Available Information

Our website address is www.chs.net and the investor relations section of our website is located at www.chs.net/investor-relations. Notwithstanding the foregoing, the information contained on our website as noted above or elsewhere in this Form 10-K is not incorporated by reference into this Form 10-K. We make available free of charge, through the investor relations section of our website, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K as well as amendments to those reports, as soon as reasonably practical after they are filed with, or furnished to, the SEC. The SEC maintains an Internet site that contains our reports, proxy and information statements, and other information that we file electronically with the SEC at www.sec.gov.

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

Regional networks are able to expand the breadth of services provided for our patients, develop centers of excellence for key services, deliver care in an organized and efficient way across the network, improve alignment with physicians and other providers, and make services more attractive to managed care and other payers.

- Patient navigation and next appointment scheduling from existing points of care;
- Availability of virtual health for certain services provided in the hospital and fordirect-to-consumer, on-demand virtual visits with physicians;
- Digital marketing and consumer engagement campaigns; and
- Other technology enabled initiatives that support connected healthcare experiences, such as patient portals, text message appointment reminders, gaps-in-care campaigns and post-discharge surveys.

Increase productivity and operating efficiencies to enhance profitability

Our hospital management teams are supported by experienced corporate leaders who have significant industry knowledge and a proven track record of success. Local hospitals benefit from centralized clinical, operational, financial and regulatory expertise that encompasses nearly every aspect of our business. Additionally, we are able to leverage deep and meaningful data sources to facilitate informed decision-making and drive operational improvements across the enterprise in areas such as drug and supply procurement, workforce optimization and staffing and emergency department and operating room performance.

Standard policies and procedures in areas ranging from physician practice management to patient accounting to construction and facilities management help to facilitate best practices, reduce variation and improve operating results. The following areas highlight some of our standardized and centralized platforms.

Billing and Collections. We have adopted standard policies and procedures with respect to billing and collections. We have automated various components of the collection cycle, including statements and collection letters, to help facilitate timely and accurate progression of our accounts through the collection cycle. We have consolidated local billing and collection functions into six centralized business offices and have completed the transition of our hospital billing departments to this new infrastructure. We are now realizing the benefits of lower patient claim denials, higher underpayment recoveries and reduced operating expenses.

Physician Support. We support newly recruited physicians to facilitate a smooth and effective transition into our communities. Newly recruited physicians participate in orientation that covers matters related to starting up a new practice or joining an established practice. For employed physicians, we utilize software solutions that monitor and help optimize their practice performance against industry standard benchmarks and best practices. We also have implemented programs to improve physician workflow, reduce physician turnover, optimize staffing at physician clinics and standardize onboarding processes.

Procurement and Materials Management. We have standardized and centralized supply chain operations to improve procurement of the medical supplies, equipment and pharmaceuticals used in our hospitals. We have an ownership interest in and participation agreement with HealthTrust Purchasing Group, L.P., or HealthTrust, a group purchasing organization, or GPO, which benefits members through scaled pricing. HealthTrust contracts with certain vendors who supply a substantial portion of our medical supplies, equipment and pharmaceuticals.

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

- Appropriate management of length of stay consistent with national standards and benchmarks;
- Reducing unnecessary utilization;
- Developing and implementing operational best practices;
- Discharge planning; and
- Compliance with applicable regulatory standards.

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For example, the Affordable Care Act has encouraged the adoption of new payment models that emphasize cost-effective delivery of care and quality of outcomes. Although the number of patients with health insurance coverage has expanded since 2010, the y0349,

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Selected Operating Data

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hospitals in Texas, as a percentage of consolidated operating revenues, were 12.2% in 2019, 11.7% in 2018 and 10.9% in 2017. Net operating revenues generated by our hospitals in Indiana, as a percentage of consolidated operating revenues, were 13.7% in 2019, 12.5% in 2018 and 11.6% in 2017.

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

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

Healthcare facility operations are also subject to certain seasonal fluctuations, including decreases in patient utilization during holiday periods and increases in colder weather months.

Government Regulation

Overview. The healthcare industry is required to comply with extensive government regulation at the federal, state and local levels. If we fail to comply with applicable laws and regulations, we may be subject to criminal penalties and civil sanctions, our hospitals could lose their licenses and we could lose our ability to participate in Medicare, Medicaid and other government programs. Hospitals must meet requirements to be certified as hospitals and qualified to participate in government programs, including those relating to the adequacy of medical care, equipment, personnel, operating policies and procedures; billing and coding for services; properly handling overpayments; classifications of levels of care provided; preparing and filing of cost reports; relationships with referral sources and referral recipients; maintenance of adequate records; hospital use; rate-setting; building codes; environmental protection; and privacy and security.

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

Government regulations may change. If that happens, we may have to make changes to our facilities, equipment, personnel and services so that our hospitals remain certified as hospitals and qualified to participate in these programs. We believe that our hospitals are in substantial compliance with current federal, state and local regulations and standards. We cannot be certain that governmental officials responsible for enforcing these laws or whistleblowers will not assert that we are in violation of them or that such statutes or regulations will be interpreted by the courts in a manner consistent with our interpretation.

Healthcare Reform. Over the last decade

Congress have stated their intent to repeal or make additional significant changes to, the Affordable Care Act, its implementation or its interpretation. As part of the tax reform legislation enacted in December 2017, effective January 1, 2019, the financial penalty enforcing the individual mandate was eliminated. Additionally, in December 2018, as a result of this change, a federal judge in Texas found the individual mandate unconstitutional and determined the rest of the Affordable Care Act was therefore invalid. In December 2019, the Fifth Circuit Court of Appeals upheld this decision with respect to the individual mandate, but remanded for further consideration of how this affects the rest of the law. Pending the appeals process, the law remains in place. The elimination of the individual mandate penalty and other changes may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased. Moreover, final rules issued in 2018 expand the availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act.

We believe that the Affordable Care Act has had a positive impact on net operating revenues and income from continuing operations as the result of the expansion of private sector and Medicaid coverage that has occurred. However, other provisions of the Affordable Care Act, such as requirements related to employee health insurance coverage, have increased our operating costs. In addition, the Affordable Care Act has made changes to Medicare and Medicaid reimbursement that could adversely impact the reimbursement we receive under these programs. These changes include a productivity offset to the Medicare market basket update and reductions to the Medicare and Medicaid disproportionate share hospital, or DSH, payments.

Substantial uncertainty remains regarding the ongoing net effect of the Affordable Care Act due to the possibility of repeal or significant additional changes to the law, clarifications and modifications resulting from executive orders, the rule-making process, the ultimate outcome of court challenges and the development of agency guidance, whether and how many states ultimately decide to expand Medicaid coverage and on what terms, the number of individuals who elect to purchase health insurance coverage and budgetary issues at federal and state levels. The impact on the healthcare industry and timing of any potential repeal of or further changes to the Affordable Care Act and any alternative provisions is unknown. For example, members of Congress have proposed measures that would expand government-sponsored coverage, including single-payor proposals, which could also significantly affect healthcare providers. Other initiatives and proposals, including those aimed at price transparency and out-of-network charges, may impact prices and the relationships between hospitals and insurers. It is difficult to predict the nature and success of future financial or delivery system reforms.

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

- making claims to Medicare for services not provided or misrepresenting actual services provided in order to obtain higher payments;
- paying money to induce the referral of patients where services are reimbursable under a federal health program; or
- paying money to limit or reduce the services provided to Medicare beneficiaries.

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

entities with which the physician has a financial relationship. Often these state laws are broad in scope and may apply regardless of the source of payment for care. These statutes typically provide for criminal and civil penalties, as well as loss of licensure. Little precedent exists for the interpretation or enforcement of these state laws.

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

Federal False Claims Act and Similar State Laws. Another significant enforcement mechanism used within the healthcare industry is the federal False Claims Act, or FCA, which can be used to prosecute Medicare and other government program fraud involving issues such as coding errors, billing for service not provided and submitting false cost reports. The FCA covers payments involving federal funds in connection with the health insurance exchanges created under the Affordable Care Act, if those payments involve any federal funds. Liability under the FCA often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The FCA broadly defines the term "knowingly." Although simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity may constitute "knowingly" submitting a false claim and result in liability. Among the many other potential bases for liability under the FCA is the knowing and improper failure to report and refund amounts owed to the government within 60 days of identifying an overpayment. An overpayment is deemed to be identified when a person has, or should have through reasonable diligence, determined that an overpayment was received and quantified the overpayment. Submission of a claim for an item or service generated in violation of the Anti-Kickback Statute constitutes a false or fraudulent claim under the FCA. In some cases, whistleblowers, the federal government and courts have taken the position that providers who allegedly have violated other statutes, such as the Stark Law, have thereby submitted false claims under the FCA.

Violations of the FCA can result in very significant monetary penalties and treble damages. For each individual violation of the FCA, the defendant must pay three times the [illegible]

Affordable Care Act, and a 0.8 percentage point downward productivity adjustment. For calendar y0ų

quality and

attempt to attract our physicians' patients to our hospitals by offering quality services and facilities, convenient locations and state-of-the-art equipment.

Trends towards transparency may have a potential impact on our competitive position in ways that we are unable to predict. CMS publicizes on its Hospital Compare website data that hospitals submit in connection with Medicare reimbursement claims, including performance data related to quality measures and patient satisfaction surveys. Federal law provides for the future expansion of the number of quality measures that must be reported. Currently, hospitals are required to publish online a list of their standard charges for items and services. Beginning in 2021, hospitals will be required to publish additional types of standard charges for all items and services, including discounted cash prices and payor-specific and de-identified negotiated charges, in a publicly accessible online file. Hospitals will also be required to publish a consumer-friendly list of charges for certain "shoppable" services (i.e., services that can be scheduled by a patient in advance) and any associated ancillary services.

period ended September 30, 2014 for further discussion of the background of this matter and details of the settlement. In addition to the amounts paid in the settlement, we executed a five-year Corporate Integrity Agreement, or CIA, with the OIG that has been incorporated into our existing and comprehensive compliance program.

On September 25, 2018, we announced a global resolution and settlement agreements ending the U.S. Department of Justice investigation into certain conduct of HMA and its affiliated entities and settling certain qui tam lawsuits that were initiated and pending, and known to us, before our acquisition by merger of HMA in 2014. Under this settlement, we made payments totaling $266 million, including interest, in the fourth quarter of 2018. See the "Legal Proceedings" discussion in Part II, Item 1 of our Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2018 and the press release filed therewith on September 25, 2018 for further discussion of this matter and the details of the settlement. Additionally, under the terms of the global settlement, our existing CIA has been amended and extended. The extension began immediately and effectively adds two years to the existing CIA, with the amended CIA now running through 2021.

The compliance measures and reporting and auditing requirements contained in the CIA include:

- continuing the duties and activities of our Corporate Compliance Officer, Corporate Compliance Work Group, and Facility Compliance Officers and committees;
- maintaining our written Code of Conduct, which sets forth our commitment to full compliance with all statutes, regulations, and guidelines applicable to federal healthcare programs;
- maintaining our written policies and procedures addressing the operation of our Compliance Program, including adherence to medical necessity and admissions standards for inpatient hospital stays;
- continuing our general compliance training;
- providing specific training for appropriate personnel on billing, case management and clinical documentation;
- engaging an independent third party to perform an annual review of our compliance with the CIA;
- continuing our Confidential Disclosure Program and hotline to enable employees or others to disclose issues or questions regarding possible inappropriate policies or behavior;
- maintaining our screening program to ensure that we do not hire or engage employees or contractors who are ineligible persons for federal healthcare programs;
- notifying the OIG of any government investigations;
- reporting any material deficiency which resulted in an overpayment to us by a federal healthcare program; and
- submitting annual reports to the OIG which describe in detail the operations of our corporate Compliance Program for the past year.

Material, uncorrected violations of the CIA could lead to our suspension or disbarment from participation in Medicare, Medicaid and other federal and state healthcare programs and repayment obligations. In addition, we are subject to possible civil penalties for failure to substantially comply with the terms of the CIA, including stipulated penalties ranging from $1,000 to $2,500 per day. We are also subject to a stipulated penalty of $50,000 for each false certification made by us or on our behalf in connection with reports required under the CIA. The CIA increases the amount of information we must provide to the federal government regarding our healthcare practices and our compliance with federal regulations. The reports we provide in connection with the CIA could result in greater scrutiny by regulatory authorities. We believe our existing Compliance Program addresses compliance with the operational terms of the CIA.

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$273 million was drawn on December 31, 2019. The aggregate amount we may draw under the ABL Facility may not exceed the “borrowing base” (as calculated thereunder) less outstanding letters of credit thereunder, which fluctuace

In addition, after entering into a definitive agreement, we may be subject to the satisfaction ofpre-closing conditions as well as necessary regulatory and governmental approvals, which, if not satisfied or obtained, may prevent us from completing the sale. Divestitures may also involve continued financial exposure related to the divested business, such as through indemnities or retained obligations, that present risk to us.

Our planned divestiture activities may present financial, managerial, and operational risks. Those risks include diversion of management attention from improving existing operations; additional restructuring charges and the related impact from separating personnel, renegotiating contracts, and restructuring financial and other systems; adverse effects on existing business relationships with patients and third-party payors; and the potential that the collectability of any patient accounts receivable retained from any divested hospital may be adversely impacted. Any of these factors could adversely affect our financial condition and results of operations.

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In addition, there are heightened coordinated civil .a

$50,000 for each false certification made by us or on our behalf, pursuant to the reporting provisions of the CIA. The CIA increases the amount of information we must provide to the federal government regarding our healthcare practices and our compliance with federal regulations. The reports we provide in connection with the CIA could result in greater scrutiny by regulatory authorities.

If we experience gro

care. The failure of one or more large employers, or the closure or substantial reduction in the number of individuals employed at manufacturing or other facilities located in or near many of the non-urban communities in which our hospitals primarily operate, could cause affected employees to move elsewhere for employment or lose insurance coverage that was otherwise available to them. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may:

- delay or forgo elective procedures;
- purchase a high-deductible insurance plan or no insurance at all, which increases a hospital's dependence onself-pay revenue; or
- choose to seek care in emergency rooms.

The occurrence of these events may cause a reduction in our revenues and adversely impact our results of operations.

If there are delays in regulatory updates by governmental entities to federal and state healthcare programs, we may experience increased volatility in our operating results as such delays may result in a timing difference between when such program revenues are earned and when they become known or estimable for purposes of accounting recognition.

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

If our adoption and utilization of electronic health record systems fails to satisfy HHS standards, our consolidated results of operations could be adversely affected, and we may be adversely affected by changing and more burdensome interoperability requirements.

Under the Health Information Technology for Economic and Clinical Health Act, or HITECH, and other laws, eligible hospitals that fail to demonstrate meaningful use of certified EHR technology and have not applied and qualified for a hardship exception are subject to reduced reimbursement from Medicare. Eligible healthcare professionals are also subject to positive or negative payment adjustments based, in part, on their use of EHR technology. Thus, if our hospitals and employed professionals are unable to properly adopt, maintain, and utilize certified EHR systems, we could be subject to penalties and lawsuits that may have an adverse effect on our consolidated financial position and consolidated results of operations.

The federal government is also promoting the efficient exchange of health care information to improve health care. The 21st Century Cures Act prohibits information blocking by health care providers and certain other entities, which is defined as engaging in activities that are likely to interfere with, prevent or materially discourage access, exchange or use of electronic health information, subject to limited exceptions. Initiatives related to health care technology and interoperability may require changes to our operations, impose new and complex obligations on us, affect our relationships with providers, vendors and other third parties and require investments in infrastructure. We may be subject to penalties for failure to comply.

Our operations could be significantly impacted by interruptions or restrictions in access to our information systems.

Our operations depend heavily on effective information systems to process clinical, operational and financial information. Information systems require an ongoing commitment of significant resources to maintain and

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
West Virginia				
Plateau Medical Center	Oak Hill	25	July, 2002	Owned
Greenbrier Valley Medical Center	Ronceverte	D 122	July, 2007	Owned
Total Licensed Beds at December 31, 2019		16,240		
Total Hospitals at December 31, 2019		102		

(1) Licensed beds aor Ď Ȯ)

and/or financial relationships with physicians. We avail ourselves of various mechanisms to address potential overpayments arising out of these issues, including repayment of claims, rebilling of claims, and participation in voluntary disclosure protocols offered by the Centers for Medicare and Medicaid Services and the Office of the Inspector General. Participating in voluntary repayments and voluntary disclosure protocols can have the potential for significant settlement obligations or even enforcement action.

The following legal proceedings are described in detail because, although they may not be required to be disclosed in this Part I, Item 3 under SEC rules, due to the nature of the business of the Company, we believe that the following discussion of these matters may provide useful information to security holders. This discussion does not include claims and lawsuits covered by medical malpractice, general liability or employment practices insurance and risk retention programs, none of which claims or lawsuits would in any event be required to be disclosed in this Part I, Item 3 under SEC rules. Certain of the matters referenced below are also discussed in Note 15 of the Notes to Consolidated Financial Statements included under Part II, Item 8 of this Form 10-K.

Shareholder Litigation

2011 Class Action Shareholder Federal Securities Cases. Three purported class action cases have been filed in the United States District Court for the Middle District of Tennessee; namely, Norfolk County Retirement System v. Community Health Systems, Inc., et al., filed May 9, 2011; De Zheng v. Community Health Systems, Inc., et al., filed May 12, 2011; and Minneapolis Firefighters Relief Association v. Community Health Systems, Inc., et al., filed June 21, 2011. All three seek class certification on behalf of purchasers of our common stock between July 27, 2006 and April 11, 2011 and allege that misleading statements resulted in artificially inflated prices for our common stock. In December 2011, the cases were consolidated for pretrial purposes and NYC Funds and its counsel were selected as lead plaintiffs/lead plaintiffs' counsel. In lieu of ruling on our motion to dismiss, the court permitted the plaintiffs to file a first amended consolidated class action complaint which was filed on October 5, 2015. Our motion to dismiss was filed on November 4, 2015 and oral [illegible] 2016. O

Wayne T. Smith, et al, filed August 20, 2019 in the United States District Court for the Middle District of Tennessee; Susheel Tanjavoor v. Wayne T. Smith, et al., filed August 29, 2019, in the United States District Court for the District of Delaware; and Roofers Local No. 149 Pension Fund v. John A. Clerico, et al, filed October 30, 2019, in the United States District Court for the District of Delaware. All four seek relief derivatively and on behalf of Community Health Systems, Inc. against certain Company officers and directors based on alleged breaches of fiduciary duty, unjust enrichment, and other acts related to certain Company disclosures in 2017 and 2018 regarding the Company's adoption of Accounting Standards Update 2014-09, which the Company adopted effective January 1, 2018. All four cases have been stayed by agreement.

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this matter, believe the attacker was a foreign “Advanced Persistent Threat” group who used highly sophisticated malware and technology to attack our systems. The attacker was able to bypass our security measures and successfully copy and transfer outside the Company certain non-medical patient identification data (such as patient names, addresses, birthdates, telephone nos., pass our

Court denied all defendants' motions to dismiss on April 20, 2018. The plaintiffs moved for class certification. Plaintiffs also amended their complaint on September 14, 2018. We moved to dismiss the additional claims in the plaintiffs' September 14, 2018 amended complaint and responded to plaintiffs' class certification motion. On March 29, 2019, the court granted our motion to dismiss the additional claims. The court granted the plaintiffs' motion for class certification on that same date. On April 12, 2019, we filed a petition for permission to appeal the court's order granting class certification with the United States Court of Appeals for the Sixth Circuit, which was denied on July 31, 2019. On May 17, 2019, the plaintiffs moved to amend their complaint for a third time to add additional claims, which the District Court denied on August 2, 2019. The trial for this matter is set for July 7, 2020. We believe the claims are without merit and will vigorously

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U.S. ex rel. Derek Lewis and Joey Neiman v. Community Health Systems, Inc., Medhost, Inc., et al. On March 14, 2019, the United States District Court for the Southern District of Florida ordered the unsealing of this qui tam suit. The order revealed that the United States had declined to intervene in the action. The complaint alleges that Community Health Systems, Inc. and its affiliated hospitals (CHS Hospitals) violated the False Claims Act by submitting claims for EHR Meaningful Use incentive payments that they knew or should have known were false. The allegations of wrongful falsity generally relate to the CHS Hospitals' use of certain software products sold to them by co-defendant, Medhost, Inc. The plaintiffs amended their complaint on July 26, 2019. We filed a motion to dismiss the complaint on September 24, 2019, which is pending. We believe this matter will be resolved without trial, and we intend to vigorously defend against the claims asserted against us.

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Item 6. Selected Financial Data

The following table summarizes specified selected financial data and should be read in conjunction with our related Consolidated Financial Statements and accompanying Notes to Consolidated Financial Statements.

Community Health Systems, Inc.
Five Year Summary of Selected Financial Data

	Year Ended December 31,				
	2019	2018	2017	2016	2015
	(in millions, except share and per share data)				
Consolidated Statement of (Loss) Income Data					
Net operating revenues	$ 13,210	$ 14,155	$ 15,353	$ 18,438	$ 19,437
Income (loss) from operations	650	208	(1,878)	(860)	1,337
(Loss) income from continuing operations	(590)	(704)	(2,384)	(1,611)	295
Net (loss) income	(590)	(704)	(2,396)	(1,626)	259
Net income attributable to noncontrolling interests	85	84	63	95	101
Net (loss) income attributable to Community Health Systems, Inc. stockholders	(675)	(788)	(2,459)	(1,721)	158

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Hospital	Buyer	City, State		

indexed for inflation annually, although increases have historically been less than actual inflation. On August 16, 2019, CMS issued the final rule to increase this index by 3.0% for hospital inpatient acute care services that are reimbursed under the prospective payment system, beginning October 1, 2019. The final rule [illegible] with other changes to payment policies is expected to yield an average 2.9% increase in reimbursement for hospital inpatient acute care services. An additional reduction applies to hospitals that do not submit required patient quality data. We are complying with this data submission requirement. Payments may also be affected by various other adjustments, such as admission and medical review criteria for inpatient services commonly known as the “two midnight rule.” This rule limits when services to Medicare beneficiaries are payable as inpatient hospital services. Reductions in the rate of increase or overall reductions in Medicare reimbursement may cause a decline in the growth of our net operating revenues.

Payment rates under the Medicaid program vary by state. In addition to the base payment rates for specific claims for services rendered to Medicaid enrollees, [illegible] reimbursement programs to mak[illegible] claims fo[illegible] car[illegible] not specif[illegible] [illegible] Merovq[illegible] bute cats, [illegible] cate o[illegible], whi[illegible] te [illegible] baa[illegible] f dites

The net results of the above-mentioned changes resulted in los.s

No discontinued operations were separately reported for the year ended December 31, 2018. Discontinued operations for the year ended December 31, 2017, include the results of operations of certain hospitals owned or leased by us as of December 31, 2017, which were classified as being held for sale or sold. The operation of these hospitals resulted in a loss, net of taxes, of $6 million for the year ended December 31, 2017. An after-tax impairment charge of $6 million was recorded during the year ended December 31, 2017, based on the difference between the estimated fair value and the carrying value of the assets held for sale. Overall, discontinued operations consisted of a loss, net of taxes, of $12 million for the year ended December 31, 2017.

Net loss, as a percentage of net operating revenues, decreased from 15.6% for the year ended December 31, 2017 to 5.0% for the year ended December 31, 2018.

Net income attributable to noncontrolling interests, as a percentage of net operating revenues increased from 0.4% for the year ended December 31, 2017 to 0.6% for the year ended December 31, 2018.

Net loss attributable to Community Health Systems, Inc. was $788 million for the year ended December 31, 2018, compared to $2.5 billion for the year ended December 31, 2017. The decrease in net loss attributable to Community Health Systems, Inc. was primarily due to the change in estimate recorded as a reduction of the net operating revenues and the impairment of goodwill and certain long-lived assets based on their estimated fair values for hospitals sold or held for sale in 2017.

Liquidity and Capital Resources

2019 Compared to 2018

Net cash provided by operating activities increased $111 million, from approximately $274 million for the year ended December 31, 2018, to approximately $385 million for the year ended December 31, 2019. The increase in cash provided by operating activities was primarily the result of $266 million paid in

primarily related to the purchase of one hospital in Mississippi, physician practices and other ancillary services. Our expenditures for the years ended December 3

consolidated fixed charge coverage ratio as such triggering event had not occurred during the last twelve months ended December 31, 2019.

we will be required to, first, repay outstanding borrowings and, second, replace or cash collateralize outstanding letters of credit, in

offering of $500 million aggregate principal amount of additional 8% Senior Secured Notes due 2026, or the Additional 2026 Notes, increasing the total aggregate principal of the 8% Senior Secured Notes due 2026 to $2.101 billion. CHS used the proceeds from the Additional 2026 Notes to repay amounts outstanding under the Revolving Facility, redeem all $121 million aggregate principal amount of CHS' then outstanding 7⅛% Senior Notes due 2020 and repay borrowings outstanding under the ABL Facility. The additional 2026 Notes have identical terms, other than issue date, issue price and the date from which interest initially accrued, as the 8% Senior Secured Notes due 2026 issued on March 6, 2019. The 8% Senior Secured Notes due 2026 bear interest at a rate of 8.000% per annum, payable semi-annually in arrears on March 15 and September 15 of each year. The 8% Senior Secured Notes due 2026 are scheduled to mature on March 15, 2026. The 8% Senior Secured Notes due 2026 are unconditionally guaranteed on a senior-priority secured basis by us and each of the CHS current and future domestic subsidiaries that provide guarantees under CHS' ABL Facility, any capital market debt securities of CHS (including CHS' outstanding senior notes) and certain other long-term debt of CHS. The 8% Senior Secured Notes due 2026 are secured by a shared first-priority lien on the Non-ABL Priority Collateral and a shared second-priority lien on the ABL Priority Collateral, in each case subject to certain exceptions. CHS terminated the Revolving Facility upon consummation of the Additional 2026 Notes offering and the outstanding letters of credit were moved under the ABL Facility.

On November 19, 2019, we issued approximately $700 million aggregate principal amount of the 8% Senior Secured Notes due 2027, or the 8% Senior Secured Notes due 2027, and approximately $1.7 billion aggregate principal amount of 6⅞% Senior Notes due 2028, or the 6⅞% Senior Notes due 2028, in exchange for approximately $2.4 billion of 6⅞% Senior Notes due 2022, or the 2019 Exchange Offer. No cash proceeds were received from the 2019 Exchange Offer. The 8% Senior Secured Notes due 2027 bear interest at a rate of 8.000% per annum, payable semi-annually in arrears on June 15 and December 15 of each year, commencing on June 15, 2020. The 8% Senior Secured Notes due 2027 are scheduled to mature on December 15, 2027. The 8% Senior Secured Notes due 2027 are unconditionally guaranteed on a senior-priority secured basis by us and each of the CHS current and future domestic subsidiaries that provide guarantees under CHS' ABL Facility, any capital market debt securities of CHS (including CHS' outstanding senior notes) and certain other long-term debt of CHS. The 8% Senior Secured Notes due 2027 are secured by shared first-priority liens on the Non-ABL Priority Collateral and shared second-priority liens on the ABL Priority Collateral, in each case subject to certain exceptions.

The 6⅞% Senior Notes due 2028 bear interest at a rate of 6.875% per annum, payable semi-annually in arrears on April 1 and October 1 of each year, commencing on April 1, 2020. The 6⅞% Senior Notes due 2028 are scheduled to mature on April 1, 2028. The 6⅞% Senior Notes due 2028 are unconditionally guaranteed on a senior-priority unsecured basis by us and each of the CHS current and future domestic subsidiaries that provide guarantees under CHS' ABL Facility, any capital market debt securities of CHS (including CHS' outstanding senior notes) and certain other long-term debt of CHS.

On January 23, 2020, we announced that CHS commenced a cash tender offer for any and all of the outstanding 5⅛% Senior Secured Notes due 2021. As of the early tender deadline on February 5, 2020, approximately $632 million aggregate principal amount of 5⅛% Senior Secured Notes due 2021, or approximately 63.25% of the outstanding 5⅛% Senior Secured Notes due 2021, had been validly tendered and not validly withdrawn. In connection with the commencement of the cash tender offer, CHS issued to holders of the 5⅛% Senior Secured Notes due 2021 a conditional notice of redemption to redeem all of the 5⅛% Senior Secured Notes due 2021 not purchased by CHS in the tender offer at a redemption price of 100.000% of the principal amount thereof plus accrued interest to, but not including, February 22, 2020.

On February 6, 2020, CHS completed a private offering of $1.462 billion aggregate principal amount of 6⅝% Senior Secured Notes due 2025, or the 6⅝% Senior Secured Notes due 2025. CHS used the net proceeds of the offering of the 6⅝% Senior Secured Notes due 2025 to (i) purchase any and all of its 5⅛% Senior Secured Notes due 2021 validly tendered and not validly withdrawn in the cash tender offer announced on January 23, 2020, (ii) redeem all of the 5⅛

We may elect from time to time to purchase our outstanding debt in open market purchases, privately negotiated transactions or otherwise. Any such debt repurchases will depend upon prevailing market conditions, our liquidity requirements, contractual restrictions, applicable securities laws requirements, and other factors.

Off-balance Sheet Arrangements

Off-balance sheet arrangements consist of letters of credit of $145 million issued on the ABL Facility, primarily in support of potential insurance-related claims and certain bonds, as well as approximately $19 million representing the maximum potential amount of future payments under physician recruiting guarantee commitments in excess of the liability recorded at December 31, 2019.

As described more fully in Note 15 of the Notes to Consolidated Financial Statements included under Part II, Item 8 of this Form10-K, at December 31, 2019, we have certain cash obligations for replacement facilities and other construction commitments of $85 million.

Noncontrolling Interests

We have sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. As of December 31, 2019, we have hospitals in 10 of the markets we serve, with noncontrolling physician ownership interests ranging from 1% to 40%. In addition, as of December 31, 2019 we have nine other hospitals with noncontrolling interests owned by non-profit entities. On August 15, 2018, we completed the acquisition of the 20% ownership interest held by the non-profit entity that was the noncontrolling interest owner of two of our hospitals in Indiana for approximately $20 million. Redeemable noncontrolling interests in equity of consolidated subsidiaries was $502 million and $504 million as of December 31, 2019 and 2018, respectively, and noncontrolling interests in equity of consolidated subsidiaries was $77 million and $72 million as of December 31, 2019 and 2018, respectively. The amount of net income attributable to noncontrolling interests was $85 million, $84 million and $63 million for the years ended December 31, 2019, 2018 and 2017, respectively. As a result of the change in the Stark Law “whole hospital” exception included in the Affordable Care Act, we are not permitted to introduce physician ownership at any of our hospital facilities that did not have physician ownership at the time of the adoption of the Affordable Care Act, or increase the aggregate percentage of physician ownership in any of our former or existing hospital joint ventures in exces inte ntage of hip in Af frjoe p exce ce a hospit

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

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 a

contractual reimbursement percentage, which is based on payor classification, historical paid claims data and, when applicable, application of the expected managed care plan reimbursement based on contract terms.

Due to the complexities involved in these estimates, actual payments we receive could be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs and managed care contracts differed by 1% at December 31, 2019 from our estimated reimbursement percentage, net loss for the year ended December 31, 2019 would have changed by approximately $80 million, and net accounts receivable at December 31, 2019 would have changed by $102 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 loss by an insignificant amount for each of the years ended December 31, 2019, 2018 and 2017.

Patient Accounts Receivable

Substantially all of our accounts receivable are related to providing healthcare services to patients at our hospitals and affiliated businesses. 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. 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 any adjustments to the transaction price for implicit price concessions by reserving a percentage of all self-pay accounts receivable without regard to aging category, based on collection history, adjusted for expected recoveries and any anticipated changes in trends. Our ability to estimate the transaction price and any implicit price concessions is not impacted by not utilizing an aging of our net accounts receivable as we believe that substantially all of the risk exists at the point in time such accounts are identified as self-pay. 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.

Patient accounts receivable are recorded at net realizable value based on certain assumptions determined by each payor. For third-party payors including Medicare, Medicaid, and Managed Care, the net realizable value is based on the estimated contractual reimbursement percentage, which is based on current contract prices or historical paid claims data by payor. For self-pay accounts receivable, which includes patients who are uninsured and the patient responsibility portion for patients with insurance, the net realizable value is determined using estimates of historical collection experience without regard to aging category. These estimates are adjusted for estimated conversions of patient responsibility portions, expected recoveries and any anticipated changes in trends.

Patient accounts receivable can be impacted by the effectiveness of our collection efforts. Additionally, significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect the net realizable value of accounts receivable. We also continually review the net realizable value of accounts receivable by monitoring historical cash collections as a percentage of trailing net operating revenues, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, the composition of self-pay receivables between pure self-pay patients and the patient responsibility portion of third-party insured receivables and the impact of recent acquisitions and dispositions. If the actual collection percentage differed by 1% at December 31, 2019 from our estimated collection percentage as a result of a change in expected recoveries, net loss for the year ended December 31, 2019 would have changed by $53 million, and net accounts receivable at December 31, 2019 would have changed by $68 million. We also continually review our overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net operating revenues, as well as

The total amount of unrecognized benefit that would impact the effective tax rate, if recognized, was approximately $1 million as of December 31, 2[illegible]

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, among other things:

- general economic and business conditions, both nationally and in the regions in which we operate;
- the impact of current or future federal and state health reform initiatives, including, without limitation, the Affordable Care Act, and the potential for the Affordable Care Act to be repealed, or found unconstitutional or otherwise invalidated, or for additional changes to the law, its implementation or its interpretation (including through executive orders and court challenges);
- the extent to and manner in which states support increases, decreases or changes in Medicaid programs, implement health insurance exchanges or alter the provision of healthcare to state residents through regulation or otherwise;
- the future and long-term viability of health insurance exchanges and potential changes to the beneficiary enrollment process;
- risks associated with our substantial indebtedness, leverage and debt service obligations, and the fact that a substantial portion of our indebtedness will mature and become due in the near future, including our ability to refinance such indebtedness on acceptable terms or to incur additional indebtedness, and our ability to remain in compliance with debt covenants;
- demographic changes;
- changes in, or the failure to comply with, federal, state or local laws or governmental regulations affecting our business;
- 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 provider arrangements with payors and the terms of these arrangements, which may be further affected by the increasing consolidation of health insurers and managed care companies and vertical integration efforts involving payors and healthcare providers;
- changes in, or the failure to comply with, contract terms with payors and changes in reimbursement policies or rates paid by federal or state healthcare programs or commercial payors;
- any potential additional impairments in the carrying value of goodwill, other intangible assets, or other long-lived assets, or changes in the useful lives of other intangible assets;
- changes in inpatient or outpatient Medicare and Medicaid payment levels and methodologies;
- the effects related to the continued implementation of the sequestration spending reductions and the potential for future deficit reduction legislation;
- increases in the amount and risk of collectability of patient accounts receivable, including decreases in collectability which may result from, among other things, self-pay growth and difficulties in recovering payments for which patients are responsible, includingco-pays and deductibles;
- the efforts of insurers, healthcare providers, large employer groups and others to contain healthcare costs, including the trend toward value-based purchasing;
- increases in wages as a result of inflation or competition for highly technical positions and rising supply and drug costs due to market pressure from pharmaceutical companies and new product releases;

- liabilities and other claims asserted against us, including self-insured malpractice claims;
- competition;
- our ability to attract and retain, at reasonable employment costs, qualified personnel, key management, physicians, nurses and other healthcare workers;
- trends toward treatment of patients in less acute or specialty healthcare settings, including ambulatory surgery centers or specialty hospitals;
- changes in medical or other technology;
- changes in U.S. GAAP;
- the availability and terms of capital to fund any additional acquisitions or replacement facilities or other capital expenditures;
- our ability to successfully make acquisitions or complete divestitures, including the disposition of hospitals and non-hospital businesses pursuant to our portfolio rationalization and deleveraging strategy, our ability to complete any such acquisitions or divestitures on desired terms or at all, the timing of the completion of any such acquisitions or divestitures, and our ability to realize the intended benefits from any such acquisitions or divestitures;
- the impact that changes in our relationships with joint venture or syndication partners could have on effectively operating our hospitals or ancillary services or in advancing strategic opportunities;
- our ability to successfully integrate any acquired hospitals, or to recognize expected synergies from acquisitions;
- the impact of seasonal severe weather conditions, including the timing and amount of insurance recoveries in relation to severe weather events;
- our ability to obtain adequate levels of insurance, including general liability, professional liability, and directors and officers liability insurance;
- timeliness of reimbursement payments received under government programs;
- effects related to pandemics, epidemics, or outbreaks of infectious diseases, including the coronavirus known as COVID-19;
- the impact of prior or potential future cyber-attacks or security breaches;
- any failure to comply with the terms of the Corporate Integrity Agreement;
- the concentration of our revenue in a small number of states;
- our ability to realize anticipated cost savings and other benefits from our current strategic and operational cost savings initiatives;
- changes in interpretations, ioio

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

Index to Financial Statements

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Community Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 2019 and 2018, the related consolidated statements of loss, comprehensive loss, stockholders' (deficit) equity, and cash flows, for each of the three years in the period ended December 31, 2019, and the related notes and the schedule listed in the Index at Item 15 (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2019 and 2018, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2019, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2019, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 20, 2020, expressed an unqualified opinion on the Company's internal control over financial reporting.

Change in Accounting Principle

As discussed in Note 1 to the financial statements, the Company has adopted Accounting Standards Codification Topic 842, "Leases", using the modified retrospective adoption method on January 1, 2019.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and Y@v

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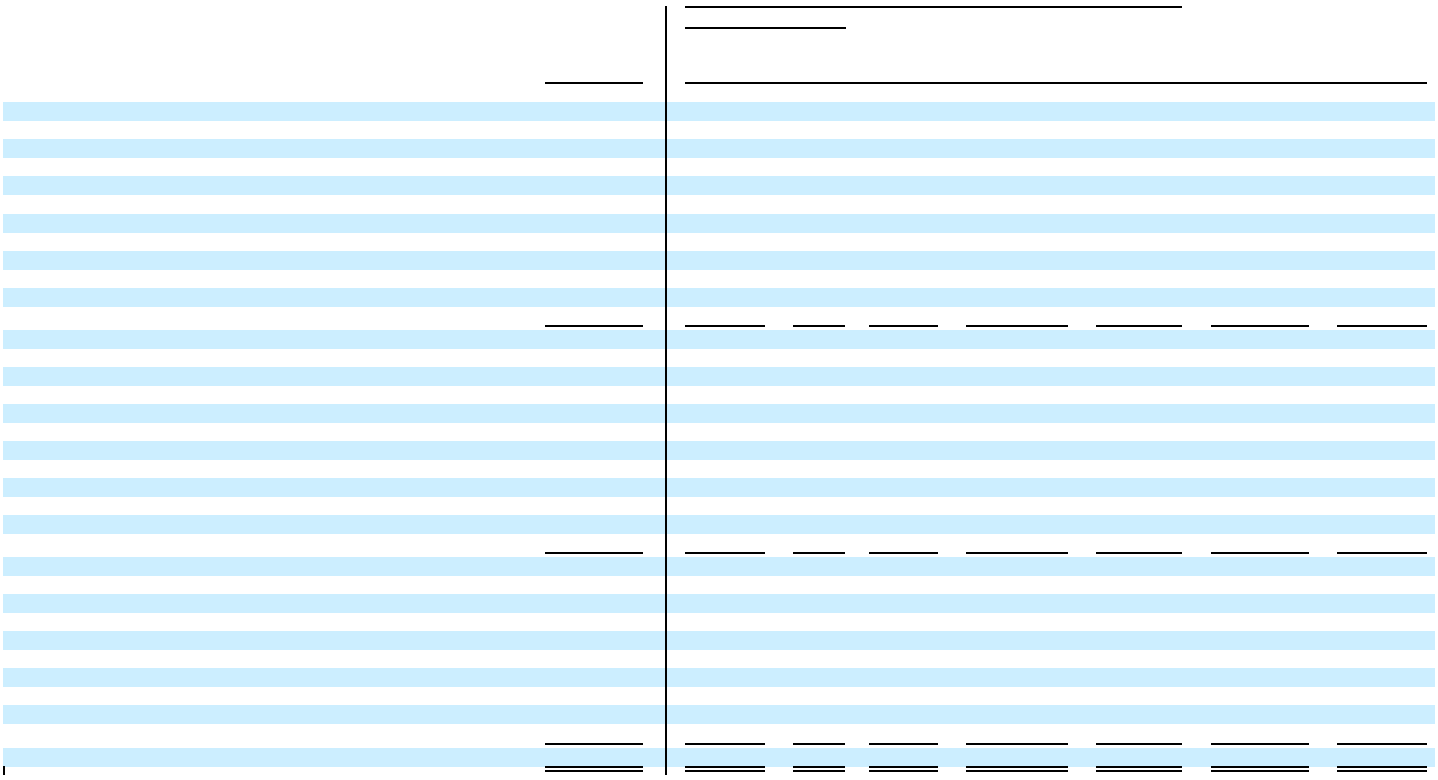

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Marketable Securities. Prior to adoption of Accounting Standards Update ("ASU") 2016-01 on January 1, 2018, the Company's marketable securities were classified as trading or available-for-sale. T

from third-party payors were $137 million and $155 million as of December 31, 2019 and December 31, 2018, respectively, and are included in other current assets in the accompanying consolidated balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 2016.

Charity Care

In the ordinary course of business, the Company renders services to patients who are financially unable to pay for hospital care. The Company's policy is to not pursue collections for such amounts; therefore, the related charges for those patients who are financially unable to pay and that otherwise do not qualify for reimbursement from a governmental program are not reported in net operating revenues, and are thus classified as charity care. The Company determines amounts that qualify for charity care primarily based on the patient's household income relative to the federal poverty level guidelines, as established by the federal government.

These charity care services are estimated to be $540 million, $491 million and $482 million for the years ended December 31, 2019, 2018 and 2017, respectively, representing the value (at the Company's standard charges) of these charity care services that are excluded from net operating revenues. The estimated cost incurred by the Company to provide these charity care services to patients who are unable to pay was approximately $66 million, $62 million and $62 million for the years ended December 31, 2019, 2018 and 2017, 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.

During 2017 and culminating with the financial close process at December 31, 2017, the Company developed new accounting methodologies and processes to implement ASU 2014-09, the accounting standard for revenue recognition that was adopted by the Company effective January 1, 2018. By implementing new data extraction techniques and updated hindsight information on historical collection data, the Company was able to better estimate the net amount after contractual allowances owed by the third-party payor and what will be owed by the patient based on historical experience. Such updated information included portfolio-level data related to historical collection amounts on an individual hospital and patient level that previously had not been readily available. Using this information the Company created a new accounting process by which it can estimate contractual allowances on a per patient basis. In addition to this new accounting methodology, the Company also revised its methods of estimating contractual allowances to (1) expand the hindsight period over which the Company analyzes payors' historical paid claims data to estimate contractual allowances, (2) expand the basis for payor denied claims to refine the hindsight reserve for such denials, and (3) adjust the contractual allowances for certain categories of commercial payors using more precise historical experience based on recent patterns of account reimbursement. Additionally, the Company evaluated the estimated collection of those amounts due from the patient as part of the Company's estimate of the allowance for doubtful accounts. This analysis also included an evaluation of patient accounts receivable retained after the divestiture of 30 hospitals throughout 2017, and certain other revenues. Based on these new accounting processes and methodologies, the Company recorded a change in estimate during the three months ended December 31, 2017 to increase contractual allowances by approximately $197 million, and to record additional provision for bad debts and increase the allowance for doubtful accounts by $394 million. The total impact of the change in estimate recorded during the three months ended December 31, 2017 was a decrease to net operating revenues of $591 million.

Electronic Health Records Incentive Reimbursement. The federal government has implemented a number of regulations and programs designed to promote the use of electronic health records ("EHR") technology and, pursuant to the Health Information Technology for Economic and Clinical Health Act ("HITECH"), established requirements for a Medicare and Medicaid incentive payments program for eligible hospitals and professionals that adopt and meaningfully use certified EHR technology. The Company utilizes a gain contingency model to recognize EHR incentive payments. Recognition occurs when the eligible hospitals adopt or demonstrate

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

lease to determine the present value of future lease payments. For leases where the implicit rate is not readily determinable, the Company's incremental borrowing rate is utilized. The Company calculates its incremental borrowing rate on a quarterly basis using a third-party financial model that estimates the rate of interest the Company would have to pay to borrow an amount equal to the total lease payments on a collateralized basis over a term similar to the lease. The Company's lease agreements do not contain any material residual value guarantees or material restrictive covenants.

The Company elected the amended transition requirements allowed for by the FASB in ASU2018-11, which provide entities relief by allowing them not to recast prior comparative periods from the adoption of ASC 842. As a result, the prior year comparative financial statements have not been restated to reflect the adoption of ASC 842. Additionally, the Company elected the package of practical expedients available in ASC 842 upon adoption whereby an entity need not reassess expired contracts for lease identification or classification as a finance or operating lease, or for the reassessment of initial direct costs. The Company has not elected the practical expedient to use hindsight to determine the lease term for its leases at transition. Certain of the Company's lease agreements have lease and non-lease components, which for the majority of leases the Company accounts for separately when the actual lease andnon-lease components are determinable. For equipment leases with immaterial non-lease components incorporated into the fixed rent payment, the Company accounts for the lease and non-lease components as a single lease component in determining the lease payment. Additionally, for certain individually insignificant equipment leases such as copiers, the Company applies a portfolio approach to effectively record the operating lease liability and ROU asset.

The adoption of ASC 842 had a material impact on the Company's consolidated balance sheet through the recording of the operating lease liabilities and related ROU assets for leases in effect at January 1, 2019, but the adoption did not have a material impact on the Company's consolidated statement of loss or consolidated statement of cash flows for the year ended December 31, 2019. The Company recorded approximately $673 million of operating lease liabilities and ROU assets on January 1, 2019 upon adoption of ASC 842, with no impact on accumulated deficit.

Physician Income Guarantees. The Company enters into physician recruiting agreements under which it supplements physician income to a minimum amount over a period of time, typically one year, while the physicians establish themselves in the community. As part of the agreements, the physicians are committed to practice in the community for a period of time, typically three years, which extends beyond their income guarantee period. The Company records an asset and liability for the estimated fair value of minimum revenue guarantees on new agreements. Adjustments to the ultimate value of the guarantee paid to physicians are recognized in the period that the change in estimate is identified. The Company amortizes an asset over the life of the agreement. As of December 31, 2019 and 2018, the unamortized portion of these physician income guarantees was $20 million and $24 million, respectively, and is recorded in other assets in the consolidated balance sheet.

Concentrations of Credit Risk. The Company grants unsecured credit to its patients, most of whom reside in the service area of the Company's facilities and are insured under third-party payor agreements. Because of the economic diversity of the Company's facilities and non-governmental third-party payors, Medicare represents the only significant concentration of credit risk from payors. Accounts receivable, net of contractual allowances, from Medicare was $268 million and $283 million at December 31, 2019 and 2018, respectively, representing 5% of consolidated net accounts receivable at both December 31, 2019 and 2018.

Accounting for the Impairment or Disposal of Long-Lived Assets. During the year ended December 31, 2019, the Company recorded a total combined impairment charge and loss on disposal of approximately $138 million, of which (i) approximately $92 million was recorded to reduce the carrying value of closed hospitals and certain

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

hospitals that have been sold or deemed held for sale based on the difference between the carrying value of the hospital disposal groups compared to estimated fair value less costs to sell and (ii) approximately $46 million was recorded primarily to adjust the carrying value of other long-lived assets at several underperforming hospitals or where the Company is in discussions with potential buyers for divestiture at a sales price that indicates a fair value below carrying value. Included in the carrying value of the hospital disposal groups at December 31, 2019 is a net allocation of approximately $167 million of goodwill allocated from the hospital operations reporting unit goodwill based on a calculation of the disposal groups' relative fair value compared to the total reporting unit. The Company will continue to evaluate the potential for further impairment of the long-lived assets of underperforming hospitals as well as evaluate offers for potential sales. Based on such analysis, additional impairment charges may be recorded in the future.

During the year ended December 31, 2018, the Company recorded a total combined impairment charge and loss on disposal of approximately $668 million, of which (i) approximately $423 million was recorded to reduce the carrying value of certain hospitals that have been sold or deemed held for sale based on the difference between the carrying value of the hospital disposal groups compared to estimated fair value less costs to sell, (ii) approximately $29 million was recorded to write-off the value of a promissory note received as consideration for the sale of three hospitals in 2017 where the buyer entered into bankruptcy proceedings, and (iii) approximately $216 million was recorded primarily to adjust the carrying value of other long-lived assets at several underperforming hospitals that have ceased operations or where the Company was in discussions with potential buyers for divestiture at a sales price that indicated a fair value below carrying value. Included in the carrying value of the hospital disposal groups at December 31, 2018 is a net allocation of approximately $186 million of goodwill allocated from the hospital operations reporting unit goodwill based on a calculation of the disposal groups' relative fair value compared to the total reporting unit.

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

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

Segment Reporting. A public company is required to report annual and interim financial and descriptive information about its reportable operating segments. Operating segments, as defined, are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker in deciding how to allocate resources and in assessing performance. Aggregation of similar operating segments into a single reportable operating segment is permitted if the businesses have similar economic characteristics and meet the criteria established by U.S. GAAP. The Company operates a single operating segment represented by hospital operations (which includes the Company's acute care hospitals and related healthcare entities that provide inpatient and outpatient healthcare services).

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

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

under the standard is recognized in current earnings. The Company has entered into several interest rate swap agreements and had one such agreement outstanding

New Accounting Pronouncements. In August 2018, the FASB issued ASU 2018-15 to provide guidance on the accounting for implementation costs incurred in

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

Hospital	Buyer	City, State	Licensed Beds	Effective Date
Carolinas Hospital System – Marion	Medical University Hospital Authority	Mullins, SC	124	March 1, 2019
Memorial Hospital of Salem County	Community Healthcare Associates, LLC	Salem, NJ	126	January 31, 2019
Mary Black Health System – Spartanburg	Spartanburg Regional Healthcare System	Spartanburg, SC	207	January 1, 2019
Mary Black Health System – Gaffney	Spartanburg Regional Healthcare System	Gaffney, SC	125	January 1, 2019
2018 Divestitures:				
Sparks Regional Medical Center	Baptist Health	Fort Smith, AR	492	November 1, 2018
Sparks Medical Center – Van Buren	Baptist Health	Van Buren, AR	103	November 1, 2018
AllianceHealth Deaconess	INTEGRIS Health	Oklahoma City, OK	238	October 1, 2018
Munroe Regional Medical Center	Adventist Health System	Ocala, FL	425	August 1, 2018
Tennova Healthcare – Dyersburg Regional	West Tennessee Healthcare	Dyersburg, TN	225	June 1, 2018
Tennova Healthcare – Regional Jackson	West Tennessee Healthcare	Jackson, TN	150	June 1, 2018
Tennova Healthcare – Volunteer Martin	West Tennessee Healthcare	Martin, TN	100	June 1, 2018
Williamson Memorial Hospital	Mingo Health Partners, LLC	Williamson, WV	76	June 1, 2018
Byrd Regional Hospital	Allegiance Health Management	Leesville, LA	60	June 1, 2018
Tennova Healthcare – Jamestown	Rennova Health, Inc.	Jamestown, TN	85	June 1, 2018
Bayfront Health Dade City	Adventist Health System	Dade City, FL	120	April 1, 2018
2017 Divestitures:				
Highlands Regional Medical Center	HCA Healthcare, Inc. (“HCA”)	Sebring, FL	126	November 1, 2017
Merit Health Northwest Mississippi	Curae Health, Inc.	Clarksdale, MS	181	November 1, 2017
Weatherford Regional Medical Center	HCA	Weatherford, TX	103	October 1, 2017
Brandywine Hospital	Reading Health System	Coatesville, PA	169	October 1, 2017
Chestnut Hill Hospital	Reading Health System	Philadelphia, PA	148	October 1, 2017
Jennersville Hospital	Reading Health System	West Grove, PA	63	October 1, 2017
Phoenixville Hospital	Reading Health System	Phoenixville, PA	151	October 1, 2017
Pottstown Memorial Medical Center	Reading Health System	Pottstown, PA	232	October 1, 2017
Yakima Regional Medical and Cardiac Center	Regional Health	Yakima, WA	214	September 1, 2017

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

Hospital	Buyer	City, State	Licensed Beds	Effective Date
Toppenish Community Hospital	Regional Health	Toppenish, WA	63	September 1, 2017
Memorial Hospital of York	PinnacleHealth System	York, PA	100	July 1, 2017
Lancaster Regional Medical Center	PinnacleHealth System	Lancaster, PA	214	July 1, 2017
Heart of Lancaster Regional Medical Center	PinnacleHealth System	Lititz, PA		

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

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

	Year Ended December 31, 2017
Net operating revenues	$ 79
Loss from operations of entities sold or held for sale before income taxes	(10)
Impairment of hospitals sold or held for sale	(8)
Loss on sale, net	(1)
Loss from discontinued operations, before tax	(19)
Income tax benefit	(7)
Loss from discontinued operations, net	$ (12)

As part of its ongoing evaluation of marketing for sale, the Company recorded an impairment charge on the carrying value of the long-lived assets at these hospitals of $8 million, net of tax, for the year ended December 31, 2017. There was no impairment charge recorded for the years ended December 31, 2019 and 2018. Interest expense was allocated to discontinued operations based on sale proceeds available for debt repayment.

The following table discloses amounts included in the balance sheet for the hospitals classified as held for sale as of December 31, 2019 and 2018 (in millions):

	December 31,	

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

With respect to the deferred tax liability pertaining to intangibles, as included above, goodwill purchased in connection with certain of the Company's business acquisitions is amortizable for income tax reporting purposes. However, for financial reporting purposes, there is no corresponding amortization allowed with respect to such purchased goodwill.

The valuation allowance for federal and state jurisdictions where the Company concluded that the associated deferred tax assets would not be realized increased by $221 million and $127 million, respectively, for the year ended December 31, 2019, and increased by $151 million and $17 million, respectively, for the year ended December 31, 2018.

The total amount of unrecognized benefit that would affect the effective tax rate, if recognized, was approximately $1 million as of December 31, 2019. A total of approximately $1 million of interest and penalties is included in the amount of the liability for uncertain tax positions at December 31, 2019. It is the Company's policy to recognize interest and penalties related to unrecognized benefits in its consolidated statements of loss as income tax expense.

It is possible the amount of unrecognized tax benefit could change in the next 12 months as a result of a lapse of the statute of limitations and settlements with taxing authorities; however, the Company does not anticipate the change will have a material impact on the Company's consolidated results of operations or consolidated financial position.

The following is a tabular reconciliation of the total amount of unrecognized tax benefit for the years ended December 31, 2019, 2018 and 2017 (in millions):

	Year Ended December 31,		
	2019	**2018**	**2017**
Unrecognized tax benefit, beginning of year	$ 29	$ 18	$ 18
Gross increases — tax positions in current period	10	11	-
Settlements	(13)	-	-
Unrecognized tax benefit, end of year	$ 26	$ 29	$ 18

The Company's federal income tax returns for the 2009 and 2010 tax years have been settled with the Internal Revenue Service. The results of these examinations were not material to the Company's consolidated results of operations or consolidated financial position. The Company's federal income tax returns for the 2014 and 2015 tax years remain under examination by the Internal Revenue Service. The Company believes the results of these examinations will not be material to its consolidated results of operations or consolidated financial position. The Company has extended the federal statute of limitations through December 31, 2020 for the tax periods ended December 31, 2014 and 2015.

Cash paid for income taxes, net of refunds received, resulted in a net refund of $3 million and $19 million during the years ended December 31, 2019 and 2018, respectively, and net cash paid of $4 million during the year ended December 31, 2017.

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

Senior Secured Notes due 2026 are discussed below. Using the proceeds from the offering, the Company repaid the outstanding balance owed under the Term H Facility and paid fees and expenses related to the offering.

On November 19, 2019, CHS completed atack-on offering of an additional $500 million aggregate principal amount of the 8% Senior Secured Notes due 2026 (the “Additional 2026 Notes”). Upon completion of suc

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

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 periods set forth below:

Period	Redemption Price

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

2019 Exchange Offer. The 8% Senior Secured Notes due 2027 bear interest at a rate of 8.000% per annum, payable semi-annually in arrears on June 15 and December 15 of each year. Interest on the 8% Senior Secured Notes due 2027 accrues from the initial issuance date of the 8% Senior Secured Notes due 2027. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months. The 8% Senior Secured Notes due 2027 are scheduled to mature on December 15, 2027. The 8% Senior Secured Notes due 2027 are unconditionally guaranteed on a senior-priority secured basis by the Company and each of the CHS current and future domestic subsidiaries that provide guarantees under the ABL Facility, any capital market debt securities of CHS (including CHS' outstanding senior notes) and certain other long-term debt of CHS.

The 8% Senior Secured Notes due 2027 and the related guarantees are secured by shared (i) first-priority liens on theNon-ABL Priority Collateral and (ii) second-priority liens on the ABL Priority Collateral that secures on a first-priority basis the ABL Facility, in each case subject to permitted liens described in the indenture governing the 8% Senior Secured Notes due 2027.

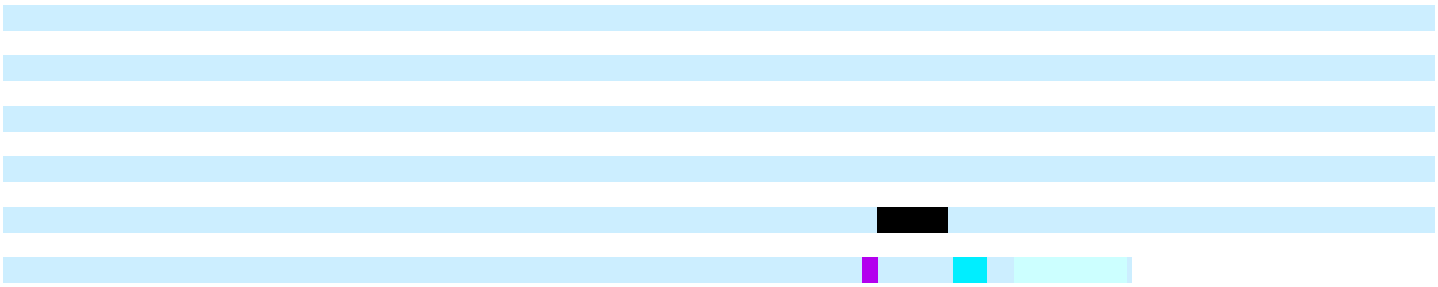
CHS is entitled, at its option, to redeem all or a portion of the 8% Senior Secured Notes due 2027 at any time prior to December 15, 2022, upon not less than 15 nor more than 60 days' notice, at a price equal to 100% of the principal amount of the 8% Senior Secured Notes due 2027 redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the indenture governing the 8% Senior Secured Notes due 2027. In addition, CHS may redeem up to 40% of the aggregate principal amount of the 8% Senior Secured Notes due 2027 at any time prior to December 15, 2022 using the net proceeds from certain equity offerings at the redemption price of 108.000% of the principal amount of the 8% Senior Secured Notes due 2027 redeemed, plus accrued and unpaid interest, if any.

CHS may redeem some or all of the 8% Senior Secured Notes due 2027 at any time on or after December 15, 2022 upon not less than 15 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
December 15, 2022 to December 14, 2023	104.000 %
December 15, 2023 to December 14, 2024	102.000 %
December 15, 2024 to December 14, 2027	100.000 %

6⅞% Senior Notes due 2028

On November 19, 2019, CHS issued approximately $1.7 billion aggregate principal amount of the 6⅞% Senior Notes due 2028 in connection with the 2019 Exchange Offer. No cash proceeds w Ď ϟ



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

Investments in equity securities. Estimated fair value is based on closing price as quoted in public markets. Prior to the adoption of ASU 2016-01 on January 1, 2018, changes in

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

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.

As of December 31, 2014, the Company had an interest rate swap with a notional amount of approximately $[illegible] with a

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

The fair values of derivative instruments in the consolidated balance sheets as of December 31, 2019 and 2018 were as follows (in millions):

	Asset Derivatives				Liability Derivatives			
	December 31, 2019		December 31, 2018		December 31, 2019		December 31, 2018	
	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	$ 3	Other long-term liabilities	$ 2	Other long-term liabilities	$ 2

8. FAIR VALUE

Fair Value Hierarchy

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

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

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

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

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

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability. Transfers between levels within the fair value hierarchy are recognized by the Company on the date of the change in circumstances that requires such transfer. There were no transfers between levels during the years ending December 31, 2019 or December 31, 2018.

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

The

the legal matters assumed in the HMA merger, which at December 31, 2017 was included in other long-term liabilities in the accompanying consolidated balance sheet. This liability did not include those matters previously accrued by HMA as a probable contingency, which were settled and paid during the year ended December 31, 2015. To develop the estimate of fair value, the Company engaged an independent third-party valuation firm to measure the liability. The valuation was made utilizing the Company's estimates of future outcomes for each legal case and simulating future outcomes based on the timing, probability and distribution of several scenarios using a Monte Carlo simulation model. Other inputs were then utilized for discounting the liability to the measurement date. The HMA legal matters underlying this fair value estimate were evaluated by management to determine the likelihood and impact of each of the potential outcomes. Using that information, as well as the potential correlation and variability associated with each case, a fair value was determined for the estimated future cash outflows to conclude or settle the HMA legal matters included in the analysis, excluding legal fees (which are expensed as incurred). Because of the unobservable nature of the majority of the inputs used to value the liability, the Company classified the fair value measurement as a Level 3 measurement in the fair value hierarchy. Prior to December 31, 2018, changes in the fair value of the CVR related legal liability were recorded in future periods through the consolidated statements of loss.

At December 31, 2018, the CVR-related legal liability was zero after taking into account the Company's payment of the amounts agreed to in the final global resolution and settlement of certain HMA legal matters during the three months ended December 31, 2018.

Fair Value of Interest Rate Swap Agreements

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 had an immaterial effect on the fair value of the related asset or liability at December 31, 2019 and 2018.

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

9. LEASES

The Company utilizes operating and finance leases for the use of certain hospitals, medical office buildings, and medical equipment. All lease agreements generally require the Company to pay maintenance, repairs, property taxes and insurance costs, which are variable amounts based on actual costs incurred during each applicable period. Such costs are not included in the determination of the ROU asset or lease liability. Variable lease cost also includes escalating rent payments that are not fixed at commencement but are based on an index that is determined in future periods over the lease term based on changes in the Consumer Price Index or other

measure of cost inflation. Most leases include one or more options to renew the lease at the end of the initial term, with renewal terms that generally extend the lease at the then market rate of rental payment. Certain leases also include an option to buy the underlying asset at or a short time prior to the termination of the lease. All such options are at the Company's discretion and are evaluated at the commencement of the lease, with only those that are reasonably certain of exercise included in determining the appropriate lease term. The components of lease cost and rent expense for the year ended December 31, 2019 are as follows (in millions):

Lease Cost	**Year Ended December 31, 2019**
Operating lease cost:	
Operating lease cost	$ 194
Short-term rent expense	114
Variable lease cost	18
Sublease income	(5)
Total operating lease cost	$ 321
Finance lease cost:	
Amortization of right-of-use assets	$ 12
Interest on finance lease liabilities	7
Total finance lease cost	$ 19

Supplemental balance sheet information related to leases was as follows (in millions):

	Balance Sheet Classification	**December 31, 2019**
Operating Leases:		
Operating Lease ROU Assets	Other assets, net	$ 607
Finance Leases:		
Finance Lease ROU Assets	*Property and equipment*	
	Land and improvements	$ 8
	Buildings and improvements	154
	Equipment and fixtures	11
	Property and equipment	173
	Less accumulated depreciation and amortization	(56)
	Property and equipment, net	$ 117
Current finance lease liabilities	Current maturities of long-term debt	$ 6
Long-term finance lease liabilities	Long-term debt	107

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

year ended December 31, 2019 was a discount rate of 4.2% and the expected long-term rate of return on assets of 6.0%.

11. STOCKHOLDERS' DEFICIT

Authorized capital shares of the Compi[illegible]

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

12. EARNINGS PER SHARE

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

	Year Ended December 31,		
	2019	2018	2017
Numerator:			
Loss from continuing operations, net of taxes	$ (590)	$ (704)	$ (2,384)
Less: Income attributable to noncontrolling interests, net of taxes	85	84	63
Loss from continuing operations attributable to Community Health Systems, Inc. common stockholders – basic and diluted	$ (675)	$ (788)	$ (2,447)
Loss from discontinued operations, net of taxes	$ -	$ -	$ (12)
Less: Loss from discontinued operations attributable to noncontrolling interests, net of taxes	-	-	-
Loss from discontinued operations attributable to Community Health Systems, Inc. common stockholders – basic and diluted	$ -	$ -	$ (12)
Denominator:			
Weighted-average number of shares outstanding – basic	113,739,046	112,728,274	111,769,821
Effect of dilutive securities:			
Restricted stock awards	-	-	-
Employee stock options	-	-	-
Other equity-based awards	-	-	-
Weighted-average number of shares outstanding – diluted	113,739,046	112,728,274	111,769,821

The Company generated a loss from continuing operations attributable to Community Health Systems, Inc. common stockholders for the years ended December 31, 2019, 2018 and 2017, so the effect of dilutive securities was excluded from the computation of diluted loss per share for those years because their effect would have been antidilutive.

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

13. EQUITY INVESTMENTS

As of December 31, 2019, the Company owned equity interests of 38.0% in two hospitals in Macon, Georgia, in which HCA owns the majority interest. On December 31, 2016, the Company sold 80% of its ownership interest in the legal entity that owned and operated its home care agency business. As part of the divestiture of its controlling interest in the home care agency business, the Company recorded an equity method investment representing its remaining 20% ownership.

In March 2005, the Company began purchasing items, primarily medical supplies, medical equipment and pharmaceuticals, under an agreement with HealthTrust Purchasing Group, L.P. ("HealthTrust"), a group purchasing organization in which the Company is a noncontrolling partner. As of December 31, 2019, the Company had a 14.5% ownership interest in HealthTrust.

The Company's investment in all of its unconsolidated affiliates was $199 million and $192 million at December 31, 2019 and 2018, respectively, and is included in other assets, net in the accompanying consolidated balance sheets. Included in the Company's results of operations is the Company's equity in pre-tax earnings from all of its investments in unconsolidated affiliates, which was $15 million, $22 million and $16 million for the years ended December 31, 2019, 2018 and 2017, respectively.

14. OTHER COMPREHENSIVE INCOME

The following tables present information about items reclassified out of accumulated other comprehensive loss by component for the years ended December 31, 2019 and 2018 (in millions, net of tax):

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available-for-Sale Debt Securities	Change in Unrecognized Pension Cost Components	Accumulated Comprehensive (Loss) Income
Balance as of December 31, 2018	$ 5	$ (7)	$ (8)	$ (10)
Other comprehensive (loss) income before reclassifications	(3)	5	(1)	1
Amounts reclassified from accumulated other compre e				

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

Details about accumulated other comprehensive (loss) income components	Amount reclassified from AOCL Year Ended December 31, 2018	Affected line item in the statement where net (loss) income is presented
Gains and losses on cash flow hedges		
Interest rate swaps	$ (10)	Interest expense, net
	2	Tax benefit
	$ (8)	Net of tax
Amortization of defined benefit pension items		
Prior service costs	$ (1)	Salaries and benefits
Settlement losses recognized		

standardized and consistent processes for handling claims and the long history and depth of company-specific data, the Company's methodologies have produced reliably determinable estimates of ultimate paid losses. Management considers any changes in the amount and pattern of its historical paid losses up through the most recent reporting period to identify any fundamental shifts or trends in claim development experience in determining the estimate of professional liability claims. However, due to the subjective nature of this estimate and the impact that previously unforeseen shifts in actual claim experience can have, future estimates of professional liability could be adversely impacted when actual paid losses develop unexpectedly based on assumptions and settlement events that were not previously known or anticipated.

During the nine months ended September 30, 2019, the Company experienced a significant increase in the amounts paid to settle outstanding professional liability claims, compared to the same period in the prior year and to previous actuarially determined estimates. This increase in claims paid related to claims incurred in 2016 and prior years and was primarily related to divested hospitals. The settlement of these claims at amounts greater than the previously determined actuarial estimates resulted in the Company recording a $70 million change in estimate during the three months ended June 30, 2019, and an additional $20 million change in estimate during the three months ended September 30, 2019 based on updated actuarial estimates. No additional change in estimate related to these claims was recorded during the three months ended December 31, 2019.

The Company is primarily self-insured for professional liability claims; however, the Company obtains excess insurance that transfers the risk of loss to a third-party insurer for claims in excess of self-insured retentions. The Company's excess insurance is underwritten on a claims-made basis. For claims reported prior to June 1, 2002, substantially all of the Company's professional and general liability risks were subject to a less than $1 million per occurrence self-insured retention and for claims reported from June 1, 2002 through June 1, 2003, these self-insured retentions were $2 million per occurrence. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 and before June 1, 2014 are self-insured up to $5 million per claim. Substantially all claims reported on or after June 1, 2014 and before June 1, 2018 are self-insured up to $10 million per claim. Substantially all claims reported on or after June 1, 2018 are self-insured up to $15 million per claim. Management on occasion has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals has been purchased through commercial insurance companies and generally covers the Company for liabilities in excess of the self-insured retentions. The excess coverage consists of multiple layers of insurance, the sum of which totals up to $95 million per occurrence and in the aggregate for claims reported on or after June 1, 2003, up to $145 million per occurrence and in the aggregate for claims reported on or after January 1, 2008, up to $195 million per occurrence and in the aggregate for claims reported on or after June 1, 2010, and up to at least $215 million per occurrence and in the aggregate for claims reported on or after June 1, 2015. In addition, for integrated occurrence malpractice claims, there is an additional $50 million of excess coverage for claims reported on or after June 1, 2014 and an additional $75 million of excess coverage for claims reported on or after June 1, 2015. For certain policy years prior to June 1, 2014, if the first aggregate layer of excess coverage becomes fully utilized, then the Company's self-insured retention will increase to $10 million per claim for any subsequent claims in that policy year until the Company's total aggregate coverage is met. Beginning June 1, 2018, this drop-down provision in the excess policies attaches over the $15 million per claim self-insured retention.

Effective June 1, 2014, the hospitals acquired from HMA were insured on a claims-made basis as described above and through commercial insurance companies as described above for substantially all claims reported on or after June 1, 2014 except for physician-related claims with an occurrence date prior to June 1, 2014. Prior to June 1, 2014, the former HMA hospitals obtained insurance coverage through a wholly-owned captive insurance subsidiary and a risk retention group subsidiary which are domiciled in the Cayman Islands and South Carolina, respectively. Those insurance subsidiaries, which are collectively referred to as the "Insurance Subsidiaries,"

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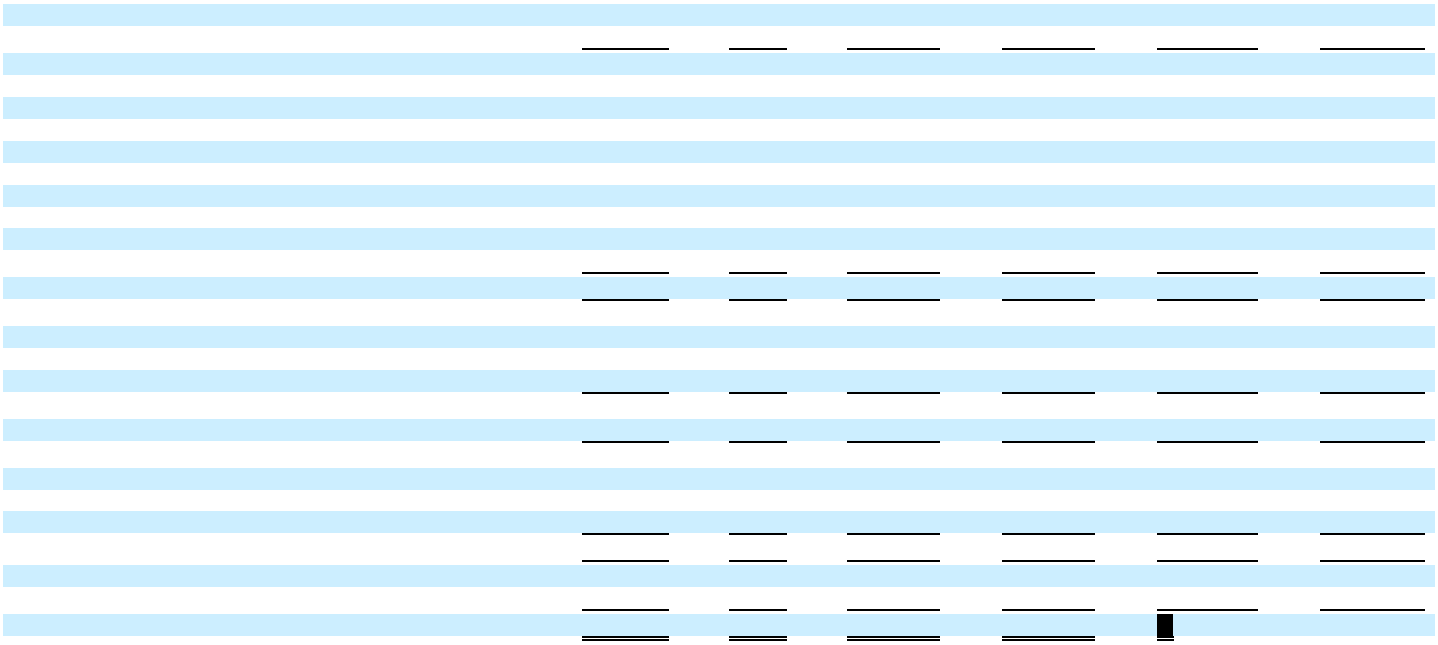

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2018

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net cash provided by (used in) operating activities	$ 40	$ (409)	$ 560	$ 83	$ -	$ 274
Cash flows from investing activities:						
Acquisitions of facilities and other related businesses	-	-	(3)	(23)	-	(26)
Purchases of property and equipment	-	-	(408)	(119)	-	(527)
Proceeds from disposition of hospitals and other ancillary operations	-	-	1	404	-	405
Proceeds from sale of property and equipment	-	-	5	3	-	8
Purchases of available-for-sale debt securities and equity securities	-	-	(54)	(24)	-	(78)
Proceeds from sales of available-for-sale debt securities and equity securities	-	-	79	35	-	114
Increase in other investments	-	(7)	(112)	(22)	-	(141)
Net cash (used in) provided by investing	-	(7)	(492)	254	-	(245)
Cash flows from financing activities:						
Repayments of debt, including withholding requirements	(1)	-	-	-	-	(1)
Deferred financing costs and other debt-related costs	-	(96)	-	-	-	(96)
Proceeds from noncontrolling investors in joint ventures	-					

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

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

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

Changes in Internal Control Over Financial Reporting

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

Management's report on internal control over financial reporting is included herein at page 171.

The attestation report from Deloitte & Touche LLP, our independent registered public accounting firm, on our internal control over financial reporting is included herein at page 172.

Item 9B. Other Information

None.

Management's Report on Internal Control over Financial Reporting

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report on Form 10-K. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States of America and include amounts based on management's estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the consolidated financial statements.

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

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

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

We conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in Internal Control – Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. This evaluation included review of the documentation of controls, evaluation of the design effectiveness of controls, testing of the operating effectiveness of controls and a conclusion on this evaluation. We have concluded that our internal control over financial reporting was effective as of December 31, 2019, based on these criteria.

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

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

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of Community Health Systems, Inc., and subsidiaries (the "Company") as of December 31, 2019, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2019, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements and financial statement schedule as of and for the year ended December 31, 2019, of the Company and our report dated February 20, 2020, expressed an unqualified opinion on those financial statements and schedule a

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Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Deloitte & Touche LLP

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The Company has adopted a Code of Conduct that is applicable to all members of the Board of Directors and our officers, as well as employees of our subsidiaries. A copy of the current version of our Code of Conduct is available in the Company-Overview – Corporate Governance section of our internet website at www.chs.net/company-overview/corporate-governance. A copy of the Code of Conduct is also available in print, free of charge, to any stockholder who requests it by writing to Community Health Systems, Inc., Investor Relations, at 4000 Meridian Boulevard, Franklin, TN 37067. The Company intend ,, [illegible] Boulev d r

accounting firm its independence and also has reviewed the amount of fees paid to the independent registered accounting firm for audit and non-audit services.

Based on the Audit and Compliance Committee's discussions with management and the independent registered public accounting firm and the Audit and Compliance Committee's review of the representations of management and the materials it received from the independent registered public accounting firm as described above, the Audit and Compliance Committee recommended to the Board of Directors that the audited consolidated financial statements be included in the Company's Annual Report on Form 10-K for the year ended December 31, 2019 for filing with the SEC.

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

THE AUDIT AND COMPLIANCE COMMITTEE
John A. Clerico
Michael Dinkins
James S. Ely III, Chair
Elizabeth T. Hirsch
H. James Williams, Ph.D.

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No.	Description
4.29	Fifth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 6.875% Senior Notes due 2022, dated as of June 30, 2015, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee (incorporated by reference to Exhibit 4.5 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2015 filed August 4, 2015 (No. 001-15925))
4.30	Sixth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 6.875% Senior Notes due 2022, dated as of September 30, 2015, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee (incorporated by reference to Exhibit 4.5 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2015 filed November 3, 2015 (No. 001-15925))
4.31	Seventh Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 6.875% Senior Notes due 2022, dated as of December 31, 2015, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee (incorporated by reference to Exhibit 4.63 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2015 filed February 17, 2016 (No. 001-15925))
4.32	Eighth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 6.875% Senior Notes due 2022, dated as of March 31, 2016, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee (incorporated by reference to Exhibit 4.5 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2016 filed May 3, 2016 (No. 001-15925))
4.33	Ninth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 6.875% Senior Notes due 2022, dated as of September 30, 2016, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee (incorporated by reference to Exhibit 4.5 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2016 filed November 2, 2016 (No. 001-15925))
4.34	Tenth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 6.875% Senior Notes due 2022, dated as of April 12, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee (incorporated by reference to Exhibit 4.4 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2018 filed May 2, 2018 (No. 001-15925))

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No.	Description
4.47	Seventh Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 6.250% Senior Secured Notes due 2023, dated as of September 27, 2019, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee and Credit Suisse AG, as Collateral Agent (incorporated by reference to Exhibit 4.14 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2019 filed October 30, 2019 (No.001-15925))
4.48	Indenture, dated as of June 22, 2018, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the guarantors party thereto, Regions Bank, as Trustee and as Junior-Priority Collateral Agent, relating to the 9.875% Junior-Priority Secured Notes due 2023 (incorporated by reference to Exhibit 4.01 to Community Health Systems, Inc.'s Current Report on Form 8-K filed June 25, 2018 (No. 001-15925))
4.49	Form of 9.875% Junior-Priority Secured Note due 2023 (included in Exhibit 4.48)
4.50	First Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 9.875% Junior-Priority Secured Notes due 2023, dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto, and Regions Bank, as Trustee and as Junior-Priority Collateral Agent (incorporated by reference to Exhibit 4.6 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2018 filed October 30, 2018 (No. 001-15925))
4.51	Second Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 9.875% Junior-Priority Secured Notes due 2023, dated as of March 31, 2019, by and among CHS/Community Health Systems, Inc., the guarantors party thereto, and Regions Bank, as Trustee and as Junior-Priority Collateral Agent (incorporated by reference to Exhibit 4.6 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2019 filed May 1, 2019 (No. 001-15925))
4.52	Third Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 9.875% Junior-Priority Secured Notes due 2023, dated as of July 1, 2019, by and among CHS/Community Health Systems, Inc., the guarantors party thereto, and Regions Bank, as Trustee and as Junior-

No.	Description
4.75	Form of 6.875% Senior Unsecured Note due 2028 (included in Exhibit 4.74)
4.76	Indenture, dated as of February 6, 2020, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the guarantors party thereto, Regions Bank, as Trustee, and Credit Suisse AG, as Collateral Agent, relating to the 6.625% Senior Secured Notes due 2025 (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed February 6, 2020 (No. 001-15925))
4.77	Form of 6.625% Senior Secured Note due 2025 (included in Exhibit 4.76)
4.78	First Lien Intercreditor Agreement, dated as of August 17, 2012, among Credit Suisse AG, as Collateral Agent, Credit Suisse AG, as authorized representative, Regions Bank, as Trustee and authorized representative, and the additional authorized representatives party thereto (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2012 filed November 1, 2012 (No. 001-15925))
4.79	Amended and Restated ABL Intercreditor Agreement, dated as of June 22, 2018, among JPMorgan Chase Bank, N.A., as ABL Agent, Credit Suisse AG, as Senior-Priority Collateral Agent, Credit Suisse AG, as Senior-Priority Non-ABL Loan Agent, Regions Bank, as 2021 Secured Notes Trustee, 2023 Secured Notes Trustee, 2024 Secured Notes Trustee, 2025 Secured Notes Trustee, 2026 Secured Notes Trustee, 2027 Secured Notes Trustee, Junior-Priority Collateral Agent, 2023 Junior-Priority Secured Notes Trustee and 2024 Junior-Priority Secured Notes Trustee, CHS/Community Health Systems, Inc., Community Health Systems, Inc., the subsidiary guarantors party thereto and each additional agent from time to time party thereto (incorporated by reference to Exhibit 4.04 to Community Health Systems, Inc.'s Current Report on Form 8-K filed June 25, 2018 (No. 001-15925))
4.80	Junior-Priority Collateral Agreement, dated as of June 22, 2018, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the subsidiaries party thereto and Regions Bank, as junior-priority collateral agent (incorporated by reference to Exhibit 4.03 to Community Health Systems, Inc.'s Current Report on Form 8-K filed June 25, 2018 (No. 001-15925))
4.81	Senior-Junior Lien Intercreditor Agreement, dated as of June 22, 2018, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the subsidiaries party thereto, Credit Suisse AG, Cayman Islands Branch, as initial Senior-Priority Collateral Agent, Regions Bank, as initial Junior-Priority Collateral Agent and each additional agent from time to time party thereto (incorporated by reference to Exhibit 4.05 to Community Health Systems, Inc.'s Current Report on Form 8-K filed June 25, 2018 (No. 001-15925))
4.82	Junior-Priority Lien Pari Passu Intercreditor Agreement, dated as of June 22, 2018, among Regions Bank, as Collateral Agent, Regions Bank, in its capacity as Trustee under the 2023 Notes Indenture, Regions Bank, in its capacity as Trustee under the 2024 Notes Indenture and each additional authorized representative from time to time party thereto (incorporated by reference to Exhibit 4.06 to Community Health Systems, Inc.'s Current Report on Form 8-K filed June 25, 2018 (No. 001-15925))
10.1	Second Amended and Restated Guarantee and Collateral Agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010, as further amended as of August 17, 2012, and as further amended and restated as of November 19, 2019, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the subsidiary guarantors party thereto and Credit Suisse AG, as Collateral Agent (incorporated by reference to Exhibit 4.5 to Community Health Systems, Inc.'s Current Report on Form 8-K filed November 19, 2019 (No. 001-15925))

No.	Description
10.2	ABL Credit Agreement, dated as of April 3, 2018, among CHS/Community Health Systems, Inc., as the Borrower, Community Health Systems, Inc., as the Parent, the subsidiaries of the Borrower party thereto, the lenders party thereto, and JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed April 3, 2018 (No. 001-15ح '

No.	Description
10.12†*	Community Health Systems Supplemental Executive Benefits, dated December 31, 2008, as amended and restated as of April 1, 2015 and December 11, 2019
10.13†	CHS/Community Health Systems, Inc. Deferred Compensation Plan, amended and restated effective January 1, 2014 (incorporated by reference to Exhibit 10.25 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2013 filed February 26, 2014 (No. 001-15925))
10.14†	Community Health Systems Deferred Compensation Plan Trust, amended and restated effective February 26, 1999 (incorporated by reference to Exhibit 10.18 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2002 filed March 27, 2003 (No. 001-15925))
10.15†	CHS NQDCP, effective as of September 1, 2009 (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Registration Statement on Form S-8 filed December 11, 2009 (No. 333-163691))
10.16†	CHS NQDCP Adoption Agreement, executed as of August 11, 2009 (incorporated by reference to Exhibit 4.3 to Community Health Systems, Inc.'s Registration Statement on Form S-8 filed December 11, 2009 (No. 333-163691))
10.17†	Guarantee, dated December 9, 2009, made by Community Health Systems, Inc. in favor of CHS/Community Health Systems, Inc. with respect to CHS/Community Health Systems, Inc.'s payment obligations under the CHS/Community Health Systems, Inc. Deferred Compensation Plan and the NQDCP (incorporated by reference to Exhibit 4.4 to Community Health Systems, Inc.'s Registration Statement on Form S-8 filed December 11, 2009 (No. 333-163691))
10.18†	Community Health Systems, Inc. 2019 Employee Performance Incentive Plan (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed February 22, 2019 (No. 001-15925))
10.19†	Community Health Systems, Inc. Dad ity H

No.	Description
10.24†	Form of Restricted Stock Award Agreement for Community Health Systems, Inc. 2009 Stock Option and Award Plan (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2013 filed July 31, 2013 (No. 001-15925))
10.25†	Form of Performance Based Restricted Stock Award Agreement (Most Highly Compensated Executive Officers) for Community Health Systems, Inc. 2009 Stock Option and Award Plan (for awards granted from March 1, 2016 through February 28, 2017) (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2016 filed May 3, 2016 (No. 001-15925))
10.26†	Form of Performance Based Restricted Stock Award Agreement (Senior Officers) for Community Health Systems, Inc. 2009 Stock Option and Award Plan (for awards granted from March 1, 2017 through February 28, 2018) (incorporated by reference to Exhibit 10.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2017 filed May 2, 2017 (No.001-15925))
10.27†	Form of Performance Based Restricted Stock Award Agreement (Senior Officers) for Community Health Systems, Inc. 2009 Stock Option and Award Plan (for awards granted beginning March 1, 2018) (incorporated by reference to Exhibit 10.46 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2017 filed February 28, 2018 (No.001-15925))
10.28†	Form of Director Restricted Stock Unit Award Agreement for Community Health Systems, Inc. 2009 Stock Option and Award Plan (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2019 filed October 30, 2019 (No. 001-15925))
10.29†	Form of Amended and Restated Change in Control Severance Agreement effective December 31, 2008(incorporated by reference to Exhibit 10.22 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.30†	Form of Change in Control Severance Agreement (for executive officers appointed since January 1, 2009) (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2014 filed May 7, 2014 (No. 001-15925))
10.31	Participation Agreement entered into as of January 1, 2005, by and between Community Health Systems Professional Services Corporation and HealthTrust Purchasing Group, L.P. (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed January 7, 2005 (No. 001-15925))
10.32	Amendment effective as of January 1, 2015, by and between CHSPSC, LLC and HealthTrust Purchasing Group, L.P., to Participation Agreement entered into as of January 1, 2005, by and between Community Health Systems Professional Services Corporation and HealthTrust Purchasing Group, L.P. (incorporated by reference to Exhibit 10.36 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2014 filed February 25, 2015 (No. 001-15925))
10.33†	Consultancy Agreement, dated December 31, 2019, by and between CHSPSC, LLC and Thomas J. Aaron (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed January 2, 2020 (No. 001-15925))
10.34†*	Executive Deferred Compensation Award between Kevin Hammons and CHSPSC, LLC, dated December 12, 2017

No.	Description
10.35†	Executive Deferred Compensation Award between Dr. Lynn Simon and CHSPSC, LLC, dated December 12, 2017 (incorporated by reference to Exhibit 10.54 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2017 filed February 28, 2018 (No. 001-15925))
21*	List of Subsidiaries

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Item 16. ***Form 10-K Summary***

None.

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SIGNATURES

Pursuant to the requirements of section 13 or 15(d) of the Securities Exchange Act of 1934,iSec

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Community Health Systems, Inc. and Subsidiaries

Schedule II — Valuation and Qualifying Accounts

Description	Balance at Beginning of Year	Acquisitions and Dispositions	Charged to Costs and Expenses	Write-offs	Balance at End of Year
			(In millions)		
Year ended December 31, 2019					
allowance for doubtful accounts (1)	$ -	$ -	$ -	$ -	$ -
Year ended December 31, 2018					
allowance for doubtful accounts (1)	$ -	$ -	$ -	$ -	$ -
Year ended December 31, 2017					
allowance for doubtful accounts	$ 3,773	$ (21)	$ 3,054	$ (2,936)	$ 3,870

(1) As discussed at Note 1 of the Notes of the Consolidated Financial Statements, on January 1, 2018, the Company adopted the new revenue recognition standard codified in ASC 606. Upon adoption of ASC 606, the allowance for doubtful accounts of approximately $3.9 billion was reclassified as a component of the net patient accounts receivable.

discouraging third parties from making proposals involving an acquisition or change of control of the Company, although these kinds of proposals, if made, might be considered desirable by a majority of our stockholders. These provisions may also have the effect of making it more difficult for third parties to cause the replacement of our current management without the concurrence of our board of directors.

Number of Directors; Removal; Vacancies

Our Certificate of Incorporation provides that the number of our directors will be determined from time to time exclusively by a vote of a majority of the members of our board of directors then in office. Our Certificate of Incorporation also provides that, subject to the rights of the holders of any series Cn s Cra

director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise, including service with respect to an employee benefit plan, against any liability asserted against such person and incurred by such person in any such capacity, or arising out of such person's status as such, whether or not the Company would have the power to indemnify such person against such liability under the provisions of the Company's Bylaws. The Company has obtained insurance policies insuring its directors and officers against certain liabilities.

The Company has entered into Indemnification Agreements (the "Indemnification Agreements") with its directors and executive officers. One of the purposes of the Indemnification Agreements is to attempt to specify the extent to which persons entitled to indemnification thereunder (the "Indemnitees") may receive indemnification. Pursuant to the Indemnification Agreements, an Indemnitee is entitled to indemnification for claims arising out of or in connection with the service of Indemnitee as a director or officer of the Company or of an affiliate. In the case of an action or proceeding other than an action by or in the right of the Company, the Indemnification Agreements provide that Indemnitee is entitled to indemnification for claims relating to (i) the fact that Indemnitee is or was an officer or director of the Company or any other entity which Indemnitee is or was or will be serving at the request of the Company, or (ii) anything done or not done by Indemnitee in any such capacity. In the case of an action by or in the right of the Company, the Indemnification Agreements provide that Indemnitee is entitled to indemnification for claims relating to (i) the fact that Indemnitee is or was an officer or director of the Company or any affiliate or (ii) anything done or not done in such capacity. The Indemnification Agreements are in addition to and are not intended to limit any rights of indemnification which are available under the Company's Certificate of Incorporation or the Company's Bylaws, or otherwise. In addition to the rights to indemnification specified therein, the Indemnification Agreements are intended to increase the certainty of receipt by the Indemnitee of the benefits to which he or she is entitled by providing specific procedures relating to indemnification.

We believe that our Certificate of Incorporation and Bylaws and insurance are necessary to attract and retain qualified persons as directors and officers.

The limitation of liability and indemnification provisions in our Certificate of Incorporation and Bylaws may discourage stockholders from bringing a lawsuit against directors for breach of their fiduciary duty. They may also reduce the likelihood of derivative litigation against directors and officers, even though an action, if successful, might benefit us and other stockholders. Furthermore, a stockholder's investment may be adversely affected to the extent we pay the costs of settlement and damage awards against directors and officers as required or allowed by these indemnification provisions.

Our Bylaws provide that, unless the Company consents in writing to the selection of an alternative forum, a state or federal court located within the State of Delaware will be the sole and exclusive forum for (i) any derivative action or proceeding brought on behalf of the Company, (ii) any action asserting a claim of breach of a fiduciary duty owed by any director, officer or other employee of the Company to the Company or the Company's stockholders, (iii) any action asserting a claim arising pursuant to any provision of the Delaware General Corporation Law, or (iv) any action asserting a claim governed by the internal affairs doctrine.

Exhibit 10.4

AMENDMENT NO. 2 dated as of November 12, 2019 (this ***"Amendment"***), to the ABL Credit Agreement dated as of April 3, 2018 (as amended by Amendment No. 1 dated as of May 3, 2018, and as further heretofore amended, supplemented, amended and restated or otherwise modified, the ***"ABL Credit Agreement"***), among CHS/COMMUNITY HEALTH SYSTEMS, INC., a Delaware corporation (the ***"Borrower"***), COMMUNITY HEALTH SYSTEMS, INC., a Delaware corporation (***"Parent"***), the lenders party thereto (the ***"Lenders"***) and JPMORGAN CHASE BANK, N.A., as administrative agent (in such capacity, the ***"Administrative Agent"***) and as collateral agent for the Lenders.

PRELIMINARY STATEMENT

SECTION 1. Defined Terms. Capitalized terms used but not otherwise defined herein (including the Preliminary Statement hereto) shall have the meanings assigned thereto in the ABL Credit Agreement. The provisions of Section 1.02 of the ABL Credit Agreement are hereby incorporated by reference herein, *mutatis mutandis*. This Amendment shall be a "Loan Document" for all purposes of the ABL Credit Agreement and the other Loan Documents.

SECTION 2. Amendments to the ABL Credit Agreement. Subject to the satisfaction of the conditions set forth in Section 4 hereof, the ABL Credit Agreement is hereby amended as follows, effective as of the Amendment No. 2 Effective Date (as defined below):

(a) The definition of the term "Term Loan Credit Agreement" in Section 1.01 of the ABL Credit Agreement is hereby amended and restated in its entirety as follows:

"***Term Loan Credit Agreement***" shall mean the Fourth Amended and Restated Credit Agreement dated as of March 23, 2018, among, *inter alia*, Parent, the Borrower, the lenders from time to time party thereto and Credit Suisse AG, Cayman Islands Branch, as administrative agent and as the Term Loan Collateral Agent, as in effect immediately prior to the repayment in full of all indebtedness outstanding thereunder and the termination of all commitments thereunder.

(b) Section 2.23 of the ABL Credit Agreement is hereby amended by:

(i) adding the following to the end of paragraph (a) thereof: "To the extent agreed by the Borrower, the Administrative Agent and the applicable Issuing Bank and pursuant to procedures acceptable to the Administrative Agent, the Borrower may designate any Letter of Credit (as defined in the Term Loan Credit Agreement) to be a Letter of Credit under this Agreement. Any such designation shall be subject to the conditions set forth in Section 4.02 and in this

Section 2.23 and upon such designation and the satisfaction of such conditions, any such Letter of Credit (as defined in the Term Loan Credit Agreement) so designated shall be deemed to have been issued under this Agreement for all purposes."; and

(ii) replacing "$50,000,000" in paragraph (b) thereof with "$200,000,000".

(c) Schedule 2.01 of the ABL Credit Agreement is hereby amended by replacing the table titled "L/C Commitments" and inserting the following in lieu thereof:

L/C COMMITMENTS*

* on file with the agent

Each I A

(a) The Administrative Agent shall have received duly executed and delivered counterparts of this Amendment that, when taken together, bear the signatures of Parent, the Borrower and the Required Lenders; and

(b) All indebtedness outstanding under the Term Loan Credit Agreement shall have been repaid in full and all commitments thereunder shall have been terminated.

SECTION 5. Designation of Letters of Credit. Pursuant to Section 2.23 of the ABL Credit Agreement as amended hereby, the Borrower and the Administrative Agent hereby agree that as of the Amendment No. 2 Effective Date, each of the letters of credit identified hereto on Schedule I shall, from such date, be deemed to have been issued under the ABL Credit Agreement as contemplated by Section 2.23 thereof as amended hereby.

SECTION 6. Miscellaneous. Except as expressly set forth herein, this Amendment shall not constitute a waiver or amendment of, or otherwise affect the rights and remedies of the Administrative Agent, the Lenders or any other Secured Party under the ABL Credit Agreement or any other Loan Document. From and after the Amendment No. 2 Effective Date, any reference to the ABL Credit Agreement shall mean the ABL Credit Agreement as modified by this Amendment. This Amendment may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Delivery by electronic transmission (e.g., "pdf") of an executed counterpart of a signature page to this Amendment shall be effective as delivery of an original executed counterpart of this Amendment. This amendment shall be governed by, and construed in accordance with, the laws of the State of New York.

[*Remainder of page intentionally left blank*]

IN WITNESS WHEREOF, the parties hereto have caused this Amendment to be duly executed by their respective authorized officers as of the date first above written.

CHS/COMMUNITY HEALTH SYSTEMS, INC.,

By: /s/ Kevin J. Hammons
Name: Kevin J. Hammons
Title: Senior Vice President, Assistant Chief Financial Officer, Chief Accounting Officer and Treasurer

COMMUNITY HEALTH SYSTEMS, INC.,

By: /s/ Kevin J. Hammons
Name: Kevin J. Hammons
Title: Senior Vice President, Assistant Chief Financial Officer, Chief Accounting Officer and Treasurer

CITIBANK, N.A.,
as a Lender and an Issuing Bank

By: /s/ David L. Smith
Name: David L. Smith
Title: Vice President and Director

[*Signature Page to Amendment No. 2 to the ABL Credit Agreement*]

BANK OF AMERICA, N.A.,
as a Lender and an Issuing Bank

By: /s/ Steven L. Hipsman
Name: Steven L. Hipsman
Title: Senior Vice President

[*Signature Page to Amendment No. 2 to the ABL Credit Agreement*]

ROYAL BANK OF CANADA,
as a Lender and an Issuing Bank

By: /s/ Jeff Patchell
Name: Jeff Patchell
Title: Attorney In Fact

[*Signature Page to Amendment No. 2 to the ABL Credit Agreement*]

WELLS FARGO BANK, NATIONAL ASSOCIATION, as a Lender and an Issuing Bank

By: /s/ Salvatore Tulu ð 3Ů ƶ ʎ 3 l' `

LENDER SIGNATURE PAGE TO THE
CHS/COMMUNITY HEALTH SYSTEMS, INC.
ABL CREDIT AGREEMENT

Name of Lender:*

By: _____
Name:
Title:

For Lenders requiring a second signature line:

By: _____
Name:
Title:

* On file with Agent

INTRODUCTION

This document outlines the supplemental benefits for eligible executive employees of affiliates of Community Health Systems, Inc. (the "Company"), including the hospital companies whose operating results are consolidated with the Company's operating results. Benefits are provided by the entity that employs the particular eligible executive (the "Employer"), provided, however, certain benefits are provided through group plans sponsored by the Employer or CHS/Community Health Systems, Inc.

Plan benefit categories are based upon your position with an affiliate of the Company. The following benefit categories are referenced throughout this summary:

Executive Corporate Vice Presidents (includes Vice Presidents (Officer) (elected by the Board of Directors of the Company), Regional Presidents, and Vice Presidents (Non-Officer)) and above

Group l Corporate Senior Directors/Directors
Facility Chief Executive Officers

Group 2 Corporate Senior Managers/Managers/Supervisors
Facility Chief Administrative Officers
Facility Chief Financial Officers
Facility Chief Nursing Officers
Facility Chief Operating Officers
Facility Assistant Chief Executive Officers
Facility Assistant Chief Financial Officers
Facility Assistant Chief Nursing Officers
Facility Administrators/Assistant Administrators

Benefit category determination is the exclusive right of the Employer at its sole discretion.

As used in this document, "Cause" means gross neglect of duties, which gross neglect continues more than 30 days after receiving written notice from the chief executive officer of the Company, its board of directors, or other officers of the Company or Employer of the actions or inactions constituting gross neglect; insubordination; intentional misconduct or deliberate disruption of the workplace and working environment; conviction of a felony; dishonesty, embezzlement, theft, or fraud committed in connection with employment resulting in substantial financial harm to the Company; the issuance of any final order for your removal as an employee or representative of the Company or Employer by any state or federal regulatory agency; and your material breach of any duty owed to the Company or Employer, including without limitation the duty of loyalty. "Cause" shall not include ordinary negligence or failure to act, whether due to an error in judgment or otherwise, if you have exercised substantial efforts in good faith to perform the duties reasonably assigned or appropriate to your position.

Act (“ADEA”), Title VII of the Civil Rights Act, Equal Pay Act, Family and Medical Leave Act, Employee Retiremen

6.

executors, administrators, representatives, successors, and assigns,ato

SIGNATURES:

EMPLOYEE SIGNATURE: _____

EMPLOYEE NAME: _____

DATE SIGNED: _____

WITNESS' SIGNATURE: _____

Emp

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/19

(*) Majority position held in an entity with physicians, non-profit entities or both
(#) Minority position held in a non-consolidating entity

Bayfront HMA Wellness Center, LLC* (FL)	
Beauco, LLC (DE)	
Beaumont Medical Center, L.P. (DE)	
Beaumont Regional, LLC (DE)	
Berwick Clinic Company, LLC (DE)	
Berwick Home Care Services, LLC# (DE)	
Berwick Hospital Company, LLC (DE)	d/b/a Berwick Hospital Center
BH Trans Company, LLC (DE)	
Biloxi H.M.A., LLC (MS)	d/b/a Merit Health Biloxi
Biloxi HMA Physician Management, LLC (MS)	
Birmingham Holdings II, LLC (DE)	
Birmingham Holdings, LLC (DE)	
Birmingham Home Care Services, LLC# (DE)	
Blackwell HMA, LLC (OK)	
Blackwell HMPN, LLC (OK)	
Blackwell Home Health & Hospice, LLC (OK)	
Bluefield Holdings, LLC (DE)	
Bluffton Health System LLC (DE)	d/b/a Bluffton Regional Medical Center
Bluffton Physician Services, LLC (DE)	
Brandon HMA, LLC (MS)	d/b/a Merit Health Rankin
Brandon Physician Management, LLC (DE)	
Brandywine Hospital Malpractice Assistance Fund, Inc. (PA)	
Brazos Valley of Texas, L.P. (DE)	
Brazos Valley Surgical Center, LLC (DE)	
Brevard HMA ALF, LLC (FL)	
Brevard HMA APO, LLC (FL)	
Brevard HMA ASC, LLC (FL)	
Brevard HMA Diagnostic Imaging, LLC (FL)	
Brevard HMA HME, LLC (FL)	
Brevard HMA Holdings, LLC (FL)	
Brevard HMA Hospitals, LLC (FL)	
Brevard HMA Investment Properties, LLC (FL)	
Brevard HMA Nursing Home, LLC (FL)	
Brooksville HMA Physician Management, LLC (FL)	
Brownsville Clinic Corp. (TN)	
Brownsville Hospital Corporation (TN)	
Brownwood Asset Holding Company, LLC (DE)	
Brownwood Hospital, L.P. (DE)	d/b/a Brownwood Regional Medical Center
Brownwood Medical Center, LLC (DE)	
Bullhead City Clinic Corp. (AZ)	
Bullhead City Hospital Corporation (AZ)	d/b/a Western Arizona Regional Medical Center
Bullhead City Hospital Investment Corporation (DE)	
Bullhead City Imaging Corporation (AZ)	
Bullhead Medical Plaza II, LLC# (AZ)	

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/19

(*) Majority position held in an entity with physicians, non-profit entities or both
(#) Minority position held in a non-consolidating entity

Bullhead Medical Plaza, Ltd.# (NV)	
Cahaba Orthopedics, LLC (DE)	
Campbell County HMA, LLC (TN)	d/b/a LaFollette Medical Center
Cardiology Associates of Spokane, LLC (DE)	
Carlisle HMA Physician Management, LLC (PA)	
Carlisle HMA Surgery Center, LLC (PA)	
Carlisle HMA, LLC (PA)	
Carlisle Medical Group, LLC (PA)	
Carlsbad Medical Center, LLC (DE)	d/b/a Carlsbad Medical Center
Carolinas Holdings, LLC (DE)	
Carolinas JV Holdings General, LLC (DE)	
Carolinas JV Holdings II, LLC (DE)	
Carolinas JV Holdings, L.P. (DE)	
Carolinas Medical Alliance, Inc. (SC)	
CDI JV, LLC# (DE)	
Cedar Park Clinic Asset Holding Company, LLC (DE)	
Cedar Park Health System, L.P.* (DE)	d/b/a Cedar Park Regional Medical Center
Cedar Park Regional Medical Group (TX)	
Cedar Park Surgery Center, L.L.P.# (TX)	
Center for Adult Healthcare, LLC (DE)	
Center for Medical Interoperability, Inc. (DE)#	
Center for Pain Management, LLC* (DE)	
Central Florida HMA Holdings, LLC (DE)	
Central Polk, LLC* (FL)	
Central States HMA Holdings, LLC (DE)	
Chester HMA Physician Management, LLC (SC)	
Chester HMA, LLC (SC)	
Chester Imaging, LLC (DE)	
Chester Medical Group, LLC (SC)	
Chester PPM, LLC (SC)	
Chesterton Surgery Center, LLC* (DE)	
Chestnut Hill Health System, LLC (DE)	
Chestnut Knoll Home Health Care, L.P.# (PA)	
CHHS Development Company, LLC (DE)	
CHHS Holdings, LLC (DE)	
CHHS Hospital Company, LLC (DE)	
CHS Kentucky Holdings, LLC (DE)	
CHS Mississippi State Political Action Committee (MS)	
CHS Pennsylvania Holdings, LLC (DE)	
CHS PSO, LLC (DE)	
CHS Realty Holdings I, Inc. (TN)	
CHS Realty Holdings II, Inc. (TN)	
CHS Realty Holdings III, LLC (DE)	
CHS Realty Holdings Joint Venture (TN)	
CHS Receivables Funding, LLC (DE)	

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CHS Tennessee Holdings, LLC (DE)	
CHS Virginia Holdings, LLC (DE)	
CHS Washington Holdings, LLC (DE)	
CHS/Community Health Systems, Inc. (DE)	
CHS/Community Health Systems, Inc. Political Action Committee	
CHS-ASC, LLC (DE)	
CHSPSC ACO 1, LLC (DE)	
CHSPSC ACO 10, LLC (DE)	
CHSPSC ACO 11, LLC (DE)	
CHSPSC ACO 12, LLC (DE)	
CHSPSC ACO 13, LLC (DE)	
CHSPSC ACO 14, LLC (DE)	
CHSPSC ACO 15, LLC (DE)	
CHSPSC ACO 16, LLC (DE)	
CHSPSC ACO 17, LLC (DE)	
CHSPSC ACO 18, LLC (DE)	
CHSPSC ACO 19, LLC (DE)	
CHSPSC ACO 2, LLC (DE)	
CHSPSC ACO 20, LLC (DE)	
CHSPSC ACO 21, LLC (DE)	
CHSPSC ACO 22, LLC (DE)	
CHSPSC ACO 23, LLC (DE)	
CHSPSC ACO 24, LLC (DE)	
CHSPSC ACO 25, LLC (DE)	
CHSPSC ACO 26, LLC (DE)	
CHSPSC ACO 27, LLC (DE)	
CHSPSC ACO 28, LLC (DE)	
CHSPSC ACO 29, LLC (DE)	
CHSPSC ACO 3, LLC (DE)	
CHSPSC ACO 30, LLC (DE)	
CHSPSC ACO 4, LLC (DE)	
CHSPSC ACO 5, LLC (DE)	
CHSPSC ACO 6, LLC (DE)	
CHSPSC ACO 7, LLC (DE)	
CHSPSC ACO 8, LLC (DE)	
CHSPSC ACO 9, LLC (DE)	
CHSPSC ACO Holdings, LLC (DE)	
CHSPSC Leasing, Inc. (DE)	
CHSPSC, LLC (DE)	
Citrus HMA, LLC (FL)	d/b/a Bayfront Health Seven Rivers
Clarksdale HMA Physician Management, LLC (MS)	
Clarksdale HMA, LLC (MS)	d/b/a Northwest Mississippi Medical Center
Clarksville Endoscopy Center, LLC* (DE)	
Clarksville Health System, G.P.* (DE)	d/b/a Tennova Healthcare — Clarksville

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Jasper Medical Group, LLC (FL)	
Jefferson ASC, LLC* (DE)	
Jefferson County HMA, LLC (TN)	d/b/a Jefferson Memorial Hospital
Jennersville Regional Hospital Malpractice Assistance Fund, Inc. (PA)	
Jourdanton Clinic Asset Holding Company, LLC (DE)	
Jourdanton Hospital Corporation (TX)	
Kay County Clinic Company, LLC (OK)	
Kay County Hospital Corporation (OK)	
Kay County Oklahoma Hospital Company, LLC (OK)	d/b/a AllianceHealth Ponca City
Kennett HMA Physician Management, LLC (MO)	
Kennett HMA, LLC (MO)	
Key West HMA Physician Management, LLC (FL)	
Key West HMA, LLC (FL)	d/b/a Lower Keys Medical Center
Key West Home Health, LLC# (FL)	
Key West Private Care, LLC# (FL)	
Keystone HMA Property Management, LLC (PA)	
Kirksville Academic Medicine, LLC (MO)	
Kirksville Clinic Corp. (MO)	
Kirksville Home Care Services, LLC# (MO)	
Kirksville Hospital Company, LLC (DE)	
Kirksville Missouri Hospital Company, LLC* (MO)	d/b/a Northeast Regional Medical Center
Kirksville Physical Therapy Services, LLC (DE)	
Knox Hospital Company, LLC (DE)	d/b/a Starke Hospital
Knoxville HMA Cardiology PPM, LLC (TN)	
Knoxville HMA Development, LLC (TN)	
Knoxville HMA Family Services, LLC (TN)	
Knoxville HMA Holdings, LLC (TN)	
Knoxville HMA Homecare DME & Hospice, LLC (TN)	
Knoxville HMA JV Holdings, LLC (TN)	
Knoxville HMA Mission Services, LLC (TN)	
Knoxville HMA Physician Management, LLC (TN)	
Knoxville HMA Wellness Center, LLC (TN)	
Knoxville Home Care Services, LLC# (DE)	
Knoxville Rehabilitation Hospital, LLC# (DE)	
Knoxville, Tennessee Turkey Creek MOB, LLC (DE)	
Kosciusko Ambulance Services, LLC (DE)	
Kosciusko Medical Group, LLC (DE)	
La Porte and Starke EMS, LLC (DE)	
La Porte Clinic Company, LLC (DE)	
La Porte Health System, LLC (DE)	
La Porte Home Care Services, LLC# (DE)	
La Porte Hospital Company, LLC (DE)	d/b/a La Porte Hospital
La Porte Occupational Health Services, LLC (DE)	
Lake Shore HMA Medical Group, LLC* (FL)	

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Lake Shore HMA, LLC* (FL)	d/b/a Shands Lake Shore Regional Medical Center
Lake Wales Clinic Corp. (FL)	
Lake Wales Hospital Corporation (FL)	
Lake Wales Hospital Investment Corporation (FL)	
Lake Wales Imaging Center, LLC (DE)	
Lakeland Home Care Services, LLC# (DE)	
Lakeway Hospital Company, LLC (TN)	
Lancaster Clinic Corp. (SC)	
Lancaster HMA Physician Management, LLC (PA)	
Lancaster HMA, LLC* (PA)	
Lancaster Hospital Corporation (DE)	
Lancaster Imaging Center, LLC (SC)	
Lancaster Medical Group HMA, LLC (PA)	
Lancaster Medical Group, LLC (PA)	
Lancaster Outpatient Imaging, LLC (PA)	
Langtree Endoscopy Center, LLC* (DE)	
LaPorte Medical Group Surgical Center, LLC# (IN)	
Laredo Clinic Asset Holding Company, LLC (DE)	
Laredo Texas Hospital Company, L.P. (TX)	d/b/a Laredo Medical Center
Las Cruces ASC-GP, LLC (DE)	
Las Cruces Home Care Services, LLC# (DE)	
Las Cruces Medical Center, LLC (DE)	d/b/a Mountain View Regional Medical Center
Las Cruces Physician Services, LLC (DE)	
Las Cruces Surgery Center — Telshor, LLC* (DE)	
Las Cruces Surgery Center, L.P.* (DE)	
Lea Regional Hospital, LLC (DE)	d/b/a Lea Regional Medical Center
Lebanon HMA Physician Management, LLC (TN)	
Lebanon HMA Surgery Center, LLC (TN)	
Lebanon HMA, LLC (TN)	
Lehigh HMA Physician Management, LLC (FL)	
Lehigh HMA, LLC (FL)	
LHT Knoxville Properties, LLC# (DE)	
Little Rock HMA, Inc. (AR)	
Live Oak HMA Medical Group, LLC* (FL)	
Live Oak HMA, LLC* (FL)	d/b/a Shands Live Oak Regional Medical Center
Logan Hospital Corporation (WV)	
Logan, West Virginia Hospital Company, LLC (WV)	
Lone Star HMA Physician Management, Inc. (TX)	
Lone Star HMA, L.P. (DE)	
Longview Clinic Operations Company, LLC (DE)	
Longview Medical Center, L.P. (DE)	d/b/a Longview Regional Medical Center
Longview Merger, LLC (DE)	

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Louisburg HMA Physician Management, LLC (NC)	
Lower Florida Keys Physician/Hospital Organization, Inc.# (FL)	
LRH, LLC (DE)	
Lufkin Clinic Asset Holding Company, LLC (DE)	
Lutheran Health Imaging, LLC (DE)	
Lutheran Health Network Investors, LLC* (DE)	
Lutheran Health Network of Indiana, LLC (DE)	
Lutheran Health Quality Alliance, LLC (DE)	
Lutheran Medical Group, LLC (DE)	
Lutheran Medical Office Park Phase II Property Owners Association, Inc. # (IN)	
Lutheran Medical Office Park Property Owners Association, Inc.# (IN)	
Lutheran Musculoskeletal Center, LLC* (DE)	
Lutheran/TRMA Network, LLC# (IN)	
Macon Healthcare, LLC# (DE)	
Madison Cardiovascular Physician Services, LLC (DE)	
Madison Clinic Corp. (TN)	
Madison Health System, LLC# (DE)	
Madison HMA Physician Management, LLC# (MS)	
Madison HMA, LLC# (MS)	d/b/a Merit Health Madison
Marion Physician Services, LLC (DE)	
Marshall County HMA, LLC (OK)	d/b/a AllianceHealth Madill
Marshall County HMPN, LLC (OK)	
Martin Clinic Corp. (TN)	
Martin Hospital Company, LLC (TN)	
Mary Black HealthNetwork, Inc.# (SC)	
Mary Black Health System LLC (DE)	
Mary Black Medical Office Building Limited Partnership (SC)	
Mary Black MOB II Limited Partnership (SC)	
Mary Black Physician Services, LLC (DE)	
Mary Black Physicians Group, LLC (DE)	
Mat-Su Regional ASC GP, LLC (DE)	
Mat-Su Regional Surgery Center, L.P. (DE)	
Mat-Su Valley II, LLC* (AK)	
Mat-Su Valley III, LLC* (AK)	
Mat-Su Valley Medical Center, LLC* (AK)	d/b/a Mat-Su Regional Medical Center
Mayes County HMA, LLC (OK)	
Mayes County HMPN, LLC (OK)	
McKenna Court Homes, LLC (DE)	
McNairy Clinic Corp. (TN)	
McNairy Hospital Corporation (TN)	
MCSA, L.L.C. (AR)	
MDSave, Inc.# (DE)	

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Rockledge HMA Medical Group, LLC (FL)
Rockledge HMA Urgent Care, LLC (FL)
Rockledge HMA, LLC (FL)
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Sebastopol, LLC (DE)	
Sebring HMA Physician Management, LLC (FL)	
Sebring Hospital Management Associates, LLC (FL)	
Seminole HMA, LLC (OK)	d/b/a AllianceHealth Seminole
Seminole HMPN, LLC (OK)	
SEPA Integrated Providers Alliance, LLC (DE)	
Sharon Clinic Company, LLC (DE)	
Sharon Pennsylvania Holdings, LLC (DE)	
Sharon Pennsylvania Hospital Company, LLC (DE)	
Sharon Regional HBP Medical Group, LLC (DE)	
Shelby Alabama Real Estate, LLC (DE)	
Shelbyville Clinic Corp. (TN)	
Shelbyville Home Care Services, LLC# (DE)	
Shelbyville Hospital Company, LLC (TN)	d/b/a Tennova Healthcare — Shelbyville
Sherman Hospital, L.P. (DE)	
Sherman Medical Center, LLC (DE)	
Siloam Springs Arkansas Hospital Company, LLC (DE)	d/b/a Siloam Springs Regional Hospital
Siloam Springs Clinic Company, LLC (DE)	
Siloam Springs Holdings, LLC (DE)	
Silver Creek MRI, LLC (AZ)	
SJ Home Care, LLC# (DE)	
SkyRidge Clinical Associates, LLC (DE)	
South Abilene Radiology, LLC (DE)	
South Arkansas Physician Services, LLC (DE)	
SouthCrest, L.L.C. (OK)	
Southeast Alabama Maternity Center, LLC (AL)	
Southeast HMA Holdings, LLC (DE)	
Southern Health Network, Inc.# (DE)	
Southern Texas Medical Center, LLC (DE)	
Southside Physician Network, LLC (DE)	
Southwest Florida HMA Holdings, LLC (DE)	
Southwest Physicians Risk Retention Group, Inc. (SC)	
Sparks PremierCare, L.L.C. (AR)	
Spokane Valley Washington Hospital Company, LLC (DE)	
Spokane Washington Hospital Company, LLC (DE)	
Spring Hill HMA Medical Group, LLC (FL)	
Springdale Home Care Services, LLC# (DE)	
Sprocket Medical Management, LLC (TX)	
SS ParentCo., LLC (DE)	
St. Cloud Physician Management, LLC* (FL)	
St. Joseph Health System, LLC* (DE)	d/b/a St. Joseph Health System
Starke HMA Medical Group, LLC* (FL)	
Starke HMA, LLC* (FL)	d/b/a Shands Starke Regional Medical Center
Statesboro HMA Medical Group, LLC (GA)	
Statesboro HMA Physician Management, LLC (GA)	

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Statesville HMA Medical Group, LLC (NC)
Statesville HMA Physician Management, LLC (NC)
Statesville HMA, LLC (NC) d/b/a Davis Regional Medical Center
Statesville PPM, LLC (NC)
StrokeCareNow, LLC# (IN)
Summit Surgical Suites, LLC* (IN)
Supply Chain Shared Service Center, LLC (DE)
Surgery Center of Midwest City, LLC enter, LL,

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Triad of Phoenix, Inc. (AZ)	
Triad RC, Inc. (DE)	
Triad-Arizona I, Inc. (AZ)	
Triad-ARMC, LLC (DE)	
Triad-Denton Hospital GP, LLC (DE)	
Triad-Denton Hospital, L.P. (DE)	
Triad-El Dorado, Inc. (AR)	
Triad-Navarro Regional Hospital Subsidiary, LLC (DE)	
Triad-South Tulsa Hospital Company, Inc. (OK)	
Tri-Irish, Inc. (DE)	
TROSCO, LLC (DE)	
Tucson Home Care Services, LLC# (DE)	
Tug Valley Healthcare Alliance, Inc. (WV)	
Tullahoma HMA Physician Management, LLC (TN)	
Tullahoma HMA, LLC (TN)	d/b/a Tennova Healthcare — Harton
Tunkhannock Hospital Company, LLC (DE)	d/b/a Tyler Memorial Hospital
Valley Advanced Imaging, LLC# (IN)	
Valley Advanced MRI, LLC# (IN)	
ValleyCare Cardiology Group, LLC (DE)	
Valparaiso Home Care Services, LLC# (DE)	
Van Buren H.M.A., LLC (AR)	
Van Buren HMA Central Business Office, LLC (AR)	
Vanderbilt-Gateway Cancer Center, G.P.# (DE)	
Venice HMA, LLC (FL)	d/b/a Venice Regional Bayfront Health
Venice Home Care Services, LLC# (DE)	
Vero Beach Florida ASC, LLC* (DE)	
VHC Holdings, LLC (DE)	
VHC Medical, LLC (DE)	
Vicksburg Healthcare, LLC (DE)	d/b/a Merit Health River Region
Vicksburg HMA Physician Management, LLC (MS)	
Victoria Ambulatory Surgery Center, L.P.# (DE)	
Victoria Clinic Asset Holding Company, LLC (DE)	
Victoria Hospital, LLC (DE)	
Victoria of Texas, L.P. (DE)	d/b/a DeTar Hospital Navarro; DeTar Hospital North
Victoria Texas Home Care Services, LLC# (DE)	
Virginia Care Company, LLC (DE)	
Virginia Hospital Company, LLC (VA)	
VirtualHealthConnect, LLC (DE)	
Warren Ohio Hospital Company, LLC (DE)	
Warren Ohio Physician Services, LLC (DE)	
Warren Ohio Rehab Hospital Company, LLC (DE)	
Warsaw Health System, LLC (DE)	d/b/a Kosciusko Community Hospital
Washington Clinic Corp. (MS)	
Washington Hospital Corporation (MS)	

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Washington Physician Corp. (MS)
WA-SPOK DH CRNA, LLC (DE)
WA-SPOK DH Urgent Care, LLC (DE)
WA-SPOK Kidney Care, LLC (DE)
WA-SPOK Medical Care, LLC (DE)
WA-SPOK Primary Care, LLC (DE)
WA-SPOK Pulmonary & Critical Care, LLC (DE)

Exhibit 31.2

CERTIFICATION PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Kevin J. Hammons, certify that:

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

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances unFb