately $0.9 million as of December 31, 2012. A total of approximately $0.5 million of interest and penalties is included in the amount of liability for uncertain tax positions at December 31, 2012. During the year ended December 31, 2012, the Company increased interest and penalties by approximately $0.1 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.

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 financial statements.

The following is a tabular reconciliation of the total amount of unrecognized tax benefit for the years ended December 31, 2012, 2011 and 2010 (in thousands):

	Year Ended December 31,		
	2012	2011	2010
Unrecognized tax benefit, beginning of year	$ 629	$ 7,458	$ 9,234
Gross increases — tax positions in prior period	1,515	349	70
Reductions — tax positions in prior period	—	(3,469)	(1,833)
Lapse of statute of limitations	—	(3,575)	—
Settlements	(1,462)	(134)	(13)
Unrecognized tax benefit, end of year	$ 682	$ 629	$ 7,458

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 Hospitals, Inc. ("Triad") for the tax periods ended December 31, 1999, December 31, 2000, April 30, 2001, June 30, 2001, December 31, 2001, December 31, 2002, December 31, 2003 and December 31, 2004. The Internal Revenue Service (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. With few exceptions, the Company is no longer subject to state income tax examinations for years prior to 2009 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, 2008, 2009 and 2010 tax years are currently under examination by the IRS. The Company anticipates reaching a resolution on the 2007 and 2008 year examinations within the next six months. The Company believes the results of these examinations will not be material to its consolidated results of operations or consolidated financial position.

Cash paid for income taxes, net of refunds received, was $55.6 million, $26.5 million, and $128.2 million during the years ended December 31, 2012, 2011, and 2010, respectively.

6. LONG-TERM DEBT

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

	December 31, 2012	December 31, 2011
Credit Facility:		
Term loan A	$ 712,500	$ —
Term loan B	3,619,062	5,949,383
Revolving credit loans	—	30,000
8⅞% Senior Notes due 2015	—	1,777,617
8% Senior Notes due 2019	2,022,829	1,000,000
7⅛% Senior Notes due 2020	1,200,000	—
5⅛% Senior Secured Notes due 2018	1,600,000	—
Receivables Facility	300,000	—
Capital lease obligations	47,951	48,361
Other	38,963	41,143
Total debt	9,541,305	8,846,504
Less current maturities	(89,911)	(63,706)
Total long-term debt	$9,451,394	$8,782,798

Credit Facility

The Company's wholly-owned subsidiary CHS/Community Health Systems, Inc. ("CHS") has obtained senior secured financing under a credit facility (the "Credit Facility") with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The Credit Facility includes a $750 million revolving credit facility for working capital and general corporate purposes. 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 B facility equal to 0.25% of the outstanding amount of such term loans. On November 5, 2010, CHS entered into an amendment and restatement of the 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. The amendment also increased CHS' ability to issue additional indebtedness under the uncommitted incremental facility to $1.0 billion from $600 million, permitted CHS to issue term loan A 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 $1.7 billion would be required to be used for repayment of existing term loans. On February 2, 2012, CHS completed a second amendment and restatement of the Credit Facility to extend an additional $1.6 billion of the term loans due 2014 under the Credit Facility to match the maturity date and interest rate margins of the term loans due January 25, 2017.

On August 3, 2012, CHS entered into Amendment No. 1 to the Credit Facility to provide increased flexibility for refinancing and repayment of the term loans due 2014 and amend certain other terms. On August 17, 2012, the Company made a prepayment of $1.6 billion on the term loans due July 25, 2014, utilizing the proceeds from the issuance of $1.6 billion of 5⅛% Senior Secured Notes due 2018. On August 22, 2012, CHS entered into a loan modification agreement with respect to the Credit Facility to extend approximately $340 million of the term loans due 2014 to match the maturity date and interest rate margins of the term loans due January 25, 2017.

On November 27, 2012, CHS entered into Amendment No. 2 to the Credit Facility to provide increased flexibility for the Company to make investments and restricted payments, incur debt related to acquisitions, amend certain other terms of the Credit Facility, including the maximum leverage ratio and interest coverage ratio financial coverage levels, and add a one year 1% prepayment premium payable in connection with a repricing of the term loans due in 2017. The extended term loans are subject to customary acceleration events and earlier maturity if the repayment, extension or refinancing with longer maturity on substantially all of the outstanding term loans maturing July 25, 2014 does not occur by April 15, 2015. The July 25, 2014 maturity date of the balance of the remaining non-extended term loans at December 31, 2012 of approximately $266.1 million remains unchanged.

Effective March 6, 2012, the Company obtained a new $750 million senior secured revolving credit facility (the "Replacement Revolver Facility") and a new $750 million incremental term loan A facility (the "Incremental Term Loan") subject to the terms and conditions set forth in the Credit Facility. The Replacement Revolver Facility replaced in full the existing revolving credit facility under the Credit Facility. The net proceeds of the Incremental Term Loan were used to repay the same amount of the existing term loans under the Credit Facility. Both the Replacement Revolver Facility and the Incremental Term Loan have a maturity date of October 25, 2016, subject to customary acceleration events and to earlier maturity if the repayment, extension or refinancing with longer maturity debt of substantially all of the Company's then outstanding term loans maturing July 25, 2014 and the now fully redeemed 8⅞% Senior Notes does not occur by April 25, 2014. The pricing on each of the Replacement Revolver Facility and the Incremental Term Loan is initially LIBOR plus a margin of 250 basis points, subject to adjustment based on the Company's leverage ratio. The Incremental Term Loan amortizes at 5% in year one, 10% in years two and three, 15% in year four and 60% in year five.

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 of its existing and subsequently acquired or organized domestic subsidiaries. All obligations under the Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of the Company, CHS and each subsidiary guarantor, including equity interests held by the Company, CHS or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries.

The loans under the Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at CHS' option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus 0.50% or (3) the adjusted London Interbank Offered Rate ("LIBOR") on such day for a three-month interest period commencing on the second business day after such day plus 1%, or (b) 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 2.50% for term loans due 2017. The applicable percentage for

Eurodollar rate loans is 2.25% for term loans due 2014 and 3.50% for term loans due 2017. The applicable percentage for revolving loans and the Incremental Term Loan is 1.50% for Alternate Base Rate loans and 2.50% for Eurodollar 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 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 is 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.

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.

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

As of December 31, 2012, the availability for additional borrowings under the Credit Facility was $750 million pursuant to the Replacement Revolver Facility, of which $37.8 million was set aside for outstanding letters of credit. CHS has the ability to amend the Credit Facility to provide for one or more tranches of term loans in an aggregate principal amount of $1.0 billion, which CHS has not yet accessed. As of December 31, 2012, the weighted-average interest rate under the Credit Facility, excluding swaps, was 4.2%.

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

Year	Amount
2013	$ 75,000
2014	358,528
2015	147,336
2016	484,836
2017	3,265,862
Thereafter	—
Total	$4,331,562

As of December 31, 2012 and 2011, the Company had letters of credit issued, primarily in support of potential insurance-related claims and certain bonds, of approximately $37.8 million and $37.7 million, respectively.

Subsequent to the issuance of the Company's 2012 Quarterly Reports on Form 10-Q, the Company determined that the conversion of the term loans due 2014 to extended term loans resulting from the second amendment and restatement of its Credit Facility on February 2, 2012 and the loan modification agreement on August 22, 2012 should be presented as net financing activities in the consolidated statement of cash flows. Such activities were presented in the previously issued Quarterly Reports on Form 10-Q as a gross-up of borrowings and repayments of debt in the condensed consolidated statement of cash flows. There was no impact on net cash flows provided by financing activities as previously presented. This correction is reflected in the consolidated statement of cash flows in this Annual Report on Form 10-K. The Company plans to correct the comparable 2012 information in future Quarterly Reports on Form 10-Q. Management does not believe such correction is material to the previously issued condensed consolidated financial statements.

8⅞% Senior Notes due 2015

The 8⅞% Senior Notes due 2015 (the "8⅞% Senior Notes") were issued by CHS in the principal amount of approximately $3.0 billion. The 8⅞% Senior Notes were to mature on July 15, 2015. The 8⅞% Senior Notes bore 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 8⅞% Senior Notes accrued from the date of original issuance. Interest was calculated on the basis of a 360-day year comprised of twelve 30-day months.

Pursuant to a registration rights agreement entered into at the time of the issuance of the 8⅞% Senior Notes, as a result of an exchange offer made by CHS, substantially all of the 8⅞% Senior Notes issued in July 2007 were exchanged in November 2007 for new notes (the "8⅞% Exchange Notes") having terms substantially identical in all material respects to the 8⅞% Senior Notes (except that the 8⅞% Exchange Notes were issued under a registration statement pursuant to the 1933 Act). References to the 8⅞% Senior Notes shall also be deemed to include the 8⅞% Exchange Notes unless the context provides otherwise.

On December 7, 2011, CHS completed the cash tender offer for $1.0 billion of the then $2.8 billion aggregate outstanding principal amount of the 8⅞% Senior Notes.

On March 21, 2012, CHS completed the cash tender offer for $850 million of the then $1.8 billion aggregate outstanding principal amount of the 8⅞% Senior Notes.

On July 18, 2012, CHS completed the cash tender offer for $639.7 million of the then $934.3 million aggregate outstanding principal amount of the 8⅞% Senior Notes. On August 17, 2012, pursuant to its redemption option, CHS redeemed the remaining $294.6 million outstanding principal of the 8⅞% Senior Notes.

8% Senior Notes due 2019

On November 22, 2011, CHS completed its offering of $1.0 billion aggregate principal amount of 8% Senior Notes due 2019 (the "8% Senior Notes"), which were issued in a private placement. The net proceeds from this issuance, together with available cash on hand, were used to finance the purchase of up to $1.0 billion aggregate principal amount of CHS' then outstanding 8⅞% Senior Notes and related fees and expenses. On March 21, 2012, CHS completed the secondary offering of $1.0 billion aggregate principal amount of 8% Senior Notes, which were issued in a private placement (at a premium of 102.5%). The net proceeds from this issuance

were used to finance the purchase of approximately $850 million aggregate principal amount of CHS' then outstanding 8⅞% Senior Notes, to pay related fees and expenses and for general corporate purposes. The 8% Senior Notes bear interest at 8% per annum, payable semiannually in arrears on May 15 and November 15, commencing May 15, 2012. Interest on the 8% Senior Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

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

Prior to November 15, 2014, CHS is entitled, at its option, to redeem a portion of the 8% Senior Notes (not to exceed 35% of the outstanding principal amount) at a redemption price of 108.000%, plus accrued and unpaid interest, with the proceeds from certain public equity offerings. Prior to November 15, 2015, CHS may redeem some or all of the 8% Senior Notes at a price equal to 100% of the principal amount of the notes redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the 8% Senior Notes indenture. On and after November 15, 2015, CHS is entitled, at its option, to redeem all or a portion of the 8% Senior Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the 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%

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

7⅛% Senior Notes due 2020

On July 18, 2012, CHS completed an underwritten public offering under its automatic shelf registration filed with the Securities and Exchange Commission (the "SEC") of $1.2 billion aggregate principal amount of 7⅛% Senior Notes due 2020 (the "7⅛% Senior Notes"). The net proceeds from this issuance were used to finance the purchase of $934.3 million aggregate principal amount of CHS' outstanding 8⅞% Senior Notes and related fees and expenses and for general corporate purposes. The 7⅛% Senior Notes bear interest at 7.125% per annum, payable semiannually in arrears on July 15 and January 15, commencing January 15, 2013. Interest on the 7⅛% 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 7⅛% Senior Notes prior to July 15, 2016.

Prior to July 15, 2015, CHS is entitled, at its option, to redeem a portion of the 7⅛% Senior Notes (not to exceed 35% of the outstanding principal amount) at a redemption price of 107.125%, plus accrued and unpaid interest, with the proceeds from certain public equity offerings. Prior to July 15, 2016, CHS may redeem some or

all of the 7⅛% Senior Notes at a price equal to 100% of the principal amount of the notes redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the 7⅛% Senior Notes indenture. On and after July 15, 2016, CHS is entitled, at its option, to redeem all or a portion of the 7⅛% Senior Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the 12-month period commencing on July 15 of the years set forth below:

Period	Redemption Price
2016	103.563%
2017	101.781%
2018 and thereafter	100.000%

5⅛% Senior Secured Notes due 2018

On August 17, 2012, CHS completed an underwritten public offering under its automatic shelf registration filed with the SEC of $1.6 billion aggregate principal amount of 5⅛% Senior Secured Notes due 2018 (the "5⅛% Senior Secured Notes"). The net proceeds from this issuance, together with available cash on hand, were used to finance the prepayment of $1.6 billion of the outstanding term loans due 2014 under the Credit Facility and related fees and expenses. The 5⅛% Senior Secured Notes bear interest at 5.125% per annum, payable semiannually in arrears on August 15 and February 15, commencing February 15, 2013. Interest on the 5⅛% Senior Secured Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months. The 5⅛% Senior Secured Notes are secured by a first-priority lien subject to a shared lien of equal priority with certain other obligations, including obligations under the Credit Facility, and subject to prior ranking liens permitted by the indenture governing the 5⅛% Senior Secured Notes on substantially the same assets, subject to certain exceptions, that secure CHS' obligations under the Credit Facility.

Except as set forth below, CHS is not entitled to redeem the 5⅛% Senior Secured Notes prior to August 15, 2015.

Prior to August 15, 2015, CHS is entitled, at its option, to redeem a portion of the 5⅛% Senior Notes (not to exceed 35% of the outstanding principal amount) at a redemption price of 105.125%, plus accrued and unpaid interest, with the proceeds from certain public equity offerings. Prior to August 15, 2015, CHS may redeem some or all of the 5⅛% Senior Secured Notes at a price equal to 100% of the principal amount of the notes redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the 5⅛% Senior Secured Notes indenture. On and after August 15, 2015, CHS is entitled, at its option, to redeem all or a portion of the 5⅛% Senior Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the 12-month period commencing on August 15 of the years set forth below:

Period	Redemption Price
2015	102.563%
2016	101.281%
2017 and thereafter	100.000%

Receivables Facility

On March 21, 2012, the Company and certain of its subsidiaries entered into an accounts receivable loan agreement (the "Receivables Facility") with a group of lenders and banks, Credit Agricolé Corporate and Investment Bank, as a managing agent and as the administrative agent, and The Bank of Nova Scotia, as a managing agent. The existing and future patient-related accounts receivable (the "Receivables") for certain of the Company's hospitals serve as collateral for the outstanding borrowings under the Receivables Facility. The interest rate on the borrowings is based on the commercial paper rate plus an applicable interest rate spread. Unless earlier terminated or subsequently extended pursuant to its terms, the Receivables Facility will expire on March 21, 2014, subject to customary termination events that could cause an early termination date. The Company maintains effective control over the Receivables because, pursuant to the terms of the Receivables Facility, the Receivables are sold from certain of the Company's subsidiaries to the Company, which then sells or contributes the Receivables to a special-purpose entity that is wholly-owned by the Company. The wholly-owned special-purpose entity in turn grants security interests in the Receivables in exchange for borrowings obtained from the group of third-party lenders and banks of up to $300 million outstanding from time to time based on the availability of eligible Receivables and other customary factors. The group of third-party lenders and banks do not have recourse to the Company or its subsidiaries beyond the assets of the wholly-owned special-purpose entity that collateralizes the loan. The Receivables and other assets of the wholly-owned special-purpose entity will be available first and foremost to satisfy the claims of the creditors of such entity. The outstanding borrowings pursuant to the Receivables Facility at December 31, 2012 totaled $300.0 million and are classified as long-term debt on the consolidated balance sheet. At December 31, 2012, the carrying amount of Receivables included in the Receivables Facility totaled approximately $927.8 million and are included in patient accounts receivable on the consolidated balance sheet.

Loss from Early Extinguishment of Debt

The financing transactions discussed above relating to the repayment of the Company's term loans under the Credit Facility and the 8⅞% Senior Notes due 2015 resulted in a loss from early extinguishment of debt of $115.5 million and $66.0 million for the years ended December 31, 2012 and 2011, respectively, and an after-tax loss of $71.8 million and $42.0 million for the years ended December 31, 2012 and 2011, respectively.

Other Debt

As of December 31, 2012, 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 22 separate interest swap agreements in effect at December 31, 2012, with an aggregate notional amount of approximately $3.1 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, 250 basis points for the Replacement Revolver Facility and the Incremental Term Loan 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, 2012, 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
2013	$ 89,911
2014	666,303
2015	151,566
2016	488,645
2017	3,287,628
Thereafter	4,834,423
Total maturities	9,518,476
Plus unamortized note premium	22,829
Total long-term debt	$9,541,305

The Company paid interest of $594.3 million, $680.7 million and $650.7 million on borrowings during the years ended December 31, 2012, 2011 and 2010, respectively.

7. FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Company using available market information as of December 31, 2012 and 2011, 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,			
	2012		2011	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Assets:				
Cash and cash equivalents	$ 387,813	$ 387,813	$ 129,865	$ 129,865
Available-for-sale securities	56,376	56,376	31,582	31,582
Trading securities	34,696	34,696	30,486	30,486
Liabilities:				
Credit Facility	4,331,562	4,357,910	5,979,383	5,780,877
8⅞% Senior Notes	—	—	1,777,617	1,842,322
8% Senior Notes	2,022,829	2,185,220	1,000,000	995,000
7⅛% Senior Notes	1,200,000	1,285,848	—	—
5⅛% Senior Secured Notes	1,600,000	1,674,480	—	—
Receivables Facility and other debt	338,963	338,963	41,143	41,143

The estimated fair value is determined using the methodologies discussed below in accordance with accounting standards related to the determination of fair value based on the U.S. GAAP fair value hierarchy as discussed in Note 8. The estimated fair value for financial instruments with a fair value that does not equal its carrying value is considered a Level 1 valuation. The Company utilizes the market approach and obtains indicative pricing from the administrative agent to the Credit Facility to determine fair values, which are validated through publicly available subscription services such as Bloomberg where relevant.

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

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

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.

8⅞% 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.

7⅛% 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.

5⅛% Senior Secured 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.

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, 2012 and 2011, 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, 2012, 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.

Interest rate swaps consisted of the following at December 31, 2012:

Swap #	Notional Amount (in 000's)	Fixed Interest Rate	Termination Date	Fair Value of Liability (in 000's)
1	$200,000	2.242%	February 28, 2013	$ 621
2	100,000	5.023%	May 30, 2013	1,947
3	300,000	5.242%	August 6, 2013	8,885
4	100,000	5.038%	August 30, 2013	3,151
5	50,000	3.586%	October 23, 2013	1,333
6	50,000	3.524%	October 23, 2013	1,308
7	100,000	5.050%	November 30, 2013	4,339
8	200,000	2.070%	December 19, 2013	3,400
9	100,000	5.231%	July 25, 2014	7,650
10	100,000	5.231%	July 25, 2014	7,650
11	200,000	5.160%	July 25, 2014	15,078
12	75,000	5.041%	July 25, 2014	5,514
13	125,000	5.022%	July 25, 2014	9,153
14	100,000	2.621%	July 25, 2014	3,560
15	100,000	3.110%	July 25, 2014	4,326
16	100,000	3.258%	July 25, 2014	4,558
17	200,000	2.693%	October 26, 2014	8,484
18	300,000	3.447%	August 8, 2016	30,395
19	200,000	3.429%	August 19, 2016	20,257
20	100,000	3.401%	August 19, 2016	10,033
21	200,000	3.500%	August 30, 2016	20,889
22	100,000	3.005%	November 30, 2016	9,069

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

Assuming no change in December 31, 2012 interest rates, approximately $94.6 million of interest expense resulting from the spread between the fixed and floating rates defined in each interest rate swap agreement will be recognized during the next 12 months. If interest rate swaps do not remain highly effective as a cash flow hedge, the derivatives' gains or losses resulting from the change in fair value reported through OCI will be reclassified into earnings.

The following tabular disclosure provides the amount of pre-tax loss recognized as a component of OCI during the years ended December 31, 2012 and 2011 (in thousands):

Derivatives in Cash Flow Hedging Relationships	Amount of Pre-Tax Loss Recognized in OCI (Effective Portion) Year Ended December 31, 2012	2011
Interest rate swaps	$(69,020)	$(122,686)

The following tabular disclosure provides the location of the effective portion of the pre-tax loss reclassified from accumulated other comprehensive loss ("AOCL") into interest expense on the consolidated statements of income during the years ended December 31, 2012 and 2011 (in thousands):

Location of Loss Reclassified from AOCL into Income (Effective Portion)	Amount of Pre-Tax Loss Reclassified from AOCL into Income (Effective Portion) Year Ended December 31, 2012	2011
Interest expense, net	$141,648	$208,985

The fair values of derivative instruments in the consolidated balance sheets as of December 31, 2012 and 2011 were as follows (in thousands):

	Asset Derivatives				Liability Derivatives			
	December 31, 2012		December 31, 2011		December 31, 2012		December 31, 2011	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives designated as hedging instruments	Other assets, net	$—	Other assets, net	$—	Other long-term liabilities	$181,600	Other long-term liabilities	$254,228

8. FAIR VALUE

Fair Value Hierarchy

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

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

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

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

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

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability.

The following table sets forth, by level within the fair value hierarchy, the financial assets and liabilities recorded at fair value on a recurring basis as of December 31, 2012 and 2011 (in thousands):

	December 31, 2012	Level 1	Level 2	Level 3
Available-for-sale securities	$ 56,376	$56,376	$ —	$ —
Trading securities	34,696	34,696	—	—
Total assets	$ 91,072	$91,072	$ —	$ —
Fair value of interest rate swap agreements	$181,600	$ —	$181,600	$ —
Total liabilities	$181,600	$ —	$181,600	$ —

	December 31, 2011	Level 1	Level 2	Level 3
Available-for-sale securities	$ 31,582	$31,582	$ —	$ —
Trading securities	30,486	30,486	—	—
Total assets	$ 62,068	$62,068	$ —	$ —
Fair value of interest rate swap agreements	$254,228	$ —	$254,228	$ —
Total liabilities	$254,228	$ —	$254,228	$ —

Available-for-sale securities and trading securities classified as Level 1 are measured using quoted market prices.

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

The Company incorporates CVAs to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. In adjusting the fair value of its interest rate swap agreements for the effect of nonperformance or credit risk, the Company has considered the impact of any netting features included in the agreements. The CVA on the Company's interest rate swap agreements at December 31, 2012 resulted in a decrease in the fair value of the related liability of $3.6

million and an after-tax adjustment of $2.3 million to OCI. The CVA on the Company's interest rate swap agreements at December 31, 2011 resulted in a decrease in the fair value of the related liability of $21.7 million and an after-tax adjustment of $13.9 million to OCI.

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

9. LEASES

The Company leases hospitals, medical office buildings, and certain equipment under capital and operating lease agreements. During 2012, 2011 and 2010, the Company entered into capital lease obligations of $5.0 million, $3.0 million and $22.7 million, respectively. All lease agreements generally require the Company to pay maintenance, repairs, property taxes and insurance costs.

Commitments relating to noncancellable operating and capital leases for each of the next five years and thereafter are as follows (in thousands):

Year Ended December 31,	Operating(1)	Capital
2013	$185,532	$ 8,795
2014	159,365	7,925
2015	129,121	6,569
2016	92,585	5,799
2017	63,851	5,600
Thereafter	156,106	52,475
Total minimum future payments	$786,560	87,163
Less: Imputed interest		(39,212)
Total capital lease obligations		47,951
Less: Current portion		(4,631)
Long-term capital lease obligations		$ 43,320

(1) Minimum lease payments have not been reduced by minimum sublease rentals due in the future of $21.0 million.

Assets capitalized under capital leases as reflected in the accompanying consolidated balance sheets were $27.9 million of land and improvements, $200.1 million of buildings and improvements and $65.1 million of equipment and fixtures as of December 31, 2012 and $27.9 million of land and improvements, $193.7 million of buildings and improvements and $69.3 million of equipment and fixtures as of December 31, 2011. The accumulated depreciation related to assets under capital leases was $129.1 million and $119.3 million as of December 31, 2012 and 2011, respectively. Depreciation of assets under capital leases is included in depreciation and amortization expense and amortization of debt discounts on capital lease obligations is included in interest expense in the consolidated statements of income.

10. EMPLOYEE BENEFIT PLANS

The Company maintains various benefit plans, including defined contribution plans, defined benefit plans and deferred compensation plans, for which the Company's subsidiary, CHS, is the plan sponsor. The CHS/Community Health Systems, Inc. Retirement Savings Plan is a defined contribution plan which covers the majority of the employees of the Company. Employees of certain subsidiaries whose employment is covered by collective bargaining agreements are eligible to participate in one of several other defined contribution plans including the CHS/Community Health Systems, Inc. Standard 401(k) Plan, which was established effective October 1, 2010 for the benefit of employees at the three hospitals acquired in Youngstown, Ohio and Warren, Ohio and their beneficiaries. This plan is structured such that employees of other subsidiaries may become eligible to participate as new entities are acquired by the Company or upon changes to collective bargaining agreements covering participants in the other defined contribution plans. Total expense to the Company under the 401(k) plans was $108.5 million, $101.7 million and $95.8 million for the years ended December 31, 2012, 2011 and 2010, respectively.

The Company maintains unfunded deferred compensation plans that allow participants to defer receipt of a portion of their compensation. The liability under the deferred compensation plans was $87.3 million and $71.4 million as of December 31, 2012 and 2011, respectively. The Company had assets of $87.1 million and $72.5 million as of December 31, 2012 and 2011, respectively, in a non-qualified plan trust generally designated to pay benefits of the deferred compensation plans, consisting of trading securities of $34.7 million and $30.5 million as of December 31, 2012 and 2011, respectively, and company-owned life insurance contracts of $52.4 million and $42.0 million as of December 31, 2012 and 2011, respectively.

The Company maintains the CHS/Community Health Systems, Inc. Retirement Income Plan, which is a defined benefit, non-contributory pension plan that covers certain employees at three of its hospitals ("Pension Plan"). The Pension Plan provides benefits to covered individuals satisfying certain age and service requirements. Employer contributions to the Pension Plan are in accordance with the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as amended. The Company expects to make no contribution to the Pension Plan in 2013. The Company also provides an unfunded Supplemental Executive Retirement Plan ("SERP") for certain members of its executive management. The Company uses a December 31 measurement date for the benefit obligations and a January 1 measurement date for its net periodic costs for both the Pension Plan and SERP. Variances from actuarially assumed rates will result in increases or decreases in benefit obligations, net periodic cost and funding requirements in future periods. The Company had available-for-sale securities in a rabbi trust generally designated to pay benefits of the SERP in the amounts of $56.4 million and $31.6 million at December 31, 2012 and 2011, respectively. These amounts are included in other assets, net on the consolidated balance sheets.

A summary of the benefit obligations and funded status for the Company's Pension and SERP Plans at December 31, 2012 and 2011 follows (in thousands):

	Pension Plan		SERP	
	2012	2011	2012	2011
Change in benefit obligation:				
Benefit obligation, beginning of year	$ 51,112	$ 39,682	$ 86,150	$ 73,840
Service cost	1,227	1,315	5,808	5,197
Interest cost	2,140	2,159	3,398	3,434
Curtailment	(814)	—	—	—
Actuarial loss	3,590	8,480	10,752	5,225
Benefits paid	(742)	(524)	(1,270)	(1,546)
Benefit obligation, end of year	56,513	51,112	104,838	86,150
Change in plan assets:				
Fair value of assets, beginning of year	35,052	34,354	—	—
Actual return on plan assets	4,013	(536)	—	—
Employer contributions	1,392	1,758	—	—
Benefits paid	(742)	(524)	—	—
Fair value of assets, end of year	39,715	35,052	—	—
Unfunded status	$(16,798)	$(16,060)	$(104,838)	$(86,150)

A summary of the amounts recognized in the accompanying consolidated balance sheets at December 31, 2012 and 2011 follows (in thousands):

	Pension Plan		SERP	
	2012	2011	2012	2011
Noncurrent asset	$ —	$ —	$ —	$ —
Current liability	—	—	—	(1,191)
Noncurrent liability	(16,798)	(16,060)	(104,838)	(84,959)
Net amount recognized in the consolidated balance sheets	$(16,798)	$(16,060)	$(104,838)	$(86,150)

A summary of the amounts recognized in AOCL at December 31, 2012 and 2011 follows (in thousands):

	Pension Plan		SERP	
	2012	2011	2012	2011
Prior service (credit) cost	$ 1	$ (1,076)	$ 5,388	$ 7,084
Net actuarial loss	14,020	13,260	32,502	23,779
Total amount recognized in AOCL	$14,021	$12,184	$37,890	$30,863

A summary of the plans' benefit obligation and the fair value of plan assets at December 31, 2012 and 2011 follows (in thousands):

	Pension Plan		SERP	
	2012	2011	2012	2011
Projected benefit obligation	$56,513	$51,112	$104,838	$86,150
Accumulated benefit obligation	56,267	50,745	93,844	66,172
Fair value of plan assets	39,715	35,052	—	—

A summary of the weighted-average assumptions used by the Company to determine benefit obligations as of December 31, 2012 and 2011 follows:

	Pension Plan		SERP	
	2012	2011	2012	2011
Discount rate	3.90%	4.33%	3.00%	4.00%
Annual salary increases	5.00%	4.50%	4.00%	4.00%

A summary of net periodic cost and other amounts recognized in OCI for the years ended December 31, 2012, 2011 and 2010 follows (in thousands):

	Pension Plan			SERP		
	2012	2011	2010	2012	2011	2010
Service cost	$ 1,227	$ 1,315	$ 1,169	$ 5,808	$ 5,197	$ 4,661
Interest cost	2,140	2,159	2,051	3,398	3,434	3,728
Expected return on plan assets	(2,866)	(2,771)	(2,497)	—	—	—
Amortization of unrecognized prior service (credit) cost	(124)	(141)	(38)	1,697	1,696	1,697
Amortization of net loss	870	—	—	2,028	1,533	1,459
Curtailment credit	(952)	—	(1,910)	—	—	—
Net periodic cost	295	562	(1,225)	12,931	11,860	11,545
Prior service cost (credit) arising during period	952	—	(2,770)	—	—	(24)
Net loss (gain) arising during period	1,630	11,787	(2,044)	10,752	5,225	4,396
Amortization of:						
Prior service credit (cost)	124	141	38	(1,697)	(1,696)	(1,697)
Net actuarial loss	(870)	—	—	(2,028)	(1,533)	(1,459)
Total amount recognized in OCI	1,836	11,928	(4,776)	7,027	1,996	1,216
Total recognized in net periodic cost and OCI	$ 2,131	$12,490	$(6,001)	$19,958	$13,856	$12,761

A summary of the expected amortization amounts to be included in net periodic cost for 2013 are as follows (in thousands):

	Pension Plan	SERP
Prior service cost	$ —	$1,078
Actuarial loss	1,044	2,446

A summary of the weighted-average assumptions used by the Company to determine net periodic cost for the years ended December 31, 2012, 2011 and 2010 follows:

	Pension Plan			SERP		
	2012	2011	2010	2012	2011	2010
Discount rate	4.33%	5.50%	5.99%	4.00%	4.75%	6.00%
Rate of compensation increase	4.50%	4.50%	4.50%	4.00%	4.00%	5.00%
Expected long-term rate of return on assets	8.00%	8.00%	8.50%	N/A	N/A	N/A

The Company's weighted-average asset allocations by asset category at December 31, 2012 and 2011 were as follows:

	Pension Plan		SERP	
	2012	2011	2012	2011
Equity securities	100.00%	100.00%	N/A	N/A
Debt securities	—%	—%	N/A	N/A
Total	100.00%	100.00%	N/A	N/A

The Pension Plan assets are invested in mutual funds with an underlying investment allocation of 60% equity securities and 40% debt securities. All assets are measured at fair value using quoted prices in active markets and therefore are classified as Level 1 measurements in the fair value hierarchy. The expected long-term rate of return for the Pension Plan assets is based on current expected long-term inflation and historical rates of return on equities and fixed income securities, taking into account the investment policy under the plan. The expected long-term rate of return is weighted based on the target allocation for each asset category. Equity securities are expected to return between 7.0% and 11.0% and debt securities are expected to return between 2.0% and 5.5%. The Company expects the Pension Plan asset managers will provide a premium of up to approximately 1.5% per annum to the respective market benchmark indices.

The Company's investment policy related to the Pension Plan is to provide for growth of capital with a moderate level of volatility by investing in accordance with the target asset allocations stated above. The Company reviews its investment policy, including its target asset allocations, on a semi-annual basis to determine whether any changes in market conditions or amendments to its pension plans require a revision to its investment policy.

The estimated future benefit payments reflecting future service as of December 31, 2012 for the Pension Plan and SERP plan follows (in thousands):

Year Ending	Pension Plan	SERP
2013	$ 1,484	—
2014	1,590	13,337
2015	1,695	4,538
2016	1,955	46,422
2017	2,040	19,221
2018-2022	13,391	23,300

11. STOCKHOLDERS' EQUITY

Authorized capital shares of the Company include 400,000,000 shares of capital stock consisting of 300,000,000 shares of common stock and 100,000,000 shares of preferred stock. Each of the aforementioned classes of capital stock has a par value of $0.01 per share. Shares of preferred stock, none of which were outstanding as of December 31, 2012, may be issued in one or more series having such rights, preferences and other provisions as determined by the Board of Directors without approval by the holders of common stock.

On December 14, 2011, the Company adopted a new open market repurchase program for up to 4,000,000 shares of the Company's common stock, not to exceed $100 million in repurchases. The new repurchase 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 of repurchases has been expended. Through December 31, 2012, no shares have been purchased and retired under this program.

On September 15, 2010, the Company commenced an open market repurchase program for up to 4,000,000 shares of the Company's 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 of repurchases has been expended. During the year ended December 31, 2012, the Company did not repurchase any shares under this program. During the year ended December 31, 2011, the Company repurchased and retired 3,469,866 shares at a weighted average price of $24.68 under this program. The cumulative number of shares that have been repurchased and retired under this program through December 31, 2012 is 3,921,138 shares at a weighted-average price of $25.39 per share.

Historically, the Company has not paid any cash dividends. In December 2012, the Company declared and paid a special dividend of $0.25 per share to holders of its common stock at the close of business as of December 17, 2012, which totaled approximately $23.0 million. In the foreseeable future, the Company does not anticipate the payment of any other cash dividends. The Company's Credit Facility limits the Company's ability to pay dividends and/or repurchase stock to an amount not to exceed $150 million in the aggregate plus the aggregate amount of proceeds from the exercise of stock options. The indentures governing the 8% Senior Notes due 2019 and the 7⅛% Senior Notes due 2020 (collectively, the "Senior Notes") and the 5⅛% Senior Secured Notes due 2018 also limit the Company's ability to pay dividends and/or repurchase stock. As of December 31, 2012, under the most restrictive test under these agreements, the Company has approximately $178.1 million remaining available with which to pay permitted dividends and/or repurchase shares of stock or its Senior Notes.

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

	Year Ended December 31,		
	2012	2011	2010
Net income attributable to Community Health Systems, Inc. stockholders	$265,640	$201,948	$279,983
Transfers to the noncontrolling interests:			
Net decrease in Community Health Systems, Inc. paid-in capital for purchase of subsidiary partnership interests	(21,537)	(4,556)	(3,529)
Net transfers to the noncontrolling interests	(21,537)	(4,556)	(3,529)
Change to Community Health Systems, Inc. stockholders' equity from net income attributable to Community Health Systems, Inc. stockholders and transfers to noncontrolling interests	$244,103	$197,392	$276,454

12. EARNINGS PER SHARE

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

	Year Ended December 31,		
	2012	2011	2010
Numerator:			
Income from continuing operations, net of taxes	$ 346,269	$ 335,894	$ 355,213
Less: Income from continuing operations attributable to noncontrolling interests, net of taxes	80,163	75,675	68,577
Income from continuing operations attributable to Community Health Systems, Inc. common stockholders — basic and diluted	$ 266,106	$ 260,219	$ 286,636
Loss from discontinued operations, net of taxes	$ (466)	$ (58,271)	$ (6,772)
Less: Loss from discontinued operations attributable to noncontrolling interests, net of taxes	—	—	(119)
Loss from discontinued operations attributable to Community Health Systems, Inc. common stockholders — basic and diluted	$ (466)	$ (58,271)	$ (6,653)
Denominator:			
Weighted-average number of shares outstanding — basic	89,242,949	89,966,933	91,718,791
Effect of dilutive securities:			
Restricted stock awards	335,664	327,652	542,488
Employee stock options	212,227	361,554	667,606
Other equity-based awards	16,097	10,209	17,163
Weighted-average number of shares outstanding — diluted	89,806,937	90,666,348	92,946,048

Dilutive securities outstanding not included in the computation of earnings per share because their effect is antidilutive were as follows:

	Year Ended December 31,		
	2012	2011	2010
Employee stock options and restricted stock awards	7,071,896	6,432,281	4,882,338

13. EQUITY INVESTMENTS

As of December 31, 2012, the Company owned equity interests of 27.5% in four hospitals in Las Vegas, Nevada, and 26.1% in one hospital in Las Vegas, Nevada, in which Universal Health Systems, Inc. owns the majority interest, and an equity interest of 38.0% in three hospitals in Macon, Georgia, in which HCA Inc. owns the majority interest.

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

	December 31,	
	2012	2011
Current assets	$ 240,086	$ 233,496
Noncurrent assets	847,484	790,125
Total assets	$1,087,570	$1,023,621
Current liabilities	$ 89,933	$ 82,687
Noncurrent liabilities	1,941	2,094
Members' equity	995,569	938,672
Noncontrolling interest	127	168
Total liabilities and equity	$1,087,570	$1,023,621

	Year Ended December 31,		
	2012	2011	2010
Revenues	$1,236,915	$1,230,146	$1,195,108
Operating costs and expenses	$1,079,055	$1,068,212	$1,044,751
Income from continuing operations before taxes	$ 157,762	$ 162,124	$ 150,640

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

The Company's investment in all of its unconsolidated affiliates was $432.1 million and $422.2 million at December 31, 2012 and 2011, respectively, and is included in other assets, net in the accompanying consolidated balance sheets. Included in the Company's results of operations is the Company's equity in pre-tax earnings from all of its investments in unconsolidated affiliates, which was $42.0 million, $49.5 million and $45.4 million for the years ended December 31, 2012, 2011 and 2010, respectively.

14. SEGMENT INFORMATION

The Company currently operates in three distinct operating segments, represented by hospital operations (which includes its general acute care hospitals and related healthcare entities that provide inpatient and outpatient healthcare services), home care agency operations (which provide in-home outpatient care), and hospital management services (which provides executive management and consulting services to non-affiliated acute care hospitals). Only the hospital operations segment meets the criteria as a separate reportable segment. The financial information for the home care agencies and hospital management services segments do not meet the quantitative thresholds for a separate identifiable reportable segment and are combined into the corporate and all other reportable segment.

The distribution between reportable segments of the Company's net operating revenues, income from continuing operations before income taxes, expenditures for segment assets and total assets is summarized in the following tables (in thousands):

	December 31,		
	2012	2011	2010
Net operating revenues:			
Hospital operations	$12,751,982	$11,631,382	$10,813,383
Corporate and all other	277,003	274,830	279,039
Total	$13,028,985	$11,906,212	$11,092,422
Income from continuing operations before income taxes:			
Hospital operations	$ 858,699	$ 720,215	$ 662,303
Corporate and all other	(354,928)	(246,668)	(143,409)
Total	$ 503,771	$ 473,547	$ 518,894
Expenditures for segment assets:			
Hospital operations	$ 729,757	$ 737,391	$ 646,509
Corporate and all other	39,033	39,322	20,869
Total	$ 768,790	$ 776,713	$ 667,378

	December 31,	
	2012	2011
Total assets:		
Hospital operations	$15,142,281	$13,984,964
Corporate and all other	1,464,054	1,223,876
Total	$16,606,335	$15,208,840

15. COMMITMENTS AND CONTINGENCIES

Construction and Other Capital Commitments. Pursuant to a hospital purchase agreement in effect as of December 31, 2012, and where final certificate of need approval has been obtained, the Company has agreed to build a replacement facility in York, Pennsylvania. The estimated construction cost, including equipment costs, is approximately $100.0 million. This project is required to be completed in 2017 and no costs were incurred in 2012 related to this replacement hospital. In October 2008, after the purchase of the noncontrolling owner's interest in the Company's Birmingham, Alabama facility, the Company initiated the purchase of a site, which includes a partially constructed hospital structure, for a potential replacement for the existing Birmingham facility. In September 2010, the Company received approval of its request for a certificate of need from the Alabama Certificate of Need Review Board. This certificate of need was challenged in the Alabama state circuit and appellate courts but has recently been upheld, with issuance subject to the final resolution of the appeal process. The Company's estimated construction costs, including the acquisition of the site and equipment costs, are approximately $280.0 million for the Birmingham replacement facility. Of this amount, approximately $3.6 million has been expended through December 31, 2012. In addition, under other purchase agreements outstanding at December 31, 2012, the Company has committed to spend approximately $493.5 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, 2012, the Company has spent approximately $254.0 million related to these commitments.

Physician Recruiting Commitments. As part of its physician recruitment strategy, the Company provides income guarantee agreements to certain physicians who agree to relocate to its communities and commit to remain in practice there. Under such agreements, the Company is required to make payments to the physicians in excess of the amounts they earned in their practice up to the amount of the income guarantee. These income guarantee periods are typically for 12 months. Such payments are recoverable by the Company from physicians who do not fulfill their commitment period, which is typically three years, to the respective community. At December 31, 2012, the maximum potential amount of future payments under these guarantees in excess of the liability recorded is $27.4 million.

Professional Liability Claims. As part of the Company's business of owning and operating hospitals, it is subject to legal actions alleging liability on its part. The Company accrues 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. The Company does not accrue for costs that are part of corporate overhead, such as the costs of 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, historical claim reporting and payment patterns, the nature and level of hospital operations and actuarially determined projections. The actuarially determined projections are based on the Company's actual claim data, including historic reporting and payment patterns which have been gathered over an approximate 20-year period. As discussed below, since the Company purchases excess insurance on a claims-made basis that transfers risk to third-party insurers, the liability it accrues does include an amount for the losses covered by its excess insurance. The Company also records a receivable for the expected reimbursement of losses covered by excess insurance. Since the Company believes that the amount and timing of its future claims payments are reliably determinable, it discounts the amount accrued for losses resulting from professional liability claims using the risk-free interest rate corresponding to the timing of expected payments.

The net present value of the projected payments was discounted using a weighted-average risk-free rate of 1.2%, 1.2% and 1.3% in 2012, 2011 and 2010, respectively. This liability is adjusted for new claims information in the period such information becomes known. The Company's estimated liability for professional and general liability claims was $621.7 million and $567.8 million as of December 31, 2012 and 2011, respectively. The estimated undiscounted claims liability was $649.4 million and $595.7 million as of December 31, 2012 and 2011, respectively. The current portion of the liability for professional and general liability claims was $106.9 million and $98.1 million as of December 31, 2012 and 2011, respectively, and is included in other accrued liabilities in the accompanying consolidated balance sheets. 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.

The Company's processes for obtaining and analyzing claims and incident data are standardized across all of its hospitals and have been consistent for many years. The Company monitors the outcomes of the medical care services that it provides and for each reported claim, the Company obtains various information concerning the facts and circumstances related to that claim. In addition, the Company routinely monitors current key statistics and volume indicators in its 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 its individual claim accruals, the Company utilizes 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 the Company's 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 company-specific historical claims data and other information. This company-specific data includes information regarding the Company's 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 the Company determines its 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 the management. Changes in reserving data or the trends and factors that influence reserving data may signal fundamental shifts in the Company's 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 the Company's methods and models use different types of data and the Company selects its liability from the results of all of these methods, it typically cannot quantify the precise impact of such factors on its estimates of the liability. Due to the Company's standardized and consistent processes for handling claims and the long history and depth of company-specific data, the Company's methodologies have produced reliably determinable estimates of ultimate paid losses.

The Company is primarily self-insured for these claims; however, the Company obtains excess insurance that transfers the risk of loss to a third-party insurer for claims in excess of self-insured retentions. The Company's excess insurance is underwritten on a claims-made basis. For claims reported prior to June 1, 2002, substantially all of the Company's professional and general liability risks were subject to a $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 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 the Company for liabilities in excess of the self-insured retentions. The excess coverage consists of multiple layers of insurance, the sum of which totals up to $95 million per occurrence and in the aggregate for claims reported on or after June 1, 2003 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 Company's self-insured retention could increase to $10 million per claim for any subsequent claims in that policy year until the Company's total aggregate coverage is met.

Effective January 1, 2008, the 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 1999 were insured through a wholly-owned insurance subsidiary of HCA, Triad's owner prior to that time, and excess loss policies maintained by HCA. HCA has agreed to indemnify the former Triad hospitals in respect of claims covered by such insurance policies arising prior to May 1999. After May 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.

Legal Matters. The Company is a party to various legal proceedings incidental to its business. In the opinion of management, any ultimate liability with respect to these actions will not have a material adverse effect on the Company's consolidated financial position, cash flows or results of operations. With respect to all litigation matters, the Company considers the likelihood of a negative outcome. If the Company determines the likelihood of a negative outcome is probable and the amount of the loss can be reasonably estimated, the Company records an estimated loss for the expected outcome of the litigation and discloses that fact together with the amount accrued, if it was estimable. If the likelihood of a negative outcome is reasonably possible and the Company is able to determine an estimate of the possible loss or a range of loss, the Company discloses that fact together with the estimate of the possible loss or range of loss. However, it is difficult to predict the outcome or estimate a possible loss or range of loss in some instances because litigation is subject to significant uncertainties.

Reasonably Possible Contingencies

For the legal matter below, the Company believes that a negative outcome is reasonably possible, but the Company is unable to determine an estimate of the possible loss or a range of loss.

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

The Company's knowledge of this matter originated in early 2006 with correspondence from the Civil Division of the Department of Justice requesting documents in an investigation it was conducting involving the Company. The inquiry related to the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients. These programs are referred to by different names, including "intergovernmental payments," "upper payment limit programs," and "Medicaid disproportionate share hospital payments." For approximately three years, the Company provided the Department of Justice with requested documents, met with its personnel on numerous occasions and otherwise cooperated in its investigation. During the course of the investigation, the Civil Division notified the Company that it believed that the Company and three of its New Mexico hospitals caused the State of New Mexico to submit improper claims for federal funds, in violation of the Federal False Claims Act. This investigation has culminated in the federal government's intervention in the referenced qui tam lawsuit, which alleges that the Company's New Mexico hospitals "caused to be filed" false claims from the period of August 2000 through June 2011. Two of the parent company's subsidiaries are also defendants in this lawsuit. The Company continues to vigorously defend this action. The current posture of this case is that discovery is closed and both parties' motions for summary judgment have been on file for approximately 11 months. There is currently no hearing date on these motions and no trial date has been set.

Matters for which an Outcome Cannot be Assessed

For all of the legal matters below, the Company cannot at this time assess what the outcome may be and is further unable to determine any estimate of loss or range of loss. Because the investigations are at a preliminary stage, there are not sufficient facts available to make these assessments.

Multi-provider National Department of Justice Investigations

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

Department of Justice Investigation of Medicare Short-Stay Admissions from Emergency Departments

In April 2011, the Company received a document subpoena 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 was directed to all of the Company's hospitals and requested documents concerning emergency department processes and procedures, including the hospitals' use of the Pro-MED Clinical Information System, a third-party software system that assists with the management of patient care and provides operational support and data collection for emergency department management. The subpoena also sought information about the Company's relationships with emergency department physicians, including financial arrangements. This investigation is being led by the Department of Justice. The Company is continuing to cooperate with the government with the ongoing document production, as well as conducting a joint medical necessity review of a sampling of medical records at a small number of hospitals.

The following matters, although initiated independently of the Department of Justice's April 2011 subpoena, are factually related in some manner to that subpoena and are grouped here for clarity.

Texas Attorney General Investigation of Emergency Department Procedures and Billing. In November 2010, the Company was served with substantially identical Civil Investigative Demands ("CIDs") from the Office of Attorney General, State of Texas for all 18 of the Company's affiliated Texas hospitals. The subject of the requests appears to concern emergency department procedures and billing. The Company has complied with these requests and provided all documentation and reports requested. The Company continues to cooperate fully with this investigation.

United States ex rel. and Reuille vs. Community Health Systems Professional Services Corporation and Lutheran Musculoskeletal Center, LLC d/b/a Lutheran Hospital (United States District Court for the Northern District of Indiana, Fort Wayne Division). This lawsuit was originally filed under seal in January 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. In December 2010, the government filed a notice that it declined to intervene in this suit. On April 22, 2011, a joint motion was filed by the relator and the Department of Justice to extend the period of time for the relator to serve the Company in the case to allow the government more time to decide if it will intervene in the case. The motion to stay was granted, as have subsequent joint motions, and the stay is currently continued until April 29, 2013. The original motion and subsequent filings gave insight to the fact that there are other qui tam complaints in other jurisdictions and that the government was consolidating its investigations and working

cooperatively with other investigative bodies (including the Attorney General of the State of Texas). The government also 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 government's consolidated investigation. The Company is cooperating fully with the government in its investigations.

Shelbyville, Tennessee OIG Subpoena. In May 2011, the Company received a subpoena from the Houston Office of the United States Department of Health and Human Services, OIG, requesting 71 patient medical records from the Company's hospital in Shelbyville, Tennessee. The Company provided the requested records and has met with the government regarding this matter. The Company continues to cooperate fully with this investigation.

SEC Subpoena. In May 2011, the Company 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 the Company's hospitals. The subpoena also requested documents relied upon by the Company in responding to the Tenet litigation, as well as other communications about the Tenet litigation. As with all government investigations, the Company is cooperating fully with the SEC.

Class Action Shareholder Federal Securities Cases. Three purported class action cases have been filed in the United States District Court for the Middle District of Tennessee; namely, Norfolk County Retirement System v. Community Health Systems, Inc., et al., filed May 5, 2011; De Zheng v. Community Health Systems, Inc., et al., filed May 12, 2011; and Minneapolis Firefighters Relief Association v. Community Health Systems, Inc., et al., filed June 2, 2011. All three seek class certification on behalf of purchasers of the Company's common stock between July 27, 2006 and April 11, 2011 and allege that misleading statements resulted in artificially inflated prices for the Company's common stock. In December 2011, the cases were consolidated for pretrial purposes and NYC Funds and its counsel were selected as lead plaintiffs/lead plaintiffs' counsel. The Company's motion to dismiss this case has been fully briefed and is pending before the court. The Company believes this consolidated matter is without merit and will vigorously defend this case.

Shareholder Derivative Actions. Three purported shareholder derivative actions have also been filed in the United States District Court for the Middle District of Tennessee; Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund v. Wayne T. Smith, et al., filed May 24, 2011; Roofers Local No. 149 Pension Fund v. Wayne T. Smith, et al., filed June 21, 2011; and Lambert Sweat v. Wayne T. Smith, et al., filed October 5, 2011. These three cases allege breach of fiduciary duty arising out of allegedly improper inpatient admission practices, mismanagement, waste and unjust enrichment. These cases have been consolidated into a single, consolidated action. The plaintiffs filed an operative amended derivative complaint in these three consolidated actions on March 15, 2012. The Company's motion to dismiss has been fully briefed and is pending before the court. The Company believes all of these matters are without merit and will vigorously defend them.

During the year ended December 31, 2012, the Company met the deductible for its directors and officers insurance policy as it relates to the legal costs for the Tenet acquisition lawsuit and shareholder lawsuits of possible improper claims submitted to Medicare and Medicaid. As a result, future legal costs that are deemed to be covered by the directors and officers insurance policy will be offset by insurance recoveries. The Company incurred the following pre-tax charges in connection with these legal matters and the government investigations, net of insurance recoveries (in thousands):

	Year Ended December 31,		
	2012	2011	2010
Professional fees and other related costs	$5,488	$15,317	$—

Probable Contingencies

In addition to the cases described above, there are a number of legal matters for which, based on information currently available, the Company believes that a negative outcome is known or is probable. In the aggregate, an estimate of these losses has been accrued in the amount of $22.6 million at December 31, 2012. Due to the uncertainties and difficulty in predicting the ultimate resolution of these contingencies, the actual amount could differ from the estimated amount; however, the Company does not believe the ultimate outcome of any of these matters would be material.

16. SUBSEQUENT EVENTS

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

17. QUARTERLY FINANCIAL DATA (UNAUDITED)

	Quarter				
	1st	2nd	3rd	4th	Total
	(in thousands, except share and per share data)				
Year ended December 31, 2012:					
Net operating revenues	$ 3,297,035	$ 3,242,974	$ 3,212,030	$ 3,276,946	$13,028,985
Income from continuing operations before income taxes	145,537	151,686	84,458	122,090	503,771
Income from continuing operations	99,718	102,167	58,758	85,626	346,269
Loss from discontinued operations	(466)	—	—	—	(466)
Net income attributable to Community Health Systems, Inc.	$ 75,474	$ 83,359	$ 44,233	$ 62,574	$ 265,640
Basic earnings (loss) per share attributable to Community Health Systems, Inc. common stockholders(1):					
Continuing operations	$ 0.86	$ 0.94	$ 0.50	$ 0.70	$ 2.98
Discontinued operations	(0.01)	—	—	—	(0.01)
Net income	$ 0.85	$ 0.94	$ 0.50	$ 0.70	$ 2.98
Diluted earnings (loss) per share attributable to Community Health Systems, Inc. common stockholders(1):					
Continuing operations	$ 0.85	$ 0.93	$ 0.49	$ 0.69	$ 2.96
Discontinued operations	(0.01)	—	—	—	(0.01)
Net income	$ 0.85	$ 0.93	$ 0.49	$ 0.69	$ 2.96
Weighted-average number of shares outstanding:					
Basic	88,674,779	89,147,472	89,259,950	89,882,380	89,242,949
Diluted	88,852,704	89,530,639	90,009,113	90,828,119	89,806,937
Year ended December 31, 2011:					
Net operating revenues	$ 2,954,083	$ 3,000,827	$ 2,945,477	$ 3,005,825	$11,906,212
Income from continuing operations before income taxes	135,697	137,695	132,517	67,638	473,547
Income from continuing operations	91,605	92,874	95,800	55,615	335,894
Loss from discontinued operations	(13,280)	(39,327)	(3,169)	(2,495)	(58,271)
Net income attributable to Community Health Systems, Inc.	$ 61,324	$ 35,389	$ 74,304	$ 30,931	$ 201,948
Basic earnings (loss) per share attributable to Community Health Systems, Inc. common stockholders(1):					
Continuing operations	$ 0.82	$ 0.82	$ 0.87	$ 0.38	$ 2.89
Discontinued operations	(0.15)	(0.43)	(0.04)	(0.03)	(0.65)
Net income	$ 0.67	$ 0.39	$ 0.83	$ 0.35	$ 2.24
Diluted earnings (loss) per share attributable to Community Health Systems, Inc. common stockholders(1):					
Continuing operations	$ 0.81	$ 0.81	$ 0.86	$ 0.38	$ 2.87
Discontinued operations	(0.14)	(0.43)	(0.04)	(0.03)	(0.64)
Net income	$ 0.67	$ 0.39	$ 0.83	$ 0.35	$ 2.23
Weighted-average number of shares outstanding:					
Basic	91,008,405	91,130,672	89,412,310	88,344,566	89,966,933
Diluted	92,136,819	91,783,725	89,857,583	88,913,813	90,666,348

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

18. SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION

The Senior Notes, which are senior unsecured obligations of CHS, and the 5⅛% Senior Secured Notes are guaranteed on a senior basis by the Company and by certain of its existing and subsequently acquired or organized 100% owned domestic subsidiaries. The Senior Notes and the 5⅛% Senior Secured Notes are guaranteed on a joint and several basis, with limited exceptions considered customary for such guarantees, including the release of the guarantee when a subsidiary's assets used in operations are sold. The following condensed consolidating financial statements present Community Health Systems, Inc. (as parent guarantor), CHS (as the issuer), the subsidiary guarantors, the subsidiary non-guarantors and eliminations. These condensed consolidating financial statements have been prepared and presented in accordance with SEC Regulation S-X Rule 3-10 "Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered."

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

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

The Company's intercompany activity consists primarily of daily cash transfers for purposes of cash management, the allocation of certain expenses and expenditures paid for by the parent on behalf of its subsidiaries, and the push down of investment in its subsidiaries. This activity also includes the intercompany transactions between consolidated entities as part of the Receivables Facility that is further discussed in Note 11. The Company's subsidiaries generally do not purchase services from one another; thus, the intercompany transactions do not represent revenue generating transactions. All intercompany transactions eliminate in consolidation.

From time to time, the Company sells and/or repurchases noncontrolling interests in consolidated subsidiaries, which may change subsidiaries between guarantors and non-guarantors. Amounts for prior periods are restated to reflect the status of guarantors or non-guarantors as of December 31, 2012.

Condensed Consolidating Statement of Income
Year Ended December 31, 2012

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In thousands)			
Operating revenues (net of contractual allowances and discounts)	$ —	$ (9,653)	$9,579,838	$5,417,994	$ —	$14,988,179
Provision for bad debts	—	—	1,323,508	635,686	—	1,959,194
Net operating revenues	—	(9,653)	8,256,330	4,782,308	—	13,028,985
Operating costs and expenses:						
Salaries and benefits	—	—	3,623,082	2,480,849	—	6,103,931
Supplies	—	—	1,297,714	675,777	—	1,973,491
Other operating expenses	—	603	1,873,782	995,401	—	2,869,786
Electronic health records incentive reimbursement	—	—	(79,936)	(46,798)	—	(126,734)
Rent	—	—	152,205	120,624	—	272,829
Depreciation and amortization	—	—	480,912	244,646	—	725,558
Total operating costs and expenses	—	603	7,347,759	4,470,499	—	11,818,861
Income from operations	—	(10,256)	908,571	311,809	—	1,210,124
Interest expense, net	—	58,726	505,270	58,937	—	622,933
Loss from early extinguishment of debt	—	115,453	—	—	—	115,453
Equity in earnings of unconsolidated affiliates	(265,640)	(348,878)	(150,606)	—	723,091	(42,033)
Impairment of long-lived assets	—	—	10,000	—	—	10,000
Income from continuing operations before income taxes	265,640	164,443	543,907	252,872	(723,091)	503,771
Provision for (benefit from) income taxes	—	(101,197)	196,351	62,348	—	157,502
Income from continuing operations	265,640	265,640	347,556	190,524	(723,091)	346,269
Discontinued operations, net of taxes:						
Loss from operations of entities sold	—	—	—	(466)	—	(466)
Impairment of hospitals sold	—	—	—	—	—	—
Loss on sale, net	—	—	—	—	—	—
Loss from discontinued operations, net of taxes	—	—	—	(466)	—	(466)
Net income	265,640	265,640	347,556	190,058	(723,091)	345,803
Less: Net income attributable to noncontrolling interests	—	—	—	80,163	—	80,163
Net income attributable to Community Health Systems, Inc. stockholders	$ 265,640	$ 265,640	$ 347,556	$ 109,895	$(723,091)	$ 265,640

Condensed Consolidating Statement of Income
Year Ended December 31, 2011

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In thousands)			
Operating revenues (net of contractual allowances and discounts)	$ —	$ —	$8,625,818	$5,000,350	$ —	$13,626,168
Provision for bad debts	—	—	1,137,662	582,294	—	1,719,956
Net operating revenues	—	—	7,488,156	4,418,056	—	11,906,212
Operating costs and expenses:						
Salaries and benefits	—	—	3,284,123	2,293,802	—	5,577,925
Supplies	—	—	1,183,817	650,289	—	1,834,106
Other operating expenses	—	—	1,634,806	880,832	—	2,515,638
Electronic health records incentive reimbursement	—	—	(43,959)	(19,438)	—	(63,397)
Rent	—	—	138,229	116,552	—	254,781
Depreciation and amortization	—	—	420,824	231,850	—	652,674
Total operating costs and expenses	—	—	6,617,840	4,153,887	—	10,771,727
Income from operations	—	—	870,316	264,169	—	1,134,485
Interest expense, net	—	87,095	495,888	61,427	—	644,410
Loss from early extinguishment of debt	—	66,019	—	—	—	66,019
Equity in earnings of unconsolidated affiliates	(201,948)	(287,903)	(65,846)	—	506,206	(49,491)
Impairment of long-lived assets	—	—	—	—	—	—
Income from continuing operations before income taxes	201,948	134,789	440,274	202,742	(506,206)	473,547
Provision for (benefit from) income taxes	—	(67,159)	158,939	45,873	—	137,653
Income from continuing operations	201,948	201,948	281,335	156,869	(506,206)	335,894
Discontinued operations, net of taxes:						
Loss from operations of entities sold	—	—	—	(7,769)	—	(7,769)
Impairment of hospitals sold	—	—	—	(47,930)	—	(47,930)
Loss on sale, net	—	—	—	(2,572)	—	(2,572)
Loss from discontinued operations, net of taxes	—	—	—	(58,271)	—	(58,271)
Net income	201,948	201,948	281,335	98,598	(506,206)	277,623
Less: Net income attributable to noncontrolling interests	—	—	—	75,675	—	75,675
Net income attributable to Community Health Systems, Inc. stockholders	$ 201,948	$ 201,948	$ 281,335	$ 22,923	$(506,206)	$ 201,948

Condensed Consolidating Statement of Income
Year Ended December 31, 2010

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In thousands)			
Operating revenues (net of contractual allowances and discounts)	$ —	$ —	$7,959,274	$4,664,000	$ —	$12,623,274
Provision for bad debts	—	—	1,018,880	511,972	—	1,530,852
Net operating revenues	—	—	6,940,394	4,152,028	—	11,092,422
Operating costs and expenses:						
Salaries and benefits	—	—	3,008,055	2,085,712	—	5,093,767
Supplies	—	—	1,113,702	624,386	—	1,738,088
Other operating expenses	—	—	1,442,230	853,833	—	2,296,063
Electronic health records incentive reimbursement	—	—	—	—	—	—
Rent	—	—	132,032	116,431	—	248,463
Depreciation and amortization	—	—	376,963	218,034	—	594,997
Total operating costs and expenses	—	—	6,072,982	3,898,396	—	9,971,378
Income from operations	—	—	867,412	253,632	—	1,121,044
Interest expense, net	—	113,464	478,004	56,125	—	647,593
Loss from early extinguishment of debt	—	—	—	—	—	—
Equity in earnings of unconsolidated affiliates	(279,983)	(322,228)	(116,313)	—	673,081	(45,443)
Impairment of long-lived assets	—	—	—	—	—	—
Income from continuing operations before income taxes	279,983	208,764	505,721	197,507	(673,081)	518,894
Provision for (benefit from) income taxes	—	(71,219)	186,105	48,795	—	163,681
Income from continuing operations	279,983	279,983	319,616	148,712	(673,081)	355,213
Discontinued operations, net of taxes:						
Loss from operations of entities sold	—	—	—	(6,772)	—	(6,772)
Impairment of hospitals sold	—	—	—	—	—	—
Loss on sale, net	—	—	—	—	—	—
Loss from discontinued operations, net of taxes	—	—	—	(6,772)	—	(6,772)
Net income	279,983	279,983	319,616	141,940	(673,081)	348,441
Less: Net income attributable to noncontrolling interests	—	—	—	68,458	—	68,458
Net income attributable to Community Health Systems, Inc. stockholders	$ 279,983	$ 279,983	$ 319,616	$ 73,482	$(673,081)	$ 279,983

Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2012

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In thousands)			
Net income	$265,640	$265,640	$347,556	$190,058	$(723,091)	$345,803
Other comprehensive income (loss), net of taxes						
Net change in fair value of interest rate swaps	46,409	46,409	—	—	(46,409)	46,409
Net change in fair value of available-for-sale securities	3,012	3,012	3,012	—	(6,024)	3,012
Amortization and recognition of unrecognized pension cost components	(10,252)	(10,252)	(10,252)	—	20,504	(10,252)
Other comprehensive income (loss)	39,169	39,169	(7,240)	—	(31,929)	39,169
Comprehensive income	304,809	304,809	340,316	190,058	(755,020)	384,972
Less: Comprehensive income attributable to noncontrolling interests	—	—	—	80,163	—	80,163
Comprehensive income attributable to Community Health Systems, Inc. stockholders	$304,809	$304,809	$340,316	$109,895	$(755,020)	$304,809

Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2011

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In thousands)			
Net income	$201,948	$201,948	$281,335	$98,598	$(506,206)	$277,623
Other comprehensive income (loss), net of taxes						
Net change in fair value of interest rate swaps	55,145	55,145	—	—	(55,145)	55,145
Net change in fair value of available-for-sale securities	(960)	(960)	(960)	—	1,920	(960)
Amortization and recognition of unrecognized pension cost components	(7,737)	(7,737)	(7,737)	—	15,474	(7,737)
Other comprehensive income (loss)	46,448	46,448	(8,697)	—	(37,751)	46,448
Comprehensive income	248,396	248,396	272,638	98,598	(543,957)	324,071
Less: Comprehensive income attributable to noncontrolling interests	—	—	—	75,675	—	75,675
Comprehensive income attributable to Community Health Systems, Inc. stockholders	$248,396	$248,396	$272,638	$22,923	$(543,957)	$248,396

Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2010

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In thousands)			
Net income	$279,983	$279,983	$319,616	$141,940	$(673,081)	$348,441
Other comprehensive income (loss), net of taxes						
Net change in fair value of interest rate swaps	(15,676)	(15,676)	—	—	15,676	(15,676)
Net change in fair value of available-for-sale securities	3,716	3,716	3,716	—	(7,432)	3,716
Amortization and recognition of unrecognized pension cost components	2,418	2,418	2,418	—	(4,836)	2,418
Other comprehensive income (loss)	(9,542)	(9,542)	6,134	—	3,408	(9,542)
Comprehensive income	270,441	270,441	325,750	141,940	(669,673)	338,899
Less: Comprehensive income attributable to noncontrolling interests	—	—	—	68,458	—	68,458
Comprehensive income attributable to Community Health Systems, Inc. stockholders	$270,441	$270,441	$325,750	$ 73,482	$(669,673)	$270,441

Condensed Consolidating Balance Sheet
December 31, 2012

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In thousands)			
ASSETS						
Current assets:						
Cash and cash equivalents	$ —	$ —	$ 271,559	$ 116,254	$ —	$ 387,813
Patient accounts receivable, net of allowance for doubtful accounts	—	—	676,649	1,390,730	—	2,067,379
Supplies	—	—	254,853	113,319	—	368,172
Prepaid income taxes	49,888	—	—	—	—	49,888
Deferred income taxes	117,045	—	—	—	—	117,045
Prepaid expenses and taxes	—	115	86,628	39,818	—	126,561
Other current assets	—	—	222,424	79,860	—	302,284
Total current assets	166,933	115	1,512,113	1,739,981	—	3,419,142
Intercompany receivable	406,534	9,837,904	3,723,120	3,262,823	(17,230,381)	—
Property and equipment, net	—	—	4,660,557	2,491,316	—	7,151,873
Goodwill	—	—	2,544,195	1,863,943	—	4,408,138
Other assets, net	—	165,236	1,273,347	816,373	(627,774)	1,627,182
Net investment in subsidiaries	2,974,965	8,686,242	3,427,182	—	(15,088,389)	—
Total assets	$3,548,432	$18,689,497	$17,140,514	$10,174,436	$(32,946,544)	$16,606,335
LIABILITIES AND EQUITY						
Current liabilities:						
Current maturities of long-term debt	$ —	$ 75,679	$ 11,103	$ 3,129	$ —	$ 89,911
Accounts payable	—	74	583,865	241,975	—	825,914
Accrued interest	—	110,091	295	316	—	110,702
Accrued liabilities	7,580	—	748,010	361,103	—	1,116,693
Total current liabilities	7,580	185,844	1,343,273	606,523	—	2,143,220
Long-term debt	—	9,079,392	53,201	318,801	—	9,451,394
Intercompany payable	—	5,639,928	11,693,119	7,822,313	(25,155,360)	—
Deferred income taxes	808,489	—	—	—	—	808,489
Other long-term liabilities	1,156	809,372	675,341	180,950	(627,774)	1,039,045
Total liabilities	817,225	15,714,536	13,764,934	8,928,587	(25,783,134)	13,442,148
Redeemable noncontrolling interests in equity of consolidated subsidiaries	—	—	—	367,666	—	367,666
Equity:						
Community Health Systems, Inc. stockholders' equity:						
Preferred stock	—	—	—	—	—	—
Common stock	929	—	1	2	(3)	929
Additional paid-in capital	1,138,274	1,176,342	1,283,499	690,929	(3,150,770)	1,138,274
Treasury stock, at cost	(6,678)	—	—	—	—	(6,678)
Accumulated other comprehensive (loss) income	(145,310)	(145,310)	(28,927)	—	174,237	(145,310)
Retained earnings	1,743,992	1,943,929	2,121,007	121,938	(4,186,874)	1,743,992
Total Community Health Systems, Inc. stockholders' equity	2,731,207	2,974,961	3,375,580	812,869	(7,163,410)	2,731,207
Noncontrolling interests in equity of consolidated subsidiaries	—	—	—	65,314	—	65,314
Total equity	2,731,207	2,974,961	3,375,580	878,183	(7,163,410)	2,796,521
Total liabilities and equity	$3,548,432	$18,689,497	$17,140,514	$10,174,436	$(32,946,544)	$16,606,335

Condensed Consolidating Balance Sheet
December 31, 2011

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In thousands)			
ASSETS						
Current assets:						
Cash and cash equivalents	$ —	$ —	$ 8,920	$ 120,945	$ —	$ 129,865
Patient accounts receivable, net of allowance for doubtful accounts	—	—	1,190,956	643,211	—	1,834,167
Supplies	—	—	237,178	109,433	—	346,611
Prepaid income taxes	101,389	—	—	—	—	101,389
Deferred income taxes	89,797	—	—	—	—	89,797
Prepaid expenses and taxes		117	87,524	24,972	—	112,613
Other current assets	—	10,235	155,097	66,315	—	231,647
Total current assets	191,186	10,352	1,679,675	964,876	—	2,846,089
Intercompany receivable	249,088	9,294,301	1,046,486	1,774,718	(12,364,593)	—
Property and equipment, net	—	—	4,631,831	2,224,145	—	6,855,976
Goodwill	—	—	2,411,521	1,853,324	—	4,264,845
Other assets, net	—	99,511	515,882	626,537	—	1,241,930
Net investment in subsidiaries	2,670,155	7,388,874	2,317,131	—	(12,376,160)	—
Total assets	$3,110,429	$16,793,038	$12,602,526	$7,443,600	$(24,740,753)	$15,208,840
LIABILITIES AND EQUITY						
Current liabilities:						
Current maturities of long—term debt	$ —	$ 49,954	$ 10,114	$ 3,638	$ —	$ 63,706
Accounts payable	—	345	535,204	213,448	—	748,997
Accrued interest	—	109,984	131	6	—	110,121
Accrued liabilities	7,580	567	688,328	291,840	—	988,315
Total current liabilities	7,580	160,850	1,233,777	508,932	—	1,911,139
Long-term debt	—	8,707,805	54,651	20,342	—	8,782,798
Intercompany payable	—	5,000,003	7,843,539	6,108,561	(18,952,103)	—
Deferred income taxes	704,725	—	—	—	—	704,725
Other long-term liabilities	1,028	254,228	435,295	259,439	—	949,990
Total liabilities	713,333	14,122,886	9,567,262	6,897,274	(18,952,103)	12,348,652
Redeemable noncontrolling interests in equity of consolidated subsidiaries	—	—	—	395,743	—	395,743
Equity:						
Community Health Systems, Inc. stockholders' equity:						
Preferred stock	—	—	—	—	—	—
Common stock	915	—	1	2	(3)	915
Additional paid—in capital	1,086,008	1,030,522	1,103,559	30,047	(2,164,128)	1,086,008
Treasury stock, at cost	(6,678)	—	—	—	—	(6,678)
Accumulated other comprehensive (loss) income	(184,479)	(184,479)	(21,687)	—	206,166	(184,479)
Retained earnings	1,501,330	1,824,109	1,953,391	53,185	(3,830,685)	1,501,330
Total Community Health Systems, Inc. stockholders' equity	2,397,096	2,670,152	3,035,264	83,234	(5,788,650)	2,397,096
Noncontrolling interests in equity of consolidated subsidiaries	—	—	—	67,349	—	67,349
Total equity	2,397,096	2,670,152	3,035,264	150,583	(5,788,650)	2,464,445
Total liabilities and equity	$3,110,429	$16,793,038	$12,602,526	$7,443,600	$(24,740,753)	$15,208,840

Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2012

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In thousands)			
Net cash (used in) provided by operating activities	$(55,122)	$ (71,683)	$ 1,156,708	$ 250,217	$ —	$ 1,280,120
Cash flows from investing activities:						
Acquisitions of facilities and other related equipment	—	—	(309,731)	(12,584)	—	(322,315)
Purchases of property and equipment	—	—	(540,816)	(227,974)	—	(768,790)
Proceeds from disposition of hospitals and other ancillary operations	—	—	—	—	—	—
Proceeds from sale of property and equipment	—	—	2,756	3,141	—	5,897
Increase in other investments	—	10,000	(231,326)	(76,668)	—	(297,994)
Net cash used in investing activities	—	10,000	(1,079,117)	(314,085)	—	(1,383,202)
Cash flows from financing activities:						
Proceeds from exercise of stock options	20,858	—	—	—	—	20,858
Repurchase of restricted stock shares for payroll tax withholding requirements	(9,314)	—	—	—	—	(9,314)
Deferred financing costs	—	(141,219)	—	—	—	(141,219)
Excess tax benefit relating to stock—based compensation	3,973	—	—	—	—	3,973
Payment of special dividend to stockholders	(22,535)	—	—	—	—	(22,535)
Stock buy-back	—	—	—	—	—	—
Proceeds from noncontrolling investors in joint ventures	—	—	—	535	—	535
Redemption of noncontrolling investments in joint ventures	—	—	—	(44,287)	—	(44,287)
Distributions to noncontrolling investors in joint ventures	—	—	—	(68,344)	—	(68,344)
Changes in intercompany balances with affiliates, net	62,140	(124,560)	189,076	(126,656)	—	—
Borrowings under credit agreement	—	3,955,000	20,866	—	—	3,975,866
Issuance of long-term debt	—	3,825,000	—	—	—	3,825,000
Proceeds from receivables facility	—	—	—	350,000	—	350,000
Repayments of long-term indebtedness	—	(7,452,538)	(24,894)	(52,071)	—	(7,529,503)
Net cash provided by (used in) financing activities	55,122	61,683	185,048	59,177	—	361,030
Net change in cash and cash equivalents	—	—	262,639	(4,691)	—	257,948
Cash and cash equivalents at beginning of period	—	—	8,920	$ 120,945	—	129,865
Cash and cash equivalents at end of period	$ —	$ —	$ 271,559	$ 116,254	$ —	$ 387,813

Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2011

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In thousands)			
Net cash (used in) provided by operating activities	$ (41,780)	$ (111,001)	$ 918,947	$ 495,742	$ —	$ 1,261,908
Cash flows from investing activities:						
Acquisitions of facilities and other related equipment	—	—	(370,243)	(45,117)	—	(415,360)
Purchases of property and equipment	—	—	(440,754)	(335,959)	—	(776,713)
Proceeds from disposition of hospitals and other ancillary operations	—	—	—	173,387	—	173,387
Proceeds from sale of property and equipment	—	—	2,283	8,877	—	11,160
Increase in other investments	—	(10,000)	(129,852)	(48,397)	—	(188,249)
Net cash used in investing activities	—	(10,000)	(938,566)	(247,209)	—	(1,195,775)
Cash flows from financing activities:						
Proceeds from exercise of stock options	18,910	—	—	—	—	18,910
Repurchase of restricted stock shares for payroll tax withholding requirements	(13,311)	—	—	—	—	(13,311)
Deferred financing costs	—	(19,352)	—	—	—	(19,352)
Excess tax benefit relating to stock-based compensation	5,290	—	—	—	—	5,290
Payment of special dividend to stockholders	—	—	—	—	—	—
Stock buy-back	(85,790)	—	—	—	—	(85,790)
Proceeds from noncontrolling investors in joint ventures	—	—	—	1,229	—	1,229
Redemption of noncontrolling investments in joint ventures	—	—	—	(13,022)	—	(13,022)
Distributions to noncontrolling investors in joint ventures	—	—	—	(56,094)	—	(56,094)
Changes in intercompany balances with affiliates, net	116,681	209,056	(175,332)	(150,405)	—	—
Borrowings under credit agreement	—	560,000	18,236	2,145	(2,145)	578,236
Issuance of long-term debt	—	1,000,000	—	—	—	1,000,000
Proceeds from receivables facility	—	—	—	—	—	—
Repayments of long-term indebtedness	—	(1,628,703)	(23,200)	(1,775)	2,145	(1,651,533)
Net cash provided by (used in) financing activities	41,780	121,001	(180,296)	(217,922)	—	(235,437)
Net change in cash and cash equivalents	—	—	(199,915)	30,611	—	(169,304)
Cash and cash equivalents at beginning of period	—	—	208,835	$ 90,334	—	299,169
Cash and cash equivalents at end of period	$ —	$ —	$ 8,920	$ 120,945	$ —	$ 129,865

Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2010

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In thousands)			
Net cash (used in) provided by operating activities	$(154,101)	$ (87,018)	$ 774,222	$ 655,627	$ —	$ 1,188,730
Cash flows from investing activities:						
Acquisitions of facilities and other related equipment	—	—	(204,773)	(43,478)	—	(248,251)
Purchases of property and equipment	—	—	(342,735)	(324,643)	—	(667,378)
Proceeds from disposition of hospitals and other ancillary operations	—	—	—	—	—	—
Proceeds from sale of property and equipment	—	—	8,140	261	—	8,401
Increase in other investments	—	—	(112,587)	(24,495)	—	(137,082)
Net cash used in investing activities	—	—	(651,955)	(392,355)	—	(1,044,310)
Cash flows from financing activities:						
Proceeds from exercise of stock options	56,916	—	—	—	—	56,916
Repurchase of restricted stock shares for payroll tax withholding requirements	—	—	—	—	—	—
Deferred financing costs	—	(13,260)	—	—	—	(13,260)
Excess tax benefit relating to stock-based compensation	10,219	—	—	—	—	10,219
Payment of special dividend to stockholders	—	—	—	—	—	—
Stock buy-back	(113,961)	—	—	—	—	(113,961)
Proceeds from noncontrolling investors in joint ventures	—	—	—	7,201	—	7,201
Redemption of noncontrolling investments in joint ventures	—	—	—	(7,318)	—	(7,318)
Distributions to noncontrolling investors in joint ventures	—	—	—	(68,113)	—	(68,113)
Changes in intercompany balances with affiliates, net	200,927	144,788	(144,642)	(201,073)	—	—
Borrowings under credit agreement	—	—	—	—	—	—
Issuance of long-term debt	—	—	—	—	—	—
Proceeds from receivables facility	—	—	—	—	—	—
Repayments of long-term indebtedness	—	(44,510)	(7,240)	(9,726)	—	(61,476)
Net cash provided by (used in) financing activities	154,101	87,018	(151,882)	(279,029)	—	(189,792)
Net change in cash and cash equivalents	—	—	(29,615)	(15,757)	—	(45,372)
Cash and cash equivalents at beginning of period	—	—	238,450	106,091	—	344,541
Cash and cash equivalents at end of period	$ —	$ —	$ 208,835	$ 90,334	$ —	$ 299,169

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosure***

None

Item 9A. ***Controls and Procedures***

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

There have been no changes in internal control over financial reporting that occurred during the period that have materially affected or are reasonably likely to materially affect our internal controls over financial reporting.

Management's report on internal control over financial reporting is included herein at page 143.

The attestation report from Deloitte & Touche LLP, our independent registered public accounting firm, on our internal control over financial reporting is included herein at page 144.

Item 9B. ***Other Information***

None

Management's Report on Internal Control over Financial Reporting

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States of America and include amounts based on management's estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the consolidated financial statements.

We are also responsible for establishing and maintaining adequate internal controls over financial reporting (as defined in Rule 13a-15(f) under the Securities and Exchange Act of 1934, as amended). We maintain a system of internal controls that is designed to provide reasonable assurance as to the fair and reliable preparation and presentation of the consolidated financial statements, as well as to safeguard assets from unauthorized use or disposition.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Conduct. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit and Compliance Committee of the Board of Directors, which is composed solely of outside directors, meets periodically with members of management, the internal auditors and the independent registered public accounting firm to review and discuss internal control over financial reporting and accounting and financial reporting matters. The independent registered public accounting firm and internal auditors report to the Audit and Compliance Committee and accordingly have full and free access to the Audit and Compliance Committee at any time.

We conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. This evaluation included review of the documentation of controls, evaluation of the design effectiveness of controls, testing of the operating effectiveness of controls and a conclusion on this evaluation. We have concluded that our internal control over financial reporting was effective as of December 31, 2012, based on these criteria.

Deloitte & Touche LLP, an independent registered public accounting firm, has issued an attestation report on our internal control over financial reporting, which is included herein.

We do not expect that our disclosure controls and procedures or our internal controls will prevent all errors and all fraud. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact there are resource constraints and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, within the Company have been detected.

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 internal control over financial reporting of Community Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 2012, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying *Management's Report on Internal Control over Financial Reporting*. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit 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 effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2012, based on the criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2012 of the Company and our report dated February 27, 2013 expressed an unqualified opinion on those financial statements.

/s/ Deloitte & Touche LLP
Nashville, Tennessee
February 27, 2013

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance***

The committee report of the Audit and Compliance Committee of the Board of Directors is presented below. The other information required by this Item is incorporated herein by reference to the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 21, 2013, under "Members of the Board of Directors," "Information About our Executive Officers," " Section 16(A) Beneficial Ownership Reporting Compliance," "Corporate Governance Principles and Board Matters" and "Committee Reports of the Board of Directors."

AUDIT AND COMPLIANCE COMMITTEE REPORT

The Audit and Compliance Committee of the Board of Directors of the Company is composed of three directors, each of whom is "independent" as defined by the listing standards of the NYSE and Section 10A-3 of the Exchange Act. All of our Audit and Compliance Committee members meet the Securities and Exchange Commission definition of "audit committee financial expert." The Audit and Compliance Committee operates under a written charter adopted by the Board of Directors, which is posted on our corporate website (www.chs.net) and which is reviewed by the Committee annually, in conjunction with the Committee's annual self-evaluation. The Company's management is responsible for its internal controls and the financial reporting process. Our independent registered public accounting firm, Deloitte & Touche LLP, is responsible for performing an independent audit of our consolidated financial statements in accordance with the standards of the Public Company Accounting Oversight Board (United States) and to issue its reports thereon. The Audit and Compliance Committee is responsible for, among other things, monitoring and overseeing these processes, and recommending to the Board of Directors: (i) that the audited consolidated financial statements be included in the Company's Annual Report on Form 10-K; and (ii) the selection of the independent registered public accounting firm to audit the consolidated financial statements of the Company.

In keeping with that responsibility, the Audit and Compliance Committee has reviewed and discussed the Company's audited consolidated financial statements with management and with the independent registered public accounting firm, reviewed internal controls and accounting procedures and provided oversight review of the Company's corporate compliance program. In addition, the Audit and Compliance Committee has discussed with the Company's independent registered public accounting firm the matters required to be discussed by the Statement on Auditing Standards No. 114, "The Auditors Communication with Those Charged with Governance."

The Audit and Compliance Committee discussed with the Company's internal auditors and independent registered public accounting firm the overall scope and plans for their respective audits. The Audit and Compliance Committee met with the internal auditors and the independent registered public accounting firm with and without management present to discuss the results of their examinations, their evaluations of the Company's internal controls and the overall quality of the Company's financial reporting.

The Audit and Compliance Committee has received the written disclosures and the letter from the independent registered public accounting firm required by applicable requirements of the Public Company Accounting Oversight Board regarding the independent accountant's communications with the audit committee concerning independence. The Audit and Compliance Committee has discussed with the independent registered public accounting firm its independence and also has reviewed the amount of fees paid to the independent registered accounting firm for audit and non-audit services.

Based on the Audit and Compliance Committee's discussions with management and the independent registered public accounting firm and the Audit and Compliance Committee's review of the representations of management and the materials it received from the independent registered public accounting firm as described above, the Audit and Compliance Committee recommended to the Board of Directors that the audited consolidated financial statements be included in the Company's Annual Report on Form 10-K for the year ended December 31, 2012 for filing with the SEC.

This report is respectfully submitted by the Audit and Compliance Committee of the Board of Directors.

THE AUDIT AND COMPLIANCE COMMITTEE

John A. Clerico, Chair
James S. Ely III
John A. Fry

Item 11. ***Executive Compensation***

The information required by this Item is incorporated herein by reference to the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 21, 2013 under "Executive Compensation."

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

The information required by this Item is incorporated herein by reference to the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 21, 2013 under "Security Ownership of Certain Beneficial Owners and Management."

Item 13. ***Certain Relationships and Related Transactions***

The information required by this Item is incorporated herein by reference to the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 21, 2013 under "Relationships and Certain Transactions Between the Company and Its Officers, Directors and 5% Beneficial Owners and Their Family Members."

Item 14. ***Principal Accountant Fees and Services***

The information required by this Item is incorporated herein by reference to the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 21, 2013 under "Ratification of the Appointment of Independent Registered Public Accounting Firm."

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

Item 15(a) 1. *Financial Statements*

Reference is made to the index of financial statements and supplementary data under Item 8 in Part II.

Item 15(a) 2. *Financial Statement Schedules*

The following financial statement schedule is filed as part of this Report at page 159 hereof:

Schedule II — *Valuation and Qualifying Accounts*

All other schedules are omitted since the required information is not present or is not present in amounts sufficient to require submission of the schedule, or because the information required is included in the consolidated financial statements and notes thereto.

Item 15(a)(3):

The following exhibits are either filed with this Report or incorporated herein by reference.

	Description
2.1	Agreement and Plan of Merger, dated as of March 19, 2007, by and among Triad Hospitals, Inc., Community Health Systems, Inc. and FWCT-1 Acquisition Corporation (incorporated by reference to Exhibit 2.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed March 19, 2007 (No. 001-15925))
3.1	Form of Restated Certificate of Incorporation of Community Health Systems, Inc. (incorporated by reference to Exhibit 3.1 to Amendment No. 4 to Community Health Systems, Inc.'s Registration Statement on Form S-1/A filed June 8, 2000 (No. 333-31790))
3.2	Certificate of Amendment to the Restated Certificate of Incorporation of Community Health Systems, Inc., dated May 18, 2010 (incorporated by reference to Exhibit 3.2 to Community Health Systems, Inc.'s Current Report on Form 8-K filed May 20, 2010 (No. 001-15925))
3.3	Amended and Restated By-Laws of Community Health Systems, Inc. (as of February 27, 2008) (incorporated by reference to Exhibit 3(ii).1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed February 29, 2008 (No. 001-15925))
4.1	Form of Common Stock Certificate (incorporated by reference to Exhibit 4.1 to Amendment No. 2 to Community Health Systems, Inc.'s Registration Statement on Form S-1/A filed May 2, 2000 (No. 333-31790))
4.2	Senior Notes Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., the Guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.3 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.3	Form of 8⅞% Senior Note due 2015 (included in Exhibit 4.2)
4.4	Registration Rights Agreement relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., the Guarantors party thereto and the Initial Purchasers (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.5	Joinder to the Registration Rights Agreement relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of July 25, 2007 (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.6	Senior Notes Indenture relating to CHS/Community Health Systems, Inc.'s 8.000% Senior Notes due 2019, dated as of November 22, 2011, by and among CHS/Community Health Systems, Inc., the Guarantors party thereto and Regions Bank, as successor trustee (incorporated by reference to Exhibit 4.6 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2011 filed February 23, 2012 (No. 001-15925))
4.7	Form of 8.000% Senior Note due 2019 (included in Exhibit 4.6)
4.8	Registration Rights Agreement relating to CHS/Community Health Systems, Inc.'s 8.000% Senior Notes due 2019, dated as of November 22, 2011, by and among CHS/Community Health Systems, Inc., the Guarantors party thereto and the Initial Purchasers (incorporated by reference to Exhibit 4.8 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2011 filed February 23, 2012 (No. 001-15925))

	Description
4.9	Senior Notes Indenture relating to CHS/Community Health Systems, Inc.'s 7.125% Senior Notes due 2020, dated as of July 18, 2012, by and among CHS/Community Health Systems, Inc., the Guarantors party thereto and Regions Bank, as Trustee (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 18, 2012 (No. 001-15925))
4.10	Form of 7.125% Senior Note due 2019 (included in Exhibit 4.9)
4.11	Senior Secured Notes Indenture relating to CHS/Community Health Systems, Inc.'s 5.125% Senior Notes due 2018, dated as of August 17, 2012, by and among CHS/Community Health Systems, Inc., the Guarantors party thereto, Regions Bank, as Trustee and Credit Suisse AG, as collateral agent (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed August 20, 2012 (No. 001-15925))
4.12	Form of 5.125% Senior Secured Note due 2020 (included in Exhibit 4.11)
4.13	First Supplemental Indenture relating to Triad Hospitals, Inc.'s 7% Senior Subordinated Notes due 2013, dated as of July 24, 2007, by and among Triad Hospitals, Inc. and The Bank of New York Trust Company, N.A. (incorporated by reference to Exhibit 4.7 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.14	Second Supplemental Indenture relating to Triad Hospitals, Inc.'s 7% Senior Notes due 2012, dated as of July 24, 2007, by and among Triad Hospitals, Inc. and The Bank of New York Trust Company, N.A. (incorporated by reference to Exhibit 4.6 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.15	First Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.4 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.16	Second Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of December 31, 2007, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.7 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
4.17	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of January 30, 2008, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.8 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
4.18	Third Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of October 10, 2008, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.9 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
4.19	Fourth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of December 1, 2008, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.10 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))

	Description
4.20	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of December 31, 2008, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.11 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
4.21	Fifth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of February 5, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.12 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
4.22	Sixth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of March 30, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2009 filed April 29, 2009 (No. 001-15925))
4.23	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of March 30, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2009 filed April 29, 2009 (No. 001-15925))
4.24	Seventh Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of June 30, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
4.25	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of June 30, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
4.26	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of December 31, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.19 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2009 filed February 26, 2010 (No. 001-15925))
4.27	Eighth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of March 31, 2010, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2010 filed April 28, 2010 (No. 001-15925))
4.28	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of March 31, 2010, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2010 filed April 28, 2010 (No. 001-15925))

	Description
4.29	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of September 30, 2010, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2010 filed October 29, 2010 (No. 001-15925))
4.30	Ninth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of October 25, 2010, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.23 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2010 filed February 25, 2011 (No. 001-15925))
4.31	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of December 31, 2010, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.24 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2010 filed February 25, 2011 (No. 001-15925))
4.32	Tenth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of June 30, 2011, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2011 filed August 1, 2011 (No. 001-15925))
4.33	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of September 1, 2011, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2011 filed October 28, 2011 (No. 001-15925))
4.34	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of September 30, 2011, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2011 filed October 28, 2011 (No. 001-15925))
4.35	Eleventh Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of October 1, 2011, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.31 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2011 filed February 23, 2012 (No. 001-15925))
4.36	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of October 22, 2011, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.32 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2011 filed February 23, 2012 (No. 001-15925))
4.37	Twelfth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of January 31, 2012, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.33 to Community Health Systems, Inc.'s Registration Statement on Form S-4/A filed April 2, 2012 (No. 333-180265))

	Description
4.38	Thirteenth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of March 31, 2012, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.34 to Community Health Systems, Inc.'s Registration Statement on Form S-4/A filed April 2, 2012 (No. 333-180265))
4.39	Fourteenth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of May 15, 2012, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.3 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 18, 2012 (No. 001-15925))
4.40	Fifteenth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8⅞% Senior Notes due 2015, dated as of July 18, 2012, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.4 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 18, 2012 (No. 001-15925))
4.41	First Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8.000% Senior Notes due 2019, dated as of January 31, 2012, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.35 to Community Health Systems, Inc.'s Registration Statement on Form S-4/A filed April 2, 2012 (No. 333-180265))
4.42	Second Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8.000% Senior Notes due 2019, dated as of March 31, 2012, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.36 to Community Health Systems, Inc.'s Registration Statement on Form S-4/A filed April 2, 2012 (No. 333-180265))
4.43	Third Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8.000% Senior Notes due 2019, dated as of May 15, 2012, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 18, 2012 (No. 001-15925))
4.44	Fourth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8.000% Senior Notes due 2019, dated as of September 30, 2012, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as successor trustee (incorporated by reference to Exhibit 4.5 to Community Health Systems, Inc.'s Quarterly report on Form 10-Q for the quarter ended September 30, 2012 filed November 1, 2012 (No. 001-15925))
4.45	First Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 7.125% Senior Notes due 2020, dated as of September 30, 2012, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee (incorporated by reference to Exhibit 4.6 to Community Health Systems, Inc.'s Quarterly report on Form 10-Q for the quarter ended September 30, 2012 filed November 1, 2012 (No. 001-15925))
4.46	First Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 5.125% Senior Secured Notes due 2018, dated as of September 30, 2012, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee (incorporated by reference to Exhibit 4.7 to Community Health Systems, Inc.'s Quarterly report on Form 10-Q for the quarter ended September 30, 2012 filed November 1, 2012 (No. 001-15925))

	Description
4.47	Amendment No. 1 and Reaffirmation Agreement, dated as of August 17, 2012, relating to the Amended and Restated Guarantee and Collateral Agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the guarantors party thereto, and Credit Suisse AG, as collateral trustee (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2012 filed November 1, 2012 (No. 001-15925))
4.48	First Lien Intercreditor Agreement, dated as of August 17, 2012, among Credit Suisse AG, as collateral agent, Credit Suisse AG, as authorized representative, Regions Bank, as Trustee and authorized representative, and the additional authorized representatives party thereto (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2012 filed November 1, 2012 (No. 001-15925))
4.49	Copyright Security Agreement, dated as of August 17, 2012, among Community Health Systems, Inc., CHS Washington Holdings, LLC, Northwest Hospital, LLC, Quorum Health Resources, LLC, and Credit Suisse AG, as collateral agent (incorporated by reference to Exhibit 4.3 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2012 filed November 1, 2012 (No. 001-15925))
4.50	Trademark Security Agreement, dated as of August 17, 2012, among CHS/Community Health Systems, Inc., Blue Island Hospital Company, LLC, CHS Washington Holdings, LLC, Quorum Health Resources, LLC, Triad Healthcare Corporation, Youngstown Ohio Hospital Company, LLC, and Credit Suisse AG, as collateral agent (incorporated by reference to Exhibit 4.4 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2012 filed November 1, 2012 (No. 001-15925))
10.1	Amendment and Restatement Agreement, dated as of November 5, 2010, to the Credit Agreement, dated as of July 25, 2007, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the subsidiaries of CHS/Community Health Systems, Inc. party thereto, the lenders party thereto and Credit Suisse AG, as Administrative Agent and Collateral Agent (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed November 9, 2010 (No. 001-15925))
10.2	Amended and Restated Credit Agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the lenders party thereto and Credit Suisse AG, as Administrative Agent and Collateral Agent (incorporated by reference to Exhibit 10.2 to Community Health Systems, Inc.'s Current Report on Form 8-K filed November 9, 2010 (No. 001-15925))
10.3	Amended and Restated Guarantee and Collateral Agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the subsidiaries of CHS/Community Health Systems, Inc. from time to time party thereto and Credit Suisse AG, as Collateral Agent (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Current Report on Form 8-K filed November 9, 2010 (No. 001-15925))
10.4	Second Amendment and Restatement Agreement, dated as of February 2, 2012, to the Credit Agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the subsidiaries of CHS/Community Health Systems, Inc. party thereto, the lenders party thereto and Credit Suisse AG, as Administrative Agent and Collateral Agent (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed February 6, 2012 (No. 001-15925))

	Description
10.5	Second Amended and Restated Credit Agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010 and February 2, 2012, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the lenders party thereto and Credit Suisse AG, as Administrative Agent and Collateral Agent (incorporated by reference to Exhibit 10.2 to Community Health Systems, Inc.'s Current Report on Form 8-K filed February 6, 2012 (No. 001-15925))
10.6	Replacement Revolving Credit Facility and Incremental Term Loan Assumption Agreement, dated as of March 6, 2012, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the subsidiary guarantors party thereto, the lenders party thereto and Credit Suisse AG, as Administrative Agent and Collateral Agent (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed March 9, 2012 (No. 001-15925))
10.7	Amendment No. 1, dated as of August 3, 2012, to the Credit Agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010, and February 2, 2012, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the lenders party thereto and Credit Suisse AG, as administrative agent and as collateral agent for the Lenders (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed August 6, 2012 (No. 001-15925))
10.8	Loan Modification Agreement, dated as of August 22, 2012, to the Credit Agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010, and February 2, 2012, and as amended as of August 3, 2012, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the guarantors party thereto, the lenders party thereto and Credit Suisse AG, as administrative agent and as collateral agent for the Lenders. (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed August 22, 2012 (No. 001-15925))
10.9	Amendment No. 2, dated as of November 27, 2012, to the Credit Agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010, and February 2, 2012, and as amended as of August 3, 2012, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the lenders party thereto and Credit Suisse AG, as administrative agent and as collateral agent for the lenders ((incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed November 28, 2012 (No. 001-15925))
10.10	Receivables Sale Agreement, dated as of March 21, 2012, among CHS/Community Health Systems, Inc., the originators party thereto and Community Health Systems Professional Services Corporation, as Collection Agent (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed March 23, 2012 (No. 001-15925))
10.11	Receivables Purchase and Contribution Agreement, dated as of March 21, 2012, among CHS/ Community Health Systems, Inc., CHS Receivables Funding, LLC and Community Health Systems Professional Services Corporation, as Collection Agent (incorporated by reference to Exhibit 10.2 to Community Health Systems, Inc.'s Current Report on Form 8-K filed March 23, 2012 (No. 001-15925))
10.12	Receivables Loan Agreement, dated as of March 21, 2012, among CHS Receivables Funding, LLC, the lenders party thereto, the managing agents party thereto, Credit Agricole Corporate and Investment Bank, as Administrative Agent, and Community Health Systems Professional Services Corporation, as Collection Agent (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Current Report on Form 8-K filed March 23, 2012 (No. 001-15925))

	Description
10.13	First Omnibus Amendment, dated July 30, 2012, to the Receivables Sale Agreement among CHS/Community Health Systems, Inc., the originators party thereto and Community Health Systems Professional Services Corporation, as Collection Agent, to the Receivables Purchase and Contribution Agreement among CHS/Community Health Systems, Inc., CHS Receivables Funding, LLC and Community Health Systems Professional Services Corporation, as Collection Agent, and to the Receivables Loan Agreement among CHS Receivables Funding, LLC, the lenders party thereto, the managing agents party thereto, Credit Agricole Corporate and Investment Bank, as Administrative Agent, and Community Health Systems Professional Services Corporation, as Collection Agent, all dated as of March 21, 2012 (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2012 filed November 1, 2012 (No. 001-15925))
10.14†	Form of Indemnification Agreement between Community Health Systems, Inc. and its directors and executive officers (incorporated by reference to Exhibit 10.8 to Amendment No. 2 to Community Health Systems, Inc.'s Registration Statement on Form S-1/A filed May 2, 2000 (No. 333-31790))
10.15†	CHS/Community Health Systems, Inc. Amended and Restated Supplemental Executive Retirement Plan (incorporated by reference to Exhibit 10.13 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.16†	Amendment No. 1, dated as of September 13, 2011, to the CHS/Community Health Systems, Inc. Amended and Restated Supplemental Executive Retirement Plan, as amended and restated on January 1, 2009 (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2011 filed October 28, 2011 (No. 001-15925))
10.17†	Community Health Systems Supplemental Executive Benefits (incorporated by reference to Exhibit 10.14 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.18†	Supplemental Executive Retirement Plan Trust, dated June 1, 2005, by and between CHS/Community Health Systems, Inc., as grantor, and Wachovia Bank, N.A., as trustee (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Current Report on Form 8-K filed June 1, 2005 (No. 001-15925))
10.19†	Community Health Systems Deferred Compensation Plan Trust, amended and restated effective February 26, 1999 (incorporated by reference to Exhibit 10.18 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2002 filed March 27, 2003 (No. 001-15925))
10.20†	CHS/Community Health Systems, Inc. Deferred Compensation Plan, amended and restated effective January 1, 2008 (incorporated by reference to Exhibit 10.12 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.21†	CHS NQDCP, effective as of September 1, 2009 (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Registration Statement on Form S-8 filed December 11, 2009 (No. 333-163691))
10.22†	CHS NQDCP Adoption Agreement, executed as of August 11, 2009 (incorporated by reference to Exhibit 4.3 to Community Health Systems, Inc.'s Registration Statement on Form S-8 filed December 11, 2009 (No. 333-163691))

	Description
10.23†	Guarantee, dated December 9, 2009, made by Community Health Systems, Inc. in favor of CHS/Community Health Systems, Inc. with respect to CHS/Community Health Systems, Inc.'s payment obligations under the CHS/Community Health Systems, Inc. Deferred Compensation Plan and the NQDCP (incorporated by reference to Exhibit 4.4 to Community Health Systems, Inc.'s Registration Statement on Form S-8 filed December 11, 2009 (No. 333-163691))
10.24†	Community Health Systems, Inc. 2004 Employee Performance Incentive Plan, as amended and restated on March 24, 2009 (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
10.25†	Amendment No. 1, dated as of December 8, 2010, to the Community Health Systems, Inc. 2004 Employee Performance Incentive Plan, as amended and restated on March 24, 2009 (incorporated by reference to Exhibit 10.14 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2010 filed February 25, 2011 (No. 001-15925))
10.26†	Form of Amended and Restated Change in Control Severance Agreement (incorporated by reference to Exhibit 10.22 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.27†	Community Health Systems, Inc. 2000 Stock Option and Award Plan, as amended and restated on March 24, 2009 (incorporated by reference to Exhibit 10.4 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
10.28†	Form of Nonqualified Stock Option Agreement (Employee) for Community Health Systems, Inc. 2000 Stock Option and Award Plan (incorporated by reference to Exhibit 10.15 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2009 filed February 26, 2010 (No. 001-15925))
10.29†	Form of Restricted Stock Award Agreement for Community Health Systems, Inc. 2000 Stock Option and Award Plan (incorporated by reference to Exhibit 10.18 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.30†	Form of Performance Based Restricted Stock Award Agreement for Community Health Systems, Inc. 2000 Stock Option and Award Plan (Most Highly Compensated Executive Officers) (incorporated by reference to Exhibit 10.20 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.31†	Form of Director Restricted Stock Unit Award Agreement for Community Health Systems, Inc. 2000 Stock Option and Award Plan (incorporated by reference to Exhibit 10.19 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2009 filed February 26, 2010 (No. 001-15925))
10.32†	Community Health Systems, Inc. Directors' Fees Deferral Plan, as amended and restated on December 10, 2008 (incorporated by reference to Exhibit 10.15 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.33†	Community Health Systems, Inc. 2009 Stock Option and Award Plan, as amended and restated on March 18, 2011 (incorporated by reference to Annex A to Community Health Systems, Inc.'s Definitive Proxy Statement on Form 14A filed April 7, 2011)
10.34†	Form of Nonqualified Stock Option Agreement (Employee) for Community Health Systems, Inc. 2009 Stock Option and Award Plan (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2011 filed April 29, 2011 (No. 001-15925))

	Description
10.35†	Form of Restricted Stock Award Agreement for Community Health Systems, Inc. 2009 Stock Option and Award Plan (incorporated by reference to Exhibit 10.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2011 filed April 29, 2011 (No. 001-15925))
10.36†	Form of Performance Based Restricted Stock Award Agreement (Most Highly Compensated Executive Officers) for Community Health Systems, Inc. 2009 Stock Option and Award Plan (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2011 filed April 29, 2011 (No. 001-15925))
10.37†	Form of Director Restricted Stock Unit Award Agreement for Community Health Systems, Inc. 2009 Stock Option and Award Plan (incorporated by reference to Exhibit 10.4 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2011 filed April 29, 2011 (No. 001-15925))
10.38	Participation Agreement entered into as of January 1, 2005, by and between Community Health Systems Professional Services Corporation and HealthTrust Purchasing Group, L.P. (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed January 7, 2005 (No. 001-15925))
12*	Computation of Ratio of Earnings to Fixed Charges
21*	List of Subsidiaries
23.1*	Consent of Deloitte & Touche LLP
31.1*	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2*	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1*	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2*	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema
101.CAL	XBRL Taxonomy Extension Calculation Linkbase
101.DEF	XBRL Taxonomy Extension Definition Linkbase
101.LAB	XBRL Taxonomy Extension Label Linkbase
101.PRE	XBRL Taxonomy Extension Presentation Linkbase

* Filed herewith.

† Indicates a management contract or compensatory plan or arrangement.

SIGNATURES

Pursuant to the requirements of section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

COMMUNITY HEALTH SYSTEMS, INC.

By: /s/ Wayne T. Smith
Wayne T. Smith
Chairman of the Board,
President and Chief Executive Officer

Date: February 27, 2013

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Name	Title	Date
/s/ WAYNE T. SMITH Wayne T. Smith	President and Chief Executive Officer and Director (principal executive officer)	2/27/2013
/s/ W. LARRY CASH W. Larry Cash	Executive Vice President, Chief Financial Officer and Director (principal financial officer)	2/27/2013
/s/ KEVIN J. HAMMONS Kevin J. Hammons	Vice President and Chief Accounting Officer (principal accounting officer)	2/27/2013
/s/ JOHN A. CLERICO John A. Clerico	Director	2/27/2013
/s/ JAMES S. ELY III James S. Ely III	Director	2/27/2013
/s/ JOHN A. FRY John A. Fry	Director	2/27/2013
/s/ WILLIAM NORRIS JENNINGS, M.D. William Norris Jennings, M.D.	Director	2/27/2013
/s/ JULIA B. NORTH Julia B. North	Director	2/27/2013
/s/ H. MITCHELL WATSON, JR. H. Mitchell Watson, Jr.	Director	2/27/2013

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 consolidated financial statements of Community Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 2012 and 2011, and for each of the three years in the period ended December 31, 2012, and the Company's internal control over financial reporting as of December 31, 2012, and have issued our reports thereon dated February 27, 2013; such reports are included elsewhere in this Form 10-K. Our audits also included the consolidated financial statement schedule of the Company listed in Item 15. This consolidated financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, such consolidated financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ Deloitte & Touche LLP
Nashville, Tennessee
February 27, 2013

Community Health Systems, Inc. and Subsidiaries

Schedule II — Valuation and Qualifying Accounts

Description	Balance at Beginning of Year	Acquisitions and Dispositions	Charged to Costs and Expenses	Write-offs	Balance at End of Year
			(In thousands)		
Year ended December 31, 2012 allowance for doubtful accounts	$1,891,334	$ —	$1,959,194	$(1,648,653)	$2,201,875
Year ended December 31, 2011 allowance for doubtful accounts	$1,639,198	$(28,954)	$1,766,201	$(1,485,111)	$1,891,334
Year ended December 31, 2010 allowance for doubtful accounts	$1,417,188	$ —	$1,588,516	$(1,366,506)	$1,639,198

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement No. 333-181630 on Form S-3 and Registration Nos. 333-44870, 333-61614, 333-100349, 333-107810, 333-121282, 333-121283, 333-144525, 333-163688, 333-163689, 333-163690, 333-163691 and 333-176893 on Form S-8 of our reports dated February 27, 2013, relating to the consolidated financial statements and consolidated financial statement schedule of Community Health Systems, Inc. and subsidiaries, and the effectiveness of Community Health Systems, Inc. and subsidiaries' internal control over financial reporting, appearing in this Annual Report on Form 10-K of Community Health Systems, Inc. and subsidiaries for the year ended December 31, 2012.

/s/ Deloitte & Touche LLP
Nashville, Tennessee
February 27, 2013

Exhibit 31.1

I, Wayne T. Smith, certify that:

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

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

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

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

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

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

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

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

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

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

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

/s/ Wayne T. Smith

Wayne T. Smith
Chairman of the Board, President
and Chief Executive Officer

Date: February 27, 2013

Exhibit 31.2

I, W. Larry Cash, certify that:

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

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

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

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

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

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

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

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

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

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

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

/s/ W. Larry Cash

W. Larry Cash
Executive Vice President,
Chief Financial Officer and Director

Date: February 27, 2013

Exhibit 32.1

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

In connection with the Annual Report of Community Health Systems, Inc. (the "Company") on Form 10-K for the period ending December 31, 2012, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Wayne T. Smith, Chairman of the Board, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ WAYNE T. SMITH

Wayne T. Smith
Chairman of the Board, President and
Chief Executive Officer

February 27, 2013

Exhibit 32.2

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

In connection with the Annual Report of Community Health Systems, Inc. (the "Company") on Form 10-K for the period ending December 31, 2012, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, W. Larry Cash, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ W. LARRY CASH

W. Larry Cash
Executive Vice President, Chief Financial Officer and Director

February 27, 2013