COMMUNITY HEALTH SYSTEMS INC
Form 10-K
February 25, 2011

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

Form 10-K

(Mark One)

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the year ended December 31, 2010

OR

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission file number 001-15925

COMMUNITY HEALTH SYSTEMS, INC.
(Exact name of registrant as specified in its charter)

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

Registrant s telephone number, including area code:
(615) 465-7000

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

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

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

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

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

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

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

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

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

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

The aggregate market value of the voting stock held by non-affiliates of the Registrant was $3,231,059,649. Market value is determined by reference to the closing price on June 30, 2010 of the Registrant s Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2010) have any non-voting common stock outstanding. As of February 17, 2011, there were 92,752,536 shares of common stock, par value $.01 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required for Part III of this annual report is incorporated by reference from portions of the Registrant s definitive proxy statement for its 2011 annual meeting of stockholders to be filed with the Securities and Exchange Commission within 120 days after the end of the Registrant s fiscal year ended December 31, 2010.

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FORM 10-K ANNUAL REPORT

COMMUNITY HEALTH SYSTEMS, INC.
Year ended December 31, 2010

EX-101 SCHEMA DOCUMENT
EX-101 CALCULATION LINKBASE DOCUMENT
EX-101 LABELS LINKBASE DOCUMENT
EX-101 PRESENTATION LINKBASE DOCUMENT
EX-101 DEFINITION LINKBASE DOCUMENT

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PART I

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

Overview of Our Company

We are the largest publicly-traded operator of hospitals in the United States in terms of number of facilities and net operating revenues. We were incorporated in 1996 as a Delaware corporation. We provide healthcare services through the hospitals that we own and operate in non-urban and selected urban markets throughout the United States. As of December 31, 2010, we owned or leased 130 hospitals, including four stand-alone rehabilitation or psychiatric hospitals. These hospitals are geographically diversified across 29 states, with an aggregate of 19,372 licensed beds. We generate revenues by providing a broad range of general and specialized hospital healthcare services to patients in the communities in which we are located. Services provided by our hospitals include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric and rehabilitation services. As part of providing these services, we also own physician practices, imaging centers and ambulatory surgery centers. Through our management and operation of these businesses, we provide standardization and centralization of operations across key business areas; strategic assistance to expand and improve services and facilities; implementation of quality of care improvement programs; and assistance in the recruitment of additional physicians to the markets in which our hospitals are located. In a number of our markets, we have partnered with local physicians or not-for-profit providers, or both, in the ownership of our facilities. In addition to our hospitals and related businesses, we also own and operate 64 licensed home care agencies and 25 hospice agencies, located primarily in markets where we also operate a hospital. Also, through our wholly-owned subsidiary, Quorum Health Resources, LLC, or QHR, we provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. The home care agencies and the hospital management services businesses constitute operating segments, but are not considered reportable segments since they do not meet the quantitative thresholds for a separate identifiable reportable segment. The financial information for our reportable operating segments is presented in Note 14 of the Notes to our Consolidated Financial Statements included under Item 8 of this Report.

Our strategy has also included growth by acquisition. We generally target hospitals in growing, non-urban and selected urban healthcare markets for acquisition because of their favorable demographic and economic trends and competitive conditions. Because these service areas have smaller populations, there are generally fewer hospitals and other healthcare service providers in these communities and generally a lower level of managed care presence in these markets. We believe that smaller populations support less direct competition for hospital-based services. Also, we believe that these communities generally view the local hospital as an integral part of the community.

During 2010, we fully resumed our acquisition strategy by acquiring five hospitals. We had limited our acquisition activity after our acquisition of Triad Hospitals, Inc., or Triad, in 2007.

Throughout this Form 10-K, we refer to Community Health Systems, Inc., or the Parent Company, and its consolidated subsidiaries in a simplified manner and on a collective basis, using words like we and our. This drafting style is suggested by the Securities and Exchange Commission, or SEC, and is not meant to indicate that the publicly-traded Parent Company or any other subsidiary of the Parent Company owns or operates any asset, business or property. The hospitals, operations and businesses described in this filing are owned and operated, and management services provided, by distinct and indirect subsidiaries of Community Health Systems, Inc.

Available Information

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

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

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

Our Business Strategy

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

increase revenue at our facilities;

improve profitability;

improve quality; and

grow through selective acquisitions.

Increase Revenue at Our Facilities

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

recruiting and/or employing additional primary care physicians and specialists;

expanding the breadth of services offered at our hospitals and in the communities in which we operate through targeted capital expenditures and physician alignment to support the addition of more complex services, including orthopedics, cardiovascular services and urology; and

providing the capital to invest in technology and the physical plant at the facilities, particularly in our emergency rooms, surgery departments, critical care departments and diagnostic services.

Physician Recruiting. The primary method of adding or expanding medical services is the recruitment of new physicians into the community. A core group of primary care physicians is necessary as an initial contact point for all local healthcare. The addition of specialists who offer services, including general surgery, obstetrics and gynecology, cardiovascular services, orthopedics and urology, completes the full range of medical and surgical services required to meet a community s core healthcare needs. At the time we acquire a hospital and from time to time thereafter, we identify the healthcare needs of the community by analyzing demographic data and patient referral trends. As a result of this analysis, we are able to determine what we believe to be the optimum mix of primary care physicians and specialists. We employ recruiters at the corporate level to support the local hospital managers in their recruitment efforts. We have increased the number of physicians affiliated with us through our recruiting efforts, net of turnover, by approximately 935 in 2010, 772 in 2009 and 686 in 2008. The percentage of recruited or other physicians commencing practice with us that were specialists was over 50% in 2010. Additionally, in response to the recent trend

in physicians seeking employment, we have begun employing more physicians, including, in some instances, acquiring physician practices. However, most of the physicians in our communities remain in private practice and are not our employees. We have been successful in recruiting physicians because of the practice opportunities afforded physicians in our markets, as well as lower managed care penetration as compared to larger urban areas.

Emergency Room Initiatives. Approximately 60% of our hospital admissions originate in the emergency room. Therefore, we systematically take steps to increase patient flow in our emergency rooms as a means of optimizing utilization rates for our hospitals. Furthermore, our patients impression of our overall operations is

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substantially influenced by our emergency rooms since generally that is our patients first experience with our hospitals. The steps we take to increase patient flow in our emergency rooms include renovating and expanding our emergency room facilities, improving service and reducing waiting times, as well as publicizing our emergency room capabilities in the local community. We have expanded or renovated 13 of our emergency rooms during the past three years, including four in 2010. We have also implemented marketing campaigns that emphasize the speed, convenience and quality of our emergency rooms to enhance each community s awareness of our emergency room services.

One component of upgrading our emergency rooms is the implementation of specialized computer software programs designed to assist physicians in making diagnoses and determining treatments. The software also benefits patients and hospital personnel by assisting in proper documentation of patient records and tracking patient flow. It enables our nurses to provide more consistent patient care and provides clear instructions to patients at time of discharge to help them better understand their treatments.

Expansion of Services. In an effort to better meet the healthcare needs of the communities we serve and to capture a greater portion of the healthcare spending in our markets, we have added a broad range of services to our facilities and in certain markets, acquired physician practices to broaden our service offerings. These services range from various types of diagnostic equipment capabilities to additional and renovated emergency rooms, surgical and critical care suites and specialty services. For example, we spent approximately $119.6 million on 35 major construction projects that were completed in 2010. The 2010 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 2010, we spent $34.7 million on construction projects related to three replacement hospitals that we are required to build pursuant to either a hospital purchase agreement or an amendment to a lease agreement. In addition, in September 2010, we received approval of our request for a certificate of need from the Alabama Certificate of Need Review Board for the construction of a replacement hospital in Birmingham, Alabama. This certificate of need remains subject to an appeal process. The total cost of these four replacement hospitals is estimated to be $598.5 million.

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

Improve Profitability

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

standardizing and centralizing our operations;

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optimizing resource allocation by utilizing our company-devised case and resource management program, which assists in improving clinical care and containing expenses;

capitalizing on purchasing efficiencies through the use of company-wide standardized purchasing contracts and terminating or renegotiating specified vendor contracts;

installing a standardized management information system, resulting in more efficient billing and collection procedures; and

monitoring and enhancing productivity of our human resources.

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, which has an average of over 25 years of experience in the healthcare industry.

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

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

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

Procurement and Materials Management. We have standardized and centralized our operations with respect to medical supplies, equipment and pharmaceuticals used in our hospitals. We have a participation agreement with HealthTrust Purchasing Group, L.P., or HealthTrust, a group purchasing organization, or GPO. HealthTrust contracts with certain vendors who supply a substantial portion of our medical supplies, equipment and pharmaceuticals. Our agreement with HealthTrust extends to January 2012, with automatic renewal terms of one year unless either party terminates by giving notice of non-renewal.

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

Other Initiatives. We have also improved margins by implementing standard programs with respect to ancillary services in areas, including emergency rooms, pharmacy, laboratory, imaging, home care, skilled nursing, centralized outpatient scheduling and health information management. We have improved quality and

reduced costs associated with these services by improving contract terms and standardizing information systems. We work to identify and communicate best practices and monitor these improvements throughout the Company.

Internal Controls Over Financial Reporting. We have centralized many of our significant internal controls over financial reporting and standardized those other controls that are performed at our hospital

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locations. We continuously monitor compliance with and evaluate the effectiveness of our internal controls over financial reporting.

Case and Resource Management. Our case and resource management program is a company-devised program developed with the goal of improving clinical care and cost containment. The program focuses on:

appropriately treating patients along the care continuum;

reducing inefficiently applied processes, procedures and resources;

developing and implementing standards for operational best practices; and

using on-site clinical facilitators to train and educate care practitioners on identified best practices.

Our case and resource management program integrates the functions of utilization review, discharge planning, overall clinical management and resource management into a single effort to improve the quality and efficiency of care. Issues evaluated in this process include patient treatment, patient length of stay and utilization of resources.

Under our case and resource management program, patient care begins with a clinical assessment of the appropriate level of care, discharge planning and medical necessity for planned services. Beginning when a patient presents to the hospital, we conduct ongoing reviews for medical necessity using appropriateness criteria. We reassess and adjust discharge plan options as the needs of the patient change. We closely monitor cases to prevent delayed service or inappropriate utilization of resources. Once the patient attains clinical improvement, we work with the attending physician to evaluate further needs for acute care treatment through discussions with the facility s physician advisor. Finally, we refer the patient to the appropriate post-hospitalization resources.

Improve Quality

We have implemented various programs to ensure continuous improvement in the quality of care provided. We have developed training programs for all senior hospital management, chief nursing officers, quality directors, physicians and other clinical staff. We share information among our hospital management to implement best practices and assist in complying with regulatory requirements. We have standardized accreditation documentation and requirements. All hospitals conduct patient, physician and staff satisfaction surveys to help identify methods of improving the quality of care.

Each of our hospitals is governed by 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.

To ensure the experience of our emergency room patients meets our service and quality expectations, we have implemented a program to contact each patient as a follow-up to the services they received. We verify that patients were able to obtain any prescriptions and outpatient appointments recommended at discharge. We also ensure that their symptoms have abated and that they understood the discharge instructions given at the hospital. Through this program, we placed in excess of one million follow-up calls in 2010.

Grow Through Selective Acquisitions

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

have a service area population between 20,000 and 400,000 with a stable or growing population base;

are the sole or primary provider of acute care services in the community;

are located in an area with the potential for service expansion;

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are not located in an area that is dependent upon a single employer or industry; and

have financial performance that we believe will benefit from our management s operating skills.

In each year since 1997, we have met or exceeded our acquisition goals. Occasionally, we have pursued acquisition opportunities outside of our specified criteria when such opportunities have had uniquely favorable characteristics. In the fourth quarter of 2008, we completed the acquisition of a two hospital system located in Spokane, Washington. In 2009, we acquired two hospitals located in Wilkes-Barre, Pennsylvania and one hospital in Siloam Springs, Arkansas and purchased the remaining equity in a hospital located in El Dorado, Arkansas in which we previously had a noncontrolling interest. In 2010, we acquired five hospitals located in Marion, South Carolina, Youngstown, Ohio, Warren, Ohio and Bluefield, West Virginia.

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

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

At the time we acquire a hospital, we may commit to an amount of capital expenditures, such as a replacement facility, renovations, or equipment over a specified period of time. As obligations under two hospital purchase agreements in effect as of December 31, 2010, we are required to build a replacement facility in Valparaiso, Indiana by April 2011 and in Siloam Springs, Arkansas by February 2013. Due to delays in receiving government approved building and zoning permits, the replacement facility in Valparaiso, Indiana is not expected to be completed until the fourth quarter of 2012. Also, as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location. Estimated construction costs, including equipment costs, are approximately $318.5 million for these three replacement facilities, of which approximately $47.4 million has been incurred to date. In addition, in October 2008, after the purchase of the noncontrolling owner s interest in our Birmingham, Alabama facility, we initiated the purchase of a site, which includes a partially constructed hospital structure, for a potential replacement to our existing Birmingham facility. In September 2010, we received approval of our request for a certificate of need from the Alabama Certificate of Need Review Board; however, this certificate of need remains subject to an appeal process. Our estimated construction costs, including the acquisition of the site and equipment costs, are approximately $280.0 million for the Birmingham replacement facility, of which approximately $1.3 million has been incurred to date. Under other purchase agreements in effect as of December 31, 2010, we have committed to spend $540.5 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, 2010, we have incurred approximately $184.5 million related to these commitments.

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On December 9, 2010, we announced that we made an offer to acquire Tenet Healthcare Corporation, or Tenet, for $6.00 per share, including $5.00 per share in cash and $1.00 per share in our common stock, which represented a premium of 40% over Tenet s closing stock price on December 9, 2010. The total value of the transaction at this offering price would be approximately $7.3 billion, including $3.3 billion of acquired equity and approximately $4.0 billion of assumed long-term debt. The offer was made in a letter to Tenet s Board of Directors on November 12, 2010, and rejected by Tenet on December 6, 2010. On December 20, 2010, we announced our intention to nominate directors for election at the 2011 Annual Meeting of Tenet, and on January 14, 2011, a full slate of 10 independent director nominees was nominated. Tenet s entire Board is up for reelection at the 2011 Annual Meeting, which has been scheduled for November 3, 2011. There can be no assurance that such a transaction will be completed or, if completed, on what terms.

Industry Overview

The Centers for Medicare and Medicaid Services, or CMS, reported that in 2009 total U.S. healthcare expenditures grew by 4.0% to approximately $2.5 trillion. CMS also projected total U.S. healthcare spending to grow by 5.1% in 2010 and by an average of 6.3% annually from 2009 through 2019. By these estimates, healthcare expenditures will account for approximately $4.6 trillion, or 19.6% of the total U.S. gross domestic product, by 2019.

Hospital services, the market in which we operate, is the largest single category of healthcare at 30% of total healthcare spending in 2009, or approximately $759.1 billion, as reported by CMS. CMS projects the hospital services category to grow by at least 4.2% per year through 2019. It expects growth in hospital healthcare spending to continue due to the aging of the U.S. population and consumer demand for expanded medical services. As hospitals remain the primary setting for healthcare delivery, CMS expects hospital services to remain the largest category of healthcare spending.

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

Urban vs. Non-Urban Hospitals

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

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

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

facility payor mix.

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

Hospital Industry Trends

Demographic Trends. According to the U.S. Census Bureau, there are presently approximately 39.6 million Americans aged 65 or older in the U.S. who comprise approximately 12.9% 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 5.6 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 25.0% from 1990 to 2009 and are expected to grow by 4.6% from 2009 to 2014. The number of people aged 65 or older in these service areas grew by 26.6% from 1990 to 2009 and is expected to grow by 15.2% from 2009 to 2014.

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

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

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

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Selected Operating Data

The following table sets forth operating statistics for our hospitals for each of the years presented, which are included in our continuing operations. Statistics for 2010 include a full year of operations for 125 hospitals and partial periods for five hospitals acquired during the year. Statistics for 2009 include a full year of operations for 121 hospitals and partial periods for three hospitals acquired during the year and one hospital in which we previously had a noncontrolling interest and purchased the remaining interest during the year. Statistics for 2008 include a full year of operations for 119 hospitals and partial periods for two hospitals acquired during the year. Statistics for hospitals which have been sold are excluded from all periods presented.

	Year Ended December 31,		
	2010	2009	2008
	(Dollars in thousands)		
Consolidated Data			
Number of hospitals (at end of period)	130	125	121
Licensed beds (at end of period)(1)	19,372	18,140	17,411
Beds in service (at end of period)(2)	16,622	15,897	15,194
Admissions(3)	693,382	692,569	668,526
Adjusted admissions(4)	1,308,334	1,275,888	1,207,756
Patient days(5)	2,948,876	2,937,194	2,835,795
Average length of stay (days)(6)	4.3	4.2	4.2
Occupancy rate (beds in service)(7)	50.0%	51.3%	52.3%
Net operating revenues	$ 12,986,500	$ 12,107,613	$ 10,919,095
Net inpatient revenues as a % of total net operating revenues	48.9%	50.1%	50.2%
Net outpatient revenues as a % of total net operating revenues	48.9%	47.6%	47.5%
Net income attributable to Community Health Systems, Inc.	$ 279,983	$ 243,150	$ 218,304
Net income attributable to Community Health Systems, Inc. as a % of total net operating revenues	2.2%	2.0%	2.0%
Liquidity Data			
Adjusted EBITDA(8)	$ 1,770,199	$ 1,671,397	$ 1,513,329
Adjusted EBITDA as a % of total net operating revenues(8)	13.6%	13.8%	13.9%
Net cash flows provided by operating activities	$ 1,188,730	$ 1,076,429	$ 1,056,581
Net cash flows provided by operating activities as a % of total net operating revenues	9.2%	8.9%	9.7%
Net cash flows used in investing activities	$ (1,044,310)	$ (867,182)	$ (665,471)
Net cash flows used in financing activities	$ (189,792)	$ (85,361)	$ (304,029)

See pages 10 and 11 for footnotes.

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	Year Ended December 31, 2010	2009	(Decrease) Increase
	(Dollars in thousands)		
Same-Store Data(9)			
Admissions(3)	675,086	692,569	(2.5)%
Adjusted admissions(4)	1,269,467	1,275,888	(0.5)%
Patient days(5)	2,858,532	2,937,194	
Average length of stay (days)(6)	4.2	4.2	
Occupancy rate (beds in service)(7)	49.8%	51.3%	
Net operating revenues	$ 12,582,406	$ 12,105,938	3.9%
Income from operations	$ 1,139,501	$ 1,083,805	5.1%
Income from operations as a % of net operating revenues	9.1%	9.0%	
Depreciation and amortization	$ 595,482	$ 566,219	
Equity in earnings of unconsolidated affiliates	$ 45,220	$ 36,409	

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

(2) Beds in service are the number of beds that are readily available for patient use.

(3) Admissions represent the number of patients admitted for inpatient treatment.

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

(5) Patient days represent the total number of days of care provided to inpatients.

(6) Average length of stay (days) represents the average number of days inpatients stay in our hospitals.

(7) We calculated occupancy rate percentages by dividing the average daily number of inpatients by the weighted-average number of beds in service.

(8) EBITDA consists of net income attributable to Community Health Systems, Inc. before interest, income taxes, depreciation and amortization. Adjusted EBITDA is EBITDA adjusted to exclude discontinued operations, gain/loss from early extinguishment of debt and net income attributable to noncontrolling interests. We have from time to time sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. We believe that it is useful to present adjusted EBITDA because it excludes the portion of EBITDA attributable to these third-party interests and clarifies for investors our portion of EBITDA generated by continuing operations. We use adjusted EBITDA as a measure of liquidity. We have included this measure because we believe it provides investors with additional information about our ability to incur and service debt and make capital expenditures. Adjusted EBITDA is the basis for a key component in the determination of our compliance with some of the covenants under our senior secured credit facility, as well as to determine the interest rate and commitment fee payable under the senior secured credit facility (although adjusted EBITDA does not include all of the adjustments described in the senior secured credit facility).

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

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The following table reconciles adjusted EBITDA, as defined, to our net cash provided by operating activities as derived directly from our Consolidated Financial Statements for the years ended December 31, 2010, 2009 and 2008 (in thousands):

	Year Ended December 31,		
	2010	2009	2008
Adjusted EBITDA	$ 1,770,199	$ 1,671,397	$ 1,513,329
Interest expense, net	(651,926)	(648,964)	(652,468)
Provision for income taxes	(159,993)	(141,325)	(125,273)
Deferred income taxes	97,370	34,268	159,870
Income from operations of hospitals sold or held for sale		1,977	9,427
Income tax expense on the (gain) loss on sale of hospitals			(8,107)
Depreciation and amortization of discontinued operations		332	7,308
Stock compensation expense	38,779	44,501	52,105
(Excess tax benefits) income tax payable increase relating to stock-based compensation	(10,219)	3,472	(1,278)
Other non-cash expenses, net	12,503	22,870	3,577
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	(27,049)	58,390	(49,578)
Supplies, prepaid expenses and other current assets	(39,904)	(34,535)	(34,397)
Accounts payable, accrued liabilities and income taxes	161,952	86,098	119,869
Other	(2,982)	(22,052)	62,197
Net cash provided by operating activities	$ 1,188,730	$ 1,076,429	$ 1,056,581

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

Sources of Revenue

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

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

The following table presents the approximate percentages of net operating revenues received from Medicare, Medicaid, managed care, self-pay and other sources for the periods indicated. The data for the years presented are not strictly comparable due to the effect that hospital acquisitions have had on these statistics.

Net Operating Revenues by Payor Source	Year Ended December 31, 2010	2009	2008
Medicare	27.2%	27.1%	27.5%
Medicaid	10.6%	9.8%	9.1%
Managed Care and other third-party payors	50.6%	51.9%	52.7%
Self-pay	11.6%	11.2%	10.7%
Total	100.0%	100.0%	100.0%

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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 net operating revenues from insurance companies with which we have insurance provider contracts, Medicare Managed Care, insurance companies for which we do not have insurance provider contracts, workers compensation carriers and non-patient service revenue, such as rental income and cafeteria sales. In the future, we generally expect revenues received from the Medicare and Medicaid programs to increase due to the general aging of the population. In addition, the Reform Legislation (as defined below) will increase the number of insured patients which should reduce revenues from self-pay patients and reduce the provision for bad debts. The Reform Legislation, however, imposes significant reductions in amounts the government pays Medicare Managed Care plans. Other provisions in the Reform Legislation impose minimum medical-loss ratios and require insurers to meet specific benefit requirements. In addition, specified managed care programs, insurance companies, and employers are actively negotiating the amounts paid to hospitals. The trend toward increased enrollment in managed care may adversely affect our net operating revenue growth. There can be no assurance that we will retain our existing reimbursement arrangements or that these third-party payors will not attempt to further reduce the rates they pay for our services.

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

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

As of December 31, 2010, Indiana, Texas and Pennsylvania represented our only areas of geographic concentration. Net operating revenues as a percentage of consolidated net operating revenues generated in Indiana were 10.3% in 2010 and 10.9% in both 2009 and 2008. Net operating revenues as a percentage of consolidated net operating revenues generated in Texas were 13.0% in 2010, 13.2% in 2009 and 13.3% in 2008. Net operating revenues as a percentage of consolidated net operating revenues generated in Pennsylvania were 10.0% in 2010, 9.9% in 2009 and 8.9% in 2008.

Hospital revenues depend upon inpatient occupancy levels, the volume of outpatient procedures, and the charges or negotiated payment rates for hospital services provided. Charges and payment rates for routine inpatient services vary

significantly depending on the type of service performed and the geographic location of

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the hospital. In recent years, we have experienced a significant increase in revenue received from outpatient services. We attribute this increase to:

- advances in technology, which have permitted us to provide more services on an outpatient basis; and
- pressure from Medicare or Medicaid programs, insurance companies, and managed care plans to reduce hospital stays and to reduce costs by having services provided on an outpatient rather than on an inpatient basis.

Government Regulation

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

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

Healthcare Reform. The American Recovery and Reinvestment Act of 2009, or ARRA, was signed into law on February 17, 2009, providing for a temporary increase in the federal matching assistance percentage (FMAP), a temporary increase in federal Medicaid Disproportionate Share Hospital, or DSH, allotments, subsidization of health insurance premiums (COBRA) for up to nine months, and grants and loans for infrastructure and incentive payments for providers who adopt and use health information technology. This act also provides penalties by reducing reimbursement from Medicare in the form of reductions to scheduled market basket increases beginning in federal fiscal year 2015 if eligible hospitals and professionals fail to demonstrate meaningful use of electronic health record technology. The 2010 Department of Defense Appropriations Act was signed into law on December 19, 2009 and expanded the subsidization of health insurance premiums (COBRA) to 15 months and extended the eligibility period for individuals losing their jobs through February 28, 2010.

The Patient Protection and Affordable Care Act, or PPACA, was signed into law on March 23, 2010. In addition, the Health Care and Education Affordability Reconciliation Act of 2010, or Reconciliation Act, which contains a number of amendments to PPACA, was signed into law on March 30, 2010. These healthcare acts, referred to collectively as the Reform Legislation, include a mandate that requires substantially all U.S. citizens to maintain medical insurance coverage which will ultimately increase the number of persons with access to health insurance in the United States. The Reform Legislation should result in a reduction in uninsured patients, which should reduce our expense from uncollectible accounts receivable; however, this legislation makes a number of other changes to Medicare and Medicaid, such as reductions to the Medicare annual market basket update for federal fiscal years 2010 through 2019,

a productivity offset to the Medicare market basket update beginning October 1, 2011, and a reduction to the Medicare and Medicaid disproportionate share payments, that could adversely impact the reimbursement received under these programs. The various provisions in the Reform Legislation that directly or indirectly affect reimbursement are scheduled to take effect over a number of years, and we cannot predict their impact at this time. Other provisions of the Reform

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Legislation, such as requirements related to employee health insurance coverage, should increase our operating costs.

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

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

The impact of the Reform Legislation on each of our hospitals will vary depending on payor mix and a variety of other factors. We anticipate that many of the provisions in the Reform Legislation will be subject to further clarification and modification through the rule-making process, the development of agency guidance and judicial interpretations. Moreover, a number of state attorneys general are challenging the legality of certain aspects of the Reform Legislation. Currently, rulings in four separate Federal District Courts, regarding the constitutionality of the Reform Legislation, have been split, with two courts ruling in favor of the legislation and two courts ruling that part or all of the Reform Legislation was unconstitutional. These decisions are likely to be appealed and may ultimately end up before the United States Supreme Court. We cannot predict the impact the Reform Legislation may have on our business, results of operations, cash flow, capital resources and liquidity or the ultimate outcome of the judicial rulings. Furthermore, we cannot predict whether we will be able to modify certain aspects of our operations to offset any potential adverse consequences from the Reform Legislation.

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

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

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

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

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of the fraud and abuse laws. Under HIPAA, any person or entity that knowingly and willfully defrauds or attempts to defraud a

healthcare benefit program, including private healthcare plans, may be subject to fines, imprisonment or both. Additionally, any person or entity that knowingly and willfully falsifies or conceals a material fact or makes any material false or fraudulent statements in connection with the delivery or payment of healthcare services by a healthcare benefit plan is subject to a fine, imprisonment or both.

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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

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a physician to refer patients to a healthcare entity in which the physician has an ownership interest if the entity is located in a rural area, as defined in the statute. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases, and recruitment agreements. From time to time, the federal government has issued regulations which interpret the provisions included in the Stark Law. The Reform Legislation changed the whole hospital exception to the Stark Law. The Reform Legislation permitted existing physician investments in a whole hospital to continue under a grandfather clause if the arrangement satisfies certain requirements and restrictions, but physicians became prohibited, from the time the Reform Legislation became effective, from increasing the aggregate percentage of their ownership in the hospital. The Reform Legislation also restricted the ability of existing physician-owned hospitals to expand the capacity of their aggregate licensed beds, operating rooms and procedure rooms. Physician investments in hospitals that are under development are protected by the grandfather clause only if the physician investments have been made and the hospital has a Medicare provider agreement as of a specific date. The whole hospital exception, as amended, also contains additional disclosure requirements. For example, a grandfathered physician-owned hospital is required to submit an annual report to the Department of Health and Human Services, or DHHS, listing each investor in the hospital, including all physician owners. In addition, grandfathered physician-owned hospitals must have procedures in place that require each referring physician owner to disclose to patients, with enough notice for the patient to make a meaningful decision regarding receipt of care, the physician s ownership interest and, if applicable, any ownership interest held by the treating physician. A grandfathered physician-owned hospital also must disclose on its web site and in any public advertising the fact that it has physician ownership. The Reform Legislation requires grandfathered physician-owned hospitals to comply with these new requirements by September 23, 2011 and requires audits of the hospitals compliance beginning no later than May 1, 2012.

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

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

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

Many states in which we operate have also adopted laws that prohibit payments to physicians in exchange for referrals similar to the federal anti-kickback statute or that otherwise prohibit fraud and abuse activities. Many states have also

passed self-referral legislation similar to the Stark Law, prohibiting the referral of patients to entities with which the physician has a financial relationship. Often these state laws are broad in scope and may apply regardless of the source of payment for care. These statutes typically provide criminal

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and civil penalties, as well as loss of licensure. Little precedent exists for the interpretation or enforcement of these state laws.

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

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

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

When a defendant is determined by a court of law to be liable under the FCA, the defendant must pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim. Settlements entered into prior to litigation usually involve a less severe calculation of damages. There are many potential bases for liability under the FCA. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The FCA broadly defines the term knowingly. Although simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity can constitute knowingly submitting a false claim and result in liability. In some cases, whistleblowers, the federal government and courts have taken the position that providers who allegedly have violated other statutes, such as the anti-kickback statute or the Stark Law, have thereby submitted false claims under the FCA. The Reform Legislation clarifies this issue with respect to the anti-kickback statute by providing that submission of a claim for an item or service generated in violation of the anti-kickback statute constitutes a false or fraudulent claim under the FCA. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Reform Legislation, the FCA is implicated by the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later. Further, the FCA will cover payments involving federal funds in connection with the new health insurance exchanges to be created pursuant to the Reform Legislation.

A number of states, including states in which we operate, have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court. The Deficit Reduction Act of 2005 creates an incentive for states to enact false claims laws that are

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comparable to the FCA. From time to time, companies in the healthcare industry, including ours, may be subject to actions under the FCA or similar state laws.

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

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

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

Certificates of Need. The construction of new facilities, the acquisition of existing facilities and the addition of new services at our facilities may be subject to state laws that require prior approval by state regulatory agencies. These CON laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. As of December 31, 2010, we operated 56 hospitals in 16 states that have adopted CON laws for acute care facilities. If we fail to obtain necessary state approval, we will not be able to expand our facilities, complete acquisitions or add new services in these states. Violation of these state laws may result in the imposition of civil sanctions or the revocation of a hospital s licenses.

HIPAA Administrative Simplification and Privacy and Security Requirements. HIPAA requires the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. The DHHS has established electronic data transmission standards that all healthcare providers must use when submitting or receiving certain healthcare transactions electronically. In addition, HIPAA requires that each provider use a National Provider Identifier. In January 2009, CMS published a final rule making changes to the formats used for certain

electronic transactions and requiring the use of updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets. Although use of the ICD-10 code sets is not mandatory until October 1, 2013, we will be modifying our payment systems and processes to prepare for their implementation. Use of the ICD-10 code sets will require significant changes; however, we believe that

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the cost of compliance with these regulations has not had and is not expected to have a material adverse effect on our business, financial position or results of operations. The Reform Legislation requires the DHHS to adopt standards for additional electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction.

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

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

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

There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. For example, in October 2007, the Federal Trade Commission issued a final rule requiring financial institutions and creditors, which arguably included hospitals and other healthcare providers, to implement written identity theft prevention programs to detect, prevent, and mitigate identity theft in connection with certain accounts. The enforcement date for this rule has been postponed until December 31, 2010. In addition, Congress recently has passed legislation that would restrict the definition of a creditor and may exempt many hospitals from complying with the rule.

Payment

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

Payments for inpatient acute services are generally made pursuant to a prospective payment system, commonly known as PPS. Under PPS, our hospitals are paid a predetermined amount for each hospital discharge based on the patient s diagnosis. Specifically, each discharge is assigned to a diagnosis-related group, commonly known as a DRG, based upon the patient s condition and treatment during the relevant inpatient stay. For the federal fiscal year 2008 (i.e., the federal fiscal year beginning October 1, 2007), each

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DRG was assigned a payment rate using 67% of the national average cost per case and 33% of the national average charge per case and 50% of the change to severity adjusted DRG weights. Severity adjusted DRG s more accurately reflect the costs a hospital incurs for caring for a patient and accounts more fully for the severity of each patient s condition. 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. 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 rates are adjusted by an update factor on October 1 of each year, the beginning of the federal fiscal year. The index used to adjust the DRG rates, known as the market basket index, gives consideration to the inflation experienced by hospitals in purchasing goods and services. DRG payment rates were increased by the full market basket index, for the federal fiscal years 2008, 2009, 2010 and 2011, or 3.3%, 3.6%, 2.1% and 2.6%, respectively. In addition, the DRG payment rates were reduced by 0.25% on April 1, 2010 and by 0.25% on October 1, 2010, as mandated by the Reform Legislation. The DRG payment rates were also reduced by 2.9% for federal fiscal year 2011 for behavioral changes in coding practices relative to MS-DRGs. The Deficit Reduction Act of 2005 imposed a two percentage point reduction to the market basket index beginning October 1, 2007, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement. Future legislation may decrease the rate of increase for DRG payments or even decrease such payment rates, but we are not able to predict the amount of any reduction or the effect that any reduction will have on us.

In addition, hospitals may qualify for Medicare disproportionate share payments when their percentage of low income patients exceeds specified regulatory thresholds. A majority of our hospitals qualify to receive Medicare disproportionate share payments. For the majority of our hospitals that qualify to receive Medicare disproportionate share payments, these payments were increased by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 effective April 1, 2004. These Medicare disproportionate share payments as a percentage of net operating revenues were 1.6%, 1.6% and 1.8% for the years ended December 31, 2010, 2009 and 2008, respectively.

Beginning August 1, 2000, we began receiving Medicare reimbursement for outpatient services through a PPS. Under the Balanced Budget Refinement Act of 1999, non-urban hospitals with 100 beds or less were held harmless through December 31, 2004 under this Medicare outpatient PPS. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 extended the hold harmless provision for non-urban hospitals with 100 beds or less and for non-urban sole community hospitals with more than 100 beds through December 31, 2005. The Deficit Reduction Act of 2005 extended the hold harmless provision for non-urban hospitals with 100 beds or less that are not sole community hospitals through December 31, 2008; however, that Act reduced the amount these hospitals would receive in hold harmless payment by 10% in 2007 and 15% in 2008. Of our 121 hospitals in continuing operations at December 31, 2008, 31 qualified for this relief. The Medicare Improvements for Patients and Providers Act extended the hold harmless provision for non-urban hospitals with 100 beds or less, including non-urban sole community hospitals, through December 31, 2009, at 85% of the hold harmless amount. Of our 125 hospitals at December 31, 2009, 44 qualified for this relief. The Reform Legislation extended the hold harmless provision for non-urban hospitals with 100 beds or less, including non-urban sole community hospitals, through December 31, 2010. Of our 130 hospitals at December 31, 2010, 46 qualified for this relief. The Medicare and Medicaid Extenders Act of 2010 extended the hold harmless provision for non-urban hospitals with 100 beds or less, including non-urban sole community hospitals, through December 31, 2011. The outpatient conversion factor was increased 3.3% effective January 1, 2008; however, coupled with adjustments to other variables with the outpatient PPS, an approximate 3.0% to 3.4% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.6% effective January 1, 2009; however, coupled with adjustments to other variables with outpatient PPS, an approximate 3.5% to

3.9% net increase in outpatient payments occurred. The outpatient conversion

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factor was increased 2.1% effective January 1, 2010; however, coupled with adjustments to other variables with outpatient PPS, an approximate 1.8% to 2.2% net increase in outpatient payments occurred. The outpatient conversion factor was increased to 2.35% effective January 1, 2011; however, coupled with adjustments to other variables with outpatient PPS, an approximate 2.1% to 2.5% net increase in outpatient payments is expected to occur. The Medicare Improvements and Extension Act of the Tax Relief and Health Care Act of 2006 imposed a two percentage point reduction to the market basket index beginning January 1, 2009, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement.

DHHS established a PPS for home health services (i.e., home care) effective October 1, 2000. The home health agency PPS per episodic payment rate increased by 3% on January 1, 2008; however, coupled with adjustments to other variables with home health agency PPS, an approximate 1.5% to 1.9% net increase in home health agency payments occurred. The home health agency PPS per episodic payment rate increased by 2.9% on January 1, 2009; however, coupled with adjustments to other variables with home health agency PPS, an approximate 0.2% net increase in home health agency payments occurred. The home health agency PPS per episodic payment rate increased by 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 is expected to occur. Reform Legislation increases the home health agency PPS per episodic payment rate by 3.0% for home health services provided to patients in rural areas on or after April 1, 2010 through December 31, 2016. The Deficit Reduction Act of 2005 imposed a two percentage point reduction to the market basket index beginning January 1, 2007, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement.

Medicaid. Most state Medicaid payments are made under a PPS or under programs which negotiate payment levels with individual hospitals. Medicaid is currently funded jointly by state and federal government. The federal government and many states are currently considering significantly reducing Medicaid funding, while at the same time expanding Medicaid benefits. Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from CMS and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Similar programs are also being considered by other states. We can provide no assurance that reductions to Medicaid fundings will not have a material adverse effect on our consolidated results of operations.

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

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

Commercial Insurance. Our hospitals provide services to individuals covered by private healthcare insurance. Private insurance carriers pay our hospitals or in some cases reimburse their policyholders based upon the hospital s established charges and the coverage provided in the insurance policy. Commercial insurers are trying to limit the costs of hospital services by negotiating discounts, including PPS, which would reduce payments by commercial

insurers to our hospitals. Reductions in payments for services provided by our hospitals to individuals covered by commercial insurers could adversely affect us.

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Supply Contracts

In March 2005, we began purchasing items, primarily medical supplies, medical equipment and pharmaceuticals, under an agreement with HealthTrust, a GPO in which we are a noncontrolling partner. Triad was also a noncontrolling partner in HealthTrust and we acquired their ownership interest and contractual rights when we acquired Triad. As of December 31, 2010, we have a 17% ownership interest in HealthTrust. By participating in this organization we are able to procure items at competitively priced rates for our hospitals. There can be no assurance that our arrangement with HealthTrust will continue to provide the discounts that we have historically received.

Competition

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

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

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

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

Compliance Program

We take an operations team approach to compliance and utilize corporate experts for program design efforts and facility leaders for employee-level implementation. 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.

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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 anti-kickback and the Stark Law, emergency department treatment and transfer requirements, and other patient disposition issues are also the focus of policy and training, standardized documentation requirements, and review and audit. Another focus of the program is the interpretation and implementation of the HIPAA standards for privacy and security.

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

Employees

At December 31, 2010, we employed approximately 64,000 full-time employees and 23,000 part-time employees. Of these employees, approximately 6,000 are union members. We currently believe that our labor relations are good.

Professional Liability Claims

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

Environmental Matters

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

We are insured for damages of personal property or environmental injury arising out of environmental impairment for both above ground and underground storage tank issues under one insurance policy for all of our hospitals. Our policy

coverage is $5 million per occurrence with a $50,000 deductible and a $20 million annual aggregate. This policy also provides pollution legal liability coverage.

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

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

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

We are significantly leveraged. The chart below shows our level of indebtedness and other information as of December 31, 2010. In connection with the consummation of our acquisition of Triad in July 2007, approximately $7.2 billion of senior secured financing under a new credit facility, or Credit Facility, was obtained by our wholly-owned subsidiary, CHS/Community Health Systems, Inc., or CHS. CHS also issued 8.875% senior notes, or the Notes, having an aggregate principal amount of approximately $3.0 billion. Both the indebtedness under the Credit Facility and the Notes are senior obligations of CHS and are guaranteed on a senior basis by us and by certain of our domestic subsidiaries. We used the net proceeds from the Notes offering and the net proceeds of the approximately $6.1 billion term loans under the Credit Facility to pay the consideration under the merger agreement with Triad, to refinance certain of our existing indebtedness and the indebtedness of Triad, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. As of December 31, 2010, a $750 million revolving credit facility was available to us for working capital and general corporate purposes under the Credit Facility, with $81.9 million of the revolving credit facility being set aside for outstanding letters of credit. On November 5, 2010, we entered into an amendment and restatement of our existing Credit Facility, which extended by two and a half years, until January 25, 2017, the maturity date of $1.5 billion of the existing term loans under the Credit Facility. The remaining approximately $4.5 billion in term loans mature in 2014. With the exception of some small principal payments of our term loans under our Credit Facility, representing less than 1% of the outstanding balance each year through 2013, approximately $4.5 billion of term loans under our Credit Facility mature in 2014, our Notes are due in 2015, and the remaining $1.5 billion in term loans mature in 2017.

	December 31, 2010 ($ in millions)
Senior secured credit facility term loans	$ 5,999.3
Notes	2,784.3
Other	87.9
Total debt	$ 8,871.5
Community Health Systems, Inc. stockholders equity	$ 2,189.5

The following table shows the ratio of earnings to fixed charges for the periods indicated:

	Year Ended December 31,				
	2006	**2007**	**2008**	**2009**	**2010**
Ratio of earnings to fixed charges(1)	3.37 x	1.20 x	1.45 x	1.59 x	1.67 x

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

As of December 31, 2010, our approximately $5.4 billion notional amount of interest rate swap agreements represented approximately 89% of our variable rate debt. On a prospective basis, a 1% change in interest rates on the remaining unhedged variable rate debt existing as of December 31, 2010, would result in interest expense fluctuating approximately $6.5 million per year.

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

incur, assume or guarantee additional indebtedness;

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issue redeemable stock and preferred stock;

repurchase capital stock;

make restricted payments, including paying dividends and making investments;

redeem debt that is junior in right of payment to the Notes;

create liens;

sell or otherwise dispose of assets, including capital stock of subsidiaries;

enter into agreements that restrict dividends from subsidiaries;

merge, consolidate, sell or otherwise dispose of substantial portions of our assets;

enter into transactions with affiliates; and

guarantee certain obligations.

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

The counterparty to the interest rate swap agreements exposes us to credit risk in the event of non-performance. However, at December 31, 2010, we do not anticipate non-performance by the counterparty due to the net settlement feature of the agreements and our liability position with respect to all of our counterparties.

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

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

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

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

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

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

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

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

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

We may be able to incur substantial additional indebtedness in the future. The terms of the indenture governing the Notes do not fully prohibit us from doing so. For example, under the indenture for the Notes, we may incur up to approximately $7.8 billion pursuant to a credit facility or a qualified receivables transaction, less certain amounts repaid with the proceeds of asset dispositions. As of December 31, 2010, our

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Credit Facility provided for commitments of up to approximately $6.7 billion in the aggregate. Additionally, our Credit Facility also gives us the ability to provide for one or more additional tranches of term loans in aggregate principal amount of up to $1.0 billion without the consent of the existing lenders if specified criteria are satisfied and $300 million of borrowing capacity from receivable transactions (including securitizations). If new debt is added to our current debt levels, the related risks that we now face could intensify.

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

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

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

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

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

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

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

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

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

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

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

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

Some of our hospitals operate in primary service areas where they compete with one other hospital; 23 of our hospitals compete with more than one other hospital in their respective primary service areas. Some of these competing hospitals use equipment and services more specialized than those available at our hospitals. In addition, some competing hospitals are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. These hospitals can make capital expenditures without paying sales, property and income taxes. We also face competition from other specialized care providers, including outpatient surgery, orthopedic, oncology and diagnostic centers.

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

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

We have a five-year participation agreement with HealthTrust, a GPO. This agreement extends to January 2012, with automatic renewal terms of one year, unless either party terminates by giving notice of non-renewal. GPOs attempt to obtain favorable pricing on medical supplies with manufacturers and vendors who sometimes negotiate exclusive supply arrangements in exchange for the discounts they give. To the extent these exclusive supply arrangements are challenged or deemed unenforceable, we could incur higher costs for our medical supplies obtained through HealthTrust. These higher costs could cause our operating results to decline.

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

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

At December 31, 2010, we had approximately $4.2 billion of goodwill recorded on our books. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. If the carrying value of our goodwill is impaired, we may incur a material non-cash charge to earnings.

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

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

Risks related to our industry

We are subject to uncertainties regarding healthcare reform.

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

ARRA was signed into law on February 17, 2009, providing for a temporary increase in the federal matching assistance percentage (FMAP), a temporary increase in federal Medicaid DSH allotments, subsidization of health insurance premiums (COBRA) for up to nine months, and grants and loans for infrastructure and incentive payments for providers who adopt and use health information technology. This act also provides penalties by reducing reimbursement from Medicare in the form of reductions to scheduled market basket increases beginning in federal fiscal year 2015 if eligible hospitals and professionals fail to demonstrate meaningful use of electronic health record technology. The 2010 Department of Defense Appropriations Act was signed into law on December 19, 2009 and expanded the subsidization of health insurance premiums (COBRA) to 15 months and extended the eligibility period for individuals losing their jobs through February 28, 2010.

PPACA was signed into law on March 23, 2010. In addition, the Reconciliation Act, which contains a number of amendments to PPACA, was signed into law on March 30, 2010. These healthcare acts, referred to collectively as the Reform Legislation, include a mandate that requires substantially all U.S. citizens to maintain medical insurance coverage which will ultimately increase the number of persons with access to health insurance in the United States. The Reform Legislation should result in a reduction in uninsured patients, which should reduce our expense from uncollectible accounts receivable; however, this legislation makes a number of other changes to Medicare and Medicaid, such as reductions to the Medicare annual market basket update for federal fiscal years 2010 through 2019, a productivity offset to the Medicare market basket update beginning October 1, 2011, and a reduction to the Medicare and Medicaid disproportionate share payments, that could adversely impact the reimbursement received under these programs. The various provisions in the Reform Legislation that directly or indirectly affect reimbursement are scheduled to take effect over a number of years, and we cannot predict their impact at this time. Other provisions of the Reform Legislation, such as requirements related to employee health insurance coverage,

should increase our operating costs.

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

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

The impact of the Reform Legislation on each of our hospitals will vary depending on payor mix and a variety of other factors. We anticipate that many of the provisions in the Reform Legislation will be subject to further clarification and modification through the rule-making process, the development of agency guidance and judicial interpretations. Moreover, a number of state attorneys general are challenging the legality of certain aspects of the Reform Legislation. Currently, rulings in four separate Federal District Courts, regarding the constitutionality of the Reform Legislation, have been split, with two courts ruling in favor of the legislation and two courts ruling that part or all of the Reform Legislation was unconstitutional. These decisions are likely to be appealed and may ultimately end up before the United States Supreme Court. We cannot predict the impact the Reform Legislation may have on our business, results of operations, cash flow, capital resources and liquidity or the ultimate outcome of the judicial rulings. Furthermore, we cannot predict whether we will be able to modify certain aspects of our operations to offset any potential adverse consequences from the Reform Legislation.

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

In 2010, 37.8% of our net operating revenues came from the Medicare and Medicaid programs. Federal healthcare expenditures continue to increase and state governments continue to face budgetary shortfalls as a result of the current economic downturn and accelerating Medicaid enrollment. As a result, federal and state governments have made, and continue to make, significant changes in the Medicare and Medicaid programs. Some of these changes have decreased, or could decrease, the amount of money we receive for our services relating to these programs.

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

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

The healthcare industry is required to comply with many laws and regulations at the federal, state, and local government levels. These laws and regulations require that hospitals meet various requirements, including

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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 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, the Department of Justice has alleged that we and three of our New Mexico hospitals have caused the state of New Mexico to submit improper claims for federal funds in violation of the Civil False Claims Act. For a further discussion of this matter, see Legal Proceedings in Item 3 of this Report.

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

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

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

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

In recent years, physicians, hospitals, and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability, or related legal theories. Even in states that have imposed caps on damages, litigants are seeking recoveries under new theories of liability that might not be subject to the caps on damages. Many of these actions involve large claims and significant defense costs. To protect us from the cost of these claims, we maintain 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, decreased in 2008 by 0.2%, increased in 2009 by 0.2% and decreased in 2010 by 0.2%. If these costs rise rapidly, our profitability could decline. For a further discussion of our insurance coverage, see our discussion of professional liability claims in Management s Discussion and Analysis of Financial Condition and Results of Operations in Item 7 of this Report.

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

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

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regulatory and investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

Currently, the global economies, and in particular the United States, are experiencing a period of economic uncertainty and the related financial markets are experiencing a high degree of volatility. This current financial turmoil is adversely affecting the banking system and financial markets and resulting in a tightening in the credit markets, a low level of liquidity in many financial markets and extreme volatility in fixed income, credit, currency and equity markets. This uncertainty poses a risk as it could potentially lead to higher levels of uninsured patients, result in higher levels of patients covered by lower paying government programs and/or result in fiscal uncertainties at both government payors and private insurers.

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

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

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

Some of the matters discussed in this Report include forward-looking statements. Statements that are predictive in nature, that depend upon or refer to future events or conditions or that include words such as expects, anticipates, intends, plans, believes, estimates, thinks, and similar expressions are forward-looking statements. These statem involve known and unknown risks, uncertainties, and other factors that may cause our actual results and performance to be materially different from any future results or performance expressed or implied by these forward-looking statements. These factors include the following:

- general economic and business conditions, both nationally and in the regions in which we operate;
- implementation and effect of potential and recently-adopted federal and state healthcare legislation;
- risks associated with our substantial indebtedness, leverage and debt service obligations;
- demographic changes;
- changes in, or the failure to comply with, governmental regulations;
- potential adverse impact of known and unknown government investigations, audits and Federal and State False Claims Act litigation;

our ability, where appropriate, to enter into and maintain managed care provider arrangements and the terms of these arrangements;

changes in, or the failure to comply with, managed care provider contracts could result in disputes and changes in reimbursement that could be applied retroactively;

changes in inpatient or outpatient Medicare and Medicaid payment levels;

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

increases in wages as a result of inflation or competition for highly technical positions and rising supply costs due to market pressure from pharmaceutical companies and new product releases;

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liabilities and other claims asserted against us, including self-insured malpractice claims;

competition;

our ability to attract and retain, without significant employment costs, qualified personnel, key management, physicians, nurses and other healthcare workers;

trends toward treatment of patients in less acute or specialty healthcare settings, including ambulatory surgery centers or specialty hospitals;

changes in medical or other technology;

changes in U.S. GAAP;

the availability and terms of capital to fund additional acquisitions or replacement facilities;

our ability to successfully acquire additional hospitals;

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

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

timeliness of reimbursement payments received under government programs.

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

Item 1B. ***Unresolved Staff Comments***

None

Item 2. ***Properties***

Corporate Headquarters

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

Hospitals

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

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For each of our hospitals owned or leased as of December 31, 2010, the following table shows its location, the date of its acquisition or lease inception and the number of licensed beds:

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Alabama				
LV Stabler Memorial Hospital	Greenville	72	October, 1994	Owned
South Baldwin Regional Medical Center	Foley	112	June, 2000	Leased
Cherokee Medical Center	Centre	60	April, 2006	Owned
DeKalb Regional Medical Center	Fort Payne	134	April, 2006	Owned
Trinity Medical Center	Birmingham	534	July, 2007	Owned
Flowers Hospital	Dothan	235	July, 2007	Owned
Medical Center Enterprise	Enterprise	131	July, 2007	Owned
Gadsden Regional Medical Center	Gadsden	346	July, 2007	Owned
Crestwood Medical Center	Huntsville	150	July, 2007	Owned
Alaska				
Mat-Su Regional Medical Center	Palmer	74	July, 2007	Owned
Arizona				
Payson Regional Medical Center	Payson	44	August, 1997	Leased
Western Arizona Regional Medical Center	Bullhead City	139	July, 2000	Owned
Northwest Medical Center	Tucson	300	July, 2007	Owned
Northwest Medical Center Oro Valley	Oro Valley	144	July, 2007	Owned
Arkansas				
Harris Hospital	Newport	133	October, 1994	Owned
Helena Regional Medical Center	Helena	155	March, 2002	Leased
Forrest City Medical Center	Forrest City	118	March, 2006	Leased
Northwest Medical Center Bentonville	Bentonville	128	July, 2007	Owned
Northwest Medical Center Springdale	Springdale	222	July, 2007	Owned
Willow Creek Women s Hospital(2)	Johnson	64	July, 2007	Owned
Siloam Springs Memorial Hospital	Siloam Springs	73	February, 2009	Leased
Medical Center of South Arkansas	El Dorado	166	April, 2009	Leased
California				
Barstow Community Hospital	Barstow	56	January, 1993	Leased
Fallbrook Hospital	Fallbrook	47	November, 1998	Operated(3)
Watsonville Community Hospital	Watsonville	106	September, 1998	Owned
Florida				
Lake Wales Medical Center	Lake Wales	160	December, 2002	Owned
North Okaloosa Medical Center	Crestview	110	March, 1996	Owned
Georgia				
Fannin Regional Hospital	Blue Ridge	50	January, 1986	Owned
Trinity Hospital of Augusta	Augusta	231	July, 2007	Leased
Illinois				
Crossroads Community Hospital	Mt. Vernon	57	October, 1994	Owned
Gateway Regional Medical Center	Granite City	382	January, 2002	Owned
Heartland Regional Medical Center	Marion	92	October, 1996	Owned
Red Bud Regional Hospital	Red Bud	31	September, 2001	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Galesburg Cottage Hospital	Galesburg	173	July, 2004	Owned
Vista Medical Center East	Waukegan	336	July, 2006	Owned
Vista Medical Center West (psychiatric and rehabilitation beds)	Waukegan	71	July, 2006	Owned
Union County Hospital	Anna	25	November, 2006	Leased
Indiana				
Porter Hospital	Valparaiso	301	May, 2007	Owned
Bluffton Regional Medical Center	Bluffton	79	July, 2007	Owned
Dupont Hospital	Fort Wayne	131	July, 2007	Owned
Lutheran Hospital	Fort Wayne	396	July, 2007	Owned
Lutheran Musculoskeletal Center(4)	Fort Wayne	39	July, 2007	Owned
Lutheran Rehabilitation Hospital (rehabilitation)	Fort Wayne	36	July, 2007	Owned
St. Joseph s Hospital	Fort Wayne	191	July, 2007	Owned
Dukes Memorial Hospital	Peru	25	July, 2007	Owned
Kosciusko Community Hospital	Warsaw	72	July, 2007	Owned
Kentucky				
Parkway Regional Hospital	Fulton	70	May, 1992	Owned
Three Rivers Medical Center	Louisa	90	May, 1993	Owned
Kentucky River Medical Center	Jackson	55	August, 1995	Leased
Louisiana				
Byrd Regional Hospital	Leesville	60	October, 1994	Owned
Northern Louisiana Medical Center	Ruston	159	April, 2007	Owned
Women & Children s Hospital	Lake Charles	88	July, 2007	Owned
Mississippi				
Wesley Medical Center	Hattiesburg	211	July, 2007	Owned
River Region Health System	Vicksburg	341	July, 2007	Owned
Missouri				
Moberly Regional Medical Center	Moberly	103	November, 1993	Owned
Northeast Regional Medical Center	Kirksville	115	December, 2000	Leased
Nevada				
Mesa View Regional Hospital	Mesquite	25	July, 2007	Owned
New Jersey				
Memorial Hospital of Salem County	Salem	140	September, 2002	Owned
New Mexico				
Mimbres Memorial Hospital	Deming	49	March, 1996	Owned
Eastern New Mexico Medical Center	Roswell	162	April, 1998	Owned
Alta Vista Regional Hospital	Las Vegas	54	April, 2000	Owned
Carlsbad Medical Center	Carlsbad	112	July, 2007	Owned
Lea Regional Medical Center	Hobbs	201	July, 2007	Owned
Mountain View Regional Medical Center	Las Cruces	168	July, 2007	Owned
North Carolina				
Martin General Hospital	Williamston	49	November, 1998	Leased

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Ohio				
Affinity Medical Center	Massillon	266	July, 2007	Owned
Northside Medical Center	Youngstown	355	October, 2010	Owned
Trumbull Memorial Hospital	Warren	311	October, 2010	Owned
Hillside Rehabilitation Hospital (rehabilitation)	Warren	69	October, 2010	Owned
Oklahoma				
Ponca City Medical Center	Ponca City	140	May, 2006	Owned
Claremore Regional Hospital	Claremore	81	July, 2007	Owned
Deaconess Hospital	Oklahoma City	313	July, 2007	Owned
SouthCrest Hospital	Tulsa	180	July, 2007	Owned
Woodward Regional Hospital	Woodward	87	July, 2007	Leased
Oregon				
McKenzie-Willamette Medical Center	Springfield	114	July, 2007	Owned
Pennsylvania				
Berwick Hospital	Berwick	101	March, 1999	Owned
Brandywine Hospital	Coatesville	243	June, 2001	Owned
Jennersville Regional Hospital	West Grove	59	October, 2001	Owned
Easton Hospital	Easton	254	October, 2001	Owned
Lock Haven Hospital	Lock Haven	47	August, 2002	Owned
Pottstown Memorial Medical Center	Pottstown	221	July, 2003	Owned
Phoenixville Hospital	Phoenixville	153	August, 2004	Owned
Chestnut Hill Hospital	Philadelphia	160	February, 2005	Owned
Sunbury Community Hospital	Sunbury	89	October, 2005	Owned
Wilkes-Barre General Hospital	Wilkes-Barre	392	April, 2009	Owned
First Hospital Wyoming Valley (psychiatric)	Wilkes-Barre	135	April, 2009	Owned
South Carolina				
Marlboro Park Hospital	Bennettsville	102	August, 1996	Leased
Chesterfield General Hospital	Cheraw	59	August, 1996	Leased
Springs Memorial Hospital	Lancaster	231	November, 1994	Owned
Carolinas Hospital System Florence	Florence	420	July, 2007	Owned
Mary Black Memorial Hospital	Spartanburg	209	July, 2007	Owned
Marion Regional Hospital	Mullins	124	July, 2010	Owned
Tennessee				
Lakeway Regional Hospital	Morristown	135	May, 1993	Owned
Regional Hospital of Jackson	Jackson	154	January, 2003	Owned
Dyersburg Regional Medical Center	Dyersburg	225	January, 2003	Owned
Haywood Park Community Hospital	Brownsville	62	January, 2003	Owned
Henderson County Community Hospital	Lexington	45	January, 2003	Owned
McKenzie Regional Hospital	McKenzie	45	January, 2003	Owned
McNairy Regional Hospital	Selmer	45	January, 2003	Owned
Volunteer Community Hospital	Martin	100	January, 2003	Owned
Heritage Medical Center	Shelbyville	60	July, 2005	Owned
Sky Ridge Medical Center	Cleveland	351	October, 2005	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Gateway Medical Center	Clarksville	270	July, 2007	Owned
Texas				
Big Bend Regional Medical Center	Alpine	25	October, 1999	Owned
Cleveland Regional Medical Center	Cleveland	107	August, 1996	Owned
Scenic Mountain Medical Center	Big Spring	150	October, 1994	Owned
Hill Regional Hospital	Hillsboro	92	October, 1994	Leased
Lake Granbury Medical Center	Granbury	83	January, 1997	Leased
South Texas Regional Medical Center	Jourdanton	67	November, 2001	Owned
Laredo Medical Center	Laredo	326	October, 2003	Owned
Weatherford Regional Medical Center	Weatherford	99	November, 2006	Leased
Abilene Regional Medical Center	Abilene	231	July, 2007	Owned
Brownwood Regional Medical Center	Brownwood	194	July, 2007	Owned
College Station Medical Center	College Station	141	July, 2007	Owned
Navarro Regional Hospital	Corsicana	162	July, 2007	Owned
Longview Regional Medical Center	Longview	131	July, 2007	Owned
Woodland Heights Medical Center	Lufkin	149	July, 2007	Owned
San Angelo Community Medical Center	San Angelo	171	July, 2007	Owned
DeTar Healthcare System	Victoria	308	July, 2007	Owned
Cedar Park Regional Medical Center	Cedar Park	77	December, 2007	Owned
Utah				
Mountain West Medical Center	Tooele	44	October, 2000	Owned
Virginia				
Southern Virginia Regional Medical Center	Emporia	80	March, 1999	Owned
Southampton Memorial Hospital	Franklin	105	March, 2000	Owned
Southside Regional Medical Center	Petersburg	300	August, 2003	Owned
Washington				
Deaconess Medical Center	Spokane	388	October, 2008	Owned
Valley Hospital and Medical Center	Spokane Valley	123	October, 2008	Owned
West Virginia				
Plateau Medical Center	Oak Hill	25	July, 2002	Owned
Greenbrier Valley Medical Center	Ronceverte	122	July, 2007	Owned
Bluefield Regional Medical Center	Bluefield	240	October, 2010	Owned
Wyoming				
Evanston Regional Hospital	Evanston	42	November, 1999	Owned
Total Licensed Beds at December 31, 2010		19,372		

(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) In 2008, we segregated this entity from Northwest Medical Center Bentonville for reporting purposes.

(3) 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.

(4) In 2008, we segregated this entity from Lutheran Hospital for reporting purposes.

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

The following table lists the hospitals owned by joint venture entities in which we do not have a consolidating ownership interest, along with our percentage ownership interest in the joint venture entity as of December 31, 2010. Information on licensed beds was provided by the majority owner and manager of each joint venture. A subsidiary of HCA is the majority owner of Macon Healthcare LLC, and a subsidiary of UHS is the majority owner of Summerlin Hospital Medical Center LLC and Valley Health System LLC.

Joint Venture	Facility Name	City	State	Licensed Beds
Macon Healthcare LLC	Coliseum Medical Center (38%)	Macon	GA	250
Macon Healthcare LLC	Coliseum Psychiatric Center (38%)	Macon	GA	60
Macon Healthcare LLC	Coliseum Northside Hospital (38%)	Macon	GA	103
Summerlin Hospital Medical Center LLC	Summerlin Hospital Medical Center (26.1%)	Las Vegas	NV	454
Valley Health System LLC	Desert Springs Hospital (27.5%)	Las Vegas	NV	286
Valley Health System LLC	Valley Hospital Medical Center (27.5%)	Las Vegas	NV	404
Valley Health System LLC	Spring Valley Hospital Medical Center (27.5%)	Las Vegas	NV	231
Valley Health System LLC	Centennial Hills Hospital Medical Center (27.5%)	Las Vegas	NV	165

Item 3. ***Legal Proceedings***

From time to time, we receive various inquiries or subpoenas from state regulators, fiscal intermediaries, the Centers for Medicare and Medicaid Services and the Department of Justice regarding various Medicare and Medicaid issues. In addition, we are subject to other claims and lawsuits arising in the ordinary course of our business. We are not aware of any pending or threatened litigation that is not covered by insurance policies or reserved for in our financial statements or which we believe would have a material adverse impact on us; however, some pending or threatened proceedings against us may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Additionally, qui tam or whistleblower actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act s requirements for filing such suits.

Community Health Systems, Inc. Legal Proceedings

On February 10, 2006, we received a letter from the Civil Division of the Department of Justice requesting documents in an investigation it was conducting involving the Company. The inquiry related to the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients. These programs are referred to by different names, including intergovernmental payments, upper payment limit programs, and Medicaid

disproportionate share hospital payments. The February 2006 letter focused on our hospitals in three states: Arkansas, New Mexico, and South Carolina. On August 31, 2006, we received a follow up letter from the Department of Justice requesting additional documents relating to the programs in New Mexico and the payments to the Company s three hospitals in that state. Through the beginning of 2009, we provided the Department of Justice with requested documents, met with its personnel on numerous occasions, and otherwise cooperated in its investigation. During the course of the investigation, the Civil Division notified us that it believed that we and these three New Mexico hospitals caused the State of New Mexico to submit improper claims for federal funds, in violation of the Federal False Claims Act. At one point, the Civil Division calculated that the three hospitals received ineligible federal participation

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payments from August 2000 to June 2006 of approximately $27.5 million and said that if it proceeded to trial, it would seek treble damages plus an appropriate penalty for each of the violations of the Federal False Claims Act. This investigation has culminated in the federal government s intervention in a qui tam lawsuit styled U.S. ex rel. Baker vs. Community Health Systems, Inc., pending in the United States District Court for the District of New Mexico. The federal government filed its complaint in intervention on June 30, 2009. The relator filed a second amended complaint on July 1, 2009. Both of these complaints expand the time period during which alleged improper payments were made. We filed motions to dismiss all of the federal government s and the relator s claims on August 28, 2009. On March 19, 2010, the court granted in part and denied in part our motion to dismiss as to the relator s complaint. On July 7, 2010, the court denied our motion to dismiss the federal government s complaint in intervention. We have filed our answer and pretrial discovery has begun. We are vigorously defending this action.

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

On April 19, 2009, we were served in Roswell, New Mexico with an answer and counterclaim in the case of Roswell Hospital Corporation d/b/a Eastern New Mexico Medical Center vs. Patrick Sisneros and Tammie McClain (sued as Jane Doe Sisneros). The case was originally filed as a collection matter. The counterclaim was filed as a putative class action and alleged theories of breach of contract, unjust enrichment, misrepresentation, prima facie tort, Fair Trade Practices Act and violation of the New Mexico RICO statute. On May 7, 2009, the hospital filed a notice of removal to federal court. On July 27, 2009, the case was remanded to state court for lack of a federal question. A motion to dismiss and a motion to dismiss misjoined counterclaim plaintiffs were filed on October 20, 2009. These motions were denied. Extensive discovery has been conducted. A motion for class certification for all uninsured patients was heard on March 3 through March 5, 2010 and on April 13, 2010, the state district court judge certified the case as a class action. Discovery is ongoing. A hearing is set for March 1, 2011 to assess the sufficiency of the methodology used to determine class damages. We are vigorously defending this action.

On December 7, 2009, we received a document subpoena from the U.S. Department of Health and Human Services, Office of the Inspector General, or OIG, requesting documents related to our hospital in Laredo, Texas. The categories of documents requested included case management, resource management, admission criteria, patient medical records, coding, billing, compliance, the Joint Commission accreditation, physician documentation, payments to referral sources, transactions involving physicians, disproportionate share hospital status, and audits by the hospital s Quality Improvement organization. On January 22, 2010, we received a request for information or assistance from the OIG s Office of Investigation requesting patient medical records from Laredo Medical Center in Laredo, Texas for certain Medicaid patients with an extended length of stay. Additional requests for records have also been received, including a request containing follow-up questions received on January 5, 2011. We are cooperating fully with these investigations.

On September 20, 2010, we received a letter from the U.S. Department of Justice, Civil Division, advising us that an investigation is being conducted to determine whether certain hospitals have improperly submitted claims for payment for implantable cardioverter defibrillators, or ICD. The period of time covered by the investigation is 2003 to the

present. The letter states that the Department of Justice s data indicates that many of our hospitals have claims that need to be reviewed to determine if Medicare payment was appropriate. We understand that the Department of Justice has submitted similar requests to many other hospitals and hospital systems across the country as well as to the ICD manufacturers themselves. We are fully cooperating

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with the government in this investigation. Because we are in the early stages of this investigation, we are unable to evaluate the outcome of this investigation.

On November 15, 2010, we were served with substantially identical Civil Investigative Demands (CIDs) from the Office of Attorney General, State of Texas for all our 18 affiliated Texas hospitals. The subject of the requests appears to concern emergency department procedures and billing. We are cooperating fully with these requests. Because we are in the early stages of this investigation, we are unable to evaluate the outcome of this investigation.

Triad Hospitals, Inc. Legal Proceedings

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

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

PART II

Item 5. ***Market for Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

We completed an initial public offering of our common stock on June 14, 2000. Our common stock began trading on June 9, 2000 and is listed on the New York Stock Exchange under the symbol CYH. At February 17, 2011, there were approximately 39 record holders of our common stock. The following table sets forth, for the periods indicated, the high and low sale prices per share of our common stock as reported by the New York Stock Exchange.

	High	Low
Year Ended December 31, 2009		
First Quarter	$ 21.60	$ 12.96
Second Quarter	28.79	13.95
Third Quarter	35.50	24.42
Fourth Quarter	38.00	29.35
Year Ended December 31, 2010		
First Quarter	$ 40.84	$ 31.00
Second Quarter	42.30	33.21
Third Quarter	34.11	25.63
Fourth Quarter	38.00	29.08

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Corporate Performance Graph

The following graph sets forth the cumulative return of our common stock during the five year period ended December 31, 2010, as compared to the cumulative return of the Standard & Poor s 500 Stock Index (S&P 500) and the cumulative return of the Dow Jones Healthcare Index. The graph assumes an initial investment of $100 in our common stock and in each of the foregoing indices and the reinvestment of dividends where applicable.

We have not paid any cash dividends since our inception, and do not anticipate the payment of cash dividends in the foreseeable future. Our Credit Facility limits our ability to pay dividends and/or repurchase stock to an amount not to exceed $50 million in the aggregate after November 5, 2010, the date of our amendment and restatement of our Credit Facility. In addition, our Credit Facility allows us to repurchase stock in an amount not to exceed the aggregate amount of proceeds from the exercise of stock options. The indenture governing our Notes also limits our ability to pay dividends and/or repurchase stock. As of December 31, 2010, under the most restrictive test under these agreements, we have approximately $96.9 million remaining available with which to pay permitted dividends and/or make stock and Note repurchases.

The following table contains information about our purchases of common stock during the three months ended December 31, 2010:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans(a)	Maximum Number of Shares That May Yet Be Purchased Under the Plans or Programs(a)
October 1, 2010 October 31, 2010	195,000	$ 30.88	195,000	3,548,728
November 1, 2010 November 30, 2010				3,548,728
December 1, 2010 December 31, 2010				3,548,728
Total	195,000	$ 30.88	195,000	3,548,728

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(a) On September 15, 2010, we commenced a new open market repurchase program for up to 4,000,000 shares of our common stock, not to exceed $100 million in repurchases. This program will conclude at the earliest of three years from the commencement date, when the maximum number of shares has been repurchased or when the maximum dollar amount has been expended. During the three months ended December 31, 2010, we repurchased and retired 195,000 shares at a weighted-average price of $30.88 per share. During the year ended December 31, 2010, we repurchased and retired 451,272 shares at a weighted-average price of $30.81 per share, which is the cumulative number of shares that have been repurchased under this program through December 31, 2010.

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

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

Community Health Systems, Inc.

Five Year Summary of Selected Financial Data

	Year Ended December 31,				
	2010	**2009**	**2008**	**2007(1)**	**2006**
	(In thousands, except share and per share data)				
Consolidated Statement of Income Data					
Net operating revenues	$ 12,986,500	$ 12,107,613	$ 10,919,095	$ 7,095,861	$ 4,180,136
Income from operations	1,114,928	1,068,665	971,880	471,612	385,057
Income from continuing operations	348,441	304,805	233,727	67,431	177,695
Net income	348,441	306,377	252,734	44,691	171,058
Net income attributable to noncontrolling interests	68,458	63,227	34,430	14,402	2,795
Net income attributable to Community Health Systems, Inc.	279,983	243,150	218,304	30,289	168,263
Basic earnings per share attributable to Community Health Systems, Inc. common stockholders(2):					
Continuing operations	$ 3.05	$ 2.67	$ 2.13	$ 0.58	$ 1.87
Discontinued operations		0.01	0.21	(0.25)	(0.10)
Net income	$ 3.05	$ 2.68	$ 2.34	$ 0.32	$ 1.77
Diluted earnings per share attributable to Community Health Systems, Inc. common stockholders(2):					

Continuing operations	$ 3.01	$ 2.64	$ 2.11	$ 0.57	$ 1.85
Discontinued operations		0.01	0.21	(0.25)	(0.10)
Net income	$ 3.01	$ 2.66	$ 2.32	$ 0.32	$ 1.75
Weighted-average number of shares outstanding					
Basic	91,718,791	90,614,886	93,371,782	93,517,337	94,983,646
Diluted(3)	92,946,048	91,517,274	94,288,829	94,642,294	96,232,910

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	Year Ended December 31,				
	2010	2009	2008	2007(1)	2006
	(In thousands, except share and per share data)				
Consolidated Balance Sheet Data					
Cash and cash equivalents	$ 299,169	$ 344,541	$ 220,655	$ 133,574	$ 40,566
Total assets	14,698,123	14,021,472	13,818,254	13,493,644	4,506,579
Long-term obligations	10,418,234	10,179,402	10,287,535	9,974,516	2,207,623
Redeemable noncontrolling interests in equity of consolidated subsidiaries	387,472	368,857	348,816	346,999	23,478
Community Health Systems, Inc. stockholders equity	2,189,464	1,950,635	1,611,029	1,687,293	1,718,697
Noncontrolling interests in equity of consolidated subsidiaries	60,913	64,782	61,457	51,419	5,057

(1) Includes the results of operations of the former Triad hospitals from July 25, 2007, the date of acquisition.

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

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

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

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

Executive Overview

We are the largest publicly-traded operator of hospitals in the United States in terms of number of facilities and net operating revenues. We provide healthcare services through these hospitals that we own and operate in non-urban and selected urban markets. We generate revenue primarily by providing a broad range of general hospital healthcare services to patients in the communities in which we are located. We currently own and operate 130 hospitals comprised of 126 general acute care hospitals and four rehabilitation or psychiatric hospitals. In addition, we own and operate home care agencies, located primarily in markets where we also operate a hospital, and through our wholly-owned subsidiary, Quorum Health Resources, LLC, or QHR, we provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. For the hospitals and home care agencies that we own and operate, we are paid for our services by governmental agencies, private insurers and directly by the patients we serve. For our management and consulting services, we are paid by the non-affiliated hospitals utilizing our services.

In 2010, we increased our acquisition activity and acquired five hospitals located in Marion, South Carolina, Youngstown and Warren, Ohio and Bluefield, West Virginia. In 2009, we acquired one hospital located in Siloam Springs, Arkansas and two hospitals located in Wilkes-Barre, Pennsylvania and the remaining interest in a hospital located in El Dorado, Arkansas. In addition, on December 31, 2009, we entered into an agreement with a

multi-specialty physician clinic that has 32 locations across the Inland Northwest region of the state of Washington. This agreement will allow our affiliated hospitals in Spokane, Washington to work with this clinic to offer a fully integrated healthcare delivery system in that market.

Our net operating revenues for the year ended December 31, 2010 increased to approximately $13.0 billion, as compared to approximately $12.1 billion for the year ended December 31, 2009. Income from continuing operations, before noncontrolling interests, for the year ended December 31, 2010 increased 14.3% over the year ended December 31, 2009. Despite low volume, this increase in income from continuing operations during the year ended December 31, 2010, as compared to the year ended December 31, 2009, is due primarily to the execution of our revenue growth initiatives at those hospitals owned throughout both years, general rate and reimbursement increases and our effective management of operating expenses. Our successful physician recruiting efforts have also been a key driver in the execution of our operating strategies. Total inpatient admissions for the year ended December 31, 2010 increased 0.1% compared to the year ended December 31, 2009 and adjusted admissions for the year ended December 31, 2010 increased 2.5% compared

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to the year ended December 31, 2009. This increase in adjusted admissions was due primarily to acquisitions during the past year, offsetting decreases in admissions at those hospitals owned throughout both years from a less severe flu season as compared to the prior year period, lower birth rates coinciding with the downturn in the economy, reductions in one day stays and certain service closures.

Self-pay revenues represented approximately 11.6% of our net operating revenues in 2010 compared to 11.2% in 2009. The value of charity care services relative to total net operating revenues was approximately 4.1% and 3.9% in 2010 and 2009, respectively.

PPACA was signed into law on March 23, 2010. In addition, the Reconciliation Act, which contains a number of amendments to PPACA, was signed into law on March 30, 2010. These healthcare acts, referred to collectively as the Reform Legislation, include a mandate that requires substantially all U.S. citizens to maintain medical insurance coverage which will ultimately increase the number of persons with access to health insurance in the United States. The Reform Legislation should result in a reduction in uninsured patients, which should reduce our expense from uncollectible accounts receivable; however, this legislation makes a number of other changes to Medicare and Medicaid, such as reductions to the Medicare annual market basket update for federal fiscal years 2010 through 2019, a productivity offset to the Medicare market basket update beginning October 1, 2011, and a reduction to the Medicare and Medicaid disproportionate share payments, that could adversely impact the reimbursement received under these programs. The various provisions in the Reform Legislation that directly or indirectly affect reimbursement are scheduled to take effect over a number of years, and we cannot predict their impact at this time. Other provisions of the Reform Legislation, such as requirements related to employee health insurance coverage, should increase our operating costs.

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

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

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

up before the United States Supreme Court. We cannot predict the impact the Reform Legislation may have on our business, results of operations, cash flow, capital resources and liquidity or the ultimate outcome of the judicial rulings. Furthermore, we cannot predict

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whether we will be able to modify certain aspects of our operations to offset any potential adverse consequences from the Reform Legislation.

As a result of our current levels of cash, available borrowing capacity, long-term outlook on our debt repayments and our continued projection of our ability to generate cash flows, we do not anticipate a significant impact on our ability to invest the necessary capital in our business over the next twelve months and into the foreseeable future. We believe there continues to be ample opportunity for growth in substantially all of our markets by decreasing the need for patients to travel outside their communities for healthcare services. Furthermore, we continue to benefit from synergies from the acquisition of Triad as well as our more recent acquisitions and will continue to strive to improve operating efficiencies and procedures in order to improve our profitability at all of our hospitals.

Acquisitions

Effective October 1, 2010, we completed the acquisition of Forum Health based in Youngstown, Ohio, a healthcare system of two acute care hospitals, one rehabilitation hospital and other healthcare providers. This healthcare system includes Northside Medical Center (355 licensed beds) located in Youngstown, Ohio and Trumbull Memorial Hospital (311 licensed beds) located in Warren, Ohio. This healthcare system also includes Hillside Rehabilitation Hospital (69 licensed beds) located in Warren, Ohio, as well as several outpatient clinics and other ancillary facilities. The total cash consideration paid for fixed assets and working capital was approximately $93.4 million and $27.8 million, respectively, with additional consideration including $40.3 million assumed in liabilities, for a total consideration of $161.5 million. This acquisition transaction was accounted for as a purchase business combination. Based upon our preliminary purchase price allocation relating to this acquisition as of December 31, 2010, approximately $8.1 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 October 1, 2010, we completed the acquisition of Bluefield Regional Medical Center (240 licensed beds) located in Bluefield, West Virginia. The total cash consideration paid for fixed assets was approximately $35.4 million, with additional consideration including $8.9 million assumed in liabilities as well as a credit applied at closing of $1.8 million for negative acquired working capital, for a total consideration of $42.5 million. This acquisition transaction was accounted for as a purchase business combination. Based upon our preliminary purchase price allocation relating to this acquisition as of December 31, 2010, approximately $2.2 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 July 7, 2010, we completed the acquisition of Marion Regional Healthcare System located in Marion, South Carolina. This healthcare system includes Marion Regional Hospital (124 licensed beds), an acute care hospital, along with a related skilled nursing facility and other ancillary services. The total cash consideration paid for fixed assets and working capital was approximately $18.6 million and $5.8 million, respectively, with additional consideration including $3.9 million assumed in liabilities, for a total consideration of $28.3 million. This acquisition transaction was accounted for as a purchase business combination. Based upon our preliminary purchase price allocation relating to this acquisition as of December 31, 2010, 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.

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

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On December 9, 2010, we announced that we made an offer to acquire Tenet for $6.00 per share, including $5.00 per share in cash and $1.00 per share in our common stock, which represented a premium of 40% over Tenet s closing stock price on December 9, 2010. The total value of the transaction at this offering price would be approximately $7.3 billion, including $3.3 billion of acquired equity and approximately $4.0 billion of assumed long-term debt. The offer was made in a letter to Tenet s Board of Directors on November 12, 2010, and rejected by Tenet on December 6, 2010. On December 20, 2010, we announced our intention to nominate directors for election at the 2011 Annual Meeting of Tenet, and on January 14, 2011, a full slate of 10 independent director nominees was nominated. Tenet s entire Board is up for reelection at the 2011 Annual Meeting, which has been scheduled for November 3, 2011. There can be no assurance that such a transaction will be completed or, if completed, on what terms.

Sources of Revenue

The following table presents the approximate percentages of net operating revenues derived from Medicare, Medicaid, managed care, self-pay and other sources for the periods indicated. The data for the years presented are not strictly comparable due to the effect that hospital acquisitions have had on these statistics.

	Year Ended December 31,		
	2010	2009	2008
Medicare	27.2%	27.1%	27.5%
Medicaid	10.6%	9.8%	9.1%
Managed Care and other third-party payors	50.6%	51.9%	52.7%
Self-pay	11.6%	11.2%	10.7%
Total	100.0%	100.0%	100.0%

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-based reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net income by an insignificant amount in each of the years ended December 31, 2010, 2009 and 2008. In the future, we expect the percentage of revenues received from the Medicare program to increase due to the general aging of the population.

Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from CMS and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Similar programs are also being considered by other states. After these supplemental programs are signed into law, we recognize revenue and related expenses in the period in which amounts are estimable and collection is reasonably assured. Reimbursement under these programs is reflected in net operating revenues and included as Medicaid revenue in the table above, and fees, taxes or other program related costs

are reflected in other operating costs and expenses.

The payment rates under the Medicare program for hospital inpatient and outpatient acute care services are based on a prospective payment system, depending upon the diagnosis of a patient s condition. These rates are indexed for inflation annually, although increases have historically been less than actual inflation. On August 16, 2010, CMS issued the final rule to adjust this index by 2.6% for hospital inpatient acute care services that are reimbursed under the prospective payment system. The final rule also makes other payment adjustments that, coupled with the 0.25% reduction to hospital inpatient rates implemented pursuant to the

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Reform Legislation referred to below, yield a net 0.4% reduction in reimbursement for hospital inpatient acute care services beginning October 1, 2010. The Reform Legislation implemented a 0.25% reduction to hospital inpatient rates effective April 1, 2010 and 0.25% reductions to hospital outpatient rates effective January 1, 2010 and January 1, 2011. Reductions in the rate of increase or overall reductions in Medicare reimbursement may cause a decline in the growth of our net operating revenues.

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

Results of Operations

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

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

	Year Ended December 31,		
	2010	2009	2008
	(Expressed as a percentage of net operating revenues)		
Consolidated			
Net operating revenues	100.0%	100.0%	100.0%
Operating expenses(a)	(86.7)	(86.5)	(86.5)
Depreciation and amortization	(4.7)	(4.7)	(4.6)
Income from operations	8.6	8.8	8.9
Interest expense, net	(5.0)	(5.4)	(6.0)
Gain from early extinguishment of debt(b)			
Equity in earnings of unconsolidated affiliates	0.3	0.3	0.4
Income from continuing operations before income taxes	3.9	3.7	3.3
Provision for income taxes	(1.2)	(1.2)	(1.2)
Income from continuing operations	2.7	2.5	2.1
Income from discontinued operations, net of taxes			0.2
Net income	2.7	2.5	2.3
Less: Net income attributable to noncontrolling interests	(0.5)	(0.5)	(0.3)
Net income attributable to Community Health Systems, Inc.	2.2%	2.0%	2.0%

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	Year Ended December 31,	
	2010	2009
	(Expressed in percentages)	
Percentage increase from same period prior year:		
Net operating revenues	7.3%	10.9%
Admissions	0.1	3.6
Adjusted admissions(c)	2.5	5.6
Average length of stay	2.4	
Net income attributable to Community Health Systems, Inc.(d)	15.1	11.4
Same-store percentage increase (decrease) from same period prior year(e):		
Net operating revenues	3.9%	5.9%
Admissions	(2.5)	(1.5)
Adjusted admissions(c)	(0.5)	0.7

(a) Operating expenses include salaries and benefits, provision for bad debts, supplies, rent and other operating expenses.

(b) Gain from early extinguishment of debt was less than 0.1% for the years ended December 31, 2009 and 2008.

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

(d) Includes income from discontinued operations, if any.

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

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

Net operating revenues increased by 7.3% to approximately $13.0 billion in 2010, from approximately $12.1 billion in 2009. Growth from hospitals owned throughout both periods contributed $476 million of that increase and $402 million was contributed by hospitals acquired in 2010 and 2009. On a same-store basis, net operating revenues increased 3.9%. The increased net operating revenues contributed by hospitals that we owned throughout both periods were primarily attributable to general rate and reimbursement increases.

On a consolidated basis, inpatient admissions increased by 0.1% and adjusted admissions increased by 2.5%. On a same-store basis, inpatient admissions decreased by 2.5% during the year ended December 31, 2010. This decrease in inpatient admissions was due primarily to a decrease in admissions from a less severe flu season as compared to the prior year period, lower birth rates coinciding with the downturn in the economy, reductions in one day stays and certain service closures during the year ended December 31, 2010, as compared to the year ended December 31, 2009.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, increased from 86.5% in 2009 to 86.7% in 2010. Salaries and benefits, as a percentage of net operating revenues, increased from 40.0% in 2009 to 40.3% in 2010 from the impact of recent acquisitions and an increase in the number of employed

physicians, which offset efficiencies gained at hospitals owned throughout both periods. Provision for bad debts, as a percentage of net revenues, increased from 12.1% in 2009 to 12.2% in 2010, which is reflective of stabilization in the economy and unemployment rates. Supplies, as a percentage of net operating revenues, decreased from 13.9% in 2009 to 13.6% in 2010. This decrease in supplies expenses is due primarily to greater utilization of and improved pricing under our purchasing program. Other operating expenses, as a percentage of net operating revenues, increased from 18.5% in 2009 to 18.6% in 2010. Rent, as a percentage of net operating revenues, remained consistent at 2.0% for 2009 and 2010. Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, remained consistent at 0.3% for 2009 and 2010.

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

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Interest expense, net, increased by $2.9 million from $649.0 million in 2009, to $651.9 million in 2010. An increase in interest rates during 2010, including the pricing increase on $1.5 billion of existing term loans under the amended Credit Facility beginning November 5, 2010, compared to 2009, resulted in an increase in interest expense of $5.4 million. Additionally, interest expense increased by $4.8 million as a result of less interest being capitalized during 2010, as compared to 2009, as the current year period had fewer major construction projects. These increases were offset by a decrease in interest expense of $7.3 million due to a decrease in our average outstanding debt during 2010, compared to 2009.

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

The net results of the above mentioned changes resulted in income from continuing operations before income taxes increasing $62.3 million from $446.1 million in 2009 to $508.4 million for 2010.

Provision for income taxes from continuing operations increased from $141.3 million in 2009 to $160.0 million in 2010 due to the increase in income from continuing operations before income taxes. Our effective tax rates were 31.5% and 31.7% for the years ended December 31, 2010 and 2009, respectively. The decrease in our effective tax rate is primarily a result of a decrease in our effective state tax rate.

Each of income from continuing operations and net income, as a percentage of net operating revenues, increased from 2.5% in 2009 to 2.7% in 2010. The increase is primarily due to the decrease in interest expense as a percentage of net operating revenues, discussed above.

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

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

Year Ended December 31, 2009 Compared to Year Ended December 31, 2008

Net operating revenues increased by 10.9% to approximately $12.1 billion in 2009, from approximately $10.9 billion in 2008. Growth from hospitals owned throughout both periods contributed $639 million of that increase and $550 million was contributed by hospitals acquired in 2009 and 2008. On a same-store basis, net operating revenues increased 5.9%. The increase from hospitals that we owned throughout both periods was primarily attributable to higher acuity level of services provided and outpatient growth, along with rate increases and favorable payor mix. These improvements were partially offset by the stronger flu and respiratory season during the year ended December 31, 2008, as compared to the year ended December 31, 2009, and the extra day from the leap year in 2008.

On a consolidated basis, inpatient admissions increased by 3.6% and adjusted admissions increased by 5.6%. On a same-store basis, inpatient admissions decreased by 1.5% during the year ended December 31, 2009. This decrease in inpatient admissions was due primarily to the strong flu and respiratory season during the year ended December 31, 2008, which did not recur during 2009, the 2008 period having one additional day because it was a leap year, and the impact of closing certain less profitable services.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, remained consistent at 86.5% for 2008 and 2009. Salaries and benefits, as a percentage of net operating revenues, remained consistent at 40.0% for 2008 and 2009. Provision for bad debts, as a percentage of net revenues, increased from 11.2% in 2008 to 12.1% in 2009. This increase in the provision for bad debts primarily represents an increase in self-pay revenues over the comparable period of 2008 due to increased charges and the impact of current economic conditions on individuals ability to pay. Supplies, as a percentage of net operating revenues, decreased from 14.0% in 2008 to 13.9% in 2009. Other operating expenses, as a percentage of net operating revenues, decreased from 19.2% in 2008 to 18.5% in 2009. This decrease in other

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operating expenses is due primarily to reductions in contract labor. Rent, as a percentage of net operating revenues, decreased from 2.1% in 2008 to 2.0% in 2009. Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, decreased from 0.4% in 2008 to 0.3% in 2009.

Depreciation and amortization increased from 4.6% of net operating revenues in 2008 to 4.7% of net operating revenues in 2009. The increase in depreciation and amortization as a percentage of net operating revenues is primarily due to the opening of three replacement hospitals in the second and third quarters of 2008.

Interest expense, net, decreased by $3.5 million from $652.5 million in 2008, to $649.0 million in 2009. A decrease in interest rates during the year ended December 31, 2009, compared to the year ended December 31, 2008, accounted for $9.9 million of this decrease. In addition, we incurred an additional $1.8 million of interest expense in 2008, which was not incurred in 2009, since 2008 was a leap year. These decreases were offset by an increase in our average outstanding debt during the year ended December 31, 2009, compared to December 31, 2008, which resulted in a $2.8 million increase in interest expense. Additionally, interest expense increased by $5.4 million as a result of more of the interest during the year ended December 31, 2008 being capitalized interest due to more major construction projects during that period, compared to the year ended December 31, 2009.

Impairment of long-lived and other assets of $12.5 million in 2009 and $5.0 million in 2008 resulted from our assessment of the recoverability of these assets.

The net results of the above mentioned changes resulted in income from continuing operations before income taxes increasing $87.1 million from $359.0 million in 2008 to $446.1 million for 2009.

Provision for income taxes from continuing operations increased from $125.3 million in 2008 to $141.3 million in 2009 due to the increase in income from continuing operations before income taxes. Our effective tax rates were 31.7% and 34.9% for the years ended December 31, 2009 and 2008, respectively. The decrease in our effective tax rate is primarily a result of the recognition of a tax benefit of $3.0 million from adjustments and revaluation of deferred income tax accounts and a decrease in our effective state tax rate.

Income from continuing operations as a percentage of net operating revenues increased from 2.1% in 2008 to 2.5% in 2009. Net income as a percentage of net operating revenues increased from 2.3% in 2008 to 2.5% in 2009. The increase in income from continuing operations as a percentage of net operating revenues is primarily due to the decrease in interest expense as a percentage of net operating revenues, discussed above.

Net income attributable to noncontrolling interests as a percentage of net operating revenues increased from 0.3% for the year ended December 31, 2008 to 0.5% for the year ended December 31, 2009. The increase in net income attributable to noncontrolling interests is due primarily to additional syndications entered into throughout 2008 and 2009.

Net income attributable to Community Health Systems, Inc. was $243.2 million in 2009 compared to $218.3 million for 2008, an increase of 11.4%. The increase in net income attributable to Community Health Systems, Inc. is reflective of the increase in net operating revenues while maintaining substantially the same profit margin levels as discussed above.

Liquidity and Capital Resources

2010 Compared to 2009

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

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in cash generated from accounts receivable of $85.4 million, primarily a result of our two-day improvement in account receivable days outstanding in 2010 compared to a five-day improvement in 2009.

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

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

In 2010, we used $113.9 million for the repurchase and retirement of 3,415,800 shares of our outstanding common stock on the open market. We believed this to be a prudent use of cash as a result of our low market valuation when compared with historical valuations of both our stock and other healthcare providers stock. Our Credit Facility limits our ability to pay dividends and/or repurchase stock to an amount not to exceed $50 million in the aggregate after November 5, 2010, the date of the amendment and restatement of our Credit Facility. In addition, our Credit Facility allows us to repurchase stock in an amount not to exceed the aggregate amount of proceeds from the exercise of stock options. The indenture governing our Notes also limits our ability to pay dividends and/or repurchase stock. As of December 31, 2010, under the most restrictive test under these agreements, we have approximately $96.9 million remaining available with which to pay permitted dividends and/or make stock and Note repurchases.

With the exception of some small principal payments of our term loans under our Credit Facility, representing less than 1% of the outstanding balance each year through 2013, approximately $4.5 billion of term loans under our Credit Facility mature in 2014, our Notes are due in 2015, and the remaining $1.5 billion in term loans mature in 2017. We believe this four to five-year period before final maturity allows sufficient time for the current financial environment to improve and permits us to make favorable changes, including refinancing, to our debt structure. We do not anticipate the need to use funds currently available under our Credit Facility for purposes of funding our operations, although these funds could be used for the purpose of making further acquisitions or for restructuring our existing debt. Furthermore, we anticipate we will remain in compliance with our debt covenants through the next 12 months and beyond into the foreseeable future.

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As described in Notes 6, 9 and 15 of the Notes to Consolidated Financial Statements, at December 31, 2010, we had certain cash obligations, which are due as follows (in thousands):

	Total	2011	2012-2014	2015-2016	2017 and thereafter
Long-term debt	$ 6,038,459	$ 57,562	$ 4,522,058	$ 31,737	$ 1,427,102
Notes	2,784,331			2,784,331	
Interest on Credit Facility and Notes(1)	2,144,685	422,198	1,207,858	511,924	2,705
Capital lease obligations, including interest	82,115	10,328	20,314	11,182	40,291
Total long-term debt	11,049,590	490,088	5,750,230	3,339,174	1,470,098
Operating leases	828,787	172,764	359,337	142,581	154,105
Replacement facilities and other capital commitments(2)	627,175	259,008	323,690	8,273	36,204
Open purchase orders(3)	209,158	209,158			
Liability for uncertain tax positions, including interest and penalties	6,054	5,298	756		
Total	$ 12,720,764	$ 1,136,316	$ 6,434,013	$ 3,490,028	$ 1,660,407

(1) Estimate of interest payments assumes the interest rates at December 31, 2010 remain constant during the period presented for the Credit Facility, which is variable rate debt. The interest rate used to calculate interest payments for the Credit Facility was the London Interbank Offered Rate, or LIBOR, as of December 31, 2010 plus the spread. The Notes are fixed at an interest rate of 8.875% per annum.

(2) Pursuant to purchase agreements in effect as of December 31, 2010 and where CON approval has been obtained, we have commitments to build the following replacement facilities and the following capital commitments. As required by an amendment to our lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location by November 2012. As part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana by April 2011. As part of an acquisition in 2009, we agreed to build a replacement hospital in Siloam Springs, Arkansas by February 2013. Construction costs, including equipment costs, for these three replacement facilities are currently estimated to be approximately $318.5 million of which approximately $47.4 million has been incurred to date. In addition, under other purchase agreements, we have committed to spend approximately $540.5 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, 2010, we have incurred approximately $184.5 million related to these commitments.

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

At December 31, 2010, we had issued letters of credit primarily in support of potential insurance related claims and specified outstanding bonds of approximately $81.9 million.

Our debt as a percentage of total capitalization decreased from 82% at December 31, 2009 to 80% at December 31, 2010.

2009 Compared to 2008

Net cash provided by operating activities increased $19.8 million, from approximately $1.1 billion for the year ended December 31, 2008 to approximately $1.1 billion for the year ended December 31, 2009. The increase is due to an increase in cash flows from net income of $53.6 million and an increase in non-cash

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depreciation and amortization expense of $59.8 million and an increase in cash generated from accounts receivable of $108.0 million, a result of the reduction in days revenue outstanding. These increases in cash flows outstanding were offset by decreases in cash flows from accounts payable, accrued liabilities and income taxes of $33.8 million, primarily as a result of the timing of payments and an increase in cash paid for income taxes during 2009. Also, other non-cash expenses decreased $83.5 million, primarily attributable to a reduction in deferred income tax expense resulting in a reduction to cash flows, and cash flows generated from the change in all other assets and liabilities decreased $84.3 million.

The cash used in investing activities was $867.2 million for the year ended December 31, 2009, compared to $665.5 million for the year ended December 31, 2008. The increase in cash used in investing activities, in comparison to the prior year, is primarily attributable to an increase in acquisitions of facilities and other related equipment of $101.9 million, a reduction in the amount of proceeds from the disposition of hospitals and other ancillary operations of $276.1 million due to the sale of one hospital in 2009 versus the sale of 11 hospitals in 2008, a reduction in the amount of the proceeds from sale of property and equipment of $9.4 million. This increase in cash used in investing activities was offset by a reduction in the amount of purchases of property and equipment of $115.3 million and a net decrease in other non-operating assets of $70.4 million, primarily attributable to a decrease in cash invested in our captive insurance subsidiary, a decrease in cash used for physician recruiting and a decrease in cash used for software related expenditures. We anticipate being able to fund future routine capital expenditures with cash flows generated from operations.

In 2009, our net cash used in financing activities decreased $218.6 million from $304.0 million in 2008 to $85.4 million in 2009, primarily due to an increase in borrowing under our Credit Facility. In January 2009, we drew down the remaining $200 million of the delayed draw term loan.

Capital Expenditures

Cash expenditures for purchases of facilities were $248.3 million in 2010, $263.8 million in 2009 and $161.9 million in 2008. Our expenditures in 2010 included $181.1 million for the purchase of five hospitals and $67.2 million for the purchase of clinics, surgery centers and physician practices. Our expenditures in 2009 included $182.2 million for the purchase of three hospitals and the remaining equity in a hospital in which we previously had a noncontrolling interest, $72.3 million for the purchase of clinics, surgery centers and physician practices, and $9.3 million for the settlement of acquired working capital. Our expenditures in 2008 included $149.1 million for the purchase of two hospitals and $12.8 million for the purchase of physician practices and a home care agency.

Excluding the cost to construct replacement hospitals, our cash expenditures for routine capital for 2010 totaled $631.7 million compared to $572.1 million in 2009, and $569.4 million in 2008. These capital expenditures related primarily to the purchase of additional equipment, minor renovations and information systems infrastructure. Costs to construct replacement hospitals totaled $35.7 million in 2010, $4.8 million in 2009 and $122.8 million in 2008. The costs to construct replacement hospitals for the year ended December 31, 2010 represent both planning and construction costs for the four replacement hospitals. The costs to construct replacement hospitals for the year ended December 31, 2009 represent planning costs for future construction projects since there were no replacement hospitals under construction at year ended December 31, 2009. In 2008, we completed construction of and opened three replacement hospitals, accounting for the higher costs incurred during the year ended December 31, 2008.

Pursuant to hospital purchase agreements in effect as of December 31, 2010, as part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana by April 2011, and as part of an acquisition in 2009, we agreed to build a replacement hospital in Siloam Springs, Arkansas by February 2013. Also, as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement facility at Barstow Community Hospital in Barstow, California. Estimated construction costs, including equipment costs, are

approximately $318.5 million for these three replacement facilities. 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

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potential replacement to our existing Birmingham facility. In September 2010, we received approval of our request for a certificate of need from the Alabama Certificate of Need Review Board; however, this certificate of need remains subject to an appeal process. Our estimated construction costs, including the acquisition of the site and equipment costs, are approximately $280.0 million for the Birmingham replacement facility. We expect total capital expenditures of approximately $750 million to $850 million in 2011 (which includes amounts which are required to be expended pursuant to the terms of hospital purchase agreements), including approximately $580 million to $660 million for renovation and equipment cost and approximately $170 million to $190 million for construction and equipment cost of the replacement hospitals.

Capital Resources

Net working capital was approximately $1.229 billion at December 31, 2010, compared to $1.217 billion at December 31, 2009, an increase of $12.0 million. Contributing to the increase in net working capital were increases in patient accounts receivable of approximately $65.6 million, supplies of approximately $17.1 million, prepaid taxes of approximately $73.1 million, deferred tax assets of approximately $35.1 million, net working capital acquired as part of our business acquisitions of approximately $5.1 million and decreases in deferred tax liabilities of approximately $19.6 million. These increases in working capital were offset by decreases in cash of approximately $45.4 million, increases in accounts payable of approximately $86.7 million and employee compensation liabilities of approximately $82.8 million. All other changes in working capital items contributed approximately $11.3 million of net working capital.

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

The term loan facility must be prepaid in an amount equal to (1) 100% of the net cash proceeds of certain asset sales and dispositions by us and our subsidiaries, subject to certain exceptions and reinvestment rights, (2) 100% of the net cash proceeds of issuances of certain debt obligations or receivables based financing by us and our subsidiaries, subject to certain exceptions, and (3) 50%, subject to reduction to a lower percentage based on our leverage ratio (as defined in the Credit Facility generally as the ratio of total debt on the date of determination to our EBITDA, as defined, for the four quarters most recently ended prior to such date), of excess cash flow (as defined) for any year, commencing in 2008, subject to certain exceptions. Voluntary prepayments and commitment reductions are permitted in whole or in part, without any premium or penalty, subject to minimum prepayment or reduction requirements.

The obligor under the Credit Facility is CHS. All of our obligations under the Credit Facility are unconditionally guaranteed by Community Health Systems, Inc. and certain existing and subsequently acquired

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

The loans under the Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at our option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus one-half of 1.0% or (3) the adjusted LIBOR rate on such day for a three-month interest period commencing on the second business day after such day plus 1%, or (b) a reserve adjusted LIBOR for dollars (Eurodollar rate) (as defined). The applicable percentage for Alternate Base Rate loans is 1.25% for term loans due 2014 and 2.25% for term loans due 2017. The applicable percentage for Eurodollar rate loans is 2.25% for term loans due 2014 and 3.5% for term loans due 2017. The applicable percentage for revolving loans was initially 1.25% for Alternate Base Rate revolving loans and 2.25% for Eurodollar revolving loans, in each case subject to reduction based on our leverage ratio. Loans under the swingline subfacility bear interest at the rate applicable to Alternate Base Rate loans under the revolving credit facility.

We have agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to Eurodollar rate loans under the revolving credit facility times the maximum aggregate amount available to be drawn under all letters of credit outstanding under the subfacility for letters of credit. The issuer of any letter of credit issued under the subfacility for letters of credit will also receive a customary fronting fee and other customary processing charges. We were initially obligated to pay commitment fees of 0.50% per annum (subject to reduction based upon our leverage ratio), on the unused portion of the revolving credit facility. For purposes of this calculation, swingline loans are not treated as usage of the revolving credit facility. With respect to the delayed draw term loan facility, we were also obligated to pay commitment fees of 0.50% per annum for the first nine months after the close of the Credit Facility and 0.75% per annum for the next three months after such nine-month period and thereafter 1.0% per annum. In each case, the commitment fee was based on the unused amount of the delayed draw term loan facility. After the draw down of the remaining $200 million of the delayed draw term loan in January 2009, we no longer pay any commitment fees for the delayed draw term loan facility. We also paid arrangement fees on the closing of the Credit Facility and pay an annual administrative agent fee.

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

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

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As of December 31, 2010, the availability for additional borrowings under our Credit Facility was approximately $750 million pursuant to the revolving credit facility, of which $81.9 million was set aside for outstanding letters of credit. We believe that these funds, along with internally generated cash and continued access to the bank credit and capital markets, will be sufficient to finance future acquisitions, capital expenditures and working capital requirements through the next 12 months and into the foreseeable future.

During the year ended December 31, 2008, we repurchased on the open market and cancelled $110.5 million of principal amount of the Notes. This resulted in a net gain from early extinguishment of debt of $2.5 million with an after-tax impact of $1.6 million. During the year ended December 31, 2009, we repurchased on the open market and cancelled $126.5 million of principal amount of the Notes. This resulted in a net gain from early extinguishment of debt of $2.7 million with an after-tax impact of $1.7 million.

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

As of December 31, 2010, we are currently a party to the following interest rate swap agreements to limit the effect of changes in interest rates on approximately 89% of our variable rate debt. On each of these swaps, we receive a variable rate of interest based on the three-month LIBOR, in exchange for the payment by us of a fixed rate of interest. We currently pay, on a quarterly basis, a margin above LIBOR of 225 basis points for revolving credit and term loans due 2014 and 350 basis points for term loans due 2017 under the Credit Facility.

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Swap #	Notional Amount (in 000 s)	Fixed Interest Rate	Termination Date	Fair Value (in 000 s)
1	$ 100,000	4.7090%	January 24, 2011	$ (294)
2	300,000	5.1140%	August 8, 2011	(8,430)
3	100,000	4.7185%	August 19, 2011	(2,674)
4	100,000	4.7040%	August 19, 2011	(2,664)
5	100,000	4.6250%	August 19, 2011	(2,602)
6	200,000	4.9300%	August 30, 2011	(5,833)
7	200,000	3.0920%	September 18, 2011	(3,632)
8	100,000	3.0230%	October 23, 2011	(1,952)
9	200,000	4.4815%	October 26, 2011	(6,328)
10	200,000	4.0840%	December 3, 2011	(6,267)
11	100,000	3.8470%	January 4, 2012	(3,112)
12	100,000	3.8510%	January 4, 2012	(3,126)
13	100,000	3.8560%	January 4, 2012	(3,131)
14	200,000	3.7260%	January 8, 2012	(6,074)
15	200,000	3.5065%	January 16, 2012	(5,723)
16	250,000	5.0185%	May 30, 2012	(14,971)
17	150,000	5.0250%	May 30, 2012	(9,074)
18	200,000	4.6845%	September 11, 2012	(13,217)
19	100,000	3.3520%	October 23, 2012	(4,639)
20	125,000	4.3745%	November 23, 2012	(8,095)
21	75,000	4.3800%	November 23, 2012	(5,087)
22	150,000	5.0200%	November 30, 2012	(12,124)
23	200,000	2.2420%	February 28, 2013	(5,961)
24	100,000	5.0230%	May 30, 2013	(9,655)
25	300,000	5.2420%	August 6, 2013	(31,963)
26	100,000	5.0380%	August 30, 2013	(10,396)
27	50,000	3.5860%	October 23, 2013	(3,367)
28	50,000	3.5240%	October 23, 2013	(3,281)
29	100,000	5.0500%	November 30, 2013	(11,036)
30	200,000	2.0700%	December 19, 2013	(4,898)
31	100,000	5.2310%	July 25, 2014	(12,977)
32	100,000	5.2310%	July 25, 2014	(12,977)
33	200,000	5.1600%	July 25, 2014	(25,460)
34	75,000	5.0405%	July 25, 2014	(9,225)
35	125,000	5.0215%	July 25, 2014	(15,293)
36	100,000	2.6210%	July 25, 2014	(3,883)
37	100,000	3.1100%	July 25, 2014	(5,590)
38	100,000	3.2580%	July 25, 2014	(5,909)[1]
39	200,000	2.6930%	October 26, 2014	(4,594)[2]
40	300,000	3.4470%	August 8, 2016	(12,337)[3]
41	200,000	3.4285%	August 19, 2016	(7,832)[4]
42	100,000	3.4010%	August 19, 2016	(3,778)[5]
43	200,000	3.5000%	August 30, 2016	(8,325)[6]
44	100,000	3.0050%	November 30, 2016	(2,740)

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(1) This interest rate swap becomes effective January 24, 2011, concurrent with the termination of swap #1.

(2) This interest rate swap becomes effective October 26, 2011, concurrent with the termination of swap #9.

(3) This interest rate swap becomes effective August 8, 2011, concurrent with the termination of swap #2.

(4) This interest rate swap becomes effective August 19, 2011, concurrent with the termination of swap #3 and #5.

(5) This interest rate swap becomes effective August 19, 2011, concurrent with the termination of swap #4.

(6) This interest rate swap becomes effective August 30, 2011, concurrent with the termination of swap #6.

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

incur, assume or guarantee additional indebtedness;

issue redeemable stock and preferred stock;

repurchase capital stock;

make restricted payments, including paying dividends and making investments;

redeem debt that is junior in right of payment to the Notes;

create liens without securing the Notes;

sell or otherwise dispose of assets, including capital stock of subsidiaries;

enter into agreements that restrict dividends from subsidiaries;

merge, consolidate, sell or otherwise dispose of substantial portions of our assets;

enter into transactions with affiliates; and

guarantee certain obligations.

In addition, our Credit Facility contains restrictive covenants and requires us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet these restricted covenants and financial ratios and tests can be affected by events beyond our control, and we cannot assure you that we will meet those tests. A breach of any of these covenants could result in a default under our Credit Facility and/or the Notes. Upon the occurrence of an event of default under our Credit Facility or the Notes, all amounts outstanding under our Credit Facility and the Notes may become 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 $81.9 million is set aside for outstanding letters of credit as of December 31, 2010) and our ability to amend the Credit Facility to provide for one or more tranches of term loans in an aggregate principal amount of $1.0 billion, our ability to add up to $300 million of

borrowing capacity from receivable transactions (including securitizations) and our continued access to the bank credit and capital markets will be sufficient to finance acquisitions, capital expenditures and working capital requirements through the next 12 months. We believe these same sources of cash, borrowings under our Credit Facility as well as access to bank credit and capital markets will be available to us beyond the next 12 months and into the foreseeable future.

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On December 22, 2008, we filed a universal automatic shelf registration statement on Form S-3ASR that will permit us, from time to time, in one or more public offerings, to offer debt securities, common stock, preferred stock, warrants, depositary shares, or any combination of such securities. The shelf registration statement will also permit our subsidiary, CHS, to offer debt securities that would be guaranteed by us, from time to time in one or more public offerings. The terms of any such future offerings would be established at the time of the offering.

Off-balance sheet arrangements

Our consolidated operating results for the years ended December 31, 2010 and 2009, included $281.0 million and $286.6 million, respectively, of net operating revenues and $26.6 million and $18.1 million, respectively, of income from continuing operations, generated from seven hospitals operated by us under operating lease arrangements. In accordance with accounting principles generally accepted in the United States of America, or U.S. GAAP, the respective assets and the future lease obligations under these arrangements are not recorded in our consolidated balance sheet. Lease payments under these arrangements are included in rent expense and totaled approximately $12.4 million and $16.5 million for the years ended December 31, 2010 and 2009, respectively. The current terms of these operating leases expire between June 2012 and December 2020, not including lease extension options. If we allow these leases to expire, we would no longer generate revenues nor incur expenses from these hospitals.

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

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

As described more fully in Note 15 of the Notes to Consolidated Financial Statements, at December 31, 2010, we have certain cash obligations for replacement facilities and other construction commitments of $627.2 million and open purchase orders for $209.2 million.

Noncontrolling Interests

We have sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. As of December 31, 2010, we have hospitals in 25 of the markets we serve, with noncontrolling physician ownership interests ranging from less than 1% to 40%, including one hospital that also had a non-profit entity as a partner. In addition, we have three other hospitals with noncontrolling interests owned by non-profit entities. During 2010 (prior to the enactment of the Reform Legislation), we sold noncontrolling interests in two of our hospitals and additional noncontrolling interests in hospitals with existing physician ownership,

for total consideration of $7.2 million. During 2009, we sold

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noncontrolling interests in six of our hospitals, including additional noncontrolling interests in hospitals with existing physician ownership, for total consideration of $19.3 million. During 2008, we sold noncontrolling interests in seven of our hospitals, including additional noncontrolling interests in hospitals with existing physician ownership, for total consideration of $82.1 million. Effective June 1, 2009, we acquired from Akron General Medical Center the remaining 20% noncontrolling interest in Massillon Community Health System, LLC not then owned by us. This entity indirectly owns and operates Affinity Medical Center of Massillon, Ohio. The purchase price for this noncontrolling interest was $1.1 million in cash. Affinity Medical Center is now wholly-owned by us. Effective June 30, 2008, we acquired the remaining 35% noncontrolling interest in Affinity Health Systems, LLC which indirectly owns and operates Trinity Medical Center (560 licensed beds) in Birmingham, Alabama, from Baptist Health Systems, Inc. of Birmingham, Alabama, or Baptist, giving us 100% ownership of that facility. The purchase price to acquire this interest was $51.5 million in cash and the cancellation of a promissory note issued by Baptist to Affinity Health Systems, LLC in the original principal amount of $32.8 million. Effective November 14, 2008, we acquired from Willamette Community Health Solutions all of its noncontrolling interest in MWMC Holdings, LLC, which indirectly owns a controlling interest in and operates McKenzie-Willamette Medical Center of Springfield, Oregon. This acquisition resulted from a put right held by Willamette Community Health Solutions in connection with the 2003 transaction establishing the joint venture. The purchase price for this noncontrolling interest was $22.7 million in cash. Physicians affiliated with Oregon Health Resources, Inc. continue to own a noncontrolling interest in the hospital. Redeemable noncontrolling interests in equity of consolidated subsidiaries was $387.5 million and $368.9 million as of December 31, 2010 and 2009, respectively, and noncontrolling interests in equity of consolidated subsidiaries was $60.9 million and $64.8 million as of December 31, 2010 and 2009, respectively, and the amount of net income attributable to noncontrolling interests was $68.5 million, $63.2 million and $34.4 million for the years ended December 31, 2010, 2009 and 2008, respectively. As a result of the change in the Stark Law whole hospital exception included in the Reform Legislation, we will not introduce physician ownership at any of our wholly-owned facilities or increase the aggregate percentage of physician ownership in any of our existing joint ventures.

Reimbursement, Legislative and Regulatory Changes

The Reform Legislation was enacted in the context of other ongoing legislative and regulatory efforts, which would reduce or otherwise adversely affect the payments we receive from Medicare and Medicaid. Within the statutory framework of the Medicare and Medicaid programs, including programs currently unaffected by the Reform Legislation, there are substantial areas subject to administrative rulings, interpretations, and discretion which may further affect payments made under those programs, and the federal and state governments might, in the future, reduce the funds available under those programs or require more stringent utilization and quality reviews of hospital facilities. Additionally, there may be a continued rise in managed care programs and additional restructuring of the financing and delivery of healthcare in the United States. These events could cause our future financial results to decline. We cannot estimate the impact of Medicare and Medicaid reimbursement changes that have been enacted or are under consideration. We cannot predict whether additional reimbursement reductions will be made or whether any such changes would have a material adverse effect on our business, financial conditions, results of operations, cash flow, capital resources and liquidity.

Inflation

The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. In addition, our suppliers pass along rising costs to us in the form of higher prices. We have implemented cost control measures, including our case and resource management program, to curb increases in operating costs and expenses. We have generally offset increases in operating costs by increasing reimbursement for services, expanding services and reducing costs in other areas. However, we cannot predict our ability to cover or offset future cost increases, particularly any increases in our cost of providing health insurance

benefits to our employees as a result of the Reform Legislation.

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Critical Accounting Policies

The discussion and analysis of our financial condition and results of operations are based upon our consolidated financial statements, which have been prepared in accordance with U.S. GAAP. The preparation of these financial statements requires us to make estimates and judgments that affect the reported amount of assets and liabilities, revenues and expenses, and related disclosure of contingent assets and liabilities at the date of our consolidated financial statements. Actual results may differ from these estimates under different assumptions or conditions.

Critical accounting policies are defined as those that are reflective of significant judgments and uncertainties, and potentially result in materially different results under different assumptions and conditions. We believe that our critical accounting policies are limited to those described below. For a detailed discussion on the application of these and other accounting policies, see Note 1 in the Notes to the Consolidated Financial Statements included under Item 8 of this Report.

Third-party Reimbursement

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. Contractual allowances are automatically calculated and recorded through our internally developed automated contractual allowance system. Within the automated system, actual Medicare DRG data and payors historical paid claims data are utilized to calculate the contractual allowances. This data is automatically updated on a monthly basis. All hospital contractual allowance calculations are subjected to monthly review by management to ensure reasonableness and accuracy. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. The process of estimating contractual allowances requires us to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification and historical paid claims data. Due to the complexities involved in these estimates, actual payments we receive could be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs and managed care contracts differed by 1% at December 31, 2010 from our estimated reimbursement percentage, net income for the year ended December 31, 2010 would have changed by approximately $30.5 million, and net accounts receivable at December 31, 2010 would have changed by $48.3 million. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net income by an insignificant amount in each of the years ended December 31, 2010, 2009 and 2008.

Allowance for Doubtful Accounts

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

procedures for walk-in and emergency room patients.

We estimate the allowance for doubtful accounts by reserving a percentage of all self-pay accounts receivable without regard to aging category, based on collection history, adjusted for expected recoveries and,

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if present, anticipated changes in trends. For all other non-self-pay payor categories, we reserve 100% of all accounts aging over 365 days from the date of discharge. The percentage used to reserve for all self-pay accounts is based on our collection history. We believe that we collect substantially all of our third-party insured receivables, which include receivables from governmental agencies.

Collections are impacted by the economic ability of patients to pay and the effectiveness of our collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect our collection of accounts receivable. The process of estimating the allowance for doubtful accounts requires us to estimate the collectability of self-pay accounts receivable, which is primarily based on our collection history, adjusted for expected recoveries and, if available, anticipated changes in collection trends. Significant change in payor mix, business office operations, economic conditions, trends in federal and state governmental healthcare coverage or other third-party payors could affect our estimates of accounts receivable collectability. If the actual collection percentage at December 31, 2010 differed by 1% from our estimated collection percentage as a result of a change in expected recoveries, net income for the year ended December 31, 2010 would have changed by $16.8 million, and net accounts receivable at December 31, 2010 would have changed by $26.6 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 $2.1 billion and $1.9 billion at December 31, 2010 and 2009, 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 46 days at December 31, 2010 and 48 days at December 31, 2009. Our target range for days revenue outstanding is from 46 to 56 days.

Total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) was approximately $7.2 billion as of December 31, 2010 and approximately $6.1 billion as of December 31, 2009.

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

	December 31,	
	2010	**2009**
Insured receivables	63.9%	62.4%

Self-pay receivables	36.1%	37.6%
Total	100.0%	100.0%

For the hospital segment, the combined total of the allowance for doubtful accounts and related allowances for other self-pay discounts and contractuals, as a percentage of gross self-pay receivables, was approximately 84% at December 31, 2010 and 82% at December 31, 2009. If the receivables that have been written-off, but where collections are still being pursued by outside collection agencies, were included in both

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the allowances and gross self-pay receivables specified above, the percentage of combined allowances to total self-pay receivables would have been approximately 91% and 90% at December 31, 2010 and 2009, respectively.

Goodwill and Other Intangibles

Goodwill represents the excess of cost over the fair value of net assets acquired. Goodwill is evaluated for impairment at the same time every year and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. There is a two-step method for determining goodwill impairment. Step one is to compare the fair value of the reporting unit with the unit s carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit s goodwill with the carrying value of the reporting unit s goodwill. We have selected September 30 as our annual testing date. Based on the results of our most recent annual impairment test, we have concluded that we do not have any reporting units that are at risk of failing step one of the goodwill impairment test.

Impairment or Disposal of Long-Lived Assets

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

Professional Liability Claims

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

The net present value of the projected payments was discounted using a weighted-average risk-free rate of 1.3%, 1.4% and 2.6% in 2010, 2009 and 2008, respectively. This liability is adjusted for new claims information in the period such information becomes known to us. Professional malpractice expense includes the losses resulting from professional liability claims and loss adjustment expense, as well as paid excess insurance premiums, and is presented within other operating expenses in the accompanying consolidated statements of income.

Our processes for obtaining and analyzing claims and incident data are standardized across all of our hospitals and have been consistent for many years. We monitor the outcomes of the medical care services that we provide and for each reported claim, we obtain various information concerning the facts and circumstances related to that claim. In

addition, we routinely monitor current key statistics and volume indicators in our assessment of utilizing historical trends. The average lag period between claim occurrence and payment of a final settlement is between four and five years, although the facts and circumstances of individual claims could

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result in the timing of such payments being different from this average. Since claims are paid promptly after settlement with the claimant is reached, settled claims represent less than 1.0% of the total liability at the end of any period.

For purposes of estimating our individual claim accruals, we utilize specific claim information, including the nature of the claim, the expected claim amount, the year in which the claim occurred and the laws of the jurisdiction in which the claim occurred. Once the case accruals for known claims are determined, information is stratified by loss layers and retentions, accident years, reported years, geography, and claims relating to the acquired Triad hospitals versus claims relating to our other hospitals. Several actuarial methods are used against this data to produce estimates of ultimate paid losses and reserves for incurred but not reported claims. Each of these methods uses our company-specific historical claims data and other information. This company-specific data includes information regarding our business, including historical paid losses and loss adjustment expenses, historical and current case loss reserves, actual and projected hospital statistical data, a variety of hospital census information, employed physician information, professional liability retentions for each policy year, geographic information and other data.

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

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

	Year Ended December 31,		
	2010	**2009**	**2008**
Accrual for professional liability claims, beginning of year	$ 431,225	$ 350,579	$ 300,184
Expense (income) related to:			
Current accident year	141,923	136,424	110,010
Prior accident years	(10,583)	(6,702)	(15,826)
(Income) expense from discounting	(2,678)	11,515	11,499
Total incurred loss and loss expense(1)	128,662	141,237	105,683
Paid claims and expenses related to:			
Current accident year	(1,980)	(1,387)	(688)
Prior accident years	(68,700)	(59,204)	(54,600)
Total paid claims and expenses	(70,680)	(60,591)	(55,288)
Accrual for professional liability claims, end of year	$		