UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the year ended December 31, 2018
OR
TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to

Commission file number 001-15925

COMMUNITY HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**13-3893191**
(State of incorporation)	

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. 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.

We have included the Chief Executive Officer and the Chief Financial Officer certifications regarding the public disclosure required by Sections 302 and 906 of the Sarbanes-Oxley Act of 2002 as Exhibits 31.1, 31.2, 32.1 and 32.2 to this Form 10-K.

Our Business Strategy

Our objective is to provide safe, high-quality healthcare for our patients and the communities we serve. We are committed to efficient, cost effective and profitable operations that seek to ensure sustainable health systems and deliver long-term shareholder value. Our efforts are focused around the following key strategies, which are designed to help us achieve our objectives:

- Become a market leader and increase market share in the communities we serve;
- Increase productivity and operating efficiencies to enhance profitability;
- Continuously improve patient safety and quality of care; and
- Optimize our portfolio through select divestitures of non-core assets while investing in markets with the best opportunities for growth.

Become a market leader and increase market share in the communities we serve

We operate across diverse markets that range from sole community providers to large regional networks. We are able to leverage our significant scale and standardized systems to provide cost-effective services and best practices for our affiliate operations. Each of our markets develops and executes a strategic plan with short- and long-term goals, based on their unique opportunities and the needs of their respective communities. As an organization, we also have ®ewed

- Digital marketing and consumer engagement campaigns; and
- 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, incylmene. We d

By divesting non-core assets, we are able to more sharply channel our resources and capital investments into strategic markets where we have the best ability to increase access and patient care, enhance our service lines, form successful joint ventures, produce growth and increase market share. As an example, we acquired 43 physician practices in 2018.

Our portfolio optimization efforts have included several transactions to date. In 2017, we divested 30 hospitals in single and multi-hospital transactions. In 2018, we divested an additional 11 hospitals in single and multi-hospital transactions. We also closed three non-core hospitals in 2018 in locations where the operations could be absorbed by one or more hospitals in the same regional network.

Industry Overview

According to the Centers for Medicare & Medicaid Services, or CMS, [illegible] projected to have grown from 2018 to nearly $3.7 trillion. The CMS projections, published in February of 2018, indicate that total U.S. healthcare spending is expected to grow by 5.5% in 2019 and 2020, and at an average annual rate of [illegible] healthcare annual expenditures will reach $5.7 trillion by 2026, accounting for approximately [illegible] of the total U.S. gross domestic product. Healthcare spending growth is projected to be largely influenced by changes in economic conditions and demographics, as well as by increasing prices for medical [illegible]

by managemen

The following table reflects the reconciliation of Adjusted EBITDA, as defined, to net loss attributable to Community Health Systems, Inc. stockholders as derived directly from our Consolidated Financial Statements for the years ended December 31, 2018, 2017 and 2016 (in millions):

	Year Ended December 31,		
	2018	2017	2016
Net loss attributable to Community Health Systems, Inc. stockholders	$ (788)	$ (2,459)	$ (1,721)
Adjustments:			
Benefit from income taxes	(11)	(449)	(104)
Depreciation and amortization	700	861	1,100
Net income attributable to noncontrolling interests	84	63	95
Loss from discontinued operations	-	12	15
Interest expense, net	976	931	962
(Gain) loss from early extinguishment of debt	(31)	40	30
Impairment and (gain) loss on sale of businesses, net	668	2,123	1,919
Change in estimate for contractual allowances and provision for bad debts	-	591	-
Gain on sale of investments in unconsolidated affiliates	-	-	(94)
Expense (income) from government and other legal settlements and related costs	11	(31)	16
Expense (income) from fair value adjustments and legal expenses related to cases covered by the CVR	13	6	(6)
Expense related to the sale of a majority interest in home care division	-	1	1
Expense related to the spin-off of QHC	-	-	12
Expense related to employee termination benefits and other restructuring charges	20	14	-
Adjusted EBITDA	$ 1,642	$ 1,703	$ 2,225

(10) Same-store operating results and statistical data exclude information for the hospitals divested or closed, including the hospitals included in the spin-off of QHC in the year ended December 31, 2016. In addition, same-store data excludes discontinued operations in the periods presented. Same-store operating results also exclude the overall impact of the change in estimate related to net patient receivables recorded in the fourth quarter of 2017. For all hospitals owned throughout both periods, the same-store operating results and statistical data reflects the indicated periods.

Sources of Revenue

The following table presents the approximate percentages of net operating revenues by payor source for the periods indicated. The data for the periods presented are not strictly comparable due to the effect that hospital acquisitions and divestitures have had on these statistics.

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, the U.S. Congress and certain state legislatures have introduced and passed a large number of proposals and legislation designed to make major changes in the healthcare system, including changes intended to increase access to health insurance. The most prominent of these efforts, the Affordable Care Act, affects how healthcare services are covered, delivered, and reimbursed, but its future is uncertain. The law has been subject to legislative and regulatory changes and court challenges, and the presidential administration and certain members of Congress have stated their intent to repeal or make additional significant changes to, the Affordable Care Act, its implementation or its interpretation. For example, the Affordable Care Act mandates that substantially all U.S. citizens maintain health insurance coverage and increases health insurance coverage through a combination of public program expansion and private sector health insurance reforms. However, as part of the tax reform legislation which was enacted in December 2017, effective January 1, 2019, the financial penalty for individuals that fail to maintain health insurance coverage associated with the individual mandate was eliminated. Additionally, 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. These changes may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased. In December 2018, a federal judge in Texas found the entire Affordable Care Act to be unconstitutional, as a result of the elimination of the individual mandate penalty as noted above. Pending the

- physician-owned entities (often referred to as physician-owned distributorships, or PODS) that derive revenue from selling, or arranging for the sale of, implantable medical devices ordered by their physician-owners for use on procedures that physician-owners perform on their own patients at hospitals or ASCs.

We have a variety of financial relationships with physicians who refer patients to our hospitals. Physicians own interests in a number of our facilities. Physicians may also own our stock. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases, management agreements and professional service agreements. We provide financial incentives to recruit physicians to relocate to communities served by our hospitals. These incentives include relocation, reimbursement for certain direct expenses, income guarantees and, in some cases, loans. Although we strive to comply with the Anti-Kickback Statute, taking into account available guidance including the "safe harbor" regulations, we cannot assure you that regulatory authorities will not determine otherwise. If that happens, we could be subject to criminal and civil penal ro hys ' rui subj

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

Many states in which we operate have also adopted laws that prohibit payments to physicians in exchange for referrals similar to the federal Anti-
[illegible] prohibiting the referral of patients with whom the physician has a financial relationship. Often these state laws are broad in scope and may apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties, as well as loss of licensure. Little precede st xcsl

facilities, complete acquisitions or significant capital expenditures or add new services in these states. V a r add i .

commonly known as a “DRG,” based upon the patient’s condition and treatment during the relevant inpatient stay. Each DRG is assigned a payment rate using 100% of the national average cost per case and 100% of the severity-adjusted DRG weights. DRG payments are based on national averages and not on charges or costs specific to a hospital. Severity-adjusted DRGs more accurately reflect the costs a hospital incurs for caring for a patient and account more fully for the severity of each patient’s condition. Howeý a .

2017, respectively. Hospitals may also qualify for Medicaid disproportionate share payments when they qualify under the state established guidelines. These Medicaid disproportionate share payments as a percentage of net operating revenues was 0.52% and 0.46% for the years ended December 31, 2018 and 2017, respectively. The Affordable Care Act also provided for reductions to the Medicaid disproportionate share payments, but Congress has delayed the implementation of those reductions until 2020.

We also receive Medicare reimbursement for hospital outpatient services through a PPS. Services paid under the hospital outpatient PPS are grouped into ambulatory payment classifications. APC payment rates are generally determined by applying a conversion factor, which CMS updates annually using a market basket. For calendar year 2018, CMS estimated an increase in hospital outpatient PPS payments of 1.4%. This reflects a market basket increase of 2.7%, with a 0.75% downward adjustment in accordance with the Affordable Care Act, a 0.6% downward productivity adjustment, and other policy changes. For calendar year 2019, CMS estimated an increase in hospital outpatient PPS payments of 0.6%. This reflects a market basket increase of 2.9%, with a 0.75% downward adjustment in accordance with the Affordable Care Act, and a 0.8% downward productivity adjustment. An additional 2.0% reduction to the market basket update applies to hospitals that do not submit required patient quality data. We are complying with this data submission requirement.

Over the next two years, CMS is imposing a site-neutral payment policy for off-campus provider-based departments paid under the outpatient PPS. Off-campus provider-based departments will be paid the Medicare Physician Fee Schedule-equivalent rate for clinic visits. CMS estimates this will result in a 0.6% reduction to hospital payments, depending on the volume of clinic visits provided at the hospitals' off-campus provider-based departments.

The Medicare reimbursement discussed above was reduced beginning in 2013 due to the Budget Control Act of 2011 that required across-the-board spending cuts to the federal budget, also known as sequestration. These sequestration cuts included reductions in payments for Medicare and other federally funded healthcare programs, including TRICARE. These reductions have been extended through 2027.

Payment under the Medicare program for physician services is based upon the Medicare Physician Fee Schedule, or MPFS, under which CMS has assigned a national relative value unit, or RVU, to most medical procedures and services that reflects the resources required to provide:e(Xc x care and other i

associate

Participation in bundled payment programs is generally voluntary, but CMS requires hospitals located in certain geographic areas to participate in bundling programs for specified orthopedic procedures. CMS has indicated that it is developing more bundled payment models. We expect value-based purchasing programs, including models that condition reimbursement on patient outcome measures, to become more common with both governmental and non-governmental payors.

Supply Contracts

We purchase items, primarily medical supplies, medical equipment and pharmaceuticals, under an agreement with HealthTrust, a GPO in which we are a noncontrolling partner. As of December 31, 2018, we had a 17.7% ownership interest in HealthTrust. By participating in this organization, we are able to procure items at competitively priced rates for our hospitals. There can be no assurance that our arrangement with HealthTrust will continue to provide the discounts that we have historically received.

Competition

The hospital industry is highly competitive. The competition among hospitals and other healthcare providers for patients has intensified as patients have become more conscious of rising costs and quality of care in the healthcare decision-making process. Certain of our hospitals are located in non-urban service areas in which we are the sole provider of general acute care health services. Those hospitals in non-urban service areas face no direct competition because there are no other hospitals in their primary service areas. However, these hospitals face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in those service areas may travel to these other hospitals for a variety of reasons, including the need for services we do not offer, payor networks that exclude our participating hospitals, or a preference to receive care in urban areas.

transparency may have a potential impact on our competitive position and patient volumes in ways that we are unable to predict. In addition, hospitals must publish online a list of their standard charges for items and services.

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
- maintaining our screening program to ensure that

affected, and our actual results may differ materially from those predicted in any forward-looking statements we make in any public disclosures. Additional factors that could affect our business, results of operations and financial cond ¸an

If our cash flows and capital resources are insufficient to fund our debt service obligations, we could face substantial liquidity problems and may be forced to reduce or delay capital expenditures, sell assets or operations, seek additional capital or restructure or refinance our indebtedness. Our ability to refinance our indebtedness on favorable terms, or at all, is directly affected by the then current general economic and financial conditions. In addition, our ability to incur secured indebtedness (which would generally enable us to achieve better pricing than the incurrence of unsecured indebtedness) depends in part on the value of our assets, which depends, in turn, on the strength of our cash flows and results of operations, and on economic and market conditions and other factors. We may find it necessary or prudent to refinance certain of our outstanding indebtedness, the terms of which may not be favorable to us.

We cannot assure you that we would be able to take any of these actions, that these actions would be successful and permit us to meet our scheduled debt service obligations or that these actions would be permitted under the terms of our existing or future debt agreements, including our credit facilities and the indentures governing our outstanding notes. For example, our debt agreements and the indentures governing our outstanding notes restrict our ability to dispose of assets and use the proceeds from any dispositions. We may not be able to consummate those dispositions and any proceeds we receive may not be adequate to meet any debt service obligations then due.

Restrictive covenants in the agreements governing our indebtedness may adversely affect us.

Our credit facilities and the indentures governing our outstanding notes contain various covenants that limit our ability to take certain actions, including our ability to:

- incur, assume or guarantee additional indebtedness;
- issue redeemable stock and preferred stock;
- repurchase capital stock;
- make restricted payments, including paying dividends and making certain loans, acquisitions and investments;
- redeem subordinated debt;
- create liens;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- impair security interests;
- enter into agreements that restrict dividends and certain other payments from subsidiaries;
- merge, consolidate, sell or otherwise dispose of substantially all our assets;
- enter into transactions with affiliates; and
- guarantee certain obligations.

In addition, our credit facilities contain restrictive covenants and require us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet these restrictive covenants and financial ratios and tests may be affected by events beyond our control, and we cannot assure you that we will meet those tests.

A breach of any of these covenants could result in a default under our credit facilities and the indentures governing our outstanding notes. Upon the occurrence of an event of default under our credit facilities or any of

The impact of past acquisitions, as well as potential future acquisitions, could have a negative effect on our operations.

Our business strategy has historically included growth by acquisitions. However, not-for-profit hospital systems and other for-profit hospital companies generally attempt to acquire the same type of hospitals as we do. LifePoint Health, Inc. is a principal competitor for acquisitions. Other competitors include HCA Holdings, Inc., or HCA, Universal Health Services, Inc., or UHS, other non-public, for profit hospitals and local market hospitals. Some of the competitors for our acquisitions have greater financial resources than we have. Furthermore, some hospitals are sold through an auction process, which may result in higher purchase prices than we believe are reasonable. Therefore, we may not be able to acquire additional hospitals on terms favorable to us.

In addition, many of the hospitals we have acquired have had lower operating margins than we do and operating losses incurred prior to the time we acquired them. Hospitals acquired in the future may have similar financial performance issues. In the past, we have experienced delays in improving the operating margins or effectively integrating the operations of certain acquired hospitals, including some hospitals acquired in connection with the HMA merger. In the future, if we are unable to improve the operating margins of acquired hospitals, operate them profitably, or effectively integrate their operations, our results of operations and business may be adversely affected.

Moreover, hospitals that we have acquired, or in the future could acquire, may have unknown or contingent liabilities, including liabilities associated with ongoing legal proceedings or for failure to comply with healthcare laws and regulations. Although we generally seek indemni [illegible]

most significant competition our hospitals face comes from hospitals outside of our primary service areas, typically hospitals in urban areas that provide more complex services. Patients in our primary service areas may travel to other hospitals because of physician referrals, payor networks that exclude our providers or the need for services we do not offer, among other reasons. Patients who receive services from these other hospitals may subsequently shift their preferences to those hospitals for the services we provide. Other healthcare providers, including outpatient surgery, orthopedic, oncology and diagnostic centers, also compete for patients. Our hospitals, our competitors, and other healthcare industry participants are increasingly implementing physician alignment strategies, such as employing physicians and participating in ACOs or other clinical integration models, which may impact our competitive position. In addition, increasing consolidation within the payor industry, vertical integration efforts involving payors and healthcare providers, and cost-reduction strategies by large employer groups and their affiliates may impact our ability to contract with payors on favorable terms and otherwise affect our competitive position.

At December 31, 2018, 38 of our hospitals competed with more than one other non-affiliated hospital in their respective primary service areas. In most markets in which we are not the sole provider of general acute care health services, our primary competitor is a municipal or not-for-profit hospital. These hospitals are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. They do not pay income or property taxes, and can make capital expenditures without paying sales tax. These financial advantages may better position these hospitals 8 r

changes in circumstances indicate that such carrying value may not be recoverable. U.S. GAAP requires us to test goodwill for impairment at least annually.

During the three months ended December 31, 2017, in connection with the preparation of the financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2017, we identified certain indicators of impairment and performed an interim goodwill impairment evaluation as of November 30, 2017. Those indicators were primarily a further decline in our market capitalization and fair value of our long-term debt during November 2017. We performed an estimated calculation of fair value in step one of the impairment test at November 30, 2017, which indicated that the carrying value of our hospital operations reporting unit exceeded its fair value. As further discussed in the footnotes to the consolidated financial statements, during the three months ended December 31, 2017 we early adopted the accounting guidance in Accounting Standards Update, or ASU, 2017-04, which eliminates the step two calculation to determine the implied value of goodwill, and instead requires an impairment of goodwill equal to the difference between the carrying value and estimated fair value of the reporting unit determined in step one. As a result of this evaluation and the early adoption of ASU 2017-04, we recorded a non-cash impairment charge of $1.419 billion to goodwill during the three months ended December 31, 2017.

In addition, during the three months ended June 30, 2016, we identified certain indicators of impairment requiring an interim goodwill impairment evaluation. Those indicators were primarily the decline in our market capitalization and fair value of long-term debt during the three months ended June 30, 2016, and a decline in our projected future earnings. We performed an estimated calculation of fair value in step one of the impairment test at June 30, 2016, which indicated that the carrying value of our hospital operations reporting unit exceeded its fair value, which calculation was updated during the three months ended September 30, 2016. A step two calculation was performed to determine the implied value of goodwill in a hypothetical purchase price allocation. Based on these analyses, we recorded a non-cash impairment charge of $1.395 billion to goodwill during the year ended December 31, 2016 based on the fair value and resulting implied goodwill at that time.

The reduction in our fair value and the resulting goodwill impairment charges recorded during 2016 and 2017 reduced the carrying value of our hospital operations reporting unit to an amount equal to our estimated fair value. This increases the risk that future declines in fair value could result in goodwill impairment. The determination of fair value in step one of our goodwill impairment analysis is based on an estimate of fair value for the hospital operations reporting unit utilizing known and estimated inputs at the evaluation date. Some of those inputs include, but are not limited to, the most recent price of our common stock or fair value of our long-term debt, estimates of future revenue and expense growth, estimated market multiples, expected capital expenditures, income tax rates, and costs of invested capital. Future estimates of fair value could be adversely affected if the actual outcome of one or more of these assumptions changes materially in the future, including further decline in our stock price or fair value of our long-term debt, lower than expected hospital volumes, higher market interest rates or increased operating costs. Such changes impacting the calculation of our fair value could result in a material impairment charge in the future.

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

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

through utilization review, reducing coverage of inpatient and emergency room services and shifting care to outpatient settings, requiring prior authorizations, and implementing alternative payment models. The ability of commercial payors to control healthcare costs using these measures may be enhanced by the increasing consolidation of insurance and managed care companies and vertical integration of health insurers with healthcare providers.

In 2018, 59.0% of our net operating revenues, came from commercial payors. Our contracts with payors require us to comply with a number of terms related to the provision of services and billing for services. If we are unable to negotiate increased reimbursement rates, maintain existing rates or other favorable contract terms, effectively respond to payor cost controls and reimbursement policies or comply with the terms of our payor contracts, the payments we receive for our services may be reduced or we may be involved in disputes with payors and experience payment denials, both prospectively and retroactively. In addition, individuals have been increasingly enrolling in high-deductible health plans, which tend to have lower reimbursement rates for providers along with higher co-pays and deductibles due from the patient in comparison to traditional health plans. These plans, sometimes referred to as consumer-directed plans, may even exclude our hospitals and employed physicians from coverage.

The demand for services provided by our hospitals and affiliated providers can be impacted by factors beyond our control.

Our admissions and adjusted admissions as well as acuity trends may be impacted by factors beyond our control. For example, seasonal fluctuations in the severity of influenza and other critical illnesses, unplanned shutdowns or unavailability of our facilities due to weather or other unforeseen events, decreases in trends in high acuity service offerings, changes in competition from other service providers, turnover in physicians affiliated with our hospitals, or changes in medical technology can have an impact on the demand for services at our hospitals and affiliated providers. The impact of these or other factors beyond our control could have an adverse effect on our business, financial position and results of operations.

We may be adversely affected by consolidation among health insurers and other industry participants.

In recent years, a number of health insurers have merged or increased efforts to consolidate with other non-governmental payors. Insurers are also increasingly pursuing alignment initiatives with healthcare providers. Consolidation within the health insurance industry may result in insurers having increased negotiating leverage and competitive advantages, such as greater access to performance and pricing data. Our ability to negotiate prices and favorable terms with health insurers in certain markets could be affected negatively as a result of this consolidation. Also, the shift toward value-based payment models could be accelerated if larger insurers, including those engaging in consolidation activities, find these models to be financially beneficial. We cannot predict whether we will be able to negotiate favorable terms with payors and otherwise respond effectively to the impact of increased consolidation in the payor industry or vertical integration efforts.

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

The healthcare industry is governed by laws and regulations at the federal, state and local government levels. These laws and regulations include standards addressing, among other issues, the adequacy of medical care, equipment, personnel, operating policies and procedures; billing and coding for services; properly handling overpayments; classification of levels of care provided; preparing and filing of cost reports; handling arir ir

In addition, there are heightened coordinated civil and criminal enforcement

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 on self-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.

A cyber-attack or security breach could result in the compromise of our facilities, confidential data or critical data systems and give rise to potential harm to patients, remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

We rely extensively on our computer systems to manage clinical and financial data, communicate with our patients, payors, vendors and other third parties and summarize and analyze operating results. We have made significant investments in technology to protect our systems, equipment and medical devices and information from cybersecurity risks. During the second quarter of 2014, our computer network was the target of an external, criminal cyber-attack in which the attacker successfully copied and transferred certain data outside the Company. This data included certain non-medical patient identification data (such as patient names, addresses, birthdates, telephone numbers and social security numbers) considered protected under HIPAA, but did not include patient credit card, medical or clinical information. The remediation efforts in response to the attack have been substantial, including continued development and enhancement of our controls, processes and practices designed to protect our systems, computers, software, data and networks from attack, damage or [illegible] investigations by various State Attorneys General and the U.S. Department of Health and Human Services Office for Civil Rights, and may be subject to additional litigation, potential governmental inquiries and potential reputation damages.

In spite of our security measures, there can be no assurance that we will not be subject to additional cyber-attacks or security breaches in the future. Additionally, in [illegible] connection with the divestiture of hospitals, we routinely agree to provide transition services to the buyer, including access to our legacy information systems, for a defined transition period. By providing access to our information systems to non-employees, we are exposed to cyber-attacks or security breaches that originate outside of our processes and practices designed to prevent such threats from occurring. Any such cyber-attacks or security breaches could impact the integrity, availability or privacy of protected health information or other [illegible]

causing staffing shortages in our facilities. Although we have disaster plans in place and operate pursuant to infectious disease protocols, the potential impact of a pandemic, epidemic or outbreak of an infectious disease with respect to our markets or our facilities is difficult to predict and could adversely impact our business.

Our performance depends on our ability to recruit and retain quality physicians.

The success of our healthcare facilities depends in part on the number and quality of the physicians on the medical staffs of our healthcare facilities, our ability to employ quality physicians, the admitting and utilization practices of employed and g

the previous year receive a 1% reduction in their total Medicare payments. Medicare does not reimburse for care related to HACs. In addition, federal funds may not be used under the Medicaid program to reimburse providers for services provided to treat HACs. Hospitals that experience excess readmissions for designated conditions receive reduced payments for all inpatient discharges. HHS also reduces Medicare inpatient hospital payments for all discharges by a required percentage and pools the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards. Further, Medicare and Medicaid require hospitals to report certain quality data to receive full reimbursement updates.

HHS has focused on tying Medicare payments to quality or value through alternative payment models, which generally aim to make providers attentive to the quality and cost of care they deliver to patients. Examples of alternative payment models include ACOs and bundled payment arrangements. An ACO is a care coordination model intended to produce savings as a result of improved quality and operational efficiency. In bundled payment models, providers receive one payment for services provided to patients for certain medical conditions or episodes of care, accepting accountability for costs and quality of care. Providers may receive supplemental Medicare payments or owe repayments to CMS depending on whether spending exceeds or falls below a specified spending target and whether certain quality standards are met. Currently, participation in Medicare bundled payment programs is voluntary, except for hospitals located in certain geographic areas with respect to specified orthopedic procedures. CMS has indicated that it is developing more voluntary and mandatory bundled payment models.

Several of the nation's largest commercial payors have also expressed an intent to increase reliance on value-based reimbursement arrangements. Further, many large commercial payors require hospitals to report quality data, and several commercial payors do not reimburse hospitals for certain preventable adverse events.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. It is unclear whether these and other alternative payment models will successfully coordinate care and reduce costs or whether they will decrease aggregate reimbursement. While we believe we are adapting our business strategies to compete in a value-based reimbursement environment, we are unable at this time to predict how this trend will affect our results of operations. If we perform at a level below the outcomes demonstrated by our competitors, are unable to meet or exceed the quality performance standards under any applicable value-based purchasing program, or otherwise fail to effectively provide or coordinate the efficient delivery of quality healthcare services, our reputation in the industry may be negatively impacted, we may receive reduced reimbursement amounts and we may owe repayments to payors, causing our revenues to decline.

Our revenues are somewhat concentrated in a small number of states which will make us particularly sensitive to regulatory and economic changes in those states.

Our revenues are particularly sensitive to regulatory and economic changes in states in which we generate a significant portion of our revenues, including Texas, Mississippi, Indiana, Alabama, and New Mexico. Accordingly, any change in the current demographic, economic, competitive, or regulatory conditions in these states could have an adverse effect on our business, financial condition, or results of operations. Changes to the Medicaid programs in these states could also have an adverse effect on our business, financial condition, results of operations, or cash flows. The Texas Healthcare Transformation and Quality Improvement Program, or the Texas Waiver Program, which provides funding for uncompensated care and delivery system reform initiatives, is operated under a waiver granted pursuant to Section 1115 of the Social Security Act. In December 2017, CMS approved an extension of this waiver through September 30, 2022, and in accordance with this extension, Texas must revise the disbursement methodology for the uncompensated care program to align with federal policies effective October 1, 2019. We cannot guarantee that revenues recognized from the program will not decrease or predict whether the Texas Waiver Program will be further extended or changed.

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

None

judgment is pending, as is plaintiff's motion for class certification. Neither motion is currently set for hearing. We believe these claims are without merit and will vigorously defend the case.

Zwick Partners, LP and Aparna Rao, individually and on behalf of all others similar

PART II

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

We completed an initial public offering of our common stock on June 14, 2000. Our common stock began trading on June 9, 2000 and is listed on the New York Stock Exchange under the symbol CYH. As of February 15, 2019, there were approximately 200 holders of record of our common stock.

Stock Performance Graph

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

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,				
	2018	2017	2016	2015	2014
	(in millions, except share and per share data)				
Consolidated Statement of (Loss) Income Data					
Net operating revenues	$ 14,155	$ 15,353	$ 18,438	$ 19,437	$ 18,639
Income (loss) from operations	208	(1,878)	(860)	1,337	1,339
(Loss) income from continuing operations	(704)	(2,384)	(1,611)	295	260
Net (loss) income	(704)	(2,396)	(1,626)	259	203
Net income attributable to noncontrolling interests	84	63	95	101	111
Net (loss) income attributable to Community Health Systems, Inc. stockholders	(788)	(2,459)	(1,721)	158	92
Basic (loss) earnings per share attributable to Community Health Systems, Inc. common stockholders (1):					
Continuing operations	$ (6.99)	$ (21.89)	$ (15.41)	$ 1.69	$ 1.33
Discontinued operations	–	(0.11)	(0.13)	(0.31)	(0.51)
Net (loss) income	$ (6.99)	$ (22.00)	$ (15.54)	$ 1.38	$ 0.82
Diluted (loss) earnings per share attributable to Community Health Systems, Inc. common stockholders (1):					
Continuing operations	$ (6.99)	$ (21.89)	$ (15.41)	$ 1.68	$ 1.32
Discontinued operations	–	(0.11)	(0.13)		

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

You should read this discussion together with our Consolidated Financial Statements

Hospital	Buyer	City, State	Licens

primarily due to improved staffing and benefit expense management. Supplies, as a percentage of net operating revenues, decreased from 17.4% for the year ended December 31, 2017 to 16.6% for the year ended December 31, 2018. Other operating expenses, as a percentage of net operating revenues, decreased from 25.2% for the year ended December 31, 2017 to 24.7% for the year ended December 31, 2018. Government and other legal settlements and related costs, as a percentage of net operating revenues, decreased from income of 0.2% for the year ended December 31, 2017 to expense of 0.1% for the year ended December 31, 2018 primarily as a result of the gain recorded from the previously announced settlement of the shareholder derivative action in January 2017. Rent, as a percentage of net operating revenues, decreased from 2.6% for the year ended December 31, 2017 to 2.4% for the year ended December 31, 2018.

Depreciation and amortization, as a percentage of net operating revenues, decreased from 5.6% for the year ended December 31, 2017 to 4.9% for the year ended December 31, 2018, primarily due to a decrease in depreciable basis of property and equipment that has been impaired and from ceasing depreciation on property and equipment at hospitals sold or held for sale.

Impairment and (gain) loss on sale of businesses was $668 million for the year ended December 31, 2018, compared to $2.1 billion for the year ended December 31, 2017. Impairment of goodwill and long-lived assets for the year ended December 31, 2018 included (i) impairment of approximately $423 million related to impairment of the long-lived assets and reporting unit goodwill allocated to hospitals that have been sold or deemed held for sale during the year ended December 31, 2018, (ii) approximately $29 million 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 recorded primarily to adjust the carrying value of other long-lived assets at several underperforming hospitals that have ceased operations or where we are in discussions with potential buyers for divestiture at a sales price that indicates a fair value below carrying value. Impairment of goodwill and long-lived assets for the year ended December 31, 2017 included impairment of approximately $388 million related to impairment of the long-lived assets and reporting unit goodwill alloc.

1.5% and 15.8% for the year ended December 31, 2018 and 2017, respectively. The decrease in our effective tax rate for the year ended December 31, 2018, when compared to the year ended December 31, 2017, was primarily due to the increase in valuation allowance recognized on IRC Section 163(j) interest carryforwards partially offset by the release of certain state valuation allowances on net operating loss carryforwards in certain jurisdictions.

Loss from continuing operations, as a percentage of net operating revenues, decreased from 15.5% for the year ended December 31, 2017 to 5.0% for the year ended December 31, 2018.

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.

Year Ended December 31, 2017 Compared to Year Ended December 31, 2016

Net operating revenues decreased by 16.7% to approximately $15.4 billion for the year ended December 31, 2017, from approximately $18.4 billion for the year ended December 31, 2016. Our provision for bad debts increased by $208 million to $3.0 billion, or 16.6% of operating revenues (before the provision for bad debts) for the year ended December 31, 2017, from $2.8 billion, or 13.3% of operating revenues (before the provision for bad debts) for the year ended December 31, 2016. Net operating revenues from same-store hospitals increased $33 million or 0.2% during the year ended December 31, 2017, as compared to the year ended December 31, 2016. Non-same-store net operating revenues decreased $3 billion during the year ended December 31, 2017, in comparison to the prior year period, with the decrease attributable primarily to the spin-off of QHC, the 30 hospitals sold during 2017 and the impact of the change in estimate recorded in 2017 to increase contractual allowances and the allowance for doubtful accounts. The decrease in same-store net operating revenues was attributable to the decline in inpatient admissions and adjusted admissions. On a consolidated basis, inpatient admissions decreased by 13.9% and adjusted admissions decreased by 14.5% during the year ended December 31, 2017 as compared to the year ended December 31, 2016. On a same-store basis, net operating revenues per adjusted admissions increased 2.0%, while inpatient admissions decreased by 1.9% and adjusted admissions decreased by 1.7% for the year ended December 31, 2017, compared to the year ended December 31, 2016.

All operating expenses calculations, as a percentage of net operating revenues, were impacted during the year ended December 31, 2017 due to the overall impact of the change in estimate related to net patient receivables recorded in the fourth quarter of 2017. T ăye20≤orded in the f . 000 000 000f 20170 sd20

loss on sale of businesses, as a percentage of net operating revenues, increased from 88.3% for the year ended December 31, 2016 to 92.8% for the year ended December 31, 2017. Salaries and benefits, as a percentage of net operating revenues, increased from 46.8% for the year ended December 31, 2016 to 48.0% for the year ended December 31, 2017. This increase in salaries and benefits, as a percentage of net operating revenues, was primarily due to the payment of severance to certain employees. Supplies, as a percentage of net operating revenues, increased from 16.3% for the year ended December 31, 2016 to 17.4% for the year ended December 31, 2017, primarily as a result of an increase in implant costs due to an increase in surgical case mix over the prior year. Other operating expenses, as a percentage of net operating revenues, increased from 23.1% for the year ended December 31, 2016 to 25.2% for the year ended December 31, 2017, primarily as a result of higher medical specialist fees, an increase in purchased services and higher information systems expense. Government and other legal settlements and related costs, as a percentage of net operating revenues, decreased from expense of 0.1% for the year ended December 31, 2016 to income of 0.2% for the year ended December 31, 2017 primarily as a result of the gain recorded from the previously announced settlement of the shareholder derivative action in January 2017. Rent, as a percentage of net operating revenues, increased from 2.4% for the year ended December 31, 2016 to 2.6% for the year ended December 31, 2017.

EHR incentive reimbursements represent those incentives under HITECH for which the recognition criterion has been met. We recognized approximately $28 million and $70 million of incentive reimbursements, or 0.2% and 0.4% of net operating revenues, for the years ended December 31, 2017 and 2016, respectively. The decrease in EHR incentive reimbursements is due to the majority of our hospitals completing the various stages of meaningful use compliance, resulting in the expected decline in reimbursement as those programs wind down. We received cash payments of $41 million and $123 million for these incentives during the years ended December 31, 2017 and 2016, respectively. There was no deferred revenue recorded at either December 31, 2017 or 2016.

Depreciation and amortization, as a percentage of net operating revenues, decreased from 6.0% for the year ended December 31, 2016 to 5.6% for the year ended December 31, 2017, primarily due to ceasing depreciation on property and equipment at hospitals sold or held for sale.

Impairment and (gain) loss on sale of businesses was $2.1 billion for the year ended December 31, 2017, compared to $1.9 billion for the year ended December 31, 2016. Impairment of goodwill and long-lived assets for the year ended December 31, 2017 included impairment of approximately $388 million related to impairment of the long-lived assets and reporting unit goodwill allocated to hospitals classified as held for sale during the year ended December 31, 2017, impairment of approximately $316 million for several underperforming hospitals as well as for the hospitals where we had received offers or executed non-binding letters of intent to sell the hospitals, and impairment of $1.419 billion related to goodwill for our hospital reporting unit. Impairment of goodwill and long-lived assets for the year ended December 31, 2016 includes impairment of approximately $12 million related to the reporting unit goodwill and fixed assets allocated to two hospitals sold during the three months ended March 31, 2016, impairment of approximately $326 million related to the reporting unit goodwill allocated to the 18 hospitals designated as held for sale during the year ended December 31, 2016, impairment of approximately $7 million related to certain long-lived assets at one of our smaller hospitals permanently closed, impairment of approximately $1.395 billion related to goodwill for our hospital reporting unit and $270 million related to the adjustment of the fair value of certain long-lived assets at certain hospitals we had sold or identified for sale and for certain underperforming hospitals.

Interest expense, net, decreased by $31 million to $931 million for the year ended December 31, 2017 compared to $962 million for the year ended December 31, 2016, primarily due to a decrease in our average outstanding debt during the year ended December 31, 2017, which resulted in a decrease in interest expense of $88 million. Additionally, a decrease in interest expense of $3 million was due to one less day of interest expense during the year ended December 31, 2017 since 2016 was a leap year, and a decrease in interest expense of $2 million for the year ended December 31, 2017 is a result of more interest being capitalized as compared to the same period in 2016 because of an increase in major construction projects during the year ended December 31,

acquisition. Through December 31, 2018, we have incurred approximately $50 million related to these commitments.

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

At December 31, 2018, we had issued letters of credit primarily in support of potential insurance related claims and specified outstanding bonds of approximately $90 million.

Our debt as a percentage of total capitalization increased from 105% for the year ended December 31, 2017 to 112% for the year ended December 31, 2018, due to an increase in accumulated deficit, offset by an overall decrease in long-term debt.

2017 Compared to 2016

Net cash provided by operating activities decreased $364 million, from approximately $1.1 billion for the year ended December 31, 2016, to approximately $773 million for the year ended December 31, 2017. The decrease in cash provided by operating activities was primarily the result of the loss of cash flow contributed from previously divested hospitals, a decrease in cash flow due to the timing of payroll funding compared to the prior year, an increase in disbu g nared to ea², ntrinet itiooutstrind due ault gusfor i uer e r²,t gusroxecidebtsbclaimude audecrease in casimpviusd.

We have senior secured financing under a credit facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent, which at December 31, 2017 included (i) a revolving credit facility with commitments through January 27, 2019 of approximately $929 million, of which a $739 million portion represented extended commitments maturing January 27, 2021, or the Revolving Facility, (ii) a Term G facility due 2019, or the Term G Facility, and (iii) a Term H facility due 2021, or the Term H Facility. The Revolving Facility includes a subfacility for letters of credit.

As of December 31, 2018, the availability for additional borrowings under the Credit Facility, subject to certain limitations as set forth in the Credit Facility, was approximately $425 million pursuant to the Revolving Facility, of which $90 million is in the form of outstanding letters of credit. CHS has the ability to amend the Credit Facility to provide for one or more tranches of term loans or increases in the Revolving Facility in an aggregate principal amount of up to $500 million. As of December 31, 2018, the weighted-average interest rate under the Credit Facility, excluding swaps, was 6.8%.

The loans under the Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at our option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the NYFRB Rate (as defined) plus 0.50% or (3) the adjusted LIBOR rate on such day for a three-month interest period commencing on the second business day after such day plus 1% or (b) LIBOR. In addition, the margin in respect of the Revolving Facility will be subject to adjustment determined by reference to a leverage-based pricing grid. Based on our current leverage, loans in respect of the Revolving Facility currently accrue interest at a rate per annum equal to LIBOR plus 2.75%, in the case of LIBOR borrowings, and Alternate Base Rate plus 1.75%, in the case of Alternate Base Rate borrowings. Prior to the Credit Facility amendment discussed below, the Term G Loan and Term H Loan accrued interest at a rate per annum equal to LIBOR plus 2.75% and 3.00%, respectively, in the case of LIBOR borrowings, and Alternate Base Rate plus 1.75% and 2.00%, respectively, in the case of Alternate Base Rate borrowings. The Term G Loan and the Term H Loan are subject to a 1.00% LIBOR floor and a 2.00% Alternate Base Rate floor.

The term loan facility must be prepaid in an amount equal to (1) 100% of the net cash proceeds of certain asset sales and dispositions by us and our subsidiaries, subject to certain exceptions and reinvestment rights (as further described below), (2) 100% of the net cash proceeds of issuances of certain debt obligations of us and our subsidiaries, subject to certain exceptions, and (3) 75%, subject to reduction to a lower percentage based on our first lien net

processing charges. We are obligated to pay commitment fees of 0.50% per annum (subject to adjustment based upon our leverage ratio), on the unused portion of the Revolving Facility.

The Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting our and our subsidiaries' ability, subject to certain exceptions, to, among other things, (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of our businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change our fiscal year. We and our subsidiaries are also required to comply with specified financial covenants (consisting of a maximum first lien net debt to consolidated EBITDA leverage ratio) and various affirmative la mp(11TDN1TDN t ζter at rs

On February 26, 2018, the Credit Facility was amended, with requisite revolving lender approval, to remove the consolidated EBITDA to interest expense ratio financial covenant, to replace the senior secured net debt to consolidated EBITDA ratio financial covenant with a first lien net debt to consolidated EBITDA ratio financial covenant, and to reduce the extended revolving credit commitments to $650 million (for a total of $840 million in revolving credit commitments when combined with the non-extended portion of the revolving credit facility). The new financial covenant provides for a maximum first lien net debt to consolidated EBITDA ratio of 5.25 to 1.0, reducing to 5.0 to 1.0 on July 1, 2018, 4.75 to 1.0 on January 1, 2019, 4.5 to 1.0 on January 1, 2020 and 4.25 to 1.0 on July 1, 2020. In addition, we agreed pursuant to the amendment to modify its ability to retain asset sale proceeds, and instead to apply them to prepayments of term loans based on pro forma first lien leverage. To the extent the pro forma ratio of first lien net debt to consolidated EBITDA is greater than or equal to 3.50 to 1.00, 100% of asset sale proceeds are required to be applied to prepay term loans, to the extent the pro forma ratio of first lien net debt to consolidated EBITDA is greater

On April 3, 2018, we and CHS entered into an asset-based loan (ABL) credit agreement, or the ABL Credit Agreement, with JPMorgan Chase Bank, N.A., as administrative agent, and the lenders and other agents party thereto. Pursuant to the ABL Credit Agreement, the lenders have extended to us

calculated borrowing base. At December 31, 2018, we were not subject to the consolidated fixed charge coverage ratio as such triggering event had not occurred during 2018.

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

On June 22, 2018, CHS completed offers to exchange (i) up to $1.925 billion aggregate principal amount of its new Junior-Priority Secured Notes due 2023, or the 2023 Junior-Priority Notes, in exchange for any and all of its $1.925 billion aggregate principal amount of outstanding 8% Senior Notes, (ii) up to $1.200 billion aggregate principal amount of its new Junior-Priority Secured Notes due 2024, or the 2024 Junior-Priority Notes, in exchange for any and all of its $1.200 billion aggregate principal amount of outstanding 7⅛% Senior Notes, and (iii) to the extent that less than all of the outstanding 8% Senior Notes and 7⅛% Senior Notes were tendered in the exchange offers, up to an aggregate principal amount of 2024 Junior-Priority Notes equal to, when taken together with the total notes issued in exchange for the validly tendered and accepted 8% Senior Notes and 7⅛% Senior Notes, $3.125 billion, in exchange for its outstanding 6⅞% Senior Notes. Upon completion of the exchange offers, CHS issued (i) approximately $1.770 billion aggregate principal amount of the 2023 Junior-Priority Notes in exchange for the same amount of 8% Senior Notes, (ii) approximately $1.079 billion aggregate principal amount of the 2024 Junior-Priority Notes in exchange for the same amount of 7⅛% Senior Notes and (iii) approximately $276 million aggregate principal amount of the 2024 Junior-Priority Notes in exchange for approximately $368 million of 6⅞% Senior Notes.

On July 6, 2018, CHS completed an offering of $1.033 billion aggregate principal amount of 8⅝% Senior Secured Notes due 2024, or the 8⅝% Senior Secured Notes due 2024 Secured Notes. We used the proceeds f0erity y y y nior-Priority thyt bitH

- make restricted payments, including paying dividends and making certain loans, acquisitions and investments;
- redeem debt that is subordinated in right of payment to our outstanding notes;
- create liens;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- impair the security interests;
- enter into agreements that restrict dividends and certain other payments from subsidiaries;
- merge, consolidate, sell or otherwise dispose of substantially all of our assets;
- enter into transactions with affiliates; and
- guarantee certain obligations.

The indentures governing each of the 2023 Junior-Priority Notes and 2024 Junior-Priority Notes also proh

Critical Accounting Policies

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

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

Revenue Recognition

Upon our adoption of the new revenue recognition standard in the Financial Accounting Standards Board, or FASB, Accounting Standards Codification Topic 606, or ASC 606, we record net operating revenues at the transaction price estimated to reflect the total consideration due from patients and third-party payors in exchange for providing goods and services in patient care. These services are considered to be a single performance obligation and have a duration of less than one year. Revenues are recorded as these goods and services are provided. The transaction price, which involves significant estimates, is determined based on our standard charges for the goods and services provided, with a reduction recorded for price concessions related to third party contractual arrangements as well as patient discounts and patient price concessions. During the year ended December 31, 2018, the impact of changes to the inputs used to determine the transaction price was considered immaterial to the current period.

Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from the Centers for Medicare & Medicaid Services and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Under these supplemental programs, we recognize revenue and related expenses in the period in which amounts are estimable and collection is reasonably assured. Reimbursement under these programs is reflected in net operating revenues and fees, taxes or other program-related costs are reflected in other operating expenses.

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. Explicit price concessions are recorded for contractual allowances that are calculated and recorded through internally-developed data collection and analysis tools to automate the monthly estimation of required contractual allowances. Within this automated system, payors' historical paid claims data are utilized to calculate the contractual allowances. This data is automatically updated on a monthly basis. All hospital contractual allowance calculations are subjected to monthly review by management to ensure reasonableness and accuracy. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which is one component of the deductions from gross revenues to arrive at net operating revenues (net of contractual allowances and discounts). The process of estimating contractual allowances requires us to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification, 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

fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

Professional Liability Claims

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

The net present value of the projected payments was discounted using a weighted-average risk-free rate of 3.1%, 2.2% and 1.8% in 2018, 2017 and 2016, respectively. This liability is adjusted for new claims information in the period such information becomes known to us. Professional malpractice expense includes the losses resulting from professional liability claims and loss adjustment expense, as well as paid excess insurance premiums, and is presented within other operating expenses in the accompanying consolidated statements of loss.

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

For purposes of estimating our individual claim accruals, we utilize specific claim information, including the nature of the claim, the expected claim amount, the year in which the claim occurred and the laws of the jurisdiction in which the claim occurred. Once the case accruals for known claims are determined, information is stratified by loss layers and retentions, accident years, reported years, geography, and claims relating to the acquired HMA hospitals versus claims relating to our other hospitals. Several actuarial methods are used against this data [illegible]

until years later. Moreover, since our methods and models use different types of data and we select our liability from the results of all of these methods, we typically cannot quantify the precise impact of such factors on our estimates of the liability. Due to our standardized and consistent processes for handling claims and the long history and depth of our company-specific data, our methodologies have produced reliably determinable estimates of ultimate paid losses.

	Year Ended December 31,		
	2018	2017	2016
Accrual for professional liability claims, beginning of year	$ 711	$ 788	$ 901
Liability for insured claims (1)	(21)	4	(15)
Liability transferred to QHC	-	-	(5)
Expense (income) related to:			
Current accident year	161	149	199
Prior accident years	14	(4)	(87)
(Income) expense from discounting	(12)	(4)	3
Total incurred loss and loss expense (2)	163	141	115
Paid claims and expenses related to:			
Current accident year	-	-	-
Prior accident years	(203)	(222)	(208)
Total paid claims and expenses	(203)	(222)	(208)
Accrual for professional liability claims, end of year	$ 650	$ 711	$ 788

(1) The liability for insured claims is recorded on the consolidated balance sheet with a corresponding insurance recovery receivable.
(2) Total expense, including premiums for insured coverage, was $199 million in 2018, $184 million in 2017 and $162 million in 2016.

Current accident year expense increased for the year ended December 31, 2018, when compared to the prior year, due to the trend of higher severity and also the increase in self-insured retention limit per claim from $10 million to $15 million. Expense related to prior accident years reflects changes in estimates resulting from the filing of claims for prior year incidents, claim settlements, updates from litigation and our ongoing investigation of open claims.

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consolidated financial position. Our federal income tax returns for the 2014 and 2015 tax years remain under examination by the IRS under e

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- our ability to successfully integrate any acquired hospitals, or to recognize expected synergies from any acquisition;

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, 2018 and 2017, 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, 2018, 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, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, 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, 2018, 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 21, 2019, expressed an unqualified opinion on the Company's internal control over financial reporting.

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

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE LOSS

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Net loss	$ (704)	$ (2,396)	$ (1,626)
Other comprehensive income (loss), net of income taxes:			
Net change in fair value of interest rate swaps, net of tax of $6, $10 and $10 for the years ended December 31, 2018, 2017 and 2016, respectively	20	19	17
Net change in fair value of available-for-sale securities, net of tax	(2)	8	(11)
Amortization and recognition of unrecognized pension cost components, net of tax of $1, $9, and $2 for the years ended December 31, 2018, 2017, and 2016, respectively	(1)	14	3
Other comprehensive income	17	41	9
Comprehensive loss	(687)	(2,355)	(1,617)
Less: Comprehensive income attributable to noncontrolling interests	84	63	95
Comprehensive loss attributable to Community Health Systems, Inc. stockholders	$ (771)	$ (2,418)	$ (1,712)

See accompanying notes to the consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' (DEFICIT) EQUITY

		Community Health Systems, Inc. Stockholders							
		Common Stock			Treasury Stock				
	Redeemable Noncontrolling Interests	Shares	Amount	Additional Paid-in Capital	Shares	Amount	Accumulated Other Comprehensive Income (Loss)	Retained Earnings (Accumulated Deficit)	Noncontrolling Interests	Total Stockholders' (Deficit) Equity
				(In millions, except share data)						
Balance, December 31, 2015	$ 571	113,732,933	$ 1	$ 1,963	(975,549)	$ (7)	$ (73)	$ 2,135	$ 86	$ 4,105
Comprehensive income (loss)	71	-	-	-	-	-	9	(1,721)	24	(1,688)
Contributions from noncontrolling interests	-	-	-	-	-	-	-	-	-	-
Distributions to noncontrolling interests, net of contributions	(69)	-	-	-	-	-	-	-	(23)	(23)
Purchase of subsidiary shares from noncontrolling interests	(14)	-	-	(9)	-	-	-	-	4	(5)
Disposition of less-than-wholly owned hospital	(3)	-	-	-	-	-	-	-	-	-
Noncontrolling interests in acquired entity	-	-	-	-	-	-	-	-	33	33
Adjustment to redemption value of redeemable noncontrolling interests	6	-	-	(6)	-	-	-	-	-	(6)
Distribution of Quorum Health Corporation	(8)	-	-	-	-	-	2	(713)	(11)	(722)
Cancellation of treasury stock	-	(975,549)	-	(7)	975,549	7	-	-	-	-
Cancellation of restricted stock for tax withholdings on vested shares	-	(368,945)	-	(6)	-	-	-	-	-	(6)
Income tax payable increase from vesting of restricted shares	-	-	-	(6)	-	-	-	-	-	(6)
Stock-based compensation	-	1,488,141	-	46	-	-	-	-	-	46
Balance, December 31, 2016	554	113,876,580	1	1,975	-	-	(62)	(299)	113	1,728
Comprehensive income (loss)	38	-	-	-	-	-	41	(2,459)	25	(2,393)
Contributions from noncontrolling interests	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	5	5
Distributions to noncontrolling interests	(71)	-	-	-	-	-	-	-	(29)	[illegible]
Purchase of subsidiary shares from noncontrorest ontro										

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. Trading securities were reported at fair value with unrealized gains and losses included in earnings. Available-for-sale securities were carried at fair value as determined by quoted market prices, with unrealized gains and losses reported as a separate component of stockholders' (deficit) equity. After adoption of ASU 2016-01 on January 1, 2018, the Company's marketable securities consist of debt securities that are classified as trading or available-for-sale and equity securities. Equity securities are reported at fair value with changes in fair value included in earnings. Available-for-sale securities are carried at fair value as determined by quoted market prices, with unrealized gains and losses reported as a separate component of stockholders' (deficit) equity. Trading securities are reported at fair value with unrealized gains and losses included in earnings. Other comprehensive loss, net of tax, included an unrealized loss of $2 million and $11 million during the years ended December 31, 2018 and 2016, respectively, and an unrealized gain of $8 million during the year ended December 31, 2017, related to these available-for-sale securities.

Property and Equipment. Property and equipment are recorded at cost. Depreciation is recognized using the straight-line method over the estimated useful lives of the land and improvements (3 to 20 years), buildings and improvements (5 to 40 years) and equipment and fixtures (3 to 18 years). Costs capitalized as construction in progress were $219 million and $222 million at December 31, 2018 and 2017, respectively. Expenditures for renovations and other significant improvements are capitalized; however, maintenance and repairs which do not improve or extend the useful lives of the respective assets are charged to operations as incurred. Interest capitalized related to construction in progress was $15 million, $11 million and $9 million for the years ended December 31, 2018, 2017 and 2016, respectively. Purchases of property and equipment and internal-use software accrued in accounts payable and not yet paid were $115 million and $166 million at December 31, 2018 and 2017, respectively.

The Company also leases certain facilities and equipment under capital leases (see Note 10). Such assets are amortized on a straight-line basis over the lesser of the term of the lease or the remaining useful lives of the applicable assets. During the year ended December 31, 2018, the Company had non-cash investing activity of $6 million related to certain facility and equipment additions that were financed through capital leases and other debt.

Goodwill. Goodwill represents the excess of the fair value of the consideration conveyed in the acquisition over the fair value of net assets acquired. Goodwill arising from business combinations is not amortized. Goodwill is required to be evaluated for impairment at the same time every year and when an event occurs or cir[illegible]same e[illegible]and bin[illegible]erome t[illegible]se[illegible](were [illegible]equized[illegible]se [illegible]were [illegible]ment at t[illegible]n

Standards Codification (“ASC”) as topic 606 (“ASC 606”). The revenue recognition standard in ASC 606 outlines a single comprehensive model for recognizing revenue as performance obligations, defined in a contract with a customer as goods or servic.ve

The Company's net operating revenues during the year ended December 31, 2018 have been presented in the following table based on an allocation of the estimated transaction price with the patient between the primary patient classification of insurance coverage (in millions):

	Year Ended December 31, 2018
Medicare	$ 3,730
Medicaid	1, l

payors of $144 million and $156 million as of December 31, 2018 and December 31, 2017, respectively, and these amounts are included in accrued liabilities-other in the accompanying consolidated balance sheets. Amounts due from third-party payors were $155 million and $153 million as of December 31, 2018 and December 31, 2017, 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 2015.

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 gJn

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-h

The adoption of this ASU is also not expected to have an impact on the Company's compliance with debt covenants.

In March 2017, the FASB issued ASU 2017-07, which changes the presentation of the components of net periodic benefit cost for sponsors of defined benefit plans for pensions. Under the changes in this ASU, the service cost component of net periodic benefit cost is reported in the same income statement line as other employee compensation costs arising from services during the reporting period. The other components of net periodic benefit cost are presented separately in a line item outside of operating income. This ASU is effective for fiscal years beginning after December 15, 2017, with early adoption permitted. The Company adopted this ASU on January 1, 2018, and the adoption of this ASU did not have a material impact on the Company's consolidated financial position or results of operations.

In August 2017, the FASB issued ASU 2017-12, which amends hedge accounting recognition and disclosure requirements to improve transparency and simplify the application of hedge accounting for certain hedging instruments. The amendments in this ASU that will have an impact on the Company include simplification of the periodic hedge effectiveness assessment, elimination of the benchmark interest rate concept for interest rate swaps, and enhancement of the ability to use the critical-terms match method for its cash flow hedges of forecasted interest payments. This ASU is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. The Company early adopted this ASU on January 1, 2018, and the adoption of this ASU did not have a material impact on the Company's consolidated financial position or results of operations.

In February 2018, the FASB issued ASU 2018-02, which allows a reclassification from accumulated other comprehensive income to retained earnings for the stranded tax effects in accumulated other comprehensive income resulting from the enactment of the comprehensive tax legislation commonly referred to as the Tax Cuts and Jobs Act (the "Tax Act") and corresponding accounting treatment recorded in the fourth quarter of 2017. The ASU is effective for all entities for fiscal years beginning after December 15, 2018, and interim periods within those fiscal years. Early adoption of the amendments in this ASU is permitted, including adoption in any interim period for reporting periods for which financial statements have not yet been issued. The Company early adopted this ASU on January 1, 2018, and the Company has elected to reclassify $6 million from accumulated other comprehensive loss to a decrease to accumulated deficit for these stranded tax effects. The stranded tax effects included in this adjustment relate solely to the reduction of the federal corporate tax rate as a result of the Tax Act. The Company's accounting policy on releasing the income tax effects of amounts from Accumulated other comprehensive loss has been to apply such amounts on a portfolio basis.

In August 2018, the FASB issued ASU 2018-15 to provide guidance on the accounting for implementation costs incurred in a cloud computing arrangement that is accounted for as a service contract. This ASU requires entities to account for such costs consistent with the guidance on capitalizing costs associated with developing or obtaining internal-use software. The ASU is effective for all entities for fiscal years beginning after December 15, 2019, and interim periods within those fiscal years, with early adoption permitted. The Company is currently evaluating the impact that adoption of this ASU will have on its consolidated financial position and results of operations.

2. ACCOUNTING FOR STOCK-BASED COMPENSATION

Stock-based compensation awards have been granted under the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan, amended and restated as of March 20, 2013 (the "2000 Plan"), and the Community Health Systems, Inc. Amended and Restated 2009 Stock Option and Award Plan, which was amended and restated as of March 14, 2018 and approved by the Company's stockholders at the annual meeting of stockholders held on May 15, 2018 (the "2009 Plan").

[illegible]

$170,000. Vesting of these RSUs occurs in one-third increments on each of the first three anniversaries of the award date or upon the director's earlier cessation of service on the board, other than for cause.

In connection with the spin-off of QHC, holders of outstanding RSUs were credited with a total of 22,021 incremental RSUs at a ratio calculated to maintain a consistent intrinsic value before and following the QHC distribution. There were no other changes to the awards and the incremental RSUs will vest in accordance with the initial vesting period of the corresponding original award.

RSUs outstanding under the 2000 Plan and the 2009 Plan as of December 31, 2018, and changes during each of the y

Arkansas. The total cash consideration paid for the 80% ownership interest in this joint venture was approximately $12 million, with additional consideration of $2 million assumed in liabilities, for a total consideration of $14 million. The value of the noncontrolling interest at acquisition was $2 million. Based upon the Company's final purchase price allocation relating to this acquisition as of December 31, 2016, approximately $12 million of goodwill has been recorded.

On March 1, 2016, one or more subsidiaries of the Company completed the acquisition of an 80% ownership interest in a joint venture entity with Indiana University Health that includes substantially all of the assets of IU Health La Porte Hospital ("La Porte") in La Porte, Indiana (227 licensed beds) and IU Health Starke Hospital ("Starke") in Knox, Indiana (50 licensed beds), and affiliated outpatient centers and physician practices. The total cash consideration paid for the 80% ownership interest in this joint venture was approximately $96 million with additional consideration of $8 million assumed in liabilities, for a total consideration of $104 million. The value of the noncontrolling interest at acquisition was $25 million. Based upon the Company's final purchase price allocation relating to this acquisition as of December 31, 2016, approximately $45 million of goodwill has been recorded. On August 15, 2018, one or more subsidiaries of the Company completed the acquisition of the 20% ownership interest held by the noncontrolling interest owner for approximately $20 million. The Company now owns 100% of the La Porte and Starke hospitals as a result of this transaction.

There were no hospital acquisitions in either the year ended December 31, 2018 or December 31, 2017. The table below summarizes the allocations of the purchase price (including assumed liabilities) for the above hospital acquisition transactions in 2016 (in millions):

	2016
Current assets	[illegible]
Property and equipment	69
Goodwill	[illegible]
Other assets	[illegible]
Long-term debt	[illegible]
Other liabilities	[illegible]
Noncontrolling interests	[illegible]
	[illegible]

Hospital	Buyer	City, State	Licensed Beds	Effective Date
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
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	148	July 1, 2017
Carlisle Regional Medical Center	PinnacleHealth System	Carlisle, PA	165	July 1, 2017
Tomball Regional Medical Center	HCA	Tomball, TX	350	July 1, 2017
South Texas Regional Medical Center	HCA	Jourdanton, TX	67	July 1, 2017
Deaconess Hospital	MultiCare Health System	Spokane, WA	388	July 1, 2017
Valley Hospital	MultiCare Health System	Spokane Valley, WA	123	July 1, 2017
Lake Area Medical Center	CHRISTUS Health	Lake Charles, LA	88	June 30, 2017
Easton Hospital	Steward Health, Inc.	Easton, PA	196	May 1, 2017
Sharon Regional Health System	Steward Health, Inc.	Sharon, PA	258	May 1, 2017
Northside Medical Center	Steward Health, Inc.	Youngstown, OH	355	May 1, 2017
Trumbull Memorial Hospital	Steward Health, Inc.	Warren, OH	311	May 1, 2017
Hillside Rehabilitation Hospital	Steward Health, Inc.	Warren, OH	69	May 1, 2017
Wuesthoff Health System – Rockledge	Steward Health, Inc.	Rockledge, FL	298	May 1, 2017
Wuesthoff Health System – Melbourne	Steward Health, Inc.	Melbourne, FL	119	May 1, 2017
Sebastian River Medical Center	Steward Health, Inc.	Sebastian, FL	154	May 1, 2017
Stringfellow Memorial Hospital	The Health Care Authority of the City of Anniston	Anniston, AL	125	May 1, 2017
Merit Health Gilmore Memorial	Curae Health, Inc.	Amory, MS	95	May 1, 2017
Merit Health Batesville	Curae Health, Inc.	Batesville, MS	112	May 1, 2017

year ended December 31, 2016, representing the net assets of QHC distributed to the Company's stockholders. Immediately following the completion of the spin-off, the Company's stockholders owned 100% of the outstanding shares of QHC common stock. Following the spin-off, QHC became an independent public company with its common stock listed for trading under the symbol "QHC" on the New York Stock Exchange.

In connection with the spin-off, the Company and QHC entered into a separation and distribution agreement as well as certain ancillary agreements on April 29, 2016. These agreements allocate between the Company and QHC the various assets, employees, liabilities and obligations (including investments, property and employee benefits and tax-related assets and liabilities) that

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 losses incurred in certain state jurisdictions where the Company concluded associated deferred tax assets would not be realized increased by $17 million and $104 million during the years ended December 31, 2018 and 2017, respectively.

SAB 118 disclosure

On December 22, 2017, the Tax Act was enacted into law, which significantly changes existing U.S. tax law and included many provisions applicable to us. The Tax Act made broad and complex changes to the U.S. tax code, including a permanent reduction in the U.S. federal corporate tax rate from 35% to 21% effective as of January 1, 2018 ("Rate Reduction").

The Tax Act also revised other aspects of the U.S. tax code, which included, but were not limited to (1) creating a new limitation on deductible interest expense; (2) changing r9s 4 r oaa' te7tax .S.S. FTWihS0 hskg

7. LONG-TERM DEBT

Long-term debt, net of unamortized debt issuance costs and discounts or premiums, consists of the following (in millions):

	December 31,	
	2018	2017
Credit Facility:		
Term G Loan	$ -	$ 1,037
Term H Loan	1,622	1,903
Revolving Credit Facility	-	-
8% Senior Notes due 2019	155	1,925
7⅛% Senior Notes due 2020	121	1,200
5⅛% Senior Secured Notes due 2021	1,000	1,000
6⅞% Senior Notes due 2022	2,632	3,000
6¼% Senior Secured Notes due 2023	3,100	3,100
8⅝% Secured Notes due 2024	1,033	-
Junior-Priority Secured Notes due 2023	1,770	-
Junior-Priority Secured Notes due 2024	1,355	-
Receivables Facility	-	565
ABL Facility	Ď î	

adjustments for interest, taxes, depreciation and amortization, net income attributable to noncontrolling interests, stock compensation expense, restructuring costs, and the financial impact of other non-cash or non-recurring items recorded during any such 12-month period. For the 12-month period ended December 31, 2018, the first lien net debt to consolidated EBITDA ratio financial covenant under the Credit Facility limited the ratio of first lien net debt to consolidated EBITDA, as defined, to less than or equal to 5.0 to 1.0. The Company was in compliance with all such covenants at December 31, 2018, with a first lien net debt to consolidated EBITDA ratio of approximately 4.84 to 1.0. As further discussed at Note 17, on February 15, 2019, the Company and CHS entered into an amendment to the Credit Facility that, among other things, increased the maximum ratio for the first lien net debt to consolidated EBITDA effective January 1, 2019.

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

As of December 31, 2018, the availability for additional borrowings under the Credit Facility, subject to certain limitations as set forth in the Credit Facility, was approximately $425 million pursuant to the Revolving Facility, of which $90 million is in the form of outstanding letters of credit and no

applied to prepay term loans; to the extent the pro forma first lien leverage ratio is less than 4.25 to 1.0 but greater than or equal to 3.75 to 1.0, 50% of such proceeds will be applied to prepay term loans; and to the extent the first lien leverage ratio is less than 3.75 to 1.0, there will be no requirement to prepay term loans with such proceeds. The Agreement also amended the Credit Facility to permit CHS to incur debt under either an asset-based loan ("ABL") facility in an amount up to $1.0 billion or maintain its Asset-Backed Securitization program. The Revolving Facility would be reduced to $425 million upon the effectiveness of the contemplated ABL facility. The Agreement also reduced the availability for incremental tranches of term loans or increases in the Revolving Facility to $500 million and removed the secured net leverage incurrence capacity to zero in the

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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
January 15, 2021 to January 14, 2022	104.313 %
January 15, 2022 to January 14, 2023	102.156 %
January 15, 2023 to January 14, 2024	100.000 %

In addition, at any time prior to January 15, 2021, CHS may redeem up to 40% of the aggregate principal amount of the 8⅝% Senior Secured Notes with the proceeds of certain equity offerings at 108.625%, plus accrued and unpaid interest, if any, to, but excluding, the applicable redemption date.

Receivables Facility

Prior to the effectiveness of the ABL Facility described above, CHS, through certain of its subsidiaries, participated in an accounts receivable loan agreement (the "Receivables Facility") with a group of lenders and banks, Credit Agricolé Corporate and Investment Bank, as a managing agent and as the administrative agent. Patient-related accounts receivable (the "Receivables") for certain affiliated hospitals served as collateral for the outstanding borrowings under the Receivables Facility. The interest rate on the borrowings was based on the commercial paper rate plus an applicable interest rate spread. The Receivables Facility was repaid in full and terminated upon the effectiveness of the ABL Facility on April 3, 2018.

Loss (Gain) from Early Extinguishment of Debt

The financing and repayment transactions discussed above resulted in a gain from the early extinguishment of debt of $31 million and a loss from early extinguishment of debt of $40 million and $30 million for the years ended December 31, 2018, 2017 and 2016, respectively, and an after-tax gain of $23 million and an after-tax loss of $26 million and $19 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Other Debt

As of December 31, 2018, other debt consisted primarily of other obligations maturing in various installments through 2028.

To limit the effect of changes in interest rates on a portion of the Company's long-term borrowings, the Company is a party to six separate interest swap agreements in effect at December 31, 2018, with an aggregate notional amount for currently effective swaps of $1.5 billion. On each of these swaps, the Company receives a variable rate of interest based on the three-month LIBOR in exchange for the payment of a fixed rate of interest. See Note 8 for additional information regarding these swaps.

The carrying value of the Company's long-term debt in the above table is presented net of unamortized deferred debt issuance costs. The estimated fair value is determined using the metho h

Level

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

Investments in Equity Securities, Available-for-sale Securities and Trading Securities

Investments in equity securities and trading securities classified as Level 1 are measured using quoted market prices. Level 2 available-for-sale securities and trading securities primarily consisted of bonds and notes issued by the United States government and its agencies and domestic and foreign corporations. The estimated fair values of these securities are determined using various valuation techniques, including a multi-dimensional relational model that incorporates standard observable inputs and assumptions such as benchmark yields, reported trades, broker/dealer quotes, issuer spreads, benchmark securities, bids/offers and other perti[illegible] Level 2

The Company maintains unfunded deferred compensation plans that allow participants to defer receipt of a portion of their compensation. The liability for the deferred compensation plans was $163 million and $189 million as of December 31, 2018 and 2017, respectively, and is included in other long-term liabilities on the consolidated balance sheets. The Company had assets of $146 million and $173 million as of December 31, 2018 and 2017, respectively, in a non-qualified plan trust generally designated to pay benefits of the deferred compensation plans, consisting of equity securities of $32 million and $37 million as of December 31, 2018 and 2017, respectively, and company-owned life insurance contracts of $114 million and $136 million as of December 31, 2018 and 2017, respectively.

The Company provides an unfunded Supplemental Executive Retirement Plan ("SERP") for certain members of its executive management. The Company uses a December 31 measurement date for the benefit obligations and a January 1 measurement date for its net periodic costs for the SERP. Variances from actuarially assumed rates will result in increases or decreases in benefit obligations and net periodic cost in future periods. Benefits expense under the SERP was $9 million, $16 million and $12 million for the years ended December 31, 2018, 2017 and 2016, respectively. The accrued benefit liability for the SERP totaled $66 million and $83 million at December 31, 2018 and 2017, respectively, and is included in other long-term liabilities on the consolidated balance sheets. The weighted-average assumptions used in determining net periodic cost for the year ended December 31, 2018 was a discount rate of 3.4% and annual salary increase of 2.0%. The Company had equity securities in a rabbi trust generally designated to pay benefits of the SERP in the amounts of $74 million and $99 million at December 31, 2018 and 2017, respectively. These amounts are included in other assets, net on the consolidated balance sheets.

During the years ended December 31, 2018 and 2017, certain members of executive management of the Company that were participants in the SERP retired and met the requirements for payout of their SERP retirement benefit. The SERP payout provisions require payment to the participant in an actuarially determined lump sum amount six months after the participant retires from the Company. Such amounts were paid out of the rabbi trust. As required by the pension accounting rules in U.S. GAAP, the Company recognized a non-cash settlement loss of approximately $2 million and $6 million during the years ended December 31, 2018 and 2017, respectively.

The Company maintains the CHS/Community Health Systems, Inc. Retirement Income Plan ("Pension Plan"), which is a defined benefit, non-contributory pension plan that covers certain employees at three of its formerly owned hospitals. The Pension Plan provides benefits to covered individuals satisfying certain age and service requirements. Employer contributions to the Pension Plan are in accordance with the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as amended. The Company expects to make contributions of approximately $1 million to the Pension Plan in 2019. The Company uses a December 31 measurement date for the benefit obligations and a January 1 measurement date for its net periodic costs for the Pension Plan. Variances from actuarially assumed rates will result in increases or decreases in benefit obligations and net periodic cost in future periods.

14. EQUITY INVESTMENTS

As of December 31, 2018, the Company owned equity interests of 38.0% in three 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, 2018, the Company had a 17.7% ownership interest in HealthTrust.

The Company's investment in all of its unconsolidated affiliates was $192 million and $171 million at December 31, 2018 and 2017, 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 $22 million, $16 million and $43 million for the years ended December 31, 2018, 2017 and 2016, respectively.

15. 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, 2018 and 2017 (in millions, net of tax):

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available-for-Sale Securities	Change in Unrecognized Pension Cost Components	Accumulated Comprehensive Income (Loss)
Balance as of December 31, 2017	$ (12)	$ (2)	$ (7)	$ (2

Details about accumulated other comprehensive (loss) income components	Amount reclassified from AOCL Year Ended December 31, 2017	Affected line item in the statement where net (loss) income is presented
Gains and losses on cash flow hedges		
Interest rate swaps	$ (30)	Interest expense, net
	11	Tax benefit
	$ (19)	Net of tax
Amortization of defined benefit pension items		
Prior service costs	$ (2)	Salaries and benefits
Actuarial losses	(1)	Salaries and benefits
Settlement losses recognized		

2016 and on June 27, 2016, the plaintiffs filed a notice of appeal to the Sixth Circuit Court of Appeals. The matter was heard on May 3, 2017. On December 13, 2017, the Sixth Circuit reversed the trial court's dismissal of the case and remanded it to the District Court. The Company filed a renewed partial motion to dismiss on February 9, 2018, which was denied by the District Court on September 24, 2018. The Company also filed a petition for a writ of certiorari to the United States Supreme Court on April 18, 2018 seeking review of the Sixth Circuit's decision. The United States Supreme Court denied the petition for a writ of certiorari on October 1, 2018. Plaintiff's motion for class certification is pending. The Company believes this consolidated matter is without merit and will vigorously defend this case.

17. SUBSEQUENT EVENTS

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

On January, 1 2019, one or more subsidiaries of the Company sold Mary Black Health System – Spartanburg (207 licensed beds) in Spartanburg, South Carolina, and Mary Black Health System – Gaffney (125 licensed beds) in Gaffney, South Carolina and their associated assets to Spartanburg Regional Healthcare System for approximately $76 million in cash pursuant to the terms of a definitiĎ ž

Condensed Consolidating Statement of Loss
Year Ended December 31, 2017

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Operating revenues (net of contractual allowances and discounts)	$ -	$ (22)	$ 10,932	$ 7,488	$ -	$ 18,398
Provision for bad debts	-	-	2,081	964	-	3,045
Net operating revenues	-	(22)	8,851	6,524	-	15,353
Operating costs and expenses:						
Salaries and benefits	-	-	3,652	3,724	-	7,376
Supplies	-	-				

Condensed Consolidating Statement of Comprehensive Loss
Year Ended December 31, 2016

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net loss	$ (1,721)	$(1,721)	$ (1,477)	$ (534)	$ 3,827	$ (1,626)
Other comprehensive income (loss), net of income taxes:						
Net change in fair value of interest rate swaps, net of tax	17	17	-	-	(17)	17
Net change in fair value of available-for-sale securities, net of tax	(11)	(11)	(11)	-	22	(11)
Amortization and recognition of unrecognized pension cost components, net of tax	3	3	3	-	(6)	3
Other comprehensive income (loss)	9	9	(8)	-	(1)	9
Comprehensive loss	(1,712)	(1,712)	(1,485)	(534)	3,826	(1,617)
Less: Comprehensive income attributable to noncontrolling interests	-	-	-	95	-	95
Comprehensive loss attributable to						
Community Health Systems, Inc. stockholders	$ (1,712)	$(1,712)	$ (1,485)	$ (629)	$ 3,826	$ (1,712)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANC TED TED FINANS

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 ges in a ime aseIcerwerwe reasonire.

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 factor andandKeh ́knhan nnhe

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, 2018, 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, 2018, 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, 2018, of the Company and our reports dated February 21, 2019, expressed an unqualified opinion on those financial statements and schedule.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying *Management's Report on Internal Control over Financial Reporting*. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We 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 audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

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

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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

Nashville, Tennessee
February 21, 2019

independence. The Audit and Compliance Committee has discussed with the independent registered public accounting firm its independence and also has reviewed the amount of fees paid to the independent registered accounting firm for audit and non-audit services.

Based on the Audit and Compliance Committee's discussions with management and the independent registered public accounting firm and the Audit and Compliance Committee's review of the representations of management and the materials it received from the independent registered public accounting firm n

Item 11. Executive Compensation

The information required by this Item is incorporated herein by reference to the Company’s definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 14, 2019 under “Executive Compensation,” “Compensation Committee Interlocks and Insider Participation,” “Non-Management Director Compensation,” and “Compensation Committee Report.”

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

The information required by this Item is incorporated herein by reference to the Company’s definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 14, 2019 under “Security Ownership of Certain Beneficial Owners and Management” and “Equity Compensation Plan Information.”

Item 13. Certain Relationship [illegible]

No.	Description
3.3	Amended and Restated By-laws of Community Health Systems, Inc. (as of December 7, 2016) (incorporated by reference to Exhibit 3.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed December 12, 2016 (No. 001-15925))
4.1	Form of Common Stock Certificate (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly ®munity e n6

No.	Description
4.11	Seventh Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8.000% Senior Notes due 2019, dated as of February 12, 2014, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as successor Trustee (incorporated by reference to Exhibit 4.12 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2013 filed February 26, 2014 (No. 001-15925))
4.12	Eighth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8.000% Senior Notes due 2019, dated as of June 30, 2014, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as successor Trustee (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2014 filed August 1, 2014 (No. 001-15925))
4.13	Ninth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8.000% Senior Notes due 2019, dated as of December 1, 2014, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as successor Trustee (incorporated by reference to Exhibit 4.14 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))
4.14	Tenth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8.000% Senior Notes due 2019, dated as of March 31, 2015, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as successor Trustee (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended

No.	Description
4.30	Seventh Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 7.125% Senior Notes due 2020, dated as of March 31, 2015, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2015 filed May 6, 2015 (No. 001-15925))
4.31	Eighth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 7.125% Senior Notes due 2020, 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 4.2 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))
4.32	Ninth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 7.125% Senior Notes due 2020, 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 4.2 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))
4.33	Tenth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 7.125% Senior Notes due 2020, 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 4.29 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))
4.34	Eleventh Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 7.125% Senior Notes due 2020, 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 4.2 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))
4.35	Twelfth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 7.125% Senior Notes due 2020, 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 4.2 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))
4.36	Thirteenth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 7.125% Senior Notes due 2020, 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 4.2 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))
4.37	Fourteenth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 7.125% Senior Notes due 2020, dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2018 filed October 30, 2018 (No. 001-15925))
4.38	Senior Secured Notes Indenture relating to CHS/Community Health Systems, Inc.'s 5.125% Senior Secured Notes due 2021, dated as of January 27, 2014, by and among FWCT-2 Escrow Corporation, Regions Bank, as Trustee, and Credit Suisse Eu a" Hdredit Suisseik, asAmunit6

No.	Description
4.48	Ninth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 5.125% Senior Secured Notes due 2021, dated as of September 30, 2016, by and among CHS/Community Health Systems, Inc., the guarantors party thereto, Regions Bank, as Trustee and Credit Suisse AG, as Collateral Agent (incorporated by reference to Exhibit 4.4 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))
4.49	Tenth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 5.125% Senior Secured Notes due 2021, dated as of April 12, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto, Regions Bank, as Trustee and Credit Suisse AG, as Collateral Agent (incorporated by reference to Exhibit 4.3 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))
4.50	Eleventh Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 5.125% Senior Secured Notes due 2021, dated as of October 3, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto, Regions Bank, as Trustee and Credit Suisse AG, as Collateral Agent (incorporated by reference to Exhibit 4.3 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	Senior Notes Indenture relating to CHS/Community Health Systems, Inc.'s 6.875% Senior Notes due 2022, dated as of January 27, 2014, by and among FWCT-2 Escrow Corporation and Regions Bank, as Trustee (incorporated by reference to Exhibit 4.3 to Community Health Systems, Inc.'s Current Report on Form 8-K filed January 28, 2014 (No. 001-15925))
4.52	Form of 6.875% Senior Note due 2022 (included in Exhibit 4.51)
4.53	First Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 6.875% Senior Notes due 2022, dated as of January 27, 2014, 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 Current Report on Form 8-K filed January 28, 2014 (No. 001-15925))
4.54	Second Supplemental Indenture relating to CHS/Community Health Systems, Inc.

No.	Description
4.68	Third Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 6.250% Senior Secured Notes due 2023, dated as of April 12, 2018, by and among CHS/Community Health Systems, Inc., the guarantors party thereto, Regions Bank, as Trustee and Credit Suisse AG, as Collateral Agent (incorporated by reference to Exhibit 4.5 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))
4.69	Fourth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 6.250% Senior 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 Credit Suisse AG, as Collateral Agent (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, 2018 filed October 30, 2018 (No. 001-15925))
4.70	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 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))
4.71	Form of Junior-Priority Secured Note due 2023 (included in Exhibit 4.0., Comp

No.	Description
4.79	Amendment No. 1 and Reaffirmation Agreement, dated as of August 17, 2012, relating to the Amended and Restated Guarantee and Collateral Agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the guarantors party thereto, and Credit Suisse AG, as Collateral Trustee (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2012 filed November 1, 2012 (No. 001-15925))
4.80	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))
4.81	Secured Notes Registration Rights Agreement, dated as of January 27, 2014, by and among FWCT-2 Escrow Corporation, Merrill Lynch,

No.	Description
4.87	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))
4.88	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))
4.89	ABL Intercreditor Agreement, dated as of April 3, 2018, among JPMorgan Chase Bank, N.A. as ABL Agent, Credit Suisse AG, as Senior Priority Non-ABL Loan Agent, Regions Bank as 2021 Secured Notes Trustee and 2023 Secured Notes Trustee, each additional agent from time to time party thereto, CHS/Community Health Systems, Inc. as Borrower, Community Health Systems, Inc., as Parent, and the subsidiaries of Borrower from time to time party thereto (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, 2018 filed May 2, 2018 (No. 001-15925))
10.1	Amended and Restated Guarantee and Collateral Agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the subsidiaries of CHS/Community Health Systems, Inc. from time to time party thereto and Credit Suisse AG, as Collateral Agent (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Current Report on Form 8-K filed November 9, 2010 (No. 001-15925))
10.2	Fourth Amendment and Restatement Agreement, dated as of March 23, 2018, to the Credit Agreement dated as of July 25, 2007, as amended and restated as of November 5, 2010, February 2, 2012 and January 27, 2014, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the subsidiary guarantors party thereto, the lenders party thereto and Credit Suisse, AG, as Administrative Agent and Collateral Agent (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed March 26, 2018 (No. 001-15925))
10.3	Amendment No. 1, dated February 15, 2019, to the Credit Agreement dated as of as of July 25, 2007, as amended and restated as of November 5, 2010, February 2, 2012, January 27, 2014, and March 23, 2018, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the subsidiary guarantors party thereto, the lenders party thereto and Credit Suisse, AG, Cayman Islands Branch, as Administrative Agent and Collateral Agent (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed February 20, 2019 (No. 001-15925))
10.4	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. 001-15925))

No.	Description
10.5	Amendment No. 1 to ABL Credit Agreement, dated as of May 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 10.4 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2018 filed July 27, 2018 (No. 001-15925))
10.6	Guarantee and Collateral Agreement to 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, t

No.	Description
10.27†	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))
10.28†	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))
10.29†	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))
10.30†	Form of Director Restricted Stock Unit Award Agreement for Community Health Systems, Inc. 2009 Stock Option and Award Plan (incorporated by reference to Exhibit 10.5 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))
10.31†	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))
10.32†	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))
10.33	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))
10.34	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))
10.35†	Consultancy Agreement, dated May 16, 2017, by and between CHSPSC, LLC and Larry Cash (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed May 17, 2017 (No. 001-15925))
10.36†	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
23.1*	Consent of Deloitte & Touche LLP
31.1*	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

No.	Description
31.2*	Certification

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

None.

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, 2018 allowance for doubtful accounts (1)	$ -	$ -	$ -	$ -	$ -
Year ended December 31, 2017 allowance for doubtful accounts	$ 3,773	$ (21)	$ 3,054	$ (2,936)	$ 3,870
Year ended December 31, 2016 allowance for doubtful accounts	$ 4,110	$ (365)	$ 2,849	$ (2,821)	$ 3,773

(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.

Community Health Systems, Inc.
SUBSIDIARY LISTING

Bayfront Health Urgent Care, LLC (DE)
Bayfront HMA Convenient Care, LLC* (FL)
Bayfront HMA Healthcare Holdings, LLC* (FL)
Bayfront HMA Home Health, LLC# (FL)
Bayfront HMA Investments, LLC* (FL)
Bayfront HMA Medical Center, LLC* (FL) d/b/a Bayfront Health St. PetersbP g

Community Health Systems, Inc.
SUBSIDIARY LISTING

Brevard HMA HME, LLC (FL)	
Brevard HMA Holdings, LLC (FL)	
Brevard HMA Home Health, LLC# (FL)	
Brevard HMA Hospice, LLC# (FL)	
Brevard HMA Hospitals, LLC (FL)	
Brevard HMA Investment Properties, LLC (FL)	
Brevard HMA Nursing Home, LLC (FL)	
Brooklyn Medical Associates, LLC (IN)	
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)	
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
Carolina Surgery Center, LLC* (SC)	
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)	
Carolinas OB/GYN Medical Group, LLC (DE)	
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)#	

Community Health Systems, Inc.
SUBSIDIARY LISTING

Center for Pain Management, LLC* (DE)
Central Florida HMA Holdings, LLC (DE)
Central Polk, LLC* (FL)
Central States HMA Holdings, LLC (DE)
Centre Home Care, LLC# (AL)
CH BH Services, LLC (DE)
Chester HMA Physician Management, LLC (SC)
Chester HMA, LLC (SC) d/b/a Chester Regional Medical Center
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)
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)

Community Health Systems, Inc.
SUBSIDIARY LISTING

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)	
Clarksville Endoscopy Center, LLC* (DE)	
Clarksville Health System, G.P.* (DE)	d/b/a Tennova Healthcare-Clarksville
Clarksville Holdings II, LLC (DE)	
Clarksville Holdings, LLC (DE)	
Clarksville Home Care Services, LLC# (DE)	
Clarksville Imaging Center, LLC# (TN)	
Clarksville Physician Services, G.P.* (DE)	
Clarksville Surgicenter, LLC# (TN)	
Cleveland Home Care Services, LLC# (DE)	
Cleveland Hospital Company, LLC (TN)	
Cleveland Medical Clinic, Inc. (TN)	
Cleveland PHO, Inc. (TN)	
Cleveland Tennessee Hospital Company, LLC# (DE)	

Crossgates HMA Medical Group, LLC (MS)	
Crossroads Healthcare Management, LLC# (TX)	
Crossroads Home Care Services, LLC# (DE)	
Crystal River HMA Physician Management, LLC (FL)	
CSMC, LLC (DE)	
CSP ASC Holdings, LLC* (DE)	
Dallas Phy Service, LLC (DE)	
Dallas Physician Practice, L.P. (DE)	
Day Surgery, Inc. (KS)	
DCF (TX)	
Deaconess Health System, LLC* (OK)	
Deaconess Holdings, LLC (DE)	
Deaconess Hospital Holdings, LLC (DE)	
Deaconess Metropolitan Physicians, LLC (DE)	
Deaconess Physician Services, LLC (DE)	
Deming Home Care Services, LLC# (DE)	
Desert Hospital Holdings, LLC (DE)	
Detar Hospital, LLC (DE)	
DFW Physerv, LLC (DE)	
DH Cardiology, LLC (DE)	
DHFW Holdings, LLC (DE)	
Diagnostic Imaging Centers of NEPA, LLC# (PA)	
Diagnostic Imaging Management of Brandywine Valley, LLC (PA)	
Diagnostic Imaging of Brandywine Valley, LP (PA)	
Dukes Health System, LLC (DE)	d/b/a Dukes Memorial Hospital
Dukes Physician Services, LLC (DE)	
Dupont Hospital, LLC* (DE)	d/b/a Dupont Hospital
Durant H.M.A., LLC* (OK)	d/b/a AllianceHealth Durant
Durant HMA Home Health, LLC (OK)	
Durant HMA Physician Management, LLC (OK)	
Dyersburg Clinic Corp. (TN)	
Dyersburg HBP Medical Group, LLC (DE)	
Dyersburg Hospital Company, LLC (TN)	
E.D. Clinics, LLC (DE)	
East Georgia HMA Physician Management, LLC (GA)	
East Georgia Regional Medical Center, LLC* (GA)	d/b/a East Georgia Regional Medical Center
East Tennessee Clinic Corp. (TN)	
East Tennessee Health Systems, Inc. (TN)	
Easton Hospital Malpractice Assistance Fund, Inc. (PA)	
El Dorado Home Care Services, LLC# (DE)	
El Dorado Surgery Center, L.P.* (DE)	
EL MED, LLC (DE)	

Community Health Systems, Inc.
SUBSIDIARY LISTING

Eligibility Screening Services, LLC (DE)	
Empire Health Services (WA)	
Emporia Clinic Corp. (VA)	
Emporia Home Care Services, LLC# (DE)	
Emporia Hospital Corporation (VA)	d/b/a Southern Virginia Regional Medical Center
Enterprise Clinic, LLC (DE)	
Fallbrook Hospital Corporation (DE)	
Fayetteville Arkansas Hospital Company, LLC* (DE)	d/b/a Northwest Health Physicians' Specialty Hospital
First Choice Health Plan of Mississippi, LLC# (MS)	
Firstcare, Inc.# (IN)	
Florence Home Care Services, LLC# (DE)	
Florida Endoscopy and Surgery Center, LLC* (FL)	
Florida HMA Holdings, LLC (DE)	
Florida HMA Regional Service Center, LLC (FL)	
Florida West Coast Health Alliance, LLC* (DE)	
Flowood Mississippi Imaging, LLC (DE)	
Flowood River Oaks HMA Medical Group, LLC (MS)	
FMG PrimeCare, LLC (DE)	
Foley Clinic Corp. (AL)	
Foley Hospital Corporation (AL)	d/b/a South Baldwin Regional Medical Center
Fort Payne Home Care, LLC# (AL)	
Fort Smith HMA Home Health, LLC# (AR)	
Fort Smith HMA PBC Management, LLC (AR)	
Fort Smith HMA Physician Management, LLC (AR)	
Fort Smith HMA, LLC (AR)	
Frankfort Health Partner, Inc. (IN)	
Franklin Clinic Corp. (VA)	
Franklin Home Care Services, LLC# (DE)	
Franklin Hospital Corporation (VA)	d/b/a Southampton Memorial Hospital
Fresenius Vascular Care (AR)	

Community Health Systems, Inc.
SUBSIDIARY LISTING

Hernando HMA, LLC* (FL)	d/b/a Bayfront Health Brooksville; Bayfront Health Spring Hill
Highland Health Systems, Inc. (TX)	
Hill Country ASC Partners, L.L.C.# (TX)	
Hill Regional Clinic Corp. (TX)	
HIM Central Services, LLC (DE)	
HMA ASC Holdings, LLC (DE)	
HMA ASCOA Holdings, LLC (DE)	
HMA Bayflite Services, LLC (FL)	
HMA CAT, LLC (TX)	
HMA Employee Disaster Relief Fund, Inc. (FL)	
HMA Fentress County General Hospital, LLC (TN)	
HMA Hospital Holdings, LP (DE)	
HMA Lake Shore, Inc.* (FL)	
HMA MRI, LLC (TX)	
HMA Oklahoma Clearing Service, LLC (OK)	
HMA Professional Services Group, LP (DE)	
HMA Santa Rosa Medical Center, LLC (FL)	d/b/a Santa Rosa Medical Center
HMA Services GP, LLC (DE)	
HMA/Solantic Joint Venture, LLC# (DE)	
HMA-ASCOA Investments, LLC* (DE)	
HMA-ASCOA Investments, LLC* (DE)	
HMA-TRI Holdings, LLC (DE)	
Hobbs Medco, LLC (DE)	
Hobbs Physician Practice, LLC (DE)	
Hood Medical Group (TX)	
Hood Medical Services, Inc. (TX)	
Hospital Laundry Services, Inc.# (IN)	
Hospital Management Associates, LLC (FL)	
Hospital Management Services of Florida, LP (FL)	
Hospital of Fulton, Inc. (KY)	
Hospital of Morristown, LLC (TN)	
Hot Springs Outpatient Surgery Center, G.P. (AR)	
HP LRHS Land, LLC# (IN)	
HTI Tucson Rehabilitation, Inc. (AZ)	
Illinois Home Care Holdings, LLC# (DE)	
Imaging JV Holdings, LLC (DE)	
INACTCO, Inc. (DE)	
Innovative Recoveries, LLC (DE)	
Intermountain Medical Group, Inc. (PA)	
IOM Health System, L.P.* (IN)	d/b/a Lutheran Hospital of tđl

Community Health Systems, Inc.
SUBSIDIARY LISTING

Jackson Home Care Services, LLC# (DE)
Jackson Hospital Corporation (TN)
Jackson, Tennessee Hospital Company, LLC* (TN)
Jamestown HMA Physician Management, LLC (TN)
Jasper Medical Group, LLC (FL)
Jefferson County HMA, LLC (TN) d/b/a Jefferson Memorial Hospital
Jennersville Regional Hospital Malpractice Assi My Jackson Home C

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)	
Lake Shore HMA, LLC* (FL)	d/b/a Shands Lake Shore Regional Medical Center
Lake Wales Clinic Corp. (FL)	
Lake Wales Hospital Corporation* (FL)	d/b/a Lake Wales Medical Center
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 Home Care Services, LLC# (DE)	
Lancaster Hospital Corporation (DE)	d/b/a Springs Memorial Hospital
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)	d/b/a Tennova Healthcare – Lebanon; Tennova Healthcare – McFarland Lebanon Campus
Lebanon Surgery Center, LLC (DE)	
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

Community Health Systems, Inc.
SUBSIDIARY LISTING

Logan

Community Health Systems, Inc.
SUBSIDIARY LISTING

Morristo

Community Health Systems, Inc.
SUBSIDIARY LISTING

Northwest Marana Hospital, LLC (DE)	
Northwest Medical Center CT/MRI at Marana, LLC (DE)	
Northwest Physicians, LLC (AR)	
Northwest Rancho Vistoso Imaging Services, LLC (DE)	
Northwest Sahuarita Hospital, LLC (DE)	
Northwest-Sparks Quality Alliance, LLC (DE)	
NOV Holdings, LLC (DE)	
NRH, LLC (DE)	
Oak Hill Clinic Corp. (WV)	
Oak Hill Hospital Corporation (WV)	d/b/a Plateau Medical Center
Ohio Sleep Disorders Centers, LLC# (OH)	
Oklahoma City ASC-GP, LLC (DE)	
Oklahoma City Home Care Services, LLC# (DE)	
Olive Branch Clinic Corp. (MS)	
Olive Branch Hospital, Inc. (MS)	
One Boyertown Properties, L.P.# (PA)	
Open Air of MSLOU, L.L.C. (LA)	
Oro Valley Hospital, LLC (DE)	d/b/a Oro Valley Hospital
OsceolaSC, LLC* (DE)	d/b/a St. Cloud Regional Medical Center
Osler HMA Medical Group, LLC (FL)	
Pacific Group ASC Division, Inc. (AZ)	
Pacific Physicians Services, LLC (DE)	
Palmer-Wasilla Health System, LLC (DE)	
Palmetto Tri-County Medical Specialists, LLC (DE)	
Palmetto Women's Care, LLC (DE)	
Panhandle Medical Center, LLC (DE)	
Panhandle Surgical Hospital, L.P. (DE)	
Parkway Regional Medical Clinic, Inc. (KY)	
Pasco Hernando HMA Physician Management, LLC* (FL)	
Pasco Regional Medical Center, LLC (FL)	

Community Health Systems, Inc.
SUBSIDIARY LISTING

QHG of Kenmare, Inc. (ND)	
QHG of Lake City, Inc. (SC)	
QHG of Minot, Inc. (ND)	
QHG of Ohio, Inc. (OH)	
QHG of South Carolina, Inc. (SC)	d/b/a Carolinas Hospital System; Carolinas Hospital System—Marion
QHG of Spartanburg, Inc. (SC)	
QHG of Springdale, Inc. (AR)	
QHG of Texas, Inc. (TX)	
QHG of Warsaw Company, LLC (DE)	
Quorum ELF, Inc. (DE)	
Quorum Health Services, Inc. (DE)	
Rankin Cardiology Center, LLC (MS)	
Red Bud Home Care Services, LLC# (DE)	
Redimed Dekalb, LLC# (IN)	
Regional Cancer Treatment Center, Ltd.# (TX)	
Regional Cardiology Center, L.L.C.# (MS)	
Regional Cardiology Group, LLC (DE)	
Regional Clinics of Longview (TX)	
Regional Employee Assistance Program (TX)	
Regional Hospital of Longview, LLC (DE)	
Regional Surgical Services, LLC (VA)	
Rehab Hospital of Fort Wayne General Partnership* (DE)	
Revenue Cycle Service Center, LLC (DE)	
River Oaks Hospital, LLC (MS)	d/b/a Merit Health River Oaks
River Oaks Management Company, LLC (MS)	
River Oaks Medical Office Building, LLC (MS)	
River Region Medical Corporation (MS)	
Riverpark Community Cath Lab, LLC# (DE)	
Riverview Regional Medical Center, LLC* (DE)	
Rockledge HMA Convenient Care, LLC (FL)	
Rockledge HMA Medical Group, LLC (FL)	
Rockledge HMA Urgent Care, LLC (FL)	
Rockledge HMA, LLC (FL)	
Rockwood Clinic Real Estate Holdings, LLC (DE)	
ROH, LLC (MS)	d/b/a Merit Health Woman’s Hospital
Ronceverte Physician Group, LLC (DE)	
Rose City HMA Medical Group, LLC* (PA)	
Rose City HMA, LLC* (PA)	
Roswell Clinic Corp. (NM)	
Roswell Community Hospital Investment Corporation (DE)	
Roswell Hospital Corporation (NM)	d/b/a Eastern New Mexico Medical Center
Russell County Clinic Corp. (VA)	

Community Health Systems, Inc.
SUBSIDIARY LISTING

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 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 Home Care Services, LLC# (DE)	
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 (DE)	
SS ParentCo., LLC (DE)	
St. Cloud Physician Management, LLC* (FL)	
St. Joseph Health System, LLC* (DE)	d/b/a St. Joseph Healt, LLC* (DE)

Community Health Systems, Inc.
SUBSIDIARY LISTING

Triad Holdings III, LLC (DE)
Triad Holdings IV, LLC (DE)
Triad Holdings V, LLC (DE)
Triad Holdings VI, Inc. (DE)
Triad Indiana Holdings, LLC* (DE)
Triad Nevada Holdings, LLC (DE)
Triad of Alabama, LLC (DE) d/b/a Flowers Hospital
Triad of Arizona (L.P.), Inc. (AZ)
Triad of Phoenix, Inc. (AZ)
Triad RC, Inc. (DE)
Triad-Arizona I, Inc. (AZ)
Triad-ARMC, LLC (DE)

Community Health Systems, Inc.
SUBSIDIARY LISTING

Wilkes-Barre Holdings, LLC (DE)
Wilkes-Barre Home Care Services, LLC# (DE)
Wilkes-Barre Hospital Company, LLC (DE) d/b/a Wilkes-Barre General Hospital
Wilkes-Barre Intermountain Clinic, LLC (DE)
Wilkes-Barre Personal Care Services, LLC (DE)
Wilkes-Barre Radiation Oncology, LLC# (DE)
Wiregrass Clinic, LLC (DE)
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Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Exhibit 31.1

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

I, Wayne T. Smith, certify that:

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

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

3. Based on my knowledge, the financial statements, and other financial information incodmisleading with em oveg di dge,

Exhibit 32.1

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

In connection with the Annual Report of Community Health Systems, Inc. (the "Company") on Form 10-K for the period ended December 31, 2018, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Wayne T. Smith, Chairman of the Board and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ Wayne T. Smith
Wayne T. Smith
Chairman of the Board and
Chief Executive Officer

February 21, 2019

Exhibit 32.2

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