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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.

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

. 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.

. 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.

- . 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.
- . 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.
- . 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.
- . 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.
- . 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.

- *C . .* . 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.

C . . 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.

C

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.

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.

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.

D e m a n d . 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.

C o n s o l i d a t i o n . In addition to our own acquisitions in recent years, consolidation activity in the hospital

	Y	1,	( )
	2012	2011	
	( )	)	
- (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):

	Y		1,
	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 and	53,407	107,032	(5,290)

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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

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.

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

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.

. 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 regulatorycostson,mwnarily the federal DRG

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

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.

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.

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.

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

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.

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.

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.

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

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

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- make restricted payments, including paying dividends and making investments,

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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.

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.

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.

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.

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

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

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.

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.

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 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 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.

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.

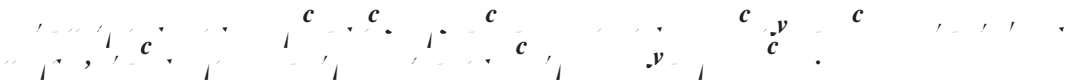
In the future, different interpretations or enforcement of these laws and regulations could subject our current practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses.

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.

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.

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.



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

- our ability, where appropriate, to enter into and maintain managed care provider arrangements and the terms of these arrangements,
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		(1)		
Vista Medical Center West (psychiatric and rehabilitation beds)	Waukegan	71	July, 2006	Owned
Union County Hospital	Anna	25	November, 2006	Leased
Porter Hospital	Valparaiso	301	May, 2007	Owned
Lutheran Health Network				

		(1)		
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
Mountain West Medical Center	Tooele	44	October, 2000	Owned
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
Rockwood Health System				
Deaconess Hospital	Spokane	388	October, 2008	Owned
Valley Hospital	Spokane Valley	123	October, 2008	Owned
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
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.

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.

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.

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

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

(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 . 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.

C *C* *C* *C* *C*). 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

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.

Not applicable.

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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.

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

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.

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.

	Year Ended December 31,				
	2012	2011	2010	2009	2008
		(In thousands, except per share 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
Cash and cash equivalents	$ 387,813	$ 129,865	$ 299,169	$ 344,541	$ 220,655
Total assets					

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.

2012 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

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 refnit1(6.tion)-2e256(255ndate)-257(that)-255(requires)-259(substeto)-wu1.1% ofand expand health

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,

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.

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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

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.

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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.

	Y		1,
	2012	2011	2010
	(	2	)
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)

	Y 1,	
	2012	2011
	( )	
( ) :		
Net operating revenues	9.4%	7.3%
Admissions	4.0	(0.5)
Adjusted admissions(b)	6.6	4.2

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.

Y 1, 2011 Y 1, 2010

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 0.4% 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.

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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 three1,

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):

		201	201 -201	201 -201	2019
Long-term debt	$ 4,370,524	$ 85,280	$ 996,599	$3,285,210	$ 3,435
8% Senior Notes	2,000,000	—	—	—	2,000,000
7⅛% Senior Notes	1,200,000	—	—	—	1,200,000
5⅛% 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 7⅛% Senior Notes are fixed at an interest rate of 7.125% per annum. The 5⅛% 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.

$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.

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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

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.

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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
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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.

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.

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,on,on,oneet tand
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.

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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

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

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.

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, 2003259(reported)-258(fmillion)-260(per)-253(occurrencWe)-252s; une is

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.

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In July 2011, the FASB issued ASU 2011-07, which requires healthcare organizations that perform services for patients for which the ultimate collection of all or a portion of the amounts billed or billable cannot be determined at the time services are rendered to present all bad debt expense associated with 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.

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.

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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 *C? ? ? ?* 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

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	2012	2011	2010
	(,		)
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
	13,028,985	11,906,212	11,092,422
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
	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			

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	2012	2011	2010
		( )	
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.

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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.

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	2012	2011	2010
		( )	
C :			
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	—

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B , , . 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.

, , . The preparation of financial statements in conformity with accounting principles

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

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.

C . 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.

A . 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.

I . 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.

C ( ). 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):

	R	2		2 ( )
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)

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

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):

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

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:

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:

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):

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	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.

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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

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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):

	Y 1,	
	2012	2011
	( )	
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

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

	Y 1,	
	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

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.

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

	Y		1,
	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

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):

	Y		1,
	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 Commu year examination the Unix periods asg

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

	1,	
	2012	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		

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

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% , 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% , 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:

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% , 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:

2016	103.563%
2017	101.781%
2018 and thereafter	

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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):

Y	
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. R R

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):

	1,			
	2012		2011	
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.

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

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

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

C . 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% . 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% . 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% . 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% . 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.

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

. 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.

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

#	(000')	R		(000')
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 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):

	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 onmsands):

10.

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

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):

	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

11.

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):

	Y		1,
	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. R R R

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):

	Y 1,		
	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:

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

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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):

	1,	
	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		

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):

	1,		
	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

	1,	
	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

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C , C . 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.

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C . 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.

C . 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 istagre1-26a60(from)justmesdrt -259(pe1.2

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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 *C . C* . 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):

	Y		1,
	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.

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

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Y 1, 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

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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 stockholdaromthe 2s (ted a0(accoun5.1(open-1.2TD[(balance)-256(s

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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

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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						

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Y 1, 2012

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

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Y 1, 2011

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	—	75,675324100(—)-5...

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Y 1, 2010

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

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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
			Y			
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

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1, 2011

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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
			Y			
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
—(6,678)	—	—	—	—	(6,678)	

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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)

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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	—	—	—	—	—	—

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

None

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.

9B. Other Information

None

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To the Board of Directors and Stockholders of
Community Health Systems, Inc.
Franklin, Tennessee

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

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

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."

12. Security Ownership of Certain Beneficial Owners and Management

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."

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."

14. Principal Accounting 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

15. Exhibits, Financial Statement Schedules

Item 15(a) 1.

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

Item 15(a) 2.

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.

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 BankInc.l7fiS.orated by reference to Exhibit 4.2 party0(2007,)-250(by)-IInc.l7eTD

4.4 Re6iorAgreement relating to CHS/Community Health Systems, Inc.'s 8

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))

4.38 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.,

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 t Report on Form 8-K filed

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 A reement, 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

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))

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))

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.

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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

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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.

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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

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			( )		
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

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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

1.1

I, Wayne T. Smith, certify that:

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

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

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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

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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