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 EXCHANGξ

TAB

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

The key elements of our business strategy are to:

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 implemented a number of strategic initiatives designed to improve market position, expand services to our patients, and capture a greater share of healthcare spending in our markets. These include:

- Strengthening regional networks and local market operations;
- Expanding patient access points, health services and infrastructure;
- Recruiting and/or employing additional primary care physicians and specialists; and
- Developing a more consumer-centric experience and facilitating connections between episodes of care.

Strengthening Regional Networks and Local Market Operations. We believe opportunities exist in select markets to create healthcare networks consisting of multiple hospitals and corresponding outpatient services.

Regional networks are able to expand the breadth of services provided for our patients, develop centers of excellence for key services, deliver care in an organized and efficient way, and improve alignment with physicians and other providers, and make services more attractive to managed care and other payers. Currently, 56 of our hospitals operate in 14 unique regional networks.

We also operate healthcare systems that are built around a single acute-care hospital. In these markets, we are focused on supporting the hospital with physician practices, outpatient services, clinical collaborations and partnerships that offer our patients health services across the continuum of care. These hospitals and their related outpatient services may operate in competitive markets or as sole community providers.

Expanding Patient Access Points, Health Services and Infrastructure. When expanding services in both the acute and non-acute care settings—our approach is standardized and strategic to ensure our investments are responsive to community and patient needs and produce sound financial results. While we continue to provide health services across

- Developing and implementing operational best practices;
- Discharge planning; and
- Compliance with applicable regulatory standards.

Our case management program integrates the functions of utilization review, discharge planning, assessment of medical necessity and resource management. Patients are assessed upon presentation to the hospital and throughout their course of care with ongoing reviews. Industry-standard criteria are utilized in patient assessments and discharge plans are adjusted according to patient needs. Cases are monitored to prevent delays in service or unnecessary utilization of resources. When a patient is ready for discharge, a case manager works with the patient's attending physician to evaluate and coordinate the patient's needs for continued care in the post-acute setting

trillion. CMS estimates that the hospital services category will amount to over $1.4 trillion in 2021 and projects growth in this category at an average of 5.9% annually from 2021 through 2028.

U.S. Hospital Industry. The U.S. hospital industry is broadly defined to include acute care, rehabilitation and psychiatric facilities that are either public (government owned and operated), not-for-profit private (religious or secular), or for-profit institutions (investor owned). According to the American Hospital Association, there are approximately 5,100 community hospitals in the U.S., which are not-for-profit owned, investor owned, or state or local government owned. Of these hospitals, approximately 35% are located in non-urban communities. We believe that a majority of these hospitals are owned by not-for-profit or governmental entities. These facilities offer a broad range of healthcare services, including internal medicine, general surgery, cardiology, oncology, orthopedics, OB/GYN and emergency services. In addition, hospitals offer other ancillary services, including psychiatric, diagnostic, rehabilitation, home care and outpatient surgery services.

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

- facility size and location;
- facility ownership structure (e.g., tax-exempt or investor owned);
- a facility's ability to participate in GPOs, such as HealthTrust; and
- facility payor mix.

Patients needing the most complex care are more often served by the larger and/or more specialized urban hospitals. We believe opportunities exist in selected urf non plor pehatardab in shtd o biietdeseran hospitals off ope-urban comɔitals off" oningoththestorope laradthp l thevices, ifer-tdtn non lar-ur l

- the need to achieve general economies of scale and to gain access to standardized and centralized functions, including favorable supply agreements and access to malpractice coverage;
- changes to healthcare payment models that emphasize cost-effective delivery of service and quality of outcomes for the entire episode of care; and
- regulatory changes.

The payor industry is also consolidating and acquiring health services providers in an effort to offer more expansive, competitive programs.

Trends in Payment for Healthcare Services. As discussed in more detail in the Government Regulation section of this Form 10-K, the impact of healthcare reform legislation, combined with the growing financial and economic pressures on the healthcare industry, has resulted in challenges to traditional reimbursement models. For example, the Affordable Care Act has encouraged the adoption of new payment models that emphasize cost-effective delivery of care and quality of outcomes. Although the number of patients with health insurance coverage has expanded since 2010, the year the Affordable Care Act was enacted, patients may face higher deductibles and increased co-payment requirements, which may result in greater write-offs of uncollectible amounts from those patients.

Shift to Outpatient Services. Because of the growing availability of stand-alone outpatient healthcare facilities, the increase in the services that can be provided at these locations, and payor policies requiring or promoting treatment in outpatient settings, many individuals are seeking a broader range of services on an outpatient basis. This trend has contributed to an increase in outpatient services while inhibiting the growth of inpatient admissions. Recent changes to Medicare policy affecting the reimbursement methodology for certain items and services provided by off-campus provider-based hospital departments have generally resulted in reduced payment rates for the

we could be subject to criminal and civil penalties, and/or exclusion from participating in Medicare, Medicaid, or other government healthcare programs.

certificate of need, or CON, laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities, significant capital expenditure or the addition of new services. As of December 31, 2020, we operated 69 hospitals in 12 states that have adopted CON laws. If we fail to obtain necessary state approval, we will not be able to expand our facilities in ed

geographic factors. In addition, hospitals may qualify for an “outlier” payment when a patient’s treatment costs are extraordinarily high and exceed a specified regulatory threshold.

The DRG payment rates for inpatient acute services are adjusted by an updatb

Beginning in 2013, the Medicare reimbursement discussed above has been reduced due to the Budget Control Act of 2011, which requires across-the-board spending cuts to the federal budget, also known as sequestration. These sequestration cuts include reductions in payments for Medicare and other federally funded healthcare programs, including TRICARE. The Coronavirus Aid, Relief and Economic Security Act, or the CARES Act, and related legislation have temporarily suspended these reductions through March 31, 2021, but also extended the reductions through 2030. Payment under the Medicare program for physician services is based upon the 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 the services relative to all other services. Each RVU is calculated based on a combination of the time and intensity of work required, overhead expense attributable to the service, and malpractice insurance expense. These elements are each modified by a geographic adjustment factor to account for local practice costs and are then aggregated. To determine the payment rate for a particular service, the sum of the geographically adjusted RVUs is multiplied by a conversion

providers to send to an insured patient’s health plan good faith estimates of the expected charges for furnishing scheduled items or services, including any item or service that is reasonably expected to be provided in conjunction with the scheduled item or service or that is reasonably expected to be delivered by another provider, before the services are delivered. If a patient is uninsured, the notice must go to the patient. If the actual charges are substantially higher than the estimate, the law includes a dispute resolution process to challenge the higher amount. The No Surprises Act will also prohibit providers from charging patients an amount beyond the in-network cost sharing amount for services rendered by out-of-network providers, subject to limited excemM to is l

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 proced

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- We could be subject to increased monetary penalties and/or other sanctions if we fail to comply with the terms of our CIA.

Risks Related to Government Regulation

- We are unable to predict the ultimate impact of health reform initiatives, including the Affordable Care Act.
- If we fail to comply with laws and regulations, we could suffer penalties or be required to make changes to our operations.
- If there are delays in regulatory updates by governmental entities, we may experience volatility in our operating results.
- If our adoption and utilization of EHR systems fails to satisfy HHS standards, our financial results could be adversely affected.
- State efforts to regulate the construction, acquisition or expansion of healthcare facilities could adversely impact us.
- State efforts to regulate the sale of municipal or other securities to raise capital, or experience

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

The ABL Facility 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, the ABL Facility contains restrictive covenants and may, in certain circumstances, require us to maintain a specified financial ratio and satisfy other financial condition tests. Our ability to meet these restrictive covenants and financial ratio and tests (if applicable) may be affected by events beyond our control, and we cannot assure you that we will meet those tests.

In addition, our ability to incur additional secured debt (other than (i) secured debt to refinance existing secured debt and (ii) indebtedness incurred under our ABL Facility) is highly limited.

A breach of any of these covenants could result in a default under the ABL Facility and the indentures governing our outstanding notes. Upon the occurrence of an event of default under the ABL Facility or any of the indentures governing our outstanding notes, all amounts outstanding under the applicable indebtedness may become immediately due and payable and all commitments under the ABL Facility to extend further credit may be terminated. If we were unable to repay those amounts, the holders of such indebtedness could, subject to applicable intercreditor agreements, proceed against the collateral granted to them to secure that indebtedness.

Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.

Our borrowings under the ABL Facility are at variable rates of interest and expose us to interest rate risk. If interest rates increase, our debt service obligations on the variable rate indebtedness would increase even though the amount borrowed remained the same, and our net income would decrease. As of December 31, 2020, there are no borrowings under the ABL Facility.

In addition, certain of our variable rate indebtedness uses London Interbank Offered Rate, or LIBOR, as a benchmark for establishing the rate of interest and may be hedged with LIBOR-based interest rate derivatives. LIBOR is the subject of national, international and other regulatory guidance and proposals for reform. These reforms and other pressures may cause LIBOR to be replaced with a new benchmark or to perform differently than in the past. The consequences of these developments cannot be entirely predicted, but could include an increase in the cost of our variable rate indebtedness.

If we default on our obligations to pay our indebtedness, we could be in default under the terms of the agreements governing our indebtedness.

If we are unable to generate sufficient cash flow and are otherwise unable to obtain funds necessary to meet required payments of principal, premium, if any, and interest on our indebtedness, or if we otherwise fail to comply with the

allowing for flexibility in delivery of care and various financial supports for health care providers are available only for the dura

A pandemic, epidemic or outbreak of an infectious disease in the markets in which we operate or that otherwise impacts our facilities could adversely impact our business.

In addition to the adverse impacts of the COVID-19 pandemic discussed above, if another pandemic, epidemic, or outbreak of an infectious disease or other public health crisis were to affect our markets, our business could be adversely affected. Any such crisis could diminish the public trust in healthcare facilities, especially hospitals that fail to accurately or timely diagnose, or that are treating (or have treated) patients affected by contagious diseases. If any of our facilities were involved in treating patients for such a contagious disease, other patients might cancel elective procedures or fail to seek needed care at our facilities. Patient volumes may decline or volumes of uninsured and underinsured patients may increase, depending on the economic circumstances surrounding the pandemic, epidemic, or outbreak. Further, any such pandemic might adversely impact our business by causing a temporary shutdown or diversion of patients, by disrupting or delaying production and delivery of materials and products in the supply chain or by causing staffing shortages in our facilities. Although we have disaster plans in place and operate pursuant to infectious disease protocols, the potential impact, as well as the public's and government's response to, of any such 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 independent physicians, maintaining good relations with those physicians and controlling costs related to the employment of physicians. Although we employ some physicians, physicians are often not employees at our healthcare facilities at which they practice. In many of the markets we serve, many physicians have admitting privileges at other healthcare facilities in addition to our healthcare facilities. Such physicians may terminate their affiliation with or employment by our healthcare facilities at any time. In addition, we may face increased challenges in this area as the physician population reaches retirement age, especially if there is a shortage of physicians willing and able to provide comparable services. Moreover, if we are unable to provide adequate support personnel or technologically advanced equipment and facilities that meet the needs of those physicians and their patients, they may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline.

Our labor costs could be adversely affected by competition for staffing, the shortage of experienced nurses and labor union activity.

In addition to our physicians, the operations of our healthcare facilities are dependent on the efforts, abilities and experience of our facility management and medical support personnel, such as nurses, pharmacists and lab technicians. We compete with other healthcare providers in recruiting and retaining qualified facility management and support personnel responsible for the daily operations of our healthcare facilities, including nurses and other non-physician healthcare professionals. In some markets, the availability of nurses and other medical support personnel has been a significant operating issue to healthcare providers. We may be required to continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary or contract personnel. In addition, the states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse-staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios.

Moreover, a newly instituted freeze and review of certain labor regulations, proposed changes to federal labor laws, and other labor-related developments arising from the recent change in presidential administration in the United States could increase the likelihood of employee unionization activity and the ability of employees to unionize. Increased or ongoing labor union activity could also adversely affect our labor costs or otherwise adversely impact us. In addition, when negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur during the negotiation process, and our continued operation during any strikes could increase our labor costs and otherwise adversely impact us.

If our labor costs continue to increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. In the event we are not entirely effective at recruiting and retaining qualified facility management, nurses and other medical support personnel, or in controlling labor costs, this could have an adverse effect on our results of operations.

The industry trend towards value-based purchasing may negatively impact our revenues.

There is a trend toward value-based purchasing of healthcare services across the healthcare industry among both government and commercial payors. Generally, value-based purchasing initiatives tie payment to the quality and efficiency of care. For example, hospital payments may be negatively impacted by the occurrence of hospital acquired conditions, or HACs. The 25% of hospitals with the worst national risk-adjusted HAC rates for all hospitals in 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 requied mtha Furtionrew

Risks Related to Legal Proceedings

We are the subject of various legal, regulatory and governmental proceedings that, if resolved unfavorably, could have an adverse effect on us, and we may be subject to other loss contingencies, both known and unknown.

We are a party to various legal, regulatory and governmental proceedings and other related matters. Those proceedings include, among other things, government investigations. In addition, we are and may become subject to other loss contingencies, both known and unknown, which may relate to past, present and future facts, events, circumstances and occurrences. Should an unfavorable outcome occur in connection with our legal, regulatory or governmental proceedings or other loss contingencies, or if we become subject to any such loss contingencies in the future, there could be an adverse impact on our financial position, results of operations and liquidity.

In [illegible] lawsuits, may lead to significant fines, penalties, damages payments or other sanctions, [illegible] settlements of lawsuits involving Medicare and Medicaid issues routinely require both [illegible] of which could have an adverse effect on our business, financial condition, results of [illegible]

We co[illegible] result of significant legal actions.

Ph[illegible] following number of legal actions alleging malpractice, product liability, [illegible] seeking recoveries under new theories of liability that might not be subject to the [illegible] damages. Many of these actions [illegible] and significant defense costs. To protect us from the cost of these claims, we maintain claims made professional malpractice [illegible]

Even an unsuccessful challenge by patients or regulatory authorities of our activities could result in adverse publicity and could require a costly response fr*q

Our networks and information systems are also subject to disruption due to events such as a m

patients; business interruptions and delays; the loss, misappropriation, corruption or unauthorized access of data or inability to access data; litigation and potential liability under privacy, security, breach notification and consumer protection laws or other applicable laws, including HIPAA; reputational damage, federal and state governmental inquiries, civil monetary penalties, settlement agreements, corrective action plans and monitoring requirements, any of which could have an adverse effect on our business, financial condition or results of operations.

Item 1B. *Unresolved Staff Comments*

None

Item 2. *Properties*

We own our corporate headquarters building located in Franklin, Tennessee. In addition to the headquarters in Franklin, we late he b

November 20, 2019, the District Court appointed Arun Bhattacharya and Michael Gaviria as lead plaintiffs in the case. The lead plaintiffs filed a consolidated class complaint on January 21, 2020. The Company filed a motion to dismiss the consolidated class complaint on March 23, 2020. That motion is pending. We believe this matter is without merit and will vigorously defend this case.

Padilla Derivative Litigation. Five purported shareholder derivative cases have been filed in two District Courts relating to the factual allegations in the Padilla litigation; namely, *Faisal Hussain v. Wayne T. Smith, et al,* filed August 12, 2019 in the United States District Court for the District of Delaware; *Roger Trombley v. Wayne T. Smith, et al,* filed August 20, 2019 in the United States District Court for the Middle District of Tennessee; *Susheel Tanjavoor v. Wayne T. Smith, et al.,* filed August 29, 2019, in the United States District Court for the District of Delaware; *Roofers Local No. 149 Pension Fund v. John A. Clerico, et al,* filed October 30, 2019, in the United States District Court for the District of Delaware; and *Kevin Aronson v. Wayne T. Smith, et al,* filed

PART II

Item 5. Market for Registrant’s Common Equity, Related Stockholder

We are a holding company which operates through our subsidiaries. The ABL Facility and the indentures governing the senior and senior secured notes contain various covenants under which th*anr lee v

The following table provides a summary of hospitals that we divested during the years ended Decembevee ee or de

In addition to the divestiture of the hospitals noted above which were completed during 2020, 2019 and 2018, we have divested four hospitals during 2021 as summarized below:

- On January 1, 2021, we completed the sale of substantially all of the assets of Lea Regional Medical Center (68 licensed beds) in Hobbs, New Mexico, to affiliates of Covenant Health System pursuant to the terms of a definitive agreement which was entered into September 8, 2020. The net proceeds from this sale were received at a preliminary closing on December 31, 2020.

- On January 1, 2021, we completed the sale of substantially all of the assets of each of Tennova Healthcare - Tullahoma (135 licensed beds) in Tullahoma, Tennessee, and Tennova Healthcare – Shelbyville (60 licensed beds) in Shelbyville, Tennessee, to Vanderbilt University Medical Center pursuant to the terms of a definitive agreement which was entered into on September 30, 2020. The net proceeds from this sale were received at a preliminary closing on December 31, 2020.

- On February 1, 2021, we sold substantially all of the assets of Northwest Mississippi Medical Center (181 licensed beds) in Clarksdale, Mississippi to affiliates of Delta Health System pursuant to the terms of a definitive agreement which was entered into on October 30, 2020, as referenced above.

In addition to the four hospital divestitures which have been completed during 2021 as noted above, we have entered into a definitive agreement to sell one additional hospital which has not been completed as summarized below:

On December 8, 2020, we entered into a definitive agreement for the sale of substantially all of the assets of AllianceHealth Midwest (255 licensed beds) in Midwest City, Oklahoma, to affiliates of SSM Health Care of Oklahoma, Inc.

There can be no assurance that this potential divestiture subject to definitive agreement will be completed, or if it is completed, the ultimate timing of the completion of this divestiture. In addition, while our portfolio rationalization and delivering strategy was completed at the end of 2020 as noted above, we continue to receive interest from potential acquirers for certain of our hospitals, and may, from time to time, consider selling additional hospitals if we consider any such disposition to be in our best interests.

We expect to use proceeds from divestitures for general corporate purposes and capital expenditures.

During the year ended December 31, 2020, we paid approximately $1 million to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by our hospitals. We allocated the purchase price to property and equipment, working capital and goodwill.

On September 19, 2019, we completed the sale and leaseback of four medical office buildings for net proceeds of $56 million to Carter Validus Mission Critical REIT II, Inc. The buildings, with a combined total of 285,337 square feet, are located in three states and support a wide array of diagnostic, medical and surgical services in an outpatient setting for the respective nearby hospitals. Based on our assessment of the control transfer principle in these leased buildings, the transaction does not qualify for sale treatment and the related leases have been recorded as financing obligations in long-term debt in the accompanying consolidated balance sheet at December 31, 2019. In addition, on December 18, 2019, we completed the sale and leaseback of one medical office building for net proceeds of approximately $4 million to an affiliate of Catalyst Healthcare Real Estate. The 30,000 square foot building is located in Arkansas and supports a wide array of diagnostic, medical and surgical services in an outpatient setting for the nearby hospital. Based on our assessment of the control transfer principle in this leased building, the transaction does not qualify for sale treatment and the related lease has been recorded as a financing obligation in long-term debt in the accompanying consolidated balance sheet at December 31, 2019.

Overview of Operating Results

Our net operating revenues for the year ended December 31, 2020 decreased $1.4 billion to approximately $11.8 billion compared to approximately $13.2 billion for the year ended December 31, 2019, primarily as a result of developments related to COVID-19 as highlighted above, and hospitals divested during 2019 and 2020. On a same-store basis, net operating revenues for the year ended December 31, 2020 decreased $396 million, also primarily as a result of the COVID-19 pandemic.

We had net income of $607 million during the year ended December 31, 2020, compared to a net loss of $590 million for the year ended December 31, 2019. Net income for the year ended December 31, 2020 included the following:

- an after-tax benefit of less than $1 million for government and other legal settlements and related costs,
- an after-tax benefit of $352 million for gain from early extinguishment of debt,

- an after-tax charge of $81 million for the impairment of goodwill and long-lived assets of hospitals sold or held for sale based on their estimated fair values, net of gains/losses recognized upon the sale of certain facilities,
- an after-tax charge of $39 million for the settlement of professional liability claims for which the third-party insurers obligation to insure the Company for the underlying loss is being litigated,
- an after-tax charge of $13 million for employee termination benefits and other restructuring costs,
- an after-tax charge of $1 million for legal expenses related to the settlement of the HMA Legal Matters, and
- income of approximately $240 million due to discrete tax benefits related to the release of federal and state valuation allowances on IRC Section 163(j) interest carryforwards as a result of an increase to the deductible interest expense allowed for 2019 and 2020 under the CARES Act that was enacted during the year ended December 31, 2020.

Net loss for the year ended December 31, 2019 included the following:
- an after-tax charge of $73 million for government and other legal settlements and related costs,
- an after-tax charge of $1 million for employee termination benefits and other restructuring costs,
- an after-tax charge of $16 million to reserve the outstanding balance of a promissory note outstanding that was received as part of the purchase price from the sale of two hospitals in 2017, net of income from a reduction of the valuation allowance on the outstanding balance of a promissory note from the buyer of another hospital,
- an after-tax charge of $42 million for loss from early extinguishment of debt,
- an after-tax charge of $71 million for a change in estimate for professional liability claims accrual, which charge resulted from a revision to the estimate for professional liability claims accrual related to claims incurred in 2016 and prior years,
- an after-tax charge of $101 million for the impairment of goodwill and long-lived assets of hospitals sold or held for sale based on their estimated fair values, net of gains/losses recognized upon the sale of certain facilities,
- an after-tax charge of $9 million for legal expenses related to the final global resolution and settlement of certain HMA legal proceedings entered into with the U.S. Department of Justice in the three months ended September 30, 2018, or the HMA Legal Matters,
- a discrete tax expense of approximately $275 million due to an increase in the valuation allowance recognized on (i) IRC Section 163(j) interest carryforwards and (ii) original issue discount deferred tax asset generated with the 2019 Exchange Offer, and
- a discrete tax benefit of $15 million for tax credits claimed in lieu of deductions for the HMA Legal Matters.

Consolidated inpatient admissions for the year ended December 31, 2020, decreased 15.7%, compared to the year ended December 31, 2019, and consolidated adjusted admissions for the year ended December 31, 2020, decreased 19.4%, compared to the year ended December 31, 2019. Same-store inpatient admissions for the year ended December 31, 2020, decreased 8.0%, compared to the year ended December 31, 2019, and same-store adjusted admissions for the year ended December 31, 2020, decreased 12.5%, compared to the year ended December 31, 2019.

Self-pay revenues represented approximately (0.2)% and 1.0% of net operating revenues for the years ended December 31, 2020 and 2019, respectively. The amount of foregone revenue related to providing charity care services as a percentage of net operating revenues was approximately 8.9% and 4.1% for the years ended December 31, 2020 and 2019, respectively. Direct and indirect costs incurred in providing charity care services as a percentage of net operating revenues was approximately 1.0% and 0.5% for the years ended December 31, 2020 and 2019, respectively.

Legislative Overview

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 that have impacted access to health insurance. The most prominent of these recent efforts, the
Affordable Care Act, has changed how healthcare services are covered, delivered and reimbursed. The Affordable Care Act initially focused on health insurance reforms to reduce the number of people that lack health insurance, primarily through a combination of public program

The future of the Affordable Care Act is uncertain. Since 2016, significant changes have been made to the Affordable Care Act, its implementation, and its interpretation, and certain members of Congress have stated their intent to repeal or make additional significant changes to the law. For example, final rules issued in 2018 expand 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. Additionally, effective January 1, 2019, the financial penalty associated with the individual mandate was eliminated as part of the 2017 tax reform legislation. In December 2018, as a result of this change, a federal judge in Texas found the individual mandate unconstitutional and determined the rest of the Affordable Care Act was therefore invalid. In December 2019, the Fifth Circuit Court of Appeals upheld this decision with respect to the individual mandate, but remanded for further consideration of how this affects the rest of the law. On November 10, 2020, the Supreme Court heard oral arguments regarding this case, and the law remains in place pending the appeals process. The Consolidated Appropriations Act, 2021 eliminated the penalty and other changes may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased.

Of critical importance to us will be the potential impact of any changes specific to the Medicaid program, including the funding and expansion provisions of the Affordable Care Act or any subsequent lỳ th]calloflidl e i e ÝMeee al ma

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away from traditional fee-for-service Medicare to Medicare managed care. The trend toward increased enrollment in Medicare and Medicaid managed care may adversely affect our operating revenue. We may also be impacted by regulatory requirements imposed on insurers, such as minimum medical-loss ratios and specific benefit requirements. Furthermore, in the normal course of business, managed care programs, insurance companies and employers [illegible] negotiate the amounts paid to hospitals. Our relationships with payors may be impacted by price transparency initiatives and out-of-network billing [illegible] There can be no assurance that we will maintain our managed care contracts on terms similar to those currently in effect or that these third-party payors will not attempt to further reduce the rates they pay for our services.

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-based reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for the treatment of patients covered by Medicare, Medicaid and non-governmental payors are generally less than our standard billing rates. We account [illegible] dicare and based on insur

hospitals during 2019 and 2020. On a consolidated basis, inpatient admissions decreased by 15.6Ď

Our provision for income taxes for the year ended December 31, 2019 was $160 million compared to a benefit from income taxes of $11 million for the year ended December 31, 2018. Our effective tax rates were (37.2%) and 1.5% for the year ended December 31, 2019 and 2018, respectively. The difference in our effective tax rate for the year ended December 31, 2019, when compared to the year ended December 31, 2018, was primarily due to an increase in the valuation allowance recognized on (i) IRC Section 163(j) interest carryforwards and (ii) original issue discount deferred tax asset generated with the 2019 Exchange Offer.

Net loss, as a percentage of net operating revenues, decreased from 5.0% for the year ended December 31, 2018 to 4.5% for the year ended December 31, 2019.

Net income attributable to noncontrolling interests, as a percentage of net operating revenues, was 0.6% for both of the years ended December 31, 2019 and 2018.

Net loss attributable to Community Health Systems, Inc. was $675 million for the year ended December 31, 2019, compared to $788 million for the year ended December 31, 2018.

Liquidity and Capital Resources

2020 Compared to 2019

Net cash provided by operating activities increased $1.8 billion, from approximately $385 million for the year ended December 31, 2019, to approximately $2.2 billion for the year ended December 31, 2020. The increase in cash provided by operating activities is primarily the result of the receipt of PHSSEF funds as well as Medicare accelerated payments during the year ended December 31, 2020, which is discussed below. Total cash paid for interest during the year ended December 31, 2020 remained consistent with

As noted above, we received Medicare accelerated payments of approximately $1.2 billion in April 2020 under the Medicare Accelerated and Advanced Payments Program. No additional Medicare accelerated payments have been received by us since such time and approximately $77 million of amounts previously received was repaid to CMS or assumed by buyers during the year ended December 31, 2020 related to divested entities. As of December 31, 2020, approximately $425 million of Medicare accelerated payments are reflected within accrued liabilities-other in the consolidated balanc ey

(3) Pursuant to hospital purchase agreements in effect as of December 31, 2020, we have commitments to build one replacement facility and the following capital commitments. As part of an acquisition in 2016, we agreed to build replacement facility Knox, Indiana. The estimated construction costs, including equipment costs, are currently estimated to be approximately $15 million, we have incurred no cost to date for the construction of

primarily represent c

	Principal Amount
6⅞% Senior Notes due 2022	$ 72
8⅛% Junior-Priority Secured Notes due 2024	6
9⅞% Junior-Priority Secured Notes due 2023	2
6⅞% Senior Notes due 2028	7
Total principal amount of debt extinguished	$ 87

A gain from early extinguishment of debt of approximately $8 million was recognized associated with these tender offers.

On December 7, 2020, we entered into a privately negotiated agreement with a multi-asset investment manager who has}

third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net income (loss) by an insignificant amount for each of the years ended December 31, 2020, 2019 and 2018.

Patient Accounts Receivable

Substantially all of our accounts receivable are related to providing healthcare services to patients at our hospitals and affiliated businesses. Collection

gross accounts receivable (prior to allowance for contractual adjustments and implicit price concessions) summarized by aging categories is as follows:

As of December 31, 2020: Me

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 the assumptions described above changes materially in the future, including a decline in our stock price or the fair value of our long-term debt, an increase in the volatility of our stock price or the fair value of our long-term debt, lower than expected net operating revenues or hospital volumes, higher market interest rates or increased operating costs. Such changes impacting the calculation of our fair value, the risks of which are amplified by the COVID-19 pandemic, could result in a material impairment charge in the future.

Impairment or Disposal of Long-Lived Assets

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

Professional Liability Claims

As part of our business of owning and operating hospitals, we are subject to legal actions alleging liability on our part. We accrue for losses resulting from such liability claims, as well as loss adjustment expenses that are out-of-pocket and directly related to such liability claims. These direct out-of-pocket expenses include fees of outside counsel and experts. We do not accrue for costs that are part of our corporate overhead, such as the costs of our in-house legal and risk management departments. The losses resulting from professional liability claims primarily consist of estimates for known claims, as well as estimates for incurred but not reported claims. The estimates are based on specific claim facts, our historical claim reporting and payment patterns, the nature and level of our hospital operations, and actuarially determined projections. The actuarially determined projections are based on our actual claim data, including historic reporting and payment patterns which have been gathered over 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 1.8%, 2.6% and 3.1% in 2020, 2019 and 2018, respectively. This liability is adjusted for new claims information in the period such information becomes known to us. Professional malpractice expense includes the losses resulting from professional liability claims and loss adjustment expense, as well as paid excess insurance premiums, and is presented within other operating expenses in the accompanying consolidated statements of income (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 to produce estimates of ultimate paid losses and reserves for incurred but not reported claims. Each of these methods uses our company-specific historical claims data and other information. This company-specific data includes information regarding our business, including historical paid losses and loss adjustment expenses, historical and current case loss reserves, actual and projected hospital statistical data, a variety of hospital census information, employed physician information, professional liability retentions for each policy year, geographic information and other data.

Based on these analyses, we determine our estimate of the professional liability claims. The determination of management’s estimate, including the preparation of the reserve analysis that supports such estimate, involves subjective judgment of management. Changes in reserving data or the trends and factors that influence reserving data may signal fundamental shifts in our future claim development patterns or may simply reflect single-period anomalies. Even if a change reflects a fundamental shift, the full extent of

expected to be discontinued. The amendments in the ASU are effective for all entities as of March 12, 2020 through December 31, 2022. The adoption of this guidance did not have a material impact on our consolidated financial position or results of operations.

We have evaluated all other recently issued, but not yet effective, ASUs and do not expect the eventual adoption of these ASUs to have a material impact our consolidated financial position or results of operations.

FORWARD-LOOKING STATEMENTS

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

- increases in the amount and risk of collectability of patient accounts receivable, including decreases in collectability which may result from, among other things, self-pay growth and difficulties in recovering payments for which patients are responsible, including co-pays and deductibles;
- the efforts of insurers, healthcare providers, large employer groups and others to contain healthcare costs, including the trend toward value-based purchasing;
- increases in wages as a result of inflation or competﾘiﾞ

Item 7A. *Quantitative and Qualitative Disclosures about Market Risk*

We are exposed to interest rate changes, primarily as a result of the ABL Facility which bears interest based on floating rates. In order to manage the volatility relating to t]M

Item 8. *Financial Statements and Supplementary Data*

Index to Financial Statements

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

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, 2020 and 2019, the related consolidated statements of income (loss), comprehensive income (loss), stockholders’ (deficit) equity, and cash flows, for each of the three years in the period ended December 31, 2020, and the related nov

Auditing management’s estimate of self-pay price concessions was complex and judgmental due to the significant data inputs and subjective assumptionsce e

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME (LOSS)

	Year Ended December 31,		
	2020	2019	2018
	(In millions, except share and per share data)		
Net operating revenues	$ 11,789	$ 13,210	$ 14,155
Operating costs and expenses:			
Salaries and benefits	5,411	5,947	6,384
Supplies	1,963	2,151	2,355
Other operating expenses	2,957	3,303	3,496
Government and other legal settlements and related costs	-	93	11
Electronic health records incentive reimbursement	-	(1)	(4)
Lease cost and rent	327	321	337
Pandemic relief funds	(601)	—	—
Depreciation and amortization	558	608	700
Impairment and (gain) loss on sale of businesses, net	48	138	668

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

	Year Ended December 31,		
	2020	2019	2018
		(In millions)	
Net income (loss)	$ 607	$ (590)	$ (704)
Other comprehensive (loss) income, net of income taxes:			
Net change in fair value of interest rate swaps, net of tax of $0, $1 million and $36 for the years ended December 31, 2020, 2019 and 2018, respectively	(1)	(3)	

1. BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES

Business. Community Health Systems, Inc. is a holding c

2020, 2019 and 2018, respectively. Purchases of property and equipment and internal-use software accrued in accounts payable and not yet paid were $100 million and $93 million at December 31, 2020 and 2019, respectively.

The Company also leases certain facilities and equipment under finance leases (see Note 9). 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, 2020, the Company had non-cash investing activity of $22 million related to certain facility and equipment additions that were financed through finance leases and other debt.

[illegible] represents the excess of the fair value of the consideration conveyed in the acquisition over the fair value of net assets acquired.

payments program for eligible hospitals and professionals that adopt and meaningfully use certified EHR technology. The Company utilizes a gain contingency model to recognize EHR incentive payments. Recognition occurs when the eligible hospitals adopt or demonstrate meaningful use of certified EHR technology.

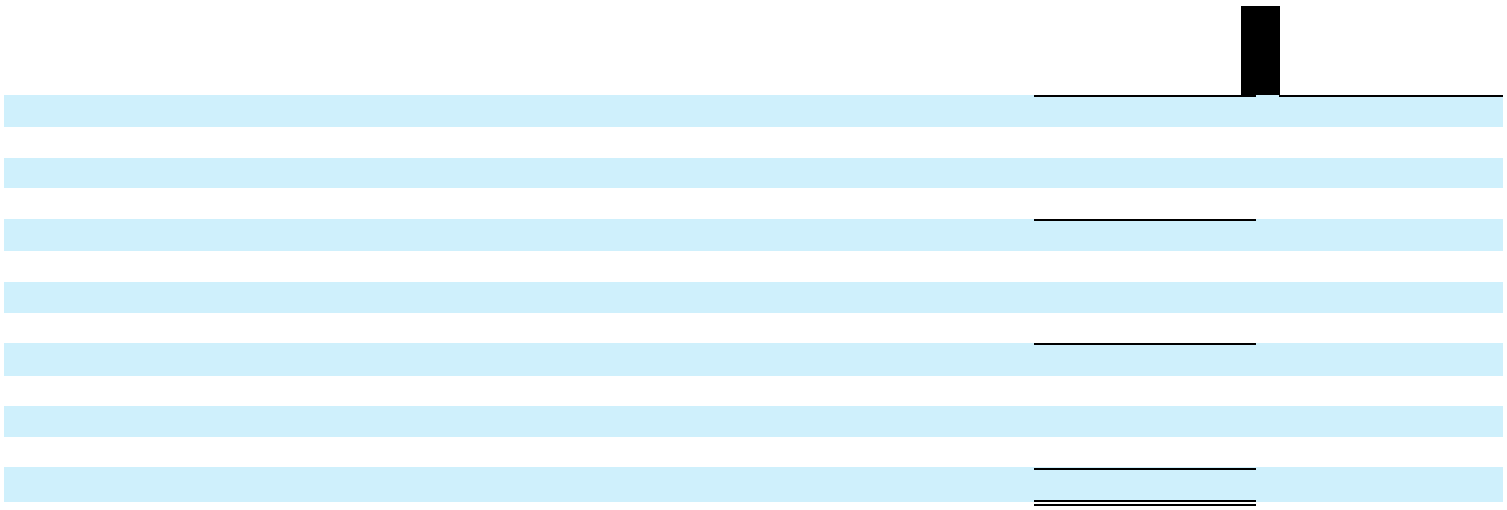
Leases. On January 1, 2019, the Company adopted the cumulative accounting standard updates initially issued by the FASB in February 2016 that amend the accounting for leases and are codified as Accounting Standards Codification Topic 842 ("ASC 842"). These changes to the lease accounting model require operating leases be recorded on the balance sheet through recognition of a liability for the discounted present value of future fixed lease payments and a corresponding right-of-use ("ROU") asset. The Company's accounting for finance leases remained substantially unchanged from its prior accounting for capital leases. The ROU asset recorded at commencement of the lease represents the right to use the underlying asset over the lease term in exchange for the lease payments. Leases with an initial term of 12 months or less that do not have an option to purchase the underlying asset that is deemed reasonably certain to be exercised are not recr

the repayment terms. The repayment terms specify that for the first 11 months after repaym

recognized over a weighted-average period of 23 months and $13 million related to outstanding unvested restricted stock and restricted stock units was expected to be recognized over a weighted-average period of 22 months. There were no modifications to awards during the years ended December 31, 2020, 2019 and 2018.

The fair value of stock options was estimated using the Black-Scholes option pricing model with the following assumptions and weighted-average fair values during the years ended December 31, 2020, 2019 and 2018:

	Year Ended December 31,		
	2020		



On October 30, 2020, one or more affiliates of the Company entered into a definitive agreement for the sale of substantially all of the assets of Northwest Mississippi Medical Center (181 licensed beds) in Clarksdale, Mississippi, to affiliates of Delta Health System. This disposition was completed on Februar

June 30, 2018, to adjust the fair value of the supplies, inventor

[redacted]	

Intangible Assets

No intangible assets other than goodwill were acquired during the years ended December 31, 2020 and 2019. The gross carrying amount of the Company's other intangible assets subject to amortization was $1 million at both December 31, 2020 and 2019, and the net carrying amount was less than $1 million at

The following table reconciles the differences between the statutory federal income tax rate and the effective tax rate (dollars in millions):

	Year Ended December 31,					
	2020		2019		2018	
	Amount	%	Amount	%	Amount	%
Provision for (benefit from) income taxes at statutory federal rate	$ 89	21.0%	$ (90)	21.0%	$ (150)	21.0%
State income taxes, net of federal income tax benefit	(15)	(3.6)	(104)	24.3	(114)	16.0
Net income attributable to noncontrolling interests	(20)	(4.7)	(18)	4.2	(18)	2.5
Change in valuation allowance	(267)	(63.2)	340	(79.2)	212	(29.7)
Change in uncertain tax position	-	-	-	-	9	(1.3)
Federal and state tax credits	-	-	-	-	(17)	2.4
Nondeductible goodwill	41	9.8	11	(2.6)	30	(4.2)
Nondeductible settlements	-	-	-	-	22	(3.1)
Nondeductible loss on divestiture	(15)	(3.4)	15	(3.5)	-	-
Other	2	0.3	6	(1.4)	15	(2.1)
(Benefit from) provision for income taxes and effective tax rate for income (loss)	$ (185)	(43.8)%	$ 160	(37.2)%	$ (11)	1.5%

The Company’s effective tax rates were (43.8)%, (37.2)% and 1.5% for the years ended December 31, 2020, 2019 and 2018, respectively. The decrease in the Company’s effective tax rate for the year ended December 31, 2020, when compared to the year ended December 31, 2019, was primarily due to a decrease in the valuation allowance recognized on IRC Section 163(j) interest carryforwards and original issue discount deferred tax asset as a result of (i) an increase to the deductible interest expense allowed for 2019 and 2020 under the CARES Act that was enacted during the three months ended March 31, 2020 and (ii) tax impacts of 2020 financing activity. The decrease in the Company’s effective tax rate for the year ended December 31, 2019, when compared to the year ended December 31, 2018, was primarily due to an increase in the valuation allowance recognized on (i) IRC Section 163(j) interest carryforwards and (ii) original issue discount deferred tax asset generated with the 2019 Exchange Offer.

Deferred income taxes are based on the estimated future tax effects of differences between the financial statement and tax bases of assets and liabilities

The following is a tabular reconciliation of the total amount of unrecognized tax benefit for the years ended December 31, 2020, 2019 and 2018 (in millions):

	Year Ended December 31,		
	2020	2019	2018
Unrecognized tax benefit, beginning of year	$ 26	$ 29	$ 18
Gross increases — tax positions in current period	19	10	11
Settlements	-	(13)	-
Unrecognized tax benefit, end of year	$ 45	$ 26	$ 29

The Company's federal income tax reome

secured basis by the Company and each of the CHS current and future domestic subsidiaries that provide guarantees under the ABL Facility, any capital market debt securities of CHS (including CHS outstanding senior notes) and certain other long-term debt of CHS.

The 5⅛% Senior Secured Notes due 2021 and the related guarantees were secured by shared (i) first-priority liens on the collateral (the "Non-ABL Priority Collateral") that also secures on a first-priority basis CHS' senior-priority secured notes and (ii) second-priority liens on the collateral (the "ABL-Priority Collateral") that secures on a first-priority basis the ABL Facility (and also secures on a second-priority basis CHS's senior-priority secured notes), in each case subject to permitted liens described in the indenture governing the 5⅛% Senior Secured

9⅞% Junior-Priority Secured Notes due 2023

On June 22, 2018, CHS completed a private offering of $1.770 billion aggregate principal amount of the 9⅞% Junior-Priority Secured Notes due June 30, 2023 (the "9⅞% Junior-Priority Secured Notes due 2023") in exchange for the same amount of 8% Senior Notes due 2019. The 9⅞% Junior-Priority Secured Notes due 2023 bore interest at a rate of 11.0o

evaluation considers a number of factors including, but not limited to, the length of time and extent to which the fair value has been less than cost, and management's ability and intent to hold the securities until fair value recovers. Based on the results of this evaluation, management concluded that as of December 31, 2020, there were no other-than-temporary losses related to available-for-sale debt securities. The recent declines in value of the securities and/or length of time they have been below cost, as well as the Company's ability and intent to hold the securities for a reasonable period of time sufficient for a projected recovery of fair value, have caused management to conclude that the securities, that have generated gross unrealized losses, were not other-than-temporarily impaired. Management will continue to monitor and evaluate the recoverability of the Company's available-for-sale debt securities.

The contractual maturities of debt-based securities held by the Company as of December 31, 2020 and 2019, excluding mutual fund holdings, are set forth in the table below (in millions). Expected maturities will differ from contractual maturities because the issuers of the debt securities may have the right to prepay their obligations without prepayment penalties.

	December 31, 2020		December 31, 2019	
	Amortized Cost	Estimated Fair Value	Amortized Cost	Estimated Fair Value

these locations whose employment is covered by collective bargaining agreements are generally eligible to participate in the CHS/Community Health Systems, Inc. Standard 401(k) Plan. Total expense to the Company under the 401(k) plans was $74 million, $85 million and $90 million for the years ended December 31, 2020, 2019 and 2018, respectively, and is recorded in salaries and benefits expense on the consolidated statements of income (loss).

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 $176 million and $175 million as of December 31, 2020 and 2019, respectively, and is included in other long-term liabilities on the consolidated balance sheets. Assets designated to pay benefits under this plan are discussed below.

The Company provides an unfunded Supplemental Executive Retirement Plan ("SERP") for certain members of its executive management team. 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.

During the year ended December 31, 2020, the Company incurred expenses in the amount of approximately $50 million related to the settlement of a professional liability claim for which the Company's third-party insurers' obligation to provide coverage to the Company in connection with the underlying loss is being litigated. In the ordinary course of business, the Company's expense with respect to professional liability claims, which is actuarially determined, is limited to amounts not covered by third-party insurance policies, which typically provide coverage for professional liability claims. The subject of the litigation for the recovery of the full amount of the $50 million settlement is whether the claim is covered under the subject policies. Aside from this matter, there were no significant changes in the Company's estimate of the reserve for professional liability claims during the year ended December 31, 2020.

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

The Company is primarily self-insured for these claims; however, the Company obtain excess insurance that transfers the risk of loss to a third-party insurer for claims in excess of our self-insured retentions. The Company's excess insurance is underwritten on a claims-made basis. For claims reported

captive insurance company, replacing the coverage provided by HCA. Substantially all claims occurring during 2007 were self-insured up to $10 million per claim.

Legal Matters. The Company is a party to various legal, regulatory and governmental proceedings incidental to its business. Based on current knowledge, management does m

17. CONDENSED FINANCIAL INFORMATION OF PARENT

Parent Company Only
Condensed Balance Sheet
(In millions)

	December 31,	
	2020	2019
ASSETS		
Prepaid income taxes	$ 50	$ 48
Total current assets	50	48
Deferred income taxes	59	38
Other assets, net	(3)	(4)
Total assets	$ 106	$ 82
LIABILITIES AND (DEFICIT) EQUITY		
Intercompany payable	$ 1,701	$ 2,099
Deferred income taxes	29	200
Other long-term liabilities	1	1
Total liabilities	1,731	2,300
Community Health Systems, Inc. stockholders' (deficit) equity:		
Preferred stock	-	-
Common stock	1	1
Additional paid-in capital	2,094	2,008
Accumulated other comprehensive (loss) income	(13)	(9)
(Accumulated deficit) retained earnings	(3,707)	(4,218)
Total Community Health Systems, Inc. stockholders' (deficit) equity	(1,625)	(2,218)
Total liabilities and (deficit) equity	$ 106	$ 82

See note to condensed financial statements of parent company.

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, wim

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, 2020, based on criteria establis]rf

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

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

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 MeetaExe

PART IV

Item 15. Exhibits and Financial Statement Schedules

Item 15(a) 1. *Financial Statements*

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

Item 15(a) 2. *Financial Statement Schedules*

The following financial statement schedule is included within the notes to the consolidated financial statements at page 130 hereof:

Schedule I – *Condensed Financial Information of Registrant*

All other schedules are omitted since the required information is not present or is not present in amounts sufficient to require submission of the schedule.

Item 15(a) 3. *Exhibits*

The following exhibits are either filed with this Report or incorporated herein by reference.

No.	Description
2.1	

No.	Description
4.36	

No.	Description
4.48	Fifth Supplemental Indenture relating to CHS/Comm

No.	Description
4.62	Third Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8.000% Senior Secured Notes due 2026, dated as of September 27, 2019, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and Regions Bank, as Trustee and Credit Suisse AG, as Collateral Agent (incorporated by reference to Exhibit 4.18 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2019 filed October 30, 2019 (No. 001-15925))
4.63	

No.	Description
4.78	

No.	Description
10.3	

SIXTEENTH SUPPLEMENTAL INDENTURE, (this "Supplemental Indenture") dated as of December 11, 2020, by and among CHS/Community Health Systems, Inc., a Delaware corporation ("Issuer"), the party that is a signatory hereto as a Guarantor (the "Guaranteeing Subsidiary") and Regions Bank, as Trustee under the Indenture referred to below.

W I T N E S S E T H:

WHEREAS, each of the Issuer, the Guarantors and the Trustee have heretofore executed and delivered an indenture dated as of January 27, 2014 (as amended, supplemented, waived or otherwise modified, the "Indenture"), providing for the issuance on such date of an aggregate principal amount of $3,000,000,000 of 6.875% Senior Notes due 2022 (the "Notes") of the Issuer;

WHEREAS, the Indenture provides that the Guaranteeing Subsidiary shall execute and deliver to the Trustee a supplemental indenture pursuant to which the Guaranteeing Subsidiary shall unconditionally guarantee all of the Issuer's Obligations under the Notes and the Indenture on the terms and conditions set forth herein and under the Indenture (the "Note Guarantee"), each on the terms and conditions set forth herein; and

WHEREAS, pursuant to Section 9.1 of the Indenture, the Issuer, any Guarantor and the Trustee are authorized to execute and deliver this Supplemental Indenture to amend or supplement the Indenture, without the consent of any Holder;

NOW, THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the receipt of which is hereby acknowledged, the Issuer, the Guaranteeing Subsidiary and the Trustee mutually covenant and agree for the benefit of the Trustee and the Holders of the Notes as follows:

ARTICLE I
DEFINITIONS

SECTION 1.1.Defined Terms. As used in this Supplemental Indenture, terms defined in the Indenture or in the preamble or recitals hereto are used herein as therein defined. The words "herein," "hereof" and "hereby" and other words of similar import used in this Supplemental Indenture refer to this Supplemental Indenture as a whole and not to any particular section hereof.

ARTICLE II
AGREEMENT TO BE BOUND; GUARANTEE

SECTION 2.1.Agreement to be Bound. The Guaranteeing Subsidiary hereby becomes a party to the Indenture as a "Guarantor" and as such will have all of the rights and be subject to all of the obligations and agreements of a "Guarantor" under the Indenture.

SECTION 2.2.Guarantee. The Guaranteeing Subsidiary agrees, on a joint and several basis with all the existing Guarantors, to fully, unconditionally and irrevocably Guarantee

to each Holder of the Notes and the T

SECTION 3.10.

REGIONS BANK,
as Trustee

By: /s/ Kristine Prall
Kristine Prall
Vice President

Exhibit 4.33

NINTH SUPPLEMENTAL INDENTURE, (this "Supplemental Indenture") dated as of December 11, 2020, by and among CHS/Community Health Systems, Inc., a Delaware corporation ("Issuer"), the party that is a signatory hereto as a Guarantor (the "

ARTICLE II
AGREEMENT TO BE BOUND; GUARANTEE

SECTION 2.1. Agreement to be Bound. The Guaranteeing Subsidiary hereby becomes a party to the First

SECTION 3.8. Ratification of Indenture; Supplemental Indentures Part of Indenture. Except as expressly amended hereby, the First Supplemental Indenture is in all respects ratified and confirmed and all the terms, conditions and provisions thereof shall remain in full force and effect. This Supplemental Indenture shall form a part of the Indenture for all purposes, and every Holder of Notes heretofore or hereafter authenticated and delivered shall be bound hereby.

SECTION 3.9. The Trustee and the Collateral Agent. Neither the Trustee nor the Collateral Agent make any representation or warranty as to the validity or sufficiency of this Supplemental Indenture or with respect to the recitals contained herein, all of which recitals are made solely by the other parties hereto.

SECTION 3.10. Counterparts. The parties hereto may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement. The exchange of copies of this Supplemental Indenture and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Supplemental Indenture as to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 3.11. Execution and Delivery. The Guaranteeing Subsidiary agrees that its Note Guarantee shall remain in full force and effect notwithstanding any absence on each Note of a notation of any such Note Guarantee.

SECTION 3.12. Headings. The headings of the Articles and the Sections in this Supplemental Indenture are for convenience of reference only and shall not be deemed to alter or affect the meaning or interpretation of any provisions hereof.

[*Signature page follows*]

IN WITNESS WHEREOF, the parties hereto have caused thi

REGIONS BANK,
as Trustee

By: /s/ Kristine Prall
Kristine Prall
Vice President

CREDIT SUISSE AG, CAYMAN ISLANDS BRANCH, as Collateral Agent

By: /s/ Lingzi Huang
Name: Lingzi Huang
Title: Authorized Signatory

By: /s/ Nicolas Thierry
Name: Nicolas Thierry
Title: Authorized Signatory

to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 3.1

REGIONS BANK,
as Trustee

By: /s/ Kristine Prall
Name: Kristine Prall
Title: Vice President

SIXTH SUPPLEMENT

REGIONS BANK,
as Trustee

By: /s/ Kristine Prall
Name: Kristine Prall
Title: Vice President

REGIONS BANK,
as Junior-Priority Collateral Agent

By: /s/ Kristine Prall
Name: Kristine Prall
Title: Vice President

By: /s/ Richard Jaegle
Name: Richard Jaegle
Title: Vice President

SIXTH SUPPLEMENTAL INDENTURE, (this "Supplemental Indenture") dated as of December 11, 2020, by and among CHS/Community Health Systems, Inc., a Delaware corporation ("Issuer"), the party that is a signatory hereto as a Guarantor (the "Guaranteeing Subsidiary"), Credit Suisse AG, as Collateral Agent, and Regions Bank, as Trustee under the Indenture referred to below.

W I T N E S S E T H:

WHEREAS, each of the Issuer, the Guarantors, the Trustee and the Collateral Agent have heretofore executed and delivered an indenture dated as of July 6, 2018 (as amended, supplemented, waived or otherwise modified, the "Indenture"), providing for the issuance on such date of an aggregate principal amount of $1,032,607,000 of 8.625% Senior Secured Notes due 2024 (the "Notes") of the Issuer;

WHEREAS, the Indenture provides that the Guaranteeing Subsidiary shall execute and deliver to the Trustee and the Collateral Agent a supplemental indenture pursuant to which the Guaranteeing Subsidiary shall unconditionally guarantee all of the Issuer's Obligations under the Notes and the Indenture on the terms and conditions set forth herein and under the Indenture (the "Note Guarantee"), each on the terms and conditions set forth herein; and

WHEREAS, pursuant to Section 9.1 of the Indenture, the Issuer, any Guarantor, the Collateral Agent and the Trustee are authorized to execute and deliver this Supplemental Indenture to amend or supplement the Indenture, without the consent of any Holder;

NOW, THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the receipt of which is hereby acknowledged, the Issuer, the Guaranteeing Subsidiary, the Collateral Agent and the Trustee mutually covenant and agree for the benefit of the Trustee, the Collateral Agent and the Holders of the Notes as follows:

ARTICLE I
DEFINITIONS

SECTION 1.1. Defined Terms. As used in this Supplemental Indenture, terms defined in the Indenture or in the preamble or recitals hereto are used herein as therein defined. The words "herein," "hereof" and "hereby" and other words of similar import used in this Supplemental Indenture refer to this Supplemental Indenture as a whole and not to any particular section hereof.

ARTICLE II
AGREEMENT TO BE BOUND; GUARANTEE

SECTION 2.1. Agreement to be Bound. The Guaranteeing Subsidiary hereby becomes a party to the Indenture as a "Guarantor" and as such will have all of the rights and be subject to all of the obligations and agreements of a "Guarantor" under the Indenture.

SECTION 2.2. Guarantee. The Guaranteeing Subsidiary agrees, on a joint and several basis with all the existing Guarantors, to fully, unconditionally and irrevocably Guarantee

REGIONS BANK,
as Trustee

By: /s/ Kristine Prall
Name: Kristine Prall
Title: Vice President

CREDIT SUISSE AG, CAYMAN ISLANDS BRANCH, as Collateral Agent

By: /s/ Lingzi Huang
Name: Lingzi Huang
Title: Authorized Signatory

By: /s/ Nicolas Thierry
Name: Nicolas Thierry
Title: Authorized Signatory

to each Holder of the Notes, the T

SECTION 3.10. Counterparts. The parties hereto may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement. The exchange of copies of this Supplemental Indenture and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Supplemental Indenture as to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 3.11. Execution and Delivery. The Guaranteeing Subsidiary agrees that its Note Guarantee shall remain in full force and effect notwithstanding any absence on each Note of a notation of any such Note Guarantee.

SECTION 3.12. Headings. The headings of the Articles and the Sections in this Supplemental Indenture are for convenience of reference only and shall not be deemed to alter or affect the meaning or interpretation of any provisions hereof.

[*Signature page follows*]

REGIONS BANK,
as Trustee

By: /s/ Kristine Prall
Name: Kristine Prall
Title: Vice President

CREDIT SUISSE AG, CAYMAN ISLANDS BRANCH, as Collateral Agent

By: /s/ Lingzi Huang
Name: Lingzi Huang
Title: Authorized Signatory

By: /s/ Nicolas Thierry
Name: Nicolas Thierry
Title: Authorized Signatory

SECOND SUPPLEMENTAL INDENTURE, (this "Supplemental Indenture") dated as of December 11, 2020, by and among CHS/Community Health Systems, Inc., a Delaware corporation ("Issuer"), the party that is a signatory hereto as a Guarantor (the "Guaranteeing Subsidiary"), Credit Suisse AG, as Collateral Agent, and Regions Bank, as Trustee under the Indenture referred to below.

W I T N E S S E T H:

WHEREAS, each of the Issuer, the Guarantors, the Trustee and the Collateral Agent have heretofore executed and delivered an indenture dated as of November 19, 2019 (as amended, supplemented, waived or otherwise modified, the "Indenture"), providing for the issuance on such date of an aggregate principal amount of $700,000,000 of 8.000% Senior Secured Notes due 2027 (the "Notes") of the Issuer;

WHEREAS, the Indenture provides that the Guaranteeing Subsidiary shall execute and deliver to the Trustee and the Collateral Agent a supplemental indenture pursuant to which the Guaranteeing Subsidiary shall unconditionally guarantee all of the Issuer's Obligations under the Notes and the Indenture on the terms and conditions set forth herein and under the Indenture (the "Note Guarantee"), each on the terms and conditions set forth herein; and

WHEREAS, pursuant to Section 9.1 of the Indenture, the Issuer, any Guarantor, the Collateral Agent and the Trustee are authorized to execute and deliver this Supplemental Indenture to amend or supplement the Indenture, without the consent of any Holder;

NOW, THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the receipt of which is hereby acknowledged, the Issuer, the Guaranteeing Subsidiary, the Collateral Agent and the Trustee mutually covenant and agree for the benefit of the Trustee, the Collateral Agent and the Holders of the Notes as follows:

ARTICLE I
DEFINITIONS

SECTION 1.1. Defined Terms. As used in this Supplemental Indenture, terms defined in the Indenture or in the preamble or recitals hereto are used herein as therein defined. The words "herein," "hereof" and "hereby" and other words of similar import used in this Supplemental Indenture refer to this Supplemental Indenture as a whole and not to any particular section hereof.

ARTICLE II
AGREEMENT TO BE BOUND; GUARANTEE

SECTION 2.1. Agreement to be Bound. The Guaranteeing Subsidiary hereby becomes a party to the Indenture as a "Guarantor" and as such will have all of the rights and be subject to all of the obligations and agreements of a "Guarantor" under the Indenture.

SECTION 2.2. Guarantee. The Guaranteeing Subsidiary agrees, on a joint and several basis with all the existing Guarantors, to fully, unconditionally and irrevocably Guarantee

to each Holder of the Notes, the Trustee and the Collateral Agent the Guaranteed Obligations pursuant to Article X of the

SECTION 3.10. Counterparts. The parties hereto may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement. The exchange of copies of this Supplemental Indenture and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Supplemental Indenture as to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 3.11. Execution and Delivery. The Guaranteeing Subsidiary agrees that its Note Guarantee shall remain in full force and effect notwithstanding any absence on each Note of a notation of any such Note Guarantee.

SECTION 3.12. Headings. The headings of the Articles and the Sections in this Supplemental Indenture are for convenience of reference only and shall not be deemed to alter or affect the meaning or interpretation of any provisions hereof.

[*Signature on following pages*]

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Indenture to be duly executed as of the date first above written.

NORTHWEST SAHUARITA HOSPITAL, LLC,

REGIONS BANK,
as Trustee

By: /s/ Kristine Prall
Name: Kristine Prall
Title: Vice President

SECOND SUPPLEMENTAL INDENTURE, (this "__ - _____

SECTION 3.10. Counterparts. The parties hereto may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement. The exchange of copies of this Supplemental Indenture and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Supplemental Indenture as to the parties hereto and may be used in lieu of the original Supplemental Indenture for all purposes. Signatures of the parties hereto transmitted by facsimile or other electronic transmission shall be deemed to be their original signatures for all purposes.

SECTION 3.11.

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Indenture to be duly executed as of the date first above written.

NORTHWEST SAHUARITA HOSPITAL, LLC,
as a Guarantor

By: /s/ R. Gabriel Ottinger
R. Gabriel Ottinger
Senior Vice President and Treasurer

Acknowledged by:

CHS/COMMUNITY HEALTH SYSTEMS, INC.

By: /s/ R. Gabriel Ottinger
R. Gabriel Ottinger
Senior Vice President and Treasurer

REGIONS BANK,
as Trustee

By: /s/ Kristine Prall
Name: Kristine Prall
Title: Vice President

[*Signature Page to Second Supplemental Indenture (2028 Notes)*]

SECOND SUPPLEMENTAL INDENTURE, (this "Supplemental Indenture") dated as of December 11, 2020, by and among CHS/Community Health Systems, Inc., a Delaware corporation ("Issuer"), the party that is a signatory hereto as a Guarantor (the "Guaranteeing Subsidiary"), Credit Suisse AG, as Collateral Agent, and Regions Bank, as Trustee under the Indenture referred to below.

W I T N E S S E T H:

WHEREAS, each of the Issuer, the Guarantors, the Trustee and the Collateral Agent have heretofore executed and delivered an indenture dated as of February 6, 2020 (as amended, supplemented, waived or otherwise modified, the "Indenture"), providing for the issuance on such date of an aggregate principal amount of $1,462,000,000 of 6.625% Senior Secured Notes due 2025 (the "

to each Holder of the Notes, the Trustee and the Collateral Agent the Guaranteed Obligations pursuant to Article X of the Indenture as and to the extent provided for therein.

ARTICLE III
MISCELLANEOUS

SECTION 3.1. Notices. All notices and other communications to the Guarantors shall be given as provided in the Indenture.

SECTION 3.2. Merger and Consolidation. The Guaranteeing Subsidiary shall not sell or otherwise dispose of all or substantially all of its assets to, or consolidate with or merge with or into, another Person (other than the Issuer or any Restricted Subsidiary that is a Guarantor or becomes a Guarantor concurrently with the transaction) except in accordance with Section 4.1(e) of the Indenture.

SECTION 3.3. Release of Guarantee. The Note Guarantees hereunder may be released in accordance with Section 10.2 of the Indenture.

SECTION 3.4. Parties. Nothing expressed or mentioned herein is intended or shall be construed to give any Person, firm or corporation, other than the Holders and the Trustee, any legal or equitable right, remedy or claim under or in respect of this Supplemental Indenture or the Indenture or any provision herein or therein contained.

SECTION 3.5. Governing Law. This Supplemental Indenture shall be governed by, and construed in accordance with, the laws of the State of New York.

SECTION 3.6. Severability. In case any provision in this Supplemental Indenture shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby and such provision shall be ineffective only to the extent of such invalidity, illegality or unenforceability.

SECTION 3.7. Benefits Acknowledged. The Guaranteeing Subsidiary's Note Guarantee is subject to the terms and conditions set forth in the Indenture. The Guaranteeing Subsidiary acknowledges that it will receive direct and indirect benefits from the financing arrangements contemplated by the Indenture and this Supplemental Indenture and that the guarantee and waivers made by it pursuant to its Note Guarantee are knowingly made in contemplation of such benefits.

SECTION 3.8. Ratification of Indenture; Supplemental Indentures Part of Indenture. Except as expressly amended hereby, the Indenture is in all respects ratified and confirmed and all the terms, conditions and provisions thereof shall remain in full force and effect. This Supplemental Indenture shall form a part of the Indenture for all purposes, and every Holder of Notes heretofore or hereafter authenticated and delivered shall be bound hereby.

SECTION 3.9. The Trustee and the Collateral Agent. Neither the Trustee nor the Collateral Agent make any representation or warranty as to the validity or sufficiency of this Supplemental Indenture or with respect to the recitals contained herein, all of which recitals are made solely by the other parties hereto.

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Indenture to be duly executed as of the date first above writtenq4‘

CREDIT SUISSE AG, CAYMAN ISLANDS BRANCH, as Collateral Agent

By: /s/ Lingzi Huang
Name: Lingzi Huang
Title: Authorized Signatory

By: /s/ Nicolas Thierry
Name: Nicolas Thierry
Title: Authorized Signatory

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

(*) Majo%

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

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

Bayfront Ambulatory Surgical Center, LLC* (DE)	
Bayfront Health Imaging Center, LLC* (DE)	
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)	
Bayfront HMA Physician Management, LLC* (FL)	
Bayfront HMA Real Estate Holdings, LLC* (FL)	
Bayfront HMA Wellness Center, LLC* (FL)	
Beauco, LLC (DE)	
Beaumont Regional, LLC (DE)	
Berwick Home Care Services, LLC# (DE)	
BH Trans Company, LLC (DE)	
BH Trans Company, LLC (DE)	
Biloxi Health System, LLC# (DE)	
Biloxi H.M.A., LLC# (MS)	d/b/a Merit Health Biloxi
Biloxi HMA Physician Management, LLC# (MS)	
Birmingham Holdings II, LLC (DE)	
Birmingham Holdings, LLC (DE)	
Birmingham Home Care Services, LLC# (DE)	
Blackwell HMA, LLC (OK)	
Blackwell HMPN, LLC (OK)	
Blackwell Home Health & Hospice, LLC (OK)	
Bluefield Holdings, LLC (DE)	
Bluffton Health System LLC (DE)	d/b/a Bluffton Regional Medical Center
Bluffton Physician Services, LLC (DE)	
Brandon HMA, LLC (MS)	d/b/a Merit Health Rankin
Brandon Physician Management, LLC (DE)	
Brandywine Hospital Malpractice Risk Retention Group, Ltd. (HI)	

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

(*) Majority position held in an entity with physicians, non-profit entities or both
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Brevard HMA ASC, LLC (FL)	
Brevard HMA Diagnostic Imaging, LLC (FL)	
Brevard HMA HME, LLC (FL)	
Brevard HMA Holdings, LLC (FL)	
Brevard HMA Hospitals, LLC (FL)	
Brevard HMA Investment Properties, LLC (FL)	
Brevard HMA Nursing Home, LLC (FL)	
Brooksville HMA Physician Management, LLC (FL)	
Brownsville Clinic Corp. (TN)	
Brownsville Hospital Corporation (TN)	
Brownwood Asset Holding Company, LLC (DE)	
Brownwood Hospital, L.P. (DE)	
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)	
Carlsbad Medical Center, LLC (NM)	

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

CHSPSC ACO 11, LLC (DE)
CHSPSC ACO 12, LLC (DE)
CHSPSC ACO 13, LLC (DE)
CHSPSC ACO 14, LLC (DE)
CHSPSC ACO 15, LLC (DE)
CHSPSC ACO 16, LLC (DE)
CHSPSC ACO 17, LLC (DE)
CHSPSC ACO 18, LLC (DE)
CHSPSC ACO 19, LLC (DE)
CHSPSC ACO 2, LLC (DE)
CHSPSC ACO 20, LLC (DE)
CHSPSC ACO 21, LLC (DE)
CHSPSC ACO 22, LLC (DE)
CHSPSC ACO 23, LLC (DE)
CHSPSC ACO 24, LLC (DE)
CHSPSC ACO 25, LLC (DE)
CHSPSC ACO 26, LLC (DE)
CHSPSC ACO 27, LLC (DE)
CHSPSC ACO 28, LLC (DE)
CHSPSC ACO 29, LLC (DE)
CHSPSC ACO 3, LLC (DE)
CHSPSC ACO 30, LLC (DE)
CHSPSC ACO 4, LLC (DE)
CHSPSC ACO 5, LLC (DE)
CHSPSC ACO 6, LLC (DE)
CHSPSC ACO 7, LLC (DE)
CHSPSC ACO 8, LLC (DE)
CHSPSC ACO 9, LLC (DE)
CHSPSC ACO Holdings, LLC (DE)
CHSPSC Leasing, Inc. (DE)
CHSPSC, LLC (DE)
Citrus HMA, LLC (FL) d/b/a Bayfront Health Seven Rivers
Clarksdale HMA Physician Management, LLC (MS)
Clarksdale HMA, LLC (MS) d/b/a Northwest Mississippi Medical Center
Clarksville Endoscopy Center, LLC* (DE)

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

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

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)	d/b/a Tennova Healthcare – Cleveland
Click to Care, LLC (FL)	
Clinton HMA, LLC (OK)	
Clinton HMPN, LLC (OK)	

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

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Community GP Corp. (DE)

Community Health Physicians, LLC (DE)

Community Health PhysiÄstment Co(DCt(l

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

(*) Majority position held in an entity with physicians, p.

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

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)	
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 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 Hospital Corporation (VA)	
FSED Management of Northwest Arkansas, LLC* (DE)	
FSED Management of West Florida, LLC* (DE)	
Gadsden HMA Physician Management, LLC* (AL)	
Gadsden Home Care Services, LLC# (DE)	
Gadsden Regional Medical Center, LLC (DE)	d/b/a Gadsden Regional Medical Center
Gadsden Regional Physician Group Practice, LLC (DE)	
Gadsden Surgery Center, Ltd.* (AL)	
Gadsden Regional Primary Care, LLC (AL)	
Gaffney Clinic Company, LLC (DE)	
Gaffney H.M.A., LLC (SC)	
Gaffney HMA Physician Management, LLC (SC)	
Gaffney PPM, LLC (SC)	
Gateway Medical Services, Inc. (FL)	
Granbury Clinic Asset Holding Company, LLC (DE)	
Granbury Hospital Corporation (TX)	d/b/a Lake Granbury Medical Center
Granbury Mammography JV, LLC# (DE)	

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

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

Grandview Medical Group Research, LLC

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

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

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-TRI Holdings, LLC (DE)

Hobbs Medco, LLC (DE)

HOF ASC Holdings, LLC (DE)

Hood Medical Group (TX)

Hospital Medical Services, Inc. (TX)

Hospital Pharmacy Services, Inc.# (IN)

Hospital Management Associates, LLC (FL)

Hospital Management Services of Florida

(*) Majority position held in an entity with physicians, non-profit entities or both
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Jackson HMA North Medical Office Building, LLC (MS)	
Jackson HMA, LLC (MS)	d/b/a Merit Health Central
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 ASC, LLC* (DE)	
Jefferson County HMA, LLC (TN)	d/b/a Jefferson Memorial Hospital
Jennersville Regional Hospital Malpractice Assistance Fund, Inc. (PA)	
Jourdanton Clinic Asset Holding Company, LLC (DE)	
Jourdanton Hospital Corporation (TX)	
Kay County Clinic Company, LLC (OK)	
Kay County Hospital Corporation (OK)	
Kay County Oklahoma Hospital Company, LLC (OK)	d/b/a AllianceHealth Ponca City
Kennett HMA Physician Management, LLC (MO)	
Kennett HMA, LLC (MO)	
Key West HMA Physician Management, LLC (FL)	
Key West HMA, LLC (FL)	d/b/a Lower Keys Medical Center
Key West Home Health, LLC# (FL)	
Key West Private Care, LLC# (FL)	
Keystone HMA Property Management, LLC (PA)	
Kirksville Academic Medicine, LLC# (MO)	d/b/a NEMA
Kirksville Clinic Corp. (MO)	
Kirksville Home Care Services, LLC# (MO)	
Kirksville Hospital Company, LLC (DE)	
Kirksville Missouri Hospital Company, LLC* (MO)	d/b/a Northeast Regional Medical Center
Kirksville Physical Therapy Services, LLC (DE)	
Knox Hospital Company, LLC (DE)	d/b/a Northwest Health – Starke
Knoxville - nal	

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

(*) Majo

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

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)	
Lebanon HMA Physician Management, LLC (TN)	
Lebanon HMA Surgery Center, LLC (TN)	
Lebanon HMA, LLC (TN)	
Lehigh HMA Physician Management, LLC (FL)	
Lehigh HMA, LLC (FL)	
LHT Knoxȳ	

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

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

Lutheran/TRMA Network, LLC# (IN)	
Macon Healthcare, LLC# (DE)	
Madison Clinic Corp. (TN)	
Madison Health System, LLC# (DE)	
Madison HMA Physician Management, LLC# (MS)	
Madison HMA, LLC# (MS)	d/b/a Merit Health Madison
Marion Physician Services, LLC (DE)	
Marshall County HMA, LLC (OK)	d/b/a AllianceHealth Madill
Marshall County HMPN, LLC (OK)	
Mary Black Health System Medical Group, LLC (DE)	
Martin Hospital Company, LLC (TN)	
Mary Black Health Network, Inc.# (SC)	
Mary Black Health System LLC (DE)	
Mary Black Medical Office (MHA)	

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

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New Cedar Lake Surgery Center, LLC# (MS)	
Newport Physician Clinics, Inc. (AR)	
North Carolina HMA Regional Service Center, LLC (NC)	
North Okaloosa Clinic Corp. (FL)	
North Okaloosa Home Health, LLC# (FL)	
North Okaloosa Medical Corp.* (FL)	
North Okaloosa Surgery Venture Corp. (FL)	
Northampton Cardiology Clinic, LLC (DE)	
Northampton Clinic Company, LLC (DE)	
Northampton Hospital Company, LLC (DE)	
Northampton Physician Services Corp. (PA)	
Northampton Urgent Care, LLC (DE)	
Northern Indiana Oncology Center of Porter Memorial Hospital, LLC* (IN)	
Northwest Allied Physicians, LLC (DE)	
Northwest Arkansas Employees, LLC (DE)	
Northwest Arkansas Hospitals, LLC (DE)	d/b/a Northwest Medical Center – Bentonville; Northwest Medical Center – Springdale; Willow Creek Women's Hospital
Northwest Arkansas Paramed Transfer, LLC (DE)	
Northwest Benton County Physician Services, LLC (DE)	
Northwest Cardiology, LLC (DE)	
Northwest HBP Medical Services, LLC (DE)	
Northwest Hospital Cardiac Diagnostics, L.P. (TN)	
Northwest Hospital, LLC (DE)	d/b/a Northwest Medical Center
Northwest Houghton Hospital, LLC (DE)	
Northwest Imaging Associates, LLC (DE)	
Northwest Indiana Health System, LLC* (DE)	
Northwest Physicians, LLC (AR)	
Northwest Sahuarita Hospital, LLC (DE)	d/b/a Northwest Medical Center Sahuarita
Northwest-Sparks Quality Alliance, LLC (DE)	
Northwest Urgent Care, 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

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

Oklahoma City ASC-GP, 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
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)	
Parkway Regional Medical Clinic, Inc. (KY)	
Pasco Hernando HMA Physician Management, LLC* (FL)	
Pasco Regional Medical Center, LLC (FL)	
Payson Healthcare Management, Inc. (AZ)	
Payson Hospital Corporation (AZ)	
PBEC HMA, Inc. (FL)	
Peckville Hospital Company, LLC (DE)	
Pecos Valley of New Mexico, LLC (DE)	
Pennsylvania Hospital Company, LLC (DE)	
Personal Home Health Care, LLC (TN)	
Petersburg Clinic Company, LLC (VA)	
Petersburg Hospital Company, LLC (VA)	
Phoenixville Hospital Company, LLC (DE)	
Phoenixville Hospital Malpractice Assimdiτ	

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

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

Port [illegible]

Health [illegible]ns, Inc.
[illegible]SUBSIDIARY [illegible]G

Exhibit 21
as of 12/31/20

(*) Majority position held in an en[illegible]sicians, nc[illegible]both
(#) Minority position held in a non-[illegible]ng entity

Regional Hospital of Longview[illegible])
Rehab H[illegible]spital of Fort Wayne[illegible]
Revenu[illegible]
River Oaks Hospital, LLC (MS[illegible] d/b/a Merit Health Riv[illegible]
River Oaks Management Compa[illegible]
River Oaks Medical Office Buildi[illegible]
River Region Medical Corpo[illegible]
Riverpark Community Cath La[illegible]
Riverview Regional Medical Cen[illegible]
Rockledge HMA Convenient Care[illegible]
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 [illegible]Group, LLC* (PA)
Rose City HMA, LLC* (PA)
Roswell Clinic Corp. (NM)
Roswell Hospital Corporation (NM) d/b/a Eastern New Mexico Medical Center

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Santa Rosa HMA Physician Management, LLC (FL)	
Santa Rosa HMA Urgent Care, LLC (FL)	
Scott County HMA, LLC (TN)	
Scranton Cardiovascular Physician Services, LLC (DE)	
Scranton Clinic Company, LLC (DE)	
Scranton Emergency Physician Services, LLC (DE)	
Scranton GP Holdings, LLC (DE)	
Scranton Holdings, LLC (DE)	
Scranton Hospital Company, LLC (DE)	d/b/a Regional Hospital of Scranton
Scranton Hospitalist Physician Services, LLC (DE)	
Scranton Quincy Ambulance, LLC (DE)	
Scranton Quincy Clinic Company, LLC (DE)	
Scranton Quincy Holdings, LLC (DE)	
Scranton Quincy Home Care Services, LLC# (DE)	
Scranton Quincy Hospital Company, LLC (DE)	d/b/a Moses Taylor Hospital
Scranton Quincy QRFS, LLC (DE)	
Sebastian HMA Physician Management, LLC (FL)	
Sebastian Home Care Services, LLC# (DE)	
Sebastian Hospital, LLC (FL)	
Sebastopol, LLC (DE)	
Sebring HMA Physician Management, LLC (FL)	
Sebring Hospital Management Associates, LLC (FL)	
Seminole HMA, LLC (OK)	d/b/a AllianceHealth Seminole
Seminole HMPN, LLC (OK)	
SEPA Integrated Providers Alliance, LLC (DE)	
Sharon Clinic Company, LLC (DE)	
Sharon Pennsylvania Holdings, LLC (DE)	
Sharon Pennsylvania Hospital Company, LLC (DE)	
Sharon Regional HBP Medical Group, LLC (DE)	
Shelby Alabama Real Estate, LLC (DE)	
Shelbyville Clinic Corp. (TN)	
Shelbyville Home Care Services, LLC# (DE)	
Shelbyville Hospital Company, LLC (TN)	
Siloam Springs Arkansas Hospital Company, LLC (DE)	d/b/a Siloam Springs Regional Hospital
Siloam Springs Clinic Company, LLC (DE)	

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Siloam Springs Holdings, LLC (DE)

Silver Creek MRI, LLC (AZ)

SJ Home Care, LLC# (DE)

SkyRidge Clinical Associates, LLC (DE)

South Abilene Radiology, LLC (DE)

South Arkansas Physician Services, LLC (DE)

SouthCrest, L.L.C. (OK)

Southeast Alabama Maternity Center, LLC (AL)

Southeast HMA Holdings, LLC (DE)

Southern Health Network, Inc.# (DE)

Southern Texas Medical Center, LLC (DE)

Southside Physician Network, LLC (DE)

Southwest Florida HMA Holdings, LLC (DE)

Southwest Physicians Risk Retention Group, Inc. (SC)

Sparks PremierCare, L.L.C. (AR)

Spokane Valley Washington Hospital Company, LLC (DE)

Spokane Washington Hospital Company, LLC (DE)

Spring Hill HMA Medical Group, LLC (FL)

Springdale Home Care Services, LLC# (DE)

Sprocket Medical Management, LLC (TX)

SS ParentCo., LLC (DE)

St. Joseph Health Syste

(*) Majority position held in an entity with physicians, non-profit entities or both
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Surgicare of Clarksville, LLC# (TN)	
Surgicare of Independence, Inc. (MO)	
Surgicare of San Leandro, Inc. (CA)	
Surgicare of Sherman, Inc. (TX)	
Surgicare Outpatient Center of Lake Charles, Inc. (LA)	
Surgicenters of America, Inc. (AZ)	
Susitna ASC Holdings, LLC* (DE)	
Susitna Surgery Center, LLC* (DE)	
Tennessee HMA Holdings, LP (DE)	
Tennessee HMA Regional Service Center, LLC (TN)	
Tennyson Holdings, LLC (DE)	
Terrell Medical Center, LLC (DE)	
Texas Bay Area Clinical Services, Inc.# (TX)	
The Sleep Disorder Center of Wyoming Valley, LLC (PA)	
The Surgery Center, LLC# (MS)	
The Vicksburg Clinic, LLC (DE)	
Timberland Medical Group (TX)	
Tomball Ambulatory Surgery Center, L.P. (TX)	
Tomball Clinic Asset Holding Company, LLC (DE)	
Tomball Texas Holdings, LLC (DE)	
Tomball Texas Hospital Company, LLC (DE)	
Tomball Texas Ventures, LLC (DE)	
Triad Healthcare, LLC (DE)	
Triad Holdings III, LLC (DE)	
Triad Holdings IV, LLC (DE)	
Triad Holdings V, LLC (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)	
Triad-Denton Hospital GP, LLC (DE)	

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

Community Health Systems, Inc.
SUBSIDIARY LISTING

Exhibit 21
as of 12/31/20

(*) Majority position held in an entity with physicians, non-profit entities or both
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Wilkes-Barre Radiation Oncology, LLC# (DE)	
Wiregrass Clinic, LLC (DE)	
Women & Children's Hospital, LLC (DE)	
Women's Health Partners, LLC (DE)	
Women's Health Specialists of Birmingham, Inc. (AL)	
Women's Health Specialists of Carlisle, LLC (PA)	
Woodland Heights Medical Center, LLC (DE)	
Woodward Clinic Company, LLC (DE)	
Woodward Health System, LLC (DE)	d/b/a AllianceHealth Woodward
Woodward Home Care Services, LLC# (DE)	
Yakima HMA Physician Management, LLC (WA)	
Yakima HMA, LLC (WA)	
York Anesthesiology Physician Services, LLC (DE)	
York Clinic Company, LLC (DE)	
York Pathology Physician Services, LLC (DE)	
York Pennsylvania Holdings, LLC (DE)	
York Pennsylvania Hospital Company, LLC (DE)	
Youngstown Ohio Hospital Company, LLC (DE)	
Youngstown Ohio Laboratory Services Company, LLC (DE)	
Youngstown Ohio Outpatient Services Company, LLC (DE)	
Youngstown Ohio Physician Services Company, LLC (DE)	
Youngstown Ohio PSC, LLC (DE)	

List of Guarantor Subsidiaries

CHS/Community Health Systems, Inc. ("CHS") is the sole issuer of the 6⅞% Senior Notes due 2022 and the 6¼% Senior Secured Notes due 2023 (collectively, "the Notes"). The following entities are direct and indirect subsidiaries of CHS which guarantee the Notes as of December 31, 2020.

1. Abilene Hospital, LLC
2. Abilene Merger, LLC
3. Affinity Health Systems, LLC
4. Affinity Hospital, LLC
5. Birmingham Holdings II, LLC
6. Birmingham Holdings, LLC
7. Bluffton Health System LLC
8. Brandon HMA, LLC
9. Brownwood Hospital, L.P.
10. Brownwood Medical C

55. Health Management Associates,*A

115. Regional Hospital of Longview, LLC
116. River Oaks Hospital, LLC
117. River Region Medical Corporation
118. ROH, LLC
119. Roswell Hospital Corporation
120. Ruston Hospital Corporation
121. Ruston Louisiana Hospital Company, LLC
122. SACMC, LLC
123. San Angelo Community Medical Center, LLC
124. San Angelo Hospital, L.P.
125. San Angelo Medical, LLC
126. Scranton Holdings, LLC
127. Scranton Hospital Company, LLC
128. Scranton Quincy Holdings, LLC
129. Scranton Quincy Hospital Company, LLC
130. Seminole HMA, LLC
131. Shelbyville Hospital Company, LLC
132. Siloam Springs Arkansas Hospital Company, LLC
133. Siloam Springs Holdings, LLC
134. Southeast HMA Holdings, LLC
135. Southern Texas Medical Center, LLC
136. Southwest Florida HMA Holdings, LLC
137. Statesville HMA, LLC
138. Tennessee HMA Holdings, LP
139. Tennyson Holdings, LLC
140. Triad Healthcare, LLC
141. Triad Holdings III, LLC
142. Triad Holdings IV, LLC
143. Triad Holdings V, LLC
144. Triad Nevada Holdings, LLC
145. Triad of Alabama, LLC
146. Triad-ARMC, LLC
147. Triad-El Dorado, Inc.
148. Triad-Navarro Regional Hospital Subsidiary, LLC
149. Tullahoma HMA, LLC
150. Tunkhannock Hospital Company, LLC (27-4566015)
151. Venice HMA, LLC
152. VHC Medical, LLC
153. Vicksburg Healthcare, LLC
154. Victoria Hospital, LLC
155. Victoria of Texas, L.P.
156. Virginia Hospital Company, LLC
157. Warsaw Health System, LLC
158. Webb Hospital Corporation
159. Webb Hospital Holdings, LLC
160. Wesley Health System LLC
161. WHMC, LLC
162. Wilkes-Barre Behavioral Hospital Company, LLC
163. Wilkes-Barre Holdings, LLC
164. Wilkes-Barre Hospital Company, LLC
165. Woodland Heights Medical Center, LLC
166. Woodward Health System, LLC

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement No. 333-230221 on Form S-3 and Registration Statement Nos. 333-61614, 333-100349, 333-107810, 333-121282, 333-144525, 333-163688, 333-163689, 333-163691, 333-176893, 333-188343, 333-190260, 333-197813, 333-207772, 333-212874, 333-214389, 333-226455 and 333-240174 on Form S-8 of our reports dated February 18, 2021, relating to the consolidated financial statements and consolidated financial statement schedule of Community Health Systems, Inc. and subsidiaries (the "Company") and the effectiveness of the Company's internal control over financial reporting, appearing in this Annual Report on Form 10-K of the Company for the year ended December 31, 2020.

/s/ Deloitte & Touche LLP

Nashville, Tennessee

February 18, 2021

Exhibit 31.1

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

I, Tim L. Hingtgen, certify that:

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

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

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and we have:

a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) designed such internal controls over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors:

a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Tim L. Hingtgen
Tim L. Hingtgen
Chief Executive Officer

Date: February 18, 2021

Exhibit 31.2

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

I, Kevin J. Hammons, certify that:

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

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

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, 2020, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Tim L. Hingtgen, 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/