COMMUNITY HEALTH SYSTEMS INC
Form 10-K
February 26, 2010

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

Form 10-K

(Mark One)

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the year ended December 31, 2009

OR

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to
Commission file number 001-15925

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

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

Registrant s telephone number, including area code:
(615) 465-7000
Securities registered pursuant to Section 12(b) of the Act:

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

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

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

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

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

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

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

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

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

The aggregate market value of the voting stock held by non-affiliates of the Registrant was $2,341,348,569. Market value is determined by reference to the closing price on June 30, 2009 of the Registrant s Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2009) have any non-voting common stock outstanding. As of February 17, 2010, there were 93,110,682 shares of common stock, par value $.01 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required for Part III of this annual report is incorporated by reference from portions of the Registrant s definitive proxy statement for its 2010 annual meeting of stockholders to be filed with the Securities and Exchange Commission within 120 days after the end of the Registrant s fiscal year ended December 31, 2009.

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FORM 10-K ANNUAL REPORT
COMMUNITY HEALTH SYSTEMS, INC.
Year ended December 31, 2009

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PART I

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

Overview of Our Company

We are the largest publicly traded operator of hospitals in the United States in terms of number of facilities and net operating revenues. We were incorporated in 1996 as a Delaware corporation. We provide healthcare services through these hospitals that we own and operate in non-urban and selected urban markets throughout the United States. As of December 31, 2009, we owned or leased 122 hospitals. These hospitals are geographically diversified across 29 states, with an aggregate of 18,140 licensed beds. We generate revenues by providing a broad range of general and specialized hospital healthcare services to patients in the communities in which we are located. Services provided by our hospitals include general acute care services, emergency room services, general and specialty surgery, critical care, internal medicine, obstetrics and diagnostic services. As part of providing these services, we also own physician practices, imaging centers, and ambulatory surgery centers. Through our management and operation of these businesses, we provide: standardization and centralization of operations across key business areas; strategic assistance to expand and improve services and facilities; implementation of quality of care improvement programs; and assistance in the recruitment of additional physicians to the markets in which our hospitals are located. In a number of our markets, we have partnered with local physicians or not-for-profit providers, or both, in the ownership of our facilities. In addition to our hospitals and related businesses, we also own and operate home care agencies, including four home care agencies located in markets where we do not operate a hospital. Through our wholly-owned subsidiary, Quorum Health Resources, LLC, or QHR, we also provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. The home care agencies and the management services businesses constitute operating segments but are not considered reportable segments since they do not meet the quantitative thresholds for a separate identifiable reportable segment. The financial information for our reportable operating segments is presented in Note 14 of the Notes to our Consolidated Financial Statements included under Item 8 of this Report.

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

Over the past three years, we have acquired 57 hospitals, including our July 25, 2007 acquisition of Triad Hospitals, Inc., or Triad, which owned and operated 50 hospitals with 49 hospitals located in 17 states in non-urban and middle market communities and one hospital located in the Republic of Ireland. As of December 31, 2009, we still own 42 of the 50 hospitals acquired from Triad. These acquisitions have expanded our operations into six states where we previously did not own facilities.

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

Available Information

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

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

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

Our Business Strategy

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

increase revenue at our facilities;
improve profitability;
improve quality; and
grow through selective acquisitions.

Increase Revenue at Our Facilities

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

recruiting additional primary care physicians and specialists;
expanding the breadth of services offered at our hospitals through targeted capital expenditures to support the addition of more complex services, including orthopedics, cardiovascular services, and urology; and
providing the capital to invest in technology and the physical plant at the facilities, particularly in our emergency rooms, surgery departments, critical care departments, and diagnostic services.

Physician Recruiting. The primary method of adding or expanding medical services is the recruitment of new physicians into the community. A core group of primary care physicians is necessary as an initial contact point for all local healthcare. The addition of specialists who offer services, including general surgery, OB/GYN, cardiovascular services, orthopedics and urology, completes the full range of medical and surgical services required to meet a community s core healthcare needs. At the time we acquire a hospital and from time to time thereafter, we identify the healthcare needs of the community by analyzing demographic data and patient referral trends. As a result of this analysis, we are able to determine what we believe to be the optimum mix of primary care physicians and specialists. We employ recruiters at the corporate level to support the local hospital managers in their recruitment efforts. We have increased the number of physicians affiliated with us through our recruiting efforts, net of turnover, by approximately 772 in 2009, 686 in 2008, and 440 in 2007. The percentage of recruited or other physicians commencing practice with us that were specialists was over 50% in 2009. Although in recent years we have begun employing more physicians, most of the physicians in our communities are in private practice and are not our employees. We have been successful in recruiting physicians because of the practice opportunities afforded physicians in our markets, as well as lower managed care penetration as compared to larger urban areas.

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Emergency Room Initiatives. Approximately 55% of our hospital admissions originate in the emergency room. Therefore, we systematically take steps to increase patient flow in our emergency rooms as a means of optimizing utilization rates for our hospitals. Furthermore, the impression of our overall operations by our customers is substantially influenced by our emergency rooms since generally that is their first experience with our hospitals. The steps we take to increase patient flow in our emergency rooms include renovating and expanding our emergency room facilities, improving service and reducing waiting times, as well as publicizing our emergency room capabilities in the local community. We have expanded or renovated 12 of our emergency rooms during the past three years, including five in 2009. We have also implemented marketing campaigns that emphasize the speed, convenience, and quality of our emergency rooms to enhance each community s awareness of our emergency room services.

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

Expansion of Services. In an effort to better meet the healthcare needs of the communities we serve and to capture a greater portion of the healthcare spending in our markets, we have added a broad range of services to our facilities. These services range from various types of diagnostic equipment capabilities to additional and renovated emergency rooms, surgical and critical care suites and specialty services. For example, in 2009, we spent $260.4 million as a part of 34 major construction projects. The 2009 projects included new emergency rooms, cardiac cathertization labs, intensive care units, hospital additions, and surgical suites. These projects improved various diagnostic and other inpatient and outpatient service capabilities. We continue to believe that appropriate capital investments in our facilities combined with the development of our service capabilities will reduce the migration of patients to competing providers while providing an attractive return on investment. We also employ a small group of clinical consultants at our corporate headquarters to assist the hospitals in their development of surgery, emergency, critical care, cardiovascular, and hospitalist services. In addition to spending capital on expanding services at our existing hospitals, we also build replacement facilities to better meet the healthcare needs of our communities. In 2009, we spent $4.8 million on planning costs for future construction projects related to three replacement hospitals, which we are required to build pursuant to either a hospital purchase agreement or an amendment to a lease agreement. The total cost of these three replacement hospitals is estimated to be $310.0 million.

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

Improve Profitability

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

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

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

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

monitoring and enhancing productivity of our human resources.

In addition, each of our hospital management teams is supported by our centralized operational, reimbursement, regulatory and compliance expertise, as well as by our senior management team, which has an average of over 25 years of experience in the healthcare industry.

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

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

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

Procurement and Materials Management. We have standardized and centralized our operations with respect to medical supplies, equipment and pharmaceuticals used in our hospitals. We have a participation agreement with HealthTrust Purchasing Group, L.P., or HealthTrust, a group purchasing organization, or GPO. HealthTrust contracts with certain vendors who supply a substantial portion of our medical supplies, equipment and pharmaceuticals. Our agreement with HealthTrust extends to January 2011, with automatic renewal terms of one year unless either party terminates by giving notice of non-renewal.

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

Other Initiatives. We have also improved margins by implementing standard programs with respect to ancillary services in areas, including emergency rooms, pharmacy, laboratory, imaging, home care, skilled nursing, centralized outpatient scheduling and health information management. We have reduced costs associated with these services by improving contract terms and standardizing information systems. We work to identify and communicate best practices and monitor these improvements throughout the Company.

Internal Controls Over Financial Reporting. We have centralized many of our significant internal controls over financial reporting and standardized those other controls that are performed at our hospital locations. We continuously monitor compliance with and evaluate the effectiveness of our internal controls over financial reporting.

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

- appropriately treating patients along the care continuum;
- reducing inefficiently applied processes, procedures and resources;
- developing and implementing standards for operational best practices; and
- using on-site clinical facilitators to train and educate care practitioners on identified best practices.

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

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

Improve Quality

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

Each of our hospitals is governed by a board of trustees, which includes members of the hospital s medical staff. The board of trustees establishes policies concerning the hospital s medical, professional, and ethical practices, monitors these practices, and is responsible for ensuring that these practices conform to legally required standards. We maintain quality assurance programs to support and monitor quality of care standards and to meet Medicare and Medicaid accreditation and regulatory requirements. Patient care evaluations and other quality of care assessment activities are reviewed and monitored continuously.

Grow Through Selective Acquisitions

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

- have a service area population between 20,000 and 400,000 with a stable or growing population base;
- are the sole or primary provider of acute care services in the community;
- are located in an area with the potential for service expansion;
- are not located in an area that is dependent upon a single employer or industry; and
- have financial performance that we believe will benefit from our management s operating skills.

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In each year since 1997, we have met or exceeded our acquisition goals. Occasionally, we have pursued acquisition opportunities outside of our specified criteria when such opportunities have had uniquely favorable characteristics. In addition to two hospitals acquired from local governmental entities in 2007, we also acquired Triad, which owned and operated 50 hospitals, of which 49 hospitals were located in 17 states across the U.S. and one hospital was located in the Republic of Ireland. Since our acquisition of Triad s 50 hospital portfolio in July, 2007, we have focused most of our efforts on integrating those hospitals, as opposed to pursuing further acquisition opportunities. In the fourth quarter of 2008, we completed the acquisition of a two hospital system located in Spokane, Washington. In 2009, we acquired two hospitals located in Wilkes-Barre, Pennsylvania and Siloam Springs, Arkansas and purchased the remaining equity in a hospital located in El Dorado, Arkansas in which we previously had a noncontrolling interest.

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

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

At the time we acquire a hospital, we may commit to an amount of capital expenditures, such as a replacement facility, renovations, or equipment over a specified period of time. As obligations under two hospital purchase agreements in effect as of December 31, 2009, we are required to build a replacement facility in Valparaiso, Indiana by April 2011 and in Siloam Springs, Arkansas by February 2013. Also, as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location. Estimated construction costs, including equipment costs, are approximately $310.0 million for these three replacement hospitals, of which approximately $12.6 million has been incurred to date. In addition, under other purchase agreements in effect as of December 31, 2009, we have committed to spend $468.5 million, generally over a five to seven year period after acquisition, for costs such as capital improvements, equipment, selected leases and physician recruiting. Through December 31, 2009, we have incurred approximately $171.4 million related to these commitments. In October 2008, after the purchase of the noncontrolling owner s interest in our Birmingham, Alabama facility, we initiated the purchase of a site for a potential replacement to our existing Birmingham facility. The new site includes a partially constructed hospital structure. This project is subject to the approval of a certificate of need, or CON, expected to be granted by mid to late 2010. Upon receiving the CON, and after resolution of any legal issues, we will complete our assessment of the costs to complete construction of the unfinished facility and relocate our existing Birmingham facility to the new site.

Industry Overview

The Centers for Medicare and Medicaid Services, or CMS, reported that in 2008 total U.S. healthcare expenditures grew by 4.4% to approximately $2.3 trillion. CMS also projected total U.S. healthcare spending to grow by 5.5% in 2009 and by an average of 6.3% annually from 2010 through 2018. By these estimates, healthcare expenditures will account for approximately $4.4 trillion, or 20.3% of the total U.S. gross domestic product, by 2018.

Hospital services, the market in which we operate, is the largest single category of healthcare at 30% of total healthcare spending in 2008, or approximately $718.4 billion, as reported by CMS. CMS projects the hospital services category to grow by at least 5.1% per year through 2018. It expects growth in hospital healthcare spending to continue due to the aging of the U.S. population and consumer demand for expanded medical services. As hospitals remain the

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primary setting for healthcare delivery, CMS expects hospital services to remain the largest category of healthcare spending.

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

Urban vs. Non-Urban Hospitals

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

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

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

We believe that non-urban hospitals are generally able to obtain higher operating margins than urban hospitals. Factors contributing to a non-urban hospital s margin advantage include fewer patients with complex medical problems, a lower cost structure, limited competition, and favorable Medicare payment provisions. Patients needing the most complex care are more often served by the larger and/or more specialized urban hospitals. A non-urban hospital s lower cost structure results from its geographic location, as well as the lower number of patients treated who need the most highly advanced services. Additionally, because non-urban hospitals are generally sole providers or one of a small group of providers in their markets, there is limited competition. This generally results in more favorable pricing with commercial payors. Medicare has special payment provisions for sole community hospitals. Under present law, hospitals that qualify for this designation can receive higher reimbursement rates. As of December 31, 2009, 26 of our hospitals were sole community hospitals. In addition, we believe that non-urban communities are generally characterized by a high level of patient and physician loyalty that fosters cooperative relationships among the local hospitals, physicians, employees and patients.

The type of third party responsible for the payment of services performed by healthcare service providers is also an important factor which affects hospital operating margins. These payors have increasingly exerted pressure on healthcare service providers to reduce the cost of care. The most active payors in this regard have been HMOs, PPOs, and other managed care organizations. The characteristics of non-urban markets make them less attractive to these managed care organizations. This is partly because the limited size of non-urban markets and their diverse, non-national employer bases minimize the ability of managed care organizations to achieve economies of scale as compared to economies of scale that can be achieved in many urban markets.

Hospital Industry Trends

Demographic Trends. According to the U.S. Census Bureau, there are presently approximately 38.9 million Americans aged 65 or older in the U.S. who comprise approximately 12.8% of the total U.S. population. By the year

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2030, the number of elderly is expected to climb to 72.1 million, or 19.3% of the total population. Due to the increasing life expectancy of Americans, the number of people aged 85 years and older is also expected to increase from 5.5 million to 8.7 million by the year 2030. This increase in life expectancy will increase demand for healthcare services and, as importantly, the demand for innovative, more sophisticated means of delivering those services. Hospitals, as the largest category of care in the healthcare market, will be among the main beneficiaries of this increase in demand. Based on data compiled for us, the populations of the service areas where our hospitals are located grew by 24.8% from 1990 to 2008 and are expected to grow by 6.1% from 2008 to 2013. The number of people aged 65 or older in these service areas grew by 25.1% from 1990 to 2008 and is expected to grow by 11.3% from 2008 to 2013.

Consolidation. During recent years a significant amount of private equity capital has been invested into the hospital industry. Also, in addition to our own acquisition of Triad in 2007, consolidation activity, primarily through mergers and acquisitions involving both for-profit and not-for-profit hospital systems is continuing. Reasons for this activity included:

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

As a result of the global economic conditions over this past year, we have seen a decline in the trend of consolidation activity, including mergers and acquisitions. We anticipate that future consolidation activity will be highly dependent on the availability of capital from the financial markets, hospital valuation levels, as well as the impact from any healthcare reform.

Selected Operating Data

The following table sets forth operating statistics for our hospitals for each of the years presented, which are included in our continuing operations. Statistics for 2009 include a full year of operations for 119 hospitals and partial periods for two hospitals acquired during the year and one hospital in which we previously had a noncontrolling interest and purchased the remaining interest during the year. Statistics for 2008 include a full year of operations for 117 hospitals and partial periods for two hospitals acquired during the year. Statistics for 2007 include a full year of operations for 70 hospitals and partial periods for 46 hospitals acquired during the year. Statistics for hospitals which have been sold are excluded from all periods presented.

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	Year Ended December 31,		
	2009	2008	2007
	(Dollars in thousands)		
Consolidated Data			
Number of hospitals (at end of period)	122	119	116
Licensed beds (at end of period)(1)	18,140	17,411	17,148
Beds in service (at end of period)(2)	15,897	15,194	14,600
Admissions(3)	692,569	668,526	461,058
Adjusted admissions(4)	1,275,888	1,207,756	846,835
Patient days(5)	2,937,194	2,835,795	1,934,120
Average length of stay (days)(6)	4.2	4.2	4.2
Occupancy rate (beds in service)(7)	51.3%	52.3%	52.1%
Net operating revenues	$ 12,107,613	$ 10,919,095	$ 7,095,861
Net inpatient revenues as a % of total net operating revenues	50.1%	50.2%	49.2%
Net outpatient revenues as a % of total net operating revenues	47.6%	47.5%	48.8%
Net Income attributable to Community Health Systems, Inc.	$ 243,150	$ 218,304	$ 30,289
Net Income attributable to Community Health Systems, Inc. as a % of total net operating revenues	2.0%	2.0%	0.4%
Liquidity Data			
Adjusted EBITDA(8)	$ 1,671,397	$ 1,513,329	$ 810,066
Adjusted EBITDA as a % of total net operating revenues(8)	13.8%	13.9%	11.4%
Net cash flows provided by operating activities	$ 1,076,429	$ 1,056,581	$ 688,438
Net cash flows provided by operating activities as a % of total net operating revenues	8.9%	9.7%	9.7%
Net cash flows used in investing activities	$ (867,182)	$ (665,471)	$ (7,498,858)
Net cash flows provided by (used in) financing activities	$ (85,361)	$ (304,029)	$ 6,903,428

See pages 10 and 11 for footnotes.

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	Year Ended December 31, 2009	2008	(Decrease) Increase
	(Dollars in thousands)		
Same-Store Data(9)			
Admissions(3)	658,215	668,526	(1.5)%
Adjusted admissions(4)	1,215,606	1,207,750	0.7%
Patient days(5)	2,768,470	2,835,795	
Average length of stay (days)(6)	4.2	4.2	
Occupancy rate (beds in service)(7)	51.1%	52.3%	
Net operating revenues	$ 11,556,401	$ 10,917,362	5.9%
Income from operations	$ 1,078,969	$ 969,737	11.3%
Income from operations as a % of net operating revenues	9.3%	8.9%	
Depreciation and amortization	$ 545,408	$ 499,386	
Equity in earnings of unconsolidated affiliates	$ 36,145	$ 43,777	

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

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

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

(4) Adjusted admissions is a general measure of combined inpatient and outpatient volume. We computed

adjusted admissions by multiplying admissions by gross patient revenues and then dividing that number by gross inpatient revenues.

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

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

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

(8) EBITDA consists of net income attributable to Community Health Systems, Inc. before interest, income taxes, depreciation and amortization. Adjusted EBITDA is EBITDA adjusted to

exclude discontinued operations, gain/loss from early extinguishment of debt and net income attributable to noncontrolling interests. We have from time to time sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. We believe that it is useful to present adjusted EBITDA because it excludes the portion of EBITDA attributable to these third party interests and clarifies for investors our portion of EBITDA generated by continuing operations. We use adjusted EBITDA as a measure of liquidity. We have included this measure because we believe it provides investors with

additional information about our ability to incur and service debt and make capital expenditures. Adjusted EBITDA is the basis for a key component in the determination of our compliance with some of the covenants under our senior secured credit facility, as well as to determine the interest rate and commitment fee payable under the senior secured credit facility (although adjusted EBITDA does not include all of the adjustments described in the senior secured credit facility).

Adjusted EBITDA is not a measurement of financial performance or liquidity under generally accepted accounting principles. It should not be considered in isolation or as a substitute for net income, operating income, cash flows from

operating, investing or financing activities, or any other measure calculated in accordance with generally accepted accounting principles. The items excluded from adjusted EBITDA are significant components in understanding and evaluating financial performance and liquidity. Our calculation of adjusted EBITDA may not be comparable to similarly titled measures reported by other companies.

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The following table reconciles adjusted EBITDA, as defined, to our net cash provided by operating activities as derived directly from our consolidated financial statements for the years ended December 31, 2009, 2008 and 2007 (in thousands):

	Year Ended December 31,		
	2009	**2008**	**2007**
Adjusted EBITDA	$ 1,671,397	$ 1,513,329	$ 810,066
Interest expense, net	(648,964)	(652,468)	(362,065)
Provision for income taxes	(141,325)	(125,273)	(39,860)
Deferred income taxes	34,268	159,870	(39,894)
Income (loss) from operations of hospitals sold or held for sale	1,977	9,427	(4,199)
Income tax (expense) benefit on the non-cash impairment and (gain) loss on sale of hospitals		(8,107)	4,457
Depreciation and amortization of discontinued operations	332	7,308	19,258
Stock compensation expense	44,501	52,105	38,771
Income tax payable increase (excess tax benefits) relating to stock-based compensation	3,472	(1,278)	(1,216)
Other non-cash (income) expenses, net	22,870	3,577	19,018
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	58,390	(49,578)	128,743
Supplies, prepaid expenses and other current assets	(34,535)	(34,397)	(31,734)
Accounts payable, accrued liabilities and income taxes	86,098	119,869	122,282
Other	(22,052)	62,197	24,811
Net cash provided by operating activities	$ 1,076,429	$ 1,056,581	$ 688,438

(9) Includes former Triad hospital s data, as if we owned them as of January 1,

2007 (acquisition date was July 25, 2007) and other acquired hospitals to the extent we operated them during comparable periods in both years. We have restated our 2008 and 2007 financial statements and statistical results to include a hospital and related businesses, which were previously reported as discontinued operations and is now included in continuing operations.

Sources of Revenue

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

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

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

Net Operating Revenues by Payor Source	2009	2008	2007
Medicare	27.1%	27.5%	29.0%
Medicaid	9.8%	9.1%	10.3%
Managed Care and other third party payors	51.9%	52.7%	50.7%
Self-pay	11.2%	10.7%	10.0%
Total	100.0%	100.0%	100.0%

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

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

In addition to government programs, we are paid by private payors, which include insurance companies, HMOs, PPOs, other managed care companies, employers, and by patients directly. Blue Cross payors are included in Managed Care and other third party payors line in the above table. Patients are generally not responsible for any difference between customary hospital charges and amounts paid for hospital services by Medicare and Medicaid programs, insurance companies, HMOs, PPOs, and other managed care companies, but are responsible for services not covered by these programs or plans, as well as for deductibles and co-insurance obligations of their coverage. The amount of these deductibles and co-insurance obligations has increased in recent years. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government or business payors. To further reduce their healthcare costs, an increasing number of insurance companies, HMOs, PPOs, and other managed care companies are negotiating discounted fee structures or fixed amounts for hospital services performed, rather than paying healthcare providers the amounts billed. We negotiate discounts with managed care companies, which are typically smaller than discounts under governmental programs. If an increased number of insurance companies, HMOs, PPOs, and other managed care companies succeed in negotiating discounted fee structures or fixed amounts, our results of operations may be negatively affected. For more information on the payment programs on which our revenues depend, see Payment on page 17.

As of December 31, 2009, Indiana and Texas represented our only areas of geographic concentration. Net operating revenues as a percentage of consolidated net operating revenues generated in Indiana were 10.9% in 2009, 10.9% in 2008 and 7.8% in 2007. Net operating revenues as a percentage of consolidated net operating revenues generated in Texas were 13.2% in 2009, 13.3% in 2008 and 12.5% in 2007. As a result of our growth and expansion of services in other states, Pennsylvania no longer represents an area of geographic concentration, as it did at December 31, 2007.

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

advances in technology, which have permitted us to provide more services on an outpatient basis; and

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pressure from Medicare or Medicaid programs, insurance companies, and managed care plans to reduce hospital stays and to reduce costs by having services provided on an outpatient rather than on an inpatient basis.

Government Regulation

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

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

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

The American Recovery and Reinvestment Act of 2009 has been signed into law providing for a temporary increase in the federal matching assistance percentage (FMAP), a temporary increase in federal Medicaid Disproportionate Share Hospital, or DSH, allotments, subsidization of health insurance premiums (COBRA) for up to nine months, and grants and loans for infrastructure and incentive payments for providers who adopt and use health information technology. The 2010 Department of Defense Appropriations Bill signed into law expands the subsidization of health insurance premiums (COBRA) to 15 months and extends the eligibility period for individuals losing their jobs through February 28, 2010. Additionally, the Obama administration has stated as a top priority its desire to reform the U.S. healthcare system with the goal of reducing the costs of healthcare and reducing the current number of uninsured and underinsured Americans. Several proposals have been considered, including cost controls on hospitals and insurance industry reforms. Currently, separate bills have been passed in both the U.S. House of Representatives and the U.S. Senate and debate in Congress is continuing in an attempt to draft a final piece of legislation. The costs of implementing the American Recovery and Reinvestment Act of 2009 and these other proposals being considered could be financed, in part, by reductions in payments to healthcare providers under Medicare, Medicaid, and other government programs. In addition, federal funding for existing programs may not be approved in the future.

The current administration and Congress have now debated healthcare reform for over one year and, at this time, we cannot predict the outcome of this debate. A reduction in uninsured patients may reduce our expense from uncollectible accounts receivable; however, legislative proposals to achieve this reduction in uninsured patients may result in lower reimbursement from other payor sources and/or a migration of patients from private payor sources to lower paying government payor sources. Furthermore, we cannot predict the course of any other future legislation, changes the current administration may seek to implement regarding healthcare or interpretations by the current administration of existing governmental healthcare programs and the related effect that any legislative or interpretive change may have on us.

Fraud and Abuse Laws. Participation in the Medicare program is heavily regulated by federal statute and regulation. If a hospital fails substantially to comply with the requirements for participating in the Medicare program,

the hospital s participation in the Medicare program may be terminated and/or civil or criminal penalties

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may be imposed. For example, a hospital may lose its ability to participate in the Medicare program if it performs any of the following acts:

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

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of the fraud and abuse laws. Under HIPAA, any person or entity that knowingly and willfully defrauds or attempts to defraud a healthcare benefit program, including private healthcare plans, may be subject to fines, imprisonment or both. Additionally, any person or entity that knowingly and willfully falsifies or conceals a material fact or makes any material false or fraudulent statements in connection with the delivery or payment of healthcare services by a healthcare benefit plan is subject to a fine, imprisonment or both.

Another law regulating the healthcare industry is a section of the Social Security Act, known as the anti-kickback statute. This law prohibits some business practices and relationships under Medicare, Medicaid, and other federal healthcare programs. These practices include the payment, receipt, offer, or solicitation of remuneration of any kind in exchange for items or services that are reimbursed under most federal or state healthcare program. Violations of the anti-kickback statute may be punished by criminal and civil fines, exclusion from federal healthcare programs, and damages up to three times the total dollar amount involved.

The Office of Inspector General of the Department of Health and Human Services, or OIG, is responsible for identifying and investigating fraud and abuse activities in federal healthcare programs. As part of its duties, the OIG provides guidance to healthcare providers by identifying types of activities that could violate the anti-kickback statute. The OIG also publishes regulations outlining activities and business relationships that would be deemed not to violate the anti-kickback statute. These regulations are known as safe harbor regulations. However, the failure of a particular activity to comply with the safe harbor regulations does not necessarily mean that the activity violates the anti-kickback statute.

The OIG has identified the following incentive arrangements as potential violations of the anti-kickback statute:

- payment of any incentive by the hospital when a physician refers a patient to the hospital;
- use of free or significantly discounted office space or equipment for physicians in facilities usually located close to the hospital;
- provision of free or significantly discounted billing, nursing, or other staff services;
- free training for a physician s office staff, including management and laboratory techniques (but excluding compliance training);
- guarantees which provide that if the physician s income fails to reach a predetermined level, the hospital will pay any portion of the remainder;
- low-interest or interest-free loans, or loans which may be forgiven if a physician refers patients to the hospital;
- payment of the costs of a physician s travel and expenses for conferences;
- payment of services which require few, if any, substantive duties by the physician, or payment for services in excess of the fair market value of the services rendered; or
- purchasing goods or services from physicians at prices in excess of their fair market value.

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We have a variety of financial relationships with physicians who refer patients to our hospitals. Physicians own interests in a number of our facilities. Physicians may also own our stock. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases, management agreements, and professional service agreements. We provide financial incentives to recruit physicians to relocate to communities served by our hospitals. These incentives include relocation, reimbursement for certain direct expenses, income guarantees and, in some cases, loans. Although we believe that we have structured our arrangements with physicians in light of the safe harbor rules, we cannot assure you that regulatory authorities will not determine otherwise. If that happens, we could be subject to criminal and civil penalties and/or exclusion from participating in Medicare, Medicaid, or other government healthcare programs.

The Social Security Act also includes a provision commonly known as the Stark law. This law prohibits physicians from referring Medicare patients to healthcare entities in which they or any of their immediate family members have ownership interests or other financial arrangements. These types of referrals are commonly known as self referrals. Sanctions for violating the Stark law include denial of payment, civil money penalties, assessments equal to twice the dollar value of each service, and exclusion from government payor programs. There are ownership and compensation arrangement exceptions to the self-referral prohibition. One exception allows a physician to make a referral to a hospital if the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. Another exception allows a physician to refer patients to a healthcare entity in which the physician has an ownership interest if the entity is located in a rural area, as defined in the statute. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases, and recruitment agreements. From time to time, the federal government has issued regulations which interpret the provisions included in the Stark law. We strive to comply with the Stark law and regulations; however, the government may interpret the law and regulations differently. If we are found to have violated the Stark law or regulations, we could be subject to significant sanctions, including damages, penalties, and exclusion from federal healthcare programs.

Many states in which we operate also have adopted similar laws relating to financial relationships with physicians. Some of these state laws apply even if the payment for care does not come from the government. These statutes typically provide criminal and civil penalties as well as loss of licensure. While there is little precedent for the interpretation or enforcement of these state laws, we have attempted to structure our financial relationships with physicians and others in light of these laws. However, if we are found to have violated these state laws, it could result in the imposition of criminal and civil penalties as well as possible licensure revocation.

False Claims Act. Another trend in healthcare litigation is the increased use of the False Claims Act, or FCA. This law makes providers liable for, among other things, the knowing submission of a false claim for reimbursement by the federal government. The FCA has been used not only by the U.S. government, but also by individuals who bring an action on behalf of the government under the law s qui tam or whistleblower provisions and share in any recovery. When a private party brings a qui tam action under the FCA, it files the complaint with the court under seal, and the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation.

Civil liability under the FCA can be up to three times the actual damages sustained by the government plus civil penalties of up to $11,000 for each separate false claim submitted to the government. There are many potential bases for liability under the FCA. Although liability under the FCA arises when an entity knowingly submits a false claim for reimbursement, the FCA defines the term knowingly to include reckless disregard of the truth or falsity of the claim being submitted.

A number of states in which we operate have enacted state false claims legislation. These state false claims laws are generally modeled on the federal FCA, with similar damages, penalties, and qui tam enforcement provisions. An increasing number of healthcare false claims cases seek recoveries under both federal and state law.

Provisions in the Deficit Reduction Act of 2005, or DRA, that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal FCA. Additionally, the DRA requires every entity that receives annual payments of at least $5 million from a state Medicaid plan to establish written policies for its employees that provide detailed information about federal and state false claims statutes and the whistleblower protections that exist under those laws. Both provisions of the DRA are expected to result in

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increased false claims litigation against health care providers. We have substantially complied with the written policy requirements.

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

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

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

Certificates of Need. The construction of new facilities, the acquisition of existing facilities and the addition of new services at our facilities may be subject to state laws that require prior approval by state regulatory agencies. These CON laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. As of December 31, 2009, we operated 54 hospitals in 16 states that have adopted CON laws for acute care facilities. If we fail to obtain necessary state approval, we will not be able to expand our facilities, complete acquisitions or add new services in these states. Violation of these state laws may result in the imposition of civil sanctions or the revocation of a hospital s licenses.

Privacy and Security Requirements of HIPAA. The Administrative Simplification Provisions of HIPAA require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. We believe we are in compliance with these regulations.

The Administrative Simplification Provisions also require CMS to adopt standards to protect the security and privacy of health-related information. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. If we violate these regulations, we could be subject to monetary fines and penalties, criminal sanctions and civil causes of action. We have implemented and operate continuing employee education programs to reinforce operational compliance with policy and procedures which adhere to privacy regulations. The HIPAA security standards and privacy regulations serve similar purposes and overlap to a certain extent, but the security regulations relate more specifically to protecting the integrity, confidentiality and

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availability of electronic protected health information while it is in our custody or being transmitted to others. We believe we have established proper controls to safeguard access to protected health information.

Payment

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

Payments for inpatient acute services are generally made pursuant to a prospective payment system, commonly known as PPS. Under PPS, our hospitals are paid a predetermined amount for each hospital discharge based on the patient s diagnosis. Specifically, each discharge is assigned to a diagnosis-related group, commonly known as a DRG, based upon the patient s condition and treatment during the relevant inpatient stay. For the federal fiscal year 2008 (i.e., the federal fiscal year beginning October 1, 2007), each DRG was assigned a payment rate using 67% of the national average cost per case and 33% of the national average charge per case and 50% of the change to severity adjusted DRG weights. Severity adjusted DRG s more accurately reflect the costs a hospital incurs for caring for a patient and accounts more fully for the severity of each patient s condition. Commencing with the federal fiscal year 2009 (i.e., the federal fiscal year beginning October 1, 2008), each DRG is assigned a payment rate using 100% of the national average cost per case and 100% of the severity adjusted DRG weights. DRG payments are based on national averages and not on charges or costs specific to a hospital. However, DRG payments are adjusted by a predetermined geographic adjustment factor assigned to the geographic area in which the hospital is located. While a hospital generally does not receive payment in addition to a DRG payment, hospitals may qualify for an outlier payment when the relevant patient s treatment costs are extraordinarily high and exceed a specified regulatory threshold.

The DRG rates are adjusted by an update factor on October 1 of each year, the beginning of the federal fiscal year. The index used to adjust the DRG rates, known as the market basket index, gives consideration to the inflation experienced by hospitals in purchasing goods and services. DRG payment rates were increased by the full market basket index, for the federal fiscal years 2007, 2008, 2009 and 2010 or 3.4%, 3.3%, 3.6% and 2.1%, respectively. The Deficit Reduction Act of 2005 imposes a two percentage point reduction to the market basket index beginning October 1, 2007, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement. Future legislation may decrease the rate of increase for DRG payments, but we are not able to predict the amount of any reduction or the effect that any reduction will have on us.

In addition, hospitals may qualify for Medicare disproportionate share payments when their percentage of low income patients exceeds specified regulatory thresholds. A majority of our hospitals qualify to receive Medicare disproportionate share payments. For the majority of our hospitals that qualify to receive Medicare disproportionate share payments, these payments were increased by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 effective April 1, 2004. These Medicare disproportionate share payments as a percentage of net operating revenues were 1.6%, 1.8% and 1.8% for the years ended December 31, 2009, 2008 and 2007, respectively.

Beginning August 1, 2000, we began receiving Medicare reimbursement for outpatient services through a PPS. Under the Balanced Budget Refinement Act of 1999, non-urban hospitals with 100 beds or less were held harmless through December 31, 2004 under this Medicare outpatient PPS. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 extended the hold harmless provision for non-urban hospitals with 100 beds or less and for non-urban sole community hospitals with more than 100 beds through December 31, 2005. The Deficit Reduction Act of 2005 extended the hold harmless provision for non-urban hospitals with 100 beds or less that are not sole community hospitals through December 31, 2008; however, that Act reduced the amount these hospitals would receive in hold harmless payment by 10% in 2007 and 15% in 2008. Of our 119 hospitals in continuing operations at December 31, 2008, 31 qualified for this relief. The Medicare Improvements for Patients and Providers Act extends the hold harmless provision for non-urban hospitals with 100 beds or less, including non-urban sole community hospitals, through December 31, 2009, at 85% of the hold harmless amount. Of our 122 hospitals at December 31, 2009, 44 qualified for this relief. The outpatient conversion factor was increased 3.4% effective January 1, 2007; however, coupled with adjustments to other variables with the outpatient PPS, an approximate 2.5% to 2.9% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.3% effective January 1, 2008; however, coupled with adjustments to other variables with the outpatient PPS, an

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approximate 3.0% to 3.4% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.6% effective January 1, 2009; however, coupled with adjustments to other variables with outpatient PPS, an approximate 3.5% to 3.9% net increase in outpatient payments is expected to occur. The outpatient conversion factor was increased 2.1% effective January 1, 2010; however, coupled with adjustments to other variables with outpatient PPS, an approximate 1.8% to 2.2% net increase in outpatient payments is expected to occur. The Medicare Improvements and Extension Act of the Tax Relief and Health Care Act of 2006 imposes a two percentage point reduction to the market basket index beginning January 1, 2009, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement.

Skilled nursing facilities and swing bed facilities were historically paid by Medicare on the basis of actual costs, subject to limitations. The Balanced Budget Act of 1997 established a PPS for Medicare skilled nursing facilities and mandated that swing bed facilities must be incorporated into the skilled nursing facility PPS. Skilled nursing facility PPS rates were increased by the full SNF market basket index of 3.1%, 3.3% and 3.4% for the federal fiscal years 2007, 2008 and 2009, respectively. For the federal fiscal year 2010 (i.e., the federal fiscal year beginning October 1, 2009), the skilled nursing PPS rates were increased by 2.2%; however, coupled with adjustments to other variables, within the skilled nursing PPS, an approximate 1.1% net decrease in skilled nursing payments is expected to occur.

The Department of Health and Human Services established a PPS for home health services (i.e. home care) effective October 1, 2000. The home health agency PPS per episodic payment rate increased by 3.3% on January 1, 2007. The home health agency PPS per episodic payment rate increased by 3% on January 1, 2008; however, coupled with adjustments to other variables with home health agency PPS, an approximate 1.5% to 1.9% net increase in home health agency payments occurred. The home health agency PPS per episodic payment rate increased by 2.9% on January 1, 2009; however, coupled with adjustments to other variables with home health agency PPS, an approximate 0.2% net increase in home health agency payments is expected to occur. The home health agency PPS per episodic payment rate increased by 2.0% on January 1, 2010; however, coupled with adjustments to other variables with home health agency PPS, an approximate 2.3% net increase in home health agency payments is expected to occur. The Deficit Reduction Act of 2005 imposes a two percentage point reduction to the market basket index beginning January 1, 2007, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement.

Medicaid. Most state Medicaid payments are made under a PPS or under programs which negotiate payment levels with individual hospitals. Medicaid is currently funded jointly by state and federal government. The federal government and many states are currently considering significantly reducing Medicaid funding, while at the same time expanding Medicaid benefits. We can provide no assurance that reductions to Medicaid fundings will not have a material adverse effect on our consolidated results of operations.

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

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

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

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Supply Contracts

In March 2005, we began purchasing items, primarily medical supplies, medical equipment and pharmaceuticals, under an agreement with HealthTrust, a GPO in which we are a noncontrolling partner. Triad was also a noncontrolling partner in HealthTrust and we acquired their ownership interest and contractual rights in the acquisition. As of December 31, 2009, we have an 18% ownership interest in HealthTrust. By participating in this organization we are able to procure items at competitively priced rates for our hospitals. There can be no assurance that our arrangement with HealthTrust will continue to provide the discounts we expect to achieve.

Competition

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

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

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

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

Compliance Program

We take an operations team approach to compliance and utilize corporate experts for program design efforts and facility leaders for employee-level implementation. Compliance is another area that demonstrates our utilization of standardization and centralization techniques and initiatives which yield efficiencies and consistency throughout our facilities. We recognize that our compliance with applicable laws and regulations depends on individual employee actions as well as company operations. Our approach focuses on integrating compliance responsibilities with operational functions. This approach is intended to reinforce our company-wide commitment to operate strictly in accordance with the laws and regulations that govern our business.

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Our company-wide compliance program has been in place since 1997. Currently, the program s elements include leadership, management and oversight at the highest levels, a Code of Conduct, risk area specific policies and procedures, employee education and training, an internal system for reporting concerns, auditing and monitoring programs, and a means for enforcing the program s policies.

Since its initial adoption, the compliance program continues to be expanded and developed to meet the industry s expectations and our needs. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring activities have been prepared and implemented to address the functional and operational aspects of our business. Included within these functional areas are materials and activities for business sub-units, including laboratory, radiology, pharmacy, emergency, surgery, observation, home care, skilled nursing, and clinics. Specific areas identified through regulatory interpretation and enforcement activities have also been addressed in our program. Claims preparation and submission, including coding, billing, and cost reports, comprise the bulk of these areas. Financial arrangements with physicians and other referral sources, including compliance with anti-kickback and Stark laws, emergency department treatment and transfer requirements, and other patient disposition issues are also the focus of policy and training, standardized documentation requirements, and review and audit. Another focus of the program is the interpretation and implementation of the HIPAA standards for privacy and security.

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

Employees

At December 31, 2009, we employed approximately 58,555 full-time employees and 20,659 part-time employees. In addition, we employed approximately 3,465 union members. We currently believe that our labor relations are good.

Professional Liability Claims

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

Environmental Matters

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

We are insured for damages of personal property or environmental injury arising out of environmental impairment for both above ground and underground storage tank issues under one insurance policy for all of our hospitals. Our policy coverage is $5 million per occurrence with a $50,000 deductible and a $20 million annual aggregate. This policy also provides pollution legal liability coverage.

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

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

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

We are significantly leveraged. The chart below shows our level of indebtedness and other information as of December 31, 2009. In connection with the consummation of our acquisition of Triad in July 2007, approximately $7.2 billion of senior secured financing under a new credit facility, or Credit Facility, was obtained by our wholly-owned subsidiary, CHS/Community Health Systems, Inc., or CHS. CHS also issued 8.875% senior notes, or the Notes, having an aggregate principal amount of approximately $3.0 billion. Both the indebtedness under the Credit Facility and the Notes are senior obligations of CHS and are guaranteed on a senior basis by us and by certain of our domestic subsidiaries. We used the net proceeds from the Notes offering and the net proceeds of the approximately $6.1 billion term loans under the Credit Facility to pay the consideration under the merger agreement with Triad, to refinance certain of our existing indebtedness and the indebtedness of Triad, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. As of December 31, 2009, a $750 million revolving credit facility was available to us for working capital and general corporate purposes under the Credit Facility, with $90.0 million of the revolving credit facility being set aside for outstanding letters of credit. With the exception of some small principal payments of our term loans under our Credit Facility, representing less than 1% of the outstanding balance each year through 2013, the term loans under our Credit Facility mature in 2014 and our Notes are not due until 2015.

	As of December 31, 2009 ($ in millions)
Senior secured credit facility	
Term loans	$ 6,043.8
Notes	2,784.3
Other	83.0
Total debt	$ 8,911.1
Community Health Systems, Inc. stockholders equity	$ 1,950.6

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

	Year Ended December 31,				
	2005	**2006**	**2007**	**2008**	**2009**
Ratio of earnings to fixed charges(1)	3.79 x	3.37 x	1.22 x	1.47 x	1.59 x

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

As of December 31, 2009, our approximately $5.4 billion notional amount of interest rate swap agreements represented approximately 89% of our variable rate debt. On a prospective basis, a 1% change in interest rates on the remaining unhedged variable rate debt existing as of December 31, 2009, would result in interest expense fluctuating

approximately $6.9 million per year.

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

- incur, assume or guarantee additional indebtedness;
- issue redeemable stock and preferred stock;
- repurchase capital stock;
- make restricted payments, including paying dividends and making investments;
- redeem debt that is junior in right of payment to the notes;
- create liens;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- enter into agreements that restrict dividends from subsidiaries;
- merge, consolidate, sell or otherwise dispose of substantial portions of our assets;
- enter into transactions with affiliates; and
- guarantee certain obligations.

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

The counterparty to the interest rate swap agreements exposes us to credit risk in the event of non-performance. However, at December 31, 2009, we do not anticipate non-performance by the counterparty due to the net settlement feature of the agreements and our liability position with respect to the majority of our counterparties.

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

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

- it may limit our ability to obtain additional debt or equity financing for working capital, capital expenditures, debt service requirements, acquisitions and general corporate or other purposes;
- a substantial portion of our cash flows from operations will be dedicated to the payment of principal and interest on our indebtedness and will not be available for other purposes, including our operations, capital expenditures, and future business opportunities;
- the debt service requirements of our indebtedness could make it more difficult for us to satisfy our financial obligations;
- some of our borrowings, including borrowings under our Credit Facility, are at variable rates of interest, exposing us to the risk of increased interest rates;
- it may limit our ability to adjust to changing market conditions and place us at a competitive disadvantage compared to our competitors that have less debt; and

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

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

We may be able to incur substantial additional indebtedness in the future. The terms of the indenture governing the Notes do not fully prohibit us from doing so. For example, under the indenture for the Notes, we may incur up to approximately $7.8 billion pursuant to a credit facility or a qualified receivables transaction, less certain amounts repaid with the proceeds of asset dispositions. Our Credit Facility provides for commitments of up to approximately $7.1 billion in the aggregate. Our Credit Facility also gives us the ability to provide for one or more additional tranches of term loans in aggregate principal amount of up to $600 million without the consent of the existing lenders if specified criteria are satisfied. If new debt is added to our current debt levels, the related risks that we now face could intensify.

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

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

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

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

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

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

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

Some states require prior approval for the construction or acquisition of healthcare facilities and for the expansion of healthcare facilities and services. In giving approval, these states consider the need for additional or expanded healthcare facilities or services. In some states in which we operate, we are required to obtain CONs, for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and some other matters. Other states may adopt similar legislation. We may not be able to obtain the required CONs or other prior approvals for additional or expanded facilities in the future. In addition, at the time we acquire a hospital, we may agree to replace or expand the facility we are acquiring. If we are not able to obtain required prior approvals, we would not be able to acquire additional hospitals and expand the breadth of services we offer.

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

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

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

The hospital industry is highly competitive. In addition to the competition we face for acquisitions and physicians, we must also compete with other hospitals and healthcare providers for patients. The competition among hospitals and other healthcare providers for patients has intensified in recent years. Our hospitals are located in non-urban service areas. In approximately 65% of our markets, we are the sole provider of general healthcare services. In most of our other markets, the primary competitor is a not-for-profit hospital. These not-for-profit hospitals generally differ in each jurisdiction. However, our hospitals face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in our primary service areas may travel to these other hospitals for a variety of reasons. These reasons include physician referrals or the need for services we do not offer. Patients who seek services from these other hospitals may subsequently shift their preferences to those hospitals for the services we provide.

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

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

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

We have a five-year participation agreement with a GPO. This agreement extends to January 2011, with automatic renewal terms of one year, unless either party terminates by giving notice of non-renewal. GPOs attempt to obtain favorable pricing on medical supplies with manufacturers and vendors who sometimes negotiate exclusive supply arrangements in exchange for the discounts they give. To the extent these exclusive supply arrangements are challenged or deemed unenforceable, we could incur higher costs for our medical supplies obtained through HealthTrust. These higher costs could cause our operating results to decline.

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

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

At December 31, 2009, we had approximately $4.2 billion of goodwill recorded on our books. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. If the carrying value of our goodwill is impaired, we may incur a material non-cash charge to earnings.

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Risks related to our industry

We are subject to uncertainties regarding healthcare reform.

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

The American Recovery and Reinvestment Act of 2009 has been signed into law providing for a temporary increase in the federal matching assistance percentage (FMAP), a temporary increase in federal Medicaid DSH allotments, subsidization of health insurance premiums (COBRA) for up to nine months, and grants and loans for infrastructure and incentive payments for providers who adopt and use health information technology. The 2010 Department of Defense Appropriations Bill signed into law expands the subsidization of health insurance premiums (COBRA) to 15 months and extends the eligibility period for individuals losing their jobs through February 28, 2010. Additionally, the Obama administration has stated as a top priority its desire to reform the U.S. healthcare system with the goal of reducing the costs of healthcare and reducing the current number of uninsured and underinsured Americans. Several proposals have been considered, including cost controls on hospitals and insurance industry reforms. Currently, separate bills have been passed in both the U.S. House of Representatives and the U.S. Senate and debate in Congress is continuing in an attempt to draft a final piece of legislation. The costs of implementing the American Recovery and Reinvestment Act of 2009 and these other proposals being considered could be financed, in part, by reductions in payments to healthcare providers under Medicare, Medicaid, and other government programs. In addition, federal funding for existing programs may not be approved in the future.

The current administration and Congress have now debated healthcare reform for over one year and, at this time, we cannot predict the outcome of this debate. A reduction in uninsured patients may reduce our expense from uncollectible accounts receivable; however, legislative proposals to achieve this reduction in uninsured patients may result in lower reimbursement from other payor sources and/or a migration of patients from private payor sources to lower paying government payor sources. Furthermore, we cannot predict the course of any other future legislation, changes the current administration may seek to implement regarding healthcare or interpretations by the current administration of existing governmental healthcare programs and the related effect that any legislative or interpretive change may have on us.

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

In 2009, 36.9% of our net operating revenues came from the Medicare and Medicaid programs. Federal healthcare expenditures continue to increase and state governments continue to face budget shortfalls as a result of the current economic downturn and accelerating Medicaid enrollment. As a result, federal and state governments have made, and continue to make, significant changes in the Medicare and Medicaid programs. Some of these changes have decreased, or could decrease, the amount of money we receive for our services relating to these programs.

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

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

The healthcare industry is required to comply with many laws and regulations at the federal, state, and local government levels. These laws and regulations require that hospitals meet various requirements, including those relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, compliance with building codes, environmental protection and privacy. These laws include the Health Insurance Portability and Accountability Act of 1996 and a section of the Social Security Act, known as the anti-kickback statute. If we fail to comply with applicable laws and regulations, including fraud and abuse laws,

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we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in the Medicare, Medicaid, and other federal and state healthcare programs.

In addition, there are heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment. The ongoing investigations of certain healthcare providers relate to various referral, inpatient status cost reporting and billing practices, laboratory and home care services, and physician ownership and joint ventures involving hospitals. For example, the Department of Justice has alleged that we and three of our New Mexico hospitals have caused the state of New Mexico to submit improper claims for federal funds in violation of the Civil False Claims Act. For a further discussion of this matter, see Legal Proceedings in Item 3 of this Report.

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

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

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

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

In recent years, physicians, hospitals, and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability, or related legal theories. Even in states that have imposed caps on damages, litigants are seeking recoveries under new theories of liability that might not be subject to the caps on damages. Many of these actions involve large claims and significant defense costs. To protect us from the cost of these claims, we maintain professional malpractice liability insurance and general liability insurance coverage in excess of those amounts for which we are self-insured. This insurance coverage is in amounts that we believe to be sufficient for our operations. However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. Our expense related to malpractice and other professional liability claims, including the cost of excess insurance, decreased in 2007 by 0.1%, decreased in 2008 by 0.2% and increased in 2009 by 0.2% as a percentage of net operating revenues. If these costs rise rapidly, our profitability could decline. For a further discussion of our insurance coverage, see our discussion of professional liability claims in Management s Discussion and Analysis of Financial Condition and Results of Operations in Item 7 of this Report.

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

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

Currently, the global economies, and in particular the United States, are experiencing a period of economic uncertainty and the related financial markets are experiencing a high degree of volatility. This current financial turmoil is adversely affecting the banking system and financial markets and resulting in a tightening in the credit

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markets, a low level of liquidity in many financial markets and extreme volatility in fixed income, credit, currency and equity markets. This uncertainty poses a risk as it could potentially lead to higher levels of uninsured patients, result in higher levels of patients covered by lower paying government programs and/or result in fiscal uncertainties at both government payors and private insurers.

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

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

- general economic and business conditions, both nationally and in the regions in which we operate;
- legislative proposals for healthcare reform and universal access to healthcare coverage;
- risks associated with our substantial indebtedness, leverage and debt service obligations;
- demographic changes;
- changes in, or the failure to comply with, governmental regulations;
- potential adverse impact of known and unknown government investigations, audits and Federal and State False Claims Act litigation;
- our ability, where appropriate, to enter into and maintain managed care provider arrangements and the terms of these arrangements;
- changes in, or the failure to comply with, managed care provider contracts could result in disputes and changes in reimbursement that could be applied retroactively;
- changes in inpatient or outpatient Medicare and Medicaid payment levels;
- increases in the amount and risk of collectability of patient accounts receivable;
- increases in wages as a result of inflation or competition for highly technical positions and rising supply costs due to market pressure from pharmaceutical companies and new product releases;
- liabilities and other claims asserted against us, including self-insured malpractice claims;
- competition;
- our ability to attract and retain, without significant employment costs, qualified personnel, key management, physicians, nurses and other healthcare workers;
- trends toward treatment of patients in less acute or specialty healthcare settings, including ambulatory surgery centers or specialty hospitals;
- changes in medical or other technology;
- changes in U.S. GAAP;
- the availability and terms of capital to fund additional acquisitions or replacement facilities;

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

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

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

timeliness of reimbursement payments received under government programs.

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

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

None

Item 2. ***Properties***

Corporate Headquarters

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

Hospitals

Our hospitals are general care hospitals offering a wide range of inpatient and outpatient medical services. These services generally include internal medicine, surgery, cardiology, oncology, orthopedics, OB/GYN, diagnostic and emergency room, laboratory, radiology, respiratory therapy, physical therapy, and rehabilitation services. In addition, some of our hospitals provide skilled nursing and home care services based on individual community needs.

For each of our hospitals owned or leased as of December 31, 2009, the following table shows its location, the date of its acquisition or lease inception and the number of licensed beds:

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Alabama				
LV Stabler Memorial Hospital	Greenville	72	October, 1994	Owned
South Baldwin Regional Medical Center	Foley	112	June, 2000	Leased
Cherokee Medical Center	Centre	60	April, 2006	Owned
Dekalb Regional Medical Center	Fort Payne	134	April, 2006	Owned
Trinity Medical Center	Birmingham	560	July, 2007	Owned
Flowers Hospital	Dothan	235	July, 2007	Owned
Medical Center Enterprise	Enterprise	131	July, 2007	Owned
Gadsden Regional Medical Center	Gadsden	346	July, 2007	Owned
Crestwood Medical Center	Huntsville	150	July, 2007	Owned
Alaska				
Mat-Su Regional Medical Center	Palmer	74	July, 2007	Owned
Arizona				
Payson Regional Medical Center	Payson	44	August, 1997	Leased
Western Arizona Regional Medical Center	Bullhead City	139	July, 2000	Owned
Northwest Medical Center	Tucson	300	July, 2007	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Northwest Medical Center Oro Valley	Oro Valley	144	July, 2007	Owned
Arkansas				
Harris Hospital	Newport	133	October, 1994	Owned
Helena Regional Medical Center	Helena	155	March, 2002	Leased
Forrest City Medical Center	Forrest City	118	March, 2006	Leased
Northwest Medical Center Bentonville	Bentonville	128	July, 2007	Owned
Northwest Medical Center Springdale	Springdale	222	July, 2007	Owned
Willow Creek Women s Hospital (2)	Johnson	64	July, 2007	Owned
Siloam Springs Memorial Hospital	Siloam Springs	73	February, 2009	Owned
Medical Center of South Arkansas	El Dorado	166	April, 2009	Leased
California				
Barstow Community Hospital	Barstow	56	January, 1993	Leased
Fallbrook Hospital	Fallbrook	47	November, 1998	Operated (3)
Watsonville Community Hospital	Watsonville	106	September, 1998	Owned
Florida				
Lake Wales Medical Center	Lake Wales	160	December, 2002	Owned
North Okaloosa Medical Center	Crestview	110	March, 1996	Owned
Georgia				
Fannin Regional Hospital	Blue Ridge	50	January, 1986	Owned
Trinity Hospital of Augusta	Augusta	231	July, 2007	Owned
Illinois				
Crossroads Community Hospital	Mt. Vernon	57	October, 1994	Owned
Gateway Regional Medical Center	Granite City	382	January, 2002	Owned
Heartland Regional Medical Center	Marion	92	October, 1996	Owned
Red Bud Regional Hospital	Red Bud	31	September, 2001	Owned
Galesburg Cottage Hospital	Galesburg	173	July, 2004	Owned
Vista Medical Center East/West	Waukegan	407	July, 2006	Owned
Union County Hospital	Anna	25	November, 2006	Leased
Indiana				
Porter Hospital	Valparaiso	301	May, 2007	Owned
Bluffton Regional Medical Center	Bluffton	79	July, 2007	Owned
Dupont Hospital	Fort Wayne	131	July, 2007	Owned
Lutheran Hospital	Fort Wayne	432	July, 2007	Owned
St. Joseph s Hospital	Fort Wayne	191	July, 2007	Owned
Dukes Memorial Hospital	Peru	25	July, 2007	Owned
Kosciusko Community Hospital	Warsaw	72	July, 2007	Owned
Lutheran Musculoskeletal Center(4)	Fort Wayne	39	July, 2007	Owned
Kentucky				

Parkway Regional Hospital	Fulton	70	May, 1992	Owned
Three Rivers Medical Center	Louisa	90	May, 1993	Owned
Kentucky River Medical Center	Jackson	55	August, 1995	Leased

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Louisiana				
Byrd Regional Hospital	Leesville	60	October, 1994	Owned
Northern Louisiana Medical Center	Ruston	159	April, 2007	Owned
Women & Children s Hospital	Lake Charles	88	July, 2007	Owned
Mississippi				
Wesley Medical Center	Hattiesburg	211	July, 2007	Owned
River Region Health System	Vicksburg	341	July, 2007	Owned
Missouri				
Moberly Regional Medical Center	Moberly	103	November, 1993	Owned
Northeast Regional Medical Center	Kirksville	115	December, 2000	Leased
Nevada				
Mesa View Regional Hospital	Mesquite	25	July, 2007	Owned
New Jersey				
Memorial Hospital of Salem County	Salem	140	September, 2002	Owned
New Mexico				
Mimbres Memorial Hospital	Deming	49	March, 1996	Owned
Eastern New Mexico Medical Center	Roswell	162	April, 1998	Owned
Alta Vista Regional Hospital	Las Vegas	54	April, 2000	Owned
Carlsbad Medical Center	Carlsbad	112	July, 2007	Owned
Lea Regional Medical Center	Hobbs	201	July, 2007	Owned
Mountain View Regional Medical Center	Las Cruces	168	July, 2007	Owned
North Carolina				
Martin General Hospital	Williamston	49	November, 1998	Leased
Ohio				
Affinity Medical Center	Massillon	166	July, 2007	Owned
Oklahoma				
Ponca City Medical Center	Ponca City	140	May, 2006	Owned
Claremore Regional Hospital	Claremore	81	July, 2007	Owned
Deaconess Hospital	Oklahoma City	313	July, 2007	Owned
SouthCrest Hospital	Tulsa	180	July, 2007	Owned
Woodward Regional Hospital	Woodward	87	July, 2007	Leased
Oregon				
McKenzie-Willamette Medical Center	Springfield	114	July, 2007	Owned
Pennsylvania				
Berwick Hospital	Berwick	101	March, 1999	Owned

Brandywine Hospital	Coatesville	179	June, 2001	Owned
Jennersville Regional Hospital	West Grove	59	October, 2001	Owned
Easton Hospital	Easton	254	October, 2001	Owned
Lock Haven Hospital	Lock Haven	49	August, 2002	Owned
Pottstown Memorial Medical Center	Pottstown	215	July, 2003	Owned
Phoenixville Hospital	Phoenixville	138	August, 2004	Owned
Chestnut Hill Hospital	Philadelphia	164	February, 2005	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Sunbury Community Hospital	Sunbury	92	October, 2005	Owned
Wilkes-Barre General Hospital	Wilkes-Barre	553	April, 2009	Owned
South Carolina				
Marlboro Park Hospital	Bennettsville	102	August, 1996	Leased
Chesterfield General Hospital	Cheraw	59	August, 1996	Leased
Springs Memorial Hospital	Lancaster	231	November, 1994	Owned
Carolinas Hospital System Florence	Florence	420	July, 2007	Owned
Mary Black Memorial Hospital	Spartanburg	209	July, 2007	Owned
Tennessee				
Lakeway Regional Hospital	Morristown	135	May, 1993	Owned
Regional Hospital of Jackson	Jackson	154	January, 2003	Owned
Dyersburg Regional Medical Center	Dyersburg	225	January, 2003	Owned
Haywood Park Community Hospital	Brownsville	62	January, 2003	Owned
Henderson County Community Hospital	Lexington	45	January, 2003	Owned
McKenzie Regional Hospital	McKenzie	45	January, 2003	Owned
McNairy Regional Hospital	Selmer	45	January, 2003	Owned
Volunteer Community Hospital	Martin	100	January, 2003	Owned
Heritage Medical Center	Shelbyville	60	July, 2005	Owned
Sky Ridge Medical Center	Cleveland	351	October, 2005	Owned
Gateway Medical Center	Clarksville	270	July, 2007	Owned
Texas				
Big Bend Regional Medical Center	Alpine	25	October, 1999	Owned
Cleveland Regional Medical Center	Cleveland	107	August, 1996	Leased
Scenic Mountain Medical Center	Big Spring	150	October, 1994	Owned
Hill Regional Hospital	Hillsboro	92	October, 1994	Owned
Lake Granbury Medical Center	Granbury	83	January, 1997	Leased
South Texas Regional Medical Center	Jourdanton	67	November, 2001	Owned
Laredo Medical Center	Laredo	326	October, 2003	Owned
Weatherford Regional Medical Center	Weatherford	99	November, 2006	Leased
Abilene Regional Medical Center	Abilene	231	July, 2007	Owned
Brownwood Regional Medical Center	Brownwood	194	July, 2007	Owned
College Station Medical Center	College Station	141	July, 2007	Owned
Navarro Regional Hospital	Corsicana	162	July, 2007	Owned
Longview Regional Medical Center	Longview	131	July, 2007	Owned
Woodland Heights Medical Center	Lufkin	149	July, 2007	Owned
San Angelo Community Medical Center	San Angelo	171	July, 2007	Owned
DeTar Healthcare System	Victoria	308	July, 2007	Owned
Cedar Park Regional Medical Center	Cedar Park	77	December, 2007	Owned
Utah				
Mountain West Medical Center	Tooele	35	October, 2000	Owned

Virginia				
Southern Virginia Regional Medical Center	Emporia	80	March, 1999	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Southampton Memorial Hospital	Franklin	105	March, 2000	Owned
Southside Regional Medical Center	Petersburg	300	August, 2003	Owned
Washington				
Deaconess Medical Center	Spokane	388	October, 2008	Owned
Valley Hospital and Medical Center	Spokane Valley	123	October, 2008	Owned
West Virginia				
Plateau Medical Center	Oak Hill	25	July, 2002	Owned
Greenbrier Valley Medical Center	Ronceverte	122	July, 2007	Owned
Wyoming				
Evanston Regional Hospital	Evanston	42	November, 1999	Owned
Total Licensed Beds at December 31, 2009		18,140		

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

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

(3) We operate this hospital under a lease-leaseback and operating agreement. We

recognize all operating statistics, revenues and expenses associated with this hospital in our consolidated financial statements.

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

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

The following table lists the hospitals owned by joint venture entities in which we do not have a consolidating ownership interest, along with our percentage ownership interest in the joint venture entity as of December 31, 2009. Information on licensed beds was provided by the majority owner and manager of each joint venture. A subsidiary of HCA is the majority owner of Macon Healthcare LLC and a subsidiary of Universal Health Systems Inc. is the majority owner of Summerlin Hospital Medical Center LLC and Valley Health System LLC.

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

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Item 3. ***Legal Proceedings***

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

Community Health Systems, Inc. Legal Proceedings

In May 1999, we were served with a complaint in U.S. ex rel. Bledsoe v. Community Health Systems, Inc., subsequently moved to the Middle District of Tennessee, Case No. 2-00-0083. This qui tam action sought treble damages and penalties under the False Claims Act against us. The relator has now dismissed this case.

In August 2004, we were served a complaint in Arleana Lawrence and Robert Hollins v. Lakeview Community Hospital and Community Health Systems, Inc. (now styled Arleana Lawrence and Lisa Nichols vs. Eufaula Community Hospital, Community Health Systems, Inc., South Baldwin Regional Medical Center and Community Health Systems Professional Services Corporation) in the Circuit Court of Barbour County, Alabama (Eufaula Division). This alleged class action was brought by the plaintiffs on behalf of themselves and as the representatives of similarly situated uninsured individuals who were treated at our Lakeview Hospital or any of our other Alabama hospitals. This case has now been dismissed.

On March 3, 2005, we were served with a complaint in Sheri Rix v. Heartland Regional Medical Center and Health Care Systems, Inc. in the Circuit Court of Williamson County, Illinois. This alleged class action was brought by the plaintiff on behalf of herself and as the representative of similarly situated uninsured individuals who were treated at our Heartland Regional Medical Center. This case has now been dismissed.

On February 10, 2006, we received a letter from the Civil Division of the Department of Justice requesting documents in an investigation it was conducting involving the Company. The inquiry related to the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients. These programs are referred to by different names, including intergovernmental payments, upper payment limit programs, and Medicaid disproportionate share hospital payments. The February 2006 letter focused on our hospitals in three states: Arkansas, New Mexico, and South Carolina. On August 31, 2006, we received a follow up letter from the Department of Justice requesting additional documents relating to the programs in New Mexico and the payments to the Company s three hospitals in that state. Through the beginning of 2009, we provided the Department of Justice with requested documents, met with them on numerous occasions, and otherwise cooperated in its investigation. During the course of the investigation, the Civil Division notified us that it believed that we and these three New Mexico hospitals caused the State of New Mexico to submit improper claims for federal funds, in violation of the Federal False Claims Act. At one point, the Civil Division calculated that the three hospitals received ineligible federal participation payments from August 2000 to June 2006 of approximately $27.5 million and said that if it proceeded to trial, it would seek treble damages plus an appropriate penalty for each of the violations of the Federal False Claims Act. This investigation has culminated in the federal government s intervention in a qui tam lawsuit styled U.S. ex rel. Baker vs. Community Health Systems, Inc., pending in the United States District Court for the District of New Mexico. The federal government filed its complaint in intervention on June 30, 2009. The relator filed a second amended complaint on July 1, 2009. Both of these complaints expand the time period during which alleged improper payments were made. We filed motions to dismiss all of the federal government s and the relator s claims on August 28, 2009. The federal government and the relator responded on October 16, 2009. We filed a reply to each response and are waiting on the court s rulings. We are vigorously defending this action.

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On June 12, 2008, two of our hospitals received letters from the U.S. Attorney s Office for the Western District of New York requesting documents in an investigation it was conducting into billing practices with respect to kyphoplasty procedures performed during the period January 1, 2002, through June 9, 2008. On September 16, 2008, one of our hospitals in South Carolina also received an inquiry. Kyphoplasty is a surgical spine procedure that returns a compromised vertebrae (either from trauma or osteoporotic disease process) to its previous height, reducing or eliminating severe pain. We have been informed that similar investigations have been initiated at unaffiliated facilities in Alabama, South Carolina, Indiana and other states. We believe that this investigation is related to a recent qui tam settlement between the same U.S. Attorney s office and the manufacturer and distributor of the Kyphon product, which is used in performing the kyphoplasty procedure. We are cooperating with the investigation by collecting and producing material responsive to the requests. At this stage, we do not have sufficient information to determine whether our hospitals have engaged in inappropriate billing for kyphoplasty procedures. We are continuing to evaluate and discuss this matter with the federal government.

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

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

Triad Hospitals, Inc. Legal Proceedings

Triad, and its subsidiary, Quorum Health Resources, Inc. are defendants in a qui tam case styled U.S. ex rel. Whitten vs. Quorum Health Resources, Inc. et al., which is pending in the Southern District of Georgia, Brunswick Division. Whitten, a long-term employee of a two hospital system in Brunswick and Camden, Georgia sued both his employer and Quorum Health Resources, Inc. and its predecessors, which had managed the facility from 1989 through September 2000; upon his termination of employment, Whitten signed a release and was paid $124,000. Whitten s original qui tam complaint was filed under seal in November 2002 and the case was unsealed in 2004. Whitten alleges various charging and billing infractions, including charging for routine equipment supplies and services not separately billable, billing for observation services that were not medically necessary or for which there was no physician order, billing labor and delivery patients for durable medical equipment that was not separately billable, inappropriate preparation of patients histories and physicals, billing for cardiac rehabilitation services without physician supervision, performing outpatient dialysis without Medicare certification, and performing mental health services without the proper staff assignments. This case has been settled for $0.3 million and final settlement documents are being prepared.

In a case styled U.S. ex rel. Bartlett vs. Quorum Health Resources, Inc., et al., pending in the Western District of Pennsylvania, Johnstown Division, the relator alleges in his second amended complaint, filed in January 2006 (the first amended complaint having been dismissed), that Quorum conspired with an unaffiliated hospital to pay an illegal remuneration in violation of the anti-kickback statute and the Stark laws, thus causing false claims to be filed. A renewed motion to dismiss that was filed in March 2006 asserting that the second amended complaint did not cure the defects contained in the first amended complaint. In September 2006, the hospital and one of the other

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defendants affiliated with the hospital filed for protection under Chapter 11 of the federal bankruptcy code, which imposed an automatic stay on proceedings in the case. Relators entered into a settlement agreement with the hospital, subject to confirmation of the hospital s reorganization plan. The District Court conducted a status conference on January 30, 2009 and later convened another conference on March 30, 2009 and heard arguments on whether to proceed with a motion to dismiss, but did not make a ruling. We believe that this case is without merit and should the stay be lifted, will continue to vigorously defend it.

Item 4. ***Submission of Matters to a Vote of Security Holders***

No matters were submitted to a vote of security holders during the fourth quarter of the year ended December 31, 2009.

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PART II

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

We completed an initial public offering of our common stock on June 14, 2000. Our common stock began trading on June 9, 2000 and is listed on the New York Stock Exchange under the symbol CYH. At February 17, 2010, there were approximately 40 record holders of our common stock. The following table sets forth, for the periods indicated, the high and low sale prices per share of our common stock as reported by the New York Stock Exchange.

	High	Low
Year Ended December 31, 2008		
First Quarter	$ 36.85	$ 29.79
Second Quarter	40.05	32.40
Third Quarter	36.81	28.24
Fourth Quarter	28.38	10.47
Year Ended December 31, 2009		
First Quarter	$ 21.60	$ 12.96
Second Quarter	28.79	13.95
Third Quarter	35.50	24.42
Fourth Quarter	38.00	29.35

In 2009, we discovered that we had inadvertently not fully complied with the registration requirements of the Securities Act of 1933 with respect to our common stock purchased in the open market on behalf of participants in certain of our employee 401(K) plans. As a result, certain plan participants who purchased these shares were offered rescission rights with respect to their interests in our common stock held under these plans. Based upon a final review of the rescission offer that ended on February 11, 2010, 793 shares of common stock were repurchased by us and other payments were made for a total of approximately $40,000. We have fulfilled the registration requirements as of December 31, 2009 in order to become fully compliant on an ongoing basis.

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Corporate Performance Graph

The following graph sets forth the cumulative return of our common stock during the five year period ended December 31, 2009, as compared to the cumulative return of the Standard & Poor s 500 Stock Index (S&P 500) and the cumulative return of the Dow Jones Healthcare Index. The graph assumes an initial investment of $100 in our common stock and in each of the foregoing indices and the reinvestment of dividends where applicable.

We have not paid any cash dividends since our inception, and do not anticipate the payment of cash dividends in the foreseeable future. Our Credit Facility limits our ability to pay dividends and/or repurchase stock and the Notes to an amount not to exceed $400 million in the aggregate (but not in excess of $200 million unless we receive confirmation from Moody s and S&P that dividends or repurchases would not result in a downgrade, qualification or withdrawal of the then corporate credit rating). The indenture governing our Notes also limits our ability to pay dividends and/or repurchase stock. As of December 31, 2009, under the most restrictive test under these agreements, we have approximately $100 million remaining available with which to pay permitted dividends and/or make stock and Note repurchases.

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

The following table summarizes specified selected financial data and should be read in conjunction with our related Consolidated Financial Statements and accompanying Notes to Consolidated Financial Statements. The amounts shown below have been adjusted for discontinued operations. We have restated our 2008 and 2007 financial statements and statistical results to include a hospital and related businesses, which were previously reported as discontinued operations and are now included in continuing operations.

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

	Year Ended December 31,				
	2009	2008	2007[1]	2006	2005
	(in thousands, except share and per share data)				
Consolidated Statement of Operations Data					
Net operating revenues	$ 12,107,613	$ 10,919,095	$ 7,095,861	$ 4,180,136	$ 3,576,117
Income from operations	1,068,665	971,880	471,612	385,057	398,463
Income from continuing operations	304,805	233,727	67,431	177,695	188,370
Net income attributable to Community Health Systems, Inc.	243,150	218,304	30,289	168,263	167,544
Income from continuing operations attributable to Community Health Systems, Inc. common stockholders per share (2):					
Basic	$ 2.67	$ 2.13	$ 0.58	$ 1.87	$ 2.13
Diluted	$ 2.64	$ 2.11	$ 0.57	$ 1.85	$ 2.00
Discontinued operations attributable to Community Health Systems, Inc. common stockholders per share (2):					
Basic	$ 0.01	$ 0.21	$ (0.25)	$ (0.10)	$ (0.24)
Diluted	$ 0.01	$ 0.21	$ (0.25)	$ (0.10)	$ (0.21)
Net income attributable to Community Health Systems, Inc. common stockholders per share (2):					
Basic	$ 2.68	$ 2.34	$ 0.32	$ 1.77	$ 1.89
Diluted	$ 2.66	$ 2.32	$ 0.32	$ 1.75	$ 1.79
Weighted-average number of shares outstanding					
Basic	90,614,886	93,371,782	93,517,337	94,983,646	88,601,168

Diluted (3)	91,517,274	94,288,829	94,642,294	96,232,910	98,579,977(4)
Cash and cash equivalents	$ 344,541	$ 220,655	$ 133,574	$ 40,566	$ 104,108
Total assets	14,021,472	13,818,254	13,493,644	4,506,579	3,934,218
Long-term obligations	10,179,402	10,287,535	9,974,516	2,207,623	1,932,238
Community Health Systems, Inc. stockholders equity	1,950,635	1,611,029	1,687,293	1,718,697	1,564,577

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

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

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

(4) Included 8,385,031 shares related to the convertible notes under the if-converted method of determining weighted average shares outstanding.

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

You should read this discussion together with our consolidated financial statements and the accompanying notes to consolidated financial statements and Selected Financial Data included elsewhere in this Form 10-K.

Executive Overview

We are the largest publicly traded operator of hospitals in the United States in terms of number of facilities and net operating revenues. We provide healthcare services through these hospitals that we own and operate in non-urban and selected urban markets. We generate revenue primarily by providing a broad range of general hospital healthcare services to patients in the communities in which we are located. We currently have 122 general acute care hospitals. In addition, we own four home care agencies, located in markets where we do not operate a hospital and through our wholly-owned subsidiary, Quorum Health Resources, LLC (QHR), we provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. We are paid for our services by governmental agencies, private insurers and directly by the patients we serve.

Over the past three years, we have acquired 57 hospitals, including the 50 hospitals owned by Triad, which we acquired on July 25, 2007. Since our acquisition of Triad, we have focused most of our efforts toward integrating the former Triad hospitals and realigning our hospital portfolio and have taken a cautious approach in acquiring additional hospitals. Our realignment has resulted in the selling of eight hospitals acquired from Triad and seven hospitals which we owned prior to the acquisition of Triad. During 2008, we acquired a two hospital system located in Spokane, Washington and in 2009 we acquired hospitals located in Siloam Springs, Arkansas, El Dorado, Arkansas and Wilkes-Barre, Pennsylvania. In addition, on December 31, 2009, we entered into an agreement with a multi-specialty physician clinic that has 32 locations across the Inland Northwest region of the state of Washington. This agreement will allow our affiliated hospitals in Spokane, Washington to work with this clinic to offer a fully integrated healthcare delivery system in that market.

During 2009, we were challenged to navigate the uncertainties of the global and domestic economies. Unemployment continued to increase, credit markets remained tightened and there remained a low level of liquidity in the financial markets. Consequently, as previously disclosed, we are continuing to take a cautious approach to our acquisition strategy during this uncertain economic environment while focusing our efforts on increasing revenue and improving profitability and quality.

Despite the uncertainties in the economy, our net operating revenues for the year ended December 31, 2009 increased to approximately $12.1 billion, as compared to approximately $10.9 billion for the year ended December 31, 2008. Income from continuing operations, before noncontrolling interests, for the year ended December 31, 2009 increased 24.3% over the year ended December 31, 2008. This increase in income from continuing operations during the year ended December 31, 2009, as compared to the year ended December 31, 2008, is due primarily to an increase in surgeries performed at our hospitals, strong outpatient growth, the realization of synergies from our acquisition of Triad and the recognition of cost savings from our ability to effectively control costs. Our successful physician recruiting efforts have also been a key driver in the execution of our operating strategies. Total inpatient admissions for the year ended December 31, 2009 increased 3.6% compared to the year ended December 31, 2008 and adjusted admissions for the year ended December 31, 2009 increased 5.6% compared to the year ended December 31, 2008. This increase in inpatient and adjusted admissions was due primarily to our recent acquisitions.

Self-pay revenues represented approximately 11.2% of our net operating revenues in 2009 compared to 10.7% in 2008. The value of charity care services relative to total net operating revenues increased to 3.9% in 2009 from 3.5% in 2008. Uninsured and underinsured patients continue to be an industry-wide issue, and we anticipate this trend will continue into the foreseeable future. Legislative reform impacting the healthcare industry remains a priority of the current presidential administration and various proposals continue to be strongly debated in Congress. Given the current level of uncertainty of what may result from these reform proposals, it is not possible, at this time, to accurately predict what impact any final legislation would have on us.

During the three months ended June 30, 2009, we decided to retain a hospital and related businesses previously classified as held for sale. Results of operations for all periods presented have been restated to include this retained

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hospital and related businesses, which previously were reported as discontinued operations. The consolidated balance sheets for each of the periods presented have been restated to present the assets and liabilities previously reported as held for sale in the applicable financial statement line items.

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

Acquisitions and Dispositions

On December 31, 2009, we completed a transaction providing $54.2 million of financing to Rockwood Clinic, P.S., a multi-specialty clinic with 32 locations across the Inland Northwest region of Eastern Washington State and Western Idaho. This transaction was accounted for as a purchase business combination as required by U.S. GAAP.

Effective June 1, 2009, we acquired from Akron General Medical Center the remaining 20% noncontrolling interest in Massillon Community Health System, LLC not then owned by us. This entity indirectly owns and operates Affinity Medical Center of Massillon, Ohio. The purchase price for this noncontrolling interest was $1.1 million in cash. Affinity Medical Center is now wholly-owned by us.

Effective April 30, 2009, we acquired Wyoming Valley Health Care System in Wilkes-Barre, Pennsylvania. This health care system includes Wilkes-Barre General Hospital, a 392-bed, full-service acute care hospital located in Wilkes-Barre, Pennsylvania, and First Hospital Wyoming Valley, a behavioral health facility located in Kingston, Pennsylvania, as well as other outpatient and ancillary services. The total consideration for fixed assets and working capital of Wyoming Valley Health Care System was approximately $179.1 million, of which $153.7 million was paid in cash, net of $14.2 million of cash in acquired bank accounts, and approximately $25.4 million was assumed in liabilities. This acquisition transaction was accounted for using the purchase method of accounting. This preliminary allocation of the purchase price has been determined by us based upon available information and the allocation is subject to the settlement of the amounts related to purchased working capital. Adjustments to the purchase price allocation are not expected to be material.

Effective April 1, 2009, we acquired from Share Foundation the remaining 50% equity interest in MCSA L.L.C., an entity in which we previously had a 50% unconsolidated noncontrolling interest. We provided MCSA L.L.C. certain management services. This acquisition resulted in us owning a 100% equity interest in that entity. MCSA L.L.C. owns and operates Medical Center of South Arkansas (166 licensed beds) in El Dorado, Arkansas. The purchase price was $26.0 million in cash. As of the acquisition date, we had a liability to MCSA L.L.C. of $14.1 million, as a result of a cash management agreement previously entered into with the hospital. Upon completion of the acquisition, this liability was eliminated in consolidation.

Effective February 1, 2009, we completed the acquisition of Siloam Springs Memorial Hospital (74 licensed beds), located in Siloam Springs, Arkansas, from the City of Siloam Springs. The total consideration for this hospital consisted of approximately $0.1 million paid in cash for working capital and approximately $1.0 million of assumed liabilities. In connection with this acquisition, we entered into a lease agreement for the existing hospital and agreed to build a replacement facility at this location, with construction required to commence by February 2011 and be completed by February 2013. As security for this obligation, we deposited $1.6 million into an escrow account at closing and agreed to deposit an additional $1.6 million by February 1, 2010, which we deposited in January 2010. If the construction of the replacement facility is not completed within the agreed time frame, the escrow balance will be remitted to the City of Siloam Springs. If the construction of the replacement facility is completed within the agreed time frame, the escrow balance will be returned to us.

Effective March 31, 2009, through our subsidiaries Triad-Denton Hospital LLC and Triad-Denton Hospital LP, we completed the settlement of pending litigation, which resulted in the sale of our ownership interest in a partnership, which owned and operated Presbyterian Hospital of Denton (255 licensed beds) in Denton, Texas, to

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Texas Health Resources for $103.0 million in cash. Also as part of the settlement, our subsidiaries transferred certain hospital related assets to Texas Health Resources.

Sources of Revenue

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

	Year Ended December 31,		
	2009	**2008**	**2007**
Medicare	27.1%	27.5%	29.0%
Medicaid	9.8%	9.1%	10.3%
Managed care and other third party payors	51.9%	52.7%	50.7%
Self pay	11.2%	10.7%	10.0%
Total	100.0%	100.0%	100.0%

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-based reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net income by an insignificant amount in each of the years ended December 31, 2009, 2008 and 2007. In the future, we expect the percentage of revenues received from the Medicare program to increase due to the general aging of the population.

The payment rates under the Medicare program for inpatient acute services are based on a prospective payment system, depending upon the diagnosis of a patient s condition. These rates are indexed for inflation annually, although the increases have historically been less than actual inflation. Reductions in the rate of increase in Medicare reimbursement may cause our net operating revenue growth to decline.

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

Results of Operations

Our hospitals offer a variety of services involving a broad range of inpatient and outpatient medical and surgical services. These include orthopedics, cardiology, occupational medicine, diagnostic services, emergency services, rehabilitation treatment, home care and skilled nursing. The strongest demand for hospital services generally occurs during January through April and the weakest demand for these services occurs during the summer months. Accordingly, eliminating the effect of new acquisitions, our net operating revenues and earnings are historically highest during the first quarter and lowest during the third quarter.

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

	Year Ended December 31,		
	2009	2008	2007
	(Expressed as a percentage of net operating revenues)		
Consolidated (a)			
Net operating revenues	100.0%	100.0%	100.0%
Operating expenses (b)	(86.5)	(86.5)	(89.0)
Depreciation and amortization	(4.7)	(4.6)	(4.4)
Income from operations	8.8	8.9	6.6
Interest expense, net	(5.4)	(6.0)	(5.1)
Gain (loss) from early extinguishment of debt (c)			(0.4)
Equity in earnings of unconsolidated affiliates	0.3	0.4	0.4
Income from continuing operations before income taxes	3.7	3.3	1.5
Provision for income taxes	(1.2)	(1.2)	(0.6)
Income from continuing operations	2.5	2.1	0.9
Income (loss) from discontinued operations, net of tax		0.2	(0.3)
Net income	2.5	2.3	0.6
Less: Net income attributable to noncontrolling interests	(0.5)	(0.3)	(0.2)
Net income attributable to Community Health Systems, Inc.	2.0%	2.0%	0.4%

	Year Ended December 31,	
	2009	**2008**
	(Expressed in percentages)	
Percentage increase from same period prior year(a):		
Net operating revenues	10.9%	53.9%
Admissions	3.6	45.0
Adjusted admissions(d)	5.6	42.8
Average length of stay		
Net income attributable to Community Health Systems, Inc. (e)	11.4	620.7
Same-store percentage increase (decrease) from same period prior year(a)(f):		
Net operating revenues	5.9%	6.4%
Admissions	(1.5)	1.8
Adjusted admissions(d)	0.7	2.1

(a) We have restated our 2008 and 2007 financial statements and

statistical results to include a hospital and related businesses, which were previously reported as discontinued operations and are now included in continuing operations.

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

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

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

(e) Includes income or loss from discontinued operations.

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

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

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

On a consolidated basis, inpatient admissions increased by 3.6% and adjusted admissions increased by 5.6%. On a same-store basis, inpatient admissions decreased by 1.5% during the year ended December 31, 2009. This decrease in

inpatient admissions was due primarily to the strong flu and respiratory season during the year ended December 31, 2008, which did not recur during 2009, the 2008 period having one additional day because it was a leap year, and the impact of closing certain less profitable services.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, remained consistent at 86.5% for 2008 and 2009. Salaries and benefits, as a percentage of net operating revenues, remained consistent at 40.0% for 2008 and 2009. Provision for bad debts, as a percentage of net revenues, increased from 11.2% in 2008 to 12.1% in 2009. This increase in the provision for bad debts primarily represents an increase in self-pay revenues over the comparable period of 2008 due to increased charges and the impact of current economic conditions on individuals ability to pay. Supplies, as a percentage of net operating revenues, decreased from 14.0% in 2008 to 13.9% in 2009. Rent and other operating expenses, as a percentage of net operating revenues, decreased from 21.3% in 2008 to 20.5% in 2009. This decrease in rent and other operating expenses is due primarily to reductions in contract labor. As part of our acquisition of Triad, we acquired noncontrolling ownership interests in several hospitals. Our percentage of ownership interests in these joint ventures provided earnings of 0.3% in 2009 compared to 0.4% in 2008 of net operating revenues. Prior to the Triad acquisition, we did not have any material noncontrolling investments in joint ventures.

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

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

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

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

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

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

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

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

Year Ended December 31, 2008 Compared to Year Ended December 31, 2007

Net operating revenues increased by 53.9% to approximately $10.9 billion in 2008, from approximately $7.1 billion in 2007. Growth from hospitals owned throughout both periods, including the former Triad Hospitals, contributed approximately $3.6 billion of that increase and $219 million was contributed by hospitals acquired in 2008 and 2007. On a same-store basis, net operating revenues increased 6.4%. The increase from hospitals that we owned throughout both periods was attributable to volume increases, rate increases, payor mix and the acuity level of services provided.

On a consolidated basis inpatient admissions increased by 45.0% and adjusted admissions increased by 42.8%. On a same-store basis, inpatient admissions increased by 1.8% during the year ended December 31, 2008. This increase in inpatient admissions was due primarily to the strong flu and respiratory season during the year ended December 31, 2008 and the 2008 period having one additional day because it was a leap year.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, decreased from 89.0% in 2007 to 86.5% in 2008. Salaries and benefits, as a percentage of net operating revenues, decreased from 40.8% in 2007 to 40.0% in 2008, primarily as a result of efficiency improvements realized at hospitals owned throughout both periods. These improvements were partially offset by an increase in the number of employed physicians as well as an increase in salaries for certain IT employees who were previously treated as leased employees with related expense previously being included in other operating expense. Provision for bad debts, as a percentage of net revenues, decreased from 12.5% in 2007 to 11.2% in 2008, due primarily to $70.1 million of additional bad debt expense recorded as a change in estimate to increase the allowance for doubtful accounts in 2007. Supplies, as a percentage of net operating revenues, increased from 13.3% in 2007 to 14.0% in 2008, primarily the result of the acquisition of the former Triad hospitals whose higher acuity of services resulted in higher supply costs than our other hospitals taken collectively, offsetting improvements from greater utilization of and improved pricing under our purchasing program. Rent and other operating expenses, as a percentage of net operating revenues, decreased from 22.4% in 2007 to 21.3% in 2008, primarily as a result of the hospitals acquired from Triad having lower rent expense as a percentage of net operating revenues. As part of our acquisition of Triad, we acquired noncontrolling ownership interests in several hospitals. Our percentage of ownership interests in these joint ventures provided earnings of 0.4% of net operating revenues during both of the years ended December 31, 2008 and 2007. Prior to the Triad acquisition, we did not have any material noncontrolling investments in joint ventures.

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Depreciation and amortization increased from 4.4% of net operating revenues in 2007 to 4.6% of net operating revenues in 2008.

Interest expense, net, increased by $290.4 million from $362.1 million in 2007, to $652.5 million in 2008. The primary reason for the increase in interest expense is the increase in our average outstanding debt during the year ended December 31, 2008, as compared to the year ended December 31, 2007, resulting in an additional $309.7 million of interest expense. Interest expense for the year ended December 31, 2008 includes a full year of interest expense from borrowings under our Credit Facility and the issuance of Notes in connection with the acquisition of Triad in 2007. Since 2008 was a leap year, one additional day in the year resulted in $1.8 million of the increase in interest expense. These increases were offset by a decrease in interest expense of $3.1 million as a result of more of the interest during the year ended December 31, 2008 being capitalized interest due to more major construction projects during that period, compared to the year ended December 31, 2007. In addition, a decrease in our effective interest rate during the year ended December 31, 2008, as compared to the year ended December 31, 2007, resulted in a decrease in interest expense of $18.0 million.

The net results of the above mentioned changes resulted in income from continuing operations before income taxes increasing $251.7 million from $107.3 million in 2007 to $359.0 million for 2008.

Provision for income taxes from continuing operations increased from $39.9 million in 2007 to $125.3 million in 2008 due to the increase in income from continuing operations before income taxes. Our effective tax rates were 34.9% and 37.2% for the years ended December 31, 2008 and 2007, respectively. The decrease in our effective tax rate is primarily a result of a decrease in our effective state tax rate.

Income from continuing operations as a percentage of net operating revenues increased from 0.9% in 2007 to 2.1% in 2008. Net income as a percentage of net operating revenues increased from 0.6% in 2007 to 2.3% in 2008. The increase in income from continuing operations as a percentage of net operating revenues is primarily due to the impact of the net decrease in expenses, as a percentage of net revenues, discussed above.

Net income attributable to noncontrolling interests as a percentage of net operating revenues was 0.3% for the year ended December 31, 2008, compared to 0.2% for the year ended December 31, 2007.

Net income attributable to Community Health Systems, Inc. was $218.3 million in 2008 compared to $30.3 million for 2007, an increase of 620.7%. The increase in net income attributable to Community Health Systems, Inc. is reflective of the impact of the net decrease in expenses discussed above, including the effect of the change in estimate that increased bad debt expense in 2007.

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Liquidity and Capital Resources

2009 Compared to 2008

Net cash provided by operating activities increased $19.8 million, from approximately $1.1 billion for the year ended December 31, 2008 to approximately $1.1 billion for the year ended December 31, 2009. The increase is due to an increase in cash flows from net income of $53.6 million and an increase in non-cash depreciation and amortization expense of $59.8 million and an increase in cash generated from accounts receivable of $108.0 million, a result of the reduction in days revenue outstanding. These increases in cash flows outstanding were offset by decreases in cash flows from accounts payable, accrued liabilities and income taxes of $33.8 million, primarily as a result of the timing of payments and an increase in cash paid for income taxes during 2009. Also, other non-cash expenses decreased $83.5 million, primarily attributable to a reduction in deferred income tax expense resulting in a reduction to cash flows, and cash flows generated from the change in all other assets and liabilities decreased $84.3 million.

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

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

In 2008, we used $90.0 million for the repurchase of 4,786,609 shares of our outstanding common stock on the open market. We believed this to be a prudent use of cash as a result of the severely depressed stock price. Our Credit Facility limits our ability to pay dividends and/or repurchase stock and the Notes to an amount not to exceed $400 million in the aggregate (but not in excess of $200 million unless we receive confirmation from Moody s and S&P that dividends or repurchases would not result in a downgrade, qualification or withdrawal of the then corporate credit rating). The indenture governing our Notes also limits our ability to pay dividends and/or repurchase stock in an amount higher than permitted by our Credit Facility. As of December 31, 2009, under the most restrictive test under these agreements, we have approximately $100 million remaining available with which to pay permitted dividends and/or make stock and Note repurchases.

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

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As described in Notes 6, 9 and 15 of the Notes to Consolidated Financial Statements, at December 31, 2009, we had certain cash obligations, which are due as follows *(in thousands)*:

	Total	2010	2011-2013	2014-2015	2016 and thereafter
Long Term Debt	$ 6,089,862	$ 59,994	$ 145,222	$ 5,862,736	$ 21,910
Senior Notes	2,784,331			2,784,331	
Interest on Bank Facility and Notes(1)	2,057,292	400,140	1,194,089	463,063	
Capital Leases, including interest	49,777	8,399	12,436	5,653	23,289
Total Long-Term Debt	10,981,262	468,533	1,351,747	9,115,783	45,199
Operating Leases	927,106	176,755	375,135	155,362	219,854
Replacement Facilities and Other Capital Commitments (2)	594,440	127,936	379,326	50,000	37,178
Open Purchase Orders (3)	201,078	201,078			
Liability for uncertain tax positions, including interest and penalties	8,869	7,194	1,675		
Total	$ 12,712,755	$ 981,496	$ 2,107,883	$ 9,321,145	$ 302,231

(1) Estimate of interest payments assumes the interest rates at December 31, 2009 remain constant during the period presented for the Credit Facility, which is variable rate debt. The interest rate used to calculate interest payments for the Credit Facility was LIBOR as of December 31, 2009 plus the spread. The Notes are fixed at an interest rate of 8.875% per annum.

(2) Pursuant to purchase agreements in effect as of December 31, 2009 and where CON approval has been obtained, we have commitments to build the following replacement facilities and the following capital commitments. As required by an amendment to our lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location by November 2012. As part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana by April 2011. As part of an acquisition in 2009, we agreed to build a replacement hospital in Siloam Springs, Arkansas by February 2013. Construction costs, including equipment costs,

for these three replacement facilities are currently estimated to be approximately $310.0 million of which approximately $12.6 million has been incurred to date. In addition, under other purchase agreements, we have committed to spend approximately $468.5 million for costs such as capital improvements, equipment, selected leases and physician recruiting. These commitments are required to be fulfilled generally over a five to seven year period after acquisition. Through December 31, 2009, we have incurred approximately $171.4 million related to these commitments.

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

At December 31, 2009, we had issued letters of credit primarily in support of potential insurance related claims and specified outstanding bonds of approximately $90.0 million.

Our debt as a percentage of total capitalization decreased from 85% at December 31, 2008 to 82% for December 31, 2009.

2008 Compared to 2007

Net cash provided by operating activities increased $368.1 million from $688.4 million for the year ended December 31, 2007 to approximately $1.1 billion for the year ended December 31, 2008. This increase is due to an increase in cash flow from net income of $208.0 million, increases in cash flows from other assets of $37.4 million and a net increase in non-cash expenses of $306.1 million, of which $174.1 million was related to depreciation and $199.8 million related to deferred income taxes. These cash flow increases were offset by decreases in cash flows from supplies, prepaid expenses and other current assets of $2.7 million, accounts receivable of $178.3 million and accounts payable, accrued liabilities and income taxes of $2.4 million. The decrease in income taxes was primarily a result of a prior year prepaid tax position which was used to offset taxes owed during the current year.

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The use of cash in investing activities decreased approximately $6.8 billion from approximately $7.5 billion in 2007 to $665.5 million in 2008, primarily as a result of the Triad acquisition occurring in 2007. The purchase of property and equipment in 2008 increased $169.4 million from $522.8 million in 2007 to $692.2 million in 2008. This increase reflects the increased number of hospitals owned by us after the acquisition of Triad.

In 2008, our net cash provided by financing activities decreased approximately $7.2 billion from approximately $6.9 billion in 2007 to a net cash used in financing activities of $304.0 million in 2008, primarily due to borrowings under our Credit Facility and issuance of Notes in connection with the acquisition of Triad in 2007. During the fourth quarter of 2008, $100 million of delayed draw term loans had been drawn by us.

Capital Expenditures

Cash expenditures for purchases of facilities were $263.8 million in 2009, $161.9 million in 2008 and approximately $7.0 billion in 2007. Our expenditures in 2009 included $182.2 million for the purchase of two hospitals and the remaining equity in a hospital in which we previously had a noncontrolling interest, $72.3 million for the purchase of clinics, surgery centers and physician practices, and $9.3 million for the settlement of acquired working capital. Our expenditures in 2008 included $149.1 million for the purchase of two hospitals and $12.8 million for the purchase of physician practices and a home care agency. Our expenditures in 2007 included approximately $6.9 billion for the purchase of Triad, $133.7 million for the purchase of two additional hospitals, $3.4 million for the purchase of physician practices, $7.7 million for equipment to integrate acquired hospitals and $8.5 million for the settlement of acquired working capital.

Excluding the cost to construct replacement hospitals, our cash expenditures for routine capital for 2009 totaled $572.1 million compared to $569.4 million in 2008, and $344.1 million in 2007. These capital expenditures related primarily to the purchase of additional equipment, minor renovations and information systems infrastructure. Costs to construct replacement hospitals totaled $4.8 million in 2009, $122.8 million in 2008 and $178.7 million in 2007. The costs to construct replacement hospitals for year ended December 31, 2009 represent planning costs for future construction projects since there were no replacement hospitals under construction at year ended December 31, 2009. In 2008, we completed construction of and opened three replacement hospitals, accounting for the higher costs incurred during the year ended December 31, 2008.

Pursuant to hospital purchase agreements in effect as of December 31, 2009, as part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana by April 2011 and as part of an acquisition in 2009, we agreed to build a replacement hospital in Siloam Springs, Arkansas by February 2013. Also as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement facility at Barstow Community Hospital in Barstow, California. Estimated construction costs, including equipment costs, are approximately $310.0 million for these three replacement facilities. We expect total capital expenditures of approximately $650 to $750 million in 2010 (which includes amounts which are required to be expended pursuant to the terms of hospital purchase agreements), including approximately $595 to $690 million for renovation and equipment cost and approximately $55 to $60 million for construction and equipment cost of the replacement hospitals.

Capital Resources

Net working capital was approximately $1.2 billion at December 31, 2009 compared to approximately $1.1 billion at December 31, 2008, an increase of $121 million. This increase was primarily attributable to an increase in working capital attributable to the acquisition of Siloam Springs Memorial Hospital, Wyoming Valley Health Care System and a controlling equity interest in MCSA L.L.C., the entity that owns and operates the Medical Center of South Arkansas in El Dorado, Arkansas, and an increase in cash as a result of cash flows from operations.

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In connection with the consummation of the Triad acquisition in July 2007, we obtained approximately $7.2 billion of senior secured financing under a Credit Facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The Credit Facility consists of an approximately $6.1 billion funded term loan facility with a maturity of seven years, a $300 million delayed draw term loan facility (reduced by us from $400 million) with a maturity of seven years and a $750 million revolving credit facility with a maturity of six years. During the fourth quarter of 2008, $100 million of the delayed draw term loan had been drawn down by us reducing the delayed draw term loan availability to $200 million at December 31, 2008. In January 2009, we drew down the remaining $200 million of the delayed draw term loan. The revolving credit facility also includes a subfacility for letters of credit and a swingline subfacility. The Credit Facility requires quarterly amortization payments of each term loan facility equal to 0.25% of the outstanding amount of the term loans, if any, with the outstanding principal balance payable on July 25, 2014.

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

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

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

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

Facility and pay an annual administrative agent fee.

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

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

As of December 31, 2009, the availability for additional borrowings under our Credit Facility was approximately $750 million pursuant to the revolving credit facility, of which $90.0 million was set aside for outstanding letters of credit. We believe that these funds, along with internally generated cash and continued access to the bank credit and capital markets, will be sufficient to finance future acquisitions, capital expenditures and working capital requirements through the next 12 months and into the foreseeable future.

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

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

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

As of December 31, 2009, we are currently a party to the following interest rate swap agreements to limit the effect of changes in interest rates on approximately 89% of our variable rate debt. On each of these swaps, we received a variable rate of interest based on the three-month London Inter-Bank Offer Rate (LIBOR), in exchange for the payment by us of a fixed rate of interest. We currently pay, on a quarterly basis, a margin above LIBOR of 225 basis points for revolving credit and term loans under the Credit Facility.

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Swap #	Notional Amount (in 000 s)	Fixed Interest Rate	Termination Date	Fair Value (in 000 s)
1	$ 200,000	2.8800%	September 17, 2010	$ (3,655)
2	100,000	4.9360%	October 4, 2010	(3,630)
3	100,000	4.7090%	January 24, 2011	(4,343)
4	300,000	5.1140%	August 8, 2011	(19,843)
5	100,000	4.7185%	August 19, 2011	(6,033)
6	100,000	4.7040%	August 19, 2011	(6,009)
7	100,000	4.6250%	August 19, 2011	(5,874)
8	200,000	4.9300%	August 30, 2011	(12,961)
9	200,000	3.0920%	September 18, 2011	(6,709)
10	100,000	3.0230%	October 23, 2011	(3,323)
11	200,000	4.4815%	October 26, 2011	(12,151)
12	200,000	4.0840%	December 3, 2011	(11,135)
13	100,000	3.8470%	January 4, 2012	(5,193)
14	100,000	3.8510%	January 4, 2012	(5,201)
15	100,000	3.8560%	January 4, 2012	(5,211)
16	200,000	3.7260%	January 8, 2012	(9,914)
17	200,000	3.5065%	January 16, 2012	(9,034)
18	250,000	5.0185%	May 30, 2012	(20,877)
19	150,000	5.0250%	May 30, 2012	(12,638)
20	200,000	4.6845%	September 11, 2012	(15,831)
21	100,000	3.3520%	October 23, 2012	(4,299)
22	125,000	4.3745%	November 23, 2012	(8,981)
23	75,000	4.3800%	November 23, 2012	(5,439)

24	150,000	5.0200%	November 30, 2012	(13,694)
25	200,000	2.2420%	February 28, 2013	1,219(1)
26	100,000	5.0230%	May 30, 2013	(9,575)
27	300,000	5.2420%	August 6, 2013	(31,724)
28	100,000	5.0380%	August 30, 2013	(9,887)
29	50,000	3.5860%	October 23, 2013	(2,282)
30	50,000	3.5240%	October 23, 2013	(2,165)
31	100,000	5.0500%	November 30, 2013	(10,077)
32	200,000	2.0700%	December 19, 2013	3,000
33	100,000	5.2310%	July 25, 2014	(11,157)
34	100,000	5.2310%	July 25, 2014	(11,157)
35	200,000	5.1600%	July 25, 2014	(21,694)
36	75,000	5.0405%	July 25, 2014	(7,744)
37	125,000	5.0215%	July 25, 2014	(12,803)
38	100,000	2.6210%	July 25, 2014	259
39	100,000	3.1100%	July 25, 2014	89(2)
40	100,000	3.2580%	July 25, 2014	153(3)
41	100,000	3.0050%	November 30, 2016	2,458

(1) This interest rate swap becomes effective September 17, 2010, concurrent with the termination of swap #1.

(2) This interest rate swap becomes effective October 4, 2010, concurrent with the termination of swap #2.

(3) This interest rate swap becomes

effective January 24, 2011, concurrent with the termination of swap #3.

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

incur, assume or guarantee additional indebtedness;

issue redeemable stock and preferred stock;

repurchase capital stock;

make restricted payments, including paying dividends and making investments;

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

create liens without securing the notes;

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

enter into agreements that restrict dividends from subsidiaries;

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

enter into transactions with affiliates; and

guarantee certain obligations.

In addition, our Credit Facility contains restrictive covenants and requires us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet these restricted covenants and financial ratios and tests can be affected by events beyond our control, and we cannot assure you that we will meet those tests. A breach of any of these covenants could result in a default under our Credit Facility and/or the Notes. Upon the occurrence of an event of default under our Credit Facility or the Notes, all amounts outstanding under our Credit Facility and the Notes may become due and payable and all commitments under the Credit Facility to extend further credit may be terminated.

We believe that internally generated cash flows, availability for additional borrowings under our Credit Facility of $750 million (consisting of a $750 million revolving credit facility) and our ability to add up to $300 million of borrowing capacity from receivable transactions (including securitizations) and continued access to the bank credit and capital markets will be sufficient to finance acquisitions, capital expenditures and working capital requirements through the next 12 months. We believe these same sources of cash flows, borrowings under our Credit Facility as well as access to bank credit and capital markets will be available to us beyond the next 12 months and into the foreseeable future. On December 22, 2008, we filed a universal automatic shelf registration statement on Form S-3ASR that will permit us, from time to time, in one or more public offerings, to offer debt securities, common stock, preferred stock, warrants, depositary shares, or any combination of such securities. The shelf registration statement will also permit our subsidiary, CHS, to offer debt securities that would be guaranteed by us, from time to time in one or more public offerings. The terms of any such future offerings would be established at the time of the offering.

Off-balance sheet arrangements

Our consolidated operating results for the years ended December 31, 2009 and 2008, included $286.6 million and $282.0 million, respectively, of net operating revenues and $18.1 million and $18.4 million, respectively, of income from continuing operations, generated from seven hospitals operated by us under operating lease arrangements. In accordance with accounting principles generally accepted in the United States of America, or U.S. GAAP, the respective assets and the future lease obligations under these arrangements are not recorded in our consolidated balance sheet. Lease payments under these arrangements are included in rent expense and totaled approximately $16.5 million and $16.7 million for the years ended December 31, 2009 and 2008, respectively. The current terms of

these operating leases expire between June 2012 and December 2020, not including lease extension options. If we allow these leases to expire, we would no longer generate revenues nor incur expenses from these hospitals.

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

As described more fully in Note 15 of the Notes to Consolidated Financial Statements, at December 31, 2009, we have certain cash obligations for replacement facilities and other construction commitments of $594.4 million and open purchase orders for $201.1 million.

Noncontrolling Interests

We have sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. As of December 31, 2009, we have hospitals in 23 of the markets we serve, with noncontrolling physician ownership interests ranging from less than 1% to 40%, including one hospital that also had a non-profit entity as a partner. In addition, we own three other hospitals with noncontrolling interests owned by non-profit entities. During 2009, we sold noncontrolling interests in six of our hospitals, including additional noncontrolling interests in hospitals with existing physician ownership, for total consideration of $19.3 million. During 2008, we sold noncontrolling interests in seven of our hospitals, including additional noncontrolling interests in hospitals with existing physician ownership, for total consideration of $82.1 million. Effective June 1, 2009, we acquired from Akron General Medical Center the remaining 20% noncontrolling interest in Massillon Community Health System, LLC not then owned by us. This entity indirectly owns and operates Affinity Medical Center of Massillon, Ohio. The purchase price for this noncontrolling interest was $1.1 million in cash. Affinity Medical Center is now wholly-owned by us. Effective June 30, 2008, we acquired the remaining 35% noncontrolling interest in Affinity Health Systems, LLC which indirectly owns and operates Trinity Medical Center (560 licensed beds) in Birmingham, Alabama, from Baptist Health Systems, Inc. of Birmingham, Alabama (Baptist), giving us 100% ownership of that facility. The purchase price to acquire this interest was $51.5 million in cash and the cancellation of a promissory note issued by Baptist to Affinity Health Systems, LLC in the original principal amount of $32.8 million. Effective November 14, 2008, we acquired from Willamette Community Health Solutions all of its noncontrolling interest in MWMC Holdings, LLC, which indirectly owns a controlling interest in and operates McKenzie-Willamette Medical Center of Springfield, Oregon. This acquisition resulted from a put right held by Willamette Community Health Solutions in connection with the 2003 transaction establishing the joint venture. The purchase price for this noncontrolling interest was $22.7 million in cash. Physicians affiliated with Oregon Health Resources, Inc. continue to own a noncontrolling interest in the hospital. Redeemable noncontrolling interests in equity of consolidated subsidiaries was $368.9 million and $348.8 million as of December 31, 2009 and 2008, respectively, and noncontrolling interests in equity of consolidated subsidiaries was $64.8 million and $61.5 million as of December 31, 2009 and 2008, respectively, and the amount of net income attributable to noncontrolling interests was $63.2 million, $34.4 million and $14.4 million for the years ended December 31, 2009, 2008 and 2007, respectively.

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Reimbursement, Legislative and Regulatory Changes

Legislative and regulatory action has resulted in continuing change in the Medicare and Medicaid reimbursement programs which will continue to limit payment increases under these programs and in some cases implement payment decreases. Within the statutory framework of the Medicare and Medicaid programs, there are substantial areas subject to administrative rulings, interpretations, and discretion which may further affect payments made under those programs, and the federal and state governments might, in the future, reduce the funds available under those programs or require more stringent utilization and quality reviews of hospital facilities. Additionally, there may be a continued rise in managed care programs and future restructuring of the financing and delivery of healthcare in the United States. These events could cause our future financial results to decline.

Inflation

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

Critical Accounting Policies

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

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

Third Party Reimbursement

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. Contractual allowances are automatically calculated and recorded through our internally developed automated contractual allowance system. Within the automated system, actual Medicare DRG data and payors historical paid claims data are utilized to calculate the contractual allowances. This data is automatically updated on a monthly basis. All hospital contractual allowance calculations are subjected to monthly review by management to ensure reasonableness and accuracy. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. The process of estimating contractual allowances requires us to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification and historical paid claims data. Due to the complexities involved in these estimates, actual payments we receive could be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs and managed care contracts differed by 1% from our estimated reimbursement percentage, net income for the year ended December 31, 2009 would have changed by approximately $24.6 million, and net accounts receivable would have changed by $40.0 million. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement

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estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net income by an insignificant amount in each of the years ended December 31, 2009, 2008 and 2007.

Allowance for Doubtful Accounts

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

We estimate the allowance for doubtful accounts by reserving a percentage of all self-pay accounts receivable without regard to aging category, based on collection history, adjusted for expected recoveries and, if present, anticipated changes in trends. For all other non self-pay payor categories we reserve 100% of all accounts aging over 365 days from the date of discharge. The percentage used to reserve for all self-pay accounts is based on our collection history. We believe that we collect substantially all of our third-party insured receivables which include receivables from governmental agencies. During the quarter ended December 31, 2007, in conjunction with our ongoing process of monitoring the net realizable value of our accounts receivable, as well as integrating the methodologies, data and assumptions used by the former Triad management, we performed various analyses, including updating a review of historical cash collections. As a result of these analyses, we noted deterioration in certain key cash collection indicators.

The primary key cash collection indicator that experienced deterioration during the fourth quarter of 2007 was cash receipts as a percentage of net revenue less bad debts. This percentage decreased to the lowest percentage experienced by us since the quarter ended September 30, 2006. Further analysis indicated the primary causes of this deterioration were a continuing increase in the volume of indigent non-resident aliens, an increase in the number of patients qualifying for charity care and a greater than expected impact of the removal of participants from TennCare (Tennessee s state provided Medicaid program) which increased the number of uninsured patients with limited financial means receiving care at our eight Tennessee hospitals. During the fourth quarter of 2007, due to the deteriorating cash collections and the desire to standardize processes with those of the former Triad hospitals, we undertook a detailed programming effort to develop data around the deteriorating classes of accounts receivable needed to update our historical cash collections percentages as well as enable us to estimate how much of certain self-pay categories ultimately convert to Medicaid, charity and indigent programs. Triad s processes for establishing contractual allowances and allowances for bad debts related to accounts classified as Medicaid pending, charity pending and indigent non-resident alien included inputs and assumptions based on the historical percentage of these accounts which ultimately qualified for specific government programs or for write-off as charity care.

We used these new inputs and assumptions regarding Medicaid pending, charity pending, and indigent non-resident alien in conjunction with the new data developed in the fourth quarter of 2007 as described above to evaluate the realizability of accounts receivable and to revise our estimate of contractual allowances for estimated amounts of self-pay accounts receivable that will ultimately qualify as charity care, or that will ultimately qualify for Medicaid, indigent care or other specific governmental reimbursement, resulting in an increase to our contractual reserves of $96.3 million as of December 31, 2007. Previous estimates of uncollectible amounts for such receivables were included in our bad debt reserves for each period.

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Furthermore, in updating the historical collection statistics of all our hospitals, we also took into account a detailed study of the historical collection information for the hospitals acquired from Triad. The updated collection statistics of the hospitals acquired from Triad also showed subsequent deterioration in cash collections similar to those experienced by the other hospitals that we own. Therefore, we also standardized the processes for calculating the allowance for doubtful accounts of the hospitals acquired from Triad to that of our other hospitals which, along with the allowance percentages determined from the new collection data, resulted in the recording of an additional $70.1 million of allowance for bad debts as of December 31, 2007.

The resulting impact of the above, net of taxes, for the year ended December 31, 2007 was a decrease to income from continuing operations of $105.4 million. We believe this lower collectability was primarily the result of an increase in the number of patients qualifying for charity care, reduced enrollment in certain state Medicaid programs and an increase in the number of indigent non-resident aliens. Collections are impacted by the economic ability of patients to pay and the effectiveness of our collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect our collection of accounts receivable. The process of estimating the allowance for doubtful accounts requires us to estimate the collectability of self-pay accounts receivable, which is primarily based on our collection history, adjusted for expected recoveries and, if available, anticipated changes in collection trends. Significant change in payor mix, business office operations, economic conditions, trends in federal and state governmental healthcare coverage or other third party payors could affect our estimates of accounts receivable collectability. If the actual collection percentage differed by 1% from our estimated collection percentage as a result of a change in expected recoveries, net income for the year ended December 31, 2009 would have changed by $14.4 million, and net accounts receivable would have changed by $23.5 million. We also continually review our overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net revenue less provision for bad debts, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, and the impact of recent acquisitions and dispositions.

Our policy is to write-off gross accounts receivable if the balance is under $10.00 or when such amounts are placed with outside collection agencies. We believe this policy accurately reflects our ongoing collection efforts and is consistent with industry practices. We had approximately $1.5 billion at December 31, 2009 and 2008, being pursued by various outside collection agencies. We expect to collect less than 3%, net of estimated collection fees, of the amounts being pursued by outside collection agencies. As these amounts have been written-off, they are not included in our gross accounts receivable or our allowance for doubtful accounts. Collections on amounts previously written-off are recognized as a reduction to bad debt expense when received. However, we take into consideration estimated collections of these future amounts written-off in evaluating the reasonableness of our allowance for doubtful accounts.

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

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

Days revenue outstanding was 48 days at December 31, 2009 and 53 days at December 31, 2008. Our target range for days revenue outstanding is from 46 to 56 days.

Total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) was approximately $6.1 billion as of December 31, 2009 and approximately $5.5 billion as of December 31, 2008.

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

	As of December 31,	
	2009	**2008**
Insured receivables	62.4%	67.0%
Self-pay receivables (a)	37.6%	33.0%

Total	100.0%	100.0%

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(a) The increase in self-pay accounts receivable as a percentage of total gross accounts receivable is primarily the result of the former Triad hospitals utilizing our internal collection agency. This began for some hospitals in 2008 and others in 2009. Prior to utilizing our internal collection agency, such accounts were written off and sent to outside collection agencies.

For the hospital segment, the combined total of the allowance for doubtful accounts and related allowances for other self-pay discounts and contractuals, as a percentage of gross self-pay receivables, was approximately 82% at December 31, 2009 and 80% at December 31, 2008. If the receivables that have been written-off, but where collections are still being pursued by outside collection agencies, were included in both the allowances and gross self-pay receivables specified above, the percentage of combined allowances to total self-pay receivables would have been approximately 89% at December 31, 2009 and 2008.

Goodwill and Other Intangibles

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

Impairment or Disposal of Long-Lived Assets

Whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, we project the undiscounted cash flows expected to be generated by these assets. If the projections indicate

that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

Professional Liability Claims

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

The net present value of the projected payments was discounted using a weighted-average risk-free rate of 1.3%, 2.6% and 4.1% in 2009, 2008 and 2007, respectively. This liability is adjusted for new claims information in the period such information becomes known to us. Professional malpractice expense includes the losses resulting from professional liability claims and loss adjustment expense, as well as paid excess insurance premiums, and is presented within other operating expenses in the accompanying consolidated statements of income.

Our processes for obtaining and analyzing claims and incident data are standardized across all of our hospitals and have been consistent for many years. We monitor the outcomes of the medical care services that we provide and

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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 4 and 5 years, although the facts and circumstances of individual claims could result in the timing of such payments being different from this average. Since claims are paid promptly after settlement with the claimant is reached, settled claims represent less than 1.0% of the total liability at the end of any period.

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

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

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

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	Year Ended December 31,		
	2009	2008	2007
Accrual for professional liability claims, January 1	$ 350,579	$ 300,184	$ 104,161
Liability acquired through acquisition:			
Gross liability acquired			197,453
Discount of liability acquired			(26,309)
Discounted liability acquired			171,144
Expense (income) related to(1):			
Current accident year	136,424	110,010	73,039
Prior accident years	(6,702)	(15,826)	7,158
Expense (income) from discounting	11,515	11,499	(1,040)
Total incurred loss and loss expense	141,237	105,683	79,157
Paid claims and expenses related to:			
Current accident year	(1,387)	(688)	(701)
Prior accident years	(59,204)	(54,600)	(53,577)
Total paid claims and expenses	(60,591)	(55,288)	(54,278)
Accrual for professional liability claims, December 31	$ 431,225	$ 350,579	$ 300,184

(1) Total expense, including premiums for insured coverage, was $176.4 million in 2009, $136.6 million in 2008 and $99.7 million in 2007.

The increase in current accident year claims expense in each year from 2007 to 2009 is consistent with the increase in net operating revenues during these periods. Income/expense related to prior accident years reflects changes in estimates resulting from the filing of claims for prior year incidents, claim settlements, updates from litigation, and our ongoing investigation of open claims. Expense/income from discounting reflects the changes in the weighted-average risk-free interest rate used and timing of estimated payments for discounting in each year.

We are primarily self-insured for these claims; however, we obtain excess insurance that transfers the risk of loss to a third-party insurer for claims in excess of our self-insured retentions. Our excess insurance is underwritten on a claims-made basis. For claims reported prior to June 1, 2002, substantially all of our professional and general liability risks were subject to a $0.5 million per occurrence self-insured retention and for claims reported from June 1, 2002 through June 1, 2003, these self-insured retentions were $2.0 million per occurrence. Substantially all claims reported

after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 are self-insured up to $5 million per claim. Management on occasion has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals has been purchased through commercial insurance companies and generally covers us for liabilities in excess of the self-insured retentions. The excess coverage consists of multiple layers of insurance, the sum of which totals up to $95 million per occurrence and in the aggregate for claims reported on or after June 1, 2003 and up to $145 million per occurrence and in the aggregate for claims incurred and reported after January 1, 2008. For certain policy years, if the first aggregate layer of excess coverage becomes fully utilized, then the self-insured retention could increase to $10 million per claim for any subsequent claims in that policy year until our total aggregate coverage is met.

Effective January 1, 2008, the former Triad hospitals are insured on a claims-made basis as described above and through commercial insurance companies as described above for substantially all claims occurring on or after January 1, 2002 and reported on or after January 1, 2008. Substantially all losses for the former Triad hospitals in periods prior to May 1999 were insured through a wholly-owned insurance subsidiary of HCA,

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Triad s owner prior to that time, and excess loss policies maintained by HCA. HCA has agreed to indemnify the former Triad hospitals in respect of claims covered by such insurance policies arising prior to May 1999. After May 1999 through December 31, 2006, the former Triad hospitals obtained insurance coverage on a claims incurred basis from HCA s wholly-owned insurance subsidiary with excess coverage obtained from other carriers that is subject to certain deductibles. Effective for claims incurred after December 31, 2006, Triad began insuring its claims from $1 million to $5 million through its wholly-owned captive insurance company, replacing the coverage provided by HCA. Substantially all claims occurring during 2007 were self-insured up to $10 million per claim.

Income Taxes

We must make estimates in recording provision for income taxes, including determination of deferred tax assets and deferred tax liabilities and any valuation allowances that might be required against the deferred tax assets. We believe that future income will enable us to realize these deferred tax assets, subject to the valuation allowance we have established. In 2009, we made adjustments to our deferred tax assets and liabilities resulting from a revaluation of these items and a decrease in our effective state tax rate that resulted in a net tax benefit of $3.0 million.

The total amount of unrecognized benefit that would impact the effective tax rate, if recognized, is approximately $9.4 million as of December 31, 2009. It is our policy to recognize interest and penalties accrued related to unrecognized benefits in our consolidated statements of income as income tax expense. Adjustments for purchase business combinations generally impact goodwill and do not affect net income. During the year ended December 31, 2009, we decreased liabilities by approximately $0.4 million and recorded $0.6 million in interest and penalties related to prior state income tax returns through our income tax provision from continuing operations, which are included in our liability for uncertain tax positions at December 31, 2009. A total of approximately $2.0 million of interest and penalties is included in the amount of liability for uncertain tax positions at December 31, 2009. During the year ended December 31, 2009, we released $0.6 million for income taxes and $0.2 million for accrued interest of our liability for uncertain tax positions, as a result of the expiration of the statute of limitations pertaining to tax positions taken in prior years relative to state tax positions.

We believe it is reasonably possible that approximately $6.4 million of our current unrecognized tax benefit may be recognized within the next twelve months as a result of a lapse of the statute of limitations and settlements with taxing authorities.

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

Prior to January 1, 2009, income attributable to noncontrolling interests was deducted from earnings before arriving at income from continuing operations. With the adoption of certain updates to the U.S. GAAP related to consolidations effective January 1, 2009, the income attributable to noncontrolling interests has been reclassified below net income and therefore is no longer deducted in arriving at income from continuing operations. However, the provision for income taxes does not change because those less than wholly-owned consolidated subsidiaries attribute their taxable income to their respective investors. Accordingly, we will not pay tax on the income attributable to the noncontrolling interests. As a result of separately reporting income that is taxed to others, our effective tax rate on continuing operations before income taxes, as reported on the face of the financial statements is 31.7%, 34.9% and 37.2% for the years ended December 31, 2009, 2008 and 2007, respectively. However, the actual effective tax rate that is attributable to our share of income from continuing operations before income taxes (income from continuing operations before income taxes, as presented on the face of the statement of income, less income from continuing operations attributable to noncontrolling interests of $62.9 million, $34.9 million and $13.4 million for the years ended December 31, 2009, 2008 and 2007, respectively) is 36.9%, 38.7% and 42.4% for the years ended December 31, 2009, 2008 and 2007, respectively.

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Recent Accounting Pronouncements

On January 1, 2010, we adopted the revisions to U.S. GAAP related to the accounting and consolidation requirements for variable interest entities. These revisions significantly change the criteria in determining the primary beneficiary of a variable interest entity, or VIE, from a more quantitative model to both a quantitative and qualitative evaluation of the enterprise that has (1) the power to direct the activities that most significantly affect the VIE s economic performance and (2) the obligation to absorb losses or the right to receive returns that could be potentially significant to the VIE. Additionally, this guidance requires ongoing reassessments of whether an enterprise is the primary beneficiary of a VIE and requires enhanced disclosures that will provide users of financial statements with more transparent information about an enterprise s involvement in a VIE. Given our limited amount of activity with entities for which these provisions would apply, the adoption of this standard is not expected to have a material effect on our consolidated results of operations or financial position, either upon adoption or into the foreseeable future.

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

We are exposed to interest rate changes, primarily as a result of our Credit Facility which bears interest based on floating rates. In order to manage the volatility relating to the market risk, we entered into interest rate swap agreements described under the heading Liquidity and Capital Resources. We do not anticipate any material changes in our primary market risk exposures in 2010. We utilize risk management procedures and controls in executing derivative financial instrument transactions. We do not execute transactions or hold derivative financial instruments for trading purposes. Derivative financial instruments related to interest rate sensitivity of debt obligations are used with the goal of mitigating a portion of the exposure when it is cost effective to do so.

A 1% change in interest rates on variable rate debt in excess of that amount covered by interest rate swaps would have resulted in interest expense fluctuating approximately $2.5 million in 2009, $13 million in 2008 and $14 million in 2007.

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

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

We have audited the accompanying consolidated balance sheets of Community Health Systems, Inc. and subsidiaries (the Company) as of December 31, 2009 and 2008, and the related consolidated statements of income, stockholders equity, and cash flows for each of the three years in the period ended December 31, 2009. These consolidated financial statements are the responsibility of the Company s management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Community Health Systems, Inc. and subsidiaries as of December 31, 2009 and 2008, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2009, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 3 to the consolidated financial statements, the Company adopted revisions to accounting principles generally accepted in the United States of America related to business combinations effective January 1, 2009.

As discussed in Note 1 to the consolidated financial statements, the Company adopted revisions to accounting principles generally accepted in the United States of America and changed its method of accounting and financial statement presentation for noncontrolling interests in equity of consolidated subsidiaries in 2009, 2008, and 2007.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company s internal control over financial reporting as of December 31, 2009, based on the criteria established in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 25, 2010 expressed an unqualified opinion on the Company s internal control over financial reporting.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 25, 2010

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2009	2008	2007
	(In thousands, except share and per share data)		
Net operating revenues	$ 12,107,613	$ 10,919,095	$ 7,095,861
Operating costs and expenses:			
Salaries and benefits	4,842,330	4,367,664	2,895,105
Provision for bad debts	1,460,307	1,218,612	886,985
Supplies	1,685,493	1,531,376	940,525
Other operating expenses	2,237,475	2,099,010	1,434,617
Rent	247,132	231,167	153,695
Depreciation and amortization	566,211	499,386	313,322
Total operating costs and expenses	11,038,948	9,947,215	6,624,249
Income from operations	1,068,665	971,880	471,612
Interest expense, net of interest income of $3,561, $7,057, and $8,181 in 2009, 2008, and 2007, respectively	648,964	652,468	362,065
(Gain) loss from early extinguishment of debt	(2,385)	(2,525)	27,388
Equity in earnings of unconsolidated affiliates	(36,521)	(42,063)	(25,132)
Impairment of long-lived and other assets	12,477	5,000	
Income from continuing operations before income taxes	446,130	359,000	107,291
Provision for income taxes	141,325	125,273	39,860
Income from continuing operations	304,805	233,727	67,431
Discontinued operations, net of taxes:			
Income (loss) from operations of hospitals sold and hospitals held for sale	1,977	9,427	(4,199)
(Loss) gain on sale of hospitals, net	(405)	9,580	(2,594)
Impairment of long-lived assets of hospitals held for sale			(15,947)
Income (loss) from discontinued operations	1,572	19,007	(22,740)
Net income	306,377	252,734	44,691
Less: Net income attributable to noncontrolling interests	63,227	34,430	14,402
Net income attributable to Community Health Systems, Inc.	$ 243,150	$ 218,304	$ 30,289
Income from continuing operations attributable to Community Health Systems, Inc. common stockholders per share (1):			
Basic	$ 2.67	$ 2.13	$ 0.58
Diluted	$ 2.64	$ 2.11	$ 0.57

Discontinued operations attributable to Community Health Systems, Inc. common stockholders per share (1):			
Basic	$ 0.01	$ 0.21	$ (0.25)
Diluted	$ 0.01	$ 0.21	$ (0.25)
Net income attributable to Community Health Systems, Inc. common stockholders per share (1):			
Basic	$ 2.68	$ 2.34	$ 0.32
Diluted	$ 2.66	$ 2.32	$ 0.32
Weighted-average number of shares outstanding:			
Basic	90,614,886	93,371,782	93,517,337
Diluted	91,517,274	94,288,829	94,642,294

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

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS

	December 31, 2009	2008
	(In thousands, except share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 344,541	$ 220,655
Patient accounts receivable, net of allowance for doubtful accounts of $1,417,188 and $1,111,131 at December 31, 2009 and December 31, 2008, respectively	1,617,903	1,625,470
Supplies	302,609	275,696
Prepaid income taxes	45,414	92,710
Deferred income taxes	80,714	91,875
Prepaid expenses and taxes	89,475	73,792
Other current assets (including assets of hospitals held for sale of $0 and $25,505 at December 31, 2009 and 2008, respectively)	194,339	224,852
Total current assets	2,674,995	2,605,050
Property and equipment:		
Land and improvements	537,307	510,292
Buildings and improvements	4,806,542	4,495,568
Equipment and fixtures	2,443,407	2,104,497
	7,787,256	7,110,357
Less accumulated depreciation and amortization	(1,655,010)	(1,215,952)
Property and equipment, net	6,132,246	5,894,405
Goodwill	4,157,927	4,166,091
Other assets, net of accumulated amortization of $197,880 and $158,532 in 2009 and 2008, respectively (including assets of hospitals held for sale of $0 and $145,799 at December 31, 2009 and 2008, respectively)	1,056,304	1,152,708
Total assets	$ 14,021,472	$ 13,818,254
LIABILITIES AND EQUITY		
Current liabilities:		
Current maturities of long-term debt	$ 66,470	$ 33,904
Accounts payable	428,565	532,595
Deferred income taxes	28,397	6,740
Accrued liabilities:		
Employee compensation	500,101	432,385

Interest	145,201	153,234
Other (including liabilities of hospitals held for sale of $0 and $67,190 at December 31, 2009 and 2008, respectively)	289,062	350,559
Total current liabilities	1,457,796	1,509,417
Long-term debt	8,844,638	8,938,185
Deferred income taxes	475,812	460,793
Other long-term liabilities	858,952	888,557
Total liabilities	11,637,198	11,796,952
Redeemable noncontrolling interests in equity of consolidated subsidiaries	368,857	348,816
Commitments and contingencies (Note 15)		
EQUITY		
Community Health Systems, Inc. stockholders equity		
Preferred stock, $.01 par value per share, 100,000,000 shares authorized; none issued		
Common stock, $.01 par value per share, 300,000,000 shares authorized; 94,013,537 shares issued and 93,037,988 shares outstanding at December 31, 2009 and 92,483,166 shares issued and 91,507,617 shares outstanding at December 31, 2008	940	925
Additional paid-in capital	1,158,359	1,136,108
Treasury stock, at cost, 975,549 shares at December 31, 2009 and December 31, 2008	(6,678)	(6,678)
Accumulated other comprehensive income (loss)	(221,385)	(295,575)
Retained earnings	1,019,399	776,249
Total Community Health Systems, Inc. stockholders equity	1,950,635	1,611,029
Noncontrolling interests in equity of consolidated subsidiaries	64,782	61,457
Total equity	2,015,417	1,672,486
Total liabilities and equity	$ 14,021,472	$ 13,818,254

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS EQUITY

	Redeemable Noncontrolling Interests	Community Health Systems, Inc. Stockholders								
		Common Stock		Additional Paid-in	Treasury Stock		Accumulated Other Comprehensive Income	Retained	Noncontrolling	
		Shares	Amount	Capital	Shares	Amount	(Loss)	Earnings	Interests	Total
						(In thousands, except share data)				
BALANCE, December 31, 2006 (as previously reported)	$	95,026,494	$ 950	$ 1,195,947	(975,549)	$ (6,678)	$ 5,798	$ 527,656	$	$ 1,723,673
January 1, 2007 adjustment to non-controlling interests from adoption of updates to U.S. GAAP	23,478			(4,976)					5,057	81
Balance, December 31, 2006 (as adjusted)	23,478	95,026,494	950	1,190,971	(975,549)	(6,678)	5,798	527,656	5,057	1,723,754
Comprehensive income (loss):										
Net income	16,243							30,289	(1,841)	28,448
Net change in fair value of interest rate swaps, net of tax benefit of $51,223							(91,063)			(91,063)
Net change in fair value of available for sale securities							237			237
Adjustment to pension							3,291			3,291

liability, net of tax of $496										
Total comprehensive income (loss)							(87,535)	30,289	(1,841)	(59,087)
Noncontrolling interests from acquisition of Triad	284,737								59,201	59,201
Net contributions (distributions) to noncontrolling interests	5,345								(1,308)	(1,308)
Purchase of subsidiary shares from noncontrolling interests	(1,339)								(18)	(18)
Sale of less than wholly-owned subsidiaries									(9,672)	(9,672)
Adjustment to redemption value of redeemable noncontrolling interests	18,535			(18,535)						(18,535)
Issuance of common stock in connection with the exercise of options		321,535	3	8,362						8,365
Tax benefit from exercise of options				(2,760)						(2,760)
Share-based compensation		1,263,056	13	38,759						38,772
BALANCE, December 31, 2007	346,999	96,611,085	966	1,216,797	(975,549)	(6,678)	(81,737)	557,945	51,419	1,738,712

Comprehensive income (loss):							
Net income	30,017				218,304	4,410	222,714
Net change in fair value of interest rate swaps, net of tax benefit of $112,915				(200,737)			(200,737)
Net change in fair value of available for sale securities				(2,613)			(2,613)
Adjustment to pension liability, net of tax of $7,262				(10,488)			(10,488)
Total comprehensive income (loss)				(213,838)	218,304	4,410	8,876
Contributions from noncontrolling interests, net of distributions	7,056					29,931	29,931
Purchase of subsidiary shares from noncontrolling interests	(73,581)					(22,497)	(22,497)
Sale of less than wholly-owned subsidiaries						(1,806)	(1,806)
Adjustment to redemption value of redeemable noncontrolling interests	38,325			(38,325)			(38,325)
Repurchases of common stock		(4,786,609)	(48)	(90,141)			(90,189)
Issuance of common stock in connection		281,831	3	1,803			1,806

with the exercise of options										
Cancellation of restricted stock for tax withholdings on vested shares		(310,806)	(3)	(5,455)						(5,458)
Tax benefit from exercise of options				(672)						(672)
Share-based compensation		687,665	7	52,101						52,108
BALANCE, December 31, 2008	348,816	92,483,166	925	1,136,108	(975,549)	(6,678)	(295,575)	776,249	61,457	1,672,486
Comprehensive income (loss):										
Net income	46,716							243,150	16,511	259,661
Net change in fair value of interest rate swaps, net of tax benefit of $42,876							76,225			76,225
Net change in fair value of available for sale securities							412			412
Adjustment to pension liability, net of tax of $3,262							(2,447)			(2,447)
Total comprehensive income (loss)							74,190	243,150	16,511	333,851
Distributions to noncontrolling interests, net of contributions	(27,072)								(13,582)	(13,582)
Purchase of subsidiary	(5,439)			3,106					396	3,502

shares from noncontrolling interests									
Sale of less than wholly-owned subsidiaries	(21,691)								
Adjustment to redemption value of redeemable noncontrolling interests	27,527			(27,527)					(27,527)
Issuance of common stock in connection with the exercise of options		680,898	7	12,760					12,767
Cancellation of restricted stock for tax withholdings on vested shares		(328,470)	(3)	(7,117)					(7,120)
Tax benefit from exercise of options				(3,472)					(3,472)
Share-based compensation		1,177,943	11	44,501					44,512
BALANCE, December 31, 2009	$ 368,857	94,013,537	$ 940	$ 1,158,359	(975,549)	$ (6,678)	$ (221,385)	$ 1,019,399	$ 64,782	$ 2,015,417

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
Cash flows from operating activities:			
Net income	$ 306,377	$ 252,734	$ 44,691
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	566,543	506,694	332,580
Deferred income taxes	34,268	159,870	(39,894)
Stock-based compensation expense	44,501	52,105	38,771
Loss (gain) on sale of hospitals and partnership interest, net	405	(17,687)	3,954
Income tax payable increase (excess tax benefit) relating to stock-based compensation	3,472	(1,278)	(1,216)
(Gain) loss on early extinguishment of debt	(2,385)	(2,525)	27,388
Impairment of long-lived and other assets	12,477	5,000	19,044
Other non-cash expenses, net	22,870	3,577	19,018
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	58,390	(49,578)	128,743
Supplies, prepaid expenses and other current assets	(34,535)	(34,397)	(31,734)
Accounts payable, accrued liabilities and income taxes	86,098	119,869	122,282
Other	(22,052)	62,197	24,811
Net cash provided by operating activities	1,076,429	1,056,581	688,438
Cash flows from investing activities:			
Acquisitions of facilities and other related equipment	(263,773)	(161,907)	(7,018,048)
Purchases of property and equipment	(576,888)	(692,233)	(522,785)
Proceeds from disposition of hospitals and other ancillary operations	89,514	365,636	109,996
Proceeds from sale of property and equipment	4,019	13,483	4,650
Increase in other non-operating assets	(120,054)	(190,450)	(72,671)
Net cash used in investing activities	(867,182)	(665,471)	(7,498,858)
Cash flows from financing activities:			
Proceeds from exercise of stock options	12,759	1,806	8,214
(Income tax payable increase) excess tax benefit relating to stock-based compensation	(3,472)	1,278	1,216
Deferred financing costs	(82)	(3,136)	(182,954)
Stock buy-back		(90,188)	
Proceeds from noncontrolling investors in joint ventures	29,838	14,329	2,351
Redemption of noncontrolling investments in joint ventures	(7,268)	(77,587)	(1,356)

Distributions to noncontrolling investors in joint ventures	(58,963)	(46,890)	(6,645)
Borrowings under credit agreement	200,000	131,277	9,221,627
Repayments of long-term indebtedness	(258,173)	(234,918)	(2,139,025)
Net cash (used in) provided by financing activities	(85,361)	(304,029)	6,903,428
Net change in cash and cash equivalents	123,886	87,081	93,008
Cash and cash equivalents at beginning of period	220,655	133,574	40,566
Cash and cash equivalents at end of period	$ 344,541	$ 220,655	$ 133,574

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Business and Summary of Significant Accounting Policies

Business. Community Health Systems, Inc. is a holding company and operates no business in its own name. On a consolidated basis, Community Health Systems, Inc. and its subsidiaries (collectively the Company) own, lease and operate acute care hospitals in non-urban and select urban markets. As of December 31, 2009, the Company owned or leased 122 hospitals, licensed for 18,140 beds in 29 states. Throughout these notes to the consolidated financial statements, Community Health Systems, Inc., (the Parent), and its consolidated subsidiaries are referred to on a collective basis as the Company. This drafting style is not meant to indicate that the publicly-traded Parent or any subsidiary of the Parent owns or operates any asset, business, or property. The hospitals, operations and businesses described in this filing are owned and operated, and management services provided, by distinct and indirect subsidiaries of Community Health Systems, Inc. References to the Company may include one or more of its subsidiaries.

As of December 31, 2009, Indiana and Texas represent the only areas of geographic concentration. Net operating revenues generated by the Company s hospitals in Indiana, as a percentage of consolidated net operating revenues, were 10.9% in 2009, 10.9% in 2008 and 7.8% in 2007. Net operating revenues generated by the Company s hospitals in Texas, as a percentage of consolidated net operating revenues, were 13.2% in 2009, 13.3% in 2008 and 12.5% in 2007. As a result of the Company s growth and expansion of services in other states, Pennsylvania no longer represents an area of geographic concentration, as it did at December 31, 2007.

Use of Estimates. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates under different assumptions or conditions.

Principles of Consolidation. The consolidated financial statements include the accounts of the Parent, its subsidiaries, all of which are controlled by the Parent through majority voting control, and variable interest entities for which the Company is the primary beneficiary. All significant intercompany accounts and transactions have been eliminated. Noncontrolling interests in less-than-wholly-owned consolidated subsidiaries of the Parent are presented as a component of total equity to distinguish between the interests of the Parent and the interests of the noncontrolling owners. Revenues, expenses and income from continuing operations from these subsidiaries are included in the consolidated amounts as presented on the consolidated statements of income, along with a net income measure that separately presents the amounts attributable to the controlling interests and the amounts attributable to the noncontrolling interests for each of the periods presented. Noncontrolling interests that are redeemable or may become redeemable at a fixed or determinable price at the option of the holder or upon the occurrence of an event outside of the control of the Company are presented in mezzanine equity on the consolidated balance sheets.

Cost of Revenue. The majority of the Company s operating expenses are cost of revenue items. Operating costs that could be classified as general and administrative by the Company would include the Company s corporate office costs at its Franklin, Tennessee offices and former offices in Brentwood, Tennessee and Plano, Texas, which were $157.9 million, $167.2 million and $133.4 million for the years ended December 31, 2009, 2008 and 2007, respectively. Included in these amounts is stock-based compensation of $44.5 million, $52.1 million and $38.8 million for the years ended December 31, 2009, 2008 and 2007, respectively.

Cash Equivalents. The Company considers highly liquid investments with original maturities of three months or less to be cash equivalents.

Supplies. Supplies, principally medical supplies, are stated at the lower of cost (first-in, first-out basis) or market.

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

Marketable Securities. The Company s marketable securities are classified as trading or available-for-sale. Available-for-sale securities are carried at fair value as determined by quoted market prices, with unrealized gains and losses reported as a separate component of stockholders equity. Trading securities are reported at fair value with unrealized gains and losses included in earnings. Interest and dividends on securities classified as available-for-sale or trading are included in net operating revenue and were not material in all periods presented. Accumulated other comprehensive income (loss) included an unrealized gain of $0.4 million at December 31, 2009 and an unrealized loss of $2.6 million at December 31, 2008, related to these available-for-sale securities.

Property and Equipment. Property and equipment are recorded at cost. Depreciation is recognized using the straight-line method over the estimated useful lives of the land and improvements (2 to 15 years; weighted average useful life is 14 years), buildings and improvements (5 to 40 years; weighted average useful life is 24 years) and equipment and fixtures (4 to 18 years; weighted average useful life is 8 years). Costs capitalized as construction in progress were $130.5 million and $196.4 million at December 31, 2009 and 2008, respectively. Expenditures for renovations and other significant improvements are capitalized; however, maintenance and repairs which do not improve or extend the useful lives of the respective assets are charged to operations as incurred. Interest capitalized related to construction in progress was $16.7 million, $22.1 million and $19.0 million for the years ended December 31, 2009, 2008 and 2007, respectively. Purchases of property and equipment accrued in accounts payable and not yet paid were $39.6 million and $31.6 million at December 31, 2009 and 2008, respectively.

The Company also leases certain facilities and equipment under capital 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.

Goodwill. Goodwill represents the excess cost over the fair value of net assets acquired. Goodwill arising from business combinations is not amortized. Goodwill is required to be evaluated for impairment at the same time every year and when an event occurs or circumstances change such that it is reasonably possible that an impairment may exist. The Company has selected September 30th as its annual testing date.

Other Assets. Other assets primarily consist of costs associated with the issuance of debt, which are included in interest expense over the life of the related debt using the effective interest method, and costs to recruit physicians to the Company s markets, which are deferred and amortized in amortization expense over the term of the respective physician recruitment contract, which is generally three years. Long-term assets held for sale at December 31, 2008 are also included in other assets.

Third-Party Reimbursement. Net patient service revenue is reported at the estimated net realizable amount from patients, third party-payors and others for services rendered. Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems, provisions of cost-reimbursement and other payment methods. Approximately 36.9% of net operating revenues for the year ended December 31, 2009, 36.6% of net operating revenues for the year ended December 31, 2008 and 39.3% of net operating revenues for the year ended December 31, 2007, are related to services rendered to patients covered by the Medicare and Medicaid programs. Revenues from Medicare outlier payments are included in the amounts received from Medicare and were approximately 0.43% of net operating revenues for 2009, 0.55% of net operating revenues for 2008, and 0.42% of net operating revenues for 2007. In addition, the Company is reimbursed by non-governmental payors using a variety of payment methodologies. Amounts received by the Company for treatment of patients covered by such programs are generally less than the standard billing rates. The differences between the estimated program reimbursement rates and the standard billing rates are accounted for as contractual adjustments, which are deducted from gross revenues to arrive at net operating revenues. These net operating revenues are an estimate of the net realizable amount due from these payors. The process of estimating contractual allowances requires the Company to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification and historical paid claims data. Due to the complexities involved in these estimates, actual payments the Company receives could be different from the amounts it estimates and records. Final settlements under certain of these programs are subject to

adjustment based on administrative review and audit by third parties. Adjustments to the estimated billings are recorded in the periods that such adjustments become known. Adjustments to previous program reimbursement estimates are accounted for as contractual allowance adjustments and reported in the

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

periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenue and net income by an insignificant amount in each of the years ended December 31, 2009, 2008 and 2007.

Amounts due to third-party payors were $78.1 million and $87.9 million as of December 31, 2009 and 2008, respectively, and are included in accrued liabilities-other in the accompanying consolidated balance sheets. Amounts due from third party payors were $96.0 million and $73.6 million as of December 31, 2009 and 2008, respectively, and are included in other current assets in the accompanying consolidated balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 2006.

Net Operating Revenues. Net operating revenues are recorded net of provisions for contractual allowance of approximately $31.5 billion, $26.6 billion and $16.7 billion in 2009, 2008 and 2007, respectively. Net operating revenues are recognized when services are provided and are reported at the estimated net realizable amount from patients, third-party payors and others for services rendered. Also included in the provision for contractual allowance shown above is the value of administrative and other discounts provided to self-pay patients eliminated from net operating revenues which was $544.2 million, $456.0 million and $266.0 million for the years ended December 31, 2009, 2008 and 2007, respectively. In the ordinary course of business, the Company renders services to patients who are financially unable to pay for hospital care. Included in the provision for contractual allowance shown above is the value (at the Company s standard charges) of these services to patients who are unable to pay that is eliminated from net operating revenues when it is determined they qualify under the Company s charity care policy. The value of these services was $472.4 million, $384.1 million and $322.2 million for the years ended December 31, 2009, 2008 and 2007, respectively. In the fourth quarter of 2007, in conjunction with an analysis of the net realizable value of accounts receivable, which included updating the Company s analysis of historical cash collections, as well as conforming estimation methodologies with those of the hospitals acquired from Triad Hospitals, Inc. (Triad), the Company revised its methodology with respect to its estimate of contractual allowances for estimated amounts of self-pay accounts receivable that will ultimately qualify as charity care, or that will ultimately qualify for Medicaid, indigent care or other specific governmental reimbursement. Previous estimates of uncollectible amounts for such receivables were included in the Company s bad debt reserves for each period. The impact of these changes in estimates decreased net operating revenues approximately $96.3 million for the year ended December 31, 2007.

Allowance for Doubtful Accounts. Accounts receivable are reduced by an allowance for amounts that could become uncollectible in the future. Substantially all of the Company s receivables are related to providing healthcare services to its hospitals patients.

During the quarter ended December 31, 2007, in conjunction with the Company s ongoing process of monitoring the net realizable value of its accounts receivable, as well as integrating the methodologies, data and assumptions used by the former Triad management, the Company performed various analyses including updating a review of historical cash collections.

The primary key cash collection indicator that experienced deterioration during the fourth quarter of 2007 was cash receipts as a percentage of net revenue less bad debts. This percentage decreased to the lowest percentage experienced by the Company since the quarter ended September 30, 2006. Further analysis indicated the primary causes of this deterioration were a continuing increase in the volume of indigent non-resident aliens, an increase in the number of patients qualifying for charity care and a greater than expected impact of the removal of participants from TennCare (Tennessee s state provided Medicaid program) which increased the number of uninsured patients with limited financial means receiving care at the Company s eight Tennessee hospitals. During the fourth quarter of 2007, due to the deteriorating cash collections and desire to standardize processes with those of the former Triad hospitals, the Company undertook a detailed programming effort to develop data around the deteriorating classes of accounts receivable needed to update its historical cash collections percentages as well as enable it to estimate how much of certain self-pay categories ultimately convert to Medicaid, charity and indigent programs. Triad s processes for establishing contractual allowances and allowances for bad debts related to accounts classified as Medicaid pending, charity pending and indigent non-resident alien included inputs and assumptions based on the historical percentage of

these accounts which ultimately qualified for specific government programs or for write-off as charity care.

The Company used these new inputs and assumptions regarding Medicaid pending, charity pending, and indigent non-resident alien in conjunction with the new data developed in the fourth quarter of 2007, as described above to evaluate the realizability of accounts receivable and to revise the Company s estimate of contractual allowances for estimated amounts of self-pay accounts receivable that will ultimately qualify as charity care, or that

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will ultimately qualify for Medicaid, indigent care or other specific governmental reimbursement, resulting in an increase to the Company s contractual reserves of $96.3 million as of December 31, 2007. Previous estimates of uncollectible amounts for such receivables were included in the Company s bad debt reserves for each period.

Furthermore, in updating the historical collection statistics of all its hospitals, the Company also took into account a detailed study of the historical collection information for the hospitals acquired from Triad. The updated collection statistics of the hospitals acquired from Triad also showed subsequent deterioration in cash collections similar to those experienced by the other hospitals that the Company owns. Therefore, the Company also standardized the processes for calculating the allowance for doubtful accounts of the hospitals acquired from Triad to that of its other hospitals which, along with the allowance percentages determined from the new collection data, resulted in the recording of an additional $70.1 million of allowance for bad debts as of December 31, 2007.

The resulting impact of the above, net of taxes, for the year ended December 31, 2007 was a decrease to income from continuing operations of $105.4 million. The Company believes this lower collectability was primarily the result of an increase in the number of patients qualifying for charity care, reduced enrollment in certain state Medicaid programs and an increase in the number of indigent non-resident aliens. Collections are impacted by the economic ability of patients to pay and the effectiveness of the Company s collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect the Company s collection of accounts receivable. The process of estimating the allowance for doubtful accounts requires the Company to estimate the collectability of self-pay accounts receivable, which is primarily based on its collection history, adjusted for expected recoveries and, if available, anticipated changes in collection trends. Significant change in payor mix, business office operations, economic conditions, trends in federal and state governmental healthcare coverage or other third-party payors could affect the Company s estimates of accounts receivable collectability.

The Company believes the revised methodology provides a better approach to estimating changes in payor mix, continued increases in charity and indigent care as well as the monitoring of historical collection patterns. The revised accounting methodology and the adequacy of resulting estimates will continue to be reviewed by monitoring accounts receivable write-offs, monitoring cash collections as a percentage of trailing net revenues less provision for bad debts, monitoring historical cash collection trends, as well as analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, and the impact of recent acquisitions and dispositions.

Physician Income Guarantees. The Company enters into physician recruiting agreements under which it supplements physician income to a minimum amount over a period of time, typically one year, while the physicians establish themselves in the community. As part of the agreements, the physicians are committed to practice in the community for a period of time, typically three years, which extends beyond their income guarantee period. The Company records an asset and liability for the estimated fair value of minimum revenue guarantees on new agreements. Adjustments to the ultimate value of the guarantee paid to physicians are recognized in the period that the change in estimate is identified. The Company amortizes an asset over the life of the agreement. As of December 31, 2009 and 2008, the unamortized portion of these physician income guarantees was $41.2 million and $49.1 million, respectively.

Concentrations of Credit Risk. The Company grants unsecured credit to its patients, most of whom reside in the service area of the Company s facilities and are insured under third-party payor agreements. Because of the economic diversity of the Company s facilities and non-governmental third-party payors, Medicare represents the only significant concentration of credit risk from payors. Accounts receivable, net of contractual allowances, from Medicare were $241.3 million and $256.6 million as of December 31, 2009 and 2008, respectively, representing 7.9% and 9.4% of consolidated net accounts receivable, before allowance for doubtful accounts, as of December 31, 2009 and 2008, respectively.

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Professional Liability Claims. The Company accrues for estimated losses resulting from professional liability. The accrual, which includes an estimate for incurred but not reported claims, is based on historical loss patterns and actuarially-determined projections and is discounted to its net present value. To the extent that subsequent claims information varies from management s estimates, the liability is adjusted when such information becomes available.

Accounting for the 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, the Company projects 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.

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

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

Accumulated Other Comprehensive Income (Loss) consists of the following (in thousands):

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Adjustment to Pension Liability	Accumulated Other Comprehensive Income (Loss)
Balance as of December 31, 2007	$ (77,748)	$ 1,021	$ (5,010)	$ (81,737)
2008 Activity, net of tax	(200,737)	(2,613)	(10,488)	(213,838)
Balance as of December 31, 2008	(278,485)	(1,592)	(15,498)	(295,575)
2009 Activity, net of tax	76,225	412	(2,447)	74,190
Balance as of December 31, 2009	$ (202,260)	$ (1,180)	$ (17,945)	$ (221,385)

Segment Reporting. A public company is required to report annual and interim financial and descriptive information about its reportable operating segments. Operating segments, as defined, are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker in deciding how to allocate resources and in assessing performance. Aggregation of similar operating segments into a single reportable operating segment is permitted if the businesses have similar economic characteristics and meet the criteria established by U.S. GAAP.

The Company operates in three distinct operating segments, represented by the hospital operations (which includes the Company s acute care hospitals and related healthcare entities that provide inpatient and outpatient healthcare services), the home care agencies operations (which provide outpatient care generally in the patient s home), and the hospital management services business (which provides executive management and consulting services to independent acute care hospitals). U.S. GAAP requires (1) that financial information be disclosed for operating segments that meet a 10% quantitative threshold of the consolidated totals of net revenue, profit or loss, or total assets; and (2) that the individual reportable segments disclosed contribute at least 75% of total consolidated net revenue.

Based on these measures, only the hospital operations segment meets the criteria as a separate reportable segment. Financial information for the home care agencies and management services segments do not meet the quantitative thresholds and are therefore combined with corporate into the all other reportable segment.

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

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The Company has entered into several interest rate swap agreements. See Note 7 for further discussion about the swap transactions.

New Accounting Pronouncement. On January 1, 2010, the Company adopted the revisions to U.S. GAAP related to the accounting and consolidation requirements for variable interest entities. These revisions significantly change the criteria in determining the primary beneficiary of a variable interest entity (VIE) from a more quantitative model to both a quantitative and qualitative evaluation of the enterprise that has (1) the power to direct the activities that most significantly affect the VIE s economic performance and (2) the obligation to absorb losses or the right to receive returns that could be potentially significant to the VIE. Additionally, this guidance requires ongoing reassessments of whether an enterprise is the primary beneficiary of a VIE and requires enhanced disclosures that will provide users of financial statements with more transparent information about an enterprise s involvement in a VIE. Given the Company s limited amount of activity with entities for which these provisions would apply, the adoption of this standard is not expected to have a material effect on the Company s consolidated results of operations or financial position, either upon adoption or into the foreseeable future.

Reclassifications. Certain amounts in the consolidated balance sheets and consolidated statements of income for all periods presented have been reclassified to reflect the adoption of changes to U.S. GAAP related to the presentation of noncontrolling interests, the provisions of which, among other things, require that minority interests be renamed noncontrolling interests and presented as a component of total equity on the consolidated balance sheets. Additionally, these changes require the presentation of a consolidated net income measure that includes the amounts attributable to both the controlling and noncontrolling interests for all periods presented. There was no impact to net income attributable to the Company for all periods presented as a result of these changes.

During the three months ended June 30, 2009, the Company decided to retain a hospital and related businesses previously classified as held for sale. Results of operations for all periods presented have been restated to include this retained hospital and related businesses, which were previously reported as discontinued operations. The consolidated balance sheets for each of the periods presented have been restated to present the assets and liabilities previously reported as held for sale in the applicable financial statement line items.

2. Accounting for Stock-Based Compensation

Stock-based compensation awards are granted under the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan (the 2000 Plan) and the Community Health Systems, Inc. 2009 Stock Option and Award Plan (the 2009 Plan).

The 2000 Plan allows for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code (IRC), as well as stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units, phantom stock and other share awards. Persons eligible to receive grants under the 2000 Plan include the Company s directors, officers, employees and consultants. To date, all options granted under the 2000 Plan have been nonqualified stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date. Options granted prior to 2005 have a 10 year contractual term, options granted in 2005 through 2007 have an eight year contractual term and options granted in 2008 and 2009 have a 10 year contractual term. The exercise price of all options granted under the 2000 Plan is equal to the fair value of the Company s common stock on the option grant date. As of December 31, 2009, 4,064,612 shares of unissued common stock remain available for future grants under the 2000 Plan.

The 2009 Plan, which was adopted by the Board of Directors of the Parent as of March 24, 2009 and approved by stockholders on May 19, 2009, provides for the grant of incentive stock options intended to qualify under Section 422 of the IRC and for the grant of stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Persons eligible to receive grants under the 2009 Plan include the Company s directors, officers, employees and consultants. The duration of any option granted under the 2009 Plan will be determined by the Company s compensation committee. Generally, however, no option may be exercised more than 10 years from the date of grant, provided that the

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compensation committee may provide that a stock option may, upon the death of the grantee, be exercised for up to one year following the date of death even if such period extends beyond 10 years. As of December 31, 2009, no grants had been made under the 2009 Plan, with 3,500,000 shares of unissued common stock remaining reserved for future grants.

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

	Year Ended December 31,		
	2009	**2008**	**2007**
Effect on income from continuing operations before income taxes	$ (44,501)	$ (52,105)	$ (38,771)
Effect on net income	$ (26,986)	$ (31,655)	$ (23,541)

At December 31, 2009, $40.3 million of unrecognized stock-based compensation expense was expected to be recognized over a weighted-average period of 20 months. Of that amount, $13.5 million related to outstanding unvested stock options expected to be recognized over a weighted-average period of 17 months and $26.9 million relates to outstanding unvested restricted stock, restricted stock units and phantom shares expected to be recognized over a weighted-average period of 21 months. There were no modifications to awards during 2009, 2008, or 2007.

The fair value of stock options was estimated using the Black Scholes option pricing model with the assumptions and weighted-average fair values during the years ended December 31, 2009, 2008 and 2007, as follows:

	Year Ended December 31,		
	2009	**2008**	**2007**
Expected volatility	40.7%	24.9%	24.4%
Expected dividends	0	0	0
Expected term	4 years	4 years	4 years
Risk-free interest rate	1.64%	2.53%	4.48%

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

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

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

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Options outstanding and exercisable under the 2000 Plan as of December 31, 2009, and changes during each of the years in the three-year period ended December 31, 2009 were as follows (in thousands, except share and per share data):

	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (In Years)	Aggregate Intrinsic Value as of December 31, 2009
Outstanding at December 31, 2006	5,482,528	$ 26.48		
Granted	3,544,000	37.79		
Exercised	(295,854)	26.89		
Forfeited and cancelled	(291,659)	35.70		
Outstanding at December 31, 2007	8,439,015	30.90		
Granted	1,251,000	31.89		
Exercised	(281,831)	22.10		
Forfeited and cancelled	(644,100)	35.71		
Outstanding at December 31, 2008	8,764,084	30.97		
Granted	1,313,000	19.43		
Exercised	(680,898)	18.74		
Forfeited and cancelled	(442,105)	31.27		
Outstanding at December 31, 2009	8,954,081	$ 30.19	5.7 years	$ 59,304
Exercisable at December 31, 2009	6,089,995	$ 30.94	4.7 years	$ 36,509

The weighted-average grant date fair value of stock options granted during the years ended December 31, 2009, 2008 and 2007, was $6.61, $7.56 and $10.24, respectively. The aggregate intrinsic value represents the number of in-the-money stock options multiplied by the difference between the Company s closing stock price on the last trading day of the reporting period and the exercise price of the respective stock options based on the closing market price of the Company s common stock at December 31, 2009 of $35.60. This amount changes based on the market value of the Company s common stock. The aggregate intrinsic value of options exercised during the years ended December 31, 2009, 2008 and 2007 was $7.6 million, $3.4 million and $3.5 million, respectively. The aggregate intrinsic value of options vested and expected to vest approximates that of the outstanding options.

The Company has also awarded restricted stock under the 2000 Plan to its directors and employees of certain subsidiaries. The restrictions on these shares generally lapse in one-third increments on each of the first three anniversaries of the award date. Certain of the restricted stock awards granted to the Company s senior executives contain a performance objective that must be met in addition to any vesting requirements. If the performance objective is not attained, the awards will be forfeited in their entirety. Once the performance objective has been attained,

restrictions will lapse in one-third increments on each of the first three anniversaries of the award date. Notwithstanding the above-mentioned performance objectives and vesting requirements, the restrictions will lapse earlier in the event of death, disability or termination of employment by the Company for any reason other than for cause of the holder of the restricted stock, or change in control of the Company. Restricted stock awards subject to performance standards are not considered outstanding for purposes of determining earnings per share until the performance objectives have been satisfied.

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Restricted stock outstanding under the 2000 Plan as of December 31, 2009, and changes during each of the years in the three-year period ended December 31, 2009 were as follows:

	Shares	Weighted Average Grant Date Fair Value
Unvested at December 31, 2006	969,691	$ 36.05
Granted	1,392,000	38.70
Vested	(384,646)	35.47
Forfeited	(20,502)	36.73
Unvested at December 31, 2007	1,956,543	38.04
Granted	795,500	31.99
Vested	(960,001)	37.64
Forfeited	(107,835)	35.62
Unvested at December 31, 2008	1,684,207	35.57
Granted	1,188,814	18.45
Vested	(965,478)	37.08
Forfeited	(10,002)	32.52
Unvested at December 31, 2009	1,897,541	$ 24.09

On February 25, 2009, under the 2000 Plan, each of the Company s outside directors received a grant of shares of phantom stock equal in value to $130,000 divided by the closing price of the Company s common stock on that date ($18.18), or 7,151 shares per director (a total of 42,906 shares of phantom stock). Pursuant to a March 24, 2009 amendment to the 2000 Plan, future grants of this type will be denominated as restricted stock unit awards. On May 19, 2009, the newly elected outside director received a grant of 7,151 restricted stock units under the 2000 Plan, having a value at the time of grant of $180,706 based upon the closing price of the Company s common stock on that date of $25.27. Vesting of these shares of phantom stock and restricted stock units occurs in one-third increments on each of the first three anniversaries of the award date. As of December 31, 2009, there were 50,057 shares of phantom stock and restricted stock units unvested at a weighted-average grant date fair value of $19.19. None of these grants were vested or canceled during the year ended December 31, 2009.

Under the Directors Fees Deferral Plan, the Company s outside directors may elect to receive share equivalent units in lieu of cash for their directors fees. These units are held in the plan until the director electing to receive the share equivalent units retires or otherwise terminates his/her directorship with the Company. Share equivalent units are converted to shares of common stock of the Company at the time of distribution. The following table represents the amount of directors fees which were deferred and the equivalent units into which they converted for each of the respective periods (in thousands, except units):

	Year Ended December 31, 2009	2008
Directors fees earned and deferred into plan	$ 80	$ 91

Equivalent units	3,284.028	3,410.470

At December 31, 2009, a total of 20,103.030 units were deferred in the plan with an aggregate fair value of $0.7 million, based on the closing market price of the Company s common stock at December 31, 2009 of $35.60.

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3. Acquisitions and Divestitures of Hospitals

Triad Acquisition

On July 25, 2007, the Company completed its acquisition of Triad. Triad owned and operated 50 hospitals with 49 hospitals located in 17 states in non-urban and middle market communities and one hospital located in the Republic of Ireland.

As of December 31, 2009, eight of the hospitals acquired from Triad have been sold. As a result of its acquisition of Triad, the Company also provides management and consulting services on a contract basis to independent hospitals, through its subsidiary, Quorum Health Resources, LLC. The Company acquired Triad for approximately $6.9 billion, including the assumption of approximately $1.7 billion of existing indebtedness.

In connection with the consummation of the acquisition of Triad, the Company s wholly-owned subsidiary CHS/Community Health Systems, Inc. (CHS) obtained approximately $7.2 billion of senior secured financing under a new credit facility (the Credit Facility) and issued approximately $3.0 billion aggregate principal amount of 8.875% senior notes due 2015 (the Notes). The Company used the net proceeds of $3.0 billion from the Notes offering and the net proceeds of approximately $6.1 billion of term loans under the Credit Facility to acquire the outstanding shares of Triad, to refinance certain of Triad s indebtedness and the Company s indebtedness, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. This Credit Facility also provides an additional $750 million revolving credit facility and had provided a $400 million delayed draw term loan facility for future acquisitions, working capital and general corporate purposes. As of December 31, 2007, the $400 million delayed draw term loan was reduced to $300 million at the request of the Company. As of December 31, 2008, $100 million of the delayed draw term loan had been drawn by the Company, reducing the delayed draw term loan availability to $200 million at that date. In January 2009, the Company drew down the remaining $200 million of the delayed draw term loan.

The total cost of the Triad acquisition has been allocated to the assets acquired and liabilities assumed based upon their respective fair values. The purchase price represented a premium over the fair value of the net tangible and identifiable intangible assets acquired for reasons such as:

strategically, Triad had operations in five states in which the Company previously had no operations;

the combined company has smaller concentrations of credit risk through greater geographic diversification;

many support functions were centralized; and

duplicate corporate functions were eliminated.

The allocation process required the analysis of acquired fixed assets, contracts, contractual commitments, and legal contingencies to identify and record the fair value of all assets acquired and liabilities assumed. The Company completed the allocation of the total cost of the Triad acquisition in the third quarter of 2008 and made a final analysis and adjustment as of December 31, 2008 to deferred tax accounts based on the final cost allocation, resulting in approximately $2.8 billion of goodwill being recorded with respect to the Triad acquisition.

Other Acquisitions

On December 31, 2009, one or more subsidiaries of the Company completed a transaction providing $54.2 million of financing to Rockwood Clinic, P.S., a multi-specialty clinic with 32 locations across the Inland Northwest region of Eastern Washington State and Western Idaho. This transaction was accounted for as a purchase business combination as required by U.S. GAAP.

Effective June 1, 2009, one or more subsidiaries of the Company acquired from Akron General Medical Center the remaining 20% noncontrolling interest in Massillon Community Health System, LLC not then owned by one or more subsidiaries of the Company. This entity indirectly owns and operates Affinity Medical Center of Massillon, Ohio. The purchase price for this noncontrolling interest was $1.1 million in cash. Affinity Medical Center is now wholly-owned by these subsidiaries of the Company.

Effective April 30, 2009, one or more subsidiaries of the Company acquired Wyoming Valley Health Care System in Wilkes-Barre, Pennsylvania. This health care system includes Wilkes-Barre General Hospital, a 392-bed,

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full-service acute care hospital located in Wilkes-Barre, Pennsylvania, and First Hospital Wyoming Valley, a behavioral health facility located in Kingston, Pennsylvania, as well as other outpatient and ancillary services. The total consideration for fixed assets and working capital of Wyoming Valley Health Care System was approximately $179.1 million, of which $153.7 million was paid in cash, net of $14.2 million of cash in acquired bank accounts, and approximately $25.4 million was assumed in liabilities. This acquisition transaction was accounted for using the purchase method of accounting. This preliminary allocation of the purchase price has been determined by the Company based upon available information and the allocation is subject to the settlement of the amounts related to purchased working capital. Adjustments to the purchase price allocation are not expected to be material.

Effective April 1, 2009, one or more subsidiaries of the Company acquired from Share Foundation the remaining 50% equity interest in MCSA L.L.C., an entity in which one or more subsidiaries of the Company previously had a 50% unconsolidated noncontrolling interest. One or more subsidiaries of the Company provided MCSA L.L.C. certain management services. This acquisition resulted in these subsidiaries of the Company owning a 100% equity interest in that entity. MCSA L.L.C. owns and operates Medical Center of South Arkansas (166 licensed beds) in El Dorado, Arkansas. The purchase price was $26.0 million in cash. As of the acquisition date, one or more subsidiaries of the Company had a liability to MCSA L.L.C. of $14.1 million, as a result of a cash management agreement previously entered into with the hospital. Upon completion of the acquisition, this liability was eliminated in consolidation.

Effective February 1, 2009, one or more subsidiaries of the Company completed the acquisition of Siloam Springs Memorial Hospital (73 licensed beds), located in Siloam Springs, Arkansas, from the City of Siloam Springs. The total consideration for this hospital consisted of approximately $0.1 million paid in cash for working capital and approximately $1.0 million of assumed liabilities. In connection with this acquisition, a subsidiary of the Company entered into a lease agreement for the existing hospital and agreed to build a replacement facility at this location, with construction required to commence by February 2011 and be completed by February 2013. As security for this obligation, a subsidiary of the Company deposited $1.6 million into an escrow account at closing and agreed to deposit an additional $1.6 million by February 1, 2010, which the Company s subsidiary deposited in January 2010. If the construction of the replacement facility is not completed within the agreed time frame, the escrow balance will be remitted to the City of Siloam Springs. If the construction of the replacement facility is completed within the agreed time frame, the escrow balance will be returned to one of these subsidiaries of the Company.

Effective November 14, 2008, one or more subsidiaries of the Company acquired from Willamette Community Health Solutions all of its noncontrolling interest in MWMC Holdings, LLC, which indirectly owns a controlling interest in and operates McKenzie-Willamette Medical Center of Springfield, Oregon. This acquisition resulted from a put right held by Willamette Community Health Solutions in connection with the 2003 transaction establishing the joint venture. The purchase price for this noncontrolling interest was $22.7 million in cash. Physicians affiliated with Oregon Healthcare Resources, Inc. continue to own a noncontrolling interest in the hospital, with the balance owned by these subsidiaries of the Company.

Effective October 1, 2008, one or more subsidiaries of the Company completed the acquisition of Deaconess Medical Center (388 licensed beds) and Valley Hospital and Medical Center (123 licensed beds) both located in Spokane, Washington, from Empire Health Services. The total consideration for these two hospitals was approximately $193.1 million, of which $158.1 million was paid in cash and approximately $35.0 million was assumed in liabilities. Based upon the Company s purchase price allocation relating to this acquisition as of September 30, 2009, no goodwill has been recorded. The acquisition transaction was accounted for using the purchase method of accounting.

Effective June 30, 2008, one or more subsidiaries of the Company acquired the remaining 35% noncontrolling interest in Affinity Health Systems, LLC, which indirectly owns and operates Trinity Medical Center (560 licensed beds) in Birmingham, Alabama, from Baptist Health Systems, Inc. of Birmingham, Alabama (Baptist), giving these subsidiaries 100% ownership of that facility. The purchase price for this noncontrolling interest was $51.5 million in cash and the cancellation of a promissory note issued by Baptist to Affinity Health Systems, LLC in the original principal amount of $32.8 million. Noncontrolling interests in Affinity Health Systems, LLC were subsequently sold

to physicians on the hospital s medical staff.

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Prior to January 1, 2009, U.S. GAAP for business combinations required certain acquisition-related costs be recognized as part of the consideration paid for a business, resulting in adjustments to the value of the acquired assets when recorded. As a result of revisions to U.S. GAAP adopted as of January 1, 2009, such acquisition-related costs must be expensed for business combinations that close subsequent to December 31, 2008. Approximately $6.7 million of acquisition costs related to prospective and completed acquisitions were expensed during the year ended December 31, 2009. The impact of this change in U.S. GAAP on the Company s consolidated results of operations or consolidated financial position in future periods will be largely dependent on the number of acquisitions pursued by the Company; however, it is not anticipated that such impact will be material.

The table below summarizes the allocations of the purchase price (including assumed liabilities) for these transactions (in thousands):

	2009	2008
Current assets	$ 83,975	$ 45,867
Property and equipment	192,668	146,021
Goodwill	12,233	
Intangible assets	11,244	
Other long-term assets	841	1,200
Liabilities	53,756	34,966

The operating results of the foregoing transactions have been included in the consolidated statements of income from their respective dates of acquisition, including net operating revenues of $308.1 million for the year ended December 31, 2009 from acquisitions that closed during 2009 and net operating revenues of $77.8 million for the year ended December 31, 2008 from acquisitions that closed during 2008. The following pro forma combined summary of operations of the Company gives effect to using historical information of the operations of these entities in 2009 and 2008 as if the transactions had occurred as of January 1, 2009 and 2008 (in thousands, except per share data):

	Year Ended December 31,	
	2009	2008
	(Unaudited)	
Pro forma net operating revenues	$ 12,372,299	$ 11,697,865
Pro forma net income	$ 235,910	$ 202,688
Pro forma net income per share:		
Basic	$ 2.60	$ 2.17
Diluted	$ 2.58	$ 2.15

Pro forma adjustments to net income include adjustments to depreciation and amortization expense, net of the related tax effect, based on the estimated fair value assigned to the long-lived assets acquired, and to interest expense, net of the related tax effect, assuming the increase in long-term debt used to fund the acquisitions had occurred as of January 1, 2008. These pro forma results are not necessarily indicative of the actual results of operations.

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Discontinued Operations

Effective March 31, 2009, the Company, through its subsidiaries Triad-Denton Hospital LLC and Triad-Denton Hospital LP, completed the settlement of pending litigation, which resulted in the sale of its ownership interest in a partnership, which owned and operated Presbyterian Hospital of Denton (255 licensed beds) in Denton, Texas, to Texas Health Resources for $103.0 million in cash. Also as part of the settlement, these subsidiaries transferred certain hospital related assets to Texas Health Resources.

Effective March 1, 2008, one or more subsidiaries of the Company sold Woodland Medical Center (100 licensed beds) located in Cullman, Alabama; Parkway Medical Center (108 licensed beds) located in Decatur, Alabama; Hartselle Medical Center (150 licensed beds) located in Hartselle, Alabama; Jacksonville Medical Center (89 licensed beds) located in Jacksonville, Alabama; National Park Medical Center (166 licensed beds) located in Hot Springs, Arkansas; St. Mary s Regional Medical Center (170 licensed beds) located in Russellville, Arkansas; Mineral Area Regional Medical Center (135 licensed beds) located in Farmington, Missouri; Willamette Valley Medical Center (80 licensed beds) located in McMinnville, Oregon; and White County Community Hospital (60 licensed beds) located in Sparta, Tennessee, to Capella Healthcare, Inc., headquartered in Franklin, Tennessee. The proceeds from this sale were $315.0 million in cash.

Effective February 21, 2008, one or more subsidiaries of the Company sold THI Ireland Holdings Limited, a private limited company incorporated in the Republic of Ireland, which leased and managed the operations of Beacon Medical Center (122 licensed beds) located in Dublin, Ireland, to Beacon Medical Group Limited, headquartered in Dublin, Ireland. The proceeds from this sale were $1.5 million in cash.

Effective February 1, 2008, one or more subsidiaries of the Company sold Russell County Medical Center (78 licensed beds) located in Lebanon, Virginia to Mountain States Health Alliance, headquartered in Johnson City, Tennessee. The proceeds from this sale were $48.6 million in cash.

Effective November 30, 2007, the Company sold Barberton Citizens Hospital (312 licensed beds) located in Barberton, Ohio to Summa Health System of Akron, Ohio. The proceeds from this sale were $53.8 million in cash.

Effective October 31, 2007, the Company sold its 60% membership interest in Northeast Arkansas Medical Center, a 104 bed facility in Jonesboro, Arkansas to Baptist Memorial Health Care (Baptist Memorial), headquartered in Memphis, Tennessee, for $16.8 million. In connection with this transaction, the Company also sold real estate and other assets to a subsidiary of Baptist Memorial for $26.2 million in cash.

Effective September 1, 2007, the Company sold its partnership interest in River West L.P., which owned and operated River West Medical Center (80 licensed beds) located in Plaquemine, Louisiana, to an affiliate of Shiloh Health Services, Inc. of Lubbock, Texas. The proceeds from this sale were $0.3 million in cash.

In connection with management s decision to sell the previously mentioned facilities, the Company has classified the results of operations of the above mentioned hospitals as discontinued operations in the accompanying consolidated statements of income. As of December 31, 2009, no hospitals are held for sale.

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Net operating revenues and loss reported for the hospitals in discontinued operations are as follows (in thousands):

	Year Ended December 31,		
	2009	2008	2007
Net operating revenues	$ 42,113	$ 237,315	$ 449,310
Income (loss) from operations of hospitals sold or held for sale before income taxes	3,024	15,956	(4,725)
(Loss) gain on sale of hospitals, net	(644)	17,687	(3,954)
Impairment of long-lived assets of hospitals held for sale			(19,044)
Income (loss) from discontinued operations, before taxes	2,380	33,643	(27,723)
Income tax expense (benefit)	808	14,636	(4,983)
Income (loss) from discontinued operations, net of tax	$ 1,572	$ 19,007	$ (22,740)

Interest expense and loss from early extinguishment of debt was allocated to discontinued operations based on estimated sales proceeds available for debt repayment and using the weighted-average borrowing rate for the year.

The assets and liabilities of the hospital held for sale as of December 31, 2008 are included in the accompanying consolidated balance sheet as follows: current assets of $25.5 million, included in other current assets; net property and equipment of $142.8 million and other long-term assets of $3.0 million, included in other assets; and current liabilities of $67.2 million, included in other accrued liabilities.

During the three months ended June 30, 2009, the Company decided to retain a hospital and related businesses previously classified as held for sale. Results of operations for all periods presented have been restated to include this retained hospital and related businesses, which were previously reported as discontinued operations. The consolidated balance sheets for each of the periods presented have been restated to present the assets and liabilities previously reported as held for sale in the applicable financial statement line items.

4. Goodwill and Other Intangible Assets

The changes in the carrying amount of goodwill are as follows (in thousands):

	Year Ended December 31,	
	2009	2008
Balance, beginning of year	$ 4,166,091	$ 4,247,714
Goodwill acquired as part of acquisitions during the year	25,813	49,368
Consideration adjustments and purchase price allocation adjustments for prior year s acquisitions	(144)	(119,650)
Adjustments for acquisition-related deferred taxes	(33,833)	
Goodwill related to hospital operations segment written off as part of disposals		(11,161)
Goodwill related to home health agencies segment written off as part of disposals		(180)
Balance, end of year	$ 4,157,927	$ 4,166,091

The Company s goodwill was adjusted in 2009 for the effects of its deferred tax analysis that reduced goodwill and acquisition-related deferred taxes by $33.8 million.

Goodwill is allocated to each identified reporting unit, which is defined as an operating segment or one level below the operating segment (referred to as a component of the entity). Management has determined that the Company s operating segments meet the criteria to be classified as reporting units. At December 31, 2009, the hospital operations

reporting unit, the home care agency operations reporting unit, and the hospital management services reporting unit had approximately $4.1 billion, $34.3 million and $33.3 million, respectively, of goodwill. At December 31,

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2008, the hospital operations reporting unit, the home care agency operations reporting unit, and the hospital management services reporting unit had approximately $4.1 billion, $34.2 million, and $33.3 million, respectively, of goodwill.

Goodwill is evaluated for impairment at the same time every year and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. There is a two-step method for determining goodwill impairment. Step one is to compare the fair value of the reporting unit with the unit s carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit s goodwill with the carrying value of the reporting unit s goodwill. The Company has selected September 30th as its annual testing date. The Company performed its last annual goodwill evaluation as of September 30, 2009, which evaluation took place during the fourth quarter of 2009. No impairment was indicated by this evaluation.

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

Approximately $21.5 million of intangible assets were acquired during the year ended December 31, 2009. The gross carrying amount of the Company s other intangible assets subject to amortization was $76.2 million at December 31, 2009 and $68.6 million at December 31, 2008, and the net carrying amount was $47.0 million at December 31, 2009 and $54.1 million at December 31, 2008. The carrying amount of the Company s other intangible assets not subject to amortization was $44.4 million and $35.2 million at December 31, 2009 and 2008, respectively. Other intangible assets are included in other assets, net on the Company s consolidated balance sheets. Substantially all of the Company s intangible assets are contract-based intangible assets related to operating licenses, management contracts, or non-compete agreements entered into in connection with acquisitions.

The weighted average amortization period for the intangible assets subject to amortization is approximately nine years. There are no expected residual values related to these intangible assets. Amortization expense for these intangible assets was $13.0 million, $6.2 million and $6.1 million during the years ended December 31, 2009, 2008 and 2007, respectively. Amortization expense on intangible assets is estimated to be $12.2 million in 2010, $6.4 million in 2011, $5.6 million in 2012, $4.3 million in 2013, $2.8 million in 2014 and $15.7 million thereafter.

5. Income Taxes

The provision for income taxes for income from continuing operations consists of the following (in thousands):

	Year Ended December 31,		
	2009	**2008**	**2007**
Current:			
Federal	$ 93,496	$ 2,129	$ 26,014
State	13,561	3,515	11,411
	107,057	5,644	37,425
Deferred:			
Federal	15,667	106,664	5,203
State	18,601	12,965	(2,768)
	34,268	119,629	2,435

Total provision for income taxes for income from continuing operations	$ 141,325	$ 125,273	$ 39,860

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

	Year Ended December 31,					
	2009		2008		2007	
	Amount	%	Amount	%	Amount	%
Provision for income taxes at statutory federal rate	$ 156,146	35.0%	$ 125,650	35.0%	$ 37,552	35.0%
State income taxes, net of federal income tax benefit	9,090	2.0	10,720	2.9	5,618	5.2
Net income attributable to noncontrolling interests	(22,006)	(4.9)	(12,216)	(3.4)	(4,680)	(4.4)
Change in valuation allowance	1,113	0.3	(110)	0.0	3,825	3.6
Federal and state tax credits	(4,241)	(1.0)	(2,270)	(0.6)	(2,625)	(2.4)
Deferred tax revaluation	(2,996)	(0.7)		0.0		0.0
Other	4,219	1.0	3,499	1.0	170	0.2
Provision for income taxes and effective tax rate for income from continuing operations	$ 141,325	31.7%	$ 125,273	34.9%	$ 39,860	37.2%

Deferred income taxes are based on the estimated future tax effects of differences between the financial statement and tax bases of assets and liabilities under the provisions of the enacted tax laws. Deferred income taxes as of December 31, 2009 and 2008 consist of (in thousands):

	As of December 31, 2009		As of December 31, 2008	
	Assets	Liabilities	Assets	Liabilities
Net operating loss and credit carryforwards	$ 121,568	$	$ 143,873	$
Property and equipment		585,001		511,687
Self-insurance liabilities	109,152		56,447	
Intangibles		171,070		147,669
Investments in unconsolidated affiliates		45,570		51,557
Other liabilities		15,395		7,315
Long-term debt and interest		21,499		30,256
Accounts receivable	44,691		23,490	
Accrued expenses	67,092		27,374	
Other comprehensive income	129,264		173,661	
Stock-based compensation	23,242		52,889	
Other	35,159		20,070	
	530,168	838,535	497,804	748,484
Valuation allowance	(115,128)		(124,978)	
Total deferred income taxes	$ 415,040	$ 838,535	$ 372,826	$ 748,484

The Company s deferred tax liabilities have been revalued and adjusted in 2009 for the effects of its deferred tax analysis, reducing acquisition-related deferred taxes by $33.8 million, goodwill by $33.8 million, other deferred tax liabilities by $3.0 million and the provision by $3.0 million. The effects of this adjustment on previously issued consolidated financial statements were not material.

The Company believes that the net deferred tax assets will ultimately be realized, except as noted below. Its conclusion is based on its estimate of future taxable income and the expected timing of temporary difference reversals. The Company has state net operating loss carry forwards of approximately $1.7 billion, which expire from 2010 to 2029. With respect to the deferred tax liability pertaining to intangibles, as included above, goodwill purchased in connection with certain of the Company s business acquisitions is amortizable for income tax reporting purposes. However, for financial reporting purposes, there is no corresponding amortization allowed with respect to such purchased goodwill.

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The valuation allowance decreased by $9.9 million during the year ended December 31, 2009 and increased $56.4 million during the year ended December 31, 2008. In addition to amounts previously discussed, the change in valuation allowance relates to a redetermination of the amount of, and realizability of, net operating losses in certain state income tax jurisdictions.

The total amount of unrecognized benefit that would impact the effective tax rate, if recognized, is approximately $9.4 million as of December 31, 2009. It is the Company s policy to recognize interest and penalties accrued related to unrecognized benefits in its consolidated statements of income as income tax expense. Adjustments for purchase business combinations generally impact goodwill and do not affect net income. During the year ended December 31, 2009, the Company decreased liabilities by approximately $0.4 million and recorded $0.6 million in interest and penalties related to prior state income tax returns through its income tax provision from continuing operations, which are included in its liability for uncertain tax positions at December 31, 2009. A total of approximately $2.0 million of interest and penalties is included in the amount of liability for uncertain tax positions at December 31, 2009. During the year ended December 31, 2009, the Company released $0.6 million for income taxes and $0.2 million for accrued interest of its liability for uncertain tax positions, as a result of the expiration of the statute of limitations pertaining to tax positions taken in prior years relative to state tax positions.

The Company believes that it is reasonably possible that approximately $6.4 million of its current unrecognized tax benefi