

COMMUNITY HEALTH SYSTEMS INC

Form 10-K

February 23, 2012

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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, 2011**

**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)

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**Delaware**  
(State of incorporation)

**13-3893191**  
(IRS Employer

Identification No.)

**4000 Meridian Boulevard**

**Franklin, Tennessee**  
(Address of principal executive offices)

**37067**  
(Zip Code)

**Registrant's telephone number, including area code:**

**(615) 465-7000**

**Securities registered pursuant to Section 12(b) of the Act:**

**Title of Each Class**  
Common Stock, \$.01 par value

**Name of Each Exchange on Which Registered**  
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 and posted on its corporate web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ 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, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒

Accelerated filer ☐

Non-accelerated filer ☐ (Do not check if a smaller reporting company)

Smaller reporting company ☐

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 \$2,368,591,590. Market value is determined by reference to the closing price on June 30, 2011 of the Registrant's Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2011) have any non-voting common stock outstanding. As of February 15, 2012, there were 91,546,078 shares of common stock, par value \$.01 per share, outstanding.

**DOCUMENTS INCORPORATED BY REFERENCE**

The information required for Part III of this annual report is incorporated by reference to portions of the Registrant's definitive proxy statement for its 2012 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, 2011.

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**PART I**

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

**Overview of Our Company**

We are one of the largest publicly-traded operators of hospitals in the United States in terms of number of facilities and net operating revenues. 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 in non-urban and selected urban markets throughout the United States. As of December 31, 2011, we owned or leased 131 hospitals, including four stand-alone rehabilitation or psychiatric hospitals. These hospitals are geographically diversified across 29 states, with an aggregate of 19,695 licensed beds. We generate revenues by providing a broad range of general and specialized hospital healthcare services to patients in the communities in which we are located. Services provided by our hospitals include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric and rehabilitation services. As an integral part of providing these services, we also employ approximately 2,000 physicians and an additional 500 licensed healthcare practitioners, and provide additional outpatient services at urgent care centers, occupational medicine clinics, imaging centers, cancer centers, ambulatory surgery centers and home health and hospice agencies. 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. In addition to our hospitals and related businesses, we also own and operate 63 licensed home care agencies and 30 licensed hospice agencies, located primarily in markets where we also operate a hospital. Also, through our wholly-owned subsidiary, Quorum Health Resources, LLC, or QHR, we provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. The home care agencies and the hospital management services businesses constitute operating segments, but are not considered reportable segments since they do not meet the quantitative thresholds for a separate identifiable reportable segment. The financial information for our reportable operating segments is presented in Note 14 of the Notes to our Consolidated Financial Statements included under Item 8 of this Report.

Our strategy has also included growth by acquisition. We generally target hospitals in growing, non-urban and selected urban healthcare markets for acquisition because of their favorable demographic and economic trends and competitive conditions. Because non-urban service areas have smaller populations, there are generally fewer hospitals and other healthcare service providers in these communities and generally a lower level of managed care presence in these markets. We believe that smaller populations support less direct competition for hospital-based services and these communities generally view the local hospital as an integral part of the community. We believe opportunities exist for skilled, disciplined operators in selected urban markets to create networks between urban hospitals and non-urban hospitals while improving physician alignment in those markets and making it more attractive to managed care.

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* and *our*. This drafting style is suggested by the Securities and Exchange Commission, or SEC, and is not meant to indicate that the publicly-traded Parent Company or any other subsidiary of the Parent Company owns or operates any asset, business or property. The hospitals, operations and businesses described in this filing are owned and operated, and management services provided, by distinct and indirect subsidiaries of Community Health Systems, Inc.

**Available Information**

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

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

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

### **Our Business Strategy**

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

increase revenue at our facilities,

improve profitability,

improve patient safety and quality of care and

grow through selective acquisitions.

#### ***Increase Revenue at Our Facilities***

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

recruiting and/or employing additional primary care physicians and specialists,

expanding the breadth of services offered at our hospitals and in the communities in which we operate through targeted capital expenditures and physician alignment to support the addition of more complex services, including orthopedics, cardiovascular services and urology and

providing the capital to invest in technology and the physical plant at our facilities, particularly in our emergency rooms, surgery departments, critical care departments and diagnostic services.

We believe that appropriate capital investments in our facilities, combined with the development of our service capabilities, will reduce the migration of patients to competing providers while providing an attractive return on investment.

Our industry is highly regulated by the government and other third parties who provide payment for the services we provide to patients. Accordingly, we seek to review all initiatives to increase revenue through our corporate-wide voluntary compliance program in an effort to ensure compliance with laws and regulation.

*Physician Recruiting.* The primary method of adding or expanding medical services is the recruitment of new physicians into the community. A core group of primary care physicians is necessary as an initial contact point for all local healthcare. The addition of specialists who offer services, including general surgery, obstetrics and gynecology, cardiovascular services, orthopedics and urology, completes the full range of

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medical and surgical services required to meet a community's core healthcare needs. At the time we acquire a hospital and from time to time thereafter, we identify the healthcare needs of the community by analyzing demographic data and patient referral trends. As a result of this analysis, we are able to determine what we believe to be the optimum mix of primary care physicians and specialists. We employ recruiters at the corporate level to support the local hospital managers in their recruitment efforts. We have increased the number of physicians affiliated with us through our

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recruiting efforts, net of turnover, by approximately 869 in 2011, 935 in 2010 and 772 in 2009. The percentage of recruited or other physicians commencing practice with us that were specialists was over 50% in 2011. Additionally, in response to the recent trend in physicians seeking employment, we have begun employing more physicians, including, in some instances, acquiring physician practices. However, most of the physicians in our communities remain in private practice and are not our employees. We believe we have been successful in recruiting physicians because of the practice opportunities afforded physicians in our markets, as well as lower managed care penetration as compared to larger urban areas.

*Emergency Room Initiatives.* Approximately 60% of our patients initiate their encounter with our hospitals through the emergency room. Accordingly, we believe that making sure that this experience is as satisfying and efficient for the patient as it reasonably can be, but at the same time seeking to ensure that a safe and high quality service is provided to each patient, will in turn result in an optimized revenue stream and provide growth in services performed by our hospitals. We take numerous steps to seek to achieve these intertwined objectives, including:

Improving safety, service, satisfaction and waiting times initiatives include rounding on patients while in the emergency room, applying quality monitoring tools in evaluating the care provided, implementing a five-level triage system and fast-tracking patients with non-emergency conditions, post-discharge calls to patients and monitoring practitioner utilization rates and practices,

Raise community awareness of the services offered and the efforts to improve service and quality through marketing campaigns and

Improving patient flow by renovating and expanding our emergency room facilities 13 such projects have been undertaken in the past three years, including four in 2011.

One of our emergency room initiatives that spans our efforts across all three of these areas is the use of specialized emergency room information management software. Such software is designed to collect information to monitor the patients' experience and care provided; assist nurses, physicians and other clinicians in communicating with each other about the clinical condition of the patients and provide consistent discharge instructions to patients. We believe that these information management systems enable our hospitals and their medical staffs to also monitor and seek to improve aggregate performance and patient outcomes. In addition, these information management systems are integral to our efforts to achieve meaningful use of electronic health records and qualify for and retain payments under the Health Information Technology for Economic and Clinical Health Act, or HITECH Act.

*Expansion of Services.* In an effort to better meet the healthcare needs of the communities we serve and to capture a greater portion of the healthcare spending in our markets, we have added a broad range of services to our facilities and, in certain markets, acquired physician practices to broaden our service offerings. These services range from various types of diagnostic equipment capabilities to additional and renovated emergency rooms, surgical and critical care suites and specialty services. For example, we spent approximately \$203.7 million on 48 major construction projects that were completed in 2011. The 2011 projects included new emergency rooms, cardiac catheterization laboratories, intensive care units, hospital additions and surgical suites. These projects improved various diagnostic and other inpatient and outpatient service capabilities. We continue to believe that appropriate capital investments in our facilities, combined with the development of our service capabilities, will reduce the migration of patients to competing providers while providing an attractive return on investment. We also employ a small group of clinical consultants at our corporate headquarters to assist the hospitals in their development of surgery, emergency, critical care, cardiovascular and hospitalist services. In addition to spending capital on expanding services at our existing hospitals, we also build replacement facilities in certain markets to better meet the healthcare needs in those communities. In 2011, we spent \$162.9 million on construction projects related to three replacement hospitals that we are required to build pursuant to either a hospital purchase agreement or an amendment to a lease agreement. In addition, in September 2010, we received approval of our request for a certificate of need, or CON, from the Alabama Certificate of Need Review Board for the construction of a replacement hospital in Birmingham, Alabama. This CON remains subject to an appeal process. The total cost of these four replacement hospitals is estimated to be \$597.2 million.



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

### ***Improve Profitability***

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

standardizing and centralizing our methods of operation and management,

improving patient safety and optimizing resource allocation through our case and resource management program, which assists in improving clinical care and containing costs,

monitoring and enhancing productivity of our human resources,

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

installing a standardized management information system, resulting in more streamlined clinical operations and more efficient billing and collection procedures.

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

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

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

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

*Procurement and Materials Management.* We have standardized and centralized our operations with respect to medical supplies, equipment and pharmaceuticals used in our hospitals. We have a participation agreement with HealthTrust Purchasing Group, L.P., or HealthTrust, a group purchasing organization, or GPO. HealthTrust contracts with certain vendors who supply a substantial portion of our medical supplies, equipment and pharmaceuticals. Our agreement with HealthTrust extends to January 2013, with automatic renewal terms of one year unless either party terminates by giving notice of non-renewal.

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

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

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

*Case and Resource Management.* The primary goal of our case management program is to ensure the delivery of 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;

discharge planning;

developing and implementing operational best practices; and

compliance with all 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 with ongoing reviews throughout their course of care. Industry standard criteria are utilized in patient assessments, and discharge plans are adjusted according to patient needs. Cases are monitored to prevent delays in service or unnecessary utilization of resources. When a patient is ready for discharge, a case manager works with the patient's attending physician to evaluate and coordinate the patient's needs for continued care in the post-acute setting. 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.

### ***Improve Patient Safety and Quality of Care***

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

We have implemented various programs to support our hospitals in an effort to ensure continuous improvement in patient safety and the quality of care provided. We have developed training programs for all senior hospital management, chief nursing officers, quality directors, physicians and other clinical staff. We share information among our hospital management to implement best practices and assist in complying with

regulatory requirements.

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We have standardized our process for documenting compliance with accreditation requirements. All hospitals conduct patient, physician and staff satisfaction surveys to help identify methods of improving patient safety and the quality of care.

To ensure the experience of our emergency room patients meets our service and quality expectations, we have implemented a program to contact selected patients as a follow-up to the services they received. We verify that patients were able to obtain any prescriptions and outpatient appointments recommended at discharge. We also ensure that their symptoms have abated and that they understood the discharge instructions given at the hospital. Through this program, we placed in excess of one million follow-up calls in 2011.

In 2011, we established a component patient safety organization, or PSO, which was listed by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality on January 11, 2012. We believe we are the first for-profit hospital company to form a component PSO and that it will assist us in improving patient safety at our hospitals.

### ***Grow Through Selective Acquisitions***

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

have a service area population between 20,000 and 400,000 with a stable or growing population base,

are the sole or primary provider of acute care services in the community,

are located in an area with the potential for service expansion,

are not located in an area that is dependent upon a single employer or industry and

have financial performance that we believe will benefit from our management's operating skills.

Occasionally, we have pursued acquisition opportunities outside of our specified criteria when such opportunities have had uniquely favorable characteristics. In addition, in recent years, we have been successful in acquiring a few multi-hospital systems. In 2009, we acquired a total of three hospitals—two hospitals located in Wilkes-Barre, Pennsylvania and one hospital in Siloam Springs, Arkansas—and purchased the remaining equity in a hospital located in El Dorado, Arkansas in which we previously had a noncontrolling interest. In 2010, we acquired five hospitals located in Marion, South Carolina; Youngstown, Ohio; Warren, Ohio and Bluefield, West Virginia and in 2011, we acquired four hospitals located in Scranton, Pennsylvania; Tunkhannock, Pennsylvania; Nanticoke, Pennsylvania and Tomball, Texas. We believe that our access to capital, reputation for providing quality care and ability to recruit physicians makes us an attractive partner for these communities.

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

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

our operating track record with respect to our other hospitals within the state.

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At the time we acquire a hospital, we may commit to an amount of capital expenditures, such as a replacement facility, renovations, or equipment over a specified period of time. As obligations under two hospital purchase agreements in effect as of December 31, 2011, we are required to build a replacement facility in Valparaiso, Indiana by April 2011 and in Siloam Springs, Arkansas by February 2013. Due to delays in receiving government approved building and zoning permits, the replacement facility in Valparaiso, Indiana is not expected to be completed until the fourth quarter of 2012. These delays did not result in any penalties under the terms of the purchase agreement and we do not expect such delays to result in any significant increase in the costs to construct the replacement facility. Also, as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location by November 2012. Estimated construction costs, including equipment costs, are approximately \$317.2 million for these three replacement facilities, of which approximately \$210.3 million has been incurred to date. In addition, in October 2008, after the purchase of the noncontrolling owner's interest in our Birmingham, Alabama facility, we initiated the purchase of a site, which includes a partially constructed hospital structure, for a potential replacement for our existing Birmingham facility. In September 2010, we received approval of our request for a CON from the Alabama Certificate of Need Review Board; however, this CON remains subject to an appeal process. Our estimated construction costs, including the acquisition of the site and equipment costs, are approximately \$280.0 million for the Birmingham replacement facility, of which approximately \$3.5 million has been incurred to date. Under other purchase agreements in effect as of December 31, 2011, we have committed to spend \$652.5 million, generally over a five to seven year period after acquisition, for costs such as capital improvements, equipment, selected leases and physician recruiting. Through December 31, 2011, we have incurred approximately \$247.8 million related to these commitments.

### **Industry Overview**

The Centers for Medicare and Medicaid Services, or CMS, reported that in 2010 total U.S. healthcare expenditures grew by 3.9% to approximately \$2.6 trillion. CMS also projected total U.S. healthcare spending to grow by 4.8% in 2011 and by an average of 5.8% annually from 2010 through 2020. By these estimates, healthcare expenditures will account for approximately \$4.6 trillion, or 19.8% of the total U.S. gross domestic product, by 2020.

Hospital services, the market in which we operate, is the largest single category of healthcare at 31.4% of total healthcare spending in 2010, or approximately \$814.0 billion, as reported by CMS. CMS projects the hospital services category to grow by at least 4.7% per year through 2020. It expects growth in hospital healthcare spending to continue due to the aging of the U.S. population and consumer demand for expanded medical services. As hospitals remain the primary setting for healthcare delivery, CMS expects hospital services to remain the largest category of healthcare spending.

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

### **Urban vs. Non-Urban Hospitals**

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

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

facility size and location,

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facility ownership structure (i.e., tax-exempt or investor owned),

a facility's ability to participate in group purchasing organizations 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 it more attractive to managed care.

### **Hospital Industry Trends**

*Demographic Trends.* According to the U.S. Census Bureau, there are presently approximately 40.3 million Americans aged 65 or older in the U.S. who comprise approximately 13.0% of the total U.S. population. By the year 2030, the number of Americans aged 65 or older is expected to climb to 72.1 million, or 19.3% of the total population. Due to the increasing life expectancy of Americans, the number of people aged 85 years and older is also expected to increase from 5.8 million to 8.7 million by the year 2030. This increase in life expectancy will increase demand for healthcare services and, as importantly, the demand for innovative, more sophisticated means of delivering those services. Hospitals, as the largest category of care in the healthcare market, will be among the main beneficiaries of this increase in demand. Based on data compiled for us, the populations of the service areas where our hospitals are located grew by 24.0% from 1990 to 2010 and are expected to grow by 3.9% from 2010 to 2015. The number of people aged 65 or older in these service areas grew by 27.4% from 1990 to 2010 and is expected to grow by 14.9% from 2010 to 2015.

*Consolidation.* In addition to our own acquisitions 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:

excess capacity of available capital,

valuation levels,

financial performance issues, including challenges associated with changes in reimbursement and collectability of self-pay revenue,

the desire to enhance the local availability of healthcare in the community,

the need and ability to recruit primary care physicians and specialists,

the need to achieve general economies of scale and to gain access to standardized and centralized functions, including favorable supply agreements and access to malpractice coverage and

regulatory changes.

The healthcare industry is also undergoing consolidation, first, in anticipation of, and second, in reaction to, efforts to reform the payment system. Hospital systems are acquiring physician practices and other outpatient and sub-acute providers to position themselves for readmission, bundling and other payment restructuring. Similarly, payors are consolidating and acquiring disease management service providers in an effort



to offer more competitive programs.

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The following table sets forth operating statistics for our hospitals for each of the years presented, which are included in our continuing operations. Statistics for 2011 include a full year of operations for 127 hospitals and partial periods for four hospitals acquired during the year. Statistics for 2010 include a full year of operations for 122 hospitals and partial periods for five hospitals acquired during the year. Statistics for 2009 include a full year of operations for 118 hospitals and partial periods for three hospitals acquired during the year and one hospital in which we previously had a noncontrolling interest and purchased the remaining interest during the year. Statistics for hospitals which have been sold are excluded from all periods presented.

	2011	Year Ended December 31, 2010	2009
	(Dollars in thousands)		
<b>Consolidated Data</b>			
Number of hospitals (at end of period)	131	127	122
Licensed beds (at end of period)(1)	19,695	19,004	17,557
Beds in service (at end of period)(2)	16,832	16,264	15,539
Admissions(3)	675,050	678,284	675,902
Adjusted admissions(4)	1,330,988	1,277,235	1,242,647
Patient days(5)	2,970,044	2,891,699	2,874,125
Average length of stay (days)(6)	4.4	4.3	4.3
Occupancy rate (beds in service)(7)	49.1%	50.2%	51.3%
Net operating revenues	\$ 13,626,168	\$ 12,623,274	\$ 11,742,454
Net inpatient revenues as a % of total net operating revenues	46.1%	49.3%	50.4%
Net outpatient revenues as a % of total net operating revenues	51.9%	48.5%	47.3%
Net income attributable to Community Health Systems, Inc.	\$ 201,948	\$ 279,983	\$ 243,150
Net income attributable to Community Health Systems, Inc. as a % of total net operating revenues	1.5%	2.2%	2.1%
<b>Liquidity Data</b>			
Adjusted EBITDA(8)	\$ 1,836,650	\$ 1,761,484	\$ 1,652,405
Adjusted EBITDA as a % of total net operating revenues(8)	13.5%	14.0%	14.1%
Net cash flows provided by operating activities	\$ 1,261,908	\$ 1,188,730	\$ 1,076,429
Net cash flows provided by operating activities as a % of total net operating revenues	9.3%	9.4%	9.2%
Net cash flows used in investing activities	\$ (1,195,775)	\$ (1,044,310)	\$ (867,182)
Net cash flows used in financing activities	\$ (235,437)	\$ (189,792)	\$ (85,361)

See pages 10 and 11 for footnotes.

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	Year Ended December 31,		(Decrease)
	2011	2010	Increase
	(Dollars in thousands)		
<b>Same-Store Data(9)</b>			
Admissions(3)			