LANCASTER HOSPITAL CORP
Form 424B5
July 10, 2012
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Filed Pursuant to Rule 424(b)(5)
Registration No. 333-181630

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	Amount to be Registered	Offering Price	Amount of Registration Fee(1)
7.125% Senior Notes due 2020	$1,200,000,000	$1,200,000,000	$137,520

(1) The registration fee, calculated in accordance with Rule 457(r), is being transmitted to the SEC on a deferred basis pursuant to Rule 456(b).

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Filed Pursuant to Rule 424(b)(5)
Registration No. 333-181630

PROSPECTUS SUPPLEMENT

(To prospectus, dated May 23, 2012)

$1,200,000,000

CHS/Community Health Systems, Inc.

7.125% Senior Notes due 2020

We are offering $1,200,000,000 aggregate principal amount of 7.125% Senior Notes due 2020 (the notes).

We will pay interest on the notes semi-annually on each January 15 and July 15. The first interest payment date on the notes will be made on January 15, 2013. The notes will mature on July 15, 2020.

We may redeem some or all of the notes at any time prior to July 15, 2016 at a price equal to 100% of the principal amount of the notes redeemed plus accrued and unpaid interest, if any, plus a make-whole premium, as described in this prospectus supplement. We may redeem some or all of the notes at any time on or after July 15, 2016 at the redemption prices set forth in this prospectus supplement, plus accrued and unpaid interest, if any. In addition, we may redeem up to 35% of the aggregate principal amount of the notes at any time prior to July 15, 2015 using the net proceeds from certain equity offerings at the redemption price set forth in this prospectus supplement, plus accrued and unpaid interest, if any. There is no sinking fund for the notes.

The notes will be our unsecured senior obligations and will rank equal in right of payment to all of our existing and future senior unsecured indebtedness, will be senior to all of our future subordinated indebtedness and will be effectively subordinated to all of our secured indebtedness, including indebtedness under our senior secured credit facilities (the Credit Facility), to the extent of the value of the assets securing such indebtedness. Our obligations under the notes will be guaranteed on a senior basis by our parent and certain of our current and future domestic subsidiaries. The notes and related guarantees will be effectively junior in right of payment to liabilities of our subsidiaries that will not guarantee the notes.

We do not intend to apply for listing of the notes on any securities exchange.

Investing in the notes involves risks. See Risk Factors beginning on page S-13 of this prospectus supplement.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or determined if this prospectus supplement or the accompanying prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

	Per Note	Total
Public offering price(1)	100.000%	$ 1,200,000,000
Underwriting discount	1.4657%	$ 17,588,400
Proceeds to us (before expenses)(1)	98.5343%	$ 1,182,411,600

(1) Plus accrued interest, if any, from July 18, 2012.

Delivery of the notes in book-entry form will be made on or about July 18, 2012.

Joint Book-Running Managers

Credit Suisse

BofA Merrill Lynch

Citigroup

Credit Agricole CIB

Goldman, Sachs & Co.

J.P. Morgan

Morgan Stanley

RBC Capital Markets

SunTrust Robinson Humphrey

Wells Fargo Securities

Co-Managers

Deutsche Bank Securities

Fifth Third Securities, Inc.

Mitsubishi UFJ Securities

Scotiabank

UBS Investment Bank

The date of this prospectus supplement is July 9, 2012.

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Prospectus Supplement

Prospectus

You should rely only on the information contained in this prospectus supplement and the accompanying prospectus or to which we have referred you. We have not authorized anyone to provide you with information that is different. If you receive any such other information, it should not be relied upon as having been authorized by us or the underwriters. This prospectus supplement and the accompanying prospectus may only be used where it is legal to sell these securities. The information in this prospectus supplement, the accompanying prospectus and the documents incorporated by reference may only be accurate as of the date of the document containing such information. You should not assume that the information contained or incorporated by reference in this prospectus supplement, the accompanying prospectus and the documents incorporated by reference is accurate as of any date other than the date of the document containing such information.

It is expected that delivery of the notes will be made against payment therefor on or about the date specified on the cover of this prospectus supplement, which is the seventh business day following the date of pricing of the notes (such settlement cycle being referred to as T+7). You should note that trading of the notes on the date of this prospectus supplement or the next three succeeding business days may be affected by the T+7 settlement. See Underwriting.

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ABOUT THIS PROSPECTUS SUPPLEMENT

This document is in two parts. The first part is this prospectus supplement, which adds, updates and changes information contained or incorporated by reference in the accompanying prospectus. The second part is the accompanying prospectus, which gives more general information, some of which may not apply to this offering of notes. If the information set forth in this prospectus supplement or any document incorporated by reference herein varies in any way from the information set forth or incorporated by reference in the accompanying prospectus, you should rely on the information contained in this prospectus supplement or any document incorporated by reference herein. If the information set forth in this prospectus supplement varies in any way from the information set forth in a document incorporated by reference herein, you should rely on the information in the more recent document.

You should rely only on the information contained in or incorporated by reference in this prospectus supplement and the accompanying prospectus. We have not, and the underwriters have not, authorized any other person to provide you with information that is different. If anyone provides you with different or inconsistent information, you should not rely on it. You should not assume that the information contained in, or the documents incorporated by reference in, this prospectus supplement or the accompanying prospectus are accurate as of any date other than their respective dates. Our business, financial condition, results of operations and prospects may have changed since those dates.

We are not, and the underwriters are not, making an offer of these notes in any jurisdiction where the offer or sale is not permitted. Before you invest in the notes, you should read the registration statement described in the accompanying prospectus (including the exhibits thereto) of which this prospectus supplement and the accompanying prospectus form a part, as well as this prospectus supplement, the accompanying prospectus and the documents incorporated by reference into this prospectus supplement and the accompanying prospectus. The documents incorporated by reference herein are described in this prospectus supplement under Incorporation of Certain Documents by Reference.

INDUSTRY AND MARKET DATA

The data included in this prospectus supplement regarding markets and ranking, including the size of certain markets and our position and the position of our competitors within these markets, are based on reports of government agencies, published industry sources and other sources we believe to be reliable. While we believe that these studies and reports and our own research and estimates are reliable and appropriate, neither we nor the underwriters have independently verified such data and neither we nor the underwriters make any representations as to the accuracy of such information. Accordingly, investors should not place undue reliance on such data.

NON-GAAP FINANCIAL MEASURES

EBITDA and Adjusted EBITDA, as presented in this prospectus supplement, are supplemental measures of our operating performance that are not required by, or presented in accordance with, generally accepted accounting principles in the United States (GAAP). They are not measurements of our financial performance under GAAP and should not be considered as alternatives to net income or any other performance measures derived in accordance with GAAP or as alternatives to cash flow from operating activities as measures of our liquidity.

We define EBITDA as net income attributable to Community Health Systems, Inc. before interest, income taxes, depreciation and amortization. We determine EBITDA in order to derive Adjusted EBITDA by adjusting EBITDA to exclude items as set forth in footnote (2) of Summary Historical Financial and Other Data

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appearing elsewhere in this prospectus supplement. We believe that the inclusion of Adjusted EBITDA in this prospectus supplement is appropriate to provide additional information that we believe investors find helpful with respect to our ability to meet our future debt service, capital expenditures and working capital requirements. In addition, we believe that analysts and rating agencies consider Adjusted EBITDA a useful measure. Our presentation of these measures should not be construed as an implication that our future results will be unaffected by unusual or non-recurring items. Our historical EBITDA and Adjusted EBITDA measures have limitations as analytical tools, and you should not consider them in isolation, or as a substitute for analysis of our results as reported under GAAP. Some of these limitations are:

- they do not reflect our cash expenditures, or future requirements for capital expenditures or contractual commitments;
- they do not reflect changes in, or cash requirements for, our working capital needs;
- they do not reflect the significant interest expense, or the cash requirements necessary to service interest or principal payments, on our substantial indebtedness;
- they do not reflect any income tax payments we may be required to make;
- although depreciation and amortization are non-cash charges, the assets being depreciated and amortized will often have to be replaced in the future, and these measures do not reflect any cash requirements for such replacements;
- they are not adjusted for all non-cash income or expense items that are reflected in our consolidated statements of cash flows;
- they do not reflect the impact on earnings of charges resulting from certain matters we consider not to be indicative of our ongoing operations; and
- other companies in our industry may calculate these measures differently than we do because such measures do not have standardized definitions, which limits their usefulness as comparative measures.

Because of these limitations, our historical EBITDA and Adjusted EBITDA measures should not be considered as measures of discretionary cash available to us to invest in the growth of our business, or as measures of cash that will be available to us to meet our obligations.

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FORWARD-LOOKING STATEMENTS

This prospectus supplement and the accompanying prospectus contain and incorporate by reference forward-looking statements within the meaning of the federal securities laws, which involve risks, assumptions and uncertainties. Statements that are predictive in nature, that depend upon or refer to future events or conditions, or that include words such as expects, anticipates, intends, plans, believes, estimates, thinks similar expressions are forward-looking statements. These statements involve known and unknown risks, assumptions, 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, but are not limited to, the following:

- general economic and business conditions, both nationally and in the regions in which we operate;
- implementation and effect of adopted and potential federal and state healthcare legislation;
- risks associated with our substantial indebtedness, leverage and debt service obligations;
- demographic changes;
- changes in, or the failure to comply with, governmental regulations;
- potential adverse impact of known and unknown government investigations, audits and federal and state False Claims Act litigation and other legal proceedings;
- our ability, where appropriate, to enter into and maintain managed care provider arrangements and the terms of these arrangements;
- changes in, or the failure to comply with, managed care provider contracts could result in disputes and changes in reimbursement that could be applied retroactively;
- changes in inpatient or outpatient Medicare and Medicaid payment levels;
- increases in the amount and risk of collectability of patient accounts receivable;
- increases in wages as a result of inflation or competition for highly technical positions and rising supply costs due to market pressure from pharmaceutical companies and new product releases;
- liabilities and other claims asserted against us, including self-insured malpractice claims;
- competition;

our ability to attract and retain, without significant employment costs, qualified personnel, key management, physicians, nurses and other healthcare workers;

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

changes in medical or other technology;

changes in GAAP;

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

our ability to successfully acquire additional hospitals or complete divestitures;

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

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

timeliness of reimbursement payments received under government programs; and

the other risk factors set forth herein and in our public filings with the SEC.

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Some of the other important factors that could cause actual results to differ materially from our expectations are disclosed under Risk Factors and elsewhere in, or incorporated by reference into, this prospectus supplement and the accompanying prospectus, including, without limitation, in our Current Report on Form 8-K filed with the SEC on May 24, 2012 under Risk Factors. Although we believe that these statements are based upon reasonable assumptions, we can give no assurance that our goals will be achieved. Given these uncertainties, prospective investors are cautioned not to place undue reliance on these forward-looking statements. These forward-looking statements are made as of the date of the document containing the applicable statement. All subsequent written and oral forward-looking statements attributable to us, or to persons acting on our behalf, are expressly qualified in their entirety by these cautionary statements. We do not undertake any obligation to publicly update or revise any forward-looking statement as a result of new information, future events or otherwise, except as otherwise required by law.

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SUMMARY

The following summary contains basic information about us and this offering, but does not contain all the information that may be important to you. For a more complete understanding of this offering, we encourage you to carefully read this entire prospectus supplement, the accompanying prospectus and the documents incorporated by reference herein and therein, including the information set forth under Risk Factors and our financial statements and related notes. Unless otherwise indicated or the context requires otherwise, references in this prospectus supplement to we, our, us and the Company refer to Community Health Systems, Inc. and its consolidated subsidiaries, including CHS/Community Health Systems, Inc., the issuer of the notes offered hereby. References to the Issuer refer to CHS/Community Health Systems, Inc. alone, and references to Holdings refer to Community Health Systems, Inc. alone. We refer to the Issuer s 8/8% Senior Notes due 2015 as the 2015 Notes and to the Issuer s 8% Senior Notes due 2019 as the 2019 Notes.

In this prospectus supplement, any amounts shown on an as adjusted basis have been adjusted to reflect, as applicable: (i) the issuance of the notes in this offering and (ii) the use of a portion of the net proceeds from this offering to repurchase all the outstanding 2015 Notes in the Tender Offer referred to below (assuming that all outstanding 2015 Notes are validly tendered prior to the Consent Expiration (as defined below) and accepted for purchase in the Tender Offer) and to pay for consents delivered in connection with the Tender Offer as described under Use of Proceeds.

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 provide healthcare services through the hospitals that we own and operate in non-urban and selected urban markets throughout the United States. As of March 31, 2012, we owned or leased 134 hospitals, geographically diversified across 29 states with 20,217 licensed beds, comprised of 130 general acute care hospitals and four stand-alone rehabilitation or psychiatric hospitals. 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. 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. Also, through our wholly-owned subsidiary, Quorum Health Resources, LLC, we provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. For the three months ended March 31, 2012, we generated net operating revenue of approximately $3.3 billion, net cash provided by operating activities of approximately $187.3 million and Adjusted EBITDA of approximately $0.5 billion. For additional information on our non-GAAP financial measures, see Non-GAAP Financial Measures and Summary Historical Financial and Other Data.

Historically, we have grown by acquiring hospitals and by improving the operations of our facilities. 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 markets generally view the local hospital as an integral part of the community. Patients needing the most complex care are more often served by the larger, more specialized urban hospitals. We believe opportunities exist for skilled, disciplined operators in

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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.

We had limited our acquisition activity after our acquisition of Triad Hospitals, Inc. in 2007 but during 2010, we fully resumed our acquisition strategy by acquiring five hospitals. During the three months ended March 31, 2012, we continued the execution of our acquisition strategy by acquiring three separate hospitals located in Scranton, Pennsylvania; Peckville, Pennsylvania; and Blue Island, Illinois, and a large physician practice located in Longview, Texas. On July 1, 2012, we acquired one hospital in York, Pennsylvania.

Our Competitive Strengths

We believe the following strengths will allow us to continue to improve our operations and profitability:

Strong presence in attractive markets. We believe we are one of the leading providers of acute care services in many of the markets we serve and we estimate that we are the sole acute care service provider in approximately 60% of these markets. We continue to focus on non-urban and smaller urban markets that may have attractive demographic growth and/or an underserved medical population. In general, reimbursement is more favorable in these markets than in markets with greater direct competition for hospital-based services. In some of our markets, we receive higher reimbursement rates from Medicare for designated sole community hospitals.

Our more recent acquisition activity has also focused on the acquisition of larger hospitals in more competitive, mid-sized urban and suburban markets. In these types of markets, we seek to develop or expand specialty services that have the potential to yield high patient and physician satisfaction, expand the hospital s local referral network, and acquire and integrate larger physician practices.

We believe our market positioning strategy will create growth opportunities and allow us to develop long-term relationships with patients, physicians, employers and third-party payors and enable us to achieve an attractive return on investments in facility expansion and physician recruitment.

Emphasis on quality of care. We intend to maintain an emphasis on patients and clinical outcomes. We understand that high levels of clinical care are only achieved when quality is a company-wide focus that embraces patient, physician and employee satisfaction and continual, systematic improvements. Seeking the highest levels of improvement typically yields the best results for patients, reduces risk and improves our financial performance. We have developed and implemented programs to support and monitor quality of care improvement that include:

- standardized data and benchmarks and sharing of best practices to assist and monitor hospital quality improvement efforts;
- recommended policies and procedures based on the best medical and scientific evidence;
- hospital-based training and coaching to achieve success with respect to expectations of accrediting agencies;
- training programs for hospital management and clinical staff regarding regulatory and reporting requirements, as well as skills in leadership, communications and service; and
- evidence-based tools for improving patient, physician and staff satisfaction.

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As a result of these efforts, we have achieved significant progress in clinical quality. Our hospitals achieved an internally reported, overall inpatient score of 98.7% for the fourth quarter of 2011, which compares to The Centers for Medicare and Medicaid Services (CMS) clinical core measures national average, from publicly reported data for all applicable hospitals, of approximately 96.0% as of December 31, 2010. Forty-one of our hospitals were named to The Joint Commission s list of 405 Top Performers on Key Quality Measures for 2010. We intend to pair our emphasis on quality of care with our highly effective corporate compliance program. We believe that a culture of compliance and unquestioned ethics is a necessary predicate to seek to improve the patient care experience.

Geographic diversity and operating scale. As of March 31, 2012, we owned or leased 134 hospitals, geographically diversified across 29 states with 20,217 licensed beds, comprised of 130 general acute care hospitals and four stand-alone rehabilitation or psychiatric hospitals. Our geographic diversity helps to mitigate risks associated with fluctuating state regulations related to Medicaid reimbursement and state-specific economic conditions. Furthermore, we believe the size of our operations enables us to realize the benefits of economies of scale, purchasing power and increased operating efficiencies and return on information technology and other capital investments. For the three months ended March 31, 2012, our largest markets by revenue contribution were Pennsylvania (13.2%), Texas (13.0%), Indiana (10.3%), Alabama (7.8%) and Tennessee (5.0%).

Strong history of revenue growth, improving profitability and generating cash flow. From the year ended December 31, 2008 to the year ended December 31, 2011, we increased net operating revenues from $9.4 billion to $11.9 billion, income from continuing operations from $238 million to $336 million, and cash flows from operating activities from $1.1 billion to $1.3 billion. For the three months ended March 31, 2012, net operating revenues were $3.3 billion, income from continuing operations was $100 million, and cash flows from operating activities was $187 million. We have improved profitability by expanding our service offerings to include more complex care, optimizing our emergency room strategy across our portfolio of hospitals, and selectively making capital investments in projects that generate a high return on investment. Consistent cash flows from operations have enabled us to invest in our operations and continue to pursue attractive growth opportunities. In 2010, we fully resumed our acquisition strategy by acquiring five hospitals and have acquired 18 hospitals since the beginning of 2008, the first full year following our acquisition of Triad Hospitals, Inc. In many cases, we have been able to acquire facilities with mid-single digit Adjusted EBITDA margins and double those margins after the acquisition. For additional information on our non-GAAP financial measures, see Non-GAAP Financial Measures and Summary Historical Financial and Other Data.

Experienced management team with a proven track record. We have a strong and committed management team that has substantial industry knowledge and a proven track record of operations success in the hospital industry. Our chief executive officer and chief financial officer each have over 30 years of experience in the healthcare industry and have worked together since 1973. In addition, our division presidents have, on average, over 20 years of healthcare experience. We have established an extensive record of providing high quality care, profitably growing our business, making and integrating strategic acquisitions and effectively reinvesting capital to execute our growth strategy.

Our Growth Strategy

We intend to continue to grow our business and improve our financial performance by implementing our growth strategy, the key elements of which are to:

Increase revenue at our facilities. We seek to increase revenues at our facilities by providing a broader range of services in a more attractive care setting. We intend to continue to expand the breadth of services

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offered at our hospitals through targeted capital expenditures to support the addition of more complex and specialty services. We have also expanded and renovated existing emergency rooms, surgical suites, intensive and critical care units and specialty services. Emergency rooms represent approximately 60% of our hospital admissions and we have taken steps to increase patient flow by renovating and expanding these facilities, improving service, reducing waiting times and implementing marketing campaigns publicizing our capabilities in the local communities. 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 primary method of expanding medical services is recruiting additional primary care physicians and specialists. We have increased the number of physicians affiliated with us through our recruiting efforts, net of turnover, by approximately 869 in 2011, 935 in 2010 and 772 in 2009. Over 50% of the physicians that commenced practice with us in 2011 were specialists. Additionally, in response to the growing trend in physicians seeking employment, we have been employing more physicians, including acquiring physician practices; however, most of the physicians in our communities remain in private practice and are not our employees.

Improve profitability. We continually focus on improving operating efficiency to increase our operating margins. We seek to implement cost containment programs and adhere to operating philosophies that include:

- standardizing and centralizing our methods of operation and management;
- 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 efficient billing and collection procedures.

Grow through selective acquisitions. Each year we intend to acquire, on a selective basis, approximately two to four hospitals that fit our acquisition criteria. Most of our acquisition targets are municipal or other not-for-profit hospitals. We believe that our access to capital, reputation for providing quality care and ability to recruit physicians make us an attractive partner for these communities. We have remained disciplined in our approach to acquisitions and in each year since 1997, we have met or exceeded our acquisition goals. In 2010, we acquired five hospitals, and in 2011, we acquired four hospitals. During the three months ended March 31, 2012, we continued the execution of our acquisition strategy by acquiring three hospitals and a large physician practice. On July 1, 2012, we acquired one hospital in York, Pennsylvania.

Our Industry

Hospital services, the market in which we operate, is the largest single category of the healthcare industry at a projected 30.9% of total healthcare spending in 2012, or approximately $873.1 billion, as projected by CMS. CMS projects the hospital services category to grow by approximately 6.2% on an average annual basis through 2020, and 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.

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We believe that we are well-positioned to benefit from the expected growth in hospital spending, as well as the shifts in demographics in the United States. According to the U.S. Census Bureau, there are approximately 40.3 million Americans aged 65 or older in the United States, 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 increase 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 the demand for innovative, more sophisticated means of delivering these services. Hospitals, as the largest category of care in the healthcare market, are expected to be among the main beneficiaries of this increase in demand. Based on data compiled for us, the populations of these 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.

The Patient Protection and Affordable Care Act (the PPACA), as amended by the Healthcare and Education Reconciliation Act of 2010 (the Reconciliation Act and, together with the PPACA, the Reform Legislation), is intended to change the way healthcare services are covered, delivered and reimbursed in the United States. It seeks to do so through expanded coverage of uninsured individuals, significant reductions in the growth of Medicare program payments, material decreases in Medicare and Medicaid disproportionate share hospital (DSH) payments, and the establishment of programs in which reimbursement is tied in part to quality, integration and the reduction of healthcare costs per beneficiary. The Reform Legislation, as originally enacted, is expected to expand health insurance coverage to approximately 32 million additional individuals by 2016 and to approximately 34 million additional individuals by 2021 through a combination of public program expansion and private sector health insurance reforms. We believe the expansion of private sector and Medicaid coverage will, over time, increase our reimbursement related to providing services to individuals who were previously uninsured. On the other hand, the reductions in the growth in Medicare payments and the decreases in DSH payments will adversely affect our government reimbursement. On June 28, 2012, the Supreme Court of the United States largely upheld the constitutionality of the Reform Legislation, though it overturned an aspect of the legislation that would have permitted the Federal government to withhold all Medicaid funding from a state if that state did not expand Medicaid coverage to the extent required by the Reform Legislation. The Supreme Court s ruling instead said that only new incremental funding could be withheld from a state in such a situation. As a result, states will face less severe financial consequences if they refuse to expand Medicaid coverage to individuals with incomes below certain thresholds. Since the Supreme Court s ruling, some states have suggested that, for budgetary and other reasons, they would not expand their Medicaid programs. If states refuse to expand their Medicaid programs, the number of uninsured patients at our hospitals will decline by a smaller margin as compared to our expectations when the Reform Legislation was first adopted. Because of the many variables involved, including the potential for changes to the law as a result of efforts to amend or repeal it, clarifications and modifications resulting from the rule-making process, the development of agency guidance and future judicial interpretations, whether and how many states decide to expand or not to expand Medicaid coverage, and budgetary issues at federal and state levels, we are unable to predict the net impact of the Reform Legislation on us. We believe, however, that our experienced management team, emphasis on quality care and diversified operations will enable us to benefit from the opportunities it presents, as well as adapt to its challenges.

Recent Developments

Credit Facilities

Effective February 2, 2012, we completed an additional amendment and restatement of the Credit Facility, which extended by two and a half years the maturity date of $1.6 billion of our then non-extended term loans under the Credit Facility, until January 25, 2017 (subject to customary acceleration events) or, if more than $50 million of our 2015 Notes are outstanding on April 15, 2015, to April 15, 2015. In addition, on March 6, 2012,

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Holdings and the Issuer entered into a new $750 million senior secured revolving credit facility (the Replacement Revolver Facility) and incurred a new $750 million incremental term loan A facility (the Incremental Term Loan). The Replacement Revolver Facility replaced in full the previously existing revolving credit facility under the Credit Agreement, dated as of July 25, 2007, as amended and restated as of November 5, 2010 and February 2, 2012 (the Credit Agreement). The proceeds of the Incremental Term Loan were used to repay existing term loans under the Credit Agreement.

On March 21, 2012, through certain of our subsidiaries, we entered into an accounts receivables loan agreement (the Receivables Facility). The existing and future patient-related accounts receivable (the Receivables) of certain of our hospitals serve as collateral for borrowings under the Receivables Facility. We may make borrowings of up to $300 million outstanding from time to time based on the availability of eligible Receivables and other customary factors. As of March 31, 2012, $300.0 million of borrowings were outstanding under the Receivables Facility. Amounts borrowed accrue interest based on a commercial paper rate plus an applicable interest rate spread. Unless earlier terminated or subsequently extended, the Receivables Facility is scheduled to expire on March 21, 2014 and all amounts outstanding will become due at such time.

2019 Notes Issuance

On March 21, 2012, we issued an additional $1.0 billion aggregate principal amount of 2019 Notes. The net proceeds from this issuance were used to finance the purchase of approximately $850 million aggregate principal amount of the then approximately $1.8 billion aggregate outstanding principal amount of 2015 Notes in a cash tender offer that we completed on April 4, 2012, to pay related fees and expenses and for general corporate purposes.

Tender Offer

On July 3, 2012, we commenced a cash tender offer to purchase any and all of our outstanding 2015 Notes and a consent solicitation to eliminate, among other things, substantially all of the restrictive covenants of the 2015 Notes, in each case, on the terms and subject to the conditions set forth in our Offer to Purchase and Consent Solicitation Statement dated July 3, 2012 (as amended or supplemented, the Tender Offer). We intend to use the net proceeds from this offering to purchase the 2015 Notes validly tendered and not validly withdrawn in the Tender Offer, to pay for consents delivered in connection with the Tender Offer, to pay related fees and expenses and, to the extent any proceeds remain, for general corporate purposes as described under Use of Proceeds.

This prospectus supplement is not an offer to purchase or a solicitation of an offer to purchase any 2015 Notes. The Tender Offer is only being made by the Offer to Purchase and Consent Solicitation Statement referred to above.

The Tender Offer is currently scheduled to expire at 5:00 p.m. on August 1, 2012. We are offering, subject to the terms and conditions of the Tender Offer, to pay a total consideration of $1,026.00 (including a consent payment of $20.00) per $1,000 principal amount of 2015 Notes validly tendered in the Tender Offer prior to 5:00 p.m. on July 17, 2012 (as the same may be extended, the Consent Expiration), plus accrued and unpaid interest. The consent payment will not be paid for any 2015 Notes accepted for purchase that are validly tendered after the Consent Expiration and prior to the expiration of the Tender Offer.

Our Corporate Information

Community Health Systems, Inc. was incorporated in the State of Delaware on June 6, 1996. CHS/Community Health Systems, Inc. was incorporated in the State of Delaware on March 25, 1985. Our principal executive offices are located at 4000 Meridian Boulevard, Franklin, Tennessee 37067, and our telephone number is (615) 465-7000. Our website is www.chs.net. **Information on our website shall not be deemed part of this prospectus supplement or the accompanying prospectus.**

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THE OFFERING

Issuer	CHS/Community Health Systems, Inc.
Notes Offered	$1,200,000,000 aggregate principal amount of 7.125% senior notes due 2020 (the notes).
Maturity Date	The notes will mature on July 15, 2020.
Interest	The notes will bear interest at a rate of 7.125% per annum.
Interest Payment Dates	The Issuer will pay interest semi-annually on January 15 and July 15 of each year. The first interest payment on the notes will be made on January 15, 2013.
Guarantees	The notes will be unconditionally guaranteed on a senior basis by Holdings and certain of our current and future domestic subsidiaries. Our non-guarantor subsidiaries accounted for: approximately $1.3 billion, or 40%, of our total net operating revenue, approximately $279 million of our net cash provided by operating activities (our consolidated net cash provided by operating activities was approximately $187 million), and approximately $167 million, or 31%, of our total Adjusted EBITDA, in each case, for the three months ended March 31, 2012; and approximately $8.7 billion, or 55%, of our total assets, and approximately $7.5 billion, or 58%, of our total liabilities, in each case, as of March 31, 2012.
Ranking	The notes and guarantees thereof will be the Issuer s and the guarantors unsecured senior obligations. Accordingly, they will: be effectively subordinated in right of payment to all of the Issuer s and the guarantors obligations under all existing and future secured indebtedness, including the borrowings under our Credit Facility, to the extent of the value of the assets securing such obligations; be structurally subordinated to all existing and future obligations of each of our subsidiaries that is not a guarantor of the notes;

rank pari passu in right of payment with all of the Issuer s and the guarantors existing and future senior indebtedness, including the 2015 Notes and 2019 Notes; and

rank senior in right of payment to any of the Issuer s and the guarantors future subordinated indebtedness.

As of March 31, 2012, we had approximately $6.3 billion aggregate principal amount of senior secured indebtedness outstanding, and an additional $750 million that we would have been able to borrow

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	under our Credit Facility, to which the notes would have been effectively subordinated to the extent of the value of the assets securing such indebtedness.
	As of March 31, 2012, we had approximately $2.0 billion aggregate principal of 2019 Notes to which the notes would have ranked *pari passu* in right of payment. The notes will also rank *pari passu* in right of payment to any 2015 Notes that remain outstanding after the Tender Offer.
Optional Redemption	Prior to July 15, 2016, we may redeem some or all of the notes at a redemption price equal to 100% of the principal amount of the notes plus accrued and unpaid interest, if any, to the applicable redemption date plus the applicable make-whole premium set forth in this prospectus supplement.
	We may redeem some or all of the notes at any time and from time to time on or after July 15, 2016, at the redemption price set forth in this prospectus supplement plus accrued and unpaid interest, if any. In addition, at any time prior to July 15, 2015, we may redeem up to 35% of the aggregate principal amount of the notes with the proceeds of certain equity offerings at the redemption price set forth in this prospectus supplement, plus accrued and unpaid interest, if any. See Description of the Notes Optional Redemption.
Change of Control	If a change of control occurs, each holder of notes will have the right to require us to purchase all or a portion of its notes at 101% of the principal amount of the notes on the date of purchase, plus any accrued and unpaid interest, if any, to the date of repurchase. See Description of the Notes Change of Control.
Certain Covenants	The indenture that will govern the notes will contain covenants that, among other things, limit our ability and the ability of our restricted subsidiaries to:
	incur or guarantee additional indebtedness;
	pay dividends or make other restricted payments;
	make certain investments;
	create or incur certain liens;
	sell assets and subsidiary stock;
	transfer all or substantially all of our assets or enter into merger or consolidation transactions; and

enter into transactions with our affiliates.

However, these limitations are subject to a number of important qualifications and exceptions. See Description of the Notes Certain Covenants.

Use of Proceeds

We intend to use the net proceeds from this offering to purchase the 2015 Notes validly tendered and not validly withdrawn in the Tender Offer, to pay for consents delivered in connection with the Tender Offer, to pay related fees and expenses and, to the extent any

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	proceeds remain, for general corporate purposes. See Use of Proceeds.
No Listing	We do not intend to list the notes on any securities exchange. Although the underwriters have informed us that they intend to make a market in the notes, they are not obligated to do so and may discontinue market-making activities at any time without notice. Accordingly, a liquid market for the notes may not be maintained.

Risk Factors

Investing in the notes involves substantial risk. See Risk Factors on page S-13 for a discussion of certain factors that you should consider before investing in the notes.

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SUMMARY HISTORICAL FINANCIAL AND OTHER DATA

The following table sets forth summary consolidated historical financial and other data as of and for the periods presented. The summary historical financial information presented below for each of the three years ended December 31, 2011 has been derived from our audited consolidated financial statements. The summary historical financial information presented below for the three months ended March 31, 2011 and 2012 has been derived from our unaudited interim consolidated financial statements. In the opinion of management, the unaudited interim financial data include all adjustments, consisting of only normal non-recurring adjustments, considered necessary for a fair presentation of this information. Our consolidated financial statements for each of the three years in the period ended December 31, 2011 have been audited by Deloitte & Touche LLP, independent registered public accounting firm.

The following summary historical financial and other data should be read in conjunction with Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations and our consolidated financial statements and the related notes thereto, included in our Current Report on Form 8-K filed with the SEC on May 24, 2012, and Part I. Item 2. Management s Discussion and Analysis of Financial Condition and Results of Operations and our unaudited interim condensed consolidated financial statements and the related notes thereto, included in our Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2012 filed with the SEC on April 27, 2012, which are incorporated by reference in this prospectus supplement. The presentation of our unaudited interim condensed consolidated financial statements in our Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2012 and the presentation of the following summary historical financial and other data is consistent with the revised presentation of certain items included in our audited consolidated financial statements, as explained in our Current Report on Form 8-K filed with the SEC on May 24, 2012.

	Year Ended December 31,			Three Months Ended March 31,	
	2009	2010	2011	2011	2012
	(Dollars in thousands)				
Consolidated Statement of Income Data					
Operating revenues (net of contractual allowances and discounts)	$ 11,742,454	$ 12,623,274	$ 13,626,168	$ 3,354,052	$ 3,783,491
Provision for bad debts	1,408,953	1,530,852	1,719,956	399,969	486,456
Net operating revenues	10,333,501	11,092,422	11,906,212	2,954,083	3,297,035
Operating costs and expenses:					
Salaries and benefits	4,701,231	5,093,767	5,577,925	1,379,367	1,524,975
Supplies	1,649,779	1,738,088	1,834,106	457,817	498,579
Other operating expenses	2,129,081	2,296,063	2,515,638	614,793	708,943
Electronic health records incentive reimbursement			(63,397)		(26,168)
Rent	237,536	248,463	254,781	63,170	67,224
Depreciation and amortization	551,043	594,997	652,674	158,155	174,354
Total operating costs and expenses	9,268,670	9,971,378	10,771,727	2,673,302	2,947,907
Income from operations	1,064,831	1,121,044	1,134,485	280,781	349,128
Interest expense, net(1)	643,608	647,593	644,410	163,218	152,175
Loss (gain) from early extinguishment of debt	(2,385)		66,019		63,429
Equity in earnings of unconsolidated affiliates	(36,531)	(45,443)	(49,491)	(18,134)	(12,013)
Impairment of long-lived and other assets	12,477				
Income from continuing operations before income taxes	447,662	518,894	473,547	135,697	145,537
Provision for income taxes	141,851	163,681	137,653	44,092	45,819
Income from continuing operations	305,811	355,213	335,894	91,605	99,718
Discontinued operations, net of taxes:					
Income (loss) from operations of entities sold	971	(6,772)	(7,769)	(1,678)	(466)
Impairment of hospitals sold			(47,930)	(8,368)	
Loss on sale, net	(405)		(2,572)	(3,234)	
Income (loss) from discontinued operations	566	(6,772)	(58,271)	(13,280)	(466)
Net income	306,377	348,441	277,623	78,325	99,252
Less: Net income attributable to noncontrolling interests	63,227	68,458	75,675	17,001	23,778
Net income attributable to Community Health Systems, Inc.	$ 243,150	$ 279,983	$ 201,948	$ 61,324	$ 75,474

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	Year Ended December 31,			Three Months Ended March 31,	
	2009	2010	2011	2011	2012
			(Dollars in thousands)		
Statement of Cash Flows Data					
Net cash provided by operating activities	$ 1,076,429	$ 1,188,730	$ 1,261,908	$ 187,511	$ 187,310
Net cash used in investing activities	(867,182)	(1,044,310)	(1,195,775)	(209,404)	(500,299)
Net cash provided by (used in) financing activities	(85,361)	(189,792)	(235,437)	(6,560)	312,422
Other Financial Data					
Adjusted EBITDA(2)	$ 1,652,405	$ 1,761,484	$ 1,836,650	$ 457,070	$ 535,495
Operating Data					
Number of hospitals (at end of period)	122	127	131	127	134
Licensed beds (at end of period)(3)	17,557	19,004	19,695	18,981	20,217
Beds in service (at end of period) (4)	15,539	16,264	16,832	16,359	17,198
Admissions(5)	675,902	678,284	675,050	176,330	181,888
Adjusted admissions(6)	1,242,647	1,277,235	1,330,988	331,849	358,815
Patient days(7)	2,874,125	2,891,699	2,970,044	781,813	804,412
Average length of stay (days)(8)	4.3	4.3	4.4	4.4	4.4
Occupancy rate (beds in service) (9)	51.3%	50.2%	49.1%	53.1%	51.7%
Net operating revenues	$ 10,333,501	$ 11,092,422	$ 11,906,212	$ 2,954,083	$ 3,297,035
Net inpatient revenues as a % of total net operating revenues before provision for bad debts	50.4%	49.3%	46.1%	49.0%	46.1%
Net outpatient revenues as a % of total net operating revenues before provision for bad debts	47.3%	48.5%	51.9%	48.8%	51.9%
Consolidated Balance Sheet Data (end of period)					
Working Capital	$ 1,217,199	$ 1,229,153	$ 934,950	$ 1,230,164	$ 1,104,067
Property and equipment, net	6,132,246	6,324,437	6,855,976	6,446,417	7,001,863
Cash and cash equivalents	344,541	299,169	129,865	270,716	129,298
Total assets	14,021,472	14,698,123	15,208,840	14,718,279	15,846,416
Long-term debt	8,844,638	8,808,382	8,782,798	8,794,146	9,243,616
Other long-term liabilities	858,952	1,001,675	949,990	952,406	986,022
Total Community Health Systems, Inc. stockholders equity	1,950,635	2,189,464	2,397,096	2,311,339	2,490,356

(1) Interest expense, net of income of approximately $4.7 million, $1.8 million and $3.6 million in 2011, 2010 and 2009, respectively.

(2) EBITDA consists of net income attributable to Community Health Systems, Inc. before interest, income taxes, depreciation and amortization. Adjusted EBITDA is EBITDA adjusted to exclude discontinued operations, gain/loss from early extinguishment of debt and net income attributable to noncontrolling interests. We have from time to time sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. We believe that it is useful to present Adjusted EBITDA because it excludes the portion of EBITDA attributable to these third-party interests and clarifies for investors our portion of EBITDA generated by continuing operations. We use EBITDA to derive Adjusted EBITDA, which we use as a measure of liquidity, and the most comparable GAAP measure is net cash provided by operating activities. We have included this measure because we believe it provides investors with additional information about our ability to incur and service debt and make capital expenditures. In addition, we believe that analysts and rating agencies consider Adjusted EBITDA a useful measure. Adjusted EBITDA is the basis for a key component in the determination of our compliance with some of the covenants under the Credit Facility, as well as to determine the interest rate and commitment fee payable under the Credit Facility (although Adjusted EBITDA as presented here does not include all of the adjustments described in the Credit Facility).

EBITDA and Adjusted EBITDA are not measurements of financial performance or liquidity under generally accepted accounting principles. They should not be considered in isolation or as a substitute for net income, operating income, cash flows from operating, investing or financing activities, or any other measure calculated in accordance with generally accepted accounting principles. The items excluded from EBITDA and Adjusted EBITDA are significant components in understanding and evaluating financial performance and liquidity. Our calculation of EBITDA and Adjusted EBITDA may not be comparable to similarly titled measures reported by other companies. See Non-GAAP Financial Measures for additional information regarding our use of these measures, including the limitations thereof.

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The following table reconciles Adjusted EBITDA, as defined, to our net cash provided by operating activities as derived directly from our consolidated financial statements for the years ended December 31, 2009, 2010 and 2011 and for the three months ended March 31, 2011 and 2012:

	Year Ended December 31,			Three Months Ended March 31,	
	2009	2010	2011	2011	2012
			(Dollars in thousands)		
Adjusted EBITDA	$ 1,652,405	$ 1,761,484	$ 1,836,650	$ 457,070	$ 535,495
Interest expense, net	(643,608)	(647,593)	(644,410)	(163,218)	(152,175)
Provision for income taxes	(141,851)	(163,681)	(137,653)	(44,092)	(45,819)
Deferred income taxes	34,268	97,370	107,032		
Income (loss) from operations of hospitals sold	971	(6,772)	(7,769)	(1,678)	(466)
Depreciation and amortization of discontinued operations	15,500	14,842	4,991	3,163	
Stock compensation expense	44,501	38,779	42,542	9,918	10,495
Income tax payable increase (excess tax benefit) relating to stock-based compensation	3,472	(10,219)	(5,290)	(4,675)	(1,004)
Other non-cash expenses, net	22,870	12,503	28,716	(11,173)	2,569
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:					
Patient accounts receivable	58,390	(27,049)	(138,332)	(56,454)	(163,484)
Supplies, prepaid expenses and other current assets	(34,535)	(39,904)	(42,858)	14,336	(125,111)
Accounts payable, accrued liabilities and income taxes	86,098	161,952	246,110	(14,938)	96,109
Other	(22,052)	(2,982)	(27,821)	(748)	30,701
Net cash provided by operating activities	$ 1,076,429	$ 1,188,730	$ 1,261,908	$ 187,511	$ 187,310

(3) 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.
(4) Beds in service are the number of beds that are readily available for patient use.
(5) Admissions represent the number of patients admitted for inpatient treatment.
(6) 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.
(7) Patient days represent the total number of days of care provided to inpatients.
(8) Average length of stay (days) represents the average number of days inpatients stay in our hospitals.
(9) We calculated occupancy rate percentages by dividing the average daily number of inpatients by the weighted-average number of beds in service.

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RISK FACTORS

You should carefully consider the risk factors set forth below, in addition to the other information presented in this prospectus supplement, the accompanying prospectus and the documents incorporated by reference before purchasing the notes. This prospectus supplement contains forward-looking statements that involve risks and uncertainties. Any of the following risks could materially and adversely affect our business, financial condition or results of operations. Additional risks and uncertainties not currently known to us or those we currently view to be immaterial may also materially and adversely affect our business, financial condition or results of operations. In such a case, you may lose all or part of your original investment.

Risks Related to the Notes and our Indebtedness

We may not be able to generate sufficient cash to service all of our indebtedness, including the notes, 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 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. See Forward-Looking Statements herein and Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources included in our Current Report on Form 8-K filed with the SEC on May 24, 2012 and in our Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2012 filed with the SEC on April 27, 2012, each of which is incorporated by reference in this prospectus supplement.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay capital expenditures, including those required for operating our existing hospitals, for integrating our historical acquisitions or for future acquisitions. We also may be forced to sell assets or operations, seek additional capital or restructure or refinance our indebtedness, including the notes. 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 Facility, the indentures that govern our 2015 Notes and 2019 Notes (collectively, the Existing Notes Indentures) and the indenture that will govern the notes. For example, our Credit Facility, the Existing Notes Indentures and the indenture that will govern the 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. See Description of Certain Indebtedness and Description of the Notes.

We are a holding company and may not have access to sufficient cash to make payments on the notes.

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, including the notes. In addition, any payments of dividends, distributions, loans or advances to us by our subsidiaries could be subject to legal and contractual restrictions. Our subsidiaries are permitted under the terms of our indebtedness, including the indenture that will govern the notes, to incur additional indebtedness that may restrict payments from those subsidiaries to us. The agreements governing the current and future indebtedness of our subsidiaries may not permit those subsidiaries to provide us with sufficient cash to fund payments on the notes when due.

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Our subsidiaries are separate and distinct legal entities, and they may have (except to the extent of any guarantees of the notes) no obligation, contingent or otherwise, to pay amounts due under the notes or to make any funds available to pay those amounts, whether by dividend, distribution, loan or other payment.

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

The Credit Facility, the Existing Notes Indentures and/or the indenture that will govern the notes contain various covenants that limit our ability and/or our restricted subsidiaries ability to:

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

In addition, our Credit Facility contains other restrictive covenants and requires us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet those 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, the 2015 Notes, the 2019 Notes and/or the notes. Upon the occurrence of an event of default under our Credit Facility or the Existing Notes Indentures, all amounts outstanding under our Credit Facility, the 2015 Notes and/or the 2019 Notes could be declared to be immediately due and payable and the lenders under the Credit Facility could terminate all commitments to extend further credit. If we were unable to repay those amounts, the lenders under our Credit Facility could proceed against the collateral granted to them to secure that indebtedness. We have pledged a significant portion of our assets as collateral under our Credit Facility. If the lenders under our Credit Facility accelerate the repayment of borrowings, we cannot assure you that we will have sufficient assets to repay our Credit Facility and our other indebtedness, including the notes.

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

Our borrowings under the Credit Facility are at variable rates of interest and expose us to interest rate risk. If interest rates increase, our debt service obligations on the variable rate indebtedness would increase even though the amount borrowed remained the same, and our net income would decrease.

Our interest expense, net, for the year ended December 31, 2011 and the three months ended March 31, 2012 was $644.4 million and $152.2 million, respectively. For the year ended December 31, 2011 and the three months ended March 31, 2012, 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 $7.2 million and $3.4 million, respectively.

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If we default on our obligations to pay our indebtedness, we may not be able to make payments on the notes.

Any default under the agreements governing our indebtedness, including a default under our Credit Facility that is not waived by the required lenders, and the remedies sought by the holders of indebtedness as a result of a default, could render us unable to pay principal, premium, if any, and interest on the notes and substantially decrease the market value of the notes. 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 the indenture that will govern the notes, the Existing Notes Indentures and our Credit Facility, we could be in default under the terms of the agreements governing our indebtedness, including our Credit Facility, the Existing Notes Indentures and the indenture that will govern the notes. In the event of any default, the holders of this 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 Facility could elect to terminate their commitments under the Credit Facility, cease making further loans and 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 Facility to avoid being in default. If we breach our covenants under our Credit Facility 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 Facility, the lenders could exercise their rights, as described above, and we could be forced into bankruptcy or liquidation. See Description of Certain Indebtedness and Description of the Notes.

Your ability to receive payments on these notes is effectively subordinated to those lenders who have a security interest in our assets to the extent of the value of those assets.

Our obligations under the notes will be unsecured, but our obligations under the Credit Facility are secured by a security interest in substantially all of our assets. The Issuer is the borrower under the Credit Facility and Holdings and certain of its existing and future domestic subsidiaries have or will guarantee the obligations under the Credit Facility on a senior secured basis. If we are declared bankrupt or insolvent, or if we default under the Credit Facility, the lenders could declare all of the funds borrowed thereunder, together with accrued and unpaid interest, immediately due and payable. If we are unable to repay such indebtedness, the lenders could foreclose on the assets securing the Credit Facility to the exclusion of holders of the notes, even if an event of default exists under the indenture governing the notes at such time. In such event, because the notes will not be secured by any of our assets, it is possible that there would be no assets remaining from which claims of the holders of notes could be satisfied or, if any assets remained, they might be insufficient to satisfy such claims fully.

Claims of holders of the notes will be structurally subordinated to claims of creditors of our subsidiaries that do not guarantee the notes.

As of the issue date, the notes will be guaranteed by certain of our domestic subsidiaries. Claims of holders of the notes will be structurally subordinated to the claims of creditors of our subsidiaries that do not guarantee the notes, including trade creditors. All obligations of these subsidiaries will have to be satisfied before any of the assets of such subsidiaries would be available for distribution, upon a liquidation or otherwise, to us or to creditors of us, including the holders of the notes.

We estimate that our non-guarantor subsidiaries would have accounted for approximately $5.0 billion, or 42%, of our total net operating revenue, approximately $574 million, or 45%, of our net cash provided by operating activities, and approximately $579 million, or 32%, of our total Adjusted EBITDA, in each case, for the year ended December 31, 2011, and approximately $1.3 billion, or 40%, of our total revenue, approximately $279 million of our net cash provided by operating activities (our consolidated net cash provided by operating activities was approximately $187 million), and approximately $167 million, or 31%, of our total Adjusted

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EBITDA, in each case for the three months ended March 31, 2012, and approximately $8.7 billion, or 55%, of our total assets, and approximately $7.5 billion, or 58%, of our total liabilities, in each case, as of March 31, 2012.

We may not be able to satisfy our obligations to holders of the notes upon a change of control.

Upon the occurrence of a change of control, as defined in the indenture governing the notes, the holders of the notes will be entitled to require us to repurchase the outstanding notes at a purchase price equal to 101% of the principal amount of the notes plus accrued and unpaid interest to the date of repurchase. Failure to make this repurchase would result in a default under the indenture. Also, our Credit Facility may effectively prevent the purchase of the notes by us if a change of control occurs and these lenders do not consent to our purchase of the notes, unless all amounts outstanding under the Credit Facility are repaid in full. Our failure to purchase or give a notice of purchase of the notes would be a default under the indenture, which would in turn be a default under the Credit Facility. In addition, a change of control may constitute an event of default under the Credit Facility. A default under the Credit Facility would result in a default under the indenture if the lenders accelerate the debt under the Credit Facility. The Existing Notes Indentures contain, and any future credit agreements or other agreements to which we become a party may contain, similar restrictions and provisions. The exercise by holders of the notes of their right to require us to repurchase the notes could cause a default under our other debt agreements due to the financial effect of these repurchases on us, even if the change of control itself does not cause a default under the indenture.

In the event of a change of control, we may not have sufficient funds to repurchase the notes and to satisfy our other obligations under the notes and any other indebtedness. The source of funds for any purchase of notes would be available cash or cash generated from other sources, which may not be available. Upon the occurrence of a change of control, we could seek to refinance our indebtedness or obtain a waiver from our lenders, but it is possible that we may not be able to obtain a waiver or refinance our indebtedness on commercially reasonable terms, if at all. On the other hand, the provisions in the indenture that will govern the notes regarding a change of control could increase the difficulty of a potential acquiror obtaining control of us. See Description of the Notes Change of Control.

The change of control provisions in the indenture that will govern the notes may not protect you in the event we consummate a highly leveraged transaction, reorganization, restructuring, merger or other similar transaction, unless such transaction constitutes a change of control under the indenture. Some of these transactions may not involve a change in voting power or beneficial ownership or, even if they do, may not involve a change in the magnitude required under the definition of Change of Control in the indenture to trigger our obligation to repurchase the notes. Except as described above, the indenture does not contain provisions that permit the holders of the notes to require us to repurchase or redeem the notes in the event of a takeover, recapitalization or similar transaction. Therefore, if an event occurs that does not constitute a change of control as defined under the indenture that will govern the notes, we will not be required to make an offer to repurchase the notes and you may be required to hold your notes despite the event. See Description of the Notes Change of Control.

Subsidiary guarantors will be automatically released from their obligations under the Credit Facility in a variety of circumstances, which may cause those subsidiary guarantors to be released from their guarantees of the notes.

While any obligations under the Credit Facility remain outstanding, any subsidiary guarantor of the notes may be released without action by, or consent of, any holder of the notes or the trustee under the indenture that will govern the notes, if any subsidiary guarantor is no longer a guarantor of obligations under the Credit Facility and such subsidiary has no outstanding debt, subject to certain exceptions. See Description of the Notes. Upon the closing of any asset sale permitted under the Credit Facility consisting of the sale of all of the equity interests of any subsidiary guarantor, the obligations of such subsidiary guarantor under the Credit Facility will be automatically discharged and released. In addition, if any shares of a subsidiary guarantor are subject to certain

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permitted interest transfers under the Credit Facility, including transfers of such shares in connection with permitted joint ventures or permitted syndication transactions under the Credit Facility, the obligations of such subsidiary guarantor under the Credit Facility will be automatically discharged and released. The lenders under our Credit Facility will have the discretion to release the guarantees under our Credit Facility in a variety of other circumstances. You will not have a claim as a creditor against any subsidiary that is no longer a guarantor of the notes, and the indebtedness and other liabilities, including trade payables, whether secured or unsecured, of those subsidiaries will effectively be senior to claims of noteholders.

Federal and state statutes allow courts, under specific circumstances, to void guarantees and require noteholders to return payments received from guarantors.

Under the terms of the indenture that will govern the notes, the notes will be guaranteed by Holdings and certain of our subsidiaries at the time of issuance. If Holdings or one of the subsidiaries that is a guarantor of the notes becomes the subject of a bankruptcy case or a lawsuit filed by unpaid creditors of any such guarantor, the guarantees entered into by these guarantors may be reviewed under the federal bankruptcy law and comparable provisions of state fraudulent transfer laws. Under these laws, a guarantee could be voided, or claims in respect of a guarantee could be subordinated to other obligations of a guarantor if, among other things, the guarantor, at the time it incurred the indebtedness evidenced by its guarantee:

- received less than reasonably equivalent value or fair consideration for entering into the guarantee; and
- either:
  - was insolvent or rendered insolvent by reason of entering into the guarantee;
  - was engaged in a business or transaction for which the guarantor s remaining assets constituted unreasonably small capital; or
  - intended to incur, or believed that it would incur, debts or contingent liabilities beyond its ability to pay such debts or contingent liabilities as they become due.

In such event, any payment by a guarantor pursuant to its guarantee could be voided and required to be returned to the guarantor, or to a fund for the benefit of the guarantor s creditors under those circumstances.

If a guarantee of a guarantor were voided as a fraudulent conveyance or held unenforceable for any other reason, in all likelihood holders of the notes would be creditors solely of CHS/Community Health Systems, Inc. and those guarantors whose guarantees had not been voided. The notes then would in effect be structurally subordinated to all liabilities of any guarantor whose guarantee was voided.

The measures of insolvency for purposes of these fraudulent transfer laws will vary depending upon the law applied in any proceeding to determine whether a fraudulent transfer has occurred. Generally, however, a guarantor would be considered insolvent if:

- the sum of its debts, including contingent liabilities, was greater than the fair saleable value of all of its assets;
- the present fair saleable value of its assets was less than the amount that would be required to pay its probable liability on its existing debts, including contingent liabilities, as they become absolute and mature; or
- it could not pay its debts or contingent liabilities as they become due.

We cannot assure you as to what standard a court would use to determine whether or not a guarantor would be solvent at the relevant time, or regardless of the standard used, that the guarantees would not be subordinated to any guarantor s other debt.

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If a court held that the guarantees should be invalidated as fraudulent conveyances, the court could void, or hold unenforceable, the guarantees, which could mean that you may not receive any payments under the guarantees and the court may direct you to return any amounts that you have already received from any guarantor. Furthermore, the holders of the notes would cease to have any direct claim against the applicable guarantor. Consequently, the applicable guarantor s assets would be applied first to satisfy the applicable guarantor s other liabilities, before any portion of its assets could be applied to the payment of the notes. Sufficient funds to repay the notes may not be available from other sources, including the remaining guarantors, if any. Moreover, the invalidation of a guarantee could result in acceleration of such debt (if not otherwise accelerated due to our or our guarantors insolvency or other proceeding).

Each guarantee contains a provision intended to limit the guarantor s liability to the maximum amount that it could incur without causing the incurrence of obligations under its guarantee to be a fraudulent transfer. This provision may not be effective to protect the guarantees from being voided under fraudulent transfer law or may reduce or eliminate the guarantor s obligation to an amount that effectively makes the guarantee worthless. For example, in 2009, the U.S. Bankruptcy Court in the Southern District of Florida in *Official Committee of Unsecured Creditors of TOUSA, Inc. v. Citicorp N. Am., Inc*. found a savings clause provision in that case to be ineffective and held the guarantees at issue in that case to be fraudulent transfers and voided them in their entirety.

There is no assurance that any active trading market will develop for the notes.

The notes are being issued to, and will be owned by, a relatively small number of beneficial owners. The underwriters have advised us that they intend to make a market in the notes, as permitted by applicable laws and regulations; however, the underwriters are not obligated to make a market in the notes, and they may discontinue their market-making activities at any time without notice. Therefore, we cannot assure you as to the development or liquidity of any trading market for the notes. The liquidity of any market for the notes will also depend on a number of factors, including:

- the number of holders of notes;
- our operating performance and financial condition;
- the market for similar securities;
- the interest of securities dealers in making a market in the notes; and
- prevailing interest rates.

Historically, the market for non-investment grade debt has been subject to disruptions that have caused substantial volatility in the prices of securities similar to the notes. We cannot assure you that the market, if any, for the notes will be free from similar disruptions or that any disruptions may not adversely affect the prices at which you may sell your notes. Therefore, we cannot assure you that you will be able to sell your notes at a particular time or that the price that you receive when you sell will be favorable.

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

We are significantly leveraged. The following table below shows our level of indebtedness and other information as of March 31, 2012. As of March 31, 2012, a $750 million revolving credit facility was available to us for working capital and general corporate purposes under the Credit Facility, with $37.7 million of the revolving credit facility being set aside for outstanding letters of credit. On November 5, 2010, we entered into an amendment and restatement of our then existing Credit Facility, which extended by two and a half years, until January 25, 2017 (subject to customary acceleration events) or, if more than $50 million of our 2015 Notes are outstanding on April 15, 2015, to April 15, 2015, the maturity date of $1.5 billion of the existing term loans under the Credit Facility. In addition, effective February 2, 2012, we completed an additional amendment and

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restatement of the Credit Facility, which extended by two and a half years the maturity date of an additional $1.6 billion of our then non-extended term loans under the Credit Facility, until January 25, 2017 (subject to customary acceleration events) or, if more than $50 million of our 2015 Notes are outstanding on April 15, 2015, to April 15, 2015. The remaining approximately $2.9 billion of term loans mature in 2014. Effective March 6, 2012, we obtained a new $750 million senior secured revolving credit facility and a new $750 million incremental term loan A facility. The senior secured revolving credit facility replaced in full the existing revolving credit facility under the Credit Facility. The net proceeds of the incremental term loan A facility were used to repay the same amount of existing term loans under the Credit Facility.

On November 22, 2011, we completed our offering of $1.0 billion aggregate principal amount of 2019 Notes. The net proceeds from this issuance, together with available cash on hand, were used to finance the purchase of $1.0 billion aggregate principal amount of outstanding 2015 Notes and to pay related fees and expenses. On March 21, 2012, we completed our offering of $1.0 billion aggregate principal amount of additional 2019 Notes. The net proceeds from this issuance, together with available cash on hand, were used to finance the purchase of approximately $850 million aggregate principal amount of outstanding 2015 Notes, to pay related fees and expenses and for general corporate purposes. The 2019 Notes, and any remaining 2015 Notes after the Tender Offer, are our unsecured senior obligations and are guaranteed on a senior basis by us and by certain of our domestic subsidiaries.

With the exception of some small principal payments of our term loans under our Credit Facility, representing less than 1% of the outstanding balance each year through 2013, approximately $2.2 billion of term loans and our $300 million receivables facility mature in 2014, any remaining 2015 Notes after the Tender Offer are due in 2015, $3.0 billion of term loans mature in 2017 and our 2019 Notes are due in 2019. The remaining $750 million of term loans under the incremental term loan A facility mature in 2016 and require quarterly amortization payments of 5% per annum during the first year, 10% per annum during the second and third years, 15% per annum during the fourth year and 60% per annum during the fifth year, in equal quarterly installments, in each case subject to customary adjustments for prepayments.

	March 31, 2012	
	Actual	As Adjusted(a)
	(Dollars in thousands)	
Credit Facility:		
Term Loan A	$ 750,000	$ 750,000
Term Loan B	5,219,062	5,219,062
Revolving credit loans		
Receivables Facility	300,000	300,000
Capital lease obligations and other	94,232	94,232
Total secured debt	$ 6,363,294	$ 6,363,294
2015 Notes	931,016(b)	
2019 Notes	2,024,694(c)	2,024,694(c)
Notes offered hereby		1,200,000
Total debt	$ 9,319,004	$ 9,587,988
Total Community Health Systems, Inc. stockholders equity	$ 2,490,356	$ 2,450,528

(a) As described under Capitalization.
(b) Net of unamortized discount of $3.3 million.
(c) Carrying amount includes unamortized premium of $24.7 million.

As of March 31, 2012, our approximately $4.2 billion notional amount of interest rate swap agreements represented approximately 66% of our variable rate debt. On a prospective basis, a 1% change in interest rates on the remaining unhedged variable rate debt existing as of March 31, 2012, would result in interest expense fluctuating approximately $21 million per year.

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The counterparty to the interest rate swap agreements exposes us to credit risk in the event of non-performance. However, at March 31, 2012, we do not anticipate non-performance by the counterparty due to the net settlement feature of the agreements and our liability position with respect to each of our counterparties.

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

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

Despite the fact that we plan to continue to manage the maturities of our indebtedness and pursue opportunistic refinancing transactions from time to time, any financing that we pursue may not be completed on terms satisfactory to us, if at all. In addition, our interest expense may increase if we extend the maturity of our indebtedness.

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

We may incur substantial additional indebtedness in the future. The terms of the indenture that will govern the notes and the Existing Notes Indentures do not fully prohibit us from doing so. For example, under such indentures, we may incur up to approximately $7.8 billion pursuant to a credit facility or a qualified receivables transaction, less certain amounts repaid with the proceeds of asset dispositions. Of this $7.8 billion, we had borrowed approximately $6.0 billion under our Credit Facility, had an unused revolving commitment for up to approximately $750 million under our Credit Facility and had $300.0 million of borrowings outstanding under the Receivables Facility, each as of March 31, 2012. As of July 6, 2012, the principal amount outstanding under our revolving credit facility was $225.0 million and the amount available for borrowing thereunder (after reducing availability for letters of credit outstanding) was $487.3 million. Of the principal amount outstanding, approximately $67.6 million was drawn to fund acquisitions in York, Pennsylvania, and other smaller acquisitions, and nearly all of the remainder was drawn to fund intra-period working capital needs, which needs were unusually large partially due to the July 4th holiday and its impact on cash flows. The principal amount outstanding under our revolving credit facility can fluctuate significantly over the course of each month and may be different, sometimes materially, from the amounts shown above or as of the end of any accounting period. Additionally, our Credit Facility also gives us the ability to provide for one or more additional tranches of term loans in the aggregate principal amount of up to $1.0 billion without the consent of the existing lenders if specified criteria are satisfied. If new debt is added to our current debt levels, the related risks that we now face could be further exacerbated.

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Risks Related to Our Business

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

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

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

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

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

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

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

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

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

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

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

The hospital industry is highly competitive. In addition to the competition we face for acquisitions and physicians, we must also compete with other hospitals and healthcare providers for patients. The competition among hospitals and other healthcare providers for patients has intensified in recent years. The majority of our hospitals are located in non-urban service areas. We estimate that we are the sole acute care service provider in approximately 60% of the markets we serve. In most of our other markets, the primary competitor is a not-for-profit hospital. These not-for-profit hospitals generally differ in each jurisdiction. However, our hospitals face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in our primary service areas may travel to these other hospitals for a variety of reasons. These reasons include physician referrals or the need for services we do not offer. Patients who seek services from these other hospitals may subsequently shift their preferences to those hospitals for the services we provide.

Some of our hospitals operate in primary service areas where they compete with one other hospital; 25 of our hospitals compete with more than one other hospital in their respective primary service areas. Some of these competing hospitals use equipment and services more specialized than those available at our hospitals. In addition, some competing hospitals are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. These hospitals do not pay income or property taxes, and can make capital expenditures without paying sales tax. We also face competition from other specialized care providers, including outpatient surgery, orthopedic, oncology and diagnostic centers.

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

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

We have a five-year participation agreement with HealthTrust Purchasing Group, L.P. (HealthTrust), a group purchasing organization (GPO). This agreement extends to January 2013, with automatic renewal terms of one year, unless either party terminates by giving notice of non-renewal. GPOs attempt to obtain favorable pricing on medical supplies with manufacturers and vendors who sometimes negotiate exclusive supply arrangements in exchange for the discounts they give. To the extent these exclusive supply arrangements are challenged or deemed unenforceable, we could incur higher costs for our medical supplies obtained through HealthTrust. These higher costs could cause our operating results to decline.

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

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

At March 31, 2012, we had approximately $4.4 billion of goodwill recorded on our books. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. If the carrying value of our goodwill is impaired, we may incur a material non-cash charge to earnings.

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. If the carrying value of those assets is impaired, we may incur a material non-cash charge to earnings.

Risks Related to Our Industry

We are subject to uncertainties regarding healthcare reform.

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

The American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law on February 17, 2009, providing for a temporary increase in the federal matching assistance percentage (FMAP), a temporary increase in federal Medicaid DSH allotments, subsidization of health insurance premiums (COBRA) for up to nine months, and grants and loans for infrastructure and incentive payments for providers who adopt and use health information technology. This act also provides penalties by reducing reimbursement from Medicare in the form of reductions to scheduled market basket increases beginning in federal fiscal year 2015 if eligible hospitals and professionals fail to demonstrate meaningful use of electronic health record technology.

The PPACA was signed into law on March 23, 2010. In addition, the Reconciliation Act, which contains a number of amendments to the PPACA, was signed into law on March 30, 2010. These healthcare acts include a mandate that requires substantially all U.S. citizens to maintain medical insurance coverage, which will ultimately increase the number of persons with access to health insurance in the United States. The Reform

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Legislation should result in a reduction in uninsured patients, which should reduce our expense from uncollectible accounts receivable; however, this legislation makes a number of other 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 which began October 1, 2011, and a reduction to the Medicare and Medicaid disproportionate share payments, that could adversely impact the reimbursement received under these programs. The various provisions in the Reform Legislation that directly or indirectly affect reimbursement are scheduled to take effect over a number of years, and we cannot predict their impact at this time. Other provisions of the Reform Legislation, such as requirements related to employee health insurance coverage, should increase our operating costs.

Also included in the Reform Legislation are provisions aimed at reducing fraud, waste and abuse in the healthcare industry. These provisions allocate significant additional resources to federal enforcement agencies and expand the use of private contractors to recover potentially inappropriate Medicare and Medicaid payments. The Reform Legislation amends several existing federal laws, including the Medicare Anti-Kickback Statute and the False Claims Act, making it easier for government agencies and private plaintiffs to prevail in lawsuits brought against healthcare providers. These amendments also make it easier for potentially severe fines and penalties to be imposed on healthcare providers accused of violating applicable laws and regulations.

In a number of markets, we have partnered with local physicians in the ownership of our facilities. Such investments have been permitted under an exception to the physician self-referral law (the Stark Law) that allows physicians to invest in an entire hospital (as opposed to individual hospital departments). The Reform Legislation changes the whole hospital exception to the Stark Law. The Reform Legislation permits existing physician investments in a whole hospital to continue under a grandfather clause if the arrangement satisfies certain requirements and restrictions, but physicians became prohibited, from the time the Reform Legislation became effective, from increasing the aggregate percentage of their ownership in the hospital.

The Reform Legislation also restricts the ability of existing physician-owned hospitals to expand the capacity of their facilities. Physician investments in hospitals that are under development are protected by the grandfather clause only if the physician investments have been made and the hospital had a Medicare provider agreement as of a specific date.

The impact of the Reform Legislation on each of our hospitals will vary depending on payor mix and a variety of other factors. On June 28, 2012, the Supreme Court of the United States largely upheld the constitutionality of the Reform Legislation, though it overturned an aspect of the legislation that would have permitted the Federal government to withhold all Medicaid funding from a state if that state did not expand Medicaid coverage to the extent required by the Reform Legislation. The Supreme Court s ruling instead said that only new incremental funding could be withheld from a state in such a situation. As a result, states will face less severe financial consequences if they refuse to expand Medicaid coverage to individuals with incomes below certain thresholds. Since the Supreme Court s ruling, some have suggested that, for budgetary and other reasons, they would not expand their Medicaid programs. If states refuse to expand their Medicaid programs, the number of uninsured patients at our hospitals will decline by a smaller margin as compared to our expectations when the Reform Legislation was first adopted. In addition, we anticipate that many of the provisions in the Reform Legislation will be subject to efforts to amend or repeal it, further clarification and modification through the rule-making process, the development of agency guidance and future judicial interpretations, individual state decisions to expand or not to expand Medicaid coverage and budgetary issues at the federal and state levels. We cannot predict the impact the Reform Legislation may have on our business, results of operations, cash flow, capital resources and liquidity, or the ultimate outcome of any clarifications or modifications to the Reform Legislation. Furthermore, we cannot predict whether we will be able to modify certain aspects of our operations to offset any potential adverse consequences from the Reform Legislation.

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

In 2011, 36.5% of our net operating revenues came from the Medicare and Medicaid programs. Federal healthcare expenditures continue to increase and state governments continue to face budgetary shortfalls as a result of the current economic downturn and accelerating Medicaid enrollment. As a result, federal and state governments have made, and continue to make, significant changes in the Medicare and Medicaid programs. Some of these changes have decreased, or could decrease, the amount of money we receive for our services relating to these programs.

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

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

The healthcare industry is required to comply with many laws and regulations at the federal, state and local government levels. These laws and regulations require that hospitals meet various requirements, including those relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, compliance with building codes, environmental protection and privacy. These laws include, in part, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and a section of the Social Security Act, known as the anti-kickback statute. If we fail to comply with applicable laws and regulations, including fraud and abuse laws, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in the Medicare, Medicaid and other federal and state healthcare programs.

In addition, there are heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment. Recent enforcement actions have focused on financial arrangements between hospitals and physicians, billing for services without adequately documenting the medical necessity for such services, 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 Certain Legal Matters below.

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

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

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

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

In recent years, physicians, hospitals and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability, or related legal theories. Even in states that have imposed caps on damages, litigants are seeking recoveries under new theories of liability that might not be subject to the caps on damages. Many of these actions involve large claims and significant defense costs. To protect us from the cost of these claims, we maintain 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 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. As a percentage of net operating revenues, our expense related to malpractice and other professional liability claims, including the cost of excess insurance, increased in 2009 by 0.3%, decreased in 2010 by 0.3%, decreased in 2011 by 0.2% and decreased by 0.1% in the three months ended March 31, 2012 from the comparable prior-year period. If these costs rise rapidly, our profitability could decline. For a further discussion of our insurance coverage, see our discussion of professional liability claims in Management s Discussion and Analysis of Financial Condition and Results of Operations in Item 7 of our Current Report on Form 8-K filed with the SEC on May 24, 2012, which is incorporated by reference in this prospectus supplement.

We are the subject of a number of legal proceedings and government investigations that, if resolved unfavorably, could have a material adverse effect on our financial condition and results of operations.

We are party to various ongoing legal proceedings and government investigations. For a further discussion of certain of these matters, see Certain Legal Matters below. Some of these legal proceedings and government investigations are at an early stage and we cannot predict how they will be resolved. Furthermore, there may be additional proceedings under seal that are not known to us. Should an unfavorable outcome occur in any of our current legal proceedings, or if successful claims or other actions are brought against us in the future, there could be a material adverse effect on our financial condition and results of operations.

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

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

Currently, the global economies, and in particular the United States, are experiencing a period of economic uncertainty and the related financial markets are experiencing a high degree of volatility. This current financial turmoil is adversely affecting the banking system and financial markets and resulting in a tightening in the credit markets, a low level of liquidity in many financial markets and extreme volatility in fixed income, credit, currency and equity markets. This uncertainty poses a risk as it could potentially lead to higher levels of uninsured patients, result in higher levels of patients covered by lower paying government programs and/or result in fiscal uncertainties at both government payors and private insurers.

If our implementation of electronic health record systems is not effective or exceeds our budget and timeline, our operations could be adversely affected.

ARRA created an incentive payment program for eligible hospitals and healthcare professionals to adopt and meaningfully use certified electronic health records (EHR) technology. The implementation of EHR that

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meets the meaningful use criteria requires a significant capital investment, and our current plan to implement EHR anticipates maximizing the incentive payment program created by ARRA. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. As additional incentive, beginning in federal fiscal year 2015, if eligible hospitals and professionals fail to demonstrate meaningful use of certified EHR technology, they will be penalized with reduced reimbursement from Medicare in the form of reductions to scheduled market basket increases. If we fail to implement HER systems effectively and in a timely manner, there could be a material adverse effect on our consolidated financial position and consolidated results of operations.

Certain Legal Matters

From time to time, we receive various inquiries or subpoenas from state regulators, fiscal intermediaries, the Centers for Medicare and Medicaid Services and the Department of Justice regarding various Medicare and Medicaid issues. In addition to the subpoenas discussed below, we are currently responding to subpoenas for matters such as: durable medical equipment (DME) vendor relationships and patient choice discharge instructions at our Washington hospitals, operations of a cardiovascular surgery department at our Oregon hospital and lab operations at a New Mexico hospital. In addition, we are subject to other claims and lawsuits arising in the ordinary course of our business. Some pending or threatened proceedings against us may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could have a material adverse effect on our business and operations. 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 against us but placed under seal by the court to comply with the False Claims Act s requirements for filing such suits.

On February 10, 2006, we received a letter from the Civil Division of the Department of Justice requesting documents in an investigation it was conducting involving the Company. The inquiry related to the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients. These programs are referred to by different names, including intergovernmental payments, upper payment limit programs, and Medicaid disproportionate share hospital payments. The February 2006 letter focused on our hospitals in three states: Arkansas, New Mexico and South Carolina. On August 31, 2006, we received a follow up letter from the Department of Justice requesting additional documents relating to the programs in New Mexico and the payments to our three hospitals in that state. Through the beginning of 2009, we provided the Department of Justice with requested documents, met with its personnel on numerous occasions and otherwise cooperated in its investigation. During the course of the investigation, the Civil Division notified us that it believed that we and these three New Mexico hospitals caused the State of New Mexico to submit improper claims for federal funds, in violation of the Federal False Claims Act. At one point, the Civil Division calculated that the three hospitals received ineligible federal participation payments from August 2000 to June 2006 of approximately $27.5 million and said that if it proceeded to trial, it would seek treble damages plus an appropriate penalty for each of the violations of the Federal False Claims Act. This investigation has culminated in the federal government s intervention in a qui tam lawsuit styled U.S. ex rel. Baker vs. Community Health Systems, Inc., pending in the United States District Court for the District of New Mexico. The federal government filed its complaint in intervention on June 30, 2009. The relator filed a second amended complaint on July 1, 2009. Both of these complaints expand the time period during which alleged improper payments were made. We filed motions to dismiss all of the federal government s and the relator s claims on August 28, 2009. On March 19, 2010, the court granted in part and denied in part our motion to dismiss as to the relator s complaint. On July 7, 2010, the court denied our motion to dismiss the federal government s complaint in intervention. On July 21, 2010, we filed our answer and pretrial discovery began. On June 2, 2011, the relator filed a Third Amended Complaint adding subsidiaries Community Health Systems Professional Services

Corporation and CHS/Community Health Systems, Inc. as defendants. On June 6, 2011, the government filed its First Amended Complaint in intervention adding Community Health Systems Professional Services Corporation as a defendant. Discovery is closed. Motions for Summary Judgment were filed on March 27, 2012 and there is currently no trial date set. On March 30, 2012, the court denied our motion to exclude Plaintiffs expert witness testimony, which we believe fails to follow the controlling Medicaid statute and regulations and results in an exaggeration of the damages estimate by fourfold. We will have the opportunity to challenge the methodology employed at trial. We are vigorously defending this action.

On June 12, 2008, two of our hospitals received letters from the United States Attorney s Office for the Western District of New York requesting documents in an investigation it was conducting into billing practices with respect to kyphoplasty procedures performed during the period January 1, 2002 through June 9, 2008. On September 16, 2008, one of our hospitals in South Carolina also received an inquiry. Kyphoplasty is a surgical spine procedure that returns a compromised vertebrae (either from trauma or osteoporotic disease process) to its previous height, reducing or eliminating severe pain. We have been informed that similar investigations have been initiated at unaffiliated facilities in Alabama, South Carolina, Indiana and other states. We believe that this investigation is related to a qui tam settlement between the same United States Attorney s office and the manufacturer and distributor of the Kyphon product, which is used in performing the kyphoplasty procedure. We are cooperating with the investigation and we are continuing to evaluate and discuss this matter with the federal government.

On April 19, 2009, we were served in Roswell, New Mexico with an answer and counterclaim in the case of Roswell Hospital Corporation d/b/a Eastern New Mexico Medical Center vs. Patrick Sisneros and Tammie McClain (sued as Jane Doe Sisneros). The case was originally filed as a collection matter. The counterclaim was filed as a putative class action and alleged theories of breach of contract, unjust enrichment, misrepresentation, prima facie tort, Fair Trade Practices Act violations and violation of the New Mexico RICO statute. On May 7, 2009, the hospital filed a notice of removal to federal court. On July 27, 2009, the case was remanded to state court for lack of a federal question. A motion to dismiss and a motion to dismiss misjoined counterclaim plaintiffs were filed on October 20, 2009. These motions were denied. Extensive discovery has been conducted. A motion for class certification for all uninsured patients was heard on March 3 through March 5, 2010 and on April 13, 2010, the state district court judge certified the case as a class action. Numerous hearings have been conducted to assess the sufficiency of the methodology used to determine class damages. On December 5, 2011, the court entered an order approving the suggested damages methodology. The court has now ordered that class notice be sent by April 30, 2012. We are vigorously defending this action.

On December 7, 2009, we received a document subpoena from the United States Department of Health and Human Services, Office of the Inspector General, or OIG, requesting documents related to our hospital in Laredo, Texas. The categories of documents requested included case management, resource management, admission criteria, patient medical records, coding, billing, compliance, the Joint Commission accreditation, physician documentation, payments to referral sources, transactions involving physicians, disproportionate share hospital status and audits by the hospital s Quality Improvement organization. On January 22, 2010, we received a request for information or assistance from the OIG s Office of Investigation requesting patient medical records from Laredo Medical Center in Laredo, Texas for certain Medicaid patients with an extended length of stay. Additional requests for records have also been received, including a request containing follow-up questions received on January 5, 2011. We continue to cooperate fully with this investigation.

On May 16, 2011, we received a subpoena dated May 10, 2011 from the Houston Office of the United States Department of Health and Human Services, OIG, requesting 71 patient medical records from our hospital in Shelbyville, Tennessee, and directing the return of the records to the Assistant United States Attorney handling the Laredo investigation. We are unaware of any connection between these two facilities other than they are both affiliated with us. We continue to cooperate fully with this investigation.

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On September 20, 2010, we received a letter from the United States Department of Justice, Civil Division, advising us that an investigation is being conducted to determine whether certain hospitals have improperly submitted claims for payment for implantable cardioverter defibrillators, or ICD. The period of time covered by the investigation is 2003 to the present. The letter states that the Department of Justice s data indicates that many of our hospitals have claims that need to be reviewed to determine if Medicare payment was appropriate. We understand that the Department of Justice has submitted similar requests to many other hospitals and hospital systems across the country as well as to the ICD manufacturers themselves. We continue to fully cooperate with the government in this investigation and have provided requested records and documents.

On November 15, 2010, we were served with substantially identical Civil Investigative Demands (CIDs) from the Office of Attorney General, State of Texas for all 18 of our affiliated Texas hospitals. The subject of the requests appears to concern emergency department procedures and billing. We have complied with these requests and are providing all documentation and reports requested. We are continuing to cooperate with the government in this investigation.

On April 8, 2011, we received a document subpoena, dated March 31, 2011, from the United States Department of Health and Human Services, OIG, in connection with an investigation of possible improper claims submitted to Medicare and Medicaid. The subpoena, issued from the OIG s Chicago, Illinois office, requested documents from all of our hospitals and appears to concern emergency department processes and procedures, including our hospitals use of the Pro-MED Clinical Information System, which is a third-party software system that assists with the management of patient care and provides operational support and data collection for emergency department management and has the ability to track discharge, transfer and admission recommendations of emergency department physicians. The subpoena also requested other information about our relationships with emergency department physicians, including financial arrangements. The subpoena s requests were very similar to those contained in the Civil Investigative Demands received by our Texas hospitals from the Office of the Attorney General of the State of Texas on November 15, 2010 (described above). This investigation is being led by the Department of Justice. We are continuing to cooperate with the government, including detailing a process for a medical necessity review by clinical reviewers and physicians of a sampling of medical records at a small number of hospitals.

On April 11, 2011, Tenet Healthcare Corporation, or Tenet, filed suit against the Company, Wayne T. Smith and W. Larry Cash in the United States District Court for the Northern District of Texas. The suit alleged we committed violations of certain federal securities laws by making certain statements in various proxy materials filed with the SEC, in connection with our offer to purchase Tenet. Tenet alleged that we engaged in a practice to under-utilize observation status and over-utilize inpatient admission status and asserts that by doing so, we created undisclosed financial and legal liability to federal, state and private payors. The suit seeks declaratory and injunctive relief and Tenet s costs. On April 19, 2011, we filed a motion to dismiss the complaint. On May 16, 2011, Tenet filed an amended complaint. On June 29, 2011, we filed a motion to dismiss the amended complaint. A hearing on our motion to dismiss occurred on September 8, 2011. On March 21, 2012, the court dismissed this case in its entirety, with prejudice.

On April 22, 2011, a joint motion was filed by the relator and the United States Department of Justice in the case styled United States ex rel. and Reuille vs. Community Health Systems Professional Services Corporation and Lutheran Musculoskeletal Center, LLC d/b/a Lutheran Hospital, in the United States District Court for the Northern District of Indiana, Fort Wayne Division. The lawsuit was originally filed under seal on January 7, 2009. The suit is brought under the False Claims Act and alleges that Lutheran Hospital of Indiana billed the Medicare program for (a) false 23 hour observation after outpatient surgeries and procedures, and (b) intentional assignment of inpatient status to one-day stays for cases that do not meet Medicare criteria for inpatient intensity of service or severity of illness. The relator had worked in the case management department of Lutheran Hospital of Indiana but was reassigned to another department in the fall of 2006. This facility was acquired by us as part of the July 25, 2007 merger transaction with Triad Hospitals, Inc. The complaint also includes allegations of age discrimination in Ms. Reuille s 2006 reassignment and retaliation in connection with her resignation on

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October 1, 2008. We had cooperated fully with the government in its investigation of this matter, but had been unaware of the exact nature of the allegations in the complaint. On December 27, 2010, the government filed a notice that it declined to intervene in this suit. The motion contained additional information about how the government intended to proceed with an investigation regarding allegations of improper billing for inpatient care at other hospitals associated with Community Health Systems, Inc. asserted in other qui tam complaints in other jurisdictions. The motion stated that the Department of Justice has consolidated its investigations of the Company and other related entities and that the Civil Division of the Department of Justice, multiple United States Attorneys offices, and the Office of Inspector General for the Department of Health and Human Services, or HHS, are now closely coordinating their investigation of these overlapping allegations. The Attorney General of Texas has initiated an investigation; the United States intends to work cooperatively with Texas and any other States investigating these allegations. The motion also stated that the Office of Audit Services for the Office of Investigations for HHS has been engaged to conduct a national audit of certain of our Medicare claims. The government confirmed that it considers the allegations made in the complaint styled Tenet Healthcare Corporation vs. Community Health Systems, Inc., et al. filed in the United States District Court for the Northern District of Texas, Dallas Division on April 11, 2011 to be related to the allegations in the qui tam and to what the government is now describing as a consolidated investigation. (Because qui tam suits are filed under seal, no one but the relator and the government knows that the suit has been filed or what allegations are being made by the relator on behalf of the government. Initially, the government has 60 days to make a determination about whether to intervene in a case and to act as the plaintiff or to decline to intervene and allow the relator to act as the plaintiff in the suit, but extensions of time are frequently granted to allow the government additional time to investigate the allegations. Even if, in the course of an investigation, the court partially unseals a complaint to allow the government and a defendant to work to a resolution of the complaint s allegations, the defendant is prohibited from revealing to anyone even that the partial unsealing has occurred. As the investigation proceeds, we may learn of additional qui tam suits filed against us or our affiliated hospitals or related entities, or that contact letters, document requests, or medical record requests we have received in the past from various governmental agencies are generated from qui tam cases filed under seal.) The motion filed on April 22, 2011 concluded by requesting a stay of the litigation in the Reuille case for 180 days, and on April 25, 2011, the court granted the motion. Our management company subsidiary, Community Health Systems Professional Services Corporation, the defendant in the Reuille case, consented to the request for the stay. On October 19, 2011, the government filed an application to transfer the Reuille case to the Middle District of Tennessee or for an extension of the stay for an additional 180 days. We agreed that a stay for an additional, but shorter period of time, 90 days, was appropriate, but did not consent to the transfer of the case. Our response setting forth our legal arguments was filed on October 24, 2011. On November 1, 2011, the court denied the motion to transfer the matter and extended the stay until April 30, 2012. On April 26, 2012, we joined the government and the relator in a motion to extend the stay in this case for an additional 180 days. As noted in that filing, we are working with the government on a probe audit of medical records (described above with respect to the April 2011 subpoena). We are cooperating fully with the government in its investigations.

On May 13, 2011, we received a subpoena from the SEC requesting documents related to or requested in connection with the various inquiries, lawsuits and investigations regarding, generally, emergency room admissions or observation practices at our hospitals. The subpoena also requested documents relied upon by us in responding to the Tenet litigation, as well as other communications about the Tenet litigation. As with all government investigations, we are cooperating fully with the SEC.

Three purported class action shareholder federal securities 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., Wayne T. Smith and W. Larry Cash, filed May 5, 2011; De Zheng v. Community Health Systems, Inc., Wayne T. Smith and W. Larry Cash, filed May 12, 2011; and Minneapolis Firefighters Relief Association v. Community Health Systems, Inc., Wayne T. Smith, W. Larry Cash and Thomas Mark Buford, filed June 2, 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. On September 20, 2011, all three were assigned to the same judge as related cases. On December 28, 2011, the

court consolidated all three shareholder cases for pretrial purposes, selected NYC Funds as lead plaintiffs, and selected NYC Funds counsel as lead plaintiffs counsel. The parties are in the process of negotiating operative dates for these consolidated shareholder federal securities actions, including dates for the filing of an operative consolidated complaint and related briefing.

Three purported shareholder derivative actions have also been filed in the United States District Court for the Middle District of Tennessee; Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund v. Wayne T. Smith, W. Larry Cash, T. Mark Buford, John A. Clerico, James S. Ely III, John A. Fry, William Norris Jennings, Julia B. North and H. Mitchell Watson, Jr., filed May 24, 2011; Roofers Local No. 149 Pension Fund v. Wayne T. Smith, W. Larry Cash, John A. Clerico, James S. Ely, III, John A. Fry, William Norris Jennings, Julia B. North and H. Mitchell Watson, Jr., filed June 21, 2011; and Lambert Sweat v. Wayne T. Smith, W. Larry Cash, T. Mark Buford, John A. Clerico, James S. Ely, III, John A. Fry, William Norris Jennings, Julia B. North, H. Mitchell Watson, Jr. and Community Health Systems, Inc., filed October 5, 2011. These three cases allege breach of fiduciary duty arising out of allegedly improper inpatient admission practices, mismanagement, waste and unjust enrichment. On September 28, 2011, the court ordered that the Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund action and the Roofers Local No. 149 Pension Fund action be consolidated for pretrial purposes, and appointed the derivative plaintiffs lead counsel. On November 29, 2011, the court ordered that the Lambert Sweat action be consolidated with the Plumbers and Roofers consolidated derivative actions. The Plaintiffs filed an operative amended derivative complaint in these three consolidated actions on March 15, 2012. A responsive pleading was filed May 14, 2012. We will vigorously defend these matters.

On June 2, 2011, an order was entered unsealing a relator s qui tam complaint in the matter of U.S. ex. rel Wood M. Deming, MD, individually and on behalf of Regional Cardiology Consultants, PC v. Jackson-Madison County General Hospital, an Affiliate of West Tennessee Healthcare, Regional Hospital of Jackson, a Division of Community Health Systems Professional Services Corporation, James Moss, individually, Timothy Puthoff, individually, Joel Perchik, MD, individually, and Elie H. Korban, MD, individually. The action is pending in the Western District of Tennessee, Jackson Division. Regional Hospital of Jackson is an affiliated hospital and Mr. Puthoff is a former chief executive officer there. The Order recited that the United States had elected to intervene to a limited degree only concerning the claims against Dr. Korban for false and fraudulent billing for allegedly unnecessary stent procedures and for causing the submission of false claims by the hospitals. The United States expressly declined to intervene in all other claims against all other named defendants. On July 28, 2011, we were served by the relator. On September 7, 2011, we filed our answer. On May 25, 2012, the relator filed an amended complaint, which we answered on June 14, 2012. We will vigorously defend this case.

On June 13, 2011, our hospital in Easton, Pennsylvania received a document subpoena from the Philadelphia office of the United States Department of Justice. The documents requested included medical records for certain urological procedures performed by a non-employed physician who is no longer on the medical staff and other records concerning the hospital s relationship with the physician. Certain procedures performed by the physician had been previously reviewed and appropriate repayments had been made. We are cooperating fully with the government in this investigation.

On February 2, 2012, an order was entered unsealing a relator s qui tam complaint in the matter of Pamela Gronemeyer ex rel. United States of America v. Crossroads Community Hospital. The action is pending in the United States District Court, Southern District of Illinois. Crossroads Community Hospital is an affiliated hospital. The order recited that the United States had declined to intervene in this matter. We had previously disclosed this matter in the context of our response to a subpoena concerning blood administration practices at an affiliated Illinois hospital. We were served in this case on April 18, 2012. We will vigorously defend this case.

On February 4, 2010, suit was filed in the matter styled Managed Care Solutions, Inc. v. Community Health Systems, Inc., United States District Court for the Southern District of Florida. Plaintiff contracted with two affiliated hospitals to provide services collecting receivables from third-party payors. Plaintiff seeks to extend the contract to additional facilities at which it never provided any services and is claiming $435 million in damages.

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A motion for summary judgment was filed on February 17, 2012. Trial is currently scheduled for September 24, 2012. We will continue to vigorously defend this action.

On January 30, 2012, an order was entered unsealing a relator s qui tam complaint in the matter of U.S. ex rel. Wilson v. Crestwood Healthcare LP d/b/a Crestwood Medical Center, et al., United States District Court for the Northern District of Alabama and originally filed on September 16, 2011. Co-defendant Dr. Pamela Hudson is the chief executive officer there. The matter concerns lease arrangements with the other named physician co-defendants. The government declined to intervene in this case. The hospital was served on February 21, 2012, and a motion to dismiss was filed on April 30, 2012. We are vigorously defending this matter.

On February 23, 2012, our hospital in Hattiesburg, Mississippi received a document subpoena from the United States Department of Health and Human Services, OIG relating to its relationship with Allegiance Health Management, Inc., or Allegiance, a company that provides intensive outpatient psychiatric (IOP) services to its patients. The subpoena seeks information concerning the hospital s financial relationship with Allegiance, medical records of patients receiving IOP services, and other documents relating to Allegiance such as agreements, policies and procedures, audits, complaints, budgets, financial analyses and identities of those delivering services. This is our only hospital that received services from this vendor. We are cooperating fully with this investigation.

On February 29, 2012, Gregg Becker, a former chief financial officer at Rockwood Clinic in Spokane, Washington, sued 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, PS in Superior Court, Spokane, Washington. On March 9, 2012, the case was removed to federal court in Spokane. 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. On April 5, 2012, motions to dismiss on the merits and jurisdictional grounds were filed in the civil case. We will vigorously defend this action.

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RATIO OF EARNINGS TO FIXED CHARGES

The following table sets forth our ratio of earnings to fixed charges for each of the periods shown on a consolidated basis. For purposes of determining the ratio of earnings to fixed charges, earnings are defined as earnings (loss) from continuing operations before income taxes, plus fixed charges. Fixed charges consist of interest expense on all indebtedness, amortization of debt discount, amortization of deferred financing costs and an interest factor attributable to operating leases.

	Fiscal Years Ended December 31,					Three Months Ended March 31,
	2007	2008	2009	2010	2011	2012
Earnings						
Income from continuing operations before provision for income taxes	$ 111,858	$ 366,287	$ 447,662	$ 518,894	$ 473,547	$ 145,537
Income from equity investees	(25,136)	(42,073)	(36,531)	(45,443)	(49,491)	(12,013)
Distributed income from equity investees	19,902	32,897	33,705	33,882	39,995	2,941
Interest and amortization of deferred finance costs	356,488	643,397	643,608	647,593	644,410	152,175
Amortization of capitalized interest	881	1,468	2,021	2,421	2,882	3,285
Implicit rental interest expense	36,696	55,440	59,384	62,116	63,695	16,806
Total Earnings	$ 500,689	$ 1,057,416	$ 1,149,849	$ 1,219,463	$ 1,175,038	$ 308,731
Fixed Charges						
Interest and amortization of deferred finance costs	$ 356,488	$ 643,397	$ 643,608	$ 647,593	$ 644,410	$ 152,175
Capitalized interest	19,009	22,087	16,649	11,316	20,998	7,199
Implicit rental interest expense	36,696	55,440	59,384	62,116	63,695	16,806
Total Fixed Charges	$ 412,193	$ 720,924	$ 719,641	$ 721,025	$ 729,103	$ 176,180
Ratio of earnings to fixed charges	1.21x	1.47x	1.60x	1.69x	1.61x	1.75x

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USE OF PROCEEDS

We intend to use the net proceeds from this offering to purchase all of the 2015 Notes validly tendered and not validly withdrawn in the Tender Offer, to pay for consents delivered in connection with the Tender Offer, to pay related fees and expenses and, to the extent any proceeds remain, for general corporate purposes. If less than all of the outstanding 2015 Notes are validly tendered and not validly withdrawn in the Tender Offer, we expect to apply a portion of the net proceeds from this offering to repurchase, redeem or otherwise retire the outstanding 2015 Notes. The underwriters and/or their respective affiliates that hold 2015 Notes may tender some or all of their 2015 Notes in the Tender Offer and receive a portion of the net proceeds from this offering as consideration for the 2015 Notes so tendered. See Underwriting.

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CAPITALIZATION

The following table sets forth our consolidated cash and cash equivalents and capitalization as of March 31, 2012:

on an actual basis; and

on an as adjusted basis to give effect to (i) the issuance of the notes offered hereby and (ii) the use of a portion of the net proceeds from this offering to repurchase all the outstanding 2015 Notes in the Tender Offer (assuming that all outstanding 2015 Notes are tendered prior to the Consent Expiration and accepted for purchase in the Tender Offer) and to pay for consents delivered in connection with the Tender Offer.

	As of March 31, 2012	
	Actual	As Adjusted
	(Dollars in thousands)	
Cash and cash equivalents	$ 129,298	$ 349,352
Debt:		
Credit Facility:		
Term Loan A	750,000	750,000
Term Loan B	5,219,062	5,219,062
Revolving credit loans(c)		
Receivables Facility	300,000	300,000
Capital lease obligations and other	94,232	94,232
Total secured debt	$ 6,363,294	$ 6,363,294
2015 Notes	931,016(a)	
2019 Notes	2,024,694(b)	2,024,694(b)
Notes offered hereby		1,200,000
Total debt	$ 9,319,004	$ 9,587,988
Total Community Health Systems, Inc. stockholders equity	2,490,356	2,450,528
Noncontrolling interests in equity of consolidated subsidiaries	61,748	61,748
Total equity	$ 2,552,104	$ 2,512,276
Total capitalization	$ 11,871,108	$ 12,100,264

(a) Net of unamortized discount of $3.3 million.

(b) Carrying amount includes unamortized premium of $24.7 million.

(c) As of July 6, 2012, the principal amount outstanding under our revolving credit facility was $225.0 million and the amount available for borrowing thereunder (after reducing availability for letters of credit outstanding) was $487.3 million. Of the principal amount outstanding, approximately $67.6 million was drawn to fund acquisitions in York, Pennsylvania, and other smaller acquisitions, and nearly all of the remainder was drawn to fund intra-period working capital needs, which needs were unusually large partially due to the July 4th holiday and its impact on cash flows. The principal amount outstanding under our revolving credit facility can fluctuate significantly over the course of each month and may be different, sometimes materially, from the amounts shown above or as of the end of any accounting period.

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DESCRIPTION OF CERTAIN INDEBTEDNESS

In connection with the consummation of the acquisition of Triad in July 2007, the Issuer obtained senior secured financing under a new credit facility, or the Credit Facility, which consisted of an approximately $6.1 billion funded term loan facility, a $400 million delayed draw term loan facility and a $750 million revolving credit facility, with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent, and issued approximately $3.0 billion aggregate principal amount of the 2015 Notes. The Company used the net proceeds from the 2015 Notes offering and the net proceeds of the approximately $6.1 billion of funded term loans under the Credit Facility to acquire the outstanding shares of Triad, to refinance certain of Triad s indebtedness and the Company s indebtedness, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. Specifically, the Company repaid its outstanding debt under the previously outstanding credit facility, the 6.50% senior subordinated notes due 2012 and certain of Triad s existing indebtedness.

Credit Facility

The Credit Facility became effective in July 2007, at which time it consisted of an approximately $6.1 billion funded term loan facility with a maturity of seven years, an undrawn $400 million delayed draw term loan facility with a maturity of seven years and a $750 million revolving credit facility with a maturity of six years. In the fourth quarter of 2007, the $400 million delayed draw term loan facility had been reduced to $300 million at the request of the Issuer. During the fourth quarter of 2008, $100 million of the delayed draw term loan was drawn down, reducing the delayed draw term loan availability to $200 million. In January 2009, the remaining $200 million of the delayed draw term loan was drawn down, and, as of December 31, 2011, there is no additional unused borrowing capacity under the delayed draw term loan. The revolving credit facility also includes a subfacility for letters of credit and a swingline subfacility. On November 5, 2010, the Issuer entered into a first amendment and restatement of its existing Credit Facility, and on February 2, 2012, the Issuer entered into a second amendment and restatement of its existing Credit Facility. The first and second amendment and restatements extended by two and a half years, until January 25, 2017, the maturity date of $3.1 billion of the term loans under the Credit Facility (the Extended Term Loans). If more than $50 million of the Existing Notes remain outstanding on April 15, 2015, without having been refinanced by indebtedness maturing no earlier than the date 91 days after January 25, 2017, then the maturity date for the Extended Term Loans will be accelerated to April 15, 2015. The maturity date of the approximately $2.9 billion of the term loans not extended pursuant to the first and second amendment and restatements is July 25, 2014 (the Non-Extended Term Loans).

On March 6, 2012, the Issuer entered into a new $750 million senior secured revolving credit facility (the Replacement Revolver Facility) and incurred a new $750 million incremental term loan A facility (the Incremental Term Loan). The Replacement Revolver Facility replaced in full the existing revolving credit facility under the Credit Facility and the proceeds of the Incremental Term Loan were used to repay Non-Extended Term Loans. The maturity date of the Replacement Revolver Facility and the Incremental Term Loan is October 25, 2016. If more than $50 million of the Non-Extended Term Loans remain outstanding on April 25, 2014, without having been refinanced by indebtedness maturing no earlier than the date 91 days after October 25, 2016, then the maturity date for the Replacement Revolver Facility and the Incremental Term Loan will be accelerated to the date that is 91 days prior to the earliest final maturity date after July 25, 2014 of any such Non-Extended Term Loans. If more than $50 million of the Existing Notes remain outstanding on April 15, 2015, without having been refinanced by indebtedness maturing no earlier than the date 91 days after October 25, 2016, then the maturity date for the Replacement Revolver Facility and the Incremental Term Loan will be accelerated to April 15, 2015.

The Credit Facility requires quarterly amortization payments in respect of Non-Extended Term Loans and Extended Term Loans equal to 0.25% of the original principal amount of such term loans subject to customary adjustments for prepayments. The Credit Facility requires quarterly amortization payments in respect of the Incremental Term Loan of 5% per annum during the first year after the incurrence of the Incremental Term Loan,

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10% per annum during the second and third years, 15% per annum during the fourth year and 60% per annum during the fifth year, in equal quarterly installments, in each case subject to customary adjustments for prepayments.

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

The borrower under the Credit Facility is the Issuer. All of the obligations under the Credit Facility are unconditionally guaranteed by Holdings and certain existing and subsequently acquired or organized domestic subsidiaries. All obligations under the Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of Holdings, the Issuer and each subsidiary guarantor, including equity interests held by Holdings, the Issuer or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, hospital syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries, in each case to the extent a pledge of the equity interests of such subsidiaries would be prohibited by a contractual obligation or requirement of law. The loans under the Credit Facility bear interest on the outstanding unpaid principal amount thereof at a per annum rate equal to an applicable percentage plus, at the Issuer s option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus one-half of 1.0% or (3) the adjusted London Interbank Offered Rate (LIBOR) on such day for a three-month interest period commencing on the second business day after such day plus 1%, or (b) a reserve adjusted LIBOR for dollars (Eurodollar rate) (as defined). The applicable percentage for Alternate Base Rate term loans is 1.25% for Non-Extended Term Loans, 2.5% for Extended Term Loans and 1.5% for Incremental Term Loans, subject to reduction based on the Company s leverage ratio in the case of Incremental Term Loans. The applicable percentage for Eurodollar rate term loans is 2.25% for Non-Extended Term Loans, 3.5% for Extended Term Loans and 2.5% for Incremental Term Loans, subject to reduction based on the Company s leverage ratio in the case of Incremental Term Loans. The applicable percentage for revolving loans under the Replacement Revolver Facility is 1.5% for Alternate Base Rate revolving loans and 2.5% for Eurodollar rate revolving loans, in each case subject to reduction based on the Company s leverage ratio. Loans under the swingline subfacility bear interest at the rate applicable to Alternate Base Rate loans under the revolving credit facility.

The Issuer has agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to Eurodollar rate loans under the revolving credit facility times the maximum aggregate amount available to be drawn under all letters of credit outstanding under the subfacility for letters of credit. The issuer of any letter of credit issued under the subfacility for letters of credit will also receive a customary fronting fee and other customary processing charges. The Issuer is initially obligated to pay commitment fees of 0.50% per annum (subject to reduction based upon the Company s leverage ratio) on the unused portion of the Replacement Revolver Facility. For purposes of this calculation, swingline loans are not treated as usage of the revolving credit facility. The Issuer paid arrangement fees on the closing of the Credit Facility and in connection with the first and second amendment and restatements, the Replacement Revolver Facility and the Incremental Term Loan, and pays an annual administrative agent fee.

The Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting Holdings and its subsidiaries ability, subject to certain exceptions, to, among other things (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay,

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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 the Company s businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change the Company s fiscal year. The Company is also required to comply with specified financial covenants (consisting of a leverage ratio and an interest coverage ratio) and various affirmative covenants.

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

Receivables Facility

On March 21, 2012, through certain of our subsidiaries, we entered into an accounts receivables loan agreement, or the Receivables Facility, with a group of conduit lenders and liquidity banks, Credit Agricolé Corporate and Investment Bank, as a managing agent and as the administrative agent, and The Bank of Nova Scotia, as a managing agent. The existing and future patient-related accounts receivable, or the Receivables, of certain of our hospitals serve as collateral for borrowings under the Receivables Facility. Amounts borrowed accrue interest based on a commercial paper rate plus an applicable interest rate spread. Unless earlier terminated or subsequently extended, the Receivables Facility is scheduled to expire on March 21, 2014, subject to customary termination events that could cause an earlier termination date. We maintain effective control over the Receivables because, pursuant to the terms of the Receivables Facility, the Receivables are sold from certain of our subsidiaries to us, and we then sell or contribute the Receivables to a special-purpose entity that is wholly-owned by us. The wholly-owned special-purpose entity in turn grants security interests in the Receivables in exchange for borrowings obtained from the group of third-party conduit lenders and liquidity banks of up to $300 million outstanding from time to time based on the availability of eligible Receivables and other customary factors. The group of third-party conduit lenders and liquidity banks do not have recourse to us or our subsidiaries beyond the assets of the wholly-owned special-purpose entity that collateralizes the loan. The Receivables and other assets of the wholly-owned special-purpose entity will be available first and foremost to satisfy the claims of the creditors of such entity. The outstanding borrowings pursuant to the Receivables Facility at March 31, 2012 totaled $300.0 million and are classified as long-term debt on the condensed consolidated balance sheet. At March 31, 2012, the carrying amount of Receivables included in the Receivables Facility totaled approximately $881.9 million and are included in patient accounts receivable on our condensed consolidated balance sheet.

The 2015 Notes

The 2015 Notes were issued in connection with the Triad acquisition in an aggregate principal amount of approximately $3.0 billion. Approximately $1.0 billion of 2015 Notes were purchased in November 2011 and approximately $850 million of 2015 Notes were purchased in April 2012 pursuant to tender offers. The 2015 Notes will mature on July 15, 2015. The 2015 Notes bear interest at the rate of 8 $^{7}/_{8}$% per annum, payable semiannually in arrears on each January 15 and July 15. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months. The Issuer is entitled, at its option, to redeem all or a portion of the 2015 Notes upon not less than 30 nor more than 60 days notice, at the redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date

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(subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the 12-month period commencing on July 15 of the years set forth below:

Period	Redemption Price
2011	104.438%
2012	102.219%
2013 and thereafter	100.000%

The 2019 Notes

On November 22, 2011, $1.0 billion aggregate principal amount of 2019 Notes were issued. The net proceeds from this issuance, together with available cash on hand, were used to purchase $1.0 billion aggregate principal amount of 2015 Notes and to pay related fees and expenses. On March 21, 2012, an additional $1.0 billion aggregate principal amount of 2019 Notes were issued. The net proceeds from this issuance were used to purchase approximately $850 million aggregate principal amount of 2015 Notes, to pay related fees and expenses and for general corporate purposes. The 2019 Notes will mature on November 15, 2019. The 2019 Notes bear interest at the rate of 8% per annum, payable semiannually in arrears on each May 15 and November 15. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months. Prior to November 15, 2015, the Issuer may redeem some or all of the 2019 Notes at a price equal to 100% of the principal amount of the notes redeemed plus accrued and unpaid interest, if any, plus a make-whole premium. On or after November 15, 2015, the Issuer is entitled, at its option, to redeem all or a portion of the 2019 Notes upon not less than 30 nor more than 60 days notice, at the redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the 12-month period commencing on November 15 of the years set forth below:

Period	Redemption Price
2015	104.000%
2016	102.000%
2017 and thereafter	100.000%

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DESCRIPTION OF THE NOTES

CHS/Community Health Systems, Inc. will issue $1,200,000,000 aggregate principal amount of 7.125% senior notes due 2020 (the *Notes*) under an Indenture (the *Indenture*) among itself, the Guarantors and Regions Bank, an Alabama banking corporation, as Trustee. The terms of the Notes will include those stated in the Indenture and those made part of the Indenture by reference to the Trust Indenture Act.

Certain terms used in this description are defined under the subheading Certain Definitions. In this description the word *Company*, *we* and *our* refers only to CHS/Community Health Systems, Inc. and not to any of its Subsidiaries.

The following description is only a summary of the material provisions of the Indenture. This summary is not a complete description of all the provisions of the Notes and is subject to, and is qualified in its entirety by reference to, the Indenture. We urge you to read the Indenture because it, not this description, defines your rights as holders of these Notes and you may request copies of it at our address set forth under the heading Where You Can Find Additional Information. You should also read carefully the section entitled Description of the Debt Securities and Guarantees of Debt Securities in the accompanying prospectus for a description of other material terms of the Indenture.

Brief Description of the Notes

These Notes:

- will be unsecured senior obligations of the Company;
- will be senior in right of payment to any future Subordinated Obligations of the Company; and
- will be guaranteed by each Guarantor on an unsecured senior basis.

Principal, Maturity and Interest

The Company will issue the Notes initially with a maximum aggregate principal amount of $1,200,000,000. The Company will issue the Notes in minimum denominations of $2,000 and any greater integral multiple of $1,000. The Notes will mature on July 15, 2020. Subject to our compliance with the covenant described under the subheading Certain Covenants Limitation on Indebtedness, we are permitted to issue more Notes from time to time. The Notes offered by the Company and any additional Notes subsequently issued under the Indenture will be treated as a single class for all purposes under the Indenture, including waivers, amendments, redemptions and offers to purchase. Unless the context otherwise requires, for all purposes of the Indenture and this *Description of the Notes*, references to *Notes* include any additional Notes actually issued.

Interest on the Notes will accrue at the rate of 7.125% per annum and will be payable semiannually in arrears on January 15 and July 15, commencing on January 15, 2013. We will make each interest payment to the Holders of record of the Notes on the immediately preceding January 1 and July 1. We will pay interest on overdue principal at 1% per annum in excess of the above rate and will pay interest on overdue installments of interest at such higher rate to the extent lawful.

Interest on the Notes will accrue from July 18, 2012. Interest will be computed on the basis of a 360-day year comprised of twelve 30-day months.

Optional Redemption

Except as set forth below, we will not be entitled to redeem the Notes at our option prior to July 15, 2016.

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On and after July 15, 2016, we will be entitled at our option to redeem all or a portion of the Notes upon not less than 30 nor more than 60 days notice, at the redemption prices (expressed in percentages of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of Holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the 12-month period commencing on July 15 of the years set forth below:

Period	Redemption Price
2016	103.563%
2017	101.781%
2018 and thereafter	100.000%

In addition, any time prior to July 15, 2015, we will be entitled at our option on one or more occasions to redeem the Notes (which includes additional Notes, if any) in an aggregate principal amount not to exceed 35% of the aggregate principal amount of the Notes (which includes additional Notes, if any) originally issued at a redemption price (expressed as a percentage of principal amount) of 107.125%, plus accrued and unpaid interest, if any, to the redemption date (subject to the right of Holders of record on the relevant record date to receive interest due on the relevant interest payment date), with the Net Cash Proceeds from one or more Public Equity Offerings (provided that if the Public Equity Offering is an offering by Parent, a portion of the Net Cash Proceeds thereof equal to the amount required to redeem any such Notes is contributed to th