COMMUNITY HEALTH SYSTEMS INC
Form 10-K
February 21, 2019
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UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the year ended December 31, 2018
OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from to
Commission file number 001-15925

COMMUNITY HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**13-3893191**
(State of incorporation)	*(IRS Employer Identification No.)*

4000 Meridian Boulevard **Franklin, Tennessee**	**37067** *(Zip Code)*

(Address of principal executive offices)

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 NO

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

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 NO

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted 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 such files). Yes No

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.

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

Large accelerated filer	Accelerated filer	Smaller reporting company
Non-accelerated filer		Emerging growth company

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.

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

The aggregate market value of the voting stock held by non-affiliates of the Registrant was $371,142,770. Market value is determined by reference to the closing price on June 30, 2018 of the Registrant s Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2018) have any non-voting common stock outstanding. As of February 15, 2019, there were 116,227,225 shares of common stock, par value $.01 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Certain information required for Part III of this annual report is incorporated by reference to portions of the Registrant s definitive proxy statement for its 2019 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, 2018.

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

Overview of Our Company

We are one of the largest publicly-traded hospital companies in the United States and a leading operator of general acute care hospitals and outpatient facilities in communities across the country. We were originally founded in 1986 and were reincorporated in 1996 as a Delaware corporation. We provide healthcare services through the hospitals that we own and operate and affiliated businesses in non-urban and selected urban markets throughout the United States. As of December 31, 2018, we owned or leased 113 hospitals with an aggregate of 18,227 licensed beds, comprised of 111 general acute care hospitals and two stand-alone rehabilitation or psychiatric hospitals. These hospitals are geographically diversified across 20 states, with the majority of our hospitals located in regional networks or in close geographic proximity to one or more of our other hospitals. We generate revenues by providing a broad range of general and specialized hospital healthcare services and outpatient services to patients in the communities in which we are located. Services provided through our hospitals and affiliated businesses include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric and rehabilitation services. We also provide additional outpatient services at urgent care centers, occupational medicine clinics, imaging centers, cancer centers and ambulatory surgery centers. An integral part of providing these services is our network of affiliated physicians at our hospitals and affiliated businesses. As of December 31, 2018, we employed approximately 2,000 physicians and an additional 1,000 licensed healthcare practitioners. 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 patient safety and quality of care improvement programs and assistance in the recruitment of additional physicians and licensed healthcare practitioners 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.

We have been implementing a portfolio rationalization and deleveraging strategy by divesting hospitals and non-hospital businesses that are attractive to strategic and other buyers. Generally, these businesses are not in one of our strategically beneficial service areas, are less complementary to our business strategy and/or have lower operating margins. In connection with our divestiture initiative, strategic buyers have made offers to buy certain of our assets. Through consideration of these offers we have divested or may divest hospitals and non-hospital businesses when we find such offers to be attractive and in line with our operating strategy. In 2018, we divested 11 hospitals for total net proceeds of approximately $405 million. In 2017, we divested 30 hospitals for total net proceeds of approximately $1.7 billion.

Additionally, as part of our portfolio rationalization strategy, on April 29, 2016, we completed a spin-off of 38 hospitals and Quorum Health Resources, LLC, or QHR (our former subsidiary through which we provided management advisory and consulting services to non-affiliated general acute care hospitals located throughout the United States), into Quorum Health Corporation, or QHC, and distributed, on a pro rata basis, all of the shares of QHC common stock to our stockholders of record as of April 22, 2016. In recognition of the spin-off, we recorded a non-cash dividend of approximately $713 million during the year ended December 31, 2016, representing the net assets of QHC distributed to our stockholders. Financial and statistical data reported in this Form 10-K include QHC operating results through the spin-off date. In connection with the spin-off, we entered into a separation and distribution agreement as well as certain ancillary agreements with QHC on April 29, 2016.

Throughout this Form 10-K, we refer to Community Health Systems, Inc., or the Parent Company, and its consolidated subsidiaries in a simplified manner and on a collective basis, using words like we, our, us and the Company. 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 particular 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.

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Available Information

Our website address is www.chs.net and the investor relations section of our website is located at www.chs.net/investor-relations. We make available free of charge, through the investor relations section of our website, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K as well as amendments to those reports, as soon as reasonably practical after they are filed with, or furnished to, the SEC. The SEC maintains an Internet site that contains our reports, proxy and information statements, and other information that we file electronically with the SEC at www.sec.gov.

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

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

Our Business Strategy

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

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

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

We operate across diverse markets that range from sole community providers to large regional networks. We are able to leverage our significant scale and standardized systems to provide cost-effective services and best practices for our affiliate operations. Each of our markets develops and executes a strategic plan with short and long-term goals, based on their unique opportunities and the needs of their respective communities. As an organization, we also have implemented a number of strategic initiatives designed to improve market position, expand services to our patients, and capture a greater share of healthcare spending in our markets. These include:

Strengthening regional networks and local market operations;

Expanding patient access points, health services and infrastructure;

Recruiting and/or employing additional primary care physicians and specialists; and

Developing a more consumer-centric experience and facilitating connections between episodes of care.

Strengthening Regional Networks and Local Market Operations. We believe opportunities exist in select markets to create healthcare networks consisting of multiple hospitals and corresponding outpatient services. Regional networks are able to expand the breadth of services provided for our patients, develop centers of excellence for key services, deliver care in an organized and efficient way across the network, improve alignment with physicians and other providers, and make services more attractive to managed care and other payers. Currently, 79 of our hospitals operate in 22 regional networks.

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

Expanding Patient Access Points, Health Services and Infrastructure. When expanding services in both the acute and non-acute care settings our approach is data-driven and strategic to ensure our investments are responsive to community and patient needs and produce sound financial results. While we continue to provide health services across a broad spectrum, we have focused our attention and resources on service lines we believe have the greatest potential for growth, including primary care, emergency medicine, orthopedics, neuroscience, cardiovascular care, surgical services and behavioral health. As the shift to delivering health services in outpatient settings accelerates, we continue to expand our care offerings beyond hospital walls to include more outpatient access through primary care practices, urgent care centers, free-standing emergency departments, ambulatory surgery centers, imaging and diagnostic centers, retail clinics and direct-to-consumer virtual health visits.

We believe expanding our patient access footprint can attract new patients and increase patient retention, as well as our ability to connect patients from one episode of care to the next appropriate care setting. We also believe our investments will enhance our long-term growth and generate increased revenue, earnings, and operating margins by providing a solid return on investment.

Recruiting and/or Employing Additional Primary Care Physicians and Specialists. The physician-patient relationship is the foundation on which all healthcare services are built. Understanding this, we continuously assess our communities to identify service gaps and practice opportunities in order to recruit an optimal mix of primary care physicians and specialists. We analyze demographic data and referral trends and employ recruiters at the corporate level to support local hospital administrators in their physician recruitment efforts. In some markets, we employ physicians, often acquiring their practices at the onset of the arrangement. However, most physicians in our communities and on our medical staffs remain in private practice and are not our employees.

We work hard to develop positive, collaborative relationships with physicians. We currently have fifteen Medicare Shared Savings Program Accountable Care Organizations which include approximately 4,500 employed and independent physicians in our communities. We look forward to realizing the benefits of these Accountable Care Organizations, including opportunities to strengthen quality, deepen clinical collaboration and demonstrate performance under a reimbursement system moving toward more value-based incentives and payments.

Developing a More Consumer-Centric Experience and Facilitating Connections between Episodes of Care. Consumers continue to take a more active role in healthcare decision-making, especially as they assume increasing responsibility for the cost of their healthcare. The rise in consumerism is highlighting customer expectations that have not always been prioritized in the healthcare setting. We are working on ways to create more enduring relationships with our patients by providing services that help people navigate their healthcare journeys and enable more seamless connections across episodes in our healthcare systems, hospitals, and physician practices. Some of these initiatives include:

- A centralized and proprietary transfer center offering services to connect emergency department and hospitalized patients requiring transfer to facilities that can best meet their needs;

Centralized patient scheduling call centers and online scheduling to ease appointment scheduling;

Patient navigation and next appointment scheduling from existing points of care;

Availability of virtual health for certain services provided in the hospital and for direct-to-consumer, on-demand virtual visits with physicians;

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Digital marketing and consumer engagement campaigns; and

Technology enabled initiatives that support connected healthcare experiences, such as patient portals, text message appointment reminders, gaps-in-care campaigns and post-discharge surveys.

Increase productivity and operating efficiencies to enhance profitability

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

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

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

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

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

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

Appropriate management of length of stay consistent with national standards and benchmarks;

Reducing unnecessary utilization;

Developing and implementing operational best practices;

Discharge planning; and

Compliance with applicable regulatory standards.

Our case management program integrates the functions of utilization review, discharge planning, assessment of medical necessity and resource management. Patients are assessed upon presentation to the hospital and throughout their course of care with ongoing reviews. Industry standard criteria are utilized in patient

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assessments and discharge plans are adjusted according to patient needs. Cases are monitored to prevent delays in service or unnecessary utilization of resources. When a patient is ready for discharge, a case manager works with the patient s attending physician to evaluate and coordinate the patient s needs for continued care in the post-acute setting. Each hospital has the support of a physician advisor to act as a liaison to the medical staff and assist with all the activities of the program.

Other Initiatives. Numerous other initiatives have been standardized or centralized and leverage data to reduce costs and increase productivity. For example, we have improved staff scheduling and efficiency by implementing standardized time keeping systems and we have implemented initiatives to reduce unnecessary overtime and guide temporary staffing decisions that align with patient admissions and acuity. We have created a centralized team and implemented standard processes for payroll processing and management of accounts payable. Likewise, we have leveraged data and expertise to optimize our performance in clinical and operating areas such as emergency room, pharmacy, laboratory, imaging and skilled nursing services and health information management. Each time we implement a new process initiative, we work to identify and communicate best practices and we monitor progress and performance improvement throughout the organization.

Continuously Improve Patient Safety and Quality of Care

We maintain quality assurance programs to monitor, support and advance quality of care standards and to meet Medicare and Medicaid accreditation and regulatory requirements. We maintain an emphasis on patient safety and clinical outcomes and we are continuously focused on ways to improve patient, physician and employee satisfaction. We believe that a focus on continuous improvement yields the best results for patients, reduces risk and liability, and creates value for the people and communities we serve.

We have developed and implemented programs to support and monitor patient safety and quality of care that include:

- Standardized data and benchmarks to monitor clinical outcomes, hospital performance and quality improvement efforts;
- Recommended policies and procedures based on medical and scientific evidence;
- Training with evidence-based tools for improving patient safety and quality of care and patient, physician and employee satisfaction;
- Leveraging technology and information sharing around evidence-based clinical best practices;
- Training programs for hospital management and clinical staff regarding regulatory and reporting requirements; and
- Implementation of specific leadership methods and error-prevention tools to create safer care environments for patients and staff.

We have operated a Patient Safety Organization, or PSO, since 2011. Our PSO is listed by the U.S. Department of Health and Human Services, or HHS, Agency for Healthcare Research and Quality. We believe our PSO has assisted, and will continue to assist us, in improving patient safety at our hospitals. The PSO has been recertified through 2019.

Optimize our portfolio through select divestitures of non-core assets while investing in markets with the best opportunities for growth

We have been reshaping our portfolio through the divestiture of non-core hospital and non-hospital assets to strategic and other buyers. In 2019, we intend to divest additional hospitals in select markets. Generally, these divested assets are less complementary to our business strategies and/or have lower operating margins. We have used, and expect to continue to use, proceeds from divestitures to reduce debt.

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

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

Industry Overview

According to the Centers for Medicare & Medicaid Services, or CMS, national healthcare expenditures grew 3.9% in 2017 to $3.5 trillion and are projected to have grown 5.3% in 2018 to nearly $3.7 trillion. The CMS projections, published in February of 2018, indicate that total U.S. healthcare spending is expected to grow by 5.5% in 2019 and 2020, and at an average annual rate of 5.7% for 2021 through 2026. CMS anticipates that total U.S. healthcare annual expenditures will reach $5.7 trillion by 2026, accounting for approximately 19.7% of the total U.S. gross domestic product. Healthcare spending is expected to be largely influenced by changes in economic conditions and demographics, as well as by increasing prices for medical goods and services. The CMS projections are constructed using a current-law framework. They are typically published once per year and are not updated to reflect interim changes. For example, the projections do not take into account the possibility of further modifications to, or repeal of, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, collectively, the Affordable Care Act.

Hospital services, the market within the healthcare industry in which we primarily operate, is the largest single category of healthcare expenditures. In 2018, hospital care expenditures are projected to have grown 5.1%, amounting to nearly $1.2 trillion. CMS estimates that the hospital services category will amount to nearly $1.3 trillion in 2019 and projects growth in this category at an average of 5.7% annually from 2019 through 2026.

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 5,300 community hospitals in the U.S., which are not-for-profit owned, investor owned, or state or local government owned. Of these hospitals, nearly 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 offer other ancillary services, including psychiatric, diagnostic, rehabilitation, home care and outpatient surgery services.

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

- facility size and location;
- facility ownership structure (e.g., tax-exempt or investor owned);

a facility s ability to participate in GPOs, such as HealthTrust; and

facility payor mix.

Patients needing the most complex care are more often served by the larger and/or more specialized urban hospitals. We believe opportunities exist in selected urban markets to create networks between urban hospitals and non-urban hospitals in order to expand the breadth of services offered in the non-urban hospitals while improving physician alignment in those markets and making them more attractive to managed care organizations.

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Hospital Industry Trends

Demographic Trends. According to the U.S. Census Bureau, in 2017, there were approximately 51 million Americans aged 65 or older in the U.S. comprising approximately 15.6% of the total U.S. population. By the year 2030, the number of Americans aged 65 or older is expected to climb to 72 million, or 19.3% of the total population. Due to the anticipated increasing life expectancy of Americans, the number of people aged 85 years and older is also expected to increase from 6 million in 2015 to 9 million by the year 2030. This anticipated 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 those impacted most directly by this increase in demand. Based on data compiled for us, the populations of the service areas where our hospitals are located grew 6.9% from 2011 to 2018 and are expected to grow by 4.2% from 2018 to 2023. The number of people aged 65 or older in these service areas grew by 26.8% from 2011 to 2018 and is expected to grow by 16.8% from 2018 to 2023. People aged 65 or older comprised 17.5% of the total population in our service areas in 2018, yet they could comprise 19.6% of the total population in our service areas by 2023.

Consolidation. In addition to our own acquisitions and dispositions in recent years, consolidation activity in the hospital industry, primarily through mergers and acquisitions involving both for-profit and not-for-profit hospital systems, is continuing. Reasons for this activity include:

- ample supply 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;
- changes to healthcare payment models that emphasize cost-effective delivery of service and quality of outcomes for the entire episode of care; and
- regulatory changes.

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

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

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

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Selected Operating Data

The following table sets forth operating statistics for each of the years presented for our hospitals that are included in our continuing operations. Statistics for 2018 include a full year of operations for 113 hospitals and partial periods for 11 hospitals divested during the year and three hospitals that ceased operations during the year reflecting the operations of these hospitals prior to divestiture or closure. Statistics for 2017 include a full year of operations for 125 hospitals and partial periods for 30 hospitals divested during the year reflecting the operations of these hospitals prior to divestiture. Statistics for 2016 include a full year of operations for 152 hospitals and partial periods for three hospitals acquired during the year reflecting the operations of these hospitals following the completion of the acquisition. Statistics for hospitals included in discontinued operations are excluded from all periods presented.

	Year Ended December 31,		
	2018	2017	2016
	(Dollars in millions)		
Consolidated Data			
Number of hospitals (at end of period)	113	125	155
Licensed beds (at end of period) (1)	18,227	20,850	26,222
Beds in service (at end of period) (2)	16,297	18,457	23,229
Admissions (3)	627,321	738,036	857,412
Adjusted admissions (4)	1,351,857	1,596,739	1,867,348
Patient days (5)	2,815,401	3,296,469	3,832,104
Average length of stay (days) (6)	4.5	4.5	4.5
Occupancy rate (beds in service) (7)	43.5 %	43.3 %	43.1 %
Net operating revenues	$ 14,155	$ 15,353	$ 18,438
Net inpatient revenues as a % of net operating revenues (8)	47.7 %	47.7 %	44.2 %
Net outpatient revenues as a % of net operating revenues (8)	52.3 %	52.3 %	55.8 %
Net loss attributable to Community Health Systems Inc. stockholders	$ (788)	$ (2,459)	$ (1,721)
Net loss attributable to Community Health Systems Inc. stockholders as a % of net operating revenues	(5.6)%	(16.0)%	(9.3) %
Adjusted EBITDA (9)	$ 1,642	$ 1,703	$ 2,225
Adjusted EBITDA as a % of net operating revenues (9)	11.6 %	11.1 %	12.1 %
Liquidity Data			
Net cash flows provided by operating activities	$ 274	$ 773	$ 1,137
Net cash flows provided by operating activities as a % of net operating revenues	1.9 %	5.0 %	6.2 %
Net cash flows (used in) provided by investing activities	$ (245)	$ 1,069	$ 630
Net cash flows used in financing activities	$ (396)	$ (1,517)	$ (1,713)

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	Year Ended December 31, 2018	2017	(Decrease) Increase
	(Dollars in millions)		
Same-Store Data (10)			
Admissions (3)	580,845	588,769	(1.3)%
Adjusted admissions (4)	1,251,066	1,255,931	(0.4)%
Patient days (5)	2,606,059	2,619,494	
Average length of stay (days) (6)	4.5	4.4	
Occupancy rate (beds in service) (7)	44.1 %	43.9 %	
Net operating revenues	$ 13,331	$ 12,969	2.8 %
Income from operations	$ 1,032	$ 990	4.2 %
Income from operations as a % of net operating revenues	7.7 %	7.6 %	
Depreciation and amortization	$ 651	$ 685	
Equity in earnings of unconsolidated affiliates	$ (21)	$ (15)	

(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 number of beds in service.

(8) This calculation excludes the change in estimate related to net patient revenue to increase contractual allowances and additional provision for bad debts recorded during the three months ended December 31, 2017.

(9) EBITDA is a non-GAAP financial measure which consists of net loss attributable to Community Health Systems, Inc. before interest, income taxes, and depreciation and amortization. Adjusted EBITDA, also a non-GAAP financial measure, is EBITDA adjusted to add back net income attributable to noncontrolling interests and to

exclude the effect of discontinued operations, loss (gain) from early extinguishment of debt, impairment and (gain) loss on sale of businesses, gain on sale of investments in unconsolidated affiliates, expense incurred related to the spin-off of QHC, expense incurred related to the sale of a majority ownership interest in the Company s home care division, expense (income) related to government and other legal settlements and related costs, expense related to employee termination benefits and other restructuring charges, expense (income) from settlement and fair value adjustments on the CVR agreement liability related to the Health Management Associates, Inc., or HMA, legal proceedings and related legal expenses, and the overall impact of the change in estimate related to net patient revenue recorded in the fourth quarter of 2017 resulting from the increase in contractual allowances and the provision for bad debts. The Company has from time to time sold noncontrolling interests in certain of its subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. The Company believes that it is useful to present Adjusted EBITDA because it adds back the portion of EBITDA attributable to these third-party interests and clarifies for investors the Company s portion of EBITDA generated by continuing operations. The Company reports Adjusted EBITDA as a measure of financial performance. Adjusted EBITDA is a key measure used

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by management to assess the operating performance of the Company s hospital operations and to make decisions on the allocation of resources. Adjusted EBITDA is also used to evaluate the performance of the Company s executive management team and is one of the primary targets used to determine short-term cash incentive compensation. In addition, management utilizes Adjusted EBITDA in assessing the Company s consolidated results of operations and operational performance and in comparing the Company s results of operations between periods. The Company believes it is useful to provide investors and other users of the Company s financial statements this performance measure to align with how management assesses the Company s results of operations. Adjusted EBITDA also is comparable to a similar metric called Consolidated EBITDA, as defined in the Company s senior secured credit facility, which is a key component in the determination of the Company s compliance with some of the covenants under the Company s senior secured credit facility (including the Company s ability to service debt and incur capital expenditures), and is used 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). For further discussion of Consolidated EBITDA and how that measure is utilized in the calculation of our debt covenants, see the Capital Resources section of Part II, Item 7 of this Form 10-K.

Adjusted EBITDA is not a measurement of financial performance under U.S. GAAP. It should not be considered in isolation or as a substitute for net income, operating income, or any other performance measure calculated in accordance with U.S. GAAP. The items excluded from Adjusted EBITDA are significant components in understanding and evaluating financial performance. The Company believes such adjustments are appropriate as the magnitude and frequency of such items can vary significantly and are not related to the assessment of normal operating performance. Additionally, this calculation of Adjusted EBITDA may not be comparable to similarly titled measures reported by other companies.

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

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

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

Sources of Revenue

The following table presents the approximate percentages of net operating revenues by payor source for the periods indicated. The data for the periods presented are not strictly comparable due to the effect that hospital acquisitions and divestitures have had on these statistics. The percentages of net operating revenues for 2017 also include the overall impact of the change in estimate recorded in the fourth quarter of 2017 to increase contractual allowances and record additional provision for bad debts.

	Year Ended December 31,		
	2018	**2017**	**2016**
Medicare	26.3 %	27.8 %	27.2 %
Medicaid	13.3	13.2	11.9
Managed Care and other third-party payors	59.0	59.8	58.4
Self-pay	1.4	(0.8)	2.5
Total	100.0 %	100.0 %	100.0 %

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As shown above, we receive a substantial portion of our revenues from the Medicare and Medicaid programs. Included in Managed Care and other third-party payors is operating revenues from insurance companies with which we have insurance provider contracts, Medicare managed care, insurance companies for which we do not have insurance provider contracts, workers compensation carriers and non-patient service revenue, such as rental income and cafeteria sales. In the future, we generally expect the portion of our revenues to be received from the Medicare and Medicaid programs to increase due to the general aging of the population. In addition, the Affordable Care Act has increased the number of insured patients in states that have expanded Medicaid, which in turn, has reduced the percentage of revenues from self-pay patients. However, it is unclear whether the trend of increased coverage will continue, due in part to the elimination of the financial penalty associated with the individual mandate, effective January 1, 2019. Further, the Affordable Care Act imposes significant reductions in amounts the government pays Medicare managed care plans. The trend toward increased enrollment in Medicare managed care may adversely affect our operating revenue growth. Other provisions in the Affordable Care Act impose minimum medical-loss ratios and require insurers to meet specific benefit requirements. Furthermore, in the normal course of business, managed care programs, insurance companies and employers actively negotiate the amounts paid to hospitals. The trend toward increased enrollment in managed care may adversely affect our operating revenue growth. There can be no assurance that we will retain our existing reimbursement arrangements or that these third-party payors will not attempt to further reduce the rates they pay for our services.

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-based reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for the treatment of patients covered by Medicare, Medicaid and non-governmental payors 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 loss by an insignificant amount in each of the years ended December 31, 2018, 2017 and 2016.

The payment rates under the Medicare program for hospital inpatient and outpatient acute care services are based on a prospective payment system, depending upon the diagnosis of a patient s condition. These rates are indexed for inflation annually, although increases have historically been less than actual inflation. On August 2, 2018, CMS issued the final rule to increase this index by 2.9% for hospital inpatient acute care services that are reimbursed under the prospective payment system, beginning October 1, 2018. The final rule provides for a 0.8% multifactor productivity reduction, 0.75% reduction to hospital inpatient rates implemented pursuant to the Affordable Care Act, and a positive 0.5% adjustment in accordance with the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, which will yield an estimated net 1.85% increase in reimbursement for hospitals. An additional reduction applies to hospitals that do not submit required patient quality data. We are complying with this data submission requirement. Payments may also be affected by admission and medical review criteria for inpatient services commonly known as the two midnight rule. Under the rule, for admissions on or after October 1, 2013, services to Medicare beneficiaries are only payable as inpatient hospital services when there is a reasonable expectation that the hospital care is medically necessary and will be required across two midnights, absent unusual circumstances. Stays expected to need less than two midnights of hospital care are subject to medical review on a case-by-case basis. Reductions in the rate of increase or overall reductions in Medicare reimbursement may cause a decline in the growth of our net operating revenues.

Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from CMS and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Similar programs are also being

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considered by other states. The programs are generally authorized for a specified period of time and require CMS s approval to be extended. CMS has indicated that it will take into account a state s status with respect to expanding its Medicaid program in considering whether to extend these supplemental programs. We are unable to predict whether or on what terms CMS will extend the supplemental programs in the states in which we operate. As a result of existing supplemental programs, we recognize revenue and related expenses in the period in which the fixed and determinable amounts are estimable and collection is reasonably assured. Reimbursement under these programs is reflected in net operating revenues and included as Medicaid revenue in the table above, and fees, taxes or other program related costs are reflected in other operating expenses.

As of December 31, 2018, Florida, Texas and Indiana represented our only areas of significant geographic concentration. Net operating revenues generated by our hospitals in Florida, as a percentage of consolidated operating revenues, were 14.3% in 2018, 14.0% in 2017 and 13.6% in 2016. Net operating revenues generated by our hospitals in Texas, as a percentage of consolidated operating revenues, were 11.7% in 2018, 10.9% in 2017 and 10.4% in 2016. Net operating revenues generated by our hospitals in Indiana, as a percentage of consolidated operating revenues, were 12.5% in 2018, 11.6% in 2017 and 9.4% in 2016.

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

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

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

Government Regulation

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

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

applicable health and administrative standards to participate in Medicare and Medicaid programs.

Government regulations may change. If that happens, we may have to make changes to our facilities, equipment, personnel and services so that our hospitals remain certified as hospitals and qualified to participate in these programs. We believe that our hospitals are in substantial compliance with current federal, state and

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local regulations and standards. We cannot be certain that governmental officials responsible for enforcing these laws or whistleblowers will not assert that we are in violation of them or that such statutes or regulations will be interpreted by the courts in a manner consistent with our interpretation.

Healthcare Reform. Over the last decade, the U.S. Congress and certain state legislatures have introduced and passed a large number of proposals and legislation designed to make major changes in the healthcare system, including changes intended to increase access to health insurance. The most prominent of these efforts, the Affordable Care Act, affects how healthcare services are covered, delivered, and reimbursed, but its future is uncertain. The law has been subject to legislative and regulatory changes and court challenges, and the presidential administration and certain members of Congress have stated their intent to repeal or make additional significant changes to, the Affordable Care Act, its implementation or its interpretation. For example, the Affordable Care Act mandates that substantially all U.S. citizens maintain health insurance coverage and increases health insurance coverage through a combination of public program expansion and private sector health insurance reforms. However, as part of the tax reform legislation which was enacted in December 2017, effective January 1, 2019, the financial penalty for individuals that fail to maintain health insurance coverage associated with the individual mandate was eliminated. Additionally, final rules issued in 2018 expand the availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. These changes may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased. In December 2018, a federal judge in Texas found the entire Affordable Care Act to be unconstitutional, as a result of the elimination of the individual mandate penalty as noted above. Pending the appeal process, the law remains in place.

We believe that the Affordable Care Act has had a positive impact on net operating revenues and income from continuing operations as the result of the expansion of private sector and Medicaid coverage that has occurred. However, other provisions of the Affordable Care Act, such as requirements related to employee health insurance coverage, have increased our operating costs. In addition, the Affordable Care Act has made changes to Medicare and Medicaid reimbursement that could adversely impact the reimbursement we receive under these programs. These changes include reductions to the Medicare annual market basket update for federal fiscal years 2010 through 2019, a productivity offset to the Medicare market basket update, and reductions to the Medicare and Medicaid disproportionate share hospital payments.

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

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

making claims to Medicare for services not provided or misrepresenting actual services provided in order to obtain higher payments;

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paying money to induce the referral of patients where services are reimbursable under a federal health program; or

paying money to limit or reduce the services provided to Medicare beneficiaries.

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

A section of the Social Security Act, known as the Anti-Kickback Statute 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 programs.

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. 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; however, such failure may lead to increased scrutiny by government enforcement authorities.

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;

coverage on the hospital s group health insurance plans at an inappropriately low cost to the physician;

purchasing goods or services from physicians at prices in excess of their fair market value;

rental of space in physician offices, at other than fair market value; or

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

We have a variety of financial relationships with physicians who refer patients to our hospitals. Physicians own interests in a number of our facilities. Physicians may also own our stock. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases, management agreements and professional service agreements. We provide financial incentives to recruit physicians to relocate to communities served by our hospitals. These incentives include relocation, reimbursement for certain direct expenses, income guarantees and, in some cases, loans. Although we strive to comply with the Anti-Kickback Statute, taking into account available guidance including the safe harbor regulations, we cannot assure you that regulatory authorities will not determine otherwise. If that happens, we could be subject to criminal and civil penalties and/or exclusion from participating in Medicare, Medicaid, or other government healthcare programs. Civil monetary penalties are increased annually based on updates to the consumer price index and were increased under the Bipartisan Budget Act of 2018.

The Social Security Act also includes a provision commonly known as the Stark Law. This law prohibits physicians from referring Medicare and Medicaid 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 monetary penalties that are increased annually based on updates to the consumer price index, and exclusion from federal healthcare programs.

There are ownership and compensation arrangement exceptions to the self-referral prohibition. One exception, known as the whole hospital 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 that interpret the provisions included in the Stark Law.

The Affordable Care Act narrowed the whole hospital exception to the Stark Law. The Affordable Care Act permitted existing physician investments in a whole hospital to continue under a grandfather clause if the arrangement satisfies certain requirements and restrictions, but physicians are prohibited, from the time the Affordable Care Act became effective, from increasing the aggregate percentage of their ownership in the hospital. The Affordable Care Act also restricts the ability of existing physician-owned hospitals to expand the capacity of their aggregate licensed beds, operating rooms and procedure rooms. The whole hospital exception also contains additional public disclosure requirements.

In addition to the restrictions and disclosure requirements applicable to physician-owned hospitals under the Stark Law, CMS regulations require physician-owned hospitals and their physician owners to disclose certain ownership information to patients. Physician-owned hospitals must disclose their physician ownership in writing to patients and must make a list of their physician owners available upon request. Additionally, each physician owner who is a member of a physician-owned hospital s medical staff must agree, as a condition of continued medical staff membership or admitting privileges, to disclose in writing to all patients whom they refer to the hospital their (or an immediate family member s) ownership interest in the hospital. A hospital is considered to be physician-owned if any physician, or an immediate family member of a physician, holds debt, stock or other types of investment in the hospital or in any owner of the hospital, excluding physician ownership through publicly-traded securities that meet certain conditions. If a hospital fails to comply with these regulations, the hospital could lose its Medicare provider agreement and be unable to participate in Medicare.

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

Many states in which we operate have also adopted laws that prohibit payments to physicians in exchange for referrals similar to the federal Anti-Kickback Statute or that otherwise prohibit fraud and abuse activities. Many states have also passed self-referral legislation similar to the Stark Law, prohibiting the referral of patients to entities with which the physician has a financial relationship. Often these state laws are broad in scope and may apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties, as well as loss of licensure. Little precedent exists for the interpretation or enforcement of these state laws.

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

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

When a defendant is determined by a court of law to be liable under the FCA, the defendant must pay three times the actual damages sustained by the government, plus substantial civil penalties for each separate false claim. These civil monetary penalties are adjusted annually based on updates to the consumer price index. Settlements entered into prior to litigation usually involve a less severe calculation of damages. The FCA also contains qui tam, or whistleblower provisions, which allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. If the government intervenes in the action and prevails, the party filing the initial complaint may share in any settlement or judgment. If the government does not intervene in the action, the

whistleblower plaintiff may pursue the action independently and may receive a larger share of any settlement or judgment. When a private party brings a qui tam action under the

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FCA, the defendant generally will not be made aware of the lawsuit until the government commences its own investigation or determines whether it will intervene. Every entity that receives at least $5 million annually in Medicaid payments must have written policies for all employees, contractors and agents providing detailed information about false claims, false statements and whistleblower protections under certain federal laws, including the FCA, and similar state laws.

A number of states, including states in which we operate, have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court. Federal law provides an incentive to states to enact false claims laws that are comparable to the FCA. From time to time, companies in the healthcare industry, including ours, may be subject to actions under the FCA or similar state laws.

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 to, or entering into fee-splitting arrangements with, 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 provide assurance 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, which are increased annually based on updates to the consumer price index. In addition, the law creates private civil remedies that 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 will not assert we are in violation of this law.

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 hospitals.

Certificates of Need. The construction of new facilities, the acquisition of existing facilities, significant capital expenditures 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, significant capital expenditure or the addition of new services. As of December 31, 2018, we operated 79 hospitals in 15 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

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facilities, complete acquisitions or significant capital expenditures 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.

HIPAA Administrative Simplification and Privacy and Security Requirements. The Health Insurance Portability and Accountability Act of 1996, or HIPAA, requires 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. HHS has established electronic data transmission standards and code sets that all healthcare providers must use when submitting or receiving certain healthcare transactions electronically. In addition, HIPAA requires that each provider use a National Provider Identifier. The Affordable Care Act requires the HHS to adopt standards for additional electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction.

As required by HIPAA, HHS has issued privacy and security regulations that extensively regulate the use and disclosure of individually identifiable health-related information and require covered entities, including health plans and most healthcare providers, to implement administrative, physical and technical practices to protect the security of individually identifiable health information that is electronically maintained or transmitted. Business associates (entities that handle identifiable health-related information on behalf of covered entities) are subject to direct liability for violation of applicable provisions of the regulations. In addition, a covered entity may be subject to penalties as a result of a business associate violating HIPAA, if the business associate is found to be an agent of the covered entity. We have developed and utilize a HIPAA compliance plan as part of our effort to comply with HIPAA privacy and security requirements. The privacy regulations and security regulations have and will continue to impose significant costs on us in order to comply with these standards.

Covered entities must report breaches of unsecured protected health information to affected individuals without unreasonable delay, but not to exceed 60 days of discovery of the breach by the covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all covered entities that report a breach involving more than 500 individuals. All non-permitted uses or disclosures of unsecured protected health information are presumed to be breaches unless the covered entity or business associate establishes that there is a low probability the information has been compromised. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information.

Violations of the HIPAA privacy and security regulations may result in criminal penalties and in substantial civil penalties per violation. The civil penalties are adjusted annually based on updates to the consumer price index. HHS is required to perform compliance audits. In addition to enforcement by HHS, state attorneys general are authorized to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. HHS may resolve HIPAA violations through informal means, such as allowing a covered entity to implement a corrective action plan, but HHS has the discretion to move directly to impose monetary penalties and is required to impose penalties for violations resulting from willful neglect. Our facilities also are subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties. For example, the Federal Trade Commission uses its consumer protection authority to initiate enforcement actions in response to data breaches.

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,

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commonly known as a DRG, based upon the patient s condition and treatment during the relevant inpatient stay. Each DRG is assigned a payment rate using 100% of the national average cost per case and 100% of the severity-adjusted DRG weights. DRG payments are based on national averages and not on charges or costs specific to a hospital. Severity-adjusted DRGs more accurately reflect the costs a hospital incurs for caring for a patient and account more fully for the severity of each patient s condition. 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 payment 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 payment 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 market basket index update of 2.7% and 2.9% for each of federal fiscal years 2018 and 2019, respectively, subject to certain reductions. For federal fiscal year 2018, the market basket update was positively adjusted by 0.46% in accordance with the 21st Century Cures Act, and reduced by 0.6% for the multi-factor productivity adjustment, reduced 0.75% in accordance with the Affordable Care Act, and reduced by 0.6% to remove the effects of prior adjustments related to the two midnight rule. For federal fiscal year 2019, the market basket update was positively adjusted by 0.5% in accordance with MACRA, and reduced 0.8% for the multi-factor productively adjustment, and reduced 0.75% in accordance with the Affordable Care Act. A 25% reduction to the market basket index occurs if patient quality data is not submitted, and a reduction of 75% of the market basket index update occurs for hospitals that fail to demonstrate meaningful use of certified electronic health records, or EHR, technology without receiving a hardship exception. Future legislation may decrease the rate of increase for DRG payments or even decrease such payment rates, but we are unable to predict the amount of any reduction or the effect that any reduction will have on us.

The DRG payment rates are also adjusted to promote value-based purchasing, linking payments to quality and efficiency. First, hospitals that meet or exceed certain quality performance standards will receive greater reimbursement under CMS s value-based purchasing program, while hospitals that do not satisfy certain quality performance standards will receive reduced Medicare inpatient hospital payments. The amount collected from the reductions is pooled and used to fund the payments that reward hospitals based on a set of quality measures that have been linked to improved clinical processes of care and patient satisfaction. CMS scores each hospital on its achievement relative to other hospitals and improvement relative to that hospital s own past performance. Second, hospitals experiencing excess readmissions for conditions designated by CMS within 30 days from the patient s date of discharge will receive inpatient payments reduced by an amount determined by comparing that hospital s readmission performance to a risk-adjusted national average. Third, the 25% of hospitals with the worst national risk-adjusted hospital acquired condition, or HAC, rates in the previous year will have their total inpatient operating Medicare payments reduced by 1%. HHS has indicated that it will increase its efforts to promote, develop and use alternative payment models such as Accountable Care Organizations, or ACOs, and bundled payment arrangements.

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. CMS also distributes a prospectively determined amount to Medicare disproportionate share hospitals based on a hospital s relative share of uncompensated care. These uncompensated care payments are drawn from pool that is funded by the 75% reduction in disproportionate share payments that was made pursuant to the Affordable Care Act. The uncompensated care pool is further reduced each year by a formula that reflects reductions in the U.S. uninsured population that is under 65 years of age. Thus, the greater the level of coverage for the uninsured, the more the Medicare uncompensated care pool will be reduced. Each eligible hospital is paid, out of the uncompensated care pool, an amount based upon its estimated cost of providing uncompensated care. These Medicare disproportionate share and uncompensated care payments as a percentage of net operating revenues

was 1.27% and 1.16% for the years ended December 31, 2018 and

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

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

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

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

Payment under the Medicare program for physician services is based upon the Medicare Physician Fee Schedule, or MPFS, under which CMS has assigned a national relative value unit, or RVU, to most medical procedures and services that reflects the resources required to provide the services relative to all other services. Each RVU is calculated based on a combination of the time and intensity of work required, overhead expense attributable to the service, and malpractice insurance expense. These elements are each modified by a geographic adjustment factor to account for local practice costs and are then aggregated. The Bipartisan Budget Act of 2018 provides for a 0.25% update to the MPFS, which is then reduced by a 0.14% budget neutrality adjustment for an overall estimated increase of 0.11% for calendar year 2019. MACRA requires the establishment of the Quality Payment Program, or QPP, a payment methodology intended to reward high-quality patient care. Beginning in 2017, physicians and certain other healthcare clinicians are required to participate in one of two QPP tracks. Under both tracks, performance data collected each performance year will affect Medicare payments two years later. CMS expects to transition increasing financial risk to providers as QPP evolves. Under the Advanced Alternative Payment Model, or Advanced APM, track, incentive payments are available based on participation in specific innovative payment models approved by CMS. Providers may earn a Medicare incentive payment and will be exempt from the reporting requirements and payment adjustments imposed under the Merit-Based Incentive Payment System, or MIPS, if the provider has sufficient participation in an Advanced APM. Alternatively, providers may participate in the MIPS track, under which physicians will receive performance-based payment incentives or payment reductions based on their performance with respect to clinical quality, resource use, clinical improvement activities, and meaningful use of EHR. MIPS consolidates components of certain previously established physician incentive programs.

Medicaid. Most state Medicaid payments are made under a PPS or under programs which negotiate payment levels with individual hospitals. Medicaid is funded jointly by state and federal government. The federal government and many states are considering various strategies to reduce Medicaid expenditures. Currently, several states utilize supplemental reimbursement programs intended to offset a portion of the costs to providers

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associated with providing care to Medicaid and indigent patients. These programs are designed with input from CMS and may be funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the healthcare providers. Many states currently operate, or have applied to CMS to operate, Medicaid programs under waivers to standard Medicaid program requirements. CMS has indicated that it intends to increase state flexibility in the administration of Medicaid programs, including allowing states to condition enrollment on work or other community engagement. We can provide no assurance that changes to Medicaid programs or reductions to Medicaid funding will not have a material adverse effect on our consolidated results of operations.

TRICARE. TRICARE is the Department of Defense s healthcare program for members of the armed forces. For inpatient services, TRICARE generally reimburses hospitals based on a DRG system modeled on the Medicare inpatient PPS. For outpatient services, TRICARE reimburses hospitals based on a PPS that is similar to that utilized for services furnished to Medicare beneficiaries.

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 OIG is also actively engaged in audits and investigations into alleged abuses of the DRG outlier payment system.

Commercial Insurance and Managed Care Companies. Our hospitals provide services to individuals covered by private healthcare insurance or by health plans administered by managed care companies. These payors 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. They try to limit the costs of hospital services by negotiating discounts, including PPS, which would reduce payments by commercial insurers or health plans to our hospitals. Commercial insurers and managed care companies also seek to reduce payments to hospitals by establishing payment rules that in effect re-characterize the services ordered by physicians. For example, some payors vigorously review each patient s length of stay in the hospital and recharacterize as outpatient all inpatient stays of less than a particular duration (e.g., 24 hours). Reductions in payments for services provided by our hospitals to individuals covered by these payors could adversely affect us.

Under the Managed Medicare program, also known as Medicare Part C, or Medicare Advantage, the federal government contracts with private health plans to provide members with Medicare benefits. The plans may choose to offer supplemental benefits and impose higher premiums and cost-sharing obligations. Similarly, managed Medicaid programs enable states to contract with private entities to handle program responsibilities like care management and claims adjudication. Enrollment in Managed Medicare and managed Medicaid programs has increased in recent years as the federal and state governments seek to control healthcare costs.

Medicare Administrative Contractors. CMS competitively bids the Medicare fiscal intermediary and Medicare carrier functions to Medicare Administrative Contractors, or MACs, in 12 jurisdictions. Each MAC is geographically assigned and serves both Part A and Part B providers within a given jurisdiction. Chain providers had the option of having all hospitals use one home office MAC, and we chose to do so. However, CMS has not converted all of our hospitals to one MAC and currently does not have an established date to accomplish the conversion. CMS periodically

re-solicits bids, and the MAC servicing a geographic area can change as a result of the bid competition. MAC transition periods can impact claims processing functions and the resulting cash flow.

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Medicare Integrity. CMS contracts with third parties to promote the integrity of the Medicare program through review of quality concerns and detection of improper payments. Quality Improvement Organizations, or QIOs, for example, are groups of physicians and other healthcare quality experts that work on behalf of CMS to ensure that Medicare pays only for goods and services that are reasonable and necessary and that are provided in the most appropriate setting. Under the Recovery Audit Contractor, or RAC, program, CMS contracts with RACs nationwide to conduct post-payment reviews to detect and correct improper payments in the Medicare program, as required by statute. RACs review claims submitted to Medicare for billing compliance, including correct coding and medical necessity. Compensation for RACs is on a contingency basis and based upon the amount of overpayments and underpayments identified, if any. CMS limits the number of claims that RACs may audit by limiting the number of records that RACs may request from hospitals based on each provider s claim denial rate for the previous year.

The RAC program s scope also includes Medicaid claims. States may coordinate with Medicaid RACs regarding recoupment of overpayments and refer suspected fraud and abuse to appropriate law enforcement agencies. Under the Medicaid Integrity Program, CMS employs private contractors, referred to as Medicaid Integrity Contractors, or MICs, to perform reviews and post-payment audits of Medicaid claims and identify overpayments. MICs are assigned to five geographic jurisdictions. Besides MICs, several other contractors and state Medicaid agencies have increased their review activities. CMS is transitioning some of its other integrity programs to a consolidated model by engaging Unified Program Integrity Contractors, or UPICs, to perform audits, investigations and other integrity activities.

We maintain policies and procedures to respond to the RAC requests and payment denials. Payment recoveries resulting from RAC reviews and denials are appealable, and we pursue reversal of adverse determinations at appropriate appeal levels. Currently, there are significant delays in the assignment of new Medicare appeals to Administrative Law Judges. According to the Office of Medicare Hearings and Appeals, the average processing time in fiscal year 2017 was approximately three years. HHS has finalized rules intended to streamline the process and improve efficiency but has also stressed the need for additional funding. Thus, we may experience significant delays in appealing any RAC payment denials. To ease the backlog of appeals, CMS has announced two new settlement initiatives. Depending upon the growth of RAC programs and our success in appealing claims in future periods, our cash flows and results of operations could be negatively impacted.

Accountable Care Organizations. With the aim of reducing healthcare costs by improving quality and operational efficiency, ACOs are gaining traction in both the public and private sectors. An ACO is a network of providers and suppliers (including hospitals, physicians and other designated professionals) which work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. ACOs are intended to produce savings as a result of improved quality and operational efficiency. Pursuant to the Affordable Care Act, HHS established a Medicare Shared Savings Program that seeks to promote accountability and coordination of care through the creation of ACOs. Medicare-approved ACOs that achieve quality performance standards established by HHS are eligible to share in a portion of the amounts saved by the Medicare program. HHS has significant discretion to determine key elements of ACO programs. Certain waivers are available from fraud and abuse laws for ACOs.

Bundled Payment Initiatives. The CMS Innovation Center is responsible for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for healthcare that create savings under the Medicare and Medicaid programs, while maintaining or improving quality of care. For example, providers participating in bundled payment initiatives accept accountability for costs and quality of care by agreeing to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care. By rewarding providers for increasing quality and reducing costs and penalizing providers if costs exceed a certain amount, bundled payment models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. The CMS Innovation Center has implemented a voluntary

bundled payment program known as the Bundled Payment for Care Improvement, or BPCI, initiative. We are participating in BPCI initiatives in ten of our markets.

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

Supply Contracts

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

Competition

The hospital industry is highly competitive. The competition among hospitals and other healthcare providers for patients has intensified as patients have become more conscious of rising costs and quality of care in the healthcare decision-making process. Certain of our hospitals are located in non-urban service areas in which we are the sole provider of general acute care health services. Those hospitals in non-urban service areas face no direct competition because there are no other hospitals in their primary service areas. However, these hospitals face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in those service areas may travel to these other hospitals for a variety of reasons, including the need for services we do not offer, payor networks that exclude our providers, 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. Our other 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. We also face competition from other specialized care providers, including outpatient surgery, orthopedic, oncology and diagnostic centers. Some competitors are implementing physician alignment strategies, such as employing physicians, acquiring physician practice groups, and participating in ACOs, or other clinical integration models. Cost-reduction strategies by large employer groups and their affiliates may increase this competition. We believe that we will continue to face increased competition in outpatient service models that become more integrated through acquisitions or partnerships between physicians, specialized care providers, and managed care payors.

In most markets in which we are not the sole provider of general acute care health services, our primary competitor is a not-for-profit hospital. These hospitals are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. These hospitals do not pay income or property taxes, and can make capital expenditures without paying sales tax. These financial advantages may better position such hospitals to maintain more modern and technologically upgraded facilities and equipment and offer services more specialized than those available at our hospitals. Recent consolidations of not-for-profit hospitals may intensify competitive pressures.

The number and quality of the physicians on a hospital s staff is an important factor in a hospital s competitive position. 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. In addition, CMS publicizes on its Hospital Compare website data that hospitals submit in connection with Medicare reimbursement claims, including performance data related to quality measures and patient satisfaction surveys. Federal law provides for the future expansion of the number of quality measures that must be reported. Additional quality measures and other future trends toward clinical

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

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. We believe 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.

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.

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 the federal anti-kickback statute and the Stark Law, 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-of-conduct.

Corporate Integrity Agreement

On August 4, 2014, we announced that we had entered into a civil settlement with the U.S. Department of Justice, other federal agencies and identified relators that concluded previously announced investigations and litigation related to short stay admissions through emergency departments at certain of our affiliated hospitals. See the Legal Proceedings discussion in Part II, Item 1 of our Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2014 for further discussion of the background of this matter and details of the settlement. In addition to the amounts paid in the settlement, we executed a five-year Corporate Integrity Agreement, or CIA, with the OIG that has been incorporated into our existing and comprehensive compliance program.

On September 25, 2018, we announced a global resolution and settlement agreements ending the U.S. Department of Justice investigation into certain conduct of HMA and its affiliated entities and settling certain qui tam lawsuits that

were initiated and pending, and known to us, before our acquisition by merger of HMA in 2014. Under this settlement, we made payments totaling $266 million, including interest, in the fourth quarter of 2018. See the Legal Proceedings discussion in Part II, Item 1 of our Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2018 and the press release filed therewith on September 25, 2018 for

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further discussion of this matter and the details of the settlement. Additionally, under the terms of the global settlement, our existing CIA has been amended and extended. The extension began immediately and effectively adds two years to the existing CIA, with the amended CIA now running through 2021.

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

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

Material, uncorrected violations of the CIA could lead to our suspension or disbarment from participation in Medicare, Medicaid and other federal and state healthcare programs and repayment obligations. In addition, we are subject to possible civil penalties for failure to substantially comply with the terms of the CIA, including stipulated

penalties ranging from $1,000 to $2,500 per day. We are also subject to a stipulated penalty of $50,000 for each false certification made by us or on our behalf in connection with reports required under the CIA. The CIA increases the amount of information we must provide to the federal government regarding our healthcare practices and our compliance with federal regulations. The reports we provide in connection with the CIA could result in greater scrutiny by regulatory authorities. We believe our existing Compliance Program addresses compliance with the operational terms of the CIA.

Employees and Medical Staff

At December 31, 2018, we had approximately 87,000 employees, including approximately 17,000 part-time employees. References herein to employees refer to employees of our affiliates. We are subject to various state and federal laws that regulate wages, hours, benefits and other terms and conditions relating to employment. At December 31, 2018, certain employees at ten of our hospitals are represented by various labor unions. It is likely that union organizing efforts will take place at additional hospitals in the future. We consider our employee relations to be good and have not experienced work stoppages that have materially, adversely affected our

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business or results of operations. Our hospitals, like most hospitals, have experienced rising labor costs. In some markets, nurse and medical support personnel availability has become a significant operating issue to healthcare providers. To address this challenge, we have implemented several initiatives to improve retention, recruiting, compensation programs and productivity.

Our hospitals are staffed by licensed physicians, including both employed physicians and physicians who are not employees of our hospitals. Some physicians provide services in our hospitals under contracts, which generally describe a term of service, provide and establish the duties and obligations of such physicians, require the maintenance of certain performance criteria and fix compensation for such services. Any licensed physician may apply to be accepted to the medical staff of any of our hospitals, but the hospital s medical staff and the appropriate governing board of the hospital, in accordance with established credentialing criteria, must approve acceptance to the staff. Members of the medical staffs of our hospitals often also serve on the medical staffs of other hospitals and may terminate their affiliation with one of our hospitals at any time.

We may be required to continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary or contract personnel. As a result, our labor costs could increase. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Certain proposed changes in federal labor laws and the National Labor Relations Board s pending modification of its election procedures could increase the likelihood of employee unionization attempts. To the extent a significant portion of our employee base unionizes, our costs could increase significantly. In addition, the states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse-staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs, and have an adverse impact on revenues if we are required to limit patient admissions in order to meet the required ratios.

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 Part II, Item 7 of this Form 10-K.

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 and pharmaceutical waste products. We do not currently expect compliance with these laws and regulations 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 $100,000 deductible and a $20 million annual aggregate. This policy also provides pollution legal liability coverage.

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

Our business faces a variety of risks. If any of the events or circumstances described in any of the following risk factors occurs, our business, results of operations or financial condition could be materially and adversely

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affected, and our actual results may differ materially from those predicted in any forward-looking statements we make in any public disclosures. Additional factors that could affect our business, results of operations and financial condition are discussed elsewhere in this Report (including in Management s Discussion and Analysis of Financial Condition and Results of Operations in Part II, Item 7 of this Form 10-K). Additional risks or uncertainties not presently known to us, or that we currently deem immaterial, also may adversely affect our business, results of operations and financial condition.

Our level of indebtedness could adversely affect our ability to refinance existing indebtedness or 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 related to our indebtedness.

We have a significant amount of indebtedness, which is more fully described in the Liquidity and Capital Resources section of Management s Discussion and Analysis of Financial Condition and Results of Operations in Part II, Item 7 of this Form 10-K and Note 7 of the Notes to Consolidated Financial Statements included under Part II, Item 8 of this Form 10-K. As of December 31, 2018, we had approximately $10.7 billion aggregate principal amount of senior secured indebtedness outstanding, and approximately $2.9 billion of senior unsecured indebtedness outstanding.

Our substantial leverage could have important consequences, including the following:

- it may limit our ability to refinance existing indebtedness or 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 to fund our operations, capital expenditures, financial obligations and future business opportunities;
- some of our borrowings, including borrowings under our credit facilities, accrue interest at variable rates, exposing us to the risk of increased interest rates;
- it may limit our ability to make strategic acquisitions or cause us to make nonstrategic divestitures;
- it may limit our ability to adjust to changing market conditions and place us at a competitive disadvantage compared to our competitors that are less highly leveraged; and
- it may increase our vulnerability in connection with adverse changes in general economic, industry or competitive conditions or government regulations or other adverse developments.

We may not be able to generate sufficient cash to service all of our indebtedness, and we may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our indebtedness depends on our financial and operating performance, which is subject to prevailing economic and competitive conditions and to financial, business, regulatory and other factors beyond our control. We cannot assure you that we will maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness.

In addition, we are a holding company with no direct operations. Our principal assets are the equity interests we hold in our operating subsidiaries. As a result, we are dependent upon dividends and other payments from our subsidiaries to generate the funds necessary to meet our outstanding debt service and other obligations. Our subsidiaries may not generate sufficient cash from operations to enable us to make principal and interest payments on our indebtedness. In addition, any payments of dividends, distributions, loans or advances to us by our subsidiaries could be subject to legal and contractual restrictions.

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

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

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

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

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

merge, consolidate, sell or otherwise dispose of substantially all our assets;

enter into transactions with affiliates; and

guarantee certain obligations.

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

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

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the indentures governing our outstanding notes, all amounts outstanding under the applicable indebtedness may become immediately due and payable and all commitments under the credit facilities to extend further credit may be terminated.

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

Our borrowings under our credit facilities are at variable rates of interest and expose us to interest rate risk. If interest rates increase, our debt service obligations on the variable rate indebtedness would increase even though the amount borrowed remained the same, and our net income would decrease. Our interest expense, net, for the year ended December 31, 2018 was $976 million. For the year ended December 31, 2018, a fluctuation in interest rates of 1% on our variable rate debt that is not hedged by interest rate swaps would have resulted in a fluctuation in our interest expense of approximately $11 million.

If we are unable to make payments on our indebtedness, we could be in default under the terms of the agreements governing our indebtedness.

If we are unable to generate sufficient cash flow and are otherwise unable to obtain funds necessary to meet required payments of principal, premium, if any, and interest on our indebtedness, or if we otherwise fail to comply with the various covenants, including financial and operating covenants, in the instruments governing our indebtedness, including covenants in our credit facilities and the indentures governing our outstanding notes, we could be in default under the terms of the agreements governing such indebtedness. In the event of any default, the holders of such indebtedness could elect to declare all the funds borrowed to be immediately due and payable, together with accrued and unpaid interest; the lenders under our credit facilities could elect to terminate their commitments thereunder, cease making further loans and direct the applicable collateral agents to institute foreclosure proceedings against our assets; and we could be forced into bankruptcy or liquidation. If our operating performance declines, we may in the future need to obtain waivers from the required lenders under our credit facilities to avoid being in default. If we breach our covenants under our credit facilities and seek a waiver, we may not be able to obtain a waiver from the required lenders. If this occurs, we would be in default under our credit facilities, the lenders could exercise their rights, as described above, and we could be forced into bankruptcy or liquidation.

We have a substantial amount of indebtedness that will mature and become due in the near future.

As further described in the Liquidity and Capital Resources section of Management s Discussion and Analysis of Financial Condition and Results of Operations in Part II, Item 7 of this Form 10-K and Note 7 of the Notes to Consolidated Financial Statements included under Part II, Item 8 of this Form 10-K, we have a substantial amount of indebtedness scheduled to mature in the near future, a significant portion of which will mature in close proximity to each other. As a result, we may not have sufficient cash to repay all amounts owing under such indebtedness and there can be no assurance that we will have the ability to borrow or otherwise raise the amounts necessary to repay all such amounts. Our ability to refinance our indebtedness on favorable terms, or at all, is dependent on (among other things) conditions in the credit and capital markets which are beyond our control.

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

We and our subsidiaries have the ability to incur substantial additional indebtedness in the future, subject to restrictions contained in our credit facilities and the indentures governing our outstanding notes. Our ABL facility provides for commitments and borrowings of up to $1.0 billion in the aggregate, of which approximately $698 million

was outstanding as of December 31, 2018. In addition, as of December 31, 2018, our revolving credit facility provided for commitments and borrowings of up to $425.0 million in the aggregate, of which none was outstanding as of December 31, 2018. On February 15, 2019, our Credit Facility was amended, which

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reduced our revolving credit commitments to $385 million. Our credit facilities also give us the ability to provide for one or more additional tranches of term loans and increases in our revolving credit facility in the aggregate principal amount of up to the greater of (x) $500 million and (y) an amount such that our senior secured net leverage ratio would not exceed 4.0:1.0 without the consent of the existing lenders if specified criteria are satisfied. If additional indebtedness is added to our current debt levels, the related risks that we currently face related to indebtedness as noted above could increase.

If we are unable to continue to complete divestitures as previously disclosed, our results of operations and financial condition could be adversely affected.

We have been implementing a portfolio rationalization and deleveraging strategy by divesting hospitals and non-hospital businesses that are attractive to strategic and other buyers. Generally, these businesses are not in one of our strategically beneficial service areas, are less complementary to our business strategy and/or have lower operating margins. In connection with our announced divestiture initiative, we have received offers from strategic buyers to buy certain of our assets. After considering these offers, we have divested or may divest hospitals and non-hospital businesses when we find such offers to be attractive and in line with our operating strategy. However, there is no assurance that contemplated divestitures will be completed, will be completed within our contemplated timeframe, or will be completed on terms favorable to us or on terms sufficient to allow us to achieve our deleveraging strategy. Additionally, the results of operations for these hospitals we plan to divest and the potential gains or losses on the sales of those businesses may adversely affect our profitability. Moreover, we may incur asset impairment charges related to planned or completed divestitures that reduce our profitability.

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

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

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

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

In particular, government investigations, as well as qui tam lawsuits, may lead to significant fines, penalties, damages payments or other sanctions, including exclusion from government healthcare programs. Settlements of lawsuits involving Medicare and Medicaid issues routinely require both monetary payments and corporate integrity agreements, each of which could have an adverse effect on our business, financial condition, results of operations

and/or cash flows.

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

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

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

Moreover, hospitals that we have acquired, or in the future could acquire, may have unknown or contingent liabilities, including liabilities associated with ongoing legal proceedings or for failure to comply with healthcare laws and regulations. Although we generally seek indemnification from 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 healthcare facilities could limit our ability to build or acquire additional healthcare facilities, renovate our facilities or expand the breadth of services we offer.

Some states in which we operate require a CON or other prior approval for the construction or acquisition of healthcare facilities, capital expenditures exceeding a prescribed amount, changes in bed capacity or services and some other matters. In evaluating a proposal, these states consider the need for additional or expanded healthcare facilities or services. If we are not able to obtain required CONs or other prior approvals, we will not be able to acquire, operate, replace or expand our facilities or expand the breadth of services we offer. Furthermore, if a CON or other prior approval upon which we relied to invest in construction of a replacement or expanded facility were to be revoked or lost through an appeal process, we may not be able to recover the value of our investment.

State efforts to regulate the sale of hospitals operated by municipal or not-for-profit entities could prevent us from acquiring these types of hospitals.

Many states have adopted legislation regarding the sale or other disposition of hospitals operated by municipal or not-for-profit entities. In some states that do not have specific legislation, the attorneys general have demonstrated an interest in these transactions under their general obligation 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 state actions could delay or even prevent our ability to acquire hospitals once we return to our acquisition strategy.

If we are unable to effectively compete, patients could use other hospitals and healthcare providers.

The healthcare industry is highly competitive among hospitals and other healthcare providers for patients, affiliations with physicians and acquisitions. However, the majority of our hospitals are located in non-urban service areas where we believe we are the sole provider of general acute care health services. As a result, the

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

At December 31, 2018, 38 of our hospitals competed with more than one other non-affiliated hospital in their respective primary service areas. In most markets in which we are not the sole provider of general acute care health services, our primary competitor is a municipal or not-for-profit hospital. These hospitals are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. They do not pay income or property taxes, and can make capital expenditures without paying sales tax. These financial advantages may better position these hospitals to maintain more modern and technologically upgraded facilities and equipment and offer services more specialized than those available at our hospitals. If our competitors are better able to attract patients with these offerings, we may experience an overall decline in patient volume.

Trends toward clinical transparency and value-based purchasing may have an unanticipated impact on our competitive position and patient volumes. The CMS Hospital Compare website makes available to the public certain data that hospitals submit in connection with Medicare reimbursement claims, including performance data related to quality measures and patient satisfaction surveys. Further, every hospital must establish and update annually a public, online listing of the hospital s standard charges for items and services. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures or on patient satisfaction surveys, or if our standard charges are higher than our competitors, we may attract fewer patients.

We expect these competitive trends to continue. If we are unable to compete effectively with other hospitals and other healthcare providers, patients may seek healthcare services at providers other than our hospitals and affiliated businesses.

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

We have a participation agreement with HealthTrust, a GPO. The current term of this agreement expires in January 2020, 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, sometimes by negotiating exclusive supply arrangements in exchange for discounts. To the extent these exclusive supply arrangements are challenged or deemed unenforceable, we could incur higher costs for our medical supplies obtained through HealthTrust. Further, costs of supplies and drugs may continue to increase due to market pressure from pharmaceutical companies and new product releases. Higher costs could continue to adversely impact our operating results. Also, 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, 2018, we had approximately $4.6 billion of goodwill. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, under U.S. GAAP, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired when events or

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

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

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

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

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

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

value of the net assets being sold. If the carrying value of our long-lived assets is impaired, we may incur a material non-cash charge to earnings.

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We are unable to predict the ultimate impact of health reform initiatives, including the Affordable Care Act, and our business may be adversely affected if the Affordable Care Act is repealed entirely or found to be unconstitutional or if provisions benefitting our operations are significantly modified.

In recent years, the U.S. Congress and certain state legislatures have introduced and passed a large number of proposals and legislation designed to make major changes in the healthcare system, including changes intended to increase access to health insurance. The most prominent of these efforts, the Affordable Care Act, affects how healthcare services are covered, delivered, and reimbursed. The Affordable Care Act mandates that substantially all U.S. citizens maintain health insurance coverage, expands health insurance coverage through a combination of public program expansion and private sector health insurance reforms, reduces Medicare reimbursement to hospitals, and promotes value-based purchasing. However, effective January 2019, the financial penalty for individuals that fail to maintain insurance coverage associated with the individual mandate was eliminated. We are unable to determine the impact of this change, but it could have an adverse effect on us.

Further, efforts by the presidential administration and certain members of Congress, as well as court challenges, to repeal or make significant changes to the Affordable Care Act, its implementation and/or its interpretation have cast considerable uncertainty on the future of the law. For example, a presidential executive order has been signed that directs agencies to minimize economic and regulatory burdens of the Affordable Care Act. In December 2018, a federal judge in Texas found the entire Affordable Care Act to be unconstitutional as a result of the individual mandate penalty being eliminated. However, the law remains in place pending appeal. In addition, CMS administrators have indicated that they intend to grant states additional flexibility in the administration of state Medicaid programs, including by expanding the scope of waivers under which states may impose different eligibility or enrollment restrictions or otherwise implement programs that vary from federal standards. In June 2018, the Department of Labor issued a final rule expanding availability of association health plans, which are not required to adhere to specific Affordable Care Act coverage mandates. There is uncertainty regarding whether, when, and how the Affordable Care Act will be further changed, what alternative provisions, if any, will be enacted, the timing of enactment and implementation of alternative provisions, the impact of alternative provisions on providers as well as other healthcare industry participants, the ultimate outcome of court challenges and how the law will be interpreted and implemented. Court challenges and changes by Congress or government agencies could eliminate or alter provisions beneficial to us while leaving in place provisions reducing our reimbursement. Government efforts to repeal or change the Affordable Care Act or implement other reform initiatives may have an adverse effect on our business, results of operations, cash flow, capital resources and liquidity. Members of Congress have also proposed measures that would expand government-sponsored coverage, including single-payor proposals. Other industry participants, such as private payors and large employer groups and their affiliates, may also introduce financial or delivery system reforms. We are unable to predict the nature and success of such initiatives.

If reimbursement rates paid by federal or state healthcare programs or commercial payors are reduced, if we are unable to maintain favorable contract terms with payors or comply with our payor contract obligations, if insured individuals move to insurance plans with greater coverage exclusions or narrower networks, or if insurance coverage is otherwise restricted or reduced, our net operating revenues may decline.

In 2018, 39.6% of our net operating revenues, came from the Medicare and Medicaid programs. However, as federal healthcare expenditures continue to increase and state governments continue to face budgetary shortfalls, federal and state governments have made, and continue to make, significant changes in the Medicare and Medicaid programs. These changes include reductions in reimbursement levels and to supplemental payment programs, like disproportionate share hospital programs, as well as new or modified demonstration projects authorized pursuant to Medicaid waivers. Some of these changes have decreased, or could decrease, the amount of money we receive for our services relating to these programs.

In addition, government and commercial payors as well as other third parties from whom we receive payment for our services attempt to control healthcare costs by, for example, requiring hospitals to discount payments for their services in exchange for exclusive or preferred participation in their benefit plans, restricting coverage

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

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

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

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

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

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

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

The healthcare industry is governed by laws and regulations at the federal, state and local government levels. These laws and regulations include standards addressing, among other issues, the adequacy of medical care, equipment, personnel, operating policies and procedures; billing and coding for services; properly handling overpayments; classification of levels of care provided; preparing and filing of cost reports; relationships with referral sources and referral recipients; maintenance of adequate records; compliance with building codes; environmental protection; privacy and security; debt collection; and communications with patients and consumers. Examples of these laws include, but are not limited to, HIPAA, the Stark Law, the federal anti-kickback statute, the FCA, the Emergency

Medical Treatment and Active Labor Act and similar state laws. If we fail to comply with applicable laws and regulations we could suffer civil sanctions and criminal penalties, including the loss of our operating licenses and our ability to participate in the Medicare, Medicaid and other federal and state healthcare programs.

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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. Enforcement actions have focused on financial arrangements between hospitals and physicians, billing for services without adequately documenting medical necessity and billing for services outside the coverage guidelines for such services. Specific to our hospitals, we have received inquiries and subpoenas from various governmental agencies regarding these and other matters, and we are also subject to various claims and lawsuits relating to such matters. For a further discussion of these matters, see Legal Proceedings in Part I, Item 3 of this Form 10-K.

In the future, evolving 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.

We could be subject to substantial uninsured liabilities or increased insurance costs as a result of significant legal actions.

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 claims made 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 may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. Additionally, our insurance coverage does not cover all claims against us, such as fines, penalties, or other damage and legal expense payments resulting from qui tam lawsuits. We cannot predict the outcome of current or future legal actions against us or the effect that judgments or settlements in such matters may have on us or on our insurance costs. Additionally, all professional and general liability insurance we purchase is subject to policy limitations. If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period. Furthermore, one or more of our insurance carriers could become insolvent and unable to fulfill its or their obligations to defend, pay or reimburse us when those obligations become due. In that case, or if payments of claims exceed our estimates or are not covered by our insurance, it could have an adverse effect on our business, financial condition or results of operations.

We could be subject to increased monetary penalties and/or other sanctions, including exclusion from federal healthcare programs, if we fail to comply with the terms of the Corporate Integrity Agreement.

On August 4, 2014, we announced that we had entered into a civil settlement with the U.S. Department of Justice, other federal agencies and identified relators that concluded previously announced investigations and litigation related to short stay admissions through emergency departments at certain of our affiliated hospitals. In addition to the amounts paid in the settlement, we executed the CIA with the OIG that has been incorporated into our existing and comprehensive compliance program. On September 25, 2018, the CIA was amended and extended in connection with the settlement of certain qui tam lawsuits related to certain conduct of HMA and its affiliated entities that were initiated and pending, and known to us, before HMA was acquired by merger in January 2014. See our discussion of these matters under the section Business of Community Health Systems, Inc. in Part I, Item 1 of this Form 10-K and Legal Proceedings in Part II, Item 1 of our Quarterly Reports on Form 10-Q for the quarterly periods ended September 30, 2014 and September 30, 2018 for further discussion of the background of these matters and details of the settlements.

Material, uncorrected violations of the CIA could lead to our suspension or disbarment from participation in Medicare, Medicaid and other federal and state healthcare programs and repayment obligations. In addition, we are subject to possible civil penalties for failure to substantially comply with the terms of the CIA, including stipulated penalties ranging between $1,000 to $2,500 per day. We are also subject to a stipulated penalty of

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

If we experience growth in self-pay volume and revenues or if we experience deterioration in the collectability of patient responsibility accounts, our financial condition or results of operations could be adversely affected.

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. 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 may affect our collection of accounts receivable and are considered in our estimates of accounts receivable collectability.

Efforts to repeal or revise the Affordable Care Act have cast considerable uncertainty on the future of the law and its effects on the size of the uninsured population. For example, Congress eliminated, effective January 1, 2019, the financial penalty associated with the Affordable Care Act s mandate that individuals enroll in an insurance plan. As a result of this change, a federal judge in Texas recently found the entire Affordable Care Act to be unconstitutional; however, the law remains in place pending appeal. The number and identity of states that choose to expand or otherwise modify Medicaid programs, and the terms of expansion and other program changes, continues to evolve. Some of these program changes, such requirements that Medicaid recipients meet certain work requirements, may reduce the number of program participants. These variables, among others, make it difficult to predict the number of uninsured individuals and what percentage of our total revenue will be comprised of self-pay revenues.

We may be adversely affected by the growth in patient responsibility accounts as a result of increases in the adoption of plan structures, including health savings accounts, narrow networks and tiered networks, that shift greater responsibility for care to individuals through greater exclusions and copayment and deductible amounts. Further, our ability to collect patient responsibility accounts may be limited by statutory, regulatory and investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients and regulatory restrictions on charges for out of network services. In addition, a deterioration of economic conditions in the United States could potentially lead to higher levels of uninsured patients, result in higher levels of patients covered by lower paying government programs, result in fiscal uncertainties at both government payors and private insurers and/or limit the economic ability of patients to make payments for which they are responsible. If we experience growth in self-pay volume or deterioration in collectability of patient responsibility accounts, our financial condition or results of operations could be adversely affected.

Many of the non-urban communities in which we operate continue to face challenging economic conditions, and the failure of certain employers, or the closure of certain manufacturing and other facilities in our markets, could have a disproportionate impact on our hospitals.

Many of the non-urban communities in which we operate continue to face challenging economic conditions, including higher levels of unemployment than other regions of the United States. In addition, the economies in the non-urban communities in which our hospitals primarily operate are often dependent on a small number of large employers, especially manufacturing or similar facilities. These employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our hospitals for care. The failure of one or more large employers, or the closure or substantial reduction in the number of individuals employed at manufacturing or other facilities located in or near many of the non-urban communities in which our hospitals

primarily operate, could cause affected employees to move elsewhere for employment or

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lose insurance coverage that was otherwise available to them. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may:

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

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

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

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

If our adoption and utilization of electronic health record systems fails to satisfy HHS standards, our consolidated results of operations could be adversely affected.

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

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

Our operations depend heavily on effective information systems to process clinical, operational and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and to develop new systems in order to keep pace with continual changes in information technology. We also sometimes rely on third-party providers of financial, clinical, patient accounting and network information services and, as a result, we face operational challenges in maintaining multiple provider platforms and facilitating the interface of such systems with one another. We rely on these third-party providers to have appropriate controls to protect confidential information. We do not control the information systems of third-party providers, and in some

cases we may have difficulty accessing information archived on third-party systems.

Our networks and information systems are also subject to disruption due to events such as a major earthquake, fire, telecommunications failure, ransomware or terrorist attacks or other catastrophic events. If the information systems on which we rely fail or are interrupted or if our access to these systems is limited in the future, it could have an adverse effect on our business, financial condition or results of operations.

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

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

In spite of our security measures, there can be no assurance that we will not be subject to additional cyber-attacks or security breaches in the future. Additionally, in the definitive agreements we enter into in connection with the divestiture of hospitals, we routinely agree to provide transition services to the buyer, including access to our legacy information systems, for a defined transition period. By providing access to our information systems to non-employees, we are exposed to cyber-attacks or security breaches that originate outside of our processes and practices designed to prevent such threats from occurring. Any such cyber-attacks or security breaches could impact the integrity, availability or privacy of protected health information or other data subject to privacy laws or disrupt our information technology systems, devices or business, including our ability to provide various healthcare services. Additionally, growing cyber-security threats related to the use of ransomware and other malicious software threaten the access and utilization of critical information technology and data. As a result, cybersecurity and the continued development and enhancement of our controls, process and practices designed to protect our information systems from attack, damage or unauthorized access remain a priority for us. Our ability to recover from a ransomware or other cyber-attack is dependent on these practices, including successful backup systems and other recovery procedures. As cyber-threats continue to evolve, we may be required to expend significant additional resources to continue to modify or enhance our protective measures or to investigate and remediate any information security vulnerabilities. If we are subject to cyber-attacks or security breaches in the future, this could result in harm to patients; business interruptions and delays; the loss, misappropriation, corruption or unauthorized access of data; litigation and potential liability under privacy, security, breach notification and consumer protection laws or other applicable laws; reputational damage and federal and state governmental inquiries, any of which could have an adverse effect on our business, financial condition or results of operations.

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

If a pandemic, epidemic, outbreak of an infectious disease or other public health crisis were to affect our markets, our business could be adversely affected. Such a crisis could diminish the public trust in healthcare facilities, especially hospitals that fail to accurately or timely diagnose, or that are treating (or have treated) patients affected by contagious diseases. If any of our facilities were involved in treating patients for such a contagious disease, other patients might cancel elective procedures or fail to seek needed care at our facilities. Further, a pandemic might adversely impact our

business by causing a temporary shutdown or diversion of patients, by disrupting or delaying production and delivery of materials and products in the supply chain or by

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

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

The success of our healthcare facilities depends in part on the number and quality of the physicians on the medical staffs of our healthcare facilities, our ability to employ quality physicians, the admitting and utilization practices of employed and independent physicians, maintaining good relations with those physicians and controlling costs related to the employment of physicians. Although we employ some physicians, physicians are often not employees at our healthcare facilities at which they practice. In many of the markets we serve, many physicians have admitting privileges at other healthcare facilities in addition to our healthcare facilities. Such physicians may terminate their affiliation with or employment by our healthcare facilities at any time. In addition, we may face increased challenges in this area as the physician population reaches retirement age, especially if there is a shortage of physicians willing and able to provide comparable services. Moreover, if we are unable to provide adequate support personnel or technologically advanced equipment and facilities that meet the needs of those physicians and their patients, they may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline.

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

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

Increased or ongoing labor union activity could also adversely affect our labor costs or otherwise adversely impact us. To the extent a significant portion of our employee base unionizes, our labor costs could increase significantly. In addition, when negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur during the negotiation process, and our continued operation during any strikes could increase our labor costs and otherwise adversely impact us.

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

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

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

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

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

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

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

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

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

extended or changed.

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

None

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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 general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric 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, 2018, 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				
South Baldwin Regional Medical Center	Foley	112	June, 2000	Leased
Grandview Medical Center	Birmingham	372	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	180	July, 2007	Owned
Alaska				
Mat-Su Regional Medical Center	Palmer	74	July, 2007	Owned
Arizona				
Western Arizona Regional Medical Center	Bullhead City	139	July, 2000	Owned
Northwest Medical Center	Tucson	300	July, 2007	Owned
Oro Valley Hospital	Oro Valley	146	July, 2007	Owned
Arkansas				
Northwest Health System				
Northwest Medical Center - Bentonville	Bentonville	128	July, 2007	Owned
Northwest Medical Center - Springdale	Springdale	222	July, 2007	Owned
Willow Creek Women s Hospital	Johnson	64	July, 2007	Owned
Northwest Health Physician s Specialty Hospital	Fayetteville	20	April, 2016	Leased
Siloam Springs Regional Hospital	Siloam Springs	73	February, 2009	Owned
Medical Center of South Arkansas	El Dorado	166	April, 2009	Leased
Florida				

Lake Wales Medical Center	Lake Wales	160	December, 2002	Owned
North Okaloosa Medical Center	Crestview	110	March, 1996	Owned
Bayfront Health Brooksville	Brooksville	120	January, 2014	Leased
Bayfront Health Port Charlotte	Port Charlotte	254	January, 2014	Owned
Bayfront Health Punta Gorda	Punta Gorda	208	January, 2014	Owned
Bayfront Health St. Petersburg	St. Petersburg	480	January, 2014	Leased
Bayfront Health Spring Hill	Spring Hill	124	January, 2014	Leased
Heart of Florida Regional Medical Center	Davenport	193	January, 2014	Owned
Lower Keys Medical Center	Key West	167	January, 2014	Leased

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Physicians Regional Healthcare System - Collier	Naples	100	January, 2014	Owned
Physicians Regional Healthcare System - Pine Ridge	Naples	101	January, 2014	Owned
Santa Rosa Medical Center	Milton	129	January, 2014	Leased
Seven Rivers Regional Medical Center	Crystal River	128	January, 2014	Owned
Shands Lake Shore Regional Medical Center	Lake City	99	January, 2014	Leased
Shands Live Oak Regional Medical Center	Live Oak	25	January, 2014	Owned
Shands Starke Regional Medical Center	Starke	49	January, 2014	Owned
St. Cloud Regional Medical Center	St. Cloud	84	January, 2014	Owned
Venice Regional Bayfront Health	Venice	312	January, 2014	Owned
Georgia				
East Georgia Regional Medical Center	Statesboro	149	January, 2014	Owned
Indiana				
Porter Hospital	Valparaiso	301	May, 2007	Owned
Lutheran Health Network				
Bluffton Regional Medical Center	Bluffton	79	July, 2007	Owned
Dupont Hospital	Fort Wayne	131	July, 2007	Owned
Lutheran Hospital	Fort Wayne	396	July, 2007	Owned
Lutheran Musculoskeletal Center	Fort Wayne	39	July, 2007	Owned
Lutheran Rehabilitation Hospital (rehabilitation)	Fort Wayne	36	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
La Porte Hospital	La Porte	227	March, 2016	Owned
Starke Hospital	Knox	53	March, 2016	Leased
Louisiana				
Northern Louisiana Medical Center	Ruston	165	April, 2007	Owned
Mississippi				
Merit Health Wesley	Hattiesburg	211	July, 2007	Owned
Merit Health River Region	Vicksburg	361	July, 2007	Owned
Merit Health Biloxi	Biloxi	198	January, 2014	Leased
Merit Health Central	Jackson	319	January, 2014	Leased
Merit Health Rankin	Brandon	134	January, 2014	Leased
Merit Health Madison	Canton	67	January, 2014	Owned
Merit Health River Oaks	Flowood	160	January, 2014	Owned
Merit Health Woman s Hospital	Flowood	109	January, 2014	Owned
Merit Health Natchez	Natchez	179	October, 2014	Owned

Missouri				
Moberly Regional Medical Center	Moberly	99	November, 1993	Owned
Northeast Regional Medical Center	Kirksville	93	December, 2000	Leased
Poplar Bluff Regional Medical Center	Poplar Bluff	412	January, 2014	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
New Jersey				
Memorial Hospital of Salem County (3)	Salem	126	September, 2002	Owned
New Mexico				
Eastern New Mexico Medical Center	Roswell	162	April, 1998	Owned
Carlsbad Medical Center	Carlsbad	115	July, 2007	Owned
Lea Regional Medical Center	Hobbs	115	July, 2007	Owned
Mountain View Regional Medical Center	Las Cruces	168	July, 2007	Owned
North Carolina				
Lake Norman Regional Medical Center	Mooresville	123	January, 2014	Owned
Davis Regional Medical Center	Statesville	144	January, 2014	Owned
Oklahoma				
AllianceHealth Ponca City	Ponca City	140	May, 2006	Owned
AllianceHealth Woodward	Woodward	87	July, 2007	Leased
AllianceHealth Clinton	Clinton	56	January, 2014	Leased
AllianceHealth Madill	Madill	25	January, 2014	Leased
AllianceHealth Durant	Durant	148	January, 2014	Owned
AllianceHealth Midwest	Midwest City	255	January, 2014	Leased
AllianceHealth Seminole	Seminole	32	January, 2014	Leased
Pennsylvania				
Commonwealth Health Network				
Berwick Hospital	Berwick	90	March, 1999	Owned
Wilkes-Barre General Hospital	Wilkes-Barre	412	April, 2009	Owned
First Hospital Wyoming Valley (psychiatric)	Wilkes-Barre	193	April, 2009	Owned
Regional Hospital of Scranton	Scranton	186	May, 2011	Owned
Tyler Memorial Hospital	Tunkhannock	44	May, 2011	Owned
Moses Taylor Hospital	Scranton	213	January, 2012	Owned
South Carolina				
Springs Memorial Hospital	Lancaster	225	November, 1994	Owned
Mary Black Memorial Hospital (2)	Spartanburg	207	July, 2007	Owned
Carolinas Hospital System	Florence	396	July, 2007	Owned
Carolinas Hospital System - Marion	Mullins	124	July, 2010	Owned
Chester Regional Medical Center	Chester	82	January, 2014	Leased
Mary Black Health System - Gaffney (2)	Gaffney	125	November, 2014	Owned
Tennessee				
Tennova Healthcare - Shelbyville	Shelbyville	60	July, 2005	Owned
Tennova Healthcare - Cleveland	Cleveland	351	October, 2005	Owned
Tennova Healthcare - Clarksville	Clarksville	270	July, 2007	Owned
Tennova Healthcare - Harton	Tullahoma	135	January, 2014	Owned

Tennova - Jefferson Memorial Hospital	Jefferson City	58	January, 2014	Leased
Tennova - LaFollette Medical Center	LaFollette	66	January, 2014	Leased
Tennova - Newport Medical Center	Newport	130	January, 2014	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Tennova - North Knoxville Medical Center	Powell	108	January, 2014	Owned
Tennova - Turkey Creek Medical Center	Knoxville	111	January, 2014	Owned
Tennova Healthcare - Lebanon	Lebanon	245	January, 2014	Owned
Texas				
Hill Regional Hospital	Hillsboro	116	October, 1994	Leased
Lake Granbury Medical Center	Granbury	73	January, 1997	Leased
Laredo Medical Center	Laredo	326	October, 2003	Owned
Abilene Regional Medical Center	Abilene	231	July, 2007	Owned
Brownwood Regional Medical Center	Brownwood	188	July, 2007	Owned
College Station Medical Center	College Station	167	July, 2007	Owned
Navarro Regional Hospital	Corsicana	162	July, 2007	Owned
Longview Regional Medical Center	Longview	224	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	304	July, 2007	Owned
Cedar Park Regional Medical Center	Cedar Park	108	December, 2007	Owned
Virginia				
Southern Virginia Regional Medical Center	Emporia	80	March, 1999	Owned
Southampton Memorial Hospital	Franklin	105	March, 2000	Owned
Southside Regional Medical Center	Petersburg	300	August, 2003	Owned
West Virginia				
Plateau Medical Center	Oak Hill	25	July, 2002	Owned
Greenbrier Valley Medical Center	Ronceverte	122	July, 2007	Owned
Bluefield Regional Medical Center	Bluefield	92	October, 2010	Owned
Total Licensed Beds at December 31, 2018		18,227		
Total Hospitals at December 31, 2018		113		

(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) Hospital sold January 1, 2019.

(3) Hospital sold January 31, 2019.

The real property of substantially all of our wholly-owned hospitals is also encumbered by mortgages to support obligations under our credit facility and outstanding senior secured notes.

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, 2018. 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.

Joint Venture	Facility Name	City	State	Licensed Beds
Macon Healthcare LLC	Coliseum Medical Center (38%)	Macon	GA	310
Macon Healthcare LLC	Coliseum Northside Hospital (38%)	Macon	GA	103

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Item 3. ***Legal Proceedings***

From time to time, we receive inquiries or subpoenas from state regulators, state Medicaid Fraud Control units, fiscal intermediaries, the Centers for Medicare and Medicaid Services, the Department of Justice and other government entities regarding various Medicare and Medicaid issues. In addition to the matters discussed below, we are currently responding to subpoenas and administrative demands concerning (a) an inquiry regarding sleep labs at two Louisiana hospitals (one formerly owned), (b) a civil investigative demand concerning short-term Medicaid eligibility determinations processed by third party vendors at one of our Pennsylvania hospitals, (c) certain cardiology procedures, medical records and quality assurance committee meeting minutes at a formerly owned Tennessee hospital, (d) a civil investigative demand relating to the Company s adoption of electronic health records technology and the meaningful use program, and (e) certain services provided to Medicaid beneficiaries at one of our New Mexico hospitals. In addition, we are subject to other claims and lawsuits arising in the ordinary course of our business including lawsuits and claims related to billing practices and the administration of charity care policies at our hospitals. Based on current knowledge, management does not believe that loss contingencies arising from pending legal, regulatory and governmental matters, including the matters described herein, will have a material adverse effect on the consolidated financial position or liquidity of the Company. However, in light of the inherent uncertainties involved in pending legal, regulatory and governmental matters, some of which are beyond our control, and the very large or indeterminate damages sought in some of these matters, an adverse outcome in one or more of these matters could be material to our results of operations or cash flows for any particular reporting period. 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. In September 2014, the Criminal Division of the United States Department of Justice, or DOJ, announced that all qui tam cases will be shared with their Division to determine if a parallel criminal investigation should be opened. The Criminal Division has also frequently stated an intention to pursue corporations in criminal prosecutions. From time to time, we detect issues of non-compliance with Federal healthcare laws pertaining to claims submission and reimbursement practices and/or financial relationships with physicians. We avail ourselves of various mechanisms to address potential overpayments arising out of these issues, including repayment of claims, rebilling of claims, and participation in voluntary disclosure protocols offered by the Centers for Medicare and Medicaid Services and the Office of the Inspector General. Participating in voluntary repayments and voluntary disclosure protocols can have the potential for significant settlement obligations or even enforcement action.

The following legal proceedings are described in detail because, although they may not be required to be disclosed in this Part I, Item 3 under SEC rules, due to the nature of the business of the Company, we believe that the following discussion of these matters may provide useful information to security holders. This discussion does not include claims and lawsuits covered by medical malpractice, general liability or employment practices insurance and risk retention programs, none of which claims or lawsuits would in any event be required to be disclosed in this Part I, Item 3 under SEC rules. Certain of the matters referenced below are also discussed in Note 16 of the Notes to Consolidated Financial Statements included under Part II, Item 8 of this Form 10-K.

Shareholder Litigation

Class Action Shareholder Federal Securities Cases. Three purported class action cases have been filed in the United States District Court for the Middle District of Tennessee; namely, Norfolk County Retirement System v. Community Health Systems, Inc., et al., filed May 9, 2011; De Zheng v. Community Health Systems, Inc., et al., filed May 12, 2011; and Minneapolis Firefighters Relief Association v. Community Health Systems, Inc., et al., filed June 21, 2011. All three seek class certification on behalf of purchasers of our common stock between July 27, 2006 and April 11, 2011 and allege that misleading statements resulted in artificially inflated prices for our common stock. In December

2011, the cases were consolidated for pretrial purposes and NYC Funds and its counsel were selected as lead plaintiffs/lead plaintiffs counsel. In lieu of ruling on our motion to dismiss, the

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court permitted the plaintiffs to file a first amended consolidated class action complaint which was filed on October 5, 2015. Our motion to dismiss was filed on November 4, 2015 and oral argument took place on April 11, 2016. Our motion to dismiss was granted on June 16, 2016 and on June 27, 2016, the plaintiffs filed a notice of appeal to the Sixth Circuit Court of Appeals. The matter was heard on May 3, 2017. On December 13, 2017, the Sixth Circuit reversed the trial court s dismissal of the case and remanded it to the District Court. We filed a renewed partial motion to dismiss on February 9, 2018, which was denied by the District Court on September 24, 2018. We also filed a petition for writ of certiorari with the United States Supreme Court on April 18, 2018 seeking review of the Sixth Circuit s decision. The United States Supreme Court denied the petition for a writ of certiorari on October 1, 2018. Plaintiff s motion for class certification is pending. We believe this consolidated matter is without merit and will vigorously defend this case.

Other Government Investigations

St. Petersburg, Florida On September 14, 2017, our hospital in St. Petersburg, Florida received a CID from the United States Department of Justice for information concerning its participation in the Florida Low Income Pool Program. The Low Income Pool Program, or LIP, is a funding pool to support healthcare providers that provide uncompensated care to Florida residents who are uninsured or underinsured. The CID seeks documentation related to agreements between the hospital and Pinellas County. We are cooperating fully with this investigation.

Commercial Litigation and Other Lawsuits

Becker v. Community Health Systems, Inc. d/b/a Community Health Systems Professional Services Corporation d/b/a Community Health Systems d/b/a Community Health Systems PSC, Inc. d/b/a Rockwood Clinic P.S. and Rockwood Clinic, P.S. (Superior Court, Spokane, Washington). This suit was filed on February 29, 2012, by a former chief financial officer at Rockwood Clinic in Spokane, Washington. Becker claims he was wrongfully terminated for allegedly refusing to certify a budget for Rockwood Clinic in 2012. On February 29, 2012, he also filed an administrative complaint with the Department of Labor, Occupational Safety and Health Administration alleging that he is a whistleblower under Sarbanes-Oxley, which was dismissed by the agency and was appealed to an administrative law judge for a hearing that occurred on January 19-26, 2016. In a decision dated November 9, 2016, the law judge awarded Becker approximately $1.9 million for front pay, back pay and emotional damages with attorney fees to be later determined. We have appealed the award to the Administrative Review Board and are awaiting its decision. At a hearing on July 27, 2012, the trial court dismissed Community Health Systems, Inc. from the state case and subsequently certified the state case for an interlocutory appeal of the denial to dismiss his employer and the management company. The appellate court accepted the interlocutory appeal, and it was argued on April 30, 2014. On August 14, 2014, the court denied our appeal. On October 20, 2014, we filed a petition to review the denial with the Washington Supreme Court. Our appeal was accepted and oral argument was heard on June 9, 2015. On September 15, 2015, the court denied our appeal and remanded to the trial court; a previous trial setting of September 12, 2016 has been vacated and not reset. We continue to vigorously defend these actions.

Cyber Attack. As previously disclosed on a Current Report on Form 8-K filed by us on August 18, 2014, our computer network was the target of an external, criminal cyber-attack that we believe occurred between April and June, 2014. We and Mandiant (a FireEye Company), the forensic expert engaged by us in connection with this matter, believe the attacker was a foreign Advanced Persistent Threat group who used highly sophisticated malware and technology to attack our systems. The attacker was able to bypass our security measures and successfully copy and transfer outside the Company certain non-medical patient identification data (such as patient names, addresses, birthdates, telephone numbers and social security numbers), but not including patient credit card, medical or clinical information. We worked closely with federal law enforcement authorities in connection with their investigation and possible prosecution of those determined to be responsible for this attack. Mandiant has conducted a thorough investigation of

this incident and continues to advise us regarding security and monitoring efforts. We have provided appropriate notification to affected patients and regulatory agencies as

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required by federal and state law. We have offered identity theft protection services to individuals affected by this attack.

We have incurred certain expenses to remediate and investigate this matter. In addition, multiple purported class action lawsuits have been filed against us and certain subsidiaries. These lawsuits allege that sensitive information was unprotected and inadequately encrypted by us. The plaintiffs claim breach of contract and other theories of recovery, and are seeking damages, as well as restitution for any identity theft. On February 4, 2015, the United States Judicial Panel on Multidistrict Litigation ordered the transfer of the purported class actions pending outside of the District Court for the Northern District of Alabama to the District Court for the Northern District of Alabama for coordinated or consolidated pretrial proceedings. A consolidated complaint was filed and we filed a motion to dismiss on September 21, 2015, which was partially argued on February 10, 2016. In an oral ruling from the bench, the court greatly limited the potential class by ruling only plaintiffs with specific injury resulting from the breach had standing to sue. Further, on jurisdictional grounds, the court dismissed Community Health Systems, Inc. from all non-Tennessee based cases. Finally, the court set April 15, 2016 for further argument on whether the remaining plaintiffs have sufficiently stated a cause of action to continue their cases. On April 15, 2016 in an oral ruling from the bench, the court dismissed additional claims and following this oral ruling only eight of the forty plaintiffs remained, with significant limitations imposed on their ability to assert claims for damages. These oral rulings were confirmed in a written order filed on September 12, 2016. On October 20, 2016, the plaintiffs filed a renewed motion for interlocutory appeal from the motion to dismiss ruling and on February 15, 2017 this motion was denied. Plaintiffs refiled their motion for permission to seek interlocutory appeal on March 15, 2017, and that motion was also denied. We have settled these class action lawsuits, and the settlement has been approved by the District Court. Notices of the settlement and claim forms have been mailed to purported class members. The deadline for purported class members to opt out of or object to the settlement is May 18, 2019.

We are also currently responding to two government investigations related to the 2014 cyber-attack. The first is being conducted by various State Attorneys General, and the second is being conducted by the U.S. Department of Health and Human Services Office for Civil Rights. We are cooperating fully with both investigations.

Empire Health Foundation v. CHS/Community Health Systems, Inc., CHS Washington Holdings, LLC, Spokane Washington Hospital Company, LLC, Spokane Valley Washington Hospital Company, LLC. This suit was filed on June 12, 2017 by Empire Health Foundation claiming Deaconess and Valley Hospitals failed to abide by charity care obligations allegedly existing in the 2008 Asset Purchase Agreement between Empire Health System and Company affiliates. The court granted in part and denied in part the hospitals motion to dismiss on October 11, 2017. All parties have filed motions for summary judgment, and those motions are pending. The trial for this matter is set for August 12, 2019. We believe these claims are without merit and will vigorously defend the case.

Gibson, individually and on behalf of all others similarly situated v. National Healthcare of Leesville, Inc. d/b/a Byrd Regional Medical Center. This case is a purported class action lawsuit filed in the 30th Judicial District Court for the State of Louisiana and served on August 3, 2016, claiming our formerly affiliated Leesville, Louisiana hospital violated payor contracts by allegedly improperly asserting hospital liens against third-party tortfeasors and seeking class certifications for any similarly situated plaintiffs. The court has certified a class and denied our motion for summary judgment. We have appealed both rulings to the Louisiana Third Circuit Court of Appeals. That appeal is pending. We believe these claims are without merit and will vigorously defend the case.

Bowden, individually and on behalf of all others similarly situated v. Ruston Louisiana Hospital Company, LLC d/b/a Northern Louisiana Medical Center. This case is a purported class action lawsuit filed in the 3rd Judicial District Court for the State of Louisiana and served on September 7, 2016, claiming our affiliated Ruston, Louisiana hospital violated payor contracts by allegedly improperly asserting hospital liens against third-party tortfeasors and seeking

class certifications for any similarly situated plaintiffs. Our motion for summary

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

Zwick Partners, LP and Aparna Rao, individually and on behalf of all others similarly situated v. Quorum Health Corporation, Community Health Systems, Inc., Wayne T. Smith, W. Larry Cash, Thomas D. Miller, and Michael J. Culotta. This purported class action lawsuit previously filed in the United States District Court, Middle District of Tennessee was amended on April 17, 2017 to include Community Health Systems, Inc., Wayne T. Smith and W. Larry Cash as additional defendants. The plaintiffs seek to represent a class of QHC shareholders and allege that the failure to record a goodwill and long-lived asset impairment charge against QHC at the time of the spin-off of QHC violated federal securities laws. The District Court denied all defendants motions to dismiss on April 20, 2018. The plaintiffs amended their complaint on September 14, 2018, and our motion to dismiss the new claims in the amended complaint is pending. Plaintiffs motion for class certification is also pending. We believe the claims are without merit and will vigorously defend the case.

R2 Investments v Quorum Health Corporation; Community Health Systems, Inc.; Wayne T. Smith; W. Larry Cash; Thomas D. Miller; Michael J. Culotta; John A. Clerico; James S. Ely, III; John A. Fry; William Norris Jennings; Julia B. North; H. Mitchell Watson, Jr.; H. James Williams. This case is pending in the Circuit Court for Williamson County, Tennessee and was served on October 26, 2017. The plaintiff alleges common law fraud and violation of Tennessee securities fraud statutes in connection with its purchase of QHC stock and QHC senior secured notes. The court granted in part and denied in part the director defendants motion to dismiss and denied the remaining defendants motions to dismiss on May 11, 2018. We believe the claims are without merit and will vigorously defend the case.

Microsoft Corporation v Community Health Systems, Inc. This case was pending in the District Court for the Middle District of Tennessee and was served on March 16, 2018. The plaintiff alleged willful copyright infringement, contributing copyright infringement, breach of contract, and breach of the implied covenant of good faith and fair dealing in connection with the alleged use of certain Microsoft products by the Company related to certain of our divestitures. We answered the complaint. Pursuant to an agreement between the parties, this case was dismissed on November 27, 2018.

Revenue Cycle Service Center and CHSPSC, LLC v QHCCS, LLC, Quorum Health Corporation and QHCCS, LLC v Community Health Systems, Inc. This case was pending in arbitration and was initiated by the Company on August 4, 2017. The Company sought unpaid amounts due from QHC related to a Computer Data Processing Transition Services Agreement and a Shared Services Transition Services Agreement (the TSAs) entered into between QHC and the Company in connection with the spin-off of QHC. QHC filed a counterclaim, claiming breach of contract and tortious interference, among others. The arbitration began on June 18, 2018 and continued through June 27, 2018. It reconvened on October 1, 2018 and concluded on October 8, 2018. On June 25, 2018, the arbitration panel issued a partial order that the TSAs were enforceable contracts and would continue by their terms until their expiration in April 2021. QHC had attempted to challenge the legal enforceability of both of those agreements. The arbitration panel issued a final order on January 3, 2019, finding in favor of the Company with respect to its claims against QHC related to the Computer Data Processing Transition Services Agreement and one of its claims against QHC related to the Shared Services Transition Services Agreement. Furthermore, the arbitration panel ruled in favor of the Company with respect to all of QHC s counterclaims.

Steadfast Insurance Company, et al v. Community Health Systems, Inc., CHS/Community Health Systems, Inc., CHSPSC, LLC and Pecos Valley of New Mexico, LLC. These cases are filed in the Superior Court for the State of Delaware and involve suits by three excess liability insurers seeking a declaration that a $73 million judgment rendered against Pecos Valley of New Mexico, LLC in *Anne Sperling, et al v. Pecos Valley of New Mexico, LLC* is not a covered loss as defined by the policies at issue. The Steadfast complaint was served on November 30, 2018. On

December 13, 2018, Admiral Insurance Company and Endurance Specialty Insurance Ltd moved to intervene in the suit as petitioners. CHS/Community Health Systems, Inc. and CHSPSC, LLC have moved to dismiss the petition filed by Steadfast Insurance Company. The judgment against Pecos Valley of New Mexico, LLC, which was rendered on September 5, 2018, in First Judicial Court of the State of New Mexico, is currently

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on appeal to the Court of Appeals of New Mexico. We believe the claims in the Steadfast litigation are without merit and will vigorously defend the case.

Qui Tam Matters Where the Government Declined Intervention

U.S. and the State of Mississippi ex rel. W. Blake Vanderlan, M.D. v. Jackson HMA, LLC d/b/a Central Mississippi Medical Center and Merit Health Central (SD Mississippi). By order filed on August 31, 2017, the court ordered the unsealing of this matter. The unsealing revealed that on August 31, 2017 the United States had declined to intervene in the allegations that certain alleged EMTALA violations at the hospital resulted in a violation of the False Claims Act. Both the hospital and the United States have filed motions to dismiss the litigation, and those motions are pending. This litigation was stayed on January 10, 2019. We believe this matter is without merit and will vigorously defend this case.

Management of Significant Legal Proceedings

In accordance with our governance documents, including our Governance Guidelines and the charter of the Audit and Compliance Committee, our management of significant legal proceedings is overseen by the independent members of the Board of Directors and, in particular, the Audit and Compliance Committee. The Audit and Compliance Committee is charged with oversight of compliance, regulatory and litigation matters, and enterprise risk management. Management has been instructed to refer all significant legal proceedings and allegations of financial statement fraud, error, or misstatement to the Audit and Compliance Committee for its oversight and evaluation. Consistent with New York Stock Exchange, Nasdaq and Sarbanes-Oxley independence requirements, the Audit and Compliance Committee is comprised entirely of individuals who are independent of our management, and all four members of the Audit and Compliance Committee are audit committee financial experts as defined in the Securities Exchange Act of 1934, as amended.

In addition, the Audit and Compliance Committee and the other independent members of the Board of Directors oversee the functions of the voluntary compliance program, including its auditing and monitoring functions and confidential disclosure program. In recent years, the voluntary compliance program has addressed the potential for a variety of billing errors that might be the subject of audits and payment denials by the CMS Recovery Audit Contractors permanent project, including MS-DRG coding, outpatient hospital and physician coding and billing, and medical necessity for services (including a focus on hospital stays of very short duration). Efforts by management, through the voluntary compliance program, to identify and limit risk from these government audits have included significant policy and guidance revisions, training and education, and auditing. The Board of Directors now oversees and reviews periodic reports of our compliance with the Corporate Integrity Agreement, or CIA, that we entered into with the United States Department of Health and Human Services Office of the Inspector General during 2014 and which was amended and extended in September 2018.

Item 4. Mine Safety Disclosures

Not applicable.

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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. As of February 15, 2019, there were approximately 200 holders of record of our common stock.

Stock Performance Graph

The following graph sets forth the cumulative return of our common stock during the five year period ended December 31, 2018, 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. The comparisons in the graph below are based on historical data and are not indicative of, or intended to forecast, future performance of our common stock. The market price of our common stock used to calculate the cumulative return has been adjusted in prior periods for the impact of the April 2016 QHC spin-off and related distribution of QHC common stock to our stockholders.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among Community Health Systems, Inc., the S&P 500 Index, and the Dow Jones US Health Care Index

We are a holding company which operates through our subsidiaries. Our Credit Facility and the indentures governing the senior and senior secured notes contain various covenants under which the assets of our subsidiaries are subject to certain restrictions relating to, among other matters, dividends and distributions, as referenced in the paragraph below.

With the exception of a special cash dividend of $0.25 per share paid by us in December 2012, historically, we have not paid any cash dividends. Subject to certain exceptions, our Credit Facility limits the ability of our

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subsidiaries to pay dividends and make distributions to us, and limits our ability to pay dividends and/or repurchase stock, to an amount not to exceed $200 million in the aggregate plus an additional $25 million in any particular year plus the aggregate amount of proceeds from the exercise of stock options. The indentures governing our senior and senior secured notes also restrict our subsidiaries from, among other matters, paying dividends and making distributions to us, which thereby limits our ability to pay dividends and/or repurchase stock. The non-cash dividend of approximately $713 million recorded during the year ended December 31, 2016 to reflect the distribution of the net assets of QHC was a permitted transaction under our Credit Facility. As of December 31, 2018, under the most restrictive test in these agreements (and subject to certain exceptions), we have approximately $100 million remaining available with which to pay permitted dividends and/or repurchase shares of our stock or our senior and senior secured notes. However, we do not intend to pay cash dividends in the foreseeable future.

On November 6, 2015, we adopted an open market repurchase program for up to 10,000,000 shares of our common stock, not to exceed $300 million in repurchases. This repurchase program expired on November 6, 2018. During the year ended December 31, 2015, we repurchased and retired 532,188 shares, which is the cumulative number of shares repurchased and retired under this program, at a weighted-average price of $27.31 per share. No shares were repurchased under this program during the years ended December 31, 2018, 2017 and 2016.

The following table contains information about our purchases of common stock during the three months ended December 31, 2018.

Period	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (b)	Maximum Number of Shares That May Yet Be Purchased Under the Plans or Programs (b)
October 1, 2018 - October 31, 2018	16,675	$ 3.21	-	9,467,812
November 1, 2018 - November 30, 2018	-	-	-	-
December 1, 2018 - December 31, 2018	40,645	4.62	-	-
Total	57,320	$ 4.21	-	-

(a) Includes 57,320 shares were withheld by us to satisfy the payment of tax obligations related to the vesting of restricted stock awards.

(b)

On November 9, 2015, we announced the adoption of an open market repurchase program for up to 10,000,000 shares of our common stock, not to exceed $300 million in repurchases. This repurchase program expired on November 6, 2018.

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Item 6. Selected Financial Data

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

Community Health Systems, Inc.

Five Year Summary of Selected Financial Data

	Year Ended December 31,				
	2018	**2017**	**2016**	**2015**	**2014**
	(in millions, except share and per share data)				
Consolidated Statement of (Loss) Income Data					
Net operating revenues	$ 14,155	$ 15,353	$ 18,438	$ 19,437	$ 18,639
Income (loss) from operations	208	(1,878)	(860)	1,337	1,339
(Loss) income from continuing operations	(704)	(2,384)	(1,611)	295	260
Net (loss) income	(704)	(2,396)	(1,626)	259	203
Net income attributable to noncontrolling interests	84	63	95	101	111
Net (loss) income attributable to Community Health Systems, Inc. stockholders	(788)	(2,459)	(1,721)	158	92
Basic (loss) earnings per share attributable to Community Health Systems, Inc. common stockholders (1):					
Continuing operations	$ (6.99)	$ (21.89)	$ (15.41)	$ 1.69	$ 1.33
Discontinued operations		(0.11)	(0.13)	(0.31)	(0.51)
Net (loss) income	$ (6.99)	$ (22.00)	$ (15.54)	$ 1.38	$ 0.82
Diluted (loss) earnings per share attributable to Community Health Systems, Inc. common stockholders (1):					

Continuing operations	$ (6.99)	$ (21.89)	$ (15.41)	$ 1.68	$ 1.32
Discontinued operations		(0.11)	(0.13)	(0.31)	(0.51)
Net (loss) income	$ (6.99)	$ (22.00)	$ (15.54)	$ 1.37	$ 0.82
Weighted-average number of shares outstanding:					
Basic	112,728,274	111,769,821	110,730,971	114,454,674	111,579,088
Diluted (2)	112,728,274	111,769,821	110,730,971	115,272,404	112,549,320
Consolidated Balance Sheet Data					
Cash and cash equivalents	$ 196	$ 563	$ 238	$ 184	$ 509
Total assets	15,859	17,450	21,944	26,595	27,118
Long-term obligations	14,426	15,259	16,775	18,847	18,915
Redeemable noncontrolling interests in equity of consolidated subsidiaries	504	527	554	571	531
Community Health Systems, Inc. stockholders (deficit) equity	(1,535)	(767)	1,615	4,019	4,003
Noncontrolling interests in equity of consolidated subsidiaries	72	75	113	86	80

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

(2) See Note 13 of the Notes to Consolidated Financial Statements included under Part II, Item 8 of this Form 10-K.

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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 one of the largest publicly traded hospital companies in the United States and a leading operator of general acute care hospitals and outpatient facilities in communities across the country. We provide healthcare services through the hospitals that we own and operate and affiliated businesses in non-urban and selected urban markets throughout the United States. We generate revenues by providing a broad range of general and specialized hospital healthcare services and outpatient services to patients in the communities in which we are located. As of December 31, 2018, we owned or leased 113 hospitals, comprised of 111 general acute care hospitals and two stand-alone rehabilitation or psychiatric hospitals. For the hospitals that we own and operate, we are paid for our services by governmental agencies, private insurers and directly by the patients we serve.

We have been implementing a portfolio rationalization and deleveraging strategy by divesting hospitals and non-hospital businesses that are attractive to strategic and other buyers. Generally, these businesses are not in one of our strategically beneficial service areas, are less complementary to our business strategy and/or have lower operating margins. In connection with our announced divestiture initiative, we have received offers from strategic buyers to buy certain of our assets. After considering these offers, we have divested or may divest hospitals and non-hospital businesses when we find such offers to be attractive and in line with our operating strategy.

Completed Divestiture and Acquisition Activity

During 2018, we completed the divestiture of 11 hospitals. These 11 hospitals represented annual net operating revenues in 2017 of approximately $950 million, and we received total net proceeds of approximately $405 million in connection with the disposition of these hospitals. In addition, in 2018, we entered into definitive agreements to sell seven additional hospitals, of which four divestitures have not yet been completed, two closed effective January 1, 2019 and one closed effective January 31, 2019.

In addition, during 2017, we completed the divestiture of 30 hospitals included in continuing operations. These 30 hospitals represented annual net operating revenues in 2016 of approximately $3.4 billion, and we received total net proceeds of approximately $1.7 billion in connection with the disposition of these hospitals.

The following table provides a summary of hospitals included in continuing operations that we divested during the years ended December 31, 2018 and 2017:

Hospital	Buyer	City, State	Licensed Beds	Effective Date
2018 Divestitures				
Bayfront Health Dade City	Adventist Health System	Dade City, FL	120	April 1, 2018
Tennova Healthcare Dyersburg Regional	West Tennessee Healthcare	Dyersburg, TN	225	June 1, 2018
	West Tennessee Healthcare	Jackson, TN	150	June 1, 2018

Tennova Healthcare Regional Jackson				
Tennova Healthcare Volunteer Martin	West Tennessee Healthcare	Martin, TN	100	June 1, 2018
Williamson Memorial Hospital	Mingo Health Partners, LLC	Williamson, WV	76	June 1, 2018
Byrd Regional Hospital	Allegiance Health Management	Leesville, LA	60	June 1, 2018
Tennova Healthcare Jamestown	Rennova Health, Inc.	Jamestown, TN	85	June 1, 2018

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Hospital	Buyer	City, State	Licensed Beds	Effective Date
Munroe Regional Medical Center	Adventist Health System	Ocala, FL	425	August 1, 2018
AllianceHealth Deaconess	INTEGRIS Health	Oklahoma City, OK	238	October 1, 2018
Sparks Regional Medical Center	Baptist Health	Fort Smith, AR	492	November 1, 2018
Sparks Medical Center Van Buren	Baptist Health	Van Buren, AR	103	November 1, 2018
2017 Divestitures				
Easton Hospital	Steward Health, Inc.	Easton, PA	196	May 1, 2017
Sharon Regional Health System	Steward Health, Inc. of the City of Anniston	Sharon, PA	258	May 1, 2017
Northside Medical Center	Steward Health, Inc.	Youngstown, OH	355	May 1, 2017
Trumbull Memorial Hospital	Steward Health, Inc.	Warren, OH	311	May 1, 2017
Hillside Rehabilitation Hospital	Steward Health, Inc.	Warren, OH	69	May 1, 2017
Wuesthoff Health System Rockledge	Steward Health, Inc.	Rockledge, FL	298	May 1, 2017
Wuesthoff Health System Melbourne	Steward Health, Inc.	Melbourne, FL	119	May 1, 2017
Sebastian River Medical Center	Steward Health, Inc.	Sebastian, FL	154	May 1, 2017
Stringfellow Memorial Hospital	The Health Care Authority	Anniston, AL	125	May 1, 2017
Merit Health Gilmore Memorial	Curae Health, Inc.	Amory, MS	95	May 1, 2017
Merit Health Batesville	Curae Health, Inc.	Batesville, MS	112	May 1, 2017
Lake Area Medical Center	CHRISTUS Health	Lake Charles, LA	88	June 30, 2017
Memorial Hospital of York	PinnacleHealth System	York, PA	100	July 1, 2017
Lancaster Regional Medical Center	PinnacleHealth System	Lancaster, PA	214	July 1, 2017
Heart of Lancaster Regional Medical Center	PinnacleHealth System	Lititz, PA	148	July 1, 2017
Carlisle Regional Medical Center	PinnacleHealth System	Carlisle, PA	165	July 1, 2017
	HCA	Tomball, TX	350	July 1, 2017

Tomball Regional Medical Center				
South Texas Regional Medical Center	HCA	Jourdanton, TX	67	July 1, 2017
Deaconess Hospital	MultiCare Health System	Spokane, WA	388	July 1, 2017
Valley Hospital	MultiCare Health System	Spokane Valley, WA	123	July 1, 2017
Yakima Regional Medical and Cardiac Center	Regional Health	Yakima, WA	214	September 1, 2017
Toppenish Community Hospital	Regional Health	Toppenish, WA	63	September 1, 2017
Weatherford Regional Medical Center	HCA	Weatherford, TX	103	October 1, 2017
Brandywine Hospital	Reading Health System	Coatesville, PA	169	October 1, 2017
Chestnut Hill Hospital	Reading Health System	Philadelphia, PA	148	October 1, 2017
Jennersville Hospital	Reading Health System	West Grove, PA	63	October 1, 2017

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Hospital	Buyer	City, State	Licensed Beds	Effective Date
Phoenixville Hospital	Reading Health System	Phoenixville, PA	151	October 1, 2017
Pottstown Memorial Medical Center	Reading Health System	Pottstown, PA	232	October 1, 2017
Highlands Regional Medical Center	HCA	Sebring, FL	126	November 1, 2017
Merit Health Northwest Mississippi	Curae Health, Inc.	Clarksdale, MS	181	November 1, 2017

On March 15, 2018, we signed a definitive agreement for the sale of Memorial Hospital of Salem County (126 licensed beds) in Salem, New Jersey, and its associated assets to Community Healthcare Associates, LLC. We closed on the sale of this hospital on January 31, 2019.

On October 11, 2018, we signed a definitive agreement for the sale of Mary Black Health System Spartanburg (207 licensed beds) in Spartanburg, South Carolina, and Mary Black Health System Gaffney (125 licensed beds) in Gaffney, South Carolina and their associated assets to Spartanburg Regional Healthcare System in Spartanburg, South Carolina. We closed on the sale of these hospitals effective January 1, 2019.

On November 19, 2018, we signed a definitive agreement for the sale of Chester Regional Medical Center (82 licensed beds) in Chester, South Carolina, Springs Memorial Hospital (225 licensed beds) in Lancaster, South Carolina, Carolinas Hospital System (396 licensed beds) in Florence, South Carolina, and Carolinas Hospital System Marion (124 licensed beds) in Mullins, South Carolina and their associated assets to Medical University Hospital Authority in Charleston, South Carolina.

In addition to the divestiture of these hospitals in 2017 and 2018, as noted above we continue to receive interest from potential buyers for certain of our hospitals. We intend to continue our portfolio rationalization strategy in 2019 and are pursuing additional interests for sale transactions, which are currently in various stages of negotiation with potential buyers. There can be no assurance that these potential divestitures (or the potential divestitures currently subject to definitive agreements) will be completed, or if they are completed, the ultimate timing of the completion of these divestitures.

Operating results and statistical data for the year ended December 31, 2017, exclude hospitals still owned and hospitals divested during the year ended December 31, 2017, that were previously classified as discontinued operations for accounting purposes.

During the year ended December 31, 2018, we paid approximately $26 million to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by our hospitals.

Overview of Operating Results

Our net operating revenues for the year ended December 31, 2018 decreased $1.2 billion to approximately $14.2 billion compared to approximately $15.4 billion for the year ended December 31, 2017, primarily as a result of hospitals divested during 2017 and 2018. On a same-store basis, net operating revenues for the year ended December 31, 2018 increased $362 million.

We had a loss from continuing operations of $704 million during the year ended December 31, 2018, compared to loss from continuing operations of $2.4 billion for the year ended December 31, 2017. Loss from continuing operations for

the year ended December 31, 2018 included the following:

an after-tax charge of $8 million for government and other legal settlements, net of related legal expenses,

an after-tax charge of $526 million for the impairment of goodwill and long-lived assets of hospitals sold or held for sale based on their estimated fair values,

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an after-tax charge of $15 million for employee termination benefits and other restructuring costs,

after-tax income of $23 million for gain from early extinguishment of debt,

an after-tax charge of $10 million from settlement adjustments to the CVR agreement liability related to HMA legal proceedings, and related legal expenses, and

a deferred tax provision of $34 million related to the write-off of deferred tax assets due to the nondeductible components of the settlement liability for the HMA legal proceedings noted above.

Loss from continuing operations before noncontrolling interests for the year ended December 31, 2017 included the following:

after-tax income of $20 million for government and other legal settlements and related legal expenses,

an after-tax charge of $26 million for loss from early extinguishment of debt,

an after-tax charge of $32 million for the estimated impact of the Tax Act,

an after-tax charge of $1 million related to the costs incurred for the 30 hospital divestitures,

an after-tax charge of $1.9 billion related to the impairment of goodwill and long-lived assets based on their estimated fair values,

an after-tax charge of $378 million related to the change in estimate for contractual allowances and provision for bad debts,

an after-tax charge of $5 million from fair value adjustments on the CVR agreement liability accounted for at fair value related to the HMA legal proceedings, and related legal expenses and

an after-tax charge of $9 million related to employee termination benefits and other restructuring charges.

During the fourth quarter of 2017, we completed an extensive analysis of our patient revenues and patient accounts receivable and developed new accounting processes and methodologies in preparation to adopt the new revenue recognition accounting standards in ASU 2014-09 on January 1, 2018. This analysis also included an evaluation of patient accounts receivable retained after the divestiture of 30 hospitals throughout 2017, and certain other revenues. Based on the information obtained, the financial results discussed below include a change in estimate recorded by us during the three months and year ended December 31, 2017 related to an increase in contractual allowances and the

provision for bad debts of approximately $591 million.

Consolidated inpatient admissions for the year ended December 31, 2018, decreased 15.0%, compared to the year ended December 31, 2017, and consolidated adjusted admissions for the year ended December 31, 2018, decreased 15.3%, compared to the year ended December 31, 2017. Same-store inpatient admissions for the year ended December 31, 2018, decreased 1.3%, compared to the year ended December 31, 2017, and same-store adjusted admissions for the year ended December 31, 2018, decreased 0.4%, compared to the year ended December 31, 2017.

Self-pay revenues represented approximately 1.4% and (0.8)% of net operating revenues for the years ended December 31, 2018 and 2017, respectively. The amount of foregone revenue related to providing charity care services as a percentage of net operating revenues was approximately 3.5% and 3.1% for the years ended December 31, 2018 and 2017, respectively. Direct and indirect costs incurred in providing charity care services as a percentage of net operating revenues was approximately 0.4% for both of the years ended December 31, 2018 and 2017.

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Legislative Overview

The U.S. Congress and certain state legislatures have introduced and passed a large number of proposals and legislation designed to make major changes in the healthcare system, including changes that have increased access to health insurance. The most prominent of these recent efforts, the Affordable Care Act, affects how healthcare services are covered, delivered and reimbursed. It mandates that substantially all U.S. citizens maintain health insurance and increases health insurance coverage through a combination of public program expansion and private sector health insurance reforms.

However, the future of the Affordable Care Act is uncertain. Since the 2016 presidential election, significant changes have been made to the Affordable Care Act, its implementation, and its interpretation. The current presidential administration and certain members of Congress have stated their intent to repeal or make additional significant changes to the law. For example, as part of the tax reform legislation which was enacted in December 2017, the financial penalty associated with the individual mandate was eliminated, effective January 1, 2019, which may result in fewer individuals electing to purchase health insurance. In addition, final rules issued in 2018 expand availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. These changes may impact the number of individuals who elect to purchase health insurance or the scope of such coverage, if purchased. Of critical importance to us will be the potential impact of any changes specific to the Medicaid funding and expansion provisions of the Affordable Care Act. We operate hospitals in five of the ten states that experienced the largest reductions in uninsured rates among adult residents between 2013 and 2015. In general, the states with the greatest reductions in the number of uninsured adult residents have expanded Medicaid. A number of states have opted out of the Medicaid coverage expansion provisions, but could ultimately decide to expand their programs at a later date. Of the 20 states in which we operated hospitals that were included in continuing operations as of December 31, 2018, 10 states have taken action to expand their Medicaid programs. At this time, the other 10 states have not, including Florida, Alabama, Tennessee and Texas, where we operated a significant number of hospitals as of December 31, 2018. Some states use, or have applied to use, waivers granted by CMS to implement expansion, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. CMS administrators have indicated that they are increasing state flexibility in the administration of Medicaid programs. For example, CMS has granted a limited number of state applications for waivers that allow a state to condition Medicaid enrollment on work or other community engagement. Several states have similar applications pending.

The Affordable Care Act makes a number of changes to Medicare and Medicaid, such as reductions to the Medicare annual market basket update for federal fiscal years 2010 through 2019, a productivity offset to the Medicare market basket update, and a reduction to the Medicare and Medicaid disproportionate share hospital payments, each of which could adversely impact the reimbursement received under these programs. The Affordable Care Act also includes provisions aimed at reducing fraud, waste and abuse in the healthcare industry.

We believe that the Affordable Care Act has had a positive impact on net operating revenues and income from continuing operations as the result of the expansion of private sector and Medicaid coverage that has occurred. However, legislative and executive branch efforts related to healthcare reform could result in increased prices for consumers purchasing health insurance coverage or the sale of insurance plans that contain gaps in coverage, which could destabilize insurance markets and impact the rates of uninsured or underinsured adults. Other provisions of the Affordable Care Act, such as requirements related to employee health insurance coverage and changes to Medicare and Medicaid reimbursement, have increased our operating costs or adversely impacted the reimbursement we receive.

It is difficult to predict the ongoing effect of the Affordable Care Act due to executive orders, changes to the law s implementation, clarifications and modifications resulting from the rule-making process, judicial interpretations resulting from court challenges to its constitutionality and interpretation, whether and how many states ultimately decide to expand Medicaid coverage, the number of uninsured who elect to purchase health insurance coverage, budgetary issues at federal and state levels, and efforts to change or repeal the statute. We

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may not be able to fully realize the positive impact the Affordable Care Act may otherwise have on our business, results of operations, cash flow, capital resources and liquidity. We cannot predict whether we will be able to modify certain aspects of our operations to offset any potential adverse consequences from the Affordable Care Act or the impact of any alternative provisions that may be adopted.

In recent years, a number of laws, including the Affordable Care Act and MACRA, have promoted shifting from traditional fee-for-service reimbursement models to alternative payment models that tie reimbursement to quality and cost of care. CMS currently administers various ACOs and bundled payment demonstration projects and has indicated that it will continue to pursue similar initiatives.

The federal government has implemented a number of regulations and programs designed to promote the use of EHR technology and pursuant to the HITECH, established requirements for a Medicare and Medicaid incentive payments program for eligible hospitals and professionals that adopt and meaningfully use certified EHR technology. These payments are available for a maximum period of five or six years, depending on the program. Our hospital facilities have been implementing EHR technology on a facility-by-facility basis since 2011. We recognize incentive reimbursement related to the Medicare or Medicaid incentives as we are able to implement the certified EHR technology and meet the defined meaningful use criteria, and information from completed cost report periods is available from which to calculate the incentive reimbursement. The timing of recognizing incentive reimbursement does not correlate with the timing of recognizing operating expenses and incurring capital costs in connection with the implementation of EHR technology which may result in material period-to-period changes in our future results of operations.

Eligible hospitals and professionals that have not demonstrated meaningful use of certified EHR technology and have not applied and qualified for a hardship exception are subject to payment adjustments. Eligible hospitals are subject to a reduced market basket update to the inpatient prospective payment system standardized amount as of 2015 and for each subsequent fiscal year. Eligible professionals are subject to a 1% per year cumulative reduction applied to the MPFS amount for covered professional services, subject to a cap of 5%. Payment adjustments for eligible professionals failing to demonstrate meaningful use will no longer be applicable beginning in 2019, when the program is scheduled to be replaced by MIPS.

As a result of our current levels of cash, available borrowing capacity, long-term outlook on our debt repayments, the refinancing of our term loans and our continued projection of our ability to generate cash flows, we anticipate that we will be able to invest the necessary capital in our business over the next twelve months. 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 will continue to strive to improve operating efficiencies and procedures in order to improve our profitability at our hospitals.

Sources of Revenue

The following table presents the approximate percentages of net operating revenues by payor source for the periods indicated. The data for the periods presented are not strictly comparable due to the effect that hospital acquisitions and divestitures have had on these statistics. The percentages of net operating revenues for 2017 also include the overall impact of the change in estimate recorded in the fourth quarter of 2017 to increase contractual allowances and record additional provision for bad debts.

	Year Ended December 31,

	2018	2017	2016
Medicare	26.3 %	27.8 %	27.2 %
Medicaid	13.3	13.2	11.9
Managed Care and other third-party payors	59.0	59.8	58.4
Self-pay	1.4	(0.8)	2.5
Total	100.0 %	100.0 %	100.0 %

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As shown above, we receive a substantial portion of our revenues from the Medicare and Medicaid programs. Included in Managed Care and other third-party payors is operating revenues from insurance companies with which we have insurance provider contracts, Medicare managed care, insurance companies for which we do not have insurance provider contracts, workers compensation carriers and non-patient service revenue, such as rental income and cafeteria sales. In the future, we generally expect the portion of revenues received from the Medicare and Medicaid programs to increase due to the general aging of the population. In addition, the Affordable Care Act has increased the number of insured patients in states that have expanded Medicaid, which in turn, has reduced the percentage of revenues from self-pay patients. However, it is unclear whether the trend of increased coverage will continue, due in part to the elimination of the financial penalty associated with the individual mandate, effective January 1, 2019. Further, the Affordable Care Act imposes significant reductions in amounts the government pays Medicare managed care plans. The trend toward increased enrollment in Medicare managed care may adversely affect our operating revenue growth. Other provisions in the Affordable Care Act impose minimum medical-loss ratios and require insurers to meet specific benefit requirements. Furthermore, in the normal course of business, managed care programs, insurance companies and employers actively negotiate the amounts paid to hospitals. The trend toward increased enrollment in managed care may adversely affect our operating revenue. There can be no assurance that we will retain our existing reimbursement arrangements or that these third-party payors will not attempt to further reduce the rates they pay for our services.

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-based reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for the treatment of patients covered by Medicare, Medicaid and non-governmental payors 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 loss by an insignificant amount in each of the years ended December 31, 2018, 2017, and 2016.

The payment rates under the Medicare program for hospital inpatient and outpatient acute care services are based on a prospective payment system, depending upon the diagnosis of a patient s condition. These rates are indexed for inflation annually, although increases have historically been less than actual inflation. On August 2, 2018, CMS issued the final rule to increase this index by 2.9% for hospital inpatient acute care services that are reimbursed under the prospective payment system, beginning October 1, 2018. The final rule provides for a 0.8% multifactor productivity reduction, a 0.75% reduction to hospital inpatient rates implemented pursuant to the Affordable Care Act, and a positive 0.5% adjustment in accordance with the MACRA, which, together will yield an estimated net 1.85% increase in reimbursement for hospitals. An additional reduction applies to hospitals that do not submit required patient quality data. We are complying with this data submission requirement. Payments may also be affected by admission and medical review criteria for inpatient services commonly known as the two midnight rule. Under the rule, for admissions on or after October 1, 2013, services to Medicare beneficiaries are only payable as inpatient hospital services when there is a reasonable expectation that the hospital care is medically necessary and will be required across two midnights, absent unusual circumstances. Stays expected to need less than two midnights of hospital care are subject to medical review on a case-by-case basis. Reductions in the rate of increase or overall reductions in Medicare reimbursement may cause a decline in the growth of our net operating revenues.

Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from CMS and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Similar programs are also being

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considered by other states. The programs are generally authorized for a specified period of time and require CMS s approval to be extended. CMS has indicated that it will take into account a state s status with respect to expanding its Medicaid program in considering whether to extend these supplemental programs. We are unable to predict whether or on what terms CMS will extend the supplemental programs in the states in which we operate. Under these supplemental programs, we recognize revenue and related expenses in the period in which amounts are estimable and collection is reasonably assured. Reimbursement under these programs is reflected in net operating revenues and included as Medicaid revenue in the table above, and fees, taxes or other program related costs are reflected in other operating expenses.

Results of Operations

Our hospitals offer a variety of services involving a broad range of inpatient and outpatient medical and surgical services. These include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic services, psychiatric and rehabilitation services. The strongest demand for hospital services generally occurs during January through April and the weakest demand for these services generally occurs during the summer months. Accordingly, eliminating the effects of new acquisitions and/or divestitures, our net operating revenues and earnings are historically highest during the first quarter and lowest during the third quarter.

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

	Year Ended December 31,		
	2018	**2017**	**2016**
Operating results, as a percentage of net operating revenues:			
Net operating revenues	100.0 %	100.0 %	100.0 %
Operating expenses (a)	(88.9)	(92.8)	(88.3)
Depreciation and amortization	(4.9)	(5.6)	(6.0)
Impairment and gain (loss) on sale of businesses, net	(4.7)	(13.8)	(10.4)
Income (loss) from operations	1.5	(12.2)	(4.7)
Interest expense, net	(6.9)	(6.1)	(5.2)
Gain (loss) from early extinguishment of debt	0.2	(0.3)	(0.2)
Gain on sale of investments in unconsolidated affiliates	-	-	0.5
Equity in earnings of unconsolidated affiliates	0.2	0.1	0.3
Loss from continuing operations before income taxes	(5.0)	(18.5)	(9.3)
Benefit from income taxes	-	3.0	0.6
Loss from continuing operations	(5.0)	(15.5)	(8.7)
Loss from discontinued operations, net of taxes	-	(0.1)	(0.1)
Net loss	(5.0)	(15.6)	(8.8)
Less: Net income attributable to noncontrolling interests	(0.6)	(0.4)	(0.5)
Net loss attributable to Community Health Systems, Inc. stockholders	(5.6)%	(16.0)%	(9.3)%

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	Year Ended December 31,	
	2018	2017
Percentage (decrease) increase from prior year:		
Net operating revenues	(7.8)%	(16.7)%
Admissions	(15.0)	(13.9)
Adjusted admissions (b)	(15.3)	(14.5)
Average length of stay	-	-
Net loss attributable to Community Health Systems, Inc. (c)	68.0	(42.9)
Same-store percentage increase (decrease) from prior year (d):		
Net operating revenues	2.8%	0.2%
Admissions	(1.3)	(1.9)
Adjusted admissions (b)	(0.4)	(1.7)

(a) Operating expenses include salaries and benefits, supplies, other operating expenses, government and other legal settlements and related costs, electronic health records incentive reimbursement and rent.

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

(c) Includes loss from discontinued operations.

(d) Includes acquired hospitals to the extent we operated them in both periods and excludes our hospitals that have previously been classified as discontinued operations for accounting purposes. In addition, also excludes information for the hospitals sold or closed during 2017 and 2018. Same-store operating results also exclude the overall impact of the change in estimate related to net patient receivables recorded in the fourth quarter of 2017.

Year Ended December 31, 2018 Compared to Year Ended December 31, 2017

Net operating revenues decreased by 7.8% to approximately $14.2 billion for the year ended December 31, 2018, from approximately $15.4 billion for the year ended December 31, 2017. Net operating revenues on a same-store basis from hospitals that were operated throughout both periods increased $362 million or 2.8% during the year ended December 31, 2018, as compared to the year ended December 31, 2017. The increase in same-store net operating revenues was attributable to improved pricing due to higher acuity, partially offset by a decline in inpatient admissions and adjusted admissions. Non-same-store net operating revenues decreased $1.6 billion during the year ended December 31, 2018, in comparison to the prior year period, with the decrease attributable primarily to the divestiture of hospitals during 2017 and 2018. On a consolidated basis, inpatient admissions decreased by 15.0% during the year ended December 31, 2018 as compared to the year ended December 31, 2017. Also on a consolidated basis, adjusted admissions decreased by 15.3% during the year ended December 31, 2018 as compared to the year ended December 31, 2017. On a same-store basis, net operating revenues per adjusted admissions increased 3.2%, while inpatient admissions decreased by 1.3% and adjusted admissions decreased by 0.4% for the year ended December 31, 2018, compared to the year ended December 31, 2017.

All operating expenses calculations, as a percentage of net operating revenues, were impacted during the year ended December 31, 2017 due to the overall impact of the change in estimate related to net patient receivables recorded in the fourth quarter of 2017. Total operating costs and expenses, as a percentage of net operating revenues, decreased from 112.2% during the year ended December 31, 2017 to 98.5% during the year ended December 31, 2018. Operating expenses, excluding depreciation and amortization and impairment and (gain) loss on sale of businesses, as a percentage of net operating revenues, decreased from 92.8% for the year ended December 31, 2017 to 88.9% for the

year ended December 31, 2018. Salaries and benefits, as a percentage of net operating revenues, decreased from 48.0% for the year ended December 31, 2017 to 45.1% for the year ended December 31, 2018. This decrease in salaries and benefits, as a percentage of net operating revenues, was

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

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

Impairment and (gain) loss on sale of businesses was $668 million for the year ended December 31, 2018, compared to $2.1 billion for the year ended December 31, 2017. Impairment of goodwill and long-lived assets for the year ended December 31, 2018 included (i) impairment of approximately $423 million related to impairment of the long-lived assets and reporting unit goodwill allocated to hospitals that have been sold or deemed held for sale during the year ended December 31, 2018, (ii) approximately $29 million recorded to write-off the value of a promissory note received as consideration for the sale of three hospitals in 2017 where the buyer entered into bankruptcy proceedings, and (iii) approximately $216 million recorded primarily to adjust the carrying value of other long-lived assets at several underperforming hospitals that have ceased operations or where we are in discussions with potential buyers for divestiture at a sales price that indicates a fair value below carrying value. Impairment of goodwill and long-lived assets for the year ended December 31, 2017 included impairment of approximately $388 million related to impairment of the long-lived assets and reporting unit goodwill allocated to hospitals classified as held for sale during the year ended December 31, 2017, impairment of approximately $316 million for several underperforming hospitals as well as for the hospitals where we have received offers or executed non-binding letters of intent to sell the hospital, and impairment of $1.419 billion related to goodwill for our hospital reporting unit.

Interest expense, net, increased by $45 million to $976 million for the year ended December 31, 2018 compared to $931 million for the year ended December 31, 2017, primarily due to an increase in interest rates during the year ended December 31, 2018 of $114 million. This increase was partially offset by a decrease in our average outstanding debt during the year ended December 31, 2018, which resulted in a decrease in interest expense of $65 million. Additionally, an increase in major construction projects during the year ended December 31, 2018 resulted in more interest being capitalized, and a decrease in interest expense of $4 million, compared to the same period in 2017.

Gain from early extinguishment of debt of $31 million was recognized during the year ended December 31, 2018 which resulted primarily from the refinancing and exchange of certain of our outstanding notes and repayment of a portion of our term loans under the Credit Facility as discussed further in Capital Resources. Loss from early extinguishment of debt of $40 million was recognized during the year ended December 31, 2017, which resulted from the repayment of certain outstanding notes and term loans under the Credit Facility.

Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, increased from 0.1% for the year ended December 31, 2017 to 0.2% for the year ended December 31, 2018.

The net results of the above-mentioned changes resulted in loss from continuing operations before income taxes decreasing $2.1 billion from loss of $2.8 billion for the year ended December 31, 2017 to loss of $715 million for the

year ended December 31, 2018.

Our benefit from income taxes on loss from continuing operations decreased from $449 million for the year ended December 31, 2017 to $11 million for the year ended December 31, 2018. Our effective tax rates were

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

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

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

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

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

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

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

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

All operating expenses calculations, as a percentage of net operating revenues, were impacted during the year ended December 31, 2017 due to the overall impact of the change in estimate related to net patient receivables recorded in

the fourth quarter of 2017. Total operating costs and expenses, as a percentage of net operating revenues, increased from 104.7% during the year ended December 31, 2016 to 112.2% during the year ended December 31, 2017. Operating expenses, excluding depreciation and amortization and impairment and (gain)

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

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

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

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

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

because of an increase in major construction projects during the year ended December 31,

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2017. These decreases were partially offset by an increase in interest rates during the year ended December 31, 2017, compared to the same period in 2016, which resulted in an increase in interest expense of $62 million.

Loss from early extinguishment of debt of $40 million was recognized during the year ended December 31, 2017. The loss from early extinguishment of debt resulted from the repayment of certain outstanding notes and term loans under the Credit Facility as discussed further in the section Capital Resources in Part II, Item 7 of this Form 10-K. Loss from early extinguishment of debt of $30 million was recognized during the year ended December 31, 2016 resulting from the repayment of certain outstanding notes and term loans under the Credit Facility.

No gain on sale of investments in unconsolidated affiliates was recognized during the year ended December 31, 2017. A gain on sale of investments in unconsolidated affiliates of $94 million was recognized during the year ended December 31, 2016 resulting from the sale of our unconsolidated minority equity interests in Valley Health System LLC, a joint venture with UHS representing four hospitals in Las Vegas, Nevada, in which we owned a 27.5% interest, and in Summerlin Hospital Medical Center LLC, a joint venture with UHS representing one hospital in Las Vegas, Nevada, in which we owned a 26.1% interest.

Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, decreased from 0.3% for the year ended December 31, 2016 to 0.1% for the year ended December 31, 2017, primarily resulting from the aforementioned sale of our investments in the joint ventures in Las Vegas, Nevada.

The net results of the above-mentioned changes resulted in loss from continuing operations before income taxes increasing $1.1 billion from loss of $1.7 billion for the year ended December 31, 2016 to loss of $2.8 billion for the year ended December 31, 2017.

The benefit from income taxes on loss from continuing operations increased from $104 million for the year ended December 31, 2016 to $449 million for the year ended December 31, 2017, primarily due to the increase in loss from continuing operations before income taxes. Our effective tax rates were 15.8% and 6.1% for the years ended December 31, 2017 and 2016, respectively. The increase in our effective tax rate for the year ended December 31, 2017, when compared to the year ended December 31, 2016, was primarily due to the differences in the non-deductible nature of certain goodwill written off in the $2.1 billion impairment and (gain) loss on sale of businesses for the year ended December 31, 2017, compared to 2016.

The benefit from income taxes includes the estimated impact of the Tax Act, which resulted in an additional provision for income taxes of $32 million during the year ended December 31, 2017, primarily related to provisional amounts recorded under SAB 118 for the remeasurement of deferred tax assets and liabilities due to the net effect of changes to the corporate tax rate in December 2017. We have accounted for the effects of the Tax Act using reasonable estimates based on currently available information and our interpretations thereof, and this estimated impact may be revised as a result of, among other things, changes in interpretations we have made and the issuance of new tax or accounting guidance.

Loss from continuing operations, as a percentage of net operating revenues, increased from 8.7% for the year ended December 31, 2016 to 15.5% for the year ended December 31, 2017.

Discontinued operations for these periods include the results of operations of certain hospitals owned or leased by us as of December 31, 2017 and 2016, which were classified as being held for sale or sold. The operation of these hospitals resulted in a loss, net of taxes, of $6 million and $7 million for the years ended December 31, 2017 and 2016, respectively. An after-tax impairment charge of $6 million and $8 million was recorded during the years ended December 31, 2017 and 2016, respectively, based on the difference between the estimated fair value and the carrying

value of the assets held for sale. Overall, discontinued operations consisted of a loss, net of taxes, of $12 million and $15 million during the years ended December 31, 2017 and 2016, respectively.

Net loss, as a percentage of net operating revenues, increased from 8.8% for the year ended December 31, 2016 to 15.6% for the year ended December 31, 2017.

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Net income attributable to noncontrolling interests, as a percentage of net operating revenues decreased from 0.5% for the year ended December 31, 2016 to 0.4% for the year ended December 31, 2017.

Net loss attributable to Community Health Systems, Inc. was $2.5 billion for the year ended December 31, 2017, compared to $1.7 billion for the year ended December 31, 2016. The increase in net loss attributable to Community Health Systems, Inc. was primarily due to the change in estimate recorded as a reduction of net operating revenues and the impairment of goodwill and certain long-lived assets based on their estimated fair values for hospitals sold or held for sale in 2017.

Liquidity and Capital Resources

2018 Compared to 2017

Net cash provided by operating activities decreased $499 million, from approximately $773 million for the year ended December 31, 2017, to approximately $274 million for the year ended December 31, 2018. The decrease in cash provided by operating activities was primarily impacted by the $266 million paid during the fourth quarter related to the global resolution and settlement of litigation and government investigation of HMA and higher interest payments due to the timing of payments and higher interest rates resulting from the refinancing activity during the year ended December 31, 2018, as well as from a decline in cash flow from patient accounts receivable collections that was impacted as the magnitude of collections on receivables at divested hospitals decreased. Other contributors to the lower cash provided by operating activities include the loss of operating cash flow contributed from previously divested hospitals and a decrease in cash received from HITECH incentive reimbursement. Such decreases were offset by improvements in cash flow from supplies, prepaid expenses and other current assets and lower malpractice claim payments compared to the same period in 2017. Total cash paid for interest during the year ended December 31, 2018, increased to approximately $936 million compared to $852 million for the year ended December 31, 2017. Cash paid for income taxes, net of refunds received, resulted in a net refund of $19 million for the year ended December 31, 2018, compared to $4 million paid for income taxes for the year ended December 31, 2017.

Our net cash used in investing activities was approximately $245 million for the year ended December 31, 2018, compared to net cash provided by investing activities of approximately $1.1 billion for the year ended December 31, 2017, a decrease of approximately $1.3 billion. The cash used in investing activities was primarily impacted by a decrease in proceeds from the disposition of hospitals and other ancillary operations of $1.3 billion as a result of fewer hospital dispositions during the year ended December 31, 2018 compared to the same period in 2017, a decrease in cash provided by the net impact of the purchases and sales of available-for-sale securities and equity securities of $47 million and an increase of $20 million in the cash used in the acquisition of facilities and other related equipment (for physician practices, clinics and other ancillary businesses as there were no hospital acquisitions during either the year ended December 31, 2018 or 2017). These increases in cash outflows were offset by a decrease in the cash used in the purchase of property and equipment of $37 million, an increase in the proceeds from the sale of property and equipment of $1 million, and a decrease in cash used for other investments (primarily from internal-use software expenditures and physician recruiting costs) of $2 million for the year ended December 31, 2018 compared to the same period in 2017.

Our net cash used in financing activities was $396 million for the year ended December 31, 2018, compared to approximately $1.5 billion for the year ended December 31, 2017, a decrease of approximately $1.1 billion. The decrease in cash used in financing activities, in comparison to the prior year period, was primarily due to the net effect of our debt repayment, refinancing activity, and cash paid for deferred financing costs and other debt-related costs.

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As described in Notes 7, 10 and 16 of the Notes to Consolidated Financial Statements, at December 31, 2018, we had certain cash obligations, which are due as follows (in millions):

	Total	2019	2020-2022	2023-2024	2025 and thereafter
Credit Facility	$ 1,622	$ -	$ 1,622	$ -	$ -
8% Senior Notes due 2019	155	155	-	-	-
7⅛% Senior Notes due 2020	121	-	121	-	-
5⅛% Senior Secured Notes due 2021	1,000	-	1,000	-	-
6⅞% Senior Notes due 2022	2,632	-	2,632	-	-
6¼% Senior Secured Notes due 2023	3,100	-	-	3,100	-
8⅝% Secured Notes due 2024	1,033	-	-	1,033	-
Junior-Priority Secured Notes due 2023	1,770	-	-	1,770	-
Junior-Priority Secured Notes due 2024	1,355	-	-	1,355	-
ABL Facility	698	-	-	698	-
Other debt	43	37	4	1	1
Total long-term debt (1)	13,529	192	5,379	7,957	1
Interest on credit facility, notes and ABL facility (2)	3,903	960	2,371	572	-
Capital lease and financing obligations, including interest	329	24	54	40	211
Operating leases	877	188	376	140	173
Replacement facilities and other capital commitments (3)	151	53	61	15	22
Open purchase orders (4)	502	467	35	-	-
Liability for uncertain tax positions, including interest and penalties	9	9	-	-	-
Total	$ 19,300	$ 1,893	$ 8,276	$ 8,724	$ 407

(1) Total long-term debt is exclusive of unamortized deferred debt issuance costs and note premium of approximately $164 million.

(2) Estimate of interest payments assumes the interest rates at December 31, 2018 remain constant during the period presented for our Credit Facility and our ABL Facility, which are variable rate debt. The interest rate used to calculate interest payments for our credit facility was the London Interbank Offered Rate, or LIBOR, as of December 31, 2018 plus the applicable spread. The 8% Senior Notes due 2019, 7⅛% Senior Notes due 2020, 5⅛% Senior Secured Notes due 2021, 6⅞% Senior Notes due 2022, 6¼% Senior Secured Notes due 2023, 8⅝% Secured Notes due 2024, Junior-Priority Secured Notes due 2023 and Junior-Priority Secured Notes due 2024 have fixed rates of interest.

(3)

Pursuant to hospital purchase agreements in effect as of December 31, 2018, we have commitments to build two replacement facilities and the following capital commitments. As part of an acquisition in 2016, we agreed to build replacement facilities in La Porte and Knox, Indiana. The estimated construction costs, including equipment costs, are currently estimated to be approximately $128 million and $15 million, respectively, of which approximately $6 million has been incurred to date for the construction of the replacement facility in La Porte. In addition, under other purchase agreements, we have committed to spend approximately $64 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

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

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

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

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

2017 Compared to 2016

Net cash provided by operating activities decreased $364 million, from approximately $1.1 billion for the year ended December 31, 2016, to approximately $773 million for the year ended December 31, 2017. The decrease in cash provided by operating activities was primarily the result of the loss of cash flow contributed from previously divested hospitals, a decrease in cash flow due to the timing of payroll funding compared to the prior year, an increase in disbursements from non-qualified employee retirement plans for retired and terminated employees, a decrease in cash received from HITECH incentive reimbursement, and other changes in working capital. Such decreases were offset by improvements in cash flow from patient accounts receivable collections, as well as the net cash received from the settlement proceeds, net of legal fees, of the shareholder derivative action in January 2017. Total cash paid for interest during the year ended December 31, 2017 decreased to approximately $852 million compared to $930 million for the year ended December 31, 2016, which is primarily related to the decrease in the average outstanding debt balance. Approximately $4 million was paid, net of refunds, for income taxes for the year ended December 31, 2017, compared to approximately $16 million net cash refund for income taxes for the year ended December 31, 2016. Included in net cash provided by operating activities for the year ended December 31, 2017 was $41 million of cash received for HITECH incentive reimbursements, compared to $123 million received for the year ended December 31, 2016.

Net cash provided by investing activities increased $439 million, from approximately $630 million for the year ended December 31, 2016 to approximately $1.1 billion for the year ended December 31, 2017. The increase in cash provided by investing activities was primarily due to an increase in proceeds from the disposition of hospitals and other ancillary operations of $1.5 billion; a decrease in the cash used in the purchase of property and equipment of $180 million, a decrease of $117 million in the cash used in the acquisition of facilities and other related equipment as there were no hospital acquisitions during the year ended December 31, 2017, compared to three hospitals acquired during the year ended December 31, 2016; an increase in cash provided by the net impact of the purchases and sales of available-for-sale securities of $124 million, and a decrease in cash used for other investments (primarily from internal-use software expenditures and physician recruiting costs) of $99 million for the year ended December 31, 2017. Included in cash outflows for other investments for the year ended December 31, 2017 is approximately $44 million of capital expenditures related to the purchase and implementation of certified EHR technology, including implementation of Cerner software at several hospital locations. The remaining cash outflows for other investments for the year ended December 31, 2017 primarily consists of purchases and development of other internal-use software and payments made under non-employee physician recruiting agreements of $99 million. The increase in cash provided by investing activities was partially offset by a decrease in cash provided by the distribution from QHC of $1.2 billion received as part of the spin-off transaction during the year ended December 31, 2016, a decrease in cash provided by the April 29, 2016 sale of our investments in unconsolidated affiliates of $403 million, related to our unconsolidated interest in two joint ventures with UHS representing five hospitals in Las Vegas, Nevada, and a decrease in the proceeds from the sale of property and equipment of $8 million. We anticipate being able to fund

future routine capital expenditures with cash flows generated from operations.

Our net cash used in financing activities was $1.5 billion for the year ended December 31, 2017, compared to $1.7 billion for the year ended December 31, 2016, a decrease of approximately $196 million. The decrease in

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cash used in financing activities, in comparison to the prior year period, is primarily due to the decrease in cash paid for the repayment of long-term debt of $1.3 billion, and the net effect of our debt repayment and refinancing activity during the year, including a decrease in our long-term borrowings and issuance of long-term debt of $938 million, and a decrease in the cash paid to repurchase vested restricted stock for payroll tax withholding requirements of $1 million. Additionally, an increase in proceeds from noncontrolling investors in joint ventures of $5 million and reduction in cash paid for the redemption of noncontrolling investments in joint ventures of $13 million, were offset by an increase of $8 million in cash paid for distributions to noncontrolling investors in joint ventures. These decreases in cash used in financing activities were partially offset by an increase in cash paid for deferred financing costs and other debt-related costs of $40 million, a decrease in the proceeds from our receivables facility of $2 million, and a decrease in proceeds of $159 million from the sale-lease back of our medical office buildings.

Capital Expenditures

Cash expenditures for purchases of facilities and other related businesses were $26 million in 2018, $6 million in 2017 and $123 million in 2016. Our expenditures for the years ended December 31, 2018, 2017 and 2016 were related to the purchase of physician practices and other ancillary services.

Excluding the cost to construct replacement hospitals, our cash expenditures for routine capital for the year ended December 31, 2018 totaled $521 million, compared to $558 million in 2017 and $732 million in 2016. These capital expenditures related primarily to the purchase of additional equipment, minor renovations and information systems infrastructure. Costs to construct replacement hospitals totaled $6 million in both 2018 and 2017 and $12 million in 2016. The costs to construct replacement hospitals for the year ended December 31, 2018 represent both planning and construction costs for the replacement facility at La Porte, Indiana. The costs to construct replacement hospitals for both of the years ended December 31, 2017 and 2016 represent both planning and construction costs for the replacement hospital we previously committed to build in York, Pennsylvania. In conjunction with the sale of Memorial Hospital of York on July 1, 2017, we no longer intend to construct this replacement hospital or have planned costs in connection therewith.

Pursuant to a hospital purchase agreement from our March 1, 2016 acquisition of La Porte Hospital and Starke Hospital, we committed to build replacement facilities in both La Porte, Indiana and Knox, Indiana. Under the terms of such agreement, construction of the replacement hospital for LaPorte Hospital is required to be completed within five years of the date of acquisition, or March 2021. In addition, construction of the replacement facility for Starke Hospital is required to be completed within five years of the date we enter into a new lease with Starke County, Indiana, the hospital lessor, or in the event we do not enter into a new lease with Starke County, construction shall be completed by September 30, 2026. We have not entered into a new lease with the lessor for Starke Hospital and currently anticipate completing construction of the Starke Hospital replacement facility in 2026. Construction costs, including equipment costs, for the La Porte and Starke replacement facilities are currently estimated to be approximately $128 million and $15 million, respectively. We expect total capital expenditures of approximately $475 million to $575 million in 2019 (which includes amounts that are required to be expended pursuant to the terms of the hospital purchase agreements), including approximately $425 million to $525 million for renovation and equipment cost and approximately $50 million for construction costs of the replacement hospital in La Porte, Indiana.

Capital Resources

Net working capital was approximately $1.2 billion at December 31, 2018, compared to $1.7 billion at December 31, 2017. Net working capital decreased by approximately $555 million between December 31, 2017 and December 31, 2018. This decrease is primarily due to the decrease in cash and increase in other current liabilities, partially offset by a decrease in accounts payable during the year ended December 31, 2018.

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

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

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

The term loan facility must be prepaid in an amount equal to (1) 100% of the net cash proceeds of certain asset sales and dispositions by us and our subsidiaries, subject to certain exceptions and reinvestment rights (as further described below), (2) 100% of the net cash proceeds of issuances of certain debt obligations or receivables-based financing by us and our subsidiaries, subject to certain exceptions, and (3) 75%, subject to reduction to a lower percentage based on our first lien net leverage ratio (as defined in the Credit Facility generally as the ratio of first lien net debt on the date of determination to our consolidated EBITDA, as defined, for the four quarters most recently ended prior to such date), of excess cash flow (as defined) for any year, 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 borrower under the Credit Facility is our wholly-owned subsidiary CHS/Community Health Systems, Inc., or CHS. All of our obligations under the Credit Facility are unconditionally guaranteed by Community Health Systems, Inc. and certain of its 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. Such assets constitute substantially the same assets, subject to certain exceptions, that secure CHS obligations under its outstanding senior secured notes.

We have agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to LIBOR borrowings under the Revolving 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

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

The Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting our and our subsidiaries ability, subject to certain exceptions, to, among other things, (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of our businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change our fiscal year. We and our subsidiaries are also required to comply with specified financial covenants (consisting of a maximum first lien net debt to consolidated EBITDA leverage ratio) and various affirmative covenants. Under the Credit Facility, the first lien net debt to consolidated EBITDA leverage ratio is calculated as the ratio of total first lien debt, less unrestricted cash and cash equivalents, to consolidated EBITDA, as defined in the Credit Facility. The calculation of consolidated EBITDA as defined in the Credit Facility is a trailing 12-month calculation that begins with net income attributable to us, with certain pro forma adjustments to consider the impact of material acquisitions or divestitures, and adjustments for interest, taxes, depreciation and amortization, net income attributable to noncontrolling interests, stock compensation expense, restructuring costs, and the financial impact of other non-cash or non-recurring items recorded during any such 12-month period. For the 12-month period ended December 31, 2018, the first lien net debt to consolidated EBITDA leverage ratio financial covenant under the Credit Facility limited the ratio of first lien net debt to consolidated EBITDA, as defined, to less than or equal to 5.0 to 1.0. We were in compliance with all such covenants at December 31, 2018, with a first lien net debt to consolidated EBITDA leverage ratio of approximately 4.84 to 1.0.

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 an available cure, (4) bankruptcy and insolvency events, (5) a cross default to certain other debt, (6) certain undischarged judgments (not paid within an applicable grace period), (7) a change of control (as defined), (8) certain ERISA-related defaults and (9) the invalidity or impairment of specified security interests, guarantees or subordination provisions in favor of the administrative agent or lenders under the Credit Facility.

On March 16, 2017, CHS completed a public offering of $2.2 billion aggregate principal amount of 6¼% Senior Secured Notes due 2023, or the 6¼% Senior Secured Notes. The net proceeds from this issuance were used to finance the purchase or redemption of $700 million aggregate principal amount of the 2018 Senior Secured Notes and related fees and expenses, and the repayment of $1.445 billion of the Term F Facility. On May 12, 2017, CHS completed a tack-on offering of $900 million aggregate principal amount of 6¼% Senior Secured Notes, increasing the total aggregate principal amount of 6¼% Senior Secured Notes to $3.1 billion. A portion of the net proceeds from this issuance were used to finance the repayment of approximately $713 million aggregate principal amount of CHS then outstanding Term A Facility and related fees and expenses. The tack-on notes have identical terms, other than issue date and issue price as the 6¼% Senior Secured Notes issued on March 16, 2017. The 6¼% Senior Secured Notes bear interest at 6.250% per annum, payable semiannually in arrears on June 30 and September 30, commencing September 30, 2017. Interest on the 6¼% Senior Secured Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months. The 2021 Senior Secured Notes, the 6¼% Senior Secured Notes and the 8⅝% Senior Secured Notes are secured by a first-priority lien subject to a shared lien of equal priority with certain other obligations, including obligations under the Credit Facility, and subject to prior ranking liens permitted by the indentures governing the 2021 Senior Secured Notes, the 6¼% Senior Secured Notes and the 8⅝% Senior Secured Notes on substantially the same assets, subject to certain exceptions, that secure CHS

obligations under the Credit Facility.

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On February 26, 2018, the Credit Facility was amended, with requisite revolving lender approval, to remove the consolidated EBITDA to interest expense ratio financial covenant, to replace the senior secured net debt to consolidated EBITDA ratio financial covenant with a first lien net debt to consolidated EBITDA ratio financial covenant, and to reduce the extended revolving credit commitments to $650 million (for a total of $840 million in revolving credit commitments when combined with the non-extended portion of the revolving credit facility). The new financial covenant provides for a maximum first lien net debt to consolidated EBITDA ratio of 5.25 to 1.0, reducing to 5.0 to 1.0 on July 1, 2018, 4.75 to 1.0 on January 1, 2019, 4.5 to 1.0 on January 1, 2020 and 4.25 to 1.0 on July 1, 2020. In addition, we agreed pursuant to the amendment to modify its ability to retain asset sale proceeds, and instead to apply them to prepayments of term loans based on pro forma first lien leverage. To the extent the pro forma ratio of first lien net debt to consolidated EBITDA is greater than or equal to 4.5 to 1.0, 100% of net cash proceeds of asset sales will be applied to prepay term loans; to the extent the first lien leverage ratio is less than 4.5 to 1.0 but greater than or equal to 4.0 to 1.0, 50% of such proceeds will be applied to prepay term loans; and to the extent the pro forma first lien leverage ratio is less than 4.0 to 1.0, there will be no requirement to prepay term loans with such proceeds. These ratios will be determined on a pro forma basis giving appropriate effect to the relevant asset sales and corresponding prepayments of term loans.

On February 15, 2019, the Credit Facility was amended, with requisite covenant lender approval, to amend the first lien net debt to EBITDA ratio financial covenant and to reduce the extended revolving credit commitments to $385 million. The amended financial covenant provides for a maximum first lien net debt to EBITDA ratio of 5.00 to 1.0 from July 1, 2018 through December 31, 2018, 5.25 to 1.0 from January 1, 2019 through December 31, 2019, 5.00 to 1.00 from January 1, 2020 through June 30, 2020, 4.50 to 1.00 from July 1, 2020 through September 30, 2020, and 4.25 to 1.0 thereafter. In addition, CHS agreed to further restrict its ability to make restricted payments. The revolving credit commitments will terminate on January 27, 2021. The amended Credit Facility includes a 91-day springing maturity date applicable if more than $250 million in the aggregate principal amount of our 8% Senior Notes due 2019, 7⅛% Senior Notes due 2020, Term H Facility or refinancings thereof are scheduled to mature or similarly become due within 91 days of such date.

On March 23, 2018, we and CHS, entered into the Fourth Amendment and Restatement Agreement to the Credit Facility, or the Agreement. In addition to including the changes described in the paragraph above, we further modified our ability to retain asset sale proceeds, and instead to apply them to prepayments of term loans based on pro forma first lien leverage. To the extent the pro forma ratio of first lien net debt to consolidated EBITDA is greater than or equal to 4.25 to 1.0, 100% of net cash proceeds of asset sales will be applied to prepay term loans; to the extent the pro forma first lien leverage ratio is less than 4.25 to 1.0 but greater than or equal to 3.75 to 1.0, 50% of such proceeds will be applied to prepay term loans; and to the extent the first lien leverage ratio is less than 3.75 to 1.0, there will be no requirement to prepay term loans with such proceeds. The Agreement also amended the Credit Facility to permit CHS to incur debt under either an asset-based loan facility, or ABL, in an amount up to $1.0 billion or maintain its Asset-Backed Securitization program. The Revolving Facility would be reduced to $425 million upon the effectiveness of the contemplated ABL facility. The Agreement also reduced the availability for incremental tranches of term loans or increases in the Revolving Facility to $500 million and removed the secured net leverage incurrence test with respect to junior secured debt. Term G Loans will accrue interest at a rate per annum initially equal to LIBOR plus 3.00%, in the case of LIBOR borrowings, and Alternate Base Rate plus 2.00%, in the case of Alternate Base Rate borrowing. Term H Loans will accrue interest at a rate per annum initially equal to LIBOR plus 3.25%, in the case of LIBOR borrowings, and Alternate Base Rate plus 2.25%, in the case of Alternate Base Rate borrowing.

Prior to the effectiveness of the ABL Facility described below, CHS, through certain of its subsidiaries, participated in an accounts receivable loan agreement, or the Receivables Facility, with a group of lenders and banks, Credit Agricolé Corporate and Investment Bank, as a managing agent and as the administrative agent. Patient-related accounts receivable, or the Receivables, for certain affiliated hospitals served as collateral for the outstanding borrowings under

the Receivables Facility. The interest rate on the borrowings was based on the commercial paper rate plus an applicable interest rate spread. The Receivables Facility was repaid in full and terminated upon the effectiveness of the ABL Facility on April 3, 2018.

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On April 3, 2018, we and CHS entered into an asset-based loan (ABL) credit agreement, or the ABL Credit Agreement, with JPMorgan Chase Bank, N.A., as administrative agent, and the lenders and other agents party thereto. Pursuant to the ABL Credit Agreement, the lenders have extended to CHS a revolving asset-based loan facility, or the ABL Facility, in the maximum aggregate principal amount of $1.0 billion, subject to borrowing base capacity. The ABL Facility includes borrowing capacity available for letters of credit of $50 million. CHS and all domestic subsidiaries of CHS that guarantee CHS other outstanding senior and senior secured indebtedness guarantee the obligations of CHS under the ABL Facility. Subject to certain exceptions, all obligations under the ABL Facility and the related guarantees are secured by a perfected first-priority security interest in substantially all of the Receivables, deposit, collection and other accounts and contract rights, books, records and other instruments related to the foregoing of the Company, CHS and the guarantors as well as a perfected junior-priority security interest in substantially all of the other assets of the Company, CHS and the guarantors, subject to customary exceptions and intercreditor arrangements. The revolving credit commitments under the Credit Facility were reduced to $425 million upon the effectiveness of the ABL facility. In connection with entering into the ABL Credit Agreement and the ABL Facility, we repaid in full and terminated our Receivables Facility. The outstanding borrowings pursuant to the ABL Facility at December 31, 2018 totaled $698 million on the consolidated balance sheet.

Borrowings under the ABL Facility bear interest at a rate per annum equal to an applicable percentage, plus, at the Borrower s option, either (a) an Alternative base rate or (b) a LIBOR rate. From and after December 31, 2018, the applicable percentage under the ABL Facility will be determined based on excess availability as a percentage of the maximum commitment amount under the ABL facility at a rate per annum of 1.25%, 1.50% and 1.75% for loans based on the Alternative base rate and 2.25%, 2.50% and 2.75% for loans based on the LIBOR rate. From and after September 30, 2018, the applicable commitment fee rate under the ABL Facility is determined based on average utilization as a percentage of the maximum commitment amount under the ABL Facility at a rate per annum of either 0.50% or 0.625% times the unused portion of the ABL facility.

Principal amounts outstanding under the ABL Facility will be due and payable in full on April 3, 2023. The ABL Facility includes a 91-day springing maturity applicable if more than $250 million in the aggregate principal amount of the Borrower s 8% Senior Notes due 2019, Term G loans due 2019, 7.125% Senior Notes due 2020, Term H loans due 2021, 5.125% Senior Secured Notes due 2021, 6.875% Senior Notes due 2022 or 6.25% Senior Secured Notes due 2023 or refinancings thereof are scheduled to mature or similarly become due on a date prior to April 3, 2023.

The ABL Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting our ability, subject to certain exceptions, to, among other things (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) engage in mergers, acquisitions and asset sales, (7) conduct transactions with affiliates, (8) alter the nature of the Company s, CHS or the guarantors businesses, (9) grant certain guarantees with respect to physician practices, (10) engage in sale and leaseback transactions or (11) change our fiscal year. We are also required to comply with a consolidated fixed coverage ratio, upon certain triggering events described below, and various affirmative covenants. The consolidated fixed coverage ratio is calculated as the ratio of (x) consolidated EBITDA (as defined in the ABL Facility) less capital expenditures to (y) the sum of consolidated interest expense (as defined in the ABL Facility), scheduled principal payments, income taxes and restricted payments made in cash or in permitted investments. For purposes of calculating the consolidated fixed charge coverage ratio, the calculation of consolidated EBITDA as defined in the ABL Facility is a trailing 12-month calculation that begins with consolidated net income attributable to Holdings, with certain adjustments for interest, taxes, depreciation and amortization, net income attributable to noncontrolling interests, stock compensation expense, restructuring costs, and the financial impact of other non-cash or non-recurring items recorded during any such 12-month period. The consolidated fixed charge coverage ratio is a required covenant only in periods where the total borrowings outstanding

under the ABL Facility reduce the amount available in the facility to less than the greater of (i) $95 million and (ii) 10% of the

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

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

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

On July 6, 2018, CHS completed an offering of $1.033 billion aggregate principal amount of 8⅝% Senior Secured Notes due 2024, or the 8⅝% Senior Secured Notes. We used the proceeds from this offering to repay the outstanding balance owed under the Term G Loan and pay fees and expenses related to the offering. The terms of the 8⅝% Senior Secured Notes are governed by an indenture, dated as of July 6, 2018, among CHS, the Company, the subsidiary guarantors party thereto, Regions Bank, as trustee and Credit Suisse AG, as collateral agent. The 8⅝% Senior Secured Notes bear interest at a rate of 8⅝% per year payable semi-annually in arrears on January 15 and July 15 of each year, commencing on January 15, 2019. The 8⅝% Senior Secured Notes are unconditionally guaranteed on a senior-priority secured basis by us and each of the CHS current and future domestic subsidiaries that provide guarantees under CHS senior secured credit facilities, CHS ABL facility, any capital market debt securities of CHS (including CHS outstanding senior notes) and certain other long-term debt of CHS.

As of December 31, 2018, we are currently a party to interest rate swap agreements to limit the effect of changes in interest rates on approximately 64.6% of our variable rate debt. On each of these swaps, we receive a variable rate of interest based on the three-month LIBOR, in exchange for the payment by us of a fixed rate of interest. See Note 8 of the Notes to Consolidated Financial Statements included under Part II, Item 8 of this Form 10-K for further information on our interest rate swap agreements.

The Credit Facility and the indentures that govern our outstanding notes contain various covenants that limit our ability to take certain actions, including our ability to:

incur, assume or guarantee additional indebtedness;

issue redeemable stock and preferred stock;

repurchase capital stock;

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make restricted payments, including paying dividends and making certain loans, acquisitions and investments;

redeem debt that is subordinated in right of payment to our outstanding notes;

create liens;

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

impair the security interests;

enter into agreements that restrict dividends and certain other payments from subsidiaries;

merge, consolidate, sell or otherwise dispose of substantially all of our assets;

enter into transactions with affiliates; and

guarantee certain obligations.

The indentures governing each of the 2023 Junior-Priority Notes and 2024 Junior-Priority Notes also prohibit CHS from purchasing, repurchasing, redeeming, defeasing or otherwise acquiring or retiring any outstanding 8% Senior Notes and 7⅛% Senior Notes after the consummation of the exchange offers described above with: (a) cash or cash equivalents on hand as of the consummation of such exchange offers; (b) cash generated from operations; (c) proceeds from assets sales; or (d) proceeds from the issuance of, or in exchange for, secured debt, in each case, prior to the date that is 60 days prior to the relevant maturity dates of such 8% Senior Notes and 7⅛% Senior Notes, as applicable.

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 indentures that govern our outstanding notes. Upon the occurrence of an event of default under our Credit Facility or indentures that govern our outstanding notes, all amounts outstanding under our Credit Facility and the indentures that govern our outstanding notes may become immediately 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 approximately $425 million, of which approximately $90 million is in the form of outstanding letters of credit, the availability under our new ABL Facility and our ability to amend the Credit Facility to provide for one or more incremental tranches of term loans and revolving credit commitments in an aggregate principal amount of up to $500 million, in each case subject to certain limitations as set forth in the Credit Facility, as well as our continued access to the capital markets, will be sufficient to finance acquisitions, capital expenditures, working capital requirements, and any equity or debt repurchases or other debt repayments we may elect to make through the next 12

months. In addition, we are currently required to utilize proceeds received from dispositions of assets, subject to certain exceptions, to repay outstanding debt.

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

Off-balance Sheet Arrangements

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

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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. At December 31, 2018, we operated one hospital under an operating lease that had an immaterial impact on our consolidated operating results. The terms of the one operating lease we currently have in place expires in December 2020, not including lease extension options. If we allow this lease to expire, we would no longer generate revenues nor incur expenses from this hospital.

As described more fully in Note 16 of the Notes to Consolidated Financial Statements included under Part II, Item 8 of this Form 10-K, at December 31, 2018, we have certain cash obligations for replacement facilities and other construction commitments of $151 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, 2018, we have hospitals in 18 of the markets we serve, with noncontrolling physician ownership interests ranging from less than 1% to 40%. In addition, as of December 31, 2018 we have eight other hospitals with noncontrolling interests owned by non-profit entities. On August 15, 2018, we completed the acquisition of the 20% ownership interest held by the non-profit entity that was the noncontrolling interest owner of two of our hospitals in Indiana for approximately $20 million. Redeemable noncontrolling interests in equity of consolidated subsidiaries was $504 million and $527 million as of December 31, 2018 and 2017, respectively, and noncontrolling interests in equity of consolidated subsidiaries was $72 million and $75 million as of December 31, 2018 and 2017, respectively. The amount of net income attributable to noncontrolling interests was $84 million, $63 million and $95 million for the years ended December 31, 2018, 2017 and 2016, respectively. As a result of the change in the Stark Law whole hospital exception included in the Affordable Care Act, we are not permitted to introduce physician ownership at any of our hospital facilities that did not have physician ownership at the time of the adoption of the Affordable Care Act, or increase the aggregate percentage of physician ownership in any of our former or existing hospital joint ventures in excess of the aggregate physician ownership level held at the time of the adoption of the Affordable Care Act.

Reimbursement, Legislative and Regulatory Changes

Ongoing legislative and regulatory efforts could reduce or otherwise adversely affect the payments we receive from Medicare and Medicaid and other payors. 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 additional restructuring of the financing and delivery of healthcare in the United States. These events could cause our future financial results to decline. We cannot estimate the impact of Medicare and Medicaid reimbursement changes that have been enacted or are under consideration. We cannot predict whether additional reimbursement reductions will be made or whether any such changes or other restructuring of the financing and delivery of healthcare would have a material adverse effect on our business, financial conditions, results of operations, cash flow, capital resources and liquidity.

Inflation

The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. In addition, our suppliers pass along rising costs to us in the form of higher prices. We have implemented cost control measures, including our case and resource management program, to curb

increases in operating costs and expenses. We have generally offset increases in operating costs by increasing reimbursement for services, expanding services and reducing costs in other areas. However, we cannot predict our ability to cover or offset future cost increases, particularly any increases in our cost of providing health insurance benefits to our employees.

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Critical Accounting Policies

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

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

Revenue Recognition

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

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

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

Due to the complexities involved in these estimates, actual payments we receive could be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs

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and managed care contracts differed by 1% at December 31, 2018 from our estimated reimbursement percentage, net loss for the year ended December 31, 2018 would have changed by approximately $96 million, and net accounts receivable at December 31, 2018 would have changed by $106 million. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net loss by an insignificant amount for each of the years ended December 31, 2018, 2017 and 2016.

Patient Accounts Receivable

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

We estimate any adjustments to the transaction price for implicit price concessions by reserving a percentage of all self-pay accounts receivable without regard to aging category, based on collection history, adjusted for expected recoveries and any anticipated changes in trends. Our ability to estimate the transaction price and any implicit price concessions is not impacted by not utilizing an aging of our net accounts receivable as we believe that substantially all of the risk exists at the point in time such accounts are identified as self-pay. The percentage used to reserve for all self-pay accounts is based on our collection history. We believe that we collect substantially all of our third-party insured receivables, which include receivables from governmental agencies.

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

Patient accounts receivable can be impacted by the effectiveness of our collection efforts. Additionally, significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect the net realizable value of accounts receivable. We also continually review the net realizable value of accounts receivable by monitoring historical cash collections as a percentage of trailing net operating revenues, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, the composition of self-pay receivables between pure self-pay patients and the patient responsibility portion of third-party insured receivables and the impact of recent acquisitions and dispositions. If the actual collection percentage differed by 1% at December 31, 2018 from our estimated collection percentage as a result of a change in expected recoveries, net loss for the year ended December 31, 2018 would have changed by $63 million, and net accounts receivable at December 31, 2018 would have changed by $69 million. We also continually review our overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net operating revenues, as well as by analyzing current period net revenue and admissions by payor classification, days revenue outstanding, the composition of self-pay receivables between pure

self-pay patients and the patient responsibility portion of third-party insured receivables and the impact of recent acquisitions and dispositions.

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

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and is consistent with industry practices. We had approximately $4.7 billion at December 31, 2018 and $4.2 billion December 31, 2017, 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 accounts receivable. Collections on amounts previously written-off are recognized as a recovery of net operating revenues when received. However, we take into consideration estimated collections of these future amounts written-off in determining the implicit price concessions used to measure the transaction price for the applicable portfolio of patient accounts receivable.

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

Patient accounts receivable from our hospitals represent approximately 98% of our total consolidated accounts receivable.

Days revenue outstanding, adjusted for the impact of receivables for state Medicaid supplemental payment programs, was 58 days at December 31, 2018 and 56 days at December 31, 2017.

Total gross accounts receivable (prior to allowance for contractual adjustments and implicit price concessions) was approximately $17.2 billion as of December 31, 2018 and approximately $18.6 billion as of December 31, 2017. The approximate percentage of total gross accounts receivable (prior to allowance for contractual adjustments and implicit price concessions) summarized by aging categories is as follows:

As of December 31, 2018

	% of Gross Receivables			
Payor	**0 - 90 Days**	**90 - 180 Days**	**180 - 365 Days**	**Over 365 Days**
Medicare	14 %	- %	- %	- %
Medicaid	7 %	1 %	1 %	1 %
Managed Care and Other	26 %	4 %	3 %	3 %
Self-Pay	9 %	8 %	10 %	13 %

As of December 31, 2017

	% of Gross Receivables			
Payor	**0 - 90 Days**	**90 - 180 Days**	**180 - 365 Days**	**Over 365 Days**
Medicare	13 %	1 %	- %	- %
Medicaid	7 %	1 %	1 %	1 %
Managed Care and Other	24 %	4 %	3 %	3 %
Self-Pay	8 %	7 %	15 %	12 %

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

	December 31,	
	2018	**2017**

Insured receivables	60.0 %	57.9 %
Self-pay receivables	40.0	42.1
Total	100.0 %	100.0 %

The combined total at our hospitals and clinics for the estimated implicit price concessions for self-pay accounts receivable and allowances for other self-pay discounts and contractuals, as a percentage of gross self-pay receivables, was approximately 90% and 92% at December 31, 2018 and December 31, 2017, respectively. During the three months ended June 30, 2018, we directed the placement with outside collection

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agencies of approximately $1.3 billion of gross self-pay accounts receivable. Since these receivables were fully reserved at the time of write-off, the overall percentage of reserves for the remaining self-pay accounts receivable decreased. 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 94% at both December 31, 2018 and December 31, 2017.

Goodwill and Other Intangibles

Goodwill represents the excess of the fair value of the consideration conveyed in the acquisition over the fair value of net assets acquired. Goodwill is evaluated for impairment annually 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. During 2017, we adopted ASU 2017-04, which allows a company to record a goodwill impairment when the reporting units carrying value exceeds the fair value determined in step one. In 2017, consistent with prior years, we performed our annual goodwill evaluation during the fourth quarter as of September 30, 2017, and then an updated evaluation as of November 30, 2017 due to the identification of certain impairment indicators. With the elimination of the time-intensive step two calculation to determine the implied value of goodwill, we considered the additional benefits of performing the annual goodwill evaluation later in the fourth quarter to coincide with the timing of the next fiscal year s budgeting and financial projection process. Based on these considerations, we elected to change the annual goodwill impairment measurement date to October 31 beginning in 2018. Our most recent goodwill evaluation was performed during the fourth quarter of 2018 with an October 31, 2018 measurement date, which indicated no impairment.

At December 31, 2018, we had approximately $4.6 billion of goodwill recorded, all of which resides at our hospital operations reporting unit.

During the three months ended December 31, 2017, in connection with the preparation of the financial statements included in our 2017 Form 10-K, we identified certain indicators of impairment and performed an interim goodwill impairment evaluation as of November 30, 2017. Those indicators were primarily a further decline in our market capitalization and fair value of our long-term debt during November 2017. We performed an estimated calculation of fair value in step one of the impairment test at November 30, 2017, which indicated that the carrying value of our hospital operations reporting unit exceeded its fair value. As a result of this evaluation and the early adoption of ASU 2017-04, we recorded a non-cash impairment charge of $1.419 billion to goodwill during the three months ended December 31, 2017.

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

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

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

Professional Liability Claims

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

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

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

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

Based on these analyses, we determine our estimate of the professional liability claims. The determination of management s estimate, including the preparation of the reserve analysis that supports such estimate, involves subjective judgment of management. Changes in reserving data or the trends and factors that influence reserving data may signal fundamental shifts in our future claim development patterns or may simply reflect single-period anomalies. Even if a change reflects a fundamental shift, the full extent of the change may not become evident

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

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

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

Current accident year expense increased for the year ended December 31, 2018, when compared to the prior year, due to the trend of higher severity and also the increase in self-insured retention limit per claim from $10 million to $15 million. Expense related to prior accident years reflects changes in estimates resulting from the filing of claims for prior year incidents, claim settlements, updates from litigation and our ongoing investigation of open claims. 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 less than $1 million per occurrence self-insured retention and for claims reported from June 1, 2002 through June 1, 2003, these self-insured retentions were $2 million per occurrence. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 and before June 1, 2014 are self-insured up to $5 million per claim. Substantially all

claims reported on or after June 1, 2014 and before June 1, 2018 are self-insured up to $10 million per claim. Substantially all claims reported on or after June 1, 2018 are self-insured up to $15 million per claim. Management, on occasion, has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals has been purchased through commercial insurance companies and generally covers 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, up to $145 million per occurrence and in the aggregate for claims reported on or after January 1, 2008, up to $195 million per occurrence and in the aggregate for claims reported on or after June 1,

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2010, and up to $220 million per occurrence and in the aggregate for claims reported on or after June 1, 2015. In addition, for integrated occurrence malpractice claims, there is an additional $50 million of excess coverage for claims reported on or after June 1, 2014 and an additional $75 million of excess coverage for claims reported on or after June 1, 2015. For certain policy years prior to June 1, 2014, if the first aggregate layer of excess coverage becomes fully utilized, then the self-insured retention will increase to $10 million per claim for any subsequent claims in that policy year until our total aggregate coverage is met. Beginning June 1, 2018, this drop-down provision in the excess policies attaches over the $15 million per claim self-insured retention.

Effective June 1, 2014, the hospitals acquired from HMA were insured on a claims-made basis as described above and through commercial insurance companies as described above for substantially all claims reported on or after June 1, 2014 except for physician-related claims with an occurrence date prior to June 1, 2014. Prior to June 1, 2014, the former HMA hospitals obtained insurance coverage through a wholly-owned captive insurance subsidiary and a risk retention group subsidiary which are domiciled in the Cayman Islands and South Carolina, respectively. Those insurance subsidiaries, which are collectively referred to as the Insurance Subsidiaries, provided (i) claims-made coverage to all of the former HMA hospitals and (ii) occurrence-basis coverage to most of the physicians employed by the former HMA hospitals. The employed physicians not covered by the Insurance Subsidiaries generally maintained claims-made policies with unrelated third party insurance companies. To mitigate the exposure of the program covering the former HMA hospitals and other healthcare facilities, the Insurance Subsidiaries bought claims-made reinsurance policies from unrelated third parties for claims above self-retention levels of $10 million or $15 million per claim, depending on the policy year.

Effective January 1, 2008, the former Triad hospitals were insured on a claims-made basis as described above and through commercial insurance companies as described above for substantially all claims occurring on or after January 1, 2002 and reported on or after January 1, 2008. Substantially all losses for the former Triad hospitals in periods prior to May 1, 1999 were insured through a wholly-owned insurance subsidiary of HCA, Triad s owner prior to that time, and excess loss policies maintained by HCA. HCA has agreed to indemnify the former Triad hospitals in respect of claims covered by such insurance policies arising prior to May 1, 1999. From May 1, 1999 through December 31, 2006, the former Triad hospitals obtained insurance coverage on a claims incurred basis from HCA s wholly-owned insurance subsidiary with excess coverage obtained from other carriers that is subject to certain deductibles. Effective for claims incurred after December 31, 2006, Triad began insuring its claims from $1 million to $5 million through its wholly-owned captive insurance company, replacing the coverage provided by HCA. Substantially all claims occurring during 2007 were self-insured up to $10 million per claim.

Income Taxes

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

The total amount of unrecognized benefit that would impact the effective tax rate, if recognized, was approximately $7 million as of December 31, 2018. A total of approximately $4 million of interest and penalties is included in the amount of liability for uncertain tax positions at December 31, 2018. It is our policy to recognize interest and penalties related to unrecognized benefits in our consolidated statements of loss as income tax expense.

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

Our federal income tax returns for the 2009 and 2010 tax years have been settled with the Internal Revenue Service. The results of these examinations were not material to our consolidated results of operations or

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consolidated financial position. Our federal income tax returns for the 2014 and 2015 tax years remain under examination by the Internal Revenue Service. We believe the results of these examinations will not be material to our consolidated results of operations or consolidated financial position. We have extended the federal statute of limitations through June 30, 2019 for Community Health Systems, Inc. for the tax periods ended December 31, 2007, 2008, 2009 and 2010, and through December 31, 2019 for the tax periods ended December 31, 2014 and 2015.

We have accounted for the effects of the Tax Act using reasonable estimates based on currently available information and our interpretations thereof, and the estimated impact of the Tax Act during the years ended December 31, 2018 and 2017. We finalized our accounting for the Tax Act in the fourth quarter of 2018 in accordance with the prescribed measurement period under SAB 118. See Note 6 of the Notes to Consolidated Financial Statements included under Part II, Item 8 of this Form 10-K for additional information.

Recent Accounting Pronouncements

In January 2016, the FASB issued ASU, 2016-01, which amends the measurement, presentation and disclosure requirements for equity investments, other than those accounted for under the equity method or that require consolidation of the investee. The ASU eliminates the classification of equity investments as available-for-sale with any changes in fair value of such investments recognized in other comprehensive income, and requires entities to measure equity investments at fair value, with any changes in fair value recognized in net income. This ASU is effective for fiscal years beginning after December 15, 2017, with early adoption permitted. To adopt this ASU, companies must record a cumulative-effect adjustment to beginning retained earnings at the beginning of the period of adoption. We adopted this ASU on January 1, 2018, and the adoption of this ASU did not have a material impact on our consolidated results of operations.

In February 2016, the FASB issued ASU 2016-02, which amends the accounting for leases, requiring lessees to recognize most leases on their balance sheet with a right-of-use asset and a corresponding lease liability. Leases will be classified as either finance or operating leases, which will impact the expense manner and timing of recognition of such leases over the lease term. The ASU also modifies the lease classification criteria for lessors and eliminates some of the real estate leasing guidance previously applied for certain leasing transactions. This ASU is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. We adopted this ASU on January 1, 2019. In July 2018, the FASB issued ASU 2018-11, which provides entities relief from the transition requirements in ASU 2016-02 by allowing them to elect not to recast prior comparative periods. We elected this method of transition upon adoption of this ASU. Because of the number of operating leases we utilize to support our operations, the adoption of this ASU will have a significant impact on our consolidated financial position, but is not expected to have a significant impact on our results of operations. We are substantially complete with our implementation efforts, pending final evaluation of the impact the adoption of this ASU will have on our consolidated financial statements. We estimate that total right-of-use assets and related operating lease liabilities between approximately $665 million and $715 million will be recorded on the consolidated balance sheet upon adoption. The adoption of this ASU is also not expected to have an impact on our compliance with debt covenants.

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

In August 2017, the FASB issued ASU 2017-12, which amends hedge accounting recognition and disclosure requirements to improve transparency and simplify the application of hedge accounting for certain hedging

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instruments. The amendments in this ASU that will have an impact on us include simplification of the periodic hedge effectiveness assessment, elimination of the benchmark interest rate concept for interest rate swaps, and enhancement of the ability to use the critical-terms match method for its cash flow hedges of forecasted interest payments. This ASU is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. We early adopted this ASU on January 1, 2018, and the adoption of this ASU did not have a material impact on our consolidated financial position or results of operations.

In February 2018, the FASB issued ASU 2018-02, which allows for a reclassification from accumulated other comprehensive income to retained earnings for the stranded tax effects in accumulated other comprehensive income resulting from the enactment of the Tax Act and corresponding accounting treatment recorded in the fourth quarter of 2017. The ASU is effective for all entities for fiscal years beginning after December 15, 2018, and interim periods within those fiscal years. Early adoption of the amendments in this ASU is permitted, including adoption in any interim period for reporting periods for which financial statements have not yet been issued. We early adopted this ASU on January 1, 2018, resulting in a reclassification of $6 million from accumulated other comprehensive loss as a decrease to accumulated deficit.

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

FORWARD-LOOKING STATEMENTS

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

- general economic and business conditions, both nationally and in the regions in which we operate;
- the impact of health reform initiatives, including the Affordable Care Act, and the potential for the Affordable Care Act to be repealed or found unconstitutional or for additional changes to the law, its implementation or its interpretation (including through executive orders and court challenges);
- the extent to which states support increases, decreases or changes in Medicaid programs, implement health insurance exchanges or alter the provision of healthcare to state residents through regulation or otherwise;
- the future and long-term viability of health insurance exchanges and potential changes to the beneficiary enrollment process;

risks associated with our substantial indebtedness, leverage and debt service obligations, and the fact that a substantial portion of our indebtedness will mature and become due in the near future, including our ability to refinance such indebtedness on acceptable terms or to incur additional indebtedness;

demographic changes;

changes in, or the failure to comply with, federal, state or local laws or governmental regulations affecting our business;

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potential adverse impact of known and unknown government investigations, audits, and federal and state false claims act litigation and other legal proceedings;

our ability, where appropriate, to enter into and maintain provider arrangements with payors and the terms of these arrangements, which may be further affected by the increasing consolidation of health insurers and managed care companies and vertical integration efforts involving payors and healthcare providers;

changes in, or the failure to comply with, contract terms with payors and changes in reimbursement rates paid by federal or state healthcare programs or commercial payors;

any potential additional impairments in the carrying value of goodwill, other intangible assets, or other long-lived assets, or changes in the useful lives of other intangible assets;

changes in inpatient or outpatient Medicare and Medicaid payment levels and methodologies;

the effects related to the continued implementation of the sequestration spending reductions and the potential for future deficit reduction legislation;

increases in the amount and risk of collectability of patient accounts receivable, including decreases in collectability which may result from, among other things, self-pay growth and difficulties in recovering payments for which patients are responsible, including co-pays and deductibles;

the efforts of insurers, healthcare providers, large employer groups and others to contain healthcare costs, including the trend toward value-based purchasing;

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

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

competition;

our ability to attract and retain, at reasonable employment costs, qualified personnel, key management, physicians, nurses and other healthcare workers;

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

changes in medical or other technology;

changes in U.S. GAAP;

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

our ability to successfully make acquisitions or complete divestitures, including the disposition of hospitals and non-hospital businesses pursuant to our portfolio rationalization and deleveraging strategy, our ability to complete any such acquisitions or divestitures on desired terms or at all, the timing of the completion of any such acquisitions or divestitures, and our ability to realize the intended benefits from any such acquisitions or divestitures;

the impact that changes in our relationships with joint venture or syndication partners could have on effectively operating our hospitals or ancillary services or in advancing strategic opportunities;

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

the impact of seasonal severe weather conditions, including the timing and amount of insurance recoveries in relation to severe weather events;

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

timeliness of reimbursement payments received under government programs;

effects related to outbreaks of infectious diseases;

the impact of prior or potential future cyber-attacks or security breaches;

any failure to comply with the terms of the Corporate Integrity Agreement;

the concentration of our revenue in a small number of states;

our ability to realize anticipated cost savings and other benefits from our current strategic and operational cost savings initiatives;

changes in interpretations, assumptions and expectations regarding the Tax Act; and

the other risk factors set forth in this Form 10-K for the year ended December 31, 2018 and our other public filings with the SEC.

Although we believe that these forward-looking statements are based upon reasonable assumptions, these assumptions are inherently subject to significant regulatory, economic and competitive uncertainties and contingencies, which are difficult or impossible to predict accurately and may be beyond our control. Accordingly, we cannot give any assurance that our expectations will in fact occur, and we caution that actual results may differ materially from those in the forward-looking statements. 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 undertake no obligation to revise or update any forward-looking statements, or to make any other forward-looking statements, whether as a result of new information, future events or otherwise.

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 to manage our exposure to these fluctuations, as described under the heading Liquidity and Capital Resources in Part II, Item 7 of this Form 10-K. 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. As of December 31, 2018, our approximately $1.5 billion notional amount of interest rate swap agreements outstanding represented approximately 64.6% of our variable rate debt.

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 $11 million in 2018, $27 million in 2017 and $50 million in 2016. On a prospective basis, a 1% change in interest rates on the remaining unhedged variable rate debt existing as of December 31, 2018, would result in interest expense fluctuating approximately $8 million per year.

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

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Stockholders and the Board of Directors of

Community Health Systems, Inc.

Franklin, Tennessee

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Community Health Systems, Inc. and subsidiaries (the Company) as of December 31, 2018 and 2017, the related consolidated statements of loss, comprehensive loss, stockholders (deficit) equity, and cash flows, for each of the three years in the period ended December 31, 2018, and the related notes and the schedule listed in the Index at Item 15 (collectively referred to as the financial statements). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company s internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 21, 2019, expressed an unqualified opinion on the Company s internal control over financial reporting.

Basis for Opinion

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

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ Deloitte & Touche LLP

Nashville, Tennessee

February 21, 2019

We have served as the Company s auditor since 1996.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF LOSS

	Year Ended December 31,		
	2018	**2017**	**2016**
	(In millions, except share and per share data)		
Operating revenues (net of contractual allowances and discounts)		$ 18,398	$ 21,275
Provision for bad debts		3,045	2,837
Net operating revenues (see Note 1)	$ 14,155	15,353	18,438
Operating costs and expenses:			
Salaries and benefits	6,384	7,376	8,624
Supplies	2,355	2,672	3,011
Other operating expenses	3,496	3,864	4,248
Government and other legal settlements and related costs	11	(31)	16
Electronic health records incentive reimbursement	(4)	(28)	(70)
Rent	337	394	450
Depreciation and amortization	700	861	1,100
Impairment and (gain) loss on sale of businesses, net	668	2,123	1,919
Total operating costs and expenses	13,947	17,231	19,298
Income (loss) from operations	208	(1,878)	(860)
Interest expense, net of interest income of $7, $11, and $14 in 2018, 2017 and 2016, respectively	976	931	962
(Gain) loss from early extinguishment of debt	(31)	40	30
Gain on sale of investments in unconsolidated affiliates	-	-	(94)
Equity in earnings of unconsolidated affiliates	(22)	(16)	(43)
Loss from continuing operations before income taxes	(715)	(2,833)	(1,715)
Benefit from income taxes	(11)	(449)	(104)
Loss from continuing operations	(704)	(2,384)	(1,611)
Discontinued operations, net of taxes:			
Loss from operations of entities sold or held for sale	-	(6)	(7)
Impairment of hospitals sold or held for sale	-	(6)	(8)
Loss from discontinued operations, net of taxes	-	(12)	(15)
Net loss	(704)	(2,396)	(1,626)

Less: Net income attributable to noncontrolling interests	84	63	95
Net loss attributable to Community Health Systems, Inc. stockholders	$ (788)	$ (2,459)	$ (1,721)
Basic loss per share attributable to Community Health Systems, Inc. common stockholders:			
Continuing operations	$ (6.99)	$ (21.89)	$ (15.41)
Discontinued operations	-	(0.11)	(0.13)
Net loss	$ (6.99)	$ (22.00)	$ (15.54)
Diluted loss per share attributable to Community Health Systems, Inc. common stockholders:			
Continuing operations	$ (6.99)	$ (21.89)	$ (15.41)
Discontinued operations	-	(0.11)	(0.13)
Net loss	$ (6.99)	$ (22.00)	$ (15.54)
Weighted-average number of shares outstanding:			
Basic	112,728,274	111,769,821	110,730,971
Diluted	112,728,274	111,769,821	110,730,971

See accompanying notes to the consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF COMPREHENSIVE LOSS

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

See accompanying notes to the consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

	December 31, 2018	December 31, 2017
	(In millions, except share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 196	$ 563
Patient accounts receivable (see Note 1)	2,352	2,384
Supplies	402	444
Prepaid income taxes	3	17
Prepaid expenses and taxes	196	198
Other current assets	400	462
Total current assets	3,549	4,068
Property and equipment		
Land and improvements	597	671
Buildings and improvements	6,228	6,971
Equipment and fixtures	3,476	3,855
Property and equipment	10,301	11,497
Less accumulated depreciation and amortization	(4,162)	(4,445)
Property and equipment, net	6,139	7,052
Goodwill	4,559	4,723
Deferred income taxes	69	62
Other assets, net of accumulated amortization of $939 and $883 at December 31, 2018 and 2017, respectively	1,543	1,545
Total assets	$ 15,859	$ 17,450
LIABILITIES AND STOCKHOLDERS DEFICIT		
Current liabilities:		
Current maturities of long-term debt	$ 204	$ 33
Accounts payable	887	967
Accrued liabilities:		
Employee compensation	627	685
Accrued interest	206	229
Other	468	442

Total current liabilities	2,392	2,356
Long-term debt	13,392	13,880
Deferred income taxes	26	19
Other long-term liabilities	1,008	1,360
Total liabilities	16,818	17,615
Redeemable noncontrolling interests in equity of consolidated subsidiaries	504	527
Commitments and contingencies (Note 16)		
STOCKHOLDERS DEFICIT		
Community Health Systems, Inc. stockholders deficit:		
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; 116,248,376 shares issued and outstanding at December 31, 2018, and 114,651,004 shares issued and outstanding at December 31, 2017	1	1
Additional paid-in capital	2,017	2,014
Accumulated other comprehensive loss	(10)	(21)
Accumulated deficit	(3,543)	(2,761)
Total Community Health Systems, Inc. stockholders deficit	(1,535)	(767)
Noncontrolling interests in equity of consolidated subsidiaries	72	75
Total stockholders deficit	(1,463)	(692)
Total liabilities and stockholders deficit	$ 15,859	$ 17,450

See accompanying notes to the consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS (DEFICIT) EQUITY

		Community Health Systems, Inc. Stockholders								
		Common Stock			Treasury Stock					
	Redeemable Noncontrolling Interests	Shares	Amount	Additional Paid-in Capital	Shares	Amount	Accumulated Other Comprehensive Income (Loss)	Retained Earnings (Accumulated Deficit)	Noncontrolling Interests	Total Stockholders (Deficit) Equity
					(In millions, except share data)					
Balance, December 31, 2015	$ 571	113,732,933	$ 1	$ 1,963	(975,549)	$ (7)	$ (73)	$ 2,135	$ 86	$ 4,105
Comprehensive income (loss)	71	-	-	-	-	-	9	(1,721)	24	(1,688)
Contributions from noncontrolling interests	-	-	-	-	-	-	-	-	-	-
Distributions to noncontrolling interests, net of contributions	(69)	-	-	-	-	-	-	-	(23)	(23)
Purchase of subsidiary shares from noncontrolling interests	(14)	-	-	(9)	-	-	-	-	4	(5)
Disposition of less-than-wholly owned hospital	(3)	-	-	-	-	-	-	-	-	-
Noncontrolling interests in acquired entity	-	-	-	-	-	-	-	-	33	33
Adjustment to redemption value of redeemable noncontrolling interests	6	-	-	(6)	-	-	-	-	-	(6)
Distribution of Quorum Health Corporation	(8)	-	-	-	-	-	2	(713)	(11)	(722)
Cancellation of treasury stock	-	(975,549)	-	(7)	975,549	7	-	-	-	-
	-	(368,945)	-	(6)	-	-	-	-	-	(6)

Cancellation of restricted stock for tax withholdings on vested shares										
Income tax payable increase from vesting of restricted shares	-	-	-	(6)	-	-	-	-	-	(6)
Stock-based compensation	-	1,488,141	-	46	-	-	-	-	-	46
Balance, December 31, 2016	554	113,876,580	1	1,975	-	-	(62)	(299)	113	1,728
Comprehensive income (loss)	38	-	-	-	-	-	41	(2,459)	25	(2,393)
Contributions from noncontrolling interests	-	-	-	-	-	-	-	-	5	5
Distributions to noncontrolling interests	(71)	-	-	-	-	-	-	-	(29)	(29)
Purchase of subsidiary shares from noncontrolling interests	(4)	-	-	(2)	-	-	-	-	-	(2)
Disposition of less-than-wholly owned hospital	2	-	-	-	-	-	-	-	(10)	(10)
Other reclassifications of noncontrolling interests	29								(29)	(29)
Noncontrolling interests in acquired entity	1	-	-	-	-	-	-	-	-	-
Adjustment to redemption value of redeemable noncontrolling interests	(22)	-	-	22	-	-	-	-	-	22
Distribution of Quorum Health Corporation	-	-	-	-	-	-	-	(3)	-	(3)
Cancellation of restricted stock for tax withholdings on vested shares	-	(560,098)	-	(5)	-	-	-	-	-	(5)
Stock-based compensation	-	1,334,522	-	24	-	-	-	-	-	24

Balance, December 31, 2017	527	114,651,004	1	2,014	-	-	(21)	(2,761)	75	(692)
Comprehensive income (loss)	54	-	-	-	-	-	17	(788)	30	(741)
Adoption of new accounting standards	-	-	-	-	-	-	(6)	6	-	-
Contributions from noncontrolling interests	3	-	-	-	-	-	-	-	-	-
Distributions to noncontrolling interests	(68)	-	-	-	-	-	-	-	(28)	(28)
Purchase of subsidiary shares from noncontrolling interests	(24)	-	-	(4)	-	-	-	-	(3)	(7)
Other reclassifications of noncontrolling interests	1	-	-	-	-	-	-	-	(2)	(2)
Noncontrolling interests in acquired entity	6	-	-	-	-	-	-	-	-	-
Adjustment to redemption value of redeemable noncontrolling interests	5	-	-	(5)	-	-	-	-	-	(5)
Cancellation of restricted stock for tax withholdings on vested shares	-	(293,735)	-	(1)	-	-	-	-	-	(1)
Income tax payable increase from vesting of restricted shares	-	333	-	-	-	-	-	-	-	-
Stock-based compensation	-	1,890,774	-	13	-	-	-	-	-	13
Balance, December 31, 2018	$ 504	116,248,376	$ 1	$ 2,017	-	$ -	$ (10)	$ (3,543)	$ 72	$ (1,463)

See accompanying notes to the consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2018	2017	2016
		(In millions)	
Cash flows from operating activities:			
Net loss	$ (704)	$ (2,396)	$ (1,626)
Adjustments to reconcile net loss to net cash provided by operating activities:			
Depreciation and amortization	700	861	1,100
Deferred income taxes	(3)	(454)	(116)
Government and other legal settlements and related costs	11	9	16
Stock-based compensation expense	13	24	46
Impairment of hospitals sold or held for sale	-	6	8
Impairment and (gain) loss on sale of businesses, net	668	2,123	1,919
(Gain) loss from early extinguishment of debt	(31)	40	30
Gain on sale of investments in unconsolidated affiliates	-	-	(94)
Other non-cash expenses, net	38	35	31
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	31	732	(96)
Supplies, prepaid expenses and other current assets	16	(33)	25
Accounts payable, accrued liabilities and income taxes	(163)	(69)	(137)
Payment of HMA legal settlement	(266)	-	-
Other	(36)	(105)	31
Net cash provided by operating activities	274	773	1,137
Cash flows from investing activities:			
Acquisitions of facilities and other related businesses	(26)	(6)	(123)
Purchases of property and equipment	(527)	(564)	(744)
Proceeds from disposition of hospitals and other ancillary operations	405	1,692	143
Proceeds from sale of property and equipment	8	7	15
Purchases of available-for-sale securities and equity securities	(78)	(125)	(505)
Proceeds from sales of available-for-sale securities and equity securities	114	208	464
Proceeds from sale of investments in unconsolidated affiliates	-	-	403
Distribution from Quorum Health Corporation	-	-	1,219
Increase in other investments	(141)	(143)	(242)
Net cash (used in) provided by investing activities	(245)	1,069	630
Cash flows from financing activities:			

Repurchase of restricted stock shares for payroll tax withholding requirements	(1)	(5)	(6)