COMMUNITY HEALTH SYSTEMS INC
Form 10-Q
August 01, 2011

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

Form 10-Q
QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934
For the quarterly period ended June 30, 2011
Commission file number 001-15925
COMMUNITY HEALTH SYSTEMS, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-3893191**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
4000 Meridian Boulevard **Franklin, Tennessee** *(Address of principal executive offices)*	**37067** *(Zip Code)*

(Registrant s telephone number)
615-465-7000

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 o No o

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 (Do not check if a smaller reporting company)	Smaller reporting company o

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

As of July 22, 2011, there were outstanding 93,212,756 shares of the Registrant s Common Stock, $0.01 par value.

Community Health Systems, Inc.
Form 10-Q
For the Three and Six Months Ended June 30, 2011

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PART I FINANCIAL INFORMATION

Item 1. ***Financial Statements***

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)
(Unaudited)

	June 30, 2011	December 31, 2010
ASSETS		
Current assets		
Cash and cash equivalents	$ 191,432	$ 299,169
Patient accounts receivable, net of allowance for doubtful accounts of $1,793,404 and $1,639,198 at June 30, 2011 and December 31, 2010, respectively	1,792,404	1,714,542
Supplies	342,268	329,114
Prepaid income taxes		118,464
Deferred income taxes	115,819	115,819
Prepaid expenses and taxes	117,458	100,754
Other current assets	175,109	193,331
Total current assets	2,734,490	2,871,193
Property and equipment	8,798,266	8,383,122
Less accumulated depreciation and amortization	(2,291,842)	(2,058,685)
Property and equipment, net	6,506,424	6,324,437
Goodwill	4,227,970	4,150,247
Other assets, net	1,356,531	1,352,246
Total assets	$ 14,825,415	$ 14,698,123
LIABILITIES AND EQUITY		
Current liabilities		
Current maturities of long-term debt	$ 70,112	$ 63,139
Accounts payable	583,924	526,338
Current income tax payable	349	
Deferred income taxes	8,882	8,882
Accrued interest	145,146	146,415
Accrued liabilities	854,329	897,266
Total current liabilities	1,662,742	1,642,040
Long-term debt	8,781,443	8,808,382
Deferred income taxes	608,177	608,177

Other long-term liabilities	1,026,069	1,001,675
Total liabilities	12,078,431	12,060,274
Redeemable noncontrolling interests in equity of consolidated subsidiaries	376,658	387,472
EQUITY		
Community Health Systems, Inc. stockholders equity		
Preferred stock, $.01 par value per share, 100,000,000 shares authorized; none issued		
Common stock, $.01 par value per share, 300,000,000 shares authorized; 93,210,424 shares issued and 92,234,875 shares outstanding at June 30, 2011, and 93,644,862 shares issued and 92,669,313 shares outstanding at December 31, 2010	932	936
Additional paid-in capital	1,119,205	1,126,751
Treasury stock, at cost, 975,549 shares at June 30, 2011 and December 31, 2010	(6,678)	(6,678)
Accumulated other comprehensive loss	(200,533)	(230,927)
Retained earnings	1,396,095	1,299,382
Total Community Health Systems, Inc. stockholders equity	2,309,021	2,189,464
Noncontrolling interests in equity of consolidated subsidiaries	61,305	60,913
Total equity	2,370,326	2,250,377
Total liabilities and equity	$ 14,825,415	$ 14,698,123

See accompanying notes to the condensed consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF INCOME
(In thousands, except share and per share data)
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	**2010**	**2011**	**2010**
Net operating revenues	$ 3,433,829	$ 3,080,646	$ 6,787,881	$ 6,149,258
Operating costs and expenses:				
Salaries and benefits	1,384,096	1,231,559	2,763,463	2,478,240
Provision for bad debts	433,002	367,002	832,971	733,503
Supplies	449,279	430,574	907,096	852,686
Other operating expenses	654,737	559,962	1,269,530	1,116,581
Rent	62,431	60,851	125,601	122,908
Depreciation and amortization	161,376	149,779	319,531	293,682
Total operating costs and expenses	3,144,921	2,799,727	6,218,192	5,597,600
Income from operations	288,908	280,919	569,689	551,658
Interest expense, net	163,230	160,759	326,448	320,182
Equity in earnings of unconsolidated affiliates	(12,017)	(10,980)	(30,151)	(23,570)
Income from continuing operations before income taxes	137,695	131,140	273,392	255,046
Provision for income taxes	44,821	42,761	88,913	82,310
Income from continuing operations	92,874	88,379	184,479	172,736
Discontinued operations, net of taxes:				
Income (loss) from operations of entities sold and held for sale	235	(2,037)	(1,443)	(1,398)
Impairment of hospitals held for sale	(39,562)		(47,930)	
Loss on sale			(3,234)	
Loss from discontinued operations, net of taxes	(39,327)	(2,037)	(52,607)	(1,398)
Net income	53,547	86,342	131,872	171,338
Less: Net income attributable to noncontrolling interests	18,158	16,277	35,159	31,266
Net income attributable to Community Health Systems, Inc.	$ 35,389	$ 70,065	$ 96,713	$ 140,072

Basic earnings (loss) per share attributable to Community Health Systems, Inc. common stockholders (1):				
Continuing operations	$ 0.82	$ 0.77	$ 1.64	$ 1.53
Discontinued operations	(0.43)	(0.02)	(0.58)	(0.01)
Net income	$ 0.39	$ 0.75	$ 1.06	$ 1.51
Diluted earnings (loss) per share attributable to Community Health Systems, Inc. common stockholders (1):				
Continuing operations	$ 0.81	$ 0.76	$ 1.62	$ 1.51
Discontinued operations	(0.43)	(0.02)	(0.57)	(0.01)
Net income	$ 0.39	$ 0.74	$ 1.05	$ 1.49
Weighted-average number of shares outstanding:				
Basic	91,130,672	93,358,771	91,069,876	92,491,839
Diluted	91,783,725	94,711,919	91,960,610	93,779,001

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

See accompanying notes to the condensed consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)
(Unaudited)

	Six Months Ended June 30,	
	2011	**2010**
Cash flows from operating activities		
Net income	$ 131,872	$ 171,338
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	324,367	301,060
Stock-based compensation expense	20,732	20,418
Loss on sale	3,234	
Impairment of hospitals held for sale	47,930	
Excess tax benefit relating to stock-based compensation	(4,659)	(10,104)
Other non-cash expenses, net	4,313	(2,342)
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:		
Patient accounts receivable	(83,082)	(63,896)
Supplies, prepaid expenses and other current assets	9,374	(1,147)
Accounts payable, accrued liabilities and income taxes	129,518	114,100
Other	1,086	12,365
Net cash provided by operating activities	584,685	541,792
Cash flows from investing activities		
Acquisitions of facilities and other related equipment	(204,264)	(2,413)
Purchases of property and equipment	(351,383)	(263,924)
Proceeds from disposition of ancillary operations	18,464	
Proceeds from sale of property and equipment	8,034	2,307
Increase in other non-operating assets	(75,211)	(64,258)
Net cash used in investing activities	(604,360)	(328,288)
Cash flows from financing activities		
Proceeds from exercise of stock options	18,831	53,615
Deferred financing costs	(234)	
Excess tax benefit relating to stock-based compensation	4,659	10,104
Stock buy-back	(50,002)	(12,242)
Proceeds from noncontrolling investors in joint ventures	863	5,155
Redemption of noncontrolling investments in joint ventures	(3,303)	(2,395)
Distributions to noncontrolling investors in joint ventures	(30,078)	(29,371)
Repayments of long-term indebtedness	(28,798)	(34,157)
Net cash used in financing activities	(88,062)	(9,291)

Net change in cash and cash equivalents	(107,737)	204,213
Cash and cash equivalents at beginning of period	299,169	344,541
Cash and cash equivalents at end of period	$ 191,432	$ 548,754
Supplemental disclosure of cash flow information:		
Interest payments	$ 327,717	$ 320,150
Income tax (refunds received) paid, net	$ (25,697)	$ 79,711

See accompanying notes to the condensed consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED)

1. BASIS OF PRESENTATION

The unaudited condensed consolidated financial statements of Community Health Systems, Inc. and its subsidiaries (the Company) as of June 30, 2011 and December 31, 2010 and for the three-month and six-month periods ended June 30, 2011 and June 30, 2010, have been prepared in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP). In the opinion of management, such information contains all adjustments, consisting only of normal recurring adjustments, necessary for a fair presentation of the results for such periods. All intercompany transactions and balances have been eliminated. The results of operations for the three and six months ended June 30, 2011, are not necessarily indicative of the results to be expected for the full fiscal year ending December 31, 2011. Certain information and disclosures normally included in the notes to consolidated financial statements have been condensed or omitted as permitted by the rules and regulations of the Securities and Exchange Commission (the SEC). The Company believes the disclosures are adequate to make the information presented not misleading. The accompanying unaudited condensed consolidated financial statements should be read in conjunction with the consolidated financial statements and notes thereto for the year ended December 31, 2010, contained in the Company s Annual Report on Form 10-K.

Noncontrolling interests in less-than-wholly-owned consolidated subsidiaries of the parent are presented as a component of total equity on the condensed consolidated balance sheets to distinguish between the interests of the parent company and the interests of the noncontrolling owners. Noncontrolling interests that are redeemable or may become redeemable at a fixed or determinable price at the option of the holder or upon the occurrence of an event outside of the control of the Company are presented in mezzanine equity on the condensed consolidated balance sheets.

During the three months ended March 31, 2011, the Company sold a multi-specialty physician clinic and made the decision to sell a hospital. In June 2011, the Company entered into a definitive agreement to sell two of its hospitals in Oklahoma. As of June 30, 2011, the Company has three hospitals held for sale. The condensed consolidated statement of income for the three and six months ended June 30, 2010 has been restated to reclassify the results of operations for these entities to discontinued operations. The condensed consolidated balance sheet as of December 31, 2010 has been restated to present the long-lived assets of the disposal group as held for sale in other assets, net for comparative purposes with the June 30, 2011 presentation.

Throughout these notes to the condensed consolidated financial statements, Community Health Systems, Inc. (the Parent), and its consolidated subsidiaries are referred to on a collective basis as the Company. This drafting style is not meant to indicate that the publicly-traded Parent or any subsidiary of the Parent owns or operates any asset, business, or property. The hospitals, operations and businesses described in this filing are owned and operated, and management services provided, by distinct and indirect subsidiaries of Community Health Systems, Inc.

2. ACCOUNTING FOR STOCK-BASED COMPENSATION

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

The 2000 Plan allows for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code (IRC), as well as stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Prior to being amended in 2009, the 2000 Plan also allowed for the grant of phantom stock. Persons eligible to receive grants under the 2000 Plan include the Company s directors, officers, employees and consultants. To date, all options granted under the 2000 Plan have been nonqualified stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date. Options granted prior to 2005 have a 10-year contractual term, options granted in 2005 through 2007 have an eight-year contractual term and options granted in 2008 or later have a 10-year contractual term. As of June 30, 2011, 127,250 shares of unissued common stock were reserved for future grants under the 2000 Plan.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)

The 2009 Plan provides for the grant of incentive stock options intended to qualify under Section 422 of the IRC and for the grant of stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Persons eligible to receive grants under the 2009 Plan include the Company s directors, officers, employees and consultants. Options granted in 2011 have a 10-year contractual term. As of June 30, 2011, 2,897,129 shares of unissued common stock were reserved for future grants under the 2009 Plan.

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Effect on income from continuing operations before income taxes	$ (10,814)	$ (10,655)	$ (20,732)	$ (20,418)
Effect on net income	$ (6,867)	$ (6,473)	$ (13,165)	$ (12,404)

At June 30, 2011, $79.5 million of unrecognized stock-based compensation expense was expected to be recognized over a weighted-average period of 26 months. Of that amount, $17.2 million related to outstanding unvested stock options was expected to be recognized over a weighted-average period of 26 months and $62.3 million related to outstanding unvested restricted stock, restricted stock units and phantom shares was expected to be recognized over a weighted-average period of 26 months. There were no modifications to awards during the three and six months ended June 30, 2011.

The fair value of stock options was estimated using the Black Scholes option pricing model with the following assumptions and weighted-average fair values during the three and six months ended June 30, 2011 and 2010:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Expected volatility	38.1%	35.3%	31.5%	33.6%
Expected dividends				
Expected term	4 years	3 years	4 years	3.1 years
Risk-free interest rate	1.35%	1.20%	1.73%	1.47%

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

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

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

factors for each population identified. The Company adjusts the estimated forfeiture rate to its actual experience.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)

Options outstanding and exercisable under the 2000 Plan and the 2009 Plan as of June 30, 2011, and changes during each of the three-month periods following December 31, 2010, were as follows (in thousands, except share and per share data):

	Shares	Weighted - Average Exercise Price	Weighted - Average Remaining Contractual Term	Aggregate Intrinsic Value as of June 30, 2011
Outstanding at December 31, 2010	7,834,332	$ 32.08		
Granted	1,329,000	37.96		
Exercised	(595,431)	30.44		
Forfeited and cancelled	(64,508)	34.84		
Outstanding at March 31, 2011	8,503,393	33.10		
Granted	45,000	28.12		
Exercised	(23,579)	29.98		
Forfeited and cancelled	(50,342)	32.70		
Outstanding at June 30, 2011	8,474,472	$ 33.08	5.8 years	$ 9,910
Exercisable at June 30, 2011	5,804,556	$ 32.78	4.3 years	$ 7,468

The weighted-average grant date fair value of stock options granted during the three months ended June 30, 2011 and 2010 was $8.89 and $10.07, respectively, and $10.29 and $8.54 during the six months ended June 30, 2011 and 2010, respectively. The aggregate intrinsic value (the number of in-the-money stock options multiplied by the difference between the Company s closing stock price on the last trading day of the reporting period ($25.68) and the exercise price of the respective stock options) in the table above represents the amount that would have been received by the option holders had all option holders exercised their options on June 30, 2011. This amount changes based on the market value of the Company s common stock. The aggregate intrinsic value of options exercised during the three months ended June 30, 2011 and 2010 was $0.2 million and $18.6 million, respectively. The aggregate intrinsic value of options exercised during the six months ended June 30, 2011 and 2010 was $6.1 million and $28.2 million, respectively. The aggregate intrinsic value of options vested and expected to vest approximates that of the outstanding options.

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

for cause of the holder of the restricted stock, or change in control of the Company. Restricted stock awards subject to performance standards are not considered outstanding for purposes of determining earnings per share until the performance objectives have been satisfied.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)

Restricted stock outstanding under the 2000 Plan and the 2009 Plan as of June 30, 2011, and changes during each of the three-month periods following December 31, 2010, were as follows:

	Shares	Weighted - Average Grant Date Fair Value
Unvested at December 31, 2010	2,125,291	$ 27.92
Granted	1,084,949	37.96
Vested	(962,662)	27.27
Forfeited		
Unvested at March 31, 2011	2,247,578	33.04
Granted	8,000	28.12
Vested	(12,000)	33.49
Forfeited		
Unvested at June 30, 2011	2,243,578	33.02

On February 25, 2009, under the 2000 Plan, each of the Company s outside directors received a grant of shares of phantom stock equal in value to approximately $130,000 divided by the closing price of the Company s common stock on that date ($18.18), or 7,151 shares per director (a total of 42,906 shares of phantom stock). Pursuant to a March 24, 2009 amendment to the 2000 Plan, all subsequent grants of this type are denominated as restricted stock unit awards. On May 19, 2009, the newly elected outside director received a grant of 7,151 restricted stock units under the 2000 Plan, having a value at the time of $180,706 based upon the closing price of the Company s common stock on that date of $25.27. On February 24, 2010, six of the Company s seven outside directors each received a grant of 4,130 restricted stock units under the 2000 Plan, having a value at the time of approximately $140,000 based upon the closing price of the Company s common stock on that date of $33.90. One outside director, who did not stand for reelection in 2010, did not receive such a grant. On February 23, 2011, each of the Company s six outside directors received a grant of 3,688 restricted stock units under the 2009 Plan, having a value at the time of approximately $140,000 based upon the closing price of the Company s common stock on that date of $37.96. Vesting of these shares of phantom stock and restricted stock units occurs in one-third increments on each of the first three anniversaries of the award date. During the three months ended June 30, 2011, 2,384 shares vested at a weighted-average grant date fair value of $25.27. During the six months ended June 30, 2011, 22,560 shares vested at a weighted-average grant date fair value of $24.68. None of these grants were canceled during the three and six months ended June 30, 2011. As of June 30, 2011, there were 52,956 shares of phantom stock and restricted stock units unvested at a weighted-average grant date fair value of $31.67.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Directors fees earned and deferred into plan	$ 55	$ 45	$ 110	$ 90
Share equivalent units	2,142	1,331	3,517	2,549

At June 30, 2011, a total of 22,318 share equivalent units were deferred in the plan with an aggregate fair value of $0.6 million, based on the closing market price of the Company s common stock at June 30, 2011 of $25.68.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)

3. COST OF REVENUE

Substantially all of the Company s operating costs and expenses are cost of revenue items. Operating costs that could be classified as general and administrative by the Company would include the Company s corporate office costs at its Franklin, Tennessee office, which were $47.8 million and $42.4 million for the three months ended June 30, 2011 and 2010, respectively, and $89.5 million and $80.2 million for the six months ended June 30, 2011 and 2010, respectively. Included in these amounts is stock-based compensation expense of $10.8 million and $10.7 million for the three months ended June 30, 2011 and 2010, respectively, and $20.7 million and $20.4 million for the six months ended June 30, 2011 and 2010, respectively.

4. USE OF ESTIMATES

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements. Actual results could differ from these estimates under different assumptions or conditions.

5. ACQUISITIONS AND DIVESTITURES

Acquisitions

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

Effective May 1, 2011, one or more subsidiaries of the Company completed the acquisition of Mercy Health Partners based in Scranton, Pennsylvania, a healthcare system of two acute care hospitals, a long-term acute care facility and other healthcare providers. This healthcare system includes Regional Hospital of Scranton (198 licensed beds) located in Scranton, Pennsylvania, and Tyler Memorial Hospital (48 licensed beds) located in Tunkhannock, Pennsylvania. This healthcare system also includes a long-term acute care facility, Special Care Hospital (67 licensed beds) located in Nanticoke, Pennsylvania, as well as several outpatient clinics and other ancillary facilities. The total cash consideration paid for fixed assets was approximately $150.5 million, with additional consideration of $12.3 million assumed in liabilities as well as a credit applied at closing of $2.1 million for negative acquired working capital, for a total consideration of $160.7 million. Based upon the Company s preliminary purchase price allocation relating to this acquisition as of June 30, 2011, approximately $42.1 million of goodwill has been recorded. The preliminary allocation of the purchase price has been determined by the Company based on available information and is subject to settling amounts related to purchased working capital and final appraisals of tangible and intangible assets. Adjustments to the purchase price allocation are not expected to be material.

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

allocation relating to this acquisition as of June 30, 2011, approximately $8.1 million of goodwill has been recorded.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)

Effective October 1, 2010, one or more subsidiaries of the Company completed the acquisition of Bluefield Regional Medical Center (240 licensed beds) located in Bluefield, West Virginia. The total cash consideration paid for fixed assets was approximately $35.4 million, with additional consideration of $8.9 million assumed in liabilities as well as a credit applied at closing of $1.8 million for negative acquired working capital, for a total consideration of $42.5 million. Based upon the Company s final purchase price allocation relating to this acquisition as of June 30, 2011, approximately $2.4 million of goodwill has been recorded.

Effective July 7, 2010, one or more subsidiaries of the Company completed the acquisition of Marion Regional Healthcare System located in Marion, South Carolina. This healthcare system includes Marion Regional Hospital (124 licensed beds), an acute care hospital, along with a related skilled nursing facility and other ancillary services. The total cash consideration paid for fixed assets and working capital was approximately $18.6 million and $5.8 million, respectively, with additional consideration of $3.9 million assumed in liabilities, for a total consideration of $28.3 million. Based upon the Company s final purchase price allocation relating to this acquisition as of June 30, 2011, no goodwill has been recorded.

Additionally, during the six months ended June 30, 2011, the Company paid approximately $55.1 million to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by its hospitals. In connection with these acquisitions, the Company allocated approximately $14.7 million of the consideration paid to property and equipment, $3.4 million to net working capital, $1.5 million to other intangible assets, and the remainder, approximately $35.5 million consisting of intangible assets that do not qualify for separate recognition, was allocated to goodwill.

Approximately $5.3 million and $1.2 million of acquisition costs related to prospective and closed acquisitions were expensed during the three months ended June 30, 2011 and 2010, respectively, and $8.7 million and $1.8 million during the six months ended June 30, 2011 and 2010, respectively.

Discontinued Operations

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

In March 2011, the Company made the decision to sell one of its hospitals. In June 2011, the Company entered into a definitive agreement to sell two of its hospitals. Accordingly, these three hospitals are classified as held for sale at June 30, 2011.

The Company has classified the results of operations for OMG and the three hospitals held for sale as discontinued operations in the accompanying condensed consolidated statements of income for the three and six months ended June 30, 2011 and 2010.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Net operating revenues	$ 68,479	$ 90,378	$ 140,563	$ 182,448
Income (loss) from operations of entities sold and held for sale before income taxes	392	(3,232)	(2,280)	(1,994)
Impairment of hospitals held for sale	(38,600)		(51,695)	
Loss on sale			(5,061)	

Loss from discontinued operations, before taxes	(38,208)	(3,232)	(59,036)	(1,994)
Income tax expense (benefit)	1,119	(1,195)	(6,429)	(596)
Loss from discontinued operations, net of taxes	$ (39,327)	$ (2,037)	$ (52,607)	$ (1,398)

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

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The long-lived assets and allocated goodwill as of December 31, 2010 of the physician clinic sold during the quarter ended March 31, 2011 and the three hospitals classified as held for sale at June 30, 2011 totaled approximately $182.7 million, and are included in the accompanying condensed consolidated balance sheet in other assets, net.

The long-lived assets and allocated goodwill as of June 30, 2011 of the three hospitals held for sale, net of impairment, totaled approximately $122.6 million and are included in the accompanying condensed consolidated balance sheet in other assets, net.

6. INCOME TAXES

The total amount of unrecognized benefit that would affect the effective tax rate, if recognized, was approximately $7.7 million as of June 30, 2011. It is the Company s policy to recognize interest and penalties related to unrecognized benefits in its condensed consolidated statements of income as income tax expense. During the six months ended June 30, 2011, the Company increased liabilities by $0.1 million and increased interest and penalties by approximately $0.2 million. A total of approximately $1.5 million of interest and penalties is included in the amount of the liability for uncertain tax positions at June 30, 2011.

The Company believes that it is reasonably possible that approximately $2.3 million of its current unrecognized tax benefit may be recognized within the next 12 months as a result of a lapse of the statute of limitations and settlements with taxing authorities.

The Company, or one of its subsidiaries, files income tax returns in the U.S. federal jurisdiction and various state jurisdictions. The Company has extended the federal statute of limitations for Triad Hospitals, Inc. (Triad) for the tax periods ended December 31, 1999, December 31, 2000, April 30, 2001, June 30, 2001, December 31, 2001, December 31, 2002 and December 31, 2003. The Company is currently under examination by the Internal Revenue Service (IRS) regarding the federal tax return of Triad for the tax periods ended December 31, 2004, December 31, 2005, December 31, 2006 and July 25, 2007. The Company believes the results of this examination will not be material to its consolidated results of operations or consolidated financial position. With few exceptions, the Company is no longer subject to state income tax examinations for years prior to 2007 and federal income tax examinations with respect to Community Health Systems, Inc. federal returns for years prior to 2007. The Company s federal income tax returns for the 2007 and 2008 tax years are currently under examination by the IRS. The Company believes the results of this examination will not be material to its consolidated results of operations or consolidated financial position.

Cash paid for income taxes, net of refunds received, resulted in a net cash refund of $25.0 million and net cash paid of $78.8 million for the three months ended June 30, 2011 and June 30, 2010, respectively. Cash paid for income taxes, net of refunds received, resulted in a net cash refund of $25.7 million and net cash paid of $79.7 million for the six months ended June 30, 2011 and June 30, 2010, respectively.

7. GOODWILL AND OTHER INTANGIBLE ASSETS

The changes in the carrying amount of goodwill for the six months ended June 30, 2011, are as follows (in thousands):

Balance as of December 31, 2010 (as previously reported)	$ 4,199,905
Goodwill allocated to disposal and hospitals held for sale	(49,658)
Balance as of December 31, 2010 (as adjusted)	4,150,247
Goodwill acquired as part of acquisitions during 2011	77,760
Consideration adjustments and purchase price allocation adjustments for prior year s acquisitions	(37)
Balance as of June 30, 2011	$ 4,227,970

Goodwill is allocated to each identified reporting unit, which is defined as an operating segment or one level below the operating segment (referred to as a component of the entity). Management has determined that the Company s operating segments meet the criteria to be classified as reporting units. At June 30, 2011, the hospital operations

reporting unit, the home care agency operations reporting unit, and the hospital management services reporting unit had approximately $4.2 billion, $35.9 million and $33.3 million, respectively, of goodwill.

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Goodwill is evaluated for impairment at the same time every year and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. There is a two-step method for determining goodwill impairment. Step one is to compare the fair value of the reporting unit with the unit s carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit s goodwill with the carrying value of the reporting unit s goodwill. The Company has selected September 30 as its annual testing date. The Company performed its last annual goodwill evaluation as of September 30, 2010, which evaluation took place during the fourth quarter of 2010. No impairment was indicated by this evaluation.

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

The gross carrying amount of the Company s other intangible assets subject to amortization was $61.7 million at June 30, 2011 and $60.5 million at December 31, 2010, and the net carrying amount was $34.1 million at June 30, 2011 and $36.1 million at December 31, 2010. The carrying amount of the Company s other intangible assets not subject to amortization was $44.1 million and $44.4 million at June 30, 2011 and December 31, 2010, respectively. Other intangible assets are included in other assets, net on the Company s condensed consolidated balance sheets. Substantially all of the Company s intangible assets are contract-based intangible assets related to operating licenses, management contracts, or non-compete agreements entered into in connection with prior acquisitions.

The weighted-average amortization period for the intangible assets subject to amortization is approximately nine years. There are no expected residual values related to these intangible assets. Amortization expense on these intangible assets was $2.3 million and $3.1 million during the three months ended June 30, 2011 and 2010, respectively, and $4.2 million and $6.3 million during the six months ended June 30, 2011 and 2010, respectively. Amortization expense on intangible assets is estimated to be $3.9 million for the remainder of 2011, $7.1 million in 2012, $4.5 million in 2013, $2.9 million in 2014, $2.5 million in 2015 and $13.2 million in 2016 and thereafter.

The gross carrying amount of capitalized software for internal use was approximately $396.9 million and $356.5 million at June 30, 2011 and December 31, 2010, respectively, and the net carrying amount considering accumulated amortization was approximately $219.1 million and $209.4 million at June 30, 2011 and December 31, 2010, respectively. The estimated amortization period for capitalized internal-use software is generally three years, except for capitalized costs related to significant system conversions, which is generally eight years. There is no expected residual value for capitalized internal-use software. At June 30, 2011, there was approximately $76.6 million of capitalized costs for internal-use software that is currently in the development stage and will begin amortization once the software project is complete and ready for its intended use. Amortization expense on capitalized internal-use software was $16.7 million and $11.0 million during the three months ended June 30, 2011 and 2010, respectively, and $34.7 million and $20.2 million during the six months ended June 30, 2011 and 2010, respectively. Amortization expense on capitalized internal-use software is estimated to be $37.5 million for the remainder of 2011, $75.1 million in 2012, $45.1 million in 2013, $18.1 million in 2014, $15.7 million in 2015 and $27.6 million in 2016 and thereafter.

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8. EARNINGS PER SHARE

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Numerator:				
Income from continuing operations, net of taxes	$ 92,874	$ 88,379	$ 184,479	$ 172,736
Less: Income from continuing operations attributable to noncontrolling interests, net of taxes	18,158	16,313	35,159	31,332
Income from continuing operations attributable to Community Health Systems, Inc. common stockholders basic and diluted	$ 74,716	$ 72,066	$ 149,320	$ 141,404
Loss from discontinued operations, net of taxes	$ (39,327)	$ (2,037)	$ (52,607)	$ (1,398)
Less: Loss from discontinued operations attributable to noncontrolling interests, net of taxes		(36)		(66)
Loss from discontinued operations attributable to Community Health Systems, Inc. common stockholders basic and diluted	$ (39,327)	$ (2,001)	$ (52,607)	$ (1,332)
Denominator:				
Weighted-average number of shares outstanding basic	91,130,672	93,358,771	91,069,876	92,491,839
Effect of dilutive securities:				
Restricted stock awards	263,876	522,496	258,871	423,442
Employee stock options	381,632	815,455	623,662	847,380
Other equity-based awards	7,545	15,197	8,201	16,340
Weighted-average number of shares outstanding diluted	91,783,725	94,711,919	91,960,610	93,779,001

Dilutive securities outstanding not included in the computation of earnings per share because their effect is

antidilutive:

Employee stock options	6,726,417	3,503,906	5,560,855	4,432,069

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9. STOCKHOLDERS EQUITY

Authorized capital shares of the Company include 400,000,000 shares of capital stock consisting of 300,000,000 shares of common stock and 100,000,000 shares of preferred stock. Each of the aforementioned classes of capital stock has a par value of $0.01 per share. Shares of preferred stock, none of which were outstanding as of June 30, 2011, may be issued in one or more series having such rights, preferences and other provisions as determined by the Board of Directors without approval by the holders of common stock.

On September 15, 2010, the Company commenced a new open market repurchase program for up to 4,000,000 shares of the Company s common stock, not to exceed $100 million in repurchases. 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 and six months ended June 30, 2011, the Company repurchased and retired 1,763,566 shares at a weighted-average price of $28.31 under this program. The cumulative number of shares that have been repurchased and retired under this program through June 30, 2011 is 2,214,838 shares at a weighted-average price of $28.82 per share.

On December 9, 2009, the Company commenced the predecessor open market repurchase program for up to 3,000,000 shares of the Company s common stock, not to exceed $100 million in repurchases. This program concluded in September 2010 when purchases approximated the total permitted maximum dollar amount allowed under the program. During the three and six months ended June 30, 2010, the Company repurchased and retired 356,000 shares at a weighted-average price of $34.24 under this program. During the year ended December 31, 2010, the Company repurchased and retired 2,964,528 shares, which is the cumulative number of shares that were repurchased under this program, at a weighted-average price of $33.69 per share.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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The following schedule presents the reconciliation of the carrying amount of total equity, equity attributable to the Company, and equity attributable to the noncontrolling interests for the six-month period ended June 30, 2011 (in thousands):

		Community Health Systems, Inc. Stockholders						
	Redeemable Noncontrolling Interests	Common Stock	Additional Paid-in Capital	Treasury Stock	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Noncontrolling Interests	Total Stockholders Equity
Balance, December 31, 2010	$ 387,472	$ 936	$ 1,126,751	$ (6,678)	$ (230,927)	$ 1,299,382	$ 60,913	$ 2,250,377
Comprehensive income:								
Net income	25,211					96,713	9,948	106,661
Net change in fair value of interest rate swaps					27,477			27,477
Net change in fair value of available-for-sale securities					1,338			1,338
Amortization and recognition of unrecognized pension cost components					1,579			1,579
Total comprehensive income	25,211				30,394	96,713	9,948	137,055
Distributions to noncontrolling interests, net of contributions	(19,387)						(9,828)	(9,828)
Purchase of subsidiary shares from noncontrolling interests	(2,792)		(498)					(498)
Other reclassifications of noncontrolling interests	(2,004)						272	272
Adjustment to redemption value of redeemable noncontrolling interests	(11,842)		11,842					11,842
Repurchases of common stock		(18)	(50,002)					(50,020)
Issuance of common stock in connection with the exercise of stock options		6	18,831					18,837
Cancellation of restricted stock for tax withholdings on vested shares		(3)	(13,110)					(13,113)
Excess tax benefit from exercise of stock options			4,659					4,659
Share-based compensation		11	20,732					20,743
Balance, June 30, 2011	$ 376,658	$ 932	$ 1,119,205	$ (6,678)	$ (200,533)	$ 1,396,095	$ 61,305	$ 2,370,326

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

	Six Months Ended June 30, 2011
Net income attributable to Community Health Systems, Inc.	$ 96,713
Transfers to the noncontrolling interests:	
Net decrease in Community Health Systems, Inc. paid-in capital for purchase of subsidiary partnership interests	(498)
Net transfers to the noncontrolling interests	(498)
Change to Community Health Systems, Inc. stockholders equity from net income attributable to Community Health Systems, Inc. and transfers to noncontrolling interests	$ 96,215

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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10. COMPREHENSIVE INCOME

The following table presents the components of comprehensive income, net of related taxes (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Net income	$ 53,547	$ 86,342	$ 131,872	$ 171,338
Net change in fair value of interest rate swaps	(8,969)	(33,694)	27,477	(45,051)
Net change in fair value of available-for-sale securities	268	476	1,338	630
Amortization and recognition of unrecognized pension cost components	807	758	1,579	5,233
Comprehensive income	45,653	53,882	162,266	132,150
Less: Comprehensive income attributable to noncontrolling interests	18,158	16,277	35,159	31,266
Comprehensive income attributable to Community Health Systems, Inc.	$ 27,495	$ 37,605	$ 127,107	$ 100,884

The net change in fair value of the interest rate swaps, the net change in fair value of available-for-sale securities and the amortization and recognition of unrecognized pension cost components are included in accumulated other comprehensive loss on the accompanying condensed consolidated balance sheets.

11. EQUITY INVESTMENTS

As of June 30, 2011, the Company owned equity interests of 27.5% in four hospitals in Las Vegas, Nevada, and 26.1% in one hospital in Las Vegas, Nevada, in which Universal Health Systems, Inc. owns the majority interest, and an equity interest of 38.0% in three hospitals in Macon, Georgia, in which HCA Inc. owns the majority interest.

Summarized combined financial information for the three and six months ended June 30, 2011 and 2010, for these unconsolidated entities in which the Company owns an equity interest is as follows (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Revenues	$373,448	$358,586	$746,039	$716,065
Operating costs and expenses	334,765	321,457	652,752	645,977
Income from continuing operations before taxes	38,652	37,113	93,236	70,045

The summarized financial information for the three and six months ended June 30, 2011 and 2010 was derived from the unaudited financial information provided to the Company by those unconsolidated entities.

The Company s investment in all of its unconsolidated affiliates was $421.0 million and $409.5 million at June 30, 2011 and December 31, 2010, respectively, and is included in other assets, net in the accompanying condensed consolidated balance sheets. Included in the Company s results of operations is the Company s equity in pre-tax earnings from all of its investments in unconsolidated affiliates, which was $12.0 million and $11.0 million for the three months ended June 30, 2011 and 2010, respectively, and $30.2 million and $23.6 million for the six months ended June 30, 2011 and 2010, respectively.

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12. LONG-TERM DEBT

Credit Facility and Notes

In connection with the consummation of the acquisition of Triad in July 2007, the Company s wholly-owned subsidiary CHS/Community Health Systems, Inc. (CHS) obtained approximately $7.2 billion of senior secured financing under a new credit facility (the Credit Facility) with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent, and issued approximately $3.0 billion aggregate principal amount of 8.875% senior notes due 2015 (the Notes). The Company used the net proceeds of $3.0 billion from the Notes offering and the net proceeds of approximately $6.1 billion of term loans under the Credit Facility to acquire the outstanding shares of Triad, to refinance certain of Triad s indebtedness and the Company s indebtedness, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. Specifically, the Company repaid its outstanding debt under the previously outstanding credit facility, the 6.50% senior subordinated notes due 2012 and certain of Triad s existing indebtedness.

The Credit Facility consisted of an approximately $6.1 billion funded term loan facility with a maturity of seven years, a $400 million delayed draw term loan facility with a maturity of seven years and a $750 million revolving credit facility with a maturity of six years. As of December 31, 2007, the $400 million delayed draw term loan facility had been reduced to $300 million at the request of CHS. During the fourth quarter of 2008, $100 million of the delayed draw term loan was drawn by CHS, reducing the delayed draw term loan availability to $200 million at December 31, 2008. In January 2009, CHS drew down the remaining $200 million of the delayed draw term loan. The revolving credit facility also includes a subfacility for letters of credit and a swingline subfacility. The Credit Facility requires quarterly amortization payments of each term loan facility equal to 0.25% of the outstanding amount of the term loans. On November 5, 2010, CHS entered into an amendment and restatement of its existing Credit Facility. The amendment 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 the 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 CHS s ability to issue additional indebtedness under the uncommitted incremental facility to $1.0 billion from $600 million, permits CHS to issue Term A term loans under the incremental facility, and provides up to $2.0 billion of borrowing capacity from receivable transactions, an increase of $0.5 billion, of which $1.7 billion would be required to be used for repayment of existing term loans.

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

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

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

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

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

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

The Notes were issued by CHS in connection with the Triad acquisition in the principal amount of approximately $3.0 billion. The Notes will mature on July 15, 2015. The Notes bear interest at the rate of 8.875% per annum, payable semiannually in arrears on January 15 and July 15, commencing January 15, 2008. Interest on the Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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Except as set forth below, CHS is not entitled to redeem the Notes prior to July 15, 2011.

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

Period	Redemption Price
2011	104.438%
2012	102.219%
2013 and thereafter	100.000%

CHS is entitled, at its option, to redeem the Notes, in whole or in part, at any time prior to July 15, 2011, upon not less than 30 or more than 60 days notice, at a redemption price equal to 100% of the principal amount of Notes redeemed plus the Applicable Premium (as defined), and accrued and unpaid interest, if any, as of the applicable redemption date.

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

As of June 30, 2011, the availability for additional borrowings under the Credit Facility was $750 million pursuant to the revolving credit facility, of which $37.9 million was set aside for outstanding letters of credit. CHS has the ability to amend the Credit Facility to provide for one or more tranches of term loans in an aggregate principal amount of $1.0 billion, which CHS has not yet accessed. CHS also has the ability to add up to $300 million of borrowing capacity from receivable transactions (including securitizations) under the Credit Facility, which has not yet been accessed. As of June 30, 2011, the weighted-average interest rate under the Credit Facility, excluding swaps, was 3.2%.

The Company paid interest of $101.6 million and $99.9 million on borrowings during the three months ended June 30, 2011 and 2010, respectively, and $327.7 million and $320.2 million for the six months ended June 30, 2011 and 2010, respectively.

13. FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Company using available market information as of June 30, 2011 and December 31, 2010, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Company could realize in a current market exchange (in thousands):

	June 30, 2011		December 31, 2010	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Assets:				
Cash and cash equivalents	$ 191,432	$ 191,432	$ 299,169	$ 299,169
Available-for-sale securities	33,097	33,097	31,570	31,570
Trading securities	38,709	38,709	35,092	35,092
Liabilities:				

Credit Facility	5,974,321	5,806,274	5,999,337	5,882,124
Senior notes	2,784,331	2,846,978	2,784,331	2,923,548
Other debt	43,478	43,478	36,122	36,122

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

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

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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Trading securities. Estimated fair value is based on closing price as quoted in public markets.

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

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

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

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

The Company assesses the effectiveness of its hedge instruments on a quarterly basis. For the three and six months ended June 30, 2011 and 2010, the Company completed an assessment of the cash flow hedge instruments and determined the hedges to be highly effective. The Company has also determined that the ineffective portion of the hedges do not have a material effect on the Company s consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements expose the Company to credit risk in the event of nonperformance. However, at June 30, 2011, each swap agreement entered into by the Company was in a net liability position so that the Company would be required to make the net settlement payments to the counterparties; the Company does not anticipate nonperformance by those counterparties. The Company does not hold or issue derivative financial instruments for trading purposes.

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Interest rate swaps consisted of the following at June 30, 2011:

Swap #	Notional Amount (in 000 s)	Fixed Interest Rate	Termination Date	Fair Value (in 000 s)
1	$300,000	5.1140%	August 8, 2011	$ 1,533
2	100,000	4.7185%	August 19, 2011	605
3	100,000	4.7040%	August 19, 2011	603
4	100,000	4.6250%	August 19, 2011	592
5	200,000	4.9300%	August 30, 2011	1,551
6	200,000	3.0920%	September 18, 2011	1,248
7	100,000	3.0230%	October 23, 2011	869
8	200,000	4.4815%	October 26, 2011	2,712
9	200,000	4.0840%	December 3, 2011	3,279
10	100,000	3.8470%	January 4, 2012	1,822
11	100,000	3.8510%	January 4, 2012	1,824
12	100,000	3.8560%	January 4, 2012	1,826
13	200,000	3.7260%	January 8, 2012	3,610
14	200,000	3.5065%	January 16, 2012	3,514
15	250,000	5.0185%	May 30, 2012	10,654
16	150,000	5.0250%	May 30, 2012	6,401
17	200,000	4.6845%	September 11, 2012	10,208
18	100,000	3.3520%	October 23, 2012	3,798
19	125,000	4.3745%	November 23, 2012	6,794
20	75,000	4.3800%	November 23, 2012	4,082
21	150,000	5.0200%	November 30, 2012	9,618
22	200,000	2.2420%	February 28, 2013	5,561
23	100,000	5.0230%	May 30, 2013	8,262
24	300,000	5.2420%	August 6, 2013	27,964
25	100,000	5.0380%	August 30, 2013	9,101
26	50,000	3.5860%	October 23, 2013	3,130
27	50,000	3.5240%	October 23, 2013	3,063
28	100,000	5.0500%	November 30, 2013	9,857
29	200,000	2.0700%	December 19, 2013	5,715
30	100,000	5.2310%	July 25, 2014	11,994
31	100,000	5.2310%	July 25, 2014	11,998
32	200,000	5.1600%	July 25, 2014	23,584
33	75,000	5.0405%	July 25, 2014	8,571
34	125,000	5.0215%	July 25, 2014	14,218
35	100,000	2.6210%	July 25, 2014	4,349
36	100,000	3.1100%	July 25, 2014	5,788
37	100,000	3.2580%	July 25, 2014	6,222
38	200,000	2.6930%	October 26, 2014	7,504 (1)
39	300,000	3.4470%	August 8, 2016	18,662 (2)
40	200,000	3.4285%	August 19, 2016	12,096 (3)
41	100,000	3.4010%	August 19, 2016	6,019 (4)
42	200,000	3.5000%	August 30, 2016	12,529 (5)

43	100,000	3.0050%	November 30, 2016	4,196

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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(1) This interest rate swap becomes effective October 26, 2011, concurrent with the termination of swap #8.

(2) This interest rate swap becomes effective August 8, 2011, concurrent with the termination of swap #1.

(3) This interest rate swap becomes effective August 19, 2011, concurrent with the termination of swaps #2 and #4.

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

(5) This interest rate swap becomes effective August 30, 2011, concurrent with the termination of swap #5.

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

Assuming no change in June 30, 2011 interest rates, approximately $176.7 million of interest expense resulting from the spread between the fixed and floating rates defined in each interest rate swap agreement will be recognized during the next 12 months. If interest rate swaps do not remain highly effective as a cash flow hedge, the derivatives gains or losses resulting from the change in fair value reported through OCI will be reclassified into earnings.

The following tabular disclosure provides the amount of pre-tax loss recognized in the condensed consolidated balance sheets as a component of OCI during the three and six months ended June 30, 2011 and 2010 (in thousands):

Derivatives in Cash Flow Hedging Relationships	Amount of Pre-Tax Loss Recognized in OCI on Derivative (Effective Portion)			
	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Interest rate swaps	$ (67,685)	$ (107,656)	$ (63,572)	$ (178,564)

The following tabular disclosure provides the location of the effective portion of the pre-tax loss reclassified from accumulated other comprehensive loss (AOCL) into interest expense on the condensed consolidated statements of income during the three and six months ended June 30, 2011 and 2010 (in thousands):

Location of Loss Reclassified from AOCL into Income (Effective Portion)	Amount of Pre-Tax Loss Reclassified from AOCL into Income (Effective Portion)			
	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Interest expense, net	$ 53,649	$ 55,009	$ 106,573	$ 108,173

The fair values of derivative instruments in the condensed consolidated balance sheets as of June 30, 2011 and December 31, 2010 were as follows (in thousands):

	Asset Derivatives		Liability Derivatives	

	June 30, 2011		December 31, 2010		June 30, 2011		December 31, 2010	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives designated as hedging instruments	Other assets, net	$	Other assets, net	$ 22	Other long-term liabilities	$297,526	Other long-term liabilities	$340,526

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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14. FAIR VALUE

Fair Value Hierarchy

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

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

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

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

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

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

The following table sets forth, by level within the fair value hierarchy, the financial assets and liabilities recorded at fair value on a recurring basis as of June 30, 2011 and December 31, 2010 (in thousands):

	June 30, 2011	Level 1	Level 2	Level 3
Available-for-sale securities	$ 33,097	$ 33,097	$	$
Trading securities	38,709	38,709		
Total assets	$ 71,806	$ 71,806	$	$
Fair value of interest rate swap agreements	$ 297,526	$	$ 297,526	$
Total liabilities	$ 297,526	$	$ 297,526	$

	December 31, 2010	Level 1	Level 2	Level 3
Available-for-sale securities	$ 31,570	$ 31,570	$	$
Trading securities	35,092	35,092		
Total assets	$ 66,662	$ 66,662	$	$

Fair value of interest rate swap agreements	$	340,526	$		$ 340,526	$
Total liabilities	$	340,526	$		$ 340,526	$

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)

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

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

The Company incorporates CVAs to appropriately reflect both its own nonperformance or credit risk and the respective counterparty s nonperformance or credit risk in the fair value measurements. In adjusting the fair value of its interest rate swap agreements for the effect of nonperformance or credit risk, the Company has considered the impact of any netting features included in the agreements. The CVA on the Company s interest rate swap agreements at June 30, 2011 resulted in a decrease in the fair value of the related liability of $11.6 million and an after-tax adjustment of $7.4 million to OCI. The CVA on the Company s interest rate swap agreements at December 31, 2010 resulted in a decrease in the fair value of the related liability of $3.9 million and an after-tax adjustment of $2.5 million to OCI.

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

The following table sets forth, by level within the fair value hierarchy, the assets recorded at fair value on a nonrecurring basis as of June 30, 2011 (in thousands):

	June 30, 2011	Level 1	Level 2	Level 3
Hospitals held for sale	$ 122,632	$	$	$ 122,632
Total	$ 122,632	$	$	$ 122,632

During the six months ended June 30, 2011, the Company made the decision to sell three of its hospitals. The carrying value of these hospitals held for sale, including an allocation of $45.3 million of reporting unit goodwill, was adjusted to the fair value, which equals the price in the definitive sale agreements less costs to sell, resulting in an after-tax impairment charge of $47.9 million.

15. RECENT ACCOUNTING PRONOUNCEMENTS

In August 2010, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2010-24, which provides clarification to companies in the healthcare industry on the accounting for professional liability insurance. This ASU states that receivables related to insurance recoveries should not be netted against the related claim liability and such claim liabilities should be determined without considering insurance recoveries. This ASU is effective for fiscal years beginning after December 15, 2010 and was adopted by the Company on January 1, 2011. The adoption of this ASU increased other current assets by $2.5 million, other assets, net by $41.1 million and long-term liabilities by $43.6 million in the condensed consolidated balance sheet at June 30, 2011 and had no impact to the condensed consolidated statement of income for the three and six months ended June 30, 2011.

In August 2010, the FASB issued ASU 2010-23, which requires a company in the healthcare industry to use its direct and indirect costs of providing charity care as the measurement basis for charity care disclosures. This ASU also requires additional disclosures of the method used to determine such costs. The Company adopted this ASU on January 1, 2011. In the ordinary course of business, the Company renders services to patients who are financially

unable to pay for hospital care. Included in the provision for contractual allowances is the value (at the Company s standard charges) of these services to patients who are unable to pay that is eliminated from net operating revenues when it is determined they qualify under the Company s charity care policy. The estimated cost incurred by the Company to provide these services to patients who are unable to pay was approximately $28.0 million and $25.3 million for the three months ended June 30, 2011 and 2010, respectively, and $54.1 million and $50.8 million for the six months ended June 30, 2011 and 2010, respectively. The estimated cost of these charity care services was determined using a ratio of cost to gross charges and applying that ratio to the gross charges associated with providing care to charity patients for the period. Gross charges associated with providing care to charity patients includes only the related charges for those patients who are financially unable to pay and qualify under the Company s charity care policy and that do not otherwise qualify for reimbursement from a governmental program.

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In July 2011, the FASB issued ASU 2011-07, which requires healthcare organizations that perform services for patients for which the ultimate collection of all or a portion of the amounts billed or billable cannot be determined at the time services are rendered to present all bad debt expense associated with patient service revenue as an offset to the patient service revenue line item in the statement of operations. The ASU also requires qualitative disclosures about the Company s policy for recognizing revenue and bad debt expense for patient service transactions and quantitative information about the effects of changes in the assessment of collectibility of patient service revenue. This ASU is effective for fiscal years beginning after December 15, 2011, and will be adopted by the Company in the first quarter of 2012. The Company is currently assessing the potential impact the adoption of this ASU will have on its consolidated results of operations and consolidated financial position.

16. SEGMENT INFORMATION

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

The distribution between reportable segments of the Company s revenues and income from continuing operations before income taxes is summarized in the following tables (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Revenues:				
Hospital operations	$ 3,361,706	$ 3,018,147	$ 6,646,174	$ 6,018,587
Corporate and all other	72,123	62,499	141,707	130,671
Total	$ 3,433,829	$ 3,080,646	$ 6,787,881	$ 6,149,258
Income from continuing operations before income taxes:				
Hospital operations	$ 184,426	$ 171,711	$ 362,539	$ 331,010
Corporate and all other	(46,731)	(40,571)	(89,147)	(75,964)
Total	$ 137,695	$ 131,140	$ 273,392	$ 255,046

17. CONTINGENCIES

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

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Reasonably Possible Contingencies

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

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

On June 12, 2008, two of the Company s hospitals received letters from the U.S. Attorney s Office for the Western District of New York requesting documents in an investigation it is 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 the Company s 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. The Company has been informed that similar investigations have been initiated at unaffiliated facilities in Alabama, South Carolina, Indiana and other states. The Company believes 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. The Company is cooperating with the investigation by collecting and producing material responsive to the requests. The Company is continuing to evaluate and discuss this matter with the federal government.

Matters for which an Outcome Cannot be Assessed

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

On April 8, 2011, the Company received a document subpoena, dated March 31, 2011, from the U.S. Department of Health and Human Services, Office of Inspector General (the OIG), in connection with an investigation of possible improper claims submitted to Medicare and Medicaid. The subpoena, issued from the OIG s Chicago, Illinois office, requested documents from all of the Company s hospitals and appears to concern emergency department processes and procedures, including the Company s hospitals use of the Pro-MED Clinical Information System, which is a third-party software system that assists with the management of patient care and provides operational support and data collection for emergency department management and has the ability to track discharge,

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transfer and admission recommendations of emergency department physicians. The subpoena also requested other information about the Company s relationships with emergency department physicians, including financial arrangements. The subpoena s requests were very similar to those contained in the Civil Investigative Demands received by the Company s Texas hospitals from the Office of the Attorney General of the State of Texas on November 15, 2010. The Company is continuing to cooperate with the government in this investigation.

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

On April 22, 2011, a joint motion was filed by the relator and the U.S. Department of Justice in the case styled United States ex rel. and Reuille vs. Community Health Systems Professional Services Corporation and Lutheran Musculoskeletal Center, LLC d/b/a Lutheran Hospital, in the United States District Court for the Northern District of Indiana, Fort Wayne Division. The lawsuit was originally filed under seal on January 7, 2009. The suit is brought under the False Claims Act and alleges that Lutheran Hospital of Indiana billed the Medicare program for (a) false 23 hour observation after outpatient surgeries and procedures, and (b) intentional assignment of inpatient status to one-day stays for cases that do not meet Medicare criteria for inpatient intensity of service or severity of illness. The relator had worked in the case management department of Lutheran Hospital of Indiana but was reassigned to another department in the fall of 2006. This facility was acquired by the Company as part of the July 25, 2007 merger transaction with Triad. The complaint also includes allegations of age discrimination in Ms. Reuille s 2006 reassignment and retaliation in connection with her resignation on October 1, 2008. The Company had cooperated fully with the government in its investigation of this matter, but had been unaware of the exact nature of the allegations in the complaint. On December 27, 2010, the government filed a notice that it declined to intervene in this suit. The motion contained additional information about how the government intended to proceed with an investigation regarding allegations of improper billing for inpatient care at other hospitals associated with Community Health Systems, Inc. . . . asserted in other qui tam complaints in other jurisdictions. The motion stated that the Department of Justice has consolidated its investigations of the Company and other related entities and that the Civil Division of the Department of Justice, multiple United States Attorneys offices, and the Office of Inspector General for the Department of Health and Human Services (the HHS) are now closely coordinating their investigation of these overlapping allegations. The Attorney General of Texas has initiated an investigation; the United States intends to work cooperatively with Texas and any other States investigating these allegations. The motion also stated that the Office of Audit Services for the Office of Investigations for HHS has been engaged to conduct a national audit of certain of the Company s Medicare claims. The government confirmed that it considers the allegations made in the complaint styled Tenet Healthcare Corporation vs. Community Health Systems, Inc., et al. filed in the United States District Court for the Northern District of Texas, Dallas Division on April 11, 2011 to be related to the allegations in the qui tam and to what the government is now describing as a consolidated investigation. Because qui tam suits are filed under seal, no one but the relator and the government knows that the suit has been filed or what allegations are being made by the relator on behalf of the government. Initially, the government has 60 days to make a determination about whether to intervene in a case and to act as the plaintiff or to decline to intervene and allow the relator to act as the plaintiff in the suit, but extensions of time are frequently granted to allow the government additional time to investigate the allegations. Even if, in the course of an investigation, the court partially unseals a complaint to allow

the government and a defendant to work to a resolution of the complaint s allegations, the defendant is prohibited from revealing to anyone even that the partial unsealing has occurred. As the investigation proceeds, the Company may learn of additional qui tam suits filed against the Company or its affiliated hospitals or related entities, or that contact letters, document requests, or medical record requests the Company has received in the past from various governmental agencies are generated from qui tam cases filed under seal. The motion filed on April 22, 2011 concluded by requesting a stay of the litigation in the Reuille case for 180 days, and on April 25, 2011, the court granted the motion. The Company s management company subsidiary, Community Health Systems Professional Services Corporation, the defendant in the Reuille case, consented to the request for the stay. The Company is cooperating fully with the government in its investigations.

Three purported class action shareholder federal securities cases have been filed in the United States District Court for the Middle District of Tennessee namely, Norfolk County Retirement System v. Community Health Systems, Inc., Wayne T.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)

Smith and W. Larry Cash, filed May 5, 2011; De Zheng v. Community Health Systems, Inc., Wayne T. Smith and W. Larry Cash, filed May 12, 2011; and Minneapolis Firefighters Relief Association v. Community Health Systems, Inc., Wayne T. Smith, W. Larry Cash and Thomas Mark Buford, filed June 2, 2011. All three seek class certification on behalf of purchasers of the Company s common stock between July 27, 2006 and April 11, 2011 and allege that misleading statements resulted in artificially inflated prices for the Company s common stock. Two shareholder derivative actions have also been filed in the United States District Court for the Middle District of Tennessee; Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund v. Wayne T. Smith, W. Larry Cash, T. Mark Buford, John A. Clerico, James S. Ely III, John A. Fry, William Norris Jennings, Julia B. North and H. Mitchell Watson, Jr., filed May 24, 2011, and Roofers Local No. 149 Pension Fund v. Wayne T. Smith, W. Larry Cash, John A. Clerico, James S. Ely, III, John A. Fry, William Norris Jennings, Julia B. North and H. Mitchell Watson, Jr., filed June 21, 2011. These two cases allege breach of fiduciary duty arising out of allegedly improper inpatient admission practices, mismanagement, waste and unjust enrichment. The Company believes all of these matters are without merit and will vigorously defend them.

The Company incurred the following pre-tax charges in connection with the Tenet acquisition lawsuit, government investigations and shareholder lawsuits of possible improper claims submitted to Medicare and Medicaid during the three and six months ending June 30, 2011 and 2010 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Professional fees and other related costs	$ 6,174	$	$ 6,174	$

18. SUBSEQUENT EVENTS

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

In July 2011, one or more subsidiaries of the Company entered into a definitive agreement to acquire substantially all of the assets of Moses Taylor Health Care System, located in northeast Pennsylvania. This healthcare system includes Moses Taylor Hospital in Scranton, Pennsylvania (217 licensed beds) and Mid-Valley Hospital in Peckville, Pennsylvania (25 licensed beds). The transaction, subject to customary federal and state regulatory approvals including review and approval by the Attorney General of the Commonwealth of Pennsylvania, is expected to be completed in late 2011 or early 2012. Also in July 2011, one or more subsidiaries of the Company entered into a definitive agreement to acquire substantially all of the assets of Tomball Regional Medical Center (357 licensed beds), located in Tomball, Texas and serving the greater northwest Houston market. The transaction, subject to customary federal and state regulatory approvals, is expected to be completed in 2011.

19. SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION

In connection with the consummation of the Triad acquisition, CHS obtained approximately $7.2 billion of senior secured financing under the Credit Facility and issued the Notes in the aggregate principal amount of approximately $3.0 billion. The Notes are senior unsecured obligations of CHS and are guaranteed on a senior basis by the Company and by certain of its existing and subsequently acquired or organized 100% owned domestic subsidiaries.

The Notes are fully and unconditionally guaranteed on a joint and several basis. The following condensed consolidating financial statements present Community Health Systems, Inc. (as parent guarantor), CHS (as the issuer), the subsidiary guarantors, the subsidiary non-guarantors and eliminations. These condensed consolidating financial statements have been prepared and presented in accordance with SEC Regulation S-X Rule 3-10 Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered.

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

Intercompany receivables and payables are presented gross in the supplemental consolidating balance sheets.

Cash flows from intercompany transactions are presented in cash flows from financing activities, as changes in intercompany balances with affiliates, net.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)

Income tax expense is allocated from the parent guarantor to the income producing operations (other guarantors and non-guarantors) and the issuer through stockholders equity. As this approach represents an allocation, the income tax expense allocation is considered non-cash for statement of cash flow purposes.

Interest expense, net has been presented to reflect net interest expense and interest income from outstanding long-term debt and intercompany balances.

The Company s intercompany activity consists primarily of daily cash transfers for purposes of cash management, the allocation of certain expenses and expenditures paid for by the parent on behalf of its subsidiaries, and the push down of investment in its subsidiaries. The Company s subsidiaries generally do not purchase services from each other; thus, the intercompany transactions do not represent revenue generating transactions. All intercompany transactions eliminate in consolidation.

From time to time, the Company sells and/or repurchases noncontrolling interests in consolidated subsidiaries, which may change subsidiaries between guarantors and non-guarantors. Amounts for prior periods are restated to reflect the status of guarantors or non-guarantors as of June 30, 2011.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)
Condensed Consolidating Balance Sheet
June 30, 2011

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
ASSETS						
Current assets:						
Cash and cash equivalents	$	$	$ 80,552	$ 110,880	$	$ 191,432
Patient accounts receivable, net of allowance for doubtful accounts			1,043,386	749,018		1,792,404
Supplies			212,873	129,395		342,268
Deferred income taxes	115,819					115,819
Prepaid expenses and taxes		17	85,760	31,681		117,458
Other current assets			110,501	64,608		175,109
Total current assets	115,819	17	1,533,072	1,085,582		2,734,490
Intercompany receivable	1,190,786	9,441,127	1,438,751	1,534,314	(13,604,978)	
Property and equipment, net			4,069,371	2,437,053		6,506,424
Goodwill			2,380,891	1,847,079		4,227,970
Other assets, net of accumulated amortization		117,845	594,289	644,397		1,356,531
Net investment in subsidiaries	1,637,169	5,856,743	2,306,109		(9,800,021)	
Total assets	$ 2,943,774	$ 15,415,732	$ 12,322,483	$ 7,548,425	$ (23,404,999)	$ 14,825,415
LIABILITIES AND EQUITY						
Current liabilities:						
Current maturities of long-term debt	$	$ 49,954	$ 17,073	$ 3,085	$	$ 70,112
Accounts payable		40	402,806	181,078		583,924
Current income tax payable	349					349
Deferred income taxes	8,882					8,882
Accrued interest		145,034	111	1		145,146
Accrued liabilities	7,580	567	576,614	269,568		854,329
Total current liabilities	16,811	195,595	996,604	453,732		1,662,742
Long-term debt		8,709,456	46,194	25,793		8,781,443
Intercompany payable		4,575,989	8,923,510	5,979,987	(19,479,486)	

Deferred income taxes	608,177					608,177
Other long-term liabilities	9,765	297,525	401,585	317,194		1,026,069
Total liabilities	634,753	13,778,565	10,367,893	6,776,706	(19,479,486)	12,078,431
Redeemable noncontrolling interests in equity of consolidated subsidiaries				376,658		376,658
Equity:						
Community Health Systems, Inc. stockholders equity:						
Preferred stock						
Common stock	932		1	2	(3)	932
Additional paid-in capital	1,119,205	663,410	709,243	120,485	(1,493,138)	1,119,205
Treasury stock, at cost	(6,678)					(6,678)
Accumulated other comprehensive (loss) income	(200,533)	(200,533)	(10,074)		210,607	(200,533)
Retained earnings	1,396,095	1,174,290	1,255,420	213,269	(2,642,979)	1,396,095
Total Community Health Systems, Inc. stockholders equity	2,309,021	1,637,167	1,954,590	333,756	(3,925,513)	2,309,021
Noncontrolling interests in equity of consolidated subsidiaries				61,305		61,305
Total equity	2,309,021	1,637,167	1,954,590	395,061	(3,925,513)	2,370,326
Total liabilities and equity	$ 2,943,774	$ 15,415,732	$ 12,322,483	$ 7,548,425	$ (23,404,999)	$ 14,825,415

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)
Condensed Consolidating Balance Sheet
December 31, 2010

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
ASSETS						
Current assets:						
Cash and cash equivalents	$	$	$ 212,035	$ 87,134	$	$ 299,169
Patient accounts receivable, net of allowance for doubtful accounts			971,220	743,322		1,714,542
Supplies			196,957	132,157		329,114
Deferred income taxes	115,819					115,819
Prepaid expenses and taxes	118,464	116	89,172	11,466		219,218
Other current assets		41	138,923	54,367		193,331
Total current assets	234,283	157	1,608,307	1,028,446		2,871,193
Intercompany receivable	1,079,295	9,002,158	1,145,185	1,484,130	(12,710,768)	
Property and equipment, net			3,816,098	2,508,339		6,324,437
Goodwill			2,331,452	1,818,795		4,150,247
Other assets, net of accumulated amortization		131,352	625,472	595,422		1,352,246
Net investment in subsidiaries	1,510,062	5,315,871	2,061,532		(8,887,465)	
Total assets	$ 2,823,640	$ 14,449,538	$ 11,588,046	$ 7,435,132	$ (21,598,233)	$ 14,698,123
LIABILITIES AND EQUITY						
Current liabilities:						
Current maturities of long-term debt	$	$ 49,953	$ 11,063	$ 2,123	$	$ 63,139
Accounts payable			362,154	164,184		526,338
Current income tax payable						
Deferred income taxes	8,882					8,882
Accrued interest		146,297	116	2		146,415
Accrued liabilities	7,595	567	569,991	319,113		897,266
Total current liabilities	16,477	196,817	943,324	485,422		1,642,040
Long-term debt		8,734,473	44,819	29,090		8,808,382
Intercompany payable		3,667,662	8,385,414	5,911,829	(17,964,905)	

Deferred income taxes	608,177					608,177
Other long-term liabilities	9,522	340,526	372,693	278,934		1,001,675
Total liabilities	634,176	12,939,478	9,746,250	6,705,275	(17,964,905)	12,060,274
Redeemable noncontrolling interests in equity of consolidated subsidiaries				387,472		387,472
Equity:						
Community Health Systems, Inc. stockholders equity:						
Preferred stock						
Common stock	936		1	2	(3)	936
Additional paid-in capital	1,126,751	640,683	682,686	103,401	(1,426,770)	1,126,751
Treasury stock, at cost	(6,678)					(6,678)
Accumulated other comprehensive (loss) income	(230,927)	(230,927)	(12,990)		243,917	(230,927)
Retained earnings	1,299,382	1,100,304	1,172,099	178,069	(2,450,472)	1,299,382
Total Community Health Systems, Inc. stockholders equity	2,189,464	1,510,060	1,841,796	281,472	(3,633,328)	2,189,464
Noncontrolling interests in equity of consolidated subsidiaries				60,913		60,913
Total equity	2,189,464	1,510,060	1,841,796	342,385	(3,633,328)	2,250,377
Total liabilities and equity	$ 2,823,640	$ 14,449,538	$ 11,588,046	$ 7,435,132	$ (21,598,233)	$ 14,698,123

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)
Condensed Consolidating Statement of Income
Three Months Ended June 30, 2011

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net operating revenues	$	$	$ 2,002,412	$ 1,431,417	$	$ 3,433,829
Operating costs and expenses:						
Salaries and benefits			767,262	616,834		1,384,096
Provision for bad debts			259,583	173,419		433,002
Supplies			262,909	186,370		449,279
Other operating expenses			393,916	260,821		654,737
Rent			31,007	31,424		62,431
Depreciation and amortization			95,559	65,817		161,376
Total operating costs and expenses			1,810,236	1,334,685		3,144,921
Income from operations			192,176	96,732		288,908
Interest expense, net		22,212	123,347	17,671		163,230
Equity in earnings of unconsolidated affiliates	(35,389)	(39,072)	(45,752)		108,196	(12,017)
Income from continuing operations before income taxes	35,389	16,860	114,581	79,061	(108,196)	137,695
Provision for (benefit from) income taxes		(18,529)	41,364	21,986		44,821
Income from continuing operations	35,389	35,389	73,217	57,075	(108,196)	92,874
Discontinued operations, net of taxes:						
Income (loss) from operations of entities sold and held for sale			2,813	(2,578)		235
Impairment of hospitals held for sale			(39,562)			(39,562)
Loss on sale						
Loss from discontinued operations, net of taxes			(36,749)	(2,578)		(39,327)
Net income	35,389	35,389	36,468	54,497	(108,196)	53,547
Less: Net income attributable to noncontrolling interests				18,158		18,158
Net income attributable to Community Health Systems, Inc.	$ 35,389	$ 35,389	$ 36,468	$ 36,339	$ (108,196)	$ 35,389

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)
Condensed Consolidating Statement of Income
Three Months Ended June 30, 2010

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net operating revenues	$	$	$ 1,770,800	$ 1,309,846	$	$ 3,080,646
Operating costs and expenses:						
Salaries and benefits			663,919	567,640		1,231,559
Provision for bad debts			220,065	146,937		367,002
Supplies			242,931	187,643		430,574
Other operating expenses			309,698	250,264		559,962
Rent			28,838	32,013		60,851
Depreciation and amortization			86,401	63,378		149,779
Total operating costs and expenses			1,551,852	1,247,875		2,799,727
Income from operations			218,948	61,971		280,919
Interest expense, net		28,433	118,682	13,644		160,759
Equity in earnings of unconsolidated affiliates	(70,065)	(82,583)	(27,298)		168,966	(10,980)
Income from continuing operations before income taxes	70,065	54,150	127,564	48,327	(168,966)	131,140
Provision for (benefit from) income taxes		(15,915)	46,694	11,982		42,761
Income from continuing operations	70,065	70,065	80,870	36,345	(168,966)	88,379
Discontinued operations, net of taxes:						
Income (loss) from operations of entities sold and held for sale			1,789	(3,826)		(2,037)
Impairment of hospitals held for sale						
Loss on sale						
Loss from discontinued operations, net of taxes			1,789	(3,826)		(2,037)
Net income	70,065	70,065	82,659	32,519	(168,966)	86,342
Less: Net income attributable to noncontrolling interests				16,277		16,277
Net income attributable to Community Health Systems, Inc.	$ 70,065	$ 70,065	$ 82,659	$ 16,242	$ (168,966)	$ 70,065

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)
Condensed Consolidating Statement of Income
Six Months Ended June 30, 2011

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net operating revenues	$	$	$ 3,932,956	$ 2,854,925	$	$ 6,787,881
Operating costs and expenses:						
Salaries and benefits			1,510,301	1,253,162		2,763,463
Provision for bad debts			499,434	333,537		832,971
Supplies			525,911	381,185		907,096
Other operating expenses			738,800	530,730		1,269,530
Rent			61,608	63,993		125,601
Depreciation and amortization			189,419	130,112		319,531
Total operating costs and expenses			3,525,473	2,692,719		6,218,192
Income from operations			407,483	162,206		569,689
Interest expense, net		50,315	244,740	31,393		326,448
Equity in earnings of unconsolidated affiliates	(96,713)	(114,604)	(77,710)		258,876	(30,151)
Income from continuing operations before income taxes	96,713	64,289	240,453	130,813	(258,876)	273,392
Provision for (benefit from) income taxes		(32,424)	86,803	34,534		88,913
Income from continuing operations	96,713	96,713	153,650	96,279	(258,876)	184,479
Discontinued operations, net of taxes:						
Income (loss) from operations of entities sold and held for sale			4,158	(5,601)		(1,443)
Impairment of hospitals held for sale			(47,930)			(47,930)
Loss on sale				(3,234)		(3,234)
Loss from discontinued operations, net of taxes			(43,772)	(8,835)		(52,607)
Net income	96,713	96,713	109,878	87,444	(258,876)	131,872
Less: Net income attributable to noncontrolling interests				35,159		35,159
Net income attributable to Community Health Systems, Inc.	$ 96,713	$ 96,713	$ 109,878	$ 52,285	$ (258,876)	$ 96,713

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)
Condensed Consolidating Statement of Income
Six Months Ended June 30, 2010

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net operating revenues	$	$	$ 3,546,129	$ 2,603,129	$	$ 6,149,258
Operating costs and expenses:						
Salaries and benefits			1,342,015	1,136,225		2,478,240
Provision for bad debts			442,530	290,973		733,503
Supplies			482,632	370,054		852,686
Other operating expenses			613,430	503,151		1,116,581
Rent			58,253	64,655		122,908
Depreciation and amortization			170,605	123,077		293,682
Total operating costs and expenses			3,109,465	2,488,135		5,597,600
Income from operations			436,664	114,994		551,658
Interest expense, net		57,447	235,294	27,441		320,182
Equity in earnings of unconsolidated affiliates	(140,072)	(166,296)	(50,851)		333,649	(23,570)
Income from continuing operations before income taxes	140,072	108,849	252,221	87,553	(333,649)	255,046
Provision for (benefit from) income taxes		(31,223)	92,817	20,716		82,310
Income from continuing operations	140,072	140,072	159,404	66,837	(333,649)	172,736
Discontinued operations, net of taxes:						
Income (loss) from operations of entities sold and held for sale			6,231	(7,629)		(1,398)
Impairment of hospitals held for sale						
Loss on sale						
Loss from discontinued operations, net of taxes			6,231	(7,629)		(1,398)
Net income	140,072	140,072	165,635	59,208	(333,649)	171,338
Less: Net income attributable to noncontrolling interests				31,266		31,266
Net income attributable to Community Health Systems, Inc.	$ 140,072	$ 140,072	$ 165,635	$ 27,942	$ (333,649)	$ 140,072

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)
Condensed Consolidating Statement of Cash Flows
Six Months Ended June 30, 2011

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Cash flows from operating activities:						
Net cash (used in) provided by operating activities	$ 1,490	$ (37,658)	$ 338,117	$ 282,736	$	$ 584,685
Cash flows from investing activities:						
Acquisitions of facilities and other related equipment			(162,692)	(41,572)		(204,264)
Purchases of property and equipment			(187,760)	(163,623)		(351,383)
Proceeds from disposition of ancillary operations				18,464		18,464
Proceeds from sale of property and equipment			881	7,153		8,034
Increase in other non-operating assets			(58,120)	(17,091)		(75,211)
Net cash used in investing activities			(407,691)	(196,669)		(604,360)
Cash flows from financing activities:						
Proceeds from exercise of stock options	18,831					18,831
Deferred financing costs		(234)				(234)
Excess tax benefit relating to stock-based compensation	4,659					4,659
Stock buy-back	(50,002)					(50,002)
Proceeds from noncontrolling investors in joint ventures				863		863
Redemption of noncontrolling investments in joint				(3,303)		(3,303)

ventures						
Distributions to noncontrolling investors in joint ventures				(30,078)		(30,078)
Changes in intercompany balances with affiliates, net	25,022	62,908	(59,406)	(28,524)		
Repayments of long-term indebtedness		(25,016)	(2,504)	(1,278)		(28,798)
Net cash provided by (used in) financing activities	(1,490)	37,658	(61,910)	(62,320)		(88,062)
Net change in cash and cash equivalents			(131,484)	23,747		(107,737)
Cash and cash equivalents at beginning of period			212,035	87,134		299,169
Cash and cash equivalents at end of period	$	$	$ 80,551	$ 110,881	$	$ 191,432

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED) (Continued)
Condensed Consolidating Statement of Cash Flows
Six Months Ended June 30, 2010

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Cash flows from operating activities:						
Net cash (used in) provided by operating activities	$ (100,143)	$ (43,029)	$ 539,874	$ 145,090	$	$ 541,792
Cash flows from investing activities:						
Acquisitions of facilities and other related equipment			(389)	(2,024)		(2,413)
Purchases of property and equipment			(169,311)	(94,613)		(263,924)
Proceeds from disposition of ancillary operations						
Proceeds from sale of property and equipment			2,151	156		2,307
Increase in other non-operating assets			(31,750)	(32,508)		(64,258)
Net cash used in investing activities			(199,299)	(128,989)		(328,288)
Cash flows from financing activities:						
Proceeds from exercise of stock options	53,615					53,615
Deferred financing costs						
Excess tax benefit relating to stock-based compensation	10,104					10,104
Stock buy-back	(12,242)					(12,242)
Proceeds from noncontrolling investors in joint ventures				5,155		5,155
Redemption of noncontrolling investments in joint				(2,395)		(2,395)

ventures						
Distributions to noncontrolling investors in joint ventures				(29,371)		(29,371)
Changes in intercompany balances with affiliates, net	48,666	64,765	(73,906)	(39,525)		
Repayments of long-term indebtedness		(21,736)	(9,996)	(2,425)		(34,157)
Net cash provided by (used in) financing activities	100,143	43,029	(83,902)	(68,561)		(9,291)
Net change in cash and cash equivalents			256,673	(52,460)		204,213
Cash and cash equivalents at beginning of period			238,495	106,046		344,541
Cash and cash equivalents at end of period	$	$	$ 495,168	$ 53,586	$	$ 548,754

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Item 2. ***Management s Discussion and Analysis of Financial Condition and Results of Operations***

You should read this discussion together with our unaudited condensed consolidated financial statements and accompanying notes included herein.

Throughout this Quarterly Report on Form 10-Q, Community Health Systems, Inc., the parent company, and its consolidated subsidiaries are referred to on a collective basis using words like we, our, us and the Company . This drafting style is not meant to indicate that the publicly-traded parent company or any subsidiary of the parent company owns or operates any asset, business, or property. The hospitals, operations and businesses described in this filing are owned and operated, and management services provided, by distinct and indirect subsidiaries of Community Health Systems, Inc.

Executive Overview

We are one of the largest publicly-traded operators of hospitals in the United States. We provide healthcare services through 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 133 hospitals comprised of 129 general acute care hospitals and four stand-alone rehabilitation or psychiatric hospitals, including three hospitals held for sale. In addition, we own and operate home care agencies, located primarily in markets where we also operate a hospital, and through our wholly-owned subsidiary, Quorum Health Resources, LLC, or QHR, we provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. For the hospitals and home care agencies that we own and operate, we are paid for our services by governmental agencies, private insurers and directly by the patients we serve. For our management and consulting services, we are paid by the non-affiliated hospitals utilizing our services. During the three months ended March 31, 2011, we sold a multi-specialty physician clinic and identified a hospital as held for sale. In June 2011, we entered into a definitive agreement to sell two additional hospitals. We anticipate closing on the sale of each of these three hospitals by September 30, 2011. Accordingly, the related results of operations, impairment of long-lived assets held for sale and the loss on sale have been classified as discontinued operations in the condensed consolidated statements of income for the three-month and six-month periods ended June 30, 2011 and 2010.

Our net operating revenues for the three months ended June 30, 2011 increased to approximately $3.4 billion, as compared to approximately $3.1 billion for the three months ended June 30, 2010. Income from continuing operations, before noncontrolling interests, for the three months ended June 30, 2011 increased 5.1% over the three months ended June 30, 2010 to $92.9 million compared to $88.4 million. This increase in income from continuing operations during the three months ended June 30, 2011, as compared to the three months ended June 30, 2010, is due primarily to hospital acquisitions, higher revenues from an increase in outpatient surgeries offsetting a decrease in inpatient admissions, an increase in the average acuity of inpatient admissions and the elimination of certain unprofitable services in a few of our hospitals. We also benefitted from general rate and reimbursement increases and continued to benefit from management of our labor and supply costs which offset increases in our provisions for bad debts and other operating expenses. Net operating revenues for the three months ended June 30, 2011 included revenue related to the final settlement of a rate-related reimbursement dispute settled in our favor and other operating expenses for the three months ended June 30, 2011 included a charge related to the final settlement of a real estate matter against us. The amounts were individually immaterial and had a net favorable impact on income from continuing operations of approximately $1 million. Our successful physician recruiting efforts continue to be a key driver in the execution of our operating strategies. Total inpatient admissions for the three months ended June 30, 2011 increased 0.6%, compared to the three months ended June 30, 2010, and adjusted admissions for the three months ended June 30, 2011 increased 5.3%, compared to the three months ended June 30, 2010. On a same-store basis, admissions decreased 5.6% and adjusted admissions decreased 0.7%, compared with the three months ended June 30, 2010.

Our net operating revenues for the six months ended June 30, 2011 increased to approximately $6.8 billion, as compared to approximately $6.1 billion for the six months ended June 30, 2010. Income from continuing operations, before noncontrolling interests, for the six months ended June 30, 2011 increased 6.8% over the six months ended June 30, 2010 to $184.5 million compared to $172.7 million. This increase in income from continuing operations

during the six months ended June 30, 2011, as compared to the six months ended June 30, 2010, is due primarily to hospital acquisitions, higher revenues from an increase in outpatient surgeries offsetting a decrease in inpatient admissions, an increase in the average acuity of inpatient admissions and the elimination of certain unprofitable services in a few of our hospitals. We also benefitted from general rate and reimbursement increases and continued to benefit from management of our labor and supply costs which offset increases in our provisions for bad debts and other operating expenses. Our successful physician recruiting efforts continue to be a key driver in the execution of our operating strategies. Total inpatient admissions for the six months ended June 30, 2011 increased 1.2%, compared to the six months ended June 30, 2010, and adjusted

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admissions for the six months ended June 30, 2011 increased 5.1%, compared to the six months ended June 30, 2010. On a same-store basis, admissions decreased 4.4% and adjusted admissions decreased 0.2%, compared to the six months ended June 30, 2010.

Self-pay revenues represented approximately 12.0% and 11.4% of our net operating revenues for the three months ended June 30, 2011 and 2010, respectively, and approximately 12.2% and 11.4% of our net operating revenues for the six months ended June 30, 2011 and 2010, respectively. The amount of foregone revenue related to providing charity care services as a percentage of net operating revenues was approximately 4.4% and 4.1% for the three months ended June 30, 2011 and 2010, respectively, and approximately 4.4% and 4.0% of our net operating revenues for the six months ended June 30, 2011 and 2010, respectively. Direct and indirect costs incurred by us in providing charity care services were approximately 0.8% of net operating revenues for the three-month periods ended June 30, 2011 and 2010 and the six-month periods ended June 30, 2011 and 2010.

On July 19, 2011, we announced that one or more of our subsidiaries has executed a definitive agreement to acquire substantially all of the assets of Moses Taylor Health Care System, located in northeast Pennsylvania. The system includes Moses Taylor Hospital (217 licensed beds) in Scranton and Mid-Valley Hospital (25 licensed beds) in Peckville. Also in July 2011, one or more of our subsidiaries entered into a definitive agreement to acquire substantially all of the assets of Tomball Regional Medical Center (357 licensed beds), located in Tomball, Texas and serving the greater northwest Houston market. The transaction, subject to customary federal and state regulatory approvals, is expected to be completed in 2011.

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

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

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

provider agreement with an effective date on or prior to December 31, 2010.

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

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In addition to the Reform Legislation, the American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act, or HITECH Act. These provisions were designed to increase the use of electronic health records, or EHR, technology and establish the requirements for a Medicare and Medicaid incentive payments program beginning in 2011 for eligible hospitals and providers that adopt and meaningfully use certified EHR technology. These incentive payments are intended to offset a portion of the cost incurred to implement and qualify as a meaningful user of EHR. Rules adopted in July 2010 by the Department of Health and Human Services established an initial set of standards and certification criteria. Our hospital facilities are scheduled to implement EHR technology on a facility-by-facility basis beginning in 2011. We anticipate recognizing revenues related to the Medicare or Medicaid incentive payments as we are able to implement the certified EHR technology and meet the defined meaningful use criteria. However, there can be no assurance that we will ultimately qualify for these incentive payments and should we qualify, the amounts received may vary from estimates as they are dependent on the availability of federal funding for both Medicare and Medicaid incentive payments, timing of the approval of state Medicaid incentive plans by the Centers for Medicare and Medicaid Services, or CMS, and the timing of our ability to implement and demonstrate meaningful use of the EHR technology. The timing of recognizing revenue from the incentive payments will not correlate with the timing of recognizing operating expenses and incurring capital costs in connection with the implementation of EHR technology which may result in material period-to-period changes in our future results of operations. Hospitals that do not qualify as a meaningful user of EHR technology by 2015 are subject to a reduced market basket update to the inpatient prospective payment system standardized amount in 2015 and each subsequent fiscal year. Although we believe that our hospital facilities will be in compliance with the EHR standards by 2015, there can be no assurance that all of our facilities will be in compliance and therefore not subject to the penalty provisions of the HITECH Act.

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

Sources of Consolidated Net Operating Revenues

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Medicare	26.8%	27.7%	27.1%	27.8%
Medicaid	10.1%	10.8%	9.9%	10.5%
Managed Care and other third-party payors	51.1%	50.1%	50.8%	50.3%
Self-pay	12.0%	11.4%	12.2%	11.4%
Total	100.0%	100.0%	100.0%	100.0%

As shown above, we receive a substantial portion of our revenues from the Medicare and Medicaid programs. Included in Managed Care and other third-party payors is net operating revenues from insurance companies with which we have insurance provider contracts, Medicare Managed Care, insurance companies for which we do not have insurance provider contracts, workers compensation carriers, and non-patient service revenue, such as rental income and cafeteria sales. In the future, we generally expect revenues received from the Medicare and Medicaid programs to

increase due to the general aging of the population. In addition, the Reform Legislation will increase the number of insured patients which should reduce revenues from self-pay patients and reduce the provision for bad debts. The Reform Legislation, however, imposes significant reductions in amounts the government pays Medicare Managed Care plans. Other provisions in the Reform Legislation impose minimum medical-loss ratios and require insurers to meet specific benefit requirements. In addition, specified managed care programs, insurance companies, and employers are actively negotiating the amounts paid to hospitals. The trend toward increased enrollment in managed care may adversely affect our net

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operating revenue growth. There can be no assurance that we will retain our existing reimbursement arrangements or that these third-party payors will not attempt to further reduce the rates they pay for our services.

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-based reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net income by an insignificant amount in each of the three-month and six-month periods ended June 30, 2011 and 2010. In the future, we expect the percentage of revenues received from the Medicare program to increase due to the general aging of the population.

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

The payment rates under the Medicare program for hospital inpatient and outpatient acute care services are based on a prospective payment system, depending upon the diagnosis of a patient s condition. These rates are indexed for inflation annually, although increases have historically been less than actual inflation. On August 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 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 each of 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 services, psychiatric and rehabilitation services. The strongest demand for hospital services generally occurs during January through April and the weakest demand for these services occurs during the summer months. Accordingly, eliminating the effect of new acquisitions, our net operating revenues and earnings are historically highest during the first quarter and lowest during the third quarter.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
	(Expressed as a percentage of net operating revenues)			
Consolidated				
Net operating revenues	100.0%	100.0%	100.0%	100.0%
Operating expenses (a)	(86.8)	(86.1)	(86.9)	(86.3)
Depreciation and amortization	(4.7)	(4.8)	(4.7)	(4.7)
Income from operations	8.5	9.1	8.4	9.0
Interest expense, net	(4.8)	(5.2)	(4.8)	(5.3)
Equity in earnings of unconsolidated affiliates	0.3	0.4	0.4	0.4
Income from continuing operations before income taxes	4.0	4.3	4.0	4.1
Provision for income taxes	(1.3)	(1.4)	(1.3)	(1.3)
Income from continuing operations	2.7	2.9	2.7	2.8
Loss from discontinued operations, net of taxes	(1.1)	(0.1)	(0.8)	
Net income	1.6	2.8	1.9	2.8
Less: Net income attributable to noncontrolling interests	(0.6)	(0.5)	(0.5)	(0.5)
Net income attributable to Community Health Systems, Inc.	1.0%	2.3%	1.4%	2.3%

	Three Months Ended June 30, 2011	Six Months Ended June 30, 2011
Percentage increase (decrease) from same period prior year:		
Net operating revenues	11.5%	10.4%
Admissions	0.6	1.2
Adjusted admissions (b)	5.3	5.1
Average length of stay	4.8	2.3
Net income attributable to Community Health Systems, Inc. (c)	(49.5)	(31.0)
Same-store percentage increase (decrease) from same period prior year (d):		
Net operating revenues	5.8%	5.6%
Admissions	(5.6)	(4.4)
Adjusted admissions (b)	(0.7)	(0.2)

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

(b)

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

(c) Includes loss from discontinued operations.

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

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

Net operating revenues increased $353.2 million to approximately $3.4 billion for the three months ended June 30, 2011, from approximately $3.1 billion for the three months ended June 30, 2010. Growth from hospitals owned throughout both periods contributed $177.7 million of that increase and hospitals acquired in 2010 along with the final settlement of a rate-related reimbursement contributed $175.5 million. On a same-store basis, net operating revenues increased 5.8%. The increased net operating revenues contributed by hospitals that we owned throughout both periods were primarily attributable to general rate and reimbursement increases including revenues from states with provider assessment programs.

On a consolidated basis, inpatient admissions increased by 0.6% and adjusted admissions increased by 5.3% during the three months ended June 30, 2011. This increase in inpatient and adjusted admissions was due primarily to acquisitions during the past twelve months. On a same-store basis, inpatient admissions decreased by 5.6% during the three months ended June 30, 2011. This decrease in same-store inpatient admissions was due primarily to a decrease in admissions from women s services including obstetrics and gynecology, reductions in one day stays from the emergency room with a corresponding increase in outpatient visits, reductions in one day stays with no emergency room charge with a corresponding increase in outpatient visits and reductions due to competition, weather and certain service closures in a few of our hospitals during the three months ended June 30, 2011, as compared to the three months ended June 30, 2010.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, increased 0.7% to 86.8% for the three months ended June 30, 2011, compared to 86.1% for the three months ended June 30, 2010. Salaries and benefits, as a percentage of net operating revenues, increased 0.3% to 40.3% for the three months ended June 30, 2011, compared to 40.0% for the three months ended June 30, 2010. This increase is due primarily to the impact of recent acquisitions and an increase in the number of employed physicians, which offset efficiencies gained at hospitals owned throughout both periods. Provision for bad debts as a percentage of net operating revenues, increased 0.7% to 12.6% for the three months ended June 30, 2011, compared to 11.9% for the three months ended June 30, 2010. This increase is due primarily to the increase in self-pay revenues as a percentage of total net operating revenues. Supplies, as a percentage of net operating revenues, decreased 0.9% to 13.1% for the three months ended June 30, 2011, as compared to 14.0% for the three months ended June 30, 2010. This decrease is due primarily to lower implant costs, medical supply costs, drug costs, pacemaker costs and an improvement in vendor rebates. Other operating expenses, as a percentage of net operating revenues, increased 0.8% to 19.0% for the three months ended June 30, 2011, as compared to 18.2% for the three months ended June 30, 2010. This increase is due primarily to an increase in provider taxes from states with provider assessment programs and increased legal expenses and other costs relating to the Tenet lawsuit, shareholder lawsuits and the governmental investigations discussed in more detail in Legal Proceedings in Part II, Item 1 of this Form 10-Q. Rent, as a percentage of net operating revenues, decreased 0.2% to 1.8% for the three months ended June 30, 2011, as compared to 2.0% for the three months ended June 30, 2010. Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, decreased 0.1% to 0.3% for the three months ended June 30, 2011, compared to 0.4% for the three months ended June 30, 2010.

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

Interest expense, net, increased by $2.5 million from $160.8 million for the three months ended June 30, 2010 to $163.2 million for the three months ended June 30, 2011. An increase in interest rates during the three months ended June 30, 2011, compared to the three months ended June 30, 2010, resulted in an increase in interest expense of $6.4 million. These increases were offset by a decrease in interest expense of $0.6 million due to a decrease in our average outstanding debt during the three months ended June 30, 2011, compared to June 30, 2010. Additionally, interest expense decreased by $3.3 million as a result of more interest being capitalized during the three months ended June 30, 2011, as compared to the three months ended June 30, 2010, as the current year period had more major construction projects.

The net of the above mentioned changes resulted in income from continuing operations before income taxes increasing $6.6 million from $131.1 million for the three months ended June 30, 2010 to $137.7 million for the three months ended June 30, 2011.

Provision for income taxes increased from $42.8 million for the three months ended June 30, 2010 to $44.8 million for the three months ended June 30, 2011, due primarily to an increase in income from continuing operations before income taxes in the comparable period in 2010, as discussed above. Our effective tax rates remained consistent at 32.6% for each of the three-month periods ended June 30, 2011 and 2010.

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Income from continuing operations, as a percentage of net operating revenues, decreased from 2.9% for the three months ended June 30, 2010 to 2.7% for the three months ended June 30, 2011. The decrease in income from continuing operations, as a percentage of net operating revenues, is primarily a result of the increases in operating expenses discussed above. Net income, as a percentage of net operating revenues, decreased from 2.8% for the three months ended June 30, 2010 to 1.6% for the three months ended June 30, 2011. The decrease in net income, as a percentage of net operating revenues, is primarily due to the loss on discontinued operations from the impairment of hospitals held for sale.

Net income attributable to noncontrolling interests as a percentage of net operating revenues, increased 0.1% to 0.6% for the three months ended June 30, 2011, compared to 0.5% for the three months ended June 30, 2010.

Net income attributable to Community Health Systems, Inc. was $35.4 million for the three months ended June 30, 2011, compared to $70.1 million for the three months ended June 30, 2010, representing a decrease of 49.5%. The decrease in net income is primarily due to the loss on discontinued operations from the impairment of hospitals held for sale.

Six Months Ended June 30, 2011 Compared to Six Months Ended June 30, 2010

Net operating revenues increased $638.6 million to approximately $6.8 billion for the six months ended June 30, 2011, from approximately $6.1 billion for the six months ended June 30, 2010. Growth from hospitals owned throughout both periods contributed $344.2 million of that increase and hospitals acquired in 2010 along with the final settlement of a rate-related reimbursement dispute contributed $294.4 million. On a same-store basis, net operating revenues increased 5.6%. The increased net operating revenues contributed by hospitals that we owned throughout both periods were primarily attributable to general rate and reimbursement increases including revenues from states with provider assessment programs.

On a consolidated basis, inpatient admissions increased by 1.2% and adjusted admissions increased by 5.1% during the six months ended June 30, 2011. This increase in inpatient and adjusted admissions was due primarily to acquisitions during the past twelve months. On a same-store basis, inpatient admissions decreased by 4.4% during the six months ended June 30, 2011. This decrease in same-store inpatient admissions was due primarily to a decrease in admissions from women s services including obstetrics and gynecology, reductions in one day stays from the emergency room with a corresponding increase in outpatient visits, reductions in one day stays with no emergency room charge with a corresponding increase in outpatient visits and reductions due to competition, weather and certain service closures in a few of our hospitals during the six months ended June 30, 2011, as compared to the six months ended June 30, 2010.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, increased 0.6% to 86.9% for the six months ended June 30, 2011, compared to 86.3% for the six months ended June 30, 2010. Salaries and benefits, as a percentage of net operating revenues, increased 0.4% to 40.7% for the six months ended June 30, 2011, compared to 40.3% for the six months ended June 30, 2010. This increase is due primarily to the impact of recent acquisitions and an increase in the number of employed physicians, which offset efficiencies gained at hospitals owned throughout both periods. Provision for bad debts as a percentage of net operating revenues, increased 0.4% to 12.3% for the six months ended June 30, 2011, compared to 11.9% for the six months ended June 30, 2010. This increase is due primarily to the increase in self-pay revenues as a percentage of total net operating revenues. Supplies, as a percentage of net operating revenues, decreased 0.5% to 13.4% for the six months ended June 30, 2011, as compared to 13.9% for the six months ended June 30, 2010. This decrease is due primarily to lower implant costs, medical supply costs, drug costs, pacemaker costs and an improvement in vendor rebates. Other operating expenses, as a percentage of net operating revenues, increased 0.4% to 18.6% for the six months ended June 30, 2011, as compared to 18.2% for the six months ended June 30, 2010. This increase is due primarily to an increase in provider taxes from states with provider assessment programs and increased legal expenses and other costs relating to the Tenet lawsuit, shareholder lawsuits and the governmental investigations discussed in more detail in Legal Proceedings in Part II, Item 1 of this Form 10-Q. Rent, as a percentage of net operating revenues, decreased 0.1% to 1.9% for the six months ended June 30, 2011, as compared to 2.0% for the six months ended June 30, 2010. Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, remained consistent at 0.4% for each of the six-month periods ended June 30, 2011 and 2010.

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

Interest expense, net, increased by $6.3 million from $320.2 million for the six months ended June 30, 2010 to $326.4 million for the six months ended June 30, 2011. An increase in interest rates during the six months ended June 30, 2011, compared to the six months ended June 30, 2010, resulted in an increase in interest expense of $11.5 million. These increases were offset by a decrease in interest expense of $1.3 million due to a decrease in our average outstanding debt during the six months ended June 30, 2011, compared to June 30, 2010. Additionally, interest expense decreased by $3.9 million as a result of more interest being capitalized

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during the six months ended June 30, 2011, as compared to the six months ended June 30, 2010, as the current year period had more major construction projects.

The net of the above mentioned changes resulted in income from continuing operations before income taxes increasing $18.4 million from $255.0 million for the six months ended June 30, 2010 to $273.4 million for the six months ended June 30, 2011.

Provision for income taxes increased from $82.3 million for the six months ended June 30, 2010 to $88.9 million for the six months ended June 30, 2011, due primarily to an increase in income from continuing operations before income taxes in the comparable period in 2010, as discussed above. Our effective tax rates were 32.5% and 32.3% for the six months ended June 30, 2011 and 2010, respectively.

Income from continuing operations, as a percentage of net operating revenues, decreased from 2.8% for the six months ended June 30, 2010 to 2.7% for the six months ended June 30, 2011. The decrease in income from continuing operations, as a percentage of net operating revenues, is primarily a result of the increased operating costs as a percentage of net revenue discussed above. Net income, as a percentage of net operating revenues, decreased from 2.8% for the six months ended June 30, 2010 to 1.9% for the six months ended June 30, 2011. The decrease in net income, as a percentage of net operating revenues, is primarily due to the loss on discontinued operations from the loss on sale, impairment of hospitals held for sale and loss on entities sold and held for sale.

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

Net income attributable to Community Health Systems, Inc. was $96.7 million for the six months ended June 30, 2011, compared to $140.1 million for the six months ended June 30, 2010, representing a decrease of 31.0%. The decrease in net income is primarily due to the loss on discontinued operations from the loss on sale, impairment of hospitals held for sale and loss on entities sold and held for sale.

Liquidity and Capital Resources

Net cash provided by operating activities increased $42.9 million, from $541.8 million for the six months ended June 30, 2010 to $584.7 million for the six months ended June 30, 2011. The increase in cash provided by operating activities, in comparison to the prior year period, is primarily due to an increase in depreciation and amortization expense of $23.3 million, impairment of long-lived assets of $47.9 million, an increase in all other non-cash expenses of $15.7 million, an increase in cash flow from the change in supplies, prepaid expenses and other current assets of $10.5 million and an increase in cash flow from the change in accounts payable, accrued liabilities and income taxes of $15.4 million, due primarily to the timing of payments during the periods. These increases were offset by a decrease in net income of $39.5 million, a decrease in cash flow from the change in accounts receivable of $19.2 million and a decrease in cash flow from the change in other assets and liabilities of $11.2 million.

The cash used in investing activities was $604.4 million for the six months ended June 30, 2011, compared to $328.3 million for the six months ended June 30, 2010. The increase in cash used in investing activities, in comparison to the prior year period, is primarily due to an increase in cash used for acquisition of facilities and other related equipment of $201.9 million, an increase in cash used for purchasing property and equipment of $87.5 million and an increase in cash used for other assets, which consists primarily of purchases and development of internal-use software and payments made under non-employee physician recruiting agreements, of $10.9 million. Other changes in cash used in investing activities were an increase in proceeds from the disposition of ancillary operations of $18.5 million and an increase in proceeds received from the sale of property and equipment of $5.7 million.

The cash used in financing activities was $88.1 million for the six months ended June 30, 2011, compared to $9.3 million for the six months ended June 30, 2010. The increase in cash used in financing activities, in comparison to the prior year period, is due primarily to a decrease in proceeds from the exercise of stock options and an increase in cash used to purchase outstanding shares under our open market repurchase program.

Capital Expenditures

Cash expenditures related to purchases of facilities were $204.3 million for the six months ended June 30, 2011, compared to $2.4 million for the six months ended June 30, 2010. The expenditures during the six months ended June 30, 2011 were for the purchase of three hospitals in Pennsylvania, surgery centers and physician practices and the settlement of working capital items from 2010

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acquisitions. The expenditures during the six months ended June 30, 2010 were for the purchase of non-hospital facilities and the settlement of working capital items from a prior year acquisition, and no hospitals were acquired during that period.

Excluding the cost to construct replacement hospitals, our cash expenditures for routine capital for the six months ended June 30, 2011 totaled $269.3 million, compared to $260.4 million for the six months ended June 30, 2010. These capital expenditures related primarily to the purchase of additional equipment, minor renovations and information systems infrastructure. Costs to construct replacement hospitals for the six months ended June 30, 2011 totaled $82.1 million, compared to $3.5 million for the six months ended June 30, 2010. The costs to construct replacement hospitals for the six months ended June 30, 2011 represented both planning and construction costs for the four replacement hospitals discussed below. The costs to construct replacement hospitals for the six months ended June 30, 2010 represented planning costs for future construction projects since there were no replacement hospitals under construction.

Pursuant to purchase agreements in effect as of June 30, 2011 and where certificate of need approval has been obtained, we have commitments to build the following three replacement facilities: As required by an amendment to our lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location by November 2012. As part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana by April 2011; however, due to delays in receiving government approved building and zoning permits, completion is not expected until the fourth quarter of 2012. These delays did not result in any penalties under the terms of the agreement and we do not expect such delays to result in any significant increase in the costs to construct the replacement facility. As part of an acquisition in 2009, we agreed to build a replacement hospital in Siloam Springs, Arkansas by February 2013. Construction costs, including equipment costs, for these three replacement facilities are currently estimated to be approximately $318.5 million, of which approximately $128.3 million has been incurred to date. In addition, in October 2008, after the purchase of the noncontrolling owner s interest in our Birmingham, Alabama facility, we initiated the purchase of a site, which includes a partially constructed hospital structure, for a potential replacement to our existing Birmingham facility. In September 2010, we received approval of our request for a certificate of need from the Alabama Certificate of Need Review Board; however, this certificate of need remains subject to an appeal process. Our estimated construction costs, including the acquisition of the site and equipment costs, are approximately $280.0 million for the Birmingham replacement facility.

Capital Resources

Net working capital was approximately $1.072 billion at June 30, 2011, compared to approximately $1.229 billion at December 31, 2010. The decrease in net working capital is primarily due to the use of free cash flow and cash on hand to complete acquisitions of a hospital system and several physician practices, repurchase outstanding shares under our repurchase program, and make repayments of certain long-term indebtedness.

In connection with the consummation of the Triad acquisition in July 2007, we obtained approximately $7.2 billion of senior secured financing under a Credit Facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The Credit Facility consisted of an approximately $6.1 billion funded term loan facility with a maturity of seven years, a $300 million delayed draw term loan facility (reduced by us from $400 million) with a maturity of seven years and a $750 million revolving credit facility with a maturity of six years. During the fourth quarter of 2008, $100 million of the delayed draw term loan 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 London Interbank Offered Rate, or LIBOR, plus 350 basis points. If more than $50 million of our Notes remain outstanding on April 15, 2015, without having been refinanced, then the maturity date for the extended term loans will be accelerated to April 15, 2015. The maturity date of the balance of the term

loans of approximately $4.5 billion remains unchanged at July 25, 2014. The amendment also increases our ability to issue additional indebtedness under the uncommitted incremental facility to $1.0 billion from $600 million, permits us to issue Term A term loans under the incremental facility, and provides up to $2.0 billion of borrowing capacity from receivable transactions, an increase of $0.5 billion, of which $1.7 billion would be required to be used for repayment of existing term loans.

The term loan facility must be prepaid in an amount equal to (1) 100% of the net cash proceeds of certain asset sales and dispositions by us and our subsidiaries, subject to certain exceptions and reinvestment rights, (2) 100% of the net cash proceeds of issuances of certain debt obligations or receivables based financing by us and our subsidiaries, subject to certain exceptions, and (3) 50%, subject to reduction to a lower percentage based on our leverage ratio (as defined in the Credit Facility generally as the ratio of total debt on the date of determination to our EBITDA, as defined, for the four quarters most recently ended prior to such date), of

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excess cash flow (as defined) for any year, commencing in 2008, subject to certain exceptions. Voluntary prepayments and commitment reductions are permitted in whole or in part, without any premium or penalty, subject to minimum prepayment or reduction requirements.

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

The loans under the Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at our option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus one-half of 1.0% or (3) the adjusted LIBOR 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 exceptions, to, among other things, (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of our businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change our fiscal year. We and our subsidiaries are also required to comply with specified financial covenants (consisting of a leverage ratio and an interest coverage ratio) and various affirmative covenants.

Events of default under the Credit Facility include, but are not limited to, (1) our failure to pay principal, interest, fees or other amounts under the credit agreement when due (taking into account any applicable grace period), (2) any representation or warranty proving to have been materially incorrect when made, (3) covenant defaults subject, with respect to certain covenants, to a grace period, (4) bankruptcy events, (5) a cross default to certain other debt, (6) certain undischarged judgments (not paid within an applicable grace period), (7) a change of control, (8) certain

ERISA-related defaults and (9) the invalidity or impairment of specified security interests, guarantees or subordination provisions in favor of the administrative agent or lenders under the Credit Facility.

As of June 30, 2011, the availability for additional borrowings under our Credit Facility was approximately $750 million pursuant to the revolving credit facility, of which $37.9 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.

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As of June 30, 2011, we are a party to the following interest rate swap agreements to limit the effect of changes in interest rates on approximately 90% of our variable rate debt. On each of these swaps, we receive a variable rate of interest based on the three-month LIBOR in exchange for the payment by us of a fixed rate of interest. We currently pay, on a quarterly basis, a margin above LIBOR of 225 basis points for revolving credit and term loans due 2014 and 350 basis points for term loans due 2017 under the Credit Facility.

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Swap #	Notional Amount (in 000 s)	Fixed Interest Rate	Termination Date	Fair Value (in 000 s)
1	$300,000	5.1140%	August 8, 2011	$ 1,533
2	100,000	4.7185%	August 19, 2011	605
3	100,000	4.7040%	August 19, 2011	603
4	100,000	4.6250%	August 19, 2011	592
5	200,000	4.9300%	August 30, 2011	1,551
6	200,000	3.0920%	September 18, 2011	1,248
7	100,000	3.0230%	October 23, 2011	869
8	200,000	4.4815%	October 26, 2011	2,712
9	200,000	4.0840%	December 3, 2011	3,279
10	100,000	3.8470%	January 4, 2012	1,822
11	100,000	3.8510%	January 4, 2012	1,824
12	100,000	3.8560%	January 4, 2012	1,826
13	200,000	3.7260%	January 8, 2012	3,610
14	200,000	3.5065%	January 16, 2012	3,514
15	250,000	5.0185%	May 30, 2012	10,654
16	150,000	5.0250%	May 30, 2012	6,401
17	200,000	4.6845%	September 11, 2012	10,208
18	100,000	3.3520%	October 23, 2012	3,798
19	125,000	4.3745%	November 23, 2012	6,794
20	75,000	4.3800%	November 23, 2012	4,082
21	150,000	5.0200%	November 30, 2012	9,618
22	200,000	2.2420%	February 28, 2013	5,561
23	100,000	5.0230%	May 30, 2013	8,262
24	300,000	5.2420%	August 6, 2013	27,964
25	100,000	5.0380%	August 30, 2013	9,101
26	50,000	3.5860%	October 23, 2013	3,130
27	50,000	3.5240%	October 23, 2013	3,063
28	100,000	5.0500%	November 30, 2013	9,857
29	200,000	2.0700%	December 19, 2013	5,715
30	100,000	5.2310%	July 25, 2014	11,994
31	100,000	5.2310%	July 25, 2014	11,998
32	200,000	5.1600%	July 25, 2014	23,584
33	75,000	5.0405%	July 25, 2014	8,571
34	125,000	5.0215%	July 25, 2014	14,218
35	100,000	2.6210%	July 25, 2014	4,349
36	100,000	3.1100%	July 25, 2014	5,788
37	100,000	3.2580%	July 25, 2014	6,222
38	200,000	2.6930%	October 26, 2014	7,504 (1)
39	300,000	3.4470%	August 8, 2016	18,662 (2)
40	200,000	3.4285%	August 19, 2016	12,096 (3)
41	100,000	3.4010%	August 19, 2016	6,019 (4)
42	200,000	3.5000%	August 30, 2016	12,529 (5)
43	100,000	3.0050%	November 30, 2016	4,196

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(1) This interest rate swap becomes effective October 26, 2011, concurrent with the termination of swap #8.

(2) This interest rate swap becomes effective August 8, 2011, concurrent with the termination of swap #1.

(3) This interest rate swap becomes effective August 19, 2011, concurrent with the termination of swaps #2 and #4.

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

(5) This interest rate swap becomes effective August 30, 2011, concurrent with the termination of swap #5.

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, availability for additional borrowings under our Credit Facility of $750 million (consisting of a $750 million revolving credit facility, of which $37.9 million is set aside for outstanding letters of credit as of June 30, 2011) and our ability to amend the Credit Facility to provide for one or more tranches of term loans in an aggregate principal amount of $1.0 billion, our ability to add up to $300 million of borrowing capacity from receivable transactions (including securitizations) and our continued access to the bank credit and capital markets will be sufficient to finance acquisitions, capital expenditures and working capital requirements through the next 12 months. We believe these same sources of cash, borrowings under our Credit Facility as well as access to bank credit and capital markets will be available to us beyond the next 12 months and into the foreseeable future.

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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.

The ratio of earnings to fixed charges for the six months ended June 30, 2011 is as follows:

	Six Months Ended June 30, 2011
Ratio of earnings to fixed charges (1)	1.70x

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

Off-balance Sheet Arrangements

Our consolidated operating results for the six months ended June 30, 2011 and 2010, included $125.8 million and $120.5 million, respectively, of net operating revenues and $10.1 million and $11.3 million, respectively, of income from operations generated from five hospitals operated by us under operating lease arrangements. In accordance with accounting principles generally accepted in the United States of America, or U.S. GAAP, the respective assets and the future lease obligations under these arrangements are not recorded on our condensed consolidated balance sheet. Lease costs under these arrangements are included in rent expense and totaled approximately $6.0 million and $6.2 million for the six months ended June 30, 2011 and 2010, respectively. The current terms of these operating leases expire between June 2012 and December 2020, not including lease extension options. If we allow these leases to expire, we would no longer generate revenue nor incur expenses from these hospitals.

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

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

Noncontrolling Interests

We have sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. As of June 30, 2011, we have hospitals in 24 of the markets we serve, with noncontrolling physician ownership interests ranging from less than 1% to 40%, including one hospital that also had a non-profit entity as a partner. In addition, we have three other hospitals with noncontrolling interests owned by non-profit entities. Redeemable noncontrolling interests in equity of consolidated subsidiaries was $376.7 million and $387.5 million as of June 30, 2011 and December 31, 2010, respectively. Noncontrolling interests in equity of consolidated subsidiaries was $61.3 million and $60.9 million as of June 30, 2011 and December 31, 2010,

respectively. The amount of net income attributable to noncontrolling interests was $18.2 million and $16.3 million for the three months ended June 30, 2011 and 2010, respectively, and $35.2 million and $31.3 million for the six months ended June 30, 2011 and 2010, respectively. As a result of the change in the Stark Law whole hospital exception included in the Reform Legislation, we will not introduce physician ownership at any of our wholly-owned facilities or increase the aggregate percentage of physician ownership in any of our existing joint ventures.

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Reimbursement, Legislative and Regulatory Changes

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

Inflation

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

Critical Accounting Policies

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

Critical accounting policies are defined as those that are reflective of significant judgments and uncertainties, and potentially result in materially different results under different assumptions and conditions. We believe that our critical accounting policies are limited to those described below.

Third Party Reimbursement

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. Contractual allowances are automatically calculated and recorded through our internally developed automated contractual allowance system. Within the automated system, actual Medicare DRG data and payors historical paid claims data are utilized to calculate the contractual allowances. This data is automatically updated on a monthly basis. All hospital contractual allowance calculations are subjected to monthly review by management to ensure reasonableness and accuracy. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. The process of estimating contractual allowances requires us to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification and historical paid claims data. Due to the complexities involved in these estimates, actual payments we receive could be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs and managed care contracts differed by 1% at June 30, 2011 from our estimated reimbursement percentage, net income for the six months ended June 30, 2011 would have changed by approximately $33.0 million, and net accounts receivable at June 30, 2011 would have changed by $52.3 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 three-month and six-month periods ended June 30, 2011 and 2010.

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Allowance for Doubtful Accounts

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

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

Collections are impacted by the economic ability of patients to pay and the effectiveness of our collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect our collection of accounts receivable. The process of estimating the allowance for doubtful accounts requires us to estimate the collectability of self-pay accounts receivable, which is primarily based on our collection history, adjusted for expected recoveries and, if available, anticipated changes in collection trends. Significant change in payor mix, business office operations, economic conditions, trends in federal and state governmental healthcare coverage or other third-party payors could affect our estimates of accounts receivable collectability. If the actual collection percentage differed by 1% at June 30, 2011 from our estimated collection percentage as a result of a change in expected recoveries, net income for the six months ended June 30, 2011 would have changed by $18.3 million, and net accounts receivable at June 30, 2011 would have changed by $29.1 million. We also continually review our overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net revenue less provision for bad debts, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding and the impact of recent acquisitions and dispositions.

Our policy is to write-off gross accounts receivable if the balance is under $10.00 or when such amounts are placed with outside collection agencies. We believe this policy accurately reflects our ongoing collection efforts and is consistent with industry practices. We had approximately $2.2 billion and $2.1 billion at June 30, 2011 and December 31, 2010, respectively, being pursued by various outside collection agencies. We expect to collect less than 3%, net of estimated collection fees, of the amounts being pursued by outside collection agencies. As these amounts have been written-off, they are not included in our gross accounts receivable or our allowance for doubtful accounts. Collections on amounts previously written-off are recognized as a reduction to bad debt expense when received. However, we take into consideration estimated collections of these future amounts written-off in evaluating the reasonableness of our allowance for doubtful accounts.

All of the following information is derived from our hospitals, excluding clinics, unless otherwise noted.

Patient accounts receivable from our hospitals represent approximately 95% of our total consolidated accounts receivable.

Days revenue outstanding was 47 days and 46 days at June 30, 2011 and December 31, 2010, respectively. Our target range for days revenue outstanding is 46 to 56 days.

Total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) was approximately $7.7 billion and $7.2 billion as of June 30, 2011 and December 31, 2010, respectively.

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

	June 30, 2011	December 31, 2010
Insured receivables	63.7%	63.9%
Self-pay receivables	36.3%	36.1%
Total	100.0%	100.0%

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

Goodwill and Other Intangibles

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

Impairment or Disposal of Long-Lived Assets

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

Professional Liability Insurance Claims

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

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

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Our processes for obtaining and analyzing claims and incident data are standardized across all of our hospitals and have been consistent for many years. We monitor the outcomes of the medical care services that we provide and for each reported claim, we obtain various information concerning the facts and circumstances related to that claim. In addition, we routinely monitor current key statistics and volume indicators in our assessment of utilizing historical trends. The average lag period between claim occurrence and payment of a final settlement is between four and five years, although the facts and circumstances of individual claims could result in the timing of such payments being different from this average. Since claims are paid promptly after settlement with the claimant is reached, settled claims represent less than 1.0% of the total liability at the end of any period.

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

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

We are primarily self-insured for these claims; however, we obtain excess insurance that transfers the risk of loss to a third-party insurer for claims in excess of our self-insured retentions. Our excess insurance is underwritten on a claims-made basis. For claims reported prior to June 1, 2002, substantially all of our professional and general liability risks were subject to a $0.5 million per occurrence self-insured retention and for claims reported from June 1, 2002 through June 1, 2003, these self-insured retentions were $2.0 million per occurrence. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 are self-insured up to $5 million per claim. Management, on occasion, has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals has been purchased through commercial insurance companies and generally covers us for liabilities in excess of the self-insured retentions. The excess coverage consists of multiple layers of insurance, the sum of which totals up to $95 million per occurrence and in the aggregate for claims reported on or after June 1, 2003 and up to $145 million per occurrence and in the aggregate for claims incurred and reported after January 1, 2008. For certain policy years, if the first aggregate layer of excess coverage becomes fully utilized, then the self-insured retention could increase to $10 million per claim for any subsequent claims in that policy year until our total aggregate coverage is met.

Effective January 1, 2008, the former Triad hospitals are insured on a claims-made basis as described above and through commercial insurance companies as described above for substantially all claims occurring on or after January 1, 2002 and reported on or after January 1, 2008. Substantially all losses for the former Triad hospitals in periods prior to May 1, 1999 were insured through a wholly-owned insurance subsidiary of HCA Inc., or HCA, Triad s owner prior to that time, and excess loss policies maintained by HCA. HCA has agreed to indemnify the former Triad hospitals in respect of claims covered by such insurance policies arising prior to May 1, 1999. From May 1, 1999 through December 31, 2006, the former Triad hospitals obtained insurance coverage on a claims incurred basis from

HCA s wholly-owned insurance subsidiary with excess coverage obtained from other carriers that is subject to certain deductibles. Effective for claims incurred after December 31, 2006, Triad began insuring its claims from $1 million to $5 million through its wholly-owned captive insurance company, replacing the coverage provided by HCA. Substantially all claims occurring during 2007 were self-insured up to $10 million per claim.

There have been no significant changes in our estimate of the reserve for professional liability claims during the three and six months ended June 30, 2011.

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Income Taxes

We must make estimates in recording provision for income taxes, including determination of deferred tax assets and deferred tax liabilities and any valuation allowances that might be required against the deferred tax assets. We believe that future income will enable us to realize certain deferred tax assets, subject to the valuation allowance we have established.

The total amount of unrecognized benefit that would impact the effective tax rate, if recognized, was approximately $7.7 million as of June 30, 2011. It is our policy to recognize interest and penalties related to unrecognized benefits in our condensed consolidated statements of income as income tax expense. A total of approximately $1.5 million of interest and penalties is included in the amount of liability for uncertain tax positions at June 30, 2011. During the six months ended June 30, 2011, we increased liabilities by $0.1 million and increased interest and penalties by approximately $0.2 million.

We believe it is reasonably possible that approximately $2.3 million of our current unrecognized tax benefit may be recognized within the next 12 months as a result of a lapse of the statute of limitations and settlements with taxing authorities.

We, or one or more of our subsidiaries, file income tax returns in the United States federal jurisdiction and various state jurisdictions. We have extended the federal statute of limitations for Triad for the tax periods ended December 31, 1999, December 31, 2000, April 30, 2001, June 30, 2001, December 31, 2001, December 31, 2002 and December 31, 2003. We are currently under examination by the Internal Revenue Service, or IRS, regarding the federal tax return of Triad for the tax periods ended December 31, 2004, December 31, 2005, December 31, 2006 and July 25, 2007. We believe the results of this examination will not be material to our consolidated results of operations or consolidated financial position. With few exceptions, we are no longer subject to state income tax examinations for years prior to 2007 and federal income tax examinations with respect to Community Health Systems, Inc. federal returns for years prior to 2007. Our federal income tax returns for the 2007 and 2008 tax years are currently under examination by the IRS. We believe the results of this examination will not be material to our consolidated results of operations or consolidated financial position.

Recent Accounting Pronouncements

In August 2010, the Financial Accounting Standards Board, or FASB, issued Accounting Standards Update, or ASU, 2010-24, which provides clarification to companies in the healthcare industry on the accounting for professional liability insurance. This ASU states that receivables related to insurance recoveries should not be netted against the related claim liability and such claim liabilities should be determined without considering insurance recoveries. This ASU is effective for fiscal years beginning after December 15, 2010 and was adopted by us on January 1, 2011. The adoption of this ASU increased other current assets by $2.5 million, other assets, net by $41.1 million and long-term liabilities by $43.6 million in the condensed consolidated balance sheet at June 30, 2011 and no impact to the condensed consolidated statement of income for the three and six months ended June 30, 2011.

In August 2010, the FASB issued ASU 2010-23, which requires a company in the healthcare industry to use its direct and indirect costs of providing charity care as the measurement basis for charity care disclosures. This ASU also requires additional disclosures of the method used to determine such costs. We adopted this ASU on January 1, 2011. In the ordinary course of business, we render services to patients who are financially unable to pay for hospital care. Included in the provision for contractual allowances is the value (at our standard charges) of these services to patients who are unable to pay that is eliminated from net operating revenues when it is determined they qualify under our charity care policy. The estimated cost incurred by us to provide these services to patients who are unable to pay was approximately $28.0 million and $25.3 million for the three months ended June 30, 2011 and 2010, respectively, and $54.1 million and $50.8 million for the six months ended June 30, 2011 and 2010, respectively. The estimated cost of these charity care services was determined using a ratio of cost to gross charges and applying that ratio to the gross charges associated with providing care to charity patients for the period. Gross charges associated with providing care to charity patients includes only the related charges for those patients who are financially unable to pay and qualify under our charity care policy and that do not otherwise qualify for reimbursement from a governmental program.

In July 2011, the FASB issued ASU 2011-07, which requires healthcare organizations that perform services for patients for which the ultimate collection of all or a portion of the amounts billed or billable cannot be determined at

the time services are rendered to present all bad debt expense associated with patient service revenue as an offset to the patient service revenue line item in the statement of operations. The ASU also requires qualitative disclosures about our policy for recognizing revenue and bad debt expense for patient service transactions and quantitative information about the effects of changes in the assessment of collectibility of patient service revenue. This ASU is effective for fiscal years beginning after

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December 15, 2011, and will be adopted by us in the first quarter of 2012. We are currently assessing the potential impact the adoption of this ASU will have on our consolidated results of operations and consolidated financial position.

FORWARD-LOOKING STATEMENTS

Some of the matters discussed in this report include forward-looking statements. Statements that are predictive in nature, that depend upon or refer to future events or conditions or that include words such as expects, anticipates, intends, plans, believes, estimates, thinks, and 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 recently-adopted and potential federal and state healthcare legislation;

risks associated with our substantial indebtedness, leverage and debt service obligations;

demographic changes;

changes in, or the failure to comply with, governmental regulations;

potential adverse impact of known and unknown government investigations, audits, and Federal and State False Claims Act litigation and other legal proceedings;

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

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

changes in inpatient or outpatient Medicare and Medicaid payment levels;

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

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

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

competition;

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

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

changes in medical or other technology;

changes in U.S. GAAP;

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

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

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

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

timeliness of reimbursement payments received under government programs.

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

Item 3. ***Quantitative and Qualitative Disclosures about Market Risk***

We are exposed to interest rate changes, primarily as a result of our Credit Facility which bears interest based on floating rates. In order to manage the volatility relating to the market risk, we entered into interest rate swap agreements described under the heading Liquidity and Capital Resources in Item 2. We do not anticipate any material changes in our primary market risk exposures in 2011. We utilize risk management procedures and controls in executing derivative financial instrument transactions. We do not execute transactions or hold derivative financial instruments for trading purposes. Derivative financial instruments related to interest rate sensitivity of debt obligations are used with the goal of mitigating a portion of the exposure when it is cost effective to do so.

A 1% change in interest rates on variable rate debt in excess of that amount covered by interest rate swaps would have resulted in interest expense fluctuating approximately $1.6 million and $1.7 million for the three months ended June 30, 2011 and 2010, respectively, and approximately $3.2 million and $3.4 million for the six months ended June 30, 2011 and 2010, respectively.

Item 4. ***Controls and Procedures***

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

There have been no changes in our internal control over financial reporting during the quarter ended June 30, 2011, that have materially affected or are reasonably likely to materially affect our internal control over financial reporting.

PART II OTHER INFORMATION

Item 1. ***Legal Proceedings***

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

Community Health Systems, Inc. Legal Proceedings

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

Medicaid disproportionate share hospital payments. The February 2006 letter

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

On June 12, 2008, two of our hospitals received letters from the United States Attorney s Office for the Western District of New York requesting documents in an investigation it was conducting into billing practices with respect to kyphoplasty procedures performed during the period January 1, 2002 through June 9, 2008. On September 16, 2008, one of our hospitals in South Carolina also received an inquiry. Kyphoplasty is a surgical spine procedure that returns a compromised vertebrae (either from trauma or osteoporotic disease process) to its previous height, reducing or eliminating severe pain. We have been informed that similar investigations have been initiated at unaffiliated facilities in Alabama, South Carolina, Indiana and other states. We believe that this investigation is related to a qui tam settlement between the same United States Attorney s office and the manufacturer and distributor of the Kyphon product, which is used in performing the kyphoplasty procedure. We are cooperating with the investigation 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 was conducted on March 1, 2011 to assess the sufficiency of the methodology used to determine class damages. On May 13, 2011, the court ordered plaintiffs to respond by June 27, 2011 with a definitive statement of how plaintiffs intend to remedy their failure to present an acceptable methodology. On July 5, 2011, we objected to plaintiffs response and on July 18, 2011 we filed a motion seeking a status hearing. We are vigorously defending this action.

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

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

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

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

On April 22, 2011, a joint motion was filed by the relator and the United States Department of Justice in the case styled United States ex rel. and Reuille vs. Community Health Systems Professional Services Corporation and Lutheran Musculoskeletal Center, LLC d/b/a Lutheran Hospital, in the United States District Court for the Northern District of Indiana, Fort Wayne Division. The lawsuit was originally filed under seal on January 7, 2009. The suit is brought under the False Claims Act and alleges that Lutheran Hospital of Indiana billed the Medicare program for (a) false 23 hour observation after outpatient surgeries and procedures, and (b) intentional assignment of inpatient status to one-day stays for cases that do not meet Medicare criteria for inpatient intensity of service or severity of illness. The relator had worked in the case management department of Lutheran Hospital of Indiana but was reassigned to another department in the fall of 2006. This facility was acquired by us as part of the July 25, 2007 merger transaction with Triad Hospitals, Inc. The complaint also includes allegations of age discrimination in Ms. Reuille s 2006 reassignment and retaliation in connection with her resignation on October 1, 2008. We had cooperated fully with the government in its investigation of this matter, but had been unaware of the exact nature of the allegations in the complaint. On December 27, 2010, the government filed a notice that it declined to intervene in

this suit. The motion contained additional information about how the government intended to proceed with an investigation regarding allegations of improper billing for inpatient care at other hospitals associated with Community Health Systems, Inc. . . . asserted in other qui tam complaints in other jurisdictions. The motion stated that the Department of Justice has consolidated its investigations of the Company and other related entities and that the Civil Division of the Department of Justice, multiple United States Attorneys offices, and the Office of Inspector General for the Department of Health and Human Services, or HHS, are now closely coordinating their investigation of these overlapping allegations. The Attorney General of Texas has initiated an investigation; the United States intends to work cooperatively with Texas and any other States investigating these allegations. The

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motion also stated that the Office of Audit Services for the Office of Investigations for HHS has been engaged to conduct a national audit of certain of our Medicare claims. The government confirmed that it considers the allegations made in the complaint styled Tenet Healthcare Corporation vs. Community Health Systems, Inc., et al. filed in the United States District Court for the Northern District of Texas, Dallas Division on April 11, 2011 to be related to the allegations in the qui tam and to what the government is now describing as a consolidated investigation. Because qui tam suits are filed under seal, no one but the relator and the government knows that the suit has been filed or what allegations are being made by the relator on behalf of the government. Initially, the government has 60 days to make a determination about whether to intervene in a case and to act as the plaintiff or to decline to intervene and allow the relator to act as the plaintiff in the suit, but extensions of time are frequently granted to allow the government additional time to investigate the allegations. Even if, in the course of an investigation, the court partially unseals a complaint to allow the government and a defendant to work to a resolution of the complaint s allegations, the defendant is prohibited from revealing to anyone even that the partial unsealing has occurred. As the investigation proceeds, we may learn of additional qui tam suits filed against us or our affiliated hospitals or related entities, or that contact letters, document requests, or medical record requests we have received in the past from various governmental agencies are generated from qui tam cases filed under seal. The motion filed on April 22, 2011 concluded by requesting a stay of the litigation in the Reuille case for 180 days, and on April 25, 2011, the court granted the motion. Our management company subsidiary, Community Health Systems Professional Services Corporation, the defendant in the Reuille case, consented to the request for the stay. We are cooperating fully with the government in its investigations.

On May 13, 2011, we received a subpoena from the SEC requesting documents related to or requested in connection with the various inquiries, lawsuits, and investigations regarding, generally, emergency room admissions or observation practices at our hospitals. The subpoena also requested documents relied upon by us in responding to the Tenet litigation, as well as other communications about the Tenet litigation. As with all government investigations, we are cooperating fully with the SEC.

Three purported class action shareholder federal securities cases have been filed in the United States District Court for the Middle District of Tennessee, namely: Norfolk County Retirement System v. Community Health Systems, Inc., Wayne T. Smith and W. Larry Cash, filed May 5, 2011; De Zheng v. Community Health Systems, Inc., Wayne T. Smith and W. Larry Cash, filed May 12, 2011; and Minneapolis Firefighters Relief Association v. Community Health Systems, Inc., Wayne T. Smith, W. Larry Cash and Thomas Mark Buford, filed June 2, 2011. All three seek class certification on behalf of purchasers of our common stock between July 27, 2006 and April 11, 2011 and allege that misleading statements resulted in artificially inflated prices for our common stock. Two shareholder derivative actions have also been filed in the United States District Court for the Middle District of Tennessee, Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund v. Wayne T. Smith, W. Larry Cash, T. Mark Buford, John A. Clerico, James S. Ely III, John A. Fry, William Norris Jennings, Julia B. North and H. Mitchell Watson, Jr., filed May 24, 2011, and Roofers Local No. 149 Pension Fund v. Wayne T. Smith, W. Larry Cash, John A. Clerico, James S. Ely, III, John A. Fry, William Norris Jennings, Julia B. North and H. Mitchell Watson, Jr., filed June 21, 2011. These two cases allege breach of fiduciary duty arising out of allegedly improper inpatient admission practices, mismanagement, waste and unjust enrichment. We believe all of these matters are without merit and will vigorously defend them.

On June 2, 2011, an order was entered unsealing a relator s qui tam complaint in the matter of U.S. ex. rel Wood M. Deming, MD, individually and on behalf of Regional Cardiology Consultants, PC v. Jackson-Madison County General Hospital, an Affiliate of West Tennessee Healthcare, Regional Hospital of Jackson, a Division of Community Health Systems Professional Services Corporation, James Moss, individually, Timothy Puthoff, individually, Joel Perchik, MD, individually, and Elie H. Korban, MD, individually. The action is pending in the Western District of Tennessee, Jackson Division. Regional Hospital of Jackson is an affiliated hospital and Mr. Puthoff is a former chief executive officer there. The Order recited that the United States had elected to intervene to a limited degree only concerning the claims against Dr. Korban for false and fraudulent billing for allegedly unnecessary stent procedures and for causing the submission of false claims by the hospitals. The United States expressly declined to intervene in all other claims against all other named defendants. On July 28, 2011, we were served by the relator. We believe the

claims against our hospital are without merit and we will vigorously defend this case.

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

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Management of Significant Legal Proceedings

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

In addition, the Audit and Compliance Committee and the other independent members of the Board of Directors oversee the functions of the voluntary compliance program, including its auditing and monitoring functions and confidential disclosure program. In recent years, the voluntary compliance program has addressed the potential for a variety of billing errors that might be the subject of audits and payment denials by the CMS Recovery Audit Contractors permanent project, including MS-DRG coding, outpatient hospital and physician coding and billing, and medical necessity for services (including a focus on hospital stays of very short duration). Efforts by management, through the voluntary compliance program, to identify and limit risk from these government audits included significant policy and guidance revisions, training and education, and auditing. With respect to Medicare inpatient admissions, improvements in case management, including updating of inpatient medical necessity criteria, heightened focus on correct use of observation status, and new policies requiring unambiguous signed physician orders prior to billing, were all adopted in 2009 and 2010. These activities were communicated to and discussed with the Audit and Compliance Committee.

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

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

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

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

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

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

Triad Hospitals, Inc. Legal Proceedings

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

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

There have been no material changes with regard to risk factors previously disclosed in our most recent annual report on Form 10-K.

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

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

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans(a)	Maximum Number of Shares That May Yet Be Purchased Under the Plans or Programs(a)
April 1, 2011 April 30, 2011		$		3,548,728
May 1, 2011 May 31, 2011	1,516,400	28.30	1,516,400	2,032,328
June 1, 2011 June 30, 2011	247,166	28.40	247,166	1,785,162
Total	1,763,566	$ 28.31	1,763,566	1,785,162

(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 both the three and six months ended June 30, 2011, we repurchased and retired 1,763,566 shares at a weighted-average price of $28.31 per share. The cumulative number of shares that have been repurchased and retired under this program through June 30, 2011 are 2,214,838 shares at a weighted-average price of $28.82.

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 June 30, 2011, under the most restrictive test under these agreements, we have approximately $65.8 million remaining available with which to pay permitted dividends and/or make stock and Note repurchases.

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

None

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

Item 5. ***Other Information***

None

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Item 6. ***Exhibits***

No.	Description
4.1	Tenth Supplemental Indenture relating to CHS/Community Health Systems, Inc. s 8 7/8% Senior Notes due 2015, dated as of June 30, 2011, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association
12	Computation of Ratio of Earnings to Fixed Charges
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

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SIGNATURES

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

COMMUNITY HEALTH SYSTEMS, INC.
(Registrant)

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

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

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

Date: July 29, 2011

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Index to Exhibits

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