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

Form 10-Q

(Mark One)

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

For the quarterly period ended June 30, 2022

or

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

For the transition period from ___________ to ________

Commission file number 001-15925

COMMUNITY HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**13-3893191**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
4000 Meridian Boulevard **Franklin, Tennessee**	**37067**
(Address of principal executive offices)	*(Zip Code)*

615-465-7000

(Registrant's telephone number)

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $.01 par value	CYH	New York Stock Exchange

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☑ No ☐

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

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

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

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

As of July 21, 2022, there were outstanding 134,713,069 shares of the Registrant's Common Stock, $0.01 par value.

Community Health Systems, Inc.
Form 10-Q
For the Three and Six Months Ended June 30, 2022

			Page
Part I.	Financial Information		
	Item 1.	Financial Statements:	
		Condensed Consolidated Statements of (Loss) Income – Three and Six Months Ended June 30, 2022 and June 30, 2021 (Unaudited)	2
		Condensed Consolidated Statements of Comprehensive (Loss) Income – Three and Six Months Ended June 30, 2022 and June 30, 2021 (Unaudited)	3
		Condensed Consolidated Balance Sheets – June 30, 2022 and December 31, 2021 (Unaudited)	4
		Condensed Consolidated Statements of Cash Flows – Six Months Ended June 30, 2022 and June 30, 2021 (Unaudited)	5
		Notes to Condensed Consolidated Financial Statements (Unaudited)	6
	Item 2.	Management's Discussion and Analysis of Financial Condition and Results of Operations	23
	Item 3.	Quantitative and Qualitative Disclosures about Market Risk	42
	Item 4.	Controls and Procedures	42
Part II.	Other Information		
	Item 1.	Legal Proceedings	43
	Item 1A.	Risk Factors	44
	Item 2.	Unregistered Sales of Equity Securities and Use of Proceeds	45
	Item 3.	Defaults Upon Senior Securities	45
	Item 4.	Mine Safety Disclosures	45
	Item 5.	Other Information	45
	Item 6.	Exhibits	46
Signatures			47

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF (LOSS) INCOME
(In millions, except share and per share data)
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2022	**2021**	**2022**	**2021**
Net operating revenues	$ 2,934	$ 3,007	$ 6,044	$ 6,020
Operating costs and expenses:				
Salaries and benefits	1,295	1,266	2,620	2,569
Supplies	487	500	985	992
Other operating expenses	830	715	1,683	1,453
Lease cost and rent	78	78	155	156
Pandemic relief funds	(8)	(1)	(55)	(83)
Depreciation and amortization	133	133	261	272
Impairment and (gain) loss on sale of businesses, net	—	2	6	23
Total operating costs and expenses	2,815	2,693	5,655	5,382
Income from operations	119	314	389	638
Interest expense, net	218	219	435	449
Loss from early extinguishment of debt	—	8	5	79
Equity in earnings of unconsolidated affiliates	(1)	(4)	(6)	(15)
(Loss) income before income taxes	(98)	91	(45)	125
Provision for income taxes	200	54	223	123
Net (loss) income	(298)	37	(268)	2
Less: Net income attributable to noncontrolling interests	28	31	59	60
Net (loss) income attributable to Community Health Systems, Inc. stockholders	$ (326)	$ 6	$ (327)	$ (58)
(Loss) earnings per share attributable to Community Health Systems, Inc. stockholders:				
Basic	$ (2.52)	$ 0.04	$ (2.54)	$ (0.46)
Diluted	$ (2.52)	$ 0.04	$ (2.54)	$ (0.46)
Weighted-average number of shares outstanding:				
Basic	129,095,571	127,069,252	128,460,419	126,414,901
Diluted	129,095,571	130,737,124	128,460,419	126,414,901

See accompanying notes to the condensed consolidated financial statements.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2022	**2021**	**2022**	**2021**
Net (loss) income	$ (298)	$ 37	$ (268)	$ 2
Other comprehensive (loss) income, net of income taxes:				
Net change in fair value of available-for-sale debt securities, net of tax	(6)	1	(14)	(3)
Amortization and recognition of unrecognized pension cost components, net of tax	—	—	—	1
Other comprehensive (loss) income	(6)	1	(14)	(2)
Comprehensive (loss) income	(304)	38	(282)	—
Less: Comprehensive income attributable to noncontrolling interests	28	31	59	60
Comprehensive (loss) income attributable to Community Health Systems, Inc. stockholders	$ (332)	$ 7	$ (341)	$ (60)

See accompanying notes to the condensed consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
(In millions, except share data)
(Unaudited)

	June 30, 2022	December 31, 2021
ASSETS		
Current assets:		
Cash and cash equivalents	$ 346	$ 507
Patient accounts receivable	2,001	2,062
Supplies	356	355
Prepaid income taxes	99	94
Prepaid expenses and taxes	263	192
Other current assets	264	269
Total current assets	3,329	3,479
Property and equipment	9,759	9,757
Less accumulated depreciation and amortization	(4,220)	(4,204)
Property and equipment, net	5,539	5,553
Goodwill	4,224	4,219
Deferred income taxes	53	53
Other assets, net	1,913	1,913
Total assets	$ 15,058	$ 15,217
LIABILITIES AND STOCKHOLDERS' DEFICIT		
Current liabilities:		
Current maturities of long-term debt	$ 32	$ 31
Current operating lease liabilities	153	147
Accounts payable	832	830
Accrued liabilities:		
Employee compensation	624	655
Accrued interest	221	225
Other	433	476
Total current liabilities	2,295	2,364
Long-term debt	12,183	12,109
Deferred income taxes	410	192
Long-term operating lease liabilities	569	535
Other long-term liabilities	759	827
Total liabilities	16,216	16,027
Redeemable noncontrolling interests in equity of consolidated subsidiaries	498	480
STOCKHOLDERS' DEFICIT		
Community Health Systems, Inc. stockholders' deficit:		
Preferred stock, $.01 par value per share, 100,000,000 shares authorized; none issued	—	—
Common stock, $.01 par value per share, 300,000,000 shares authorized; 134,683,113 shares issued and outstanding at June 30, 2022, and 132,146,282 shares issued and outstanding at December 31, 2021	1	1
Additional paid-in capital	2,090	2,118
Accumulated other comprehensive loss	(27)	(14)
Accumulated deficit	(3,804)	(3,477)
Total Community Health Systems, Inc. stockholders' deficit	(1,740)	(1,372)
Noncontrolling interests in equity of consolidated subsidiaries	84	82
Total stockholders' deficit	(1,656)	(1,290)
Total liabilities and stockholders' deficit	$ 15,058	$ 15,217

See accompanying notes to the condensed consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(In millions)
(Unaudited)

	Six Months Ended June 30,	
	2022	**2021**
Cash flows from operating activities:		
Net (loss) income	$ (268)	$ 2
Adjustments to reconcile net (loss) income to net cash provided by operating activities:		
Depreciation and amortization	261	272
Deferred income taxes	221	118
Stock-based compensation expense	8	13
Impairment and (gain) loss on sale of businesses, net	6	23
Loss from early extinguishment of debt	5	79
Other non-cash expenses, net	95	(3)
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:		
Patient accounts receivable	61	(32)
Supplies, prepaid expenses and other current assets	(72)	31
Repayment/derecognition of Medicare accelerated payments	—	(134)
Accounts payable, accrued liabilities and income taxes	(63)	(2)
Other	(100)	(87)
Net cash provided by operating activities	154	280
Cash flows from investing activities:		
Acquisitions of facilities and other related businesses	(4)	(4)
Purchases of property and equipment	(191)	(212)
Proceeds from disposition of hospitals and other ancillary operations	3	7
Proceeds from sale of property and equipment	7	3
Purchases of available-for-sale debt securities and equity securities	(55)	(63)
Proceeds from sales of available-for-sale debt securities and equity securities	41	48
Purchases of investments in unconsolidated affiliates	(8)	(2)
Increase in other investments	(30)	(32)
Net cash used in investing activities	(237)	(255)
Cash flows from financing activities:		
Repurchase of restricted stock shares for payroll tax withholding requirements	(8)	(5)
Deferred financing costs and other debt-related costs	(73)	(310)
Proceeds from noncontrolling investors in joint ventures	1	—
Redemption of noncontrolling investments in joint ventures	(1)	(3)
Distributions to noncontrolling investors in joint ventures	(73)	(66)
Other borrowings	34	19
Issuance of long-term debt	1,535	4,310
Repayments of long-term indebtedness	(1,493)	(4,396)
Net cash used in financing activities	(78)	(451)
Net change in cash and cash equivalents	(161)	(426)
Cash and cash equivalents at beginning of period	507	1,676
Cash and cash equivalents at end of period	$ 346	$ 1,250
Supplemental disclosure of cash flow information:		
Interest payments	$ (410)	$ (304)
Income tax payments, net	$ (6)	$ (1)

See accompanying notes to the condensed consolidated financial statements.

1. BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES

The unaudited condensed consolidated financial statements of Community Health Systems, Inc. (the "Parent" or "Parent Company") and its subsidiaries (the "Company") as of June 30, 2022 and December 31, 2021 and for the three-month and six-month periods ended June 30, 2022 and 2021, have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP"). In the opinion of management, such information contains all adjustments, consisting only of normal recurring adjustments, necessary for a fair presentation of the results for such periods. All intercompany transactions and balances have been eliminated. The results of operations for the three and six months ended June 30, 2022, are not necessarily indicative of the results to be expected for the full fiscal year ending December 31, 2022. The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements. Actual results could differ from these estimates under different assumptions or conditions.

Certain information and disclosures normally included in the notes to the consolidated financial statements have been condensed or omitted as permitted by the rules and regulations of the Securities and Exchange Commission (the "SEC"). The Company believes the disclosures are adequate to make the information presented not misleading. The accompanying unaudited condensed consolidated financial statements should be read in conjunction with the consolidated financial statements and notes thereto for the year ended December 31, 2021, contained in the Company's Annual Report on Form 10-K filed with the SEC on February 17, 2022 ("2021 Form 10-K").

Reclassifications. Certain prior period amounts have been reclassified to conform to the current period presentation within the condensed consolidated statements of cash flows.

Noncontrolling interests in less-than-wholly-owned consolidated subsidiaries of the Parent are presented as a component of total equity on the condensed consolidated balance sheets to distinguish between the interests of the Parent Company and the interests of the noncontrolling owners. Noncontrolling interests that are redeemable or may become redeemable at a fixed or determinable price at the option of the holder or upon the occurrence of an event outside of the control of the Company are presented in mezzanine equity on the condensed consolidated balance sheets.

Substantially all of the Company's operating costs and expenses are "cost of revenue" items. Operating costs that could be classified as general and administrative by the Company include the Company's corporate office costs at its Franklin, Tennessee office, which were $57 million and $52 million for the three months ended June 30, 2022 and 2021, respectively, and $120 million and $112 million for the six months ended June 30, 2022 and 2021, respectively.

Throughout these notes to the unaudited condensed consolidated financial statements, Community Health Systems, Inc., and its consolidated subsidiaries are referred to on a collective basis as the "Company." This drafting style is not meant to indicate that the publicly traded Parent or any particular subsidiary of the Parent owns or operates any asset, business, or property. The hospitals, operations and businesses described in this filing are owned and operated by distinct and indirect subsidiaries of Community Health Systems, Inc.

Revenue Recognition.

Net Operating Revenues

Net operating revenues are recorded at the transaction price estimated by the Company to reflect the total consideration due from patients and third-party payors in exchange for providing goods and services in patient care. These services are considered to be a single performance obligation and have a duration of less than one year. Revenues are recorded as these goods and services are provided. The transaction price, which involves significant estimates, is determined based on the Company's standard charges for the goods and services provided, with a reduction recorded for price concessions related to third party contractual arrangements as well as patient discounts and other patient price concessions. During each of the three and six-month periods ended June 30, 2022 and 2021, the impact of changes to the inputs used to determine the transaction price was considered immaterial.

Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers that is not specifically tied to an individual's care, some of which offsets a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from the Centers for Medicare & Medicaid Services ("CMS") and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Under these supplemental programs, the Company recognizes revenue and related expenses in the period in which amounts are estimable and payment is reasonably assured. Reimbursement under these programs is reflected in net operating revenues. Taxes or other program-related costs are reflected in other operating expenses.

The Company's net operating revenues during the three and six months ended June 30, 2022 and 2021 have been presented in the following table based on an allocation of the estimated transaction price with the patient between the primary patient classification of insurance coverage (in millions):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2022	2021	2022	2021
Medicare	$ 616	$ 642	$ 1,285	$ 1,335
Medicaid	445	420	912	811
Managed Care and other third-party payors	1,862	1,919	3,794	3,835
Self-pay	11	26	53	39
Total	$ 2,934	$ 3,007	$ 6,044	$ 6,020

Patient Accounts Receivable

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

Patient accounts receivable can be impacted by the effectiveness of the Company's collection efforts. Additionally, significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect the net realizable value of accounts receivable. The Company also continually reviews the net realizable value of accounts receivable by monitoring historical cash collections as a percentage of trailing net operating revenues, as well as by analyzing current period net revenue and admissions by payor classification, days revenue outstanding, the composition of self-pay receivables between pure self-pay patients and the patient responsibility portion of third-party insured receivables, the impact of recent acquisitions and dispositions and the impact of current economic and other events.

Final settlements for some payors and programs are subject to adjustment based on administrative review and audit by third parties. As a result of these final settlements, the Company has recorded amounts due to third-party payors of $107 million and $118 million as of June 30, 2022 and December 31, 2021, respectively, and these amounts are included in accrued liabilities-other in the accompanying condensed consolidated balance sheets. Amounts due from third-party payors were $100 million and $114 million as of June 30, 2022 and December 31, 2021, respectively, and are included in other current assets in the accompanying condensed consolidated balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 2017.

Charity Care

In the ordinary course of business, the Company renders services to patients who are financially unable to pay for hospital care. The Company's policy is to not pursue collections for such amounts; therefore, the related charges for those patients who are financially unable to pay and that otherwise do not qualify for reimbursement from a governmental program are not reported in net operating revenues, and are thus classified as charity care. The Company determines amounts that qualify for charity care based on the patient's household income relative to the federal poverty level guidelines, as established by the federal government. The Company updated its policy during the three months ended March 31, 2022 in a manner which increased the number of accounts qualifying for charity care. This resulted in an increase in charity care services during the three and six months ended June 30, 2022 compared to the three and six months ended June 30, 2021.

These charity care services are estimated to be $409 million and $215 million for the three months ended June 30, 2022 and 2021, respectively, and $772 million and $444 million for the six months ended June 30, 2022 and 2021, respectively, representing the value (at the Company's standard charges) of these charity care services that are excluded from net operating revenues. The estimated cost incurred by the Company to provide these charity care services to patients who are unable to pay was approximately $47 million and $26 million during the three months ended June 30, 2022 and 2021, respectively, and $88 million and $52 million during the six months ended June 30, 2022 and 2021, respectively. The estimated cost of these charity care services was determined using a ratio of cost to gross charges and applying that ratio to the gross charges associated with providing care to charity patients for the period.

Accounting for the Impairment or Disposal of Long-Lived Assets. During the six months ended June 30, 2022, the Company recorded an impairment charge of approximately $6 million to adjust the carrying value of long-lived assets at a hospital that was subsequently sold at a sales price below carrying value.

During the six months ended June 30, 2021, the Company recorded a total combined net loss on disposal of approximately $23 million, of which (i) approximately $28 million was recorded to adjust the carrying value of long-lived assets at several hospitals that were sold at a sales price below carrying value, (ii) approximately $3 million was recorded related to divestiture related expenses, (iii) approximately $8 million of gain was recorded related to the disposal of the Company's majority interest in a surgery center that was sold on January 1, 2021, and (iv) approximately $7 million of goodwill was allocated to facilities disposed of during the six months ended June 30, 2021.

The Company will continue to evaluate the potential for impairment of the long-lived assets of hospitals and other held-and-used businesses as well as evaluate offers for potential sales, as applicable. Based on such analysis, additional impairment charges may be recorded in the future.

Pandemic Relief Funds

During the six months ended June 30, 2022 and 2021, the Company received approximately $52 million and $7 million, respectively, in pandemic relief fund payments through various federal, state and local programs. Approximately $8 million and $1 million during the three months ended June 30, 2022 and 2021, respectively, and $55 million and $83 million during the six months ended June 30, 2022 and 2021, respectively, was recognized as a reduction to operating costs and expenses, as denoted by the caption "pandemic relief funds" within the condensed consolidated statements of (loss) income. Approximately $11 million of unrecognized pandemic relief funds received are reflected within accrued liabilities-other in the condensed consolidated balance sheet as of June 30, 2022. Such unrecognized amounts may either be returned or may be recognized in future periods if the underlying conditions for recognition are reasonably assured of having been met. The Company's accounting policies for the recognition of pandemic relief funds is unchanged from the policies described in Note 1 to the Company's consolidated financial statements included in the 2021 Form 10-K.

2. ACCOUNTING FOR STOCK-BASED COMPENSATION

Stock-based compensation awards have been granted under the Community Health Systems, Inc. Amended and Restated 2009 Stock Option and Award Plan, which was amended and restated as of March 17, 2021 and approved by the Company's stockholders at the annual meeting of stockholders held on May 11, 2021 (the "2009 Plan").

The 2009 Plan provides for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code ("IRC") and for the grant of stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Persons eligible to receive grants under the 2009 Plan include the Company's directors, officers, employees and consultants. As of June 30, 2022, 6,906,176 shares of unissued common stock were reserved for future grants under the 2009 Plan.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2022	2021	2022	2021
Effect on (loss) income before income taxes	$ (3)	$ (5)	$ (8)	$ (13)
Effect on net (loss) income	$ (2)	$ (4)	$ (7)	$ (10)

At June 30, 2022, $45 million of unrecognized stock-based compensation expense related to outstanding unvested stock options, restricted stock and restricted stock units (the terms of which are summarized below) was expected to be recognized over a weighted-average period of 27 months. Of that amount, $7 million relates to outstanding unvested stock options expected to be recognized over a weighted-average period of 26 months and $38 million relates to outstanding unvested restricted stock and restricted stock units expected to be recognized over a weighted-average period of 27 months. There were no modifications to awards during the six months ended June 30, 2022 and 2021.

To date, all options granted under the 2009 Plan have been "nonqualified" stock options for tax purposes. Generally, these options vest in one-third increments on each of the first three anniversaries of the award date and have a 10-year contractual term. The exercise price of all options granted under the 2009 Plan is equal to the fair value of the Company's common stock on the option grant date.

The fair value of stock options was estimated using the Black Scholes option pricing model with the following assumptions and weighted-average fair values during the three and six months ended June 30, 2022 and 2021:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2022	2021	2022	2021
Expected volatility	N/A	N/A	84.3% - 87.5%	84.3% - 88.9%
Expected dividends	N/A	N/A	—	—
Expected term	N/A	N/A	3 - 6 years	3 - 6 years
Risk-free interest rate	N/A	N/A	1.5% - 1.6%	0.3% - 0.9%

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

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

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

Options outstanding and exercisable under the 2009 Plan as of June 30, 2022, and changes during each of the three-month periods following December 31, 2021, was as follows (in millions, except share and per share data):

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term	Aggregate Intrinsic Value as of June 30, 2022
Outstanding at December 31, 2021	2,301,753	$ 6.77		
Granted	760,000	10.18		
Exercised	(56,500)	4.97		
Forfeited and cancelled	(151,002)	14.67		
Outstanding at March 31, 2022	2,854,251	7.30		
Granted	—	—		
Exercised	—	—		
Forfeited and cancelled	—	—		
Outstanding at June 30, 2022	2,854,251	$ 7.30	8.3 years	$ —
Exercisable at June 30, 2022	1,320,912	$ 5.63	7.5 years	$ —

The weighted-average grant date fair value of stock options granted during the six months ended June 30, 2022 and 2021 was $7.25 and $6.22, respectively. The aggregate intrinsic value (calculated as the number of in-the-money stock options multiplied by the difference between the Company's closing stock price on the last trading day of the reporting period ($3.75) and the exercise price of the respective stock options) in the table above represents the amount that would have been received by the option holders had all option holders exercised their options on June 30, 2022. This amount changes based on the market value of the Company's common stock. The aggregate intrinsic value of options exercised was less than $1 million during both of the six-month periods ended June 30, 2022 and 2021. No options were exercised during the three-month periods ended June 30, 2022 and 2021. The aggregate intrinsic value of options vested and expected to vest approximates that of the outstanding options.

The Company has also awarded restricted stock under the 2009 Plan to employees of certain subsidiaries. With respect to time-based vesting restricted stock that has been awarded under the 2009 Plan, the restrictions on these shares have generally lapsed in one-third increments on each of the first three anniversaries of the award date. In addition, certain of the restricted stock awards granted to the Company's senior executives have contained performance objectives required to be met in addition to any time-based vesting requirements. If the applicable performance objectives are not attained, these awards will be forfeited in their entirety. For performance-based awards, the performance objectives are measured cumulatively over a three-year period. If the applicable target performance objective is met at the end of the three-year period, then the restricted stock award subject to such performance objective will vest in full on the third anniversary of the award date. Additionally, for these performance-based awards, based on the level of achievement for the applicable performance objective within the parameters specified in the award agreement, the number of shares to be issued in connection with the vesting of the award may be adjusted to decrease or increase the number of shares specified in the original award. Notwithstanding the above-mentioned performance objectives and vesting requirements, the restrictions with respect to restricted stock granted under the 2009 Plan may lapse earlier in the event of death or disability of the holder of the restricted stock, or change in control of the Company. On March 1, 2022, restricted stock awards subject to performance objectives granted on March 1, 2019 vested at 200% of the shares originally granted based on the Company's cumulative performance compared to objectives for the 2019 through 2021 performance period. Restricted stock awards subject to performance objectives that have not yet been satisfied are not considered outstanding for purposes of determining earnings per share unless the performance objectives have been satisfied on the basis of results through the end of each respective reporting period.

Restricted stock outstanding under the 2009 Plan as of June 30, 2022, and changes during each of the three-month periods following December 31, 2021, was as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested at December 31, 2021	4,995,314	$ 6.30
Granted	3,179,000	9.05
Vested	(2,516,247)	5.62
Forfeited	(30,000)	6.87
Unvested at March 31, 2022	5,628,067	8.61
Granted	41,000	5.00
Vested	(17,000)	10.65
Forfeited	(72,670)	9.77
Unvested at June 30, 2022	5,579,397	8.56

Restricted stock units ("RSUs") have been granted to the Company's non-management directors under the 2009 Plan. Each of the Company's then serving non-management directors received grants under the 2009 Plan of 17,682 RSUs and 19,296 RSUs on March 1, 2022 and 2021, respectively. The March 2022 and 2021 grants had a grant date fair value of approximately $180,000 and $170,000, respectively. On June 1, 2022, a new non-management director received a grant of 17,682 RSUs with a grant date fair value of approximately $88,000. Vesting of these RSUs occurs in one-third increments on each of the first three anniversaries of the award date or upon the director's earlier cessation of service on the board, other than for cause. Each non-management director may elect, prior to the beginning of the calendar year in which the award is granted, to defer the receipt of shares of the Company's common stock issuable upon vesting until either his or her (i) separation from service with the Company or (ii) attainment of an age specified in advance by the non-management director. A total of three directors elected to defer the receipt of RSUs granted on March 1, 2022 to a future date and a total of four directors elected to defer the receipt of RSUs granted on March 1, 2021 to a future date.

RSUs outstanding under the 2009 Plan as of June 30, 2022, and changes during each of the three-month periods following December 31, 2021, was as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested at December 31, 2021	486,598	$ 6.17
Granted	159,138	10.18
Vested	(151,058)	5.63
Forfeited	—	—
Unvested at March 31, 2022	494,678	7.63
Granted	17,682	5.00
Vested	—	—
Forfeited	—	—
Unvested at June 30, 2022	512,360	7.54

3. ACQUISITIONS AND DIVESTITURES

Acquisitions

The Company accounts for all transactions that represent business combinations using the acquisition method of accounting, where the identifiable assets acquired, the liabilities assumed and any noncontrolling interest in the acquired entity are recognized and measured at their fair values on the date the Company obtains control of the acquiree. Such fair values that are not finalized for reporting periods following the acquisition date are estimated and recorded as provisional amounts. Adjustments to these provisional amounts during the measurement period (defined as the date through which all information required to identify and measure the consideration transferred, the assets acquired, the liabilities assumed and any noncontrolling interests has been obtained, limited to one year from the acquisition date) are recorded when identified. Goodwill is determined as the excess of the fair value of the consideration conveyed in the acquisition over the fair value of the net assets acquired.

During the six months ended June 30, 2022, one or more subsidiaries of the Company paid approximately $4 million to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by the Company's affiliated hospitals. The Company allocated the purchase price to property and equipment, working capital, noncontrolling interests and goodwill.

Divestitures

No hospitals were divested during the six months ended June 30, 2022. The following table provides a summary of hospitals that the Company divested during the year ended December 31, 2021:

Hospital	Buyer	City, State	Licensed Beds	Effective Date
Lea Regional Medical Center	Covenant Health System	Hobbs, NM	84	January 1, 2021
Tennova Healthcare - Tullahoma	Vanderbilt University Medical Center	Tullahoma, TN	135	January 1, 2021
Tennova Healthcare - Shelbyville	Vanderbilt University Medical Center	Shelbyville, TN	60	January 1, 2021
Northwest Mississippi Medical Center	Delta Health System	Clarksdale, MS	181	February 1, 2021
AllianceHealth Midwest	SSM Health Care of Oklahoma	Midwest City, OK	255	April 1, 2021

On March 7, 2022, one or more affiliates of the Company entered into a definitive agreement for the sale of substantially all of the assets of AllianceHealth Seminole (32 licensed beds) in Seminole, Oklahoma, to affiliates of SSM Health Care of Oklahoma. This disposition was completed on July 1, 2022 as further described in Note 13.

No divestitures or potential divestitures meet the criteria for reporting as a discontinued operation as of June 30, 2022.

4. GOODWILL

The changes in the carrying amount of goodwill for the six months ended June 30, 2022 are as follows (in millions):

Balance, as of December 31, 2021		
Goodwill	$	7,033
Accumulated impairment losses		(2,814)
		4,219
Goodwill acquired as part of acquisitions during current year		5
Goodwill allocated to hospitals held for sale		—
Balance, as of June 30, 2022		
Goodwill		7,038
Accumulated impairment losses		(2,814)
	$	4,224

Goodwill is allocated to each identified reporting unit, which is defined as an operating segment or one level below the operating segment (referred to as a component of the entity). Management has determined that the Company's operating segment meets the criteria to be classified as a reporting unit.

Goodwill is evaluated for impairment annually and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. The Company performed its last annual goodwill impairment evaluation during the fourth quarter of 2021 using an October 31, 2021 measurement date, which indicated no impairment.

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

The determination of fair value in the Company's goodwill impairment analysis is based on an estimate of fair value for the reporting unit utilizing known and estimated inputs at the evaluation date. Some of those inputs include, but are not limited to, the most recent price of the Company's common stock and fair value of long-term debt, recent financial results of the Company, estimates of future revenue and expense growth, estimated market multiples, expected capital expenditures, income tax rates, and costs of invested capital.

A detailed evaluation of potential impairment indicators was performed as of June 30, 2022, which specifically considered declines in the fair market value of the Company's outstanding senior secured and unsecured notes and common stock during the six months ended June 30, 2022, as well as macroeconomic conditions and the Company's recent financial results, including the effect of increased wage and contract labor expense. On the basis of available evidence, as of June 30, 2022, the Company concluded that the fair value of the reporting unit was not more likely than not reduced to an amount less than its carrying value.

Future estimates of fair value could be adversely affected if the actual outcome of one or more of the assumptions described above changes materially in the future, including a decline in the Company's stock price and the fair value of its long-term debt, an increase in the volatility of the Company's stock price and the fair value of its long-term debt, lower than expected volumes and/or net operating revenues, higher market interest rates or increased operating costs. Such changes impacting the calculation of fair value could result in a material impairment charge in the future.

5. INCOME TAXES

The total amount of unrecognized benefit that would affect the effective tax rate, if recognized, was less than $1 million as of June 30, 2022. A total of less than $1 million of interest and penalties is included in the amount of the liability for uncertain tax positions at June 30, 2022. It is the Company's policy to recognize interest and penalties related to unrecognized benefits in its condensed consolidated statements of (loss) income as income tax expense.

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

The Company's federal income tax return for the 2018 tax year remains under examination by the Internal Revenue Service. The Company believes the result of this examination will not be material to its consolidated results of operations or consolidated financial position. The Company has extended the federal statute of limitations through December 31, 2023 for the tax period ended December 31, 2018.

The Company's provision for income taxes was $200 million and $54 million for the three months ended June 30, 2022 and 2021, respectively, and $223 million and $123 million for the six months ended June 30, 2022 and 2021, respectively. The Company's effective tax rates were (204.1)% and 59.3% for the three months ended June 30, 2022 and 2021, respectively, and (495.6)% and 98.4% for the six months ended June 30, 2022 and 2021, respectively. The increase in the provision for income taxes for the three and six months ended June 30, 2022 compared to the three and six months ended June 30, 2021 was primarily due to an increase in non-deductible interest as a result of a decline in projected adjusted taxable income for 2022 compared to 2021, compounded by an adverse change in the IRC Section 163(j) limit for deductible interest expense beginning in 2022. The difference in the Company's effective tax rate for the three and six months ended June 30, 2022 compared to the three and six months June 30, 2021 is due to an increase in the provision for income taxes and the Company reporting loss before income taxes in the current year periods compared to income before income taxes in the prior year periods.

Cash paid for income taxes, net of refunds received, resulted in a net payment of approximately $4 million and $1 million during the three months ended June 30, 2022 and 2021, respectively, and $6 million and $1 million during the six months ended June 30, 2022 and 2021, respectively.

6. LONG-TERM DEBT

Long-term debt, net of unamortized deferred debt issuance costs, consists of the following (in millions):

	June 30, 2022	December 31, 2021
6⅝% Senior Secured Notes due 2025	$ —	$ 1,462
8% Senior Secured Notes due 2026	2,101	2,101
8% Senior Secured Notes due 2027	700	700
5⅝% Senior Secured Notes due 2027	1,900	1,900
6⅞% Senior Notes due 2028	767	767
6% Senior Secured Notes due 2029	900	900
5¼% Senior Secured Notes due 2030	1,535	—
4¾% Senior Secured Notes due 2031	1,095	1,095
6⅞% Junior-Priority Secured Notes due 2029	1,775	1,775
6⅛% Junior-Priority Secured Notes due 2030	1,440	1,440
ABL Facility	—	—
Finance lease and financing obligations	428	398
Other	48	37
Less: Unamortized deferred debt issuance costs and note premium	(474)	(435)
Total debt	12,215	12,140
Less: Current maturities	(32)	(31)
Total long-term debt	$ 12,183	$ 12,109

On February 4, 2022, CHS/Community Health Systems, Inc. ("CHS") completed a private offering of $1.535 billion aggregate principal amount of 5¼% Senior Secured Notes due May 15, 2030 (the "5¼% Senior Secured Notes due 2030"). The proceeds of the offering were used to redeem the 6⅝% Senior Secured Notes due 2025 on February 4, 2022, and to pay related fees and expenses. The 5¼% Senior Secured Notes due 2030 bear interest at a rate of 5.250% per year payable semi-annually in arrears on May 15 and November 15, commencing on November 15, 2022. The 5¼% Senior Secured Notes due 2030 are unconditionally guaranteed on a senior-priority secured basis by the Company and each of the current and future domestic subsidiaries of CHS that provide guarantees under the revolving asset-based loan facility (the "ABL Facility"), any capital market debt securities of CHS (including CHS' outstanding senior notes) and certain other long-term debt of CHS.

The 5¼% Senior Secured Notes due 2030 and the related guarantees are secured by shared (i) first-priority liens on the collateral that also secures on a first-priority basis CHS' senior-priority secured notes and (ii) second-priority liens on the collateral that secures on a first-priority basis the ABL Facility, in each case subject to permitted liens described in the indenture governing the 5¼% Senior Secured Notes due 2030.

CHS is entitled, at its option, to redeem all or a portion of the 5¼% Senior Secured Notes due 2030 at any time prior to May 15, 2025, upon not less than 10 nor more than 60 days' notice, at a price equal to 100% of the principal amount of the 5¼% Senior Secured Notes due 2030 redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the indenture governing the 5¼% Senior Secured Notes due 2030.

CHS may redeem up to 40% of the aggregate principal amount of the 5¼% Senior Secured Notes due 2030 at any time prior to May 15, 2025 using the net proceeds from certain equity offerings at a redemption price of 105.250% of the principal amount of the 5¼% Senior Secured Notes due 2030 redeemed, plus accrued and unpaid interest, if any. In addition, any time prior to May 15, 2025, but not more than once during each twelve-month period, CHS may redeem up to 10% of the original aggregate principal amount of the 5¼% Senior Secured Notes due 2030 at a redemption price equal to 103% of the principal amount of the 5¼% Senior Secured Notes due 2030 to be redeemed, plus accrued and unpaid interest, if any.

At any time and from time to time on or after May 15, 2025, CHS may redeem the 5¼% Senior Secured Notes due 2030 in whole or in part, upon not less than 10 nor more than 60 days' prior written notice at a redemption price equal to the percentage of principal amount set forth below plus accrued and unpaid interest, if any, on the 5¼% Senior Secured Notes due 2030 redeemed, to, but excluding, the applicable date of redemption, if redeemed during the twelve-month period beginning on May 15 of the years indicated below:

Period	Redemption Price
May 15, 2025 to May 14, 2026	102.625%
May 15, 2026 to May 14, 2027	101.313%
May 15, 2027 to May 14, 2030	100.000%

The maximum aggregate principal amount under the ABL Facility is $1.0 billion. At June 30, 2022, the available borrowing base under the ABL Facility was $978 million, of which $84 million was reserved for outstanding letters of credit and $894 million represented excess availability. Letters of credit were reduced during the six months ended June 30, 2022 by $19 million due to a reduction in an insurance-related letter of credit. The Company had no outstanding borrowings as of June 30, 2022. The issued letters of credit are primarily in support of potential insurance-related claims and certain bonds.

The ABL Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting the Company's ability, subject to certain exceptions, to, among other things (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) engage in mergers, acquisitions and asset sales, (7) conduct transactions with affiliates, (8) alter the nature of the Company's, CHS' or the guarantors' businesses, (9) grant certain guarantees with respect to physician practices, (10) engage in sale and leaseback transactions or (11) change the Company's fiscal year. The Company is also required to comply with a consolidated fixed charge coverage ratio, upon certain triggering events described below, and various affirmative covenants. The consolidated fixed charge coverage ratio is calculated as the ratio of (x) consolidated EBITDA (as defined in the ABL Facility) less capital expenditures to (y) the sum of consolidated interest expense (as defined in the ABL Facility), scheduled principal payments, income taxes and restricted payments made in cash or in permitted investments. For purposes of calculating the consolidated fixed charge coverage ratio, the calculation of consolidated EBITDA as defined in the ABL Facility is a trailing 12-month calculation that begins with the Company's consolidated net income, with certain adjustments for interest, taxes, depreciation and amortization, net income attributable to noncontrolling interests, stock compensation expense, restructuring costs, and the financial impact of other non-cash or non-recurring items recorded during any such 12-month period. The consolidated fixed charge coverage ratio is a required covenant only in periods where the total borrowings outstanding under the ABL Facility reduce the amount available in the facility to less than the greater of (i) $95 million or (ii) 10% of the calculated borrowing base. As a result, in the event the Company has less than $95 million available under the ABL Facility, the Company would need to comply with the consolidated fixed charge coverage ratio. At June 30, 2022, the Company is not subject to the consolidated fixed charge coverage ratio as such triggering event had not occurred during the twelve months ended June 30, 2022.

The Company paid interest of $168 million and $101 million on borrowings during the three months ended June 30, 2022 and 2021, respectively, and $410 million and $304 million on borrowings during the six months ended June 30, 2022 and 2021, respectively.

7. FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Company using available market information as of June 30, 2022 and December 31, 2021, and valuation methodologies considered appropriate. The estimates presented in the table below are not necessarily indicative of amounts the Company could realize in a current market exchange (in millions):

	June 30, 2022		December 31, 2021	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Assets:				
Cash and cash equivalents	$ 346	$ 346	$ 507	$ 507
Investments in equity securities	115	115	144	144
Available-for-sale debt securities	177	177	178	178
Trading securities	12	12	13	13
Liabilities:				
6⅝% Senior Secured Notes due 2025	—	—	1,434	1,517
8% Senior Secured Notes due 2026	2,080	1,915	2,078	2,210
8% Senior Secured Notes due 2027	693	637	692	758
5⅝% Senior Secured Notes due 2027	1,826	1,613	1,819	2,011
6⅞% Senior Notes due 2028	759	455	759	758
6% Senior Secured Notes due 2029	862	744	860	966
5¼% Senior Secured Notes due 2030	1,443	1,178	—	—
4¾% Senior Secured Notes due 2031	1,090	806	1,090	1,108
6⅞% Junior-Priority Secured Notes due 2029	1,633	1,158	1,625	1,823
6⅛% Junior-Priority Secured Notes due 2030	1,356	903	1,352	1,431
ABL Facility and other debt	43	43	32	32

The carrying value of the Company's long-term debt in the above table is presented net of unamortized deferred debt issuance costs. The estimated fair value is determined using the methodologies discussed below in accordance with accounting standards related to the determination of fair value based on the GAAP fair value hierarchy as discussed in Note 8. The estimated fair value for financial instruments with a fair value that does not equal its carrying value is considered a Level 1 valuation. The Company utilizes the market approach and obtains indicative pricing through publicly available subscription services such as Bloomberg to determine fair values where relevant.

Cash and cash equivalents. The carrying amount approximates fair value due to the short-term maturity of these instruments (less than three months).

Investments in equity securities. Estimated fair value is based on closing price as quoted in public markets.

Available-for-sale debt securities. Estimated fair value is based on closing price as quoted in public markets or other various valuation techniques.

Trading securities. Estimated fair value is based on closing price as quoted in public markets.

Senior Notes, Senior Secured Notes and Junior-Priority Secured Notes. Estimated fair value is based on the closing market price for these notes.

ABL Facility and other debt. The carrying amount of the ABL Facility and all other debt approximates fair value due to the nature of these obligations.

8. FAIR VALUE

Fair Value Hierarchy

Fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, the Company utilizes the GAAP fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

The inputs used to measure fair value are classified into the following fair value hierarchy:

Level 1: Quoted market prices in active markets for identical assets or liabilities.

Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.

Level 3: Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability. Transfers between levels within the fair value hierarchy are recognized by the Company on the date of the change in circumstances that requires such transfer. There were no transfers between levels during the six-month periods ended June 30, 2022 or 2021.

The following table sets forth, by level within the fair value hierarchy, the financial assets and liabilities recorded at fair value on a recurring basis as of June 30, 2022 and December 31, 2021 (in millions):

	June 30, 2022	Level 1	Level 2	Level 3
Investments in equity securities	$ 115	$ 115	$ —	$ —
Available-for-sale debt securities	177	—	177	—
Trading securities	12	—	12	—
Total assets	$ 304	$ 115	$ 189	$ —

	December 31, 2021	Level 1	Level 2	Level 3
Investments in equity securities	$ 144	$ 144	$ —	$ —
Available-for-sale debt securities	178	—	178	—
Trading securities	13	—	13	—
Total assets	$ 335	$ 144	$ 191	$ —

Investments in Equity Securities, Available-for-Sale Debt Securities and Trading Securities

Investments in equity securities classified as Level 1 are measured using quoted market prices. Level 2 available-for-sale debt securities and trading securities primarily consisted of bonds and notes issued by the United States government and its agencies and domestic and foreign corporations. The estimated fair values of these securities are determined using various valuation techniques, including a multi-dimensional relational model that incorporates standard observable inputs and assumptions such as benchmark yields, reported trades, broker/dealer quotes, issuer spreads, benchmark securities, bids/offers and other pertinent reference data.

9. LEASES

The Company utilizes operating and finance leases for the use of certain hospitals, medical office buildings, and medical equipment. The components of lease cost and rent expense for the three and six months ended June 30, 2022 and 2021 are as follows (in millions):

	Three Months Ended June 30,		Six Months Ended June 30,	
Lease Cost	**2022**	**2021**	**2022**	**2021**
Operating lease cost:				
Operating lease cost	$ 53	$ 50	$ 104	$ 99
Short-term rent expense	21	23	44	47
Variable lease cost	5	6	9	12
Sublease income	(1)	(1)	(2)	(2)
Total operating lease cost	$ 78	$ 78	$ 155	$ 156
Finance lease cost:				
Amortization of right-of-use assets	$ 4	$ 1	$ 7	$ 4
Interest on finance lease liabilities	4	2	8	3
Total finance lease cost	$ 8	$ 3	$ 15	$ 7

Supplemental balance sheet information related to leases is as follows (in millions):

	Balance Sheet Classification	June 30, 2022	December 31, 2021
Operating Leases:			
Operating lease right-of-use assets	Other assets, net	$ 709	$ 668
Finance Leases:			
Finance lease right-of-use assets	*Property and equipment*		
	Land and improvements	$ 8	$ 8
	Buildings and improvements	326	289
	Equipment and fixtures	12	17
	Property and equipment	346	314
	Less accumulated depreciation and amortization	(60)	(54)
	Property and equipment, net	$ 286	$ 260
Current finance lease liabilities	Current maturities of long-term debt	$ 3	$ 8
Long-term finance lease liabilities	Long-term debt	268	233

Supplemental cash flow information related to leases for the six months ended June 30, 2022 and 2021 is as follows (in millions):

	Six Months Ended June 30,	
Cash flow information	**2022**	**2021**
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases (1)	$ 101	$ 102
Operating cash flows from finance leases	8	3
Financing cash flows from finance leases	8	3
Right-of-use assets obtained in exchange for new finance lease liabilities	42	15
Right-of-use assets obtained in exchange for new operating lease liabilities	92	36

(1) Included in the change in other operating assets and liabilities in the condensed consolidated statements of cash flows.

10. STOCKHOLDERS' DEFICIT

Authorized capital shares of the Company include 400,000,000 shares of capital stock consisting of 300,000,000 shares of common stock and 100,000,000 shares of preferred stock. Each of the aforementioned classes of capital stock has a par value of $0.01 per share. Shares of preferred stock, none of which were outstanding as of June 30, 2022, may be issued in one or more series having such rights, preferences and other provisions as determined by the Board of Directors without approval by the holders of common stock.

The Company is a holding company which operates through its subsidiaries. The ABL Facility and the indentures governing each series of the Company's outstanding notes contain various covenants under which the assets of the subsidiaries of the Company are subject to certain restrictions relating to, among other matters, dividends and distributions, as referenced in the paragraph below.

The ABL Facility and the indentures governing each series of the Company's outstanding notes restrict the Company's subsidiaries from, among other matters, paying dividends and making distributions to the Company, which thereby limits the Company's ability to pay dividends and/or repurchase stock. As of June 30, 2022, under the most restrictive test in these agreements (and subject to certain exceptions), the Company has approximately $300 million of capacity to pay permitted dividends and/or repurchase shares of stock or make other restricted payments.

The following schedule presents the reconciliation of the carrying amount of total equity, equity attributable to the Company's stockholders, and equity attributable to noncontrolling interests as of June 30, 2022, and during each of the three-month periods following December 31, 2021 (in millions):

		Community Health Systems, Inc. Stockholders					
	Redeemable Noncontrolling Interest	Common Stock	Additional Paid-In Capital	Accumulated Other Comprehensive Loss (Income) (1)	Accumulated Deficit	Noncontrolling Interest	Total Stockholders' Deficit (1)
Balance, December 31, 2021	$ 480	$ 1	$ 2,118	$ (14)	$ (3,477)	$ 82	$ (1,290)
Comprehensive income (loss)	16	—	—	(8)	(1)	15	6
Distributions to noncontrolling interests	(12)	—	—	—	—	(17)	(17)
Purchases of subsidiary shares from noncontrolling interests	1	—	(1)	—	—	—	(1)
Contributions from noncontrolling interests	1	—	—	—	—	—	—
Adjustment to redemption value of redeemable noncontrolling interests	7	—	(7)	—	—	—	(7)
Cancellation of restricted stock for tax withholdings on vested shares	—	—	(8)	—	—	—	(8)
Share-based compensation	—	—	5	—	—	—	5
Balance, March 31, 2022	493	1	2,107	(22)	(3,478)	80	(1,312)
Comprehensive income (loss)	21	—	—	(6)	(326)	7	(324)
Distributions to noncontrolling interests	(39)	—	—	—	—	(5)	(5)
Noncontrolling interest in acquired entity	3	—	—	—	—	2	2
Adjustment to redemption value of redeemable noncontrolling interests	20	—	(20)	—	—	—	(20)
Share-based compensation	—	—	3	—	—	—	3
Balance, June 30, 2022	$ 498	$ 1	$ 2,090	$ (27)	$ (3,804)	$ 84	$ (1,656)

(1) Totals may not add due to rounding.

The following schedule presents the reconciliation of the carrying amount of total equity, equity attributable to the Company's stockholders, and equity attributable to the noncontrolling interests as of June 30, 2021, and during each of the three-month periods following December 31, 2020 (in millions):

		Community Health Systems, Inc. Stockholders					
	Redeemable Noncontrolling Interest	Common Stock	Additional Paid-In Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Noncontrolling Interest	Total Stockholders' Deficit
Balance, December 31, 2020	$ 484	$ 1	$ 2,094	$ (13)	$ (3,707)	$ 87	$ (1,538)
Comprehensive income (loss)	21	—	—	(3)	(64)	8	(59)
Distributions to noncontrolling interests	(12)	—	—	—	—	(9)	(9)
Dispositions of less-than-wholly owned business	(7)	—	—	—	—	—	—
Noncontrolling interest in acquired entity	2	—	—	—	—	—	—
Adjustment to redemption value of redeemable noncontrolling interests	(7)	—	7	—	—	—	7
Cancellation of restricted stock for tax withholdings on vested shares	—	—	(4)	—	—	—	(4)
Share-based compensation	—	—	8	—	—	—	8
Balance, March 31, 2021	481	1	2,105	(16)	(3,771)	86	(1,595)
Comprehensive income	24	—	—	1	6	7	14
Distributions to noncontrolling interests	(31)	—	—	—	—	(14)	(14)
Purchase of subsidiary shares from noncontrolling interests	(2)	—	—	—	—	—	—
Other reclassifications of noncontrolling interests	1	—	(1)	—	—	—	(1)
Adjustment to redemption value of redeemable noncontrolling interests	25	—	(25)	—	—	—	(25)
Share-based compensation	—	—	5	—	—	—	5
Balance, June 30, 2021	$ 498	$ 1	$ 2,084	$ (15)	$ (3,765)	$ 79	$ (1,616)

The following schedule discloses the effects of changes in the Company’s ownership interest in its less-than-wholly-owned subsidiaries on Community Health Systems, Inc. stockholders’ deficit (in millions):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2022	2021	2022	2021
Net (loss) income attributable to Community Health Systems, Inc. stockholders	$ (326)	$ 6	$ (327)	$ (58)
Transfers to the noncontrolling interests:				
Net (decrease) increase in Community Health Systems, Inc. paid-in-capital for purchase of subsidiary partnership interests	—	—	(1)	—
Net transfers to the noncontrolling interests	—	—	(1)	—
Change to Community Health Systems, Inc. stockholders' deficit from net (loss) income attributable to Community Health Systems, Inc. stockholders and transfers to noncontrolling interests	$ (326)	$ 6	$ (328)	$ (58)

11. EARNINGS PER SHARE

The following table sets forth the components of the denominator for the computation of basic and diluted earnings per share for net (loss) income attributable to Community Health Systems, Inc. stockholders:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2022	2021	2022	2021
Weighted-average number of shares outstanding — basic	129,095,571	127,069,252	128,460,419	126,414,901
Effect of dilutive securities:				
Restricted stock awards	—	2,530,006	—	—
Employee stock options	—	800,599	—	—
Other equity-based awards	—	337,267	—	—
Weighted-average number of shares outstanding — diluted	129,095,571	130,737,124	128,460,419	126,414,901

The Company generated a loss attributable to Community Health Systems, Inc. stockholders for the three months ended June 30, 2022 and both of the six-month periods ended June 30, 2022 and 2021, so the effect of dilutive securities is not considered because their effect would be antidilutive. If the Company had generated income during the three months ended June 30, 2022, the effect of restricted stock awards, employee stock options, and other equity-based awards on the diluted shares calculation would have been an increase of 1,152,737 shares. If the Company had generated income during the six months ended June 30, 2022 and 2021, the effect of restricted stock awards, employee stock options, and other equity-based awards on the diluted shares calculation would have been an increase of 1,675,586 shares and 2,967,814 shares, respectively.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2022	2021	2022	2021
Dilutive securities outstanding not included in the computation of earnings per share because their effect is antidilutive:				
Employee stock options and restricted stock awards	4,439,146	747,668	2,858,073	803,127

12. CONTINGENCIES

The Company is a party to various legal, regulatory and governmental proceedings incidental to its business. Based on current knowledge, management does not believe that loss contingencies arising from pending legal, regulatory and governmental matters will have a material adverse effect on the condensed consolidated financial position or liquidity of the Company. However, in light of the inherent uncertainties involved in pending legal, regulatory and governmental matters, some of which are beyond the Company's control, and the very large or indeterminate damages sought in some of these matters, an adverse outcome in one or more of these matters could be material to the Company's results of operations or cash flows for any particular reporting period.

With respect to all legal, regulatory and governmental proceedings, the Company considers the likelihood of a negative outcome. If the Company determines the likelihood of a negative outcome with respect to any such matter is probable and the amount of the loss can be reasonably estimated, the Company records an accrual for the estimated loss for the expected outcome of the matter. If the likelihood of a negative outcome with respect to material matters is reasonably possible and the Company is able to determine an estimate of the possible loss or a range of loss, whether in excess of a related accrued liability or where there is no accrued liability, the Company discloses the estimate of the possible loss or range of loss. However, the Company is unable to estimate a possible loss or range of loss in some instances based on the significant uncertainties involved in, and/or the preliminary nature of, certain legal, regulatory and governmental matters.

Probable Contingencies

The table below presents a reconciliation of the beginning and ending liability balances (in millions) during the six months ended June 30, 2022, with respect to the Company's determination of the contingencies of the Company in respect of which an accrual has been recorded. The liability as of June 30, 2022 is comprised of individually insignificant amounts for various matters.

Summary of Recorded Amounts

	Probable Contingencies
Balance as of December 31, 2021	$ 20
Expense	4
Cash payments	(9)
Balance as of June 30, 2022	$ 15

In accordance with applicable accounting guidance, the Company establishes a liability for litigation, regulatory and governmental matters for which, based on information currently available, the Company believes that a negative outcome is known or is probable and the amount of the loss is reasonably estimable. For all such matters (whether or not discussed in this contingencies footnote), such amounts have been recorded in other accrued liabilities on the condensed consolidated balance sheet and are included in the table above. Due to the uncertainties and difficulty in predicting the ultimate resolution of these contingencies, the actual amount could differ from the estimated amount reflected as a liability on the condensed consolidated balance sheet.

13. SUBSEQUENT EVENTS

The Company has evaluated all material events occurring subsequent to the balance sheet date for events requiring disclosure or recognition in the condensed consolidated financial statements.

On July 1, 2022, one or more affiliates of the Company sold substantially all of the assets of AllianceHealth Seminole (32 licensed beds) in Seminole, Oklahoma, to affiliates of SSM Health Care of Oklahoma. The net proceeds from this sale were received at a preliminary closing on June 30, 2022.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

You should read this discussion together with our condensed consolidated financial statements and the accompanying notes included herein.

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

Executive Overview

We are one of the nation's largest healthcare companies. Our affiliates are leading providers of healthcare services, developing and operating healthcare delivery systems in 48 distinct markets across 16 states. As of June 30, 2022, our subsidiaries own or lease 84 affiliated hospitals (inclusive of a de novo hospital which commenced operations during the three months ended June 30, 2022), with approximately 13,000 beds, and operate more than 1,000 sites of care, including physician practices, urgent care centers, freestanding emergency departments, occupational medicine clinics, imaging centers, cancer centers and ambulatory surgery centers. We generate revenues by providing a broad range of general and specialized hospital healthcare services and outpatient services to patients in the communities in which we are located. We are paid for our services by governmental agencies, private insurers and directly by the patients we serve.

Recent Developments and COVID-19 Pandemic

Economic conditions in the United States have been deteriorating in various respects, and the United States economy continues to experience significant inflationary pressures, an extremely competitive labor market, and disruptions to supply networks. In this regard, we have incurred, and may continue to incur, certain increased expenses arising from these economic conditions, including additional labor, supply chain, capital and other expenditures. Moreover, taking into account these developments, during the second quarter of 2022, we experienced unfavorable changes in payor mix, declines in patient volumes, wage inflation for permanent employees and increased rates for and greater utilization of temporary contract labor (including contract nursing personnel). These factors had a material unfavorable impact on our financial results during the second quarter of 2022, and may have an unfavorable impact on our financial results in future periods which could be material. While we have implemented cost containment and other measures to try to counteract these developments, we may continue to be unable to fully offset the impact of these factors on the operation of our business.

In addition, as a provider of healthcare services, we have been and continue to be affected by the public health and economic effects of the COVID-19 pandemic, which has been declared a public health emergency by the Secretary of the U.S. Department of Health and Human Services, or HHS. While we are not able to fully quantify the impact that the COVID-19 pandemic will have on our future financial results, developments related to COVID-19 may continue to affect our financial performance. The ongoing impact of the pandemic on our financial results will depend on, among other factors, the duration and severity of the pandemic, the impact of the pandemic on economic conditions, the volume of canceled or rescheduled procedures at our facilities, and the spread of potentially more contagious and/or virulent forms of the virus, including any variants of the virus that may be resistant to currently available vaccines.

If economic conditions in the United States further significantly deteriorate and/ or public health conditions related to the COVID-19 pandemic significantly worsen, any such developments could materially and adversely affect our results of operations, financial position, and/or our cash flows.

Completed Divestiture and Acquisition Activity

No hospitals were divested during the six months ended June 30, 2022. On March 7, 2022, we entered into a definitive agreement for the sale of substantially all of the assets of AllianceHealth Seminole (32 licensed beds) in Seminole, Oklahoma, to affiliates of SSM Health Care of Oklahoma. The proceeds from this sale were received at a preliminary closing on June 30, 2022, and the disposition was completed on July 1, 2022.

During 2021, we completed the divestiture of five hospitals, including three which closed effective January 1, 2021 (for these hospitals we received net proceeds at a preliminary closing on December 31, 2020). These five hospitals represented annual net operating revenues in 2020 of approximately $275 million and, including the net proceeds for the three hospital divestitures that preliminarily closed on December 31, 2020, we received total net proceeds of approximately $28 million in connection with their disposition.

The following table provides a summary of hospitals that we divested during the year ended December 31, 2021:

Hospital	Buyer	City, State	Licensed Beds	Effective Date
Lea Regional Medical Center	Covenant Health System	Hobbs, NM	84	January 1, 2021
Tennova Healthcare - Tullahoma	Vanderbilt University Medical Center	Tullahoma, TN	135	January 1, 2021
Tennova Healthcare - Shelbyville	Vanderbilt University Medical Center	Shelbyville, TN	60	January 1, 2021
Northwest Mississippi Medical Center	Delta Health System	Clarksdale, MS	181	February 1, 2021
AllianceHealth Midwest	SSM Health Care of Oklahoma	Midwest City, OK	255	April 1, 2021

We continue to receive interest from potential acquirers for certain of our hospitals, and may, from time to time, consider selling additional hospitals if we consider any such disposition to be in our best interests. We expect proceeds from any such divestitures to be used for general corporate purposes and capital expenditures.

During the six months ended June 30, 2022, we paid approximately $4 million to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by our hospitals. We allocated the purchase price to property and equipment, working capital, noncontrolling interests and goodwill.

Overview of Operating Results

Net operating revenues decreased from $3.0 billion for the three months ended June 30, 2021 to $2.9 billion for the three months ended June 30, 2022. On a same-store basis, net operating revenues for the three months ended June 30, 2022 decreased $79 million.

We had net loss of $(298) million during the three months ended June 30, 2022, compared to net income of $37 million for the three months ended June 30, 2021.

Net income for the three months ended June 30, 2021 included the following:

- an after-tax charge of $23 million for loss from early extinguishment of debt, and
- an after-tax charge of $1 million for the impairment of goodwill and long-lived assets of divested businesses based on their estimated fair values.

There were no similar adjustments to net loss for the three months ended June 30, 2022.

Consolidated inpatient admissions for the three months ended June 30, 2022, decreased 3.4%, compared to the three months ended June 30, 2021. Consolidated adjusted admissions for the three months ended June 30, 2022, decreased 0.4%, compared to the three months ended June 30, 2021. Same-store inpatient admissions for the three months ended June 30, 2022, decreased 3.5%, compared to the three months ended June 30, 2021, and same-store adjusted admissions for the three months ended June 30, 2022, decreased 0.5%, compared to the three months ended June 30, 2021.

Net operating revenues increased from $6.020 billion for the six months ended June 30, 2021 to $6.044 billion for the six months ended June 30, 2022. On a same-store basis, net operating revenues for the six months ended June 30, 2022 increased $34 million.

We had net loss of $(268) million during the six months ended June 30, 2022, compared to net income of $2 million for the six months ended June 30, 2021. Net loss for the six months ended June 30, 2022 included the following:

- an after-tax charge of $14 million for loss from early extinguishment of debt, and
- an after-tax charge of $5 million for the impairment of long-lived assets of a hospital that was subsequently sold at a sales price below carrying value.

Net income for the six months ended June 30, 2021 included the following:

- an after-tax charge of $116 million for loss from early extinguishment of debt, and
- an after-tax charge of $18 million for the impairment of goodwill and long-lived assets of divested businesses based on their estimated fair values.

Consolidated inpatient admissions for the six months ended June 30, 2022, decreased 2.5%, compared to the six months ended June 30, 2021. Consolidated adjusted admissions for the six months ended June 30, 2022, increased 0.8%, compared to the six months ended June 30, 2021. Same-store inpatient admissions for the six months ended June 30, 2022, decreased 1.9%, compared to the six months ended June 30, 2021, and same-store adjusted admissions for the six months ended June 30, 2022, increased 1.3%, compared to the six months ended June 30, 2021.

Self-pay revenues represented approximately 0.4% and 0.9% of net operating revenues for the three months ended June 30, 2022 and 2021, respectively, and 0.9% and 0.7% for the six months ended June 30, 2022 and 2021, respectively. The amount of foregone revenue related to providing charity care services as a percentage of net operating revenues was approximately 13.9% and 7.1% for the three months ended June 30, 2022 and 2021, respectively, and 12.8% and 7.4% for the six months ended June 30, 2022 and 2021, respectively. Direct and indirect costs incurred in providing charity care services as a percentage of net operating revenues was approximately 1.6% and 0.9% for the three months ended June 30, 2022 and 2021, respectively, and 1.5% and 0.9% for the six months ended June 30, 2022 and 2021, respectively.

Overview of Legislative and Other Governmental Developments

The U.S. Congress and certain state legislatures have introduced and passed a large number of proposals and legislation designed to make major changes in the healthcare system, including changes that have impacted access to health insurance. The most prominent of these efforts, the Affordable Care Act, regulates how healthcare services are covered, delivered and reimbursed. The Affordable Care Act increased health insurance coverage through a combination of public program expansion and private sector health insurance reforms. The Affordable Care Act also made a number of changes to Medicare and Medicaid reimbursement, such as a productivity offset to the Medicare market basket update and reductions to Medicare and Medicaid disproportionate share hospital, or DSH, payments. However, reductions to Medicaid DSH payments have been delayed by the Consolidated Appropriations Act, or the CAA, through 2023 (to begin in federal fiscal year 2024).

The Affordable Care Act has been subject to legislative and regulatory changes and court challenges. For example, effective January 1, 2019, the financial penalty associated with the mandate that most individuals enroll in a health insurance plan was effectively eliminated. This change resulted in legal challenges to the constitutionality of the individual mandate and validity of the Affordable Care Act as a whole. However, in June 2021, the U.S. Supreme Court determined that the plaintiffs lacked standing, allowing the law to remain in place. Nonetheless, the elimination of the individual mandate penalty and other changes may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased. Some states have imposed individual health insurance mandates, and other states have explored or offer public health insurance options.

The current presidential administration has indicated that it generally intends to protect and strengthen the Affordable Care Act and Medicaid programs. For example, in January 2021, President Biden issued an executive order that instructed certain governmental agencies to review and reconsider their existing policies and rules that limit access to health insurance coverage. In a final rule published in September 2021, HHS extended the annual open enrollment period for coverage through federal marketplaces and granted state exchanges flexibility to lengthen their open enrollment periods.

Of critical importance to us is the potential impact of any changes specific to the Medicaid program, including the funding and expansion provisions of the Affordable Care Act and subsequent legislation or agency initiatives. Historically, the states with the greatest reductions in the number of uninsured adult residents have expanded Medicaid. A number of states have opted out of the Medicaid coverage expansion provisions, but could ultimately decide to expand their programs at a later date. Of the 16 states in which we operated hospitals as of June 30, 2022, nine states have taken action to expand their Medicaid programs. At this time, the other seven states have not, including Florida, Alabama, Tennessee, Mississippi and Texas, where we operated a significant number of hospitals as of June 30, 2022. In addition, some states use, or have applied to use, waivers granted by CMS to implement expansion, impose different eligibility or enrollment conditions, or otherwise implement programs that vary from federal standards.

There is uncertainty regarding the ongoing net effect of the Affordable Care Act due to the potential for continued changes to the law's implementation and its interpretation by government agencies and courts. There is also uncertainty regarding the potential impact of other health reform efforts at the federal and state levels. Some reforms may have a positive impact on our business, while others may increase our operating costs, adversely impact the reimbursement we receive, or require us to modify certain aspects of our operations. For example, some members of Congress have proposed measures that would expand government-sponsored health insurance coverage, including single-payor models, and some states have implemented or are considering public health insurance options. Legislative and executive branch efforts related to healthcare reform could result in increased prices for consumers purchasing health insurance coverage or destabilize insurance markets, among other effects. Some current initiatives, requirements and proposals, including those aimed at price transparency and out-of-network charges, may impact prices, our competitive position and the relationships between hospitals, insurers and patients. For example, the No Surprises Act currently requires providers to provide a good faith estimate of expected charges to uninsured or self-pay individuals in connection with scheduled items or services, upon request of the individual. It also requires providers to send an insured patient's health plan a good faith estimate of expected charges, including billing and diagnostic codes, prior to when the patient is scheduled to receive the item or service. HHS is deferring enforcement of the good faith estimate requirement for insured patients until it issues additional regulations.

In recent years, a number of laws, including the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act, have promoted shifting from traditional fee-for-service reimbursement models to alternative payment models that tie reimbursement to quality and cost of care. For example, CMS currently administers various accountable care organizations and bundled payment demonstration projects. In October 2021, the CMS Innovation Center published an outline of its strategy for the next decade, noting the need to accelerate the movement to value-based care and drive broader system transformation. However, the COVID-19 pandemic may impact provider performance and data reporting under value-based care initiatives. CMS has temporarily modified requirements of certain programs by, for example, implementing special scoring and payment policies intended to mitigate negative impacts of the public health emergency on hospitals participating in the Hospital Value-Based Purchasing Program and similar programs.

In response to the COVID-19 pandemic, federal and state governments have passed legislation, promulgated regulations, and taken other administrative actions intended to assist healthcare providers in providing care to COVID-19 and other patients during the public health emergency and to provide financial relief. These measures include temporary relief from Medicare conditions of participation requirements for healthcare providers, temporary relaxation of licensure requirements for healthcare professionals, temporary relaxation of privacy restrictions for telehealth remote communications, promoting use of telehealth by temporarily expanding the scope of services for which Medicare reimbursement is available, and limited waivers of fraud and abuse laws for activities related to COVID-19 during the public health emergency period.

Primary legislative sources of COVID-19 relief include the Coronavirus Aid, Relief and Economic Security Act, or the CARES Act, the Paycheck Protection Program and Health Care Enhancement Act, or the PPPHCE Act, the CAA, and the American Rescue Plan Act of 2021, or the ARPA. Together, these stimulus laws authorize over $186 billion in funding to be distributed through the Public Health and Social Services Emergency Fund, or the PHSSEF, to eligible providers, including public entities and Medicare- and/or Medicaid-enrolled providers. PHSSEF payments are intended to compensate healthcare providers for lost revenues or incremental expenses incurred in response to the COVID-19 pandemic and are not required to be repaid, provided that recipients attest to and comply with certain terms and conditions, including limitations on balance billing, not using PHSSEF funds to reimburse expenses or losses that other sources have been or are obligated to reimburse and audit and reporting requirements.

In addition, the CARES Act expanded the Medicare Accelerated and Advance Payment Program to increase cash flow to providers impacted by the COVID-19 pandemic. Inpatient acute care hospitals were able to request accelerated payment of up to 100% of their Medicare payment amount for a six-month period. The Medicare Accelerated and Advanced Payment Program payments are advances that providers must repay. Providers are required to repay accelerated payments beginning one year after the payment was issued. After such one-year period, Medicare payments owed to providers will be recouped according to the repayment terms.

The CARES Act and related legislation include other provisions offering financial relief, for example suspending the Medicare sequestration payment adjustment from May 1, 2020 through December 31, 2021, which would have otherwise reduced payments to Medicare providers by 2% as required by the Budget Control Act of 2011 (but also extending sequestration through 2030). Congress further delayed these sequestration cuts through March 31, 2022, and reduced the sequestration adjustment to 1% from April 1 through June 30, 2022, but increased the reductions set for 2030. The CARES Act and related legislation also delay scheduled reductions to Medicaid DSH payments, provide a 20% add-on to the inpatient prospective payment system diagnosis-related group, or PPS DRG, rate for COVID-19 patients for the duration of the public health emergency, permitted the deferral of payment of the employer portion of social security taxes between March 27, 2020 and December 31, 2020, with 50% of the deferred amount due December 31, 2021 and the remaining 50% due December 31, 2022, and provided claims reimbursement to healthcare providers for the provision of COVID-19 testing, treatment, and vaccine administration to uninsured individuals by way of the Health Resources & Services Administration, or HRSA, COVID-19 Uninsured Program. However, in addition to providing funding for healthcare providers, the ARPA increased the federal budget deficit in a manner that triggers an additional statutorily mandated sequestration under the Pay-As-You-Go Act of 2010. As a result, an additional Medicare spending reduction of up to 4% was required to take effect in January 2022. However, Congress has delayed implementation of this payment reduction until 2023.

Through June 30, 2022, net of amounts that have been repaid to the respective federal, state, and local agencies, we received approximately $815 million in pandemic relief fund payments through various federal, state and local programs on a cumulative basis since their enactment. Of the net amount received to-date, approximately $52 million was received during the six months ended June 30, 2022 and the remainder was received during the years ended December 31, 2021 and 2020. Payments recognized to-date have not impacted net operating revenues, and had a positive impact on net (loss) income attributable to Community Health Systems, Inc. stockholders during the three months ended June 30, 2022 and 2021, in the amount of $6 million and less than $1 million, respectively, and $41 million and $63 million during the six months ended June 30, 2022 and 2021, respectively. Amounts received through various federal, state or local programs that have not yet been recognized or otherwise have not been refunded to HHS are included within accrued liabilities-other in the condensed consolidated balance sheets, and such unrecognized amounts may be returned to HHS or the respective state or local agency, as applicable, or may be recognized in future periods if the underlying conditions for recognition are reasonably assured of being met. We have satisfied all current reporting requirements for pandemic relief funds received to-date, as applicable.

With respect to the Medicare Accelerated and Advanced Payment Program, we received Medicare accelerated payments of approximately $1.2 billion in April 2020. No additional Medicare accelerated payments have been received by us since such time and because CMS is no longer accepting new applications for accelerated payments, we do not expect to receive additional Medicare accelerated payments. CMS began recouping Medicare accelerated payments in April 2021. As of December 31, 2021, all Medicare accelerated payments received by us were recouped or repaid to CMS or assumed by buyers related to hospitals we divested. In this regard, approximately $1.1 billion and $77 million of Medicare accelerated payments were recouped or repaid to CMS or assumed by buyers related to hospitals we divested during the years ended December 31, 2021 and 2020, respectively.

There is still uncertainty regarding the magnitude and timing of any future payments or benefits that we may receive or realize under the CARES Act and other stimulus legislation passed in response to the COVID-19 pandemic, although we do not currently expect to receive the same level of payments or benefits in future periods that we received or realized earlier in the pandemic. In addition, the public health emergency continues to evolve. Some of the measures allowing for flexibility in delivery of care and various financial supports for healthcare providers are available only until funds expire or for the duration of the public health emergency, and it is unclear whether or for how long the public health emergency declaration will be extended. The current declaration expires October 13, 2022. The HHS Secretary may choose to renew the declaration for successive 90-day periods for as long as the emergency continues to exist and may terminate the declaration whenever he determines that the public health emergency no longer exists, but has indicated that HHS will provide states with 60 days' notice prior to termination of the declaration. The federal government may consider additional stimulus and relief efforts, but we are unable to predict whether additional stimulus measures will be enacted or their impact on us. For example, the HRSA COVID-19 Uninsured Program has stopped accepting claims for reimbursement for testing, treatment, and vaccinations, and we are unable to predict whether this program will receive additional funding. There can be no assurance as to the total amount of financial and other types of assistance that we will receive under federal, state and local stimulus or relief programs, and it is difficult to predict the impact of such measures on our operations or how they will affect operations of our competitors. Further, there can be no assurance that the terms of provider relief funding or other programs will not change or be interpreted in ways that affect our funding or eligibility to participate or our ability to comply with applicable requirements and retain amounts received. We continue to assess the potential impact of the CARES Act and other enacted stimulus legislation, the potential impact of future stimulus measures, if any, and the impact of other laws, regulations, and guidance related to COVID-19 on our business, results of operations, financial condition and cash flows.

In June 2019, the U.S. Supreme Court ruled in *Azar v. Allina Health Services* that HHS failed to comply with statutory notice and comment rulemaking procedures before announcing an earlier policy related to DSH payments made under Medicare to hospitals. In response to this adverse ruling, CMS proposed a rule in August 2020 in an attempt to retroactively cure the underlying procedural errors cited by the U.S. Supreme Court as the basis in their decision. CMS's action has introduced uncertainty regarding the potential outcomes from the Supreme Court ruling, and the proposed rule has resulted in further litigation. If HHS or CMS are unsuccessful in their attempt to assert the proposed rule or another legal basis for their policy, one potential outcome is the federal government could be required to reimburse hospitals, including our affiliated hospitals, for Medicare DSH payments which otherwise would have been payable over certain prior time periods absent the enactment of this policy. While the ruling in *Allina* was specific to the DSH payments calculated for federal fiscal year 2012 for the plaintiff hospitals, the *Allina* precedent could result in higher DSH payments for federal fiscal years 2005 to 2013. There continues to be uncertainty regarding the extent to which, if any, Medicare DSH payments would be remitted to our affiliated hospitals as the result of *Allina* and subsequent litigation as well as litigation related to other Medicare DSH issues, and, if so, the timing of any such payments. If it were ultimately determined that our affiliated hospitals are entitled to receive such Medicare DSH payments for these prior time periods, these payments could have a material positive impact on a non-recurring basis in any future period in which net income is recognized in respect thereof as well as on our cash flows from operations in any future period in which these payments are received; however, based on recent judicial developments, we believe the likelihood of our affiliated hospitals receiving any Medicare DSH payments in respect of prior periods as set forth above has decreased.

In June 2022, the U.S. Supreme Court ruled in *American Hospital Association v. Becerra*, a case on the 340B Drug Pricing Program that could impact Medicare reimbursement to us, both in respect of past periods and future periods. The 340B program allows certain non-profit healthcare organizations that care for many uninsured and low-income patients to purchase outpatient drugs from pharmaceutical manufacturers at discounted rates. Our hospitals do not participate in the 340B program. In 2018, HHS implemented a payment policy that reduced Medicare payments to 340B hospitals for most drugs obtained at 340B-discounted rates. These payment cuts resulted in increased payments for non-340B hospitals, including our facilities. In *Becerra*, the U.S. Supreme Court determined that HHS unlawfully reduced reimbursement rates for 340B hospitals. The remedy in the case has not yet been determined. However, if it is determined that budget neutrality applies to the remedy, companies or entities that operate non-340B hospitals such as us may be required to repay previously received payments, which could have a material adverse impact on our financial results in any future reporting period in which such future repayments are recognized or paid. In addition, depending on future Medicare payment policies, companies or entities that operate non-340B hospitals such as us could receive decreased reimbursement going forward for outpatient drugs, which would adversely impact our results on a prospective basis.

As a result of our current levels of cash, pandemic relief fund payments we may in the future receive under federal, state or local stimulus or relief programs, available borrowing capacity, long-term outlook on our debt repayments, the refinancing of certain of our notes, proceeds from any potential future disposition of hospitals or other investments such as our minority equity interests in various businesses, as applicable, and the continued projection of our ability to generate cash flows, we anticipate that we will be able to invest the necessary capital in our business over the next twelve months and for the foreseeable future thereafter. We believe there continues to be ample opportunity to strengthen our market share in substantially all of our markets by decreasing the need for patients to travel outside their communities for healthcare. Furthermore, we will continue to strive to improve operating efficiencies and procedures in order to improve the performance of our hospitals.

Sources of Revenue

The following table presents the approximate percentages of net operating revenues by payor source for the periods indicated. The data for the periods presented are not strictly comparable due to the effect that businesses acquired, sold, closed or opened during each of the respective periods, as applicable, have had on these statistics.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2022	2021	2022	2021
Medicare	21.0%	21.4%	21.2%	22.2%
Medicaid	15.2	14.0	15.1	13.5
Managed Care and other third-party payors	63.4	63.7	62.8	63.6
Self-pay	0.4	0.9	0.9	0.7
Total	100.0%	100.0%	100.0%	100.0%

As shown above, we receive a substantial portion of our revenues from the Medicare and Medicaid programs. Included in Managed Care and other third-party payors is operating revenues from insurance companies with which we have insurance provider contracts, Medicare managed care, insurance companies for which we do not have insurance provider contracts, workers' compensation carriers and non-patient service revenue, such as rental income and cafeteria sales. In the future, we generally expect the portion of revenues

received from the Medicare and Medicaid programs to increase over the long-term due to the general aging of the population and other factors, including health reform initiatives. There has been a trend toward increased enrollment in Medicare and Medicaid managed care, which may adversely affect our operating revenue. We may also be impacted by regulatory requirements imposed on insurers, such as minimum medical-loss ratios and specific benefit requirements. Furthermore, in the normal course of business, managed care programs, insurance companies and employers actively negotiate the amounts paid to hospitals. Our relationships with payors may be impacted by price transparency initiatives and out-of-network billing restrictions, including those in the No Surprises Act, which took effect January 1, 2022. There can be no assurance that we will retain our existing reimbursement arrangements or that third-party payors will not attempt to further reduce the rates they pay for our services.

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-based reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for the treatment of patients covered by Medicare, Medicaid and non-governmental payors are generally less than our standard billing rates. We account for the differences between the estimated program reimbursement rates and our standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net (loss) income by an insignificant amount in each of the three and six-month periods ended June 30, 2022 and 2021.

The payment rates under the Medicare program for hospital inpatient and outpatient acute care services are based on prospective payment systems, which depend upon a patient’s diagnosis or the clinical complexity of services provided to a patient, among other factors. These rates are indexed for inflation annually, although increases have historically been less than actual inflation. On August 13, 2021, CMS published the final rule to increase this index by 2.7% for hospital inpatient acute care services that are reimbursed under the prospective payment system for federal fiscal year 2022 (which began October 1, 2021). Together with other changes to payment policies, payment rates for hospital inpatient acute care services are expected to increase approximately 2.5%. Hospitals that do not submit required patient quality data are subject to a reduction in payments. We are complying with this data submission requirement. Payments may also be affected by various other adjustments, including those that depend on patient-specific or hospital specific factors. For example, the “two midnight rule” establishes admission and medical review criteria for inpatient services limiting when services to Medicare beneficiaries are payable as inpatient hospital services. Reductions in the rate of increase or overall reductions in Medicare reimbursement may cause a decline in the growth of our net operating revenues.

Payment rates under the Medicaid program vary by state. In addition to the base payment rates for specific claims for services rendered to Medicaid enrollees, several states utilize supplemental reimbursement programs to make separate payments that are not specifically tied to an individual’s care, some of which offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from CMS and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. The programs are generally authorized for a specified period of time and require CMS’s approval to be extended. We are unable to predict whether or on what terms CMS will extend the supplemental programs in the states in which we operate. Under these supplemental programs, we recognize revenue and related expenses in the period in which amounts are estimable and payment is reasonably assured. Reimbursement under these programs is reflected in net operating revenues and included as Medicaid revenue in the table above, and fees, taxes or other program related costs are reflected in other operating expenses.

Results of Operations

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2022	2021	2022	2021
Operating results, as a percentage of net operating revenues:				
Net operating revenues	100.0%	100.0%	100.0%	100.0%
Operating expenses (a)	(91.4)	(85.1)	(89.2)	(84.5)
Depreciation and amortization	(4.5)	(4.4)	(4.3)	(4.5)
Impairment and (gain) loss on sale of businesses, net	—	(0.1)	(0.1)	(0.4)
Income from operations	4.1	10.4	6.4	10.6
Interest expense, net	(7.4)	(7.2)	(7.2)	(7.5)
Loss from early extinguishment of debt	—	(0.3)	—	(1.3)
Equity in earnings of unconsolidated affiliates	—	0.1	0.1	0.2
(Loss) income before income taxes	(3.3)	3.0	(0.7)	2.0
Provision for income taxes	(6.8)	(1.8)	(3.7)	(2.0)
Net (loss) income	(10.1)	1.2	(4.4)	—
Less: Net income attributable to noncontrolling interests	(1.0)	(1.0)	(1.0)	(1.0)
Net (loss) income attributable to Community Health Systems, Inc. stockholders	(11.1)%	0.2%	(5.4)%	(1.0)%

	Three Months Ended June 30,		Six Months Ended June 30,	
	2022	2021	2022	2021
Percentage (decrease) increase from prior year:				
Net operating revenues	(2.4)%	19.4%	0.4%	8.6%
Admissions (b)	(3.4)	4.8	(2.5)	(5.5)
Adjusted admissions (c)	(0.4)	15.7	0.8	(2.0)
Average length of stay (d)	—	—	2.1	6.7
Net (loss) income attributable to Community Health Systems, Inc. stockholders	(5,533.3)	(91.4)	(463.8)	(166.7)
Same-store percentage (decrease) increase from prior year (e):				
Net operating revenues	(2.6)%	30.2%	0.6%	19.2%
Admissions (b)	(3.5)	17.0	(1.9)	5.1
Adjusted admissions (c)	(0.5)	28.5	1.3	8.7

(a) Operating expenses include salaries and benefits, supplies, other operating expenses, and lease cost and rent, net of the reduction in operating expenses through June 30, 2022 and 2021, resulting from the recognition of pandemic relief funds.
(b) Admissions represents the number of patients admitted for inpatient treatment.
(c) 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.
(d) Average length of stay represents the average number of days inpatients stay in our hospitals.
(e) Excludes information for businesses sold or closed during each of the respective periods, as applicable, and one hospital opened in 2022.

Items (b) – (e) are metrics used to manage our performance. These metrics provide useful insight to investors about the volume and acuity of services we provide, which aid in evaluating our financial results.

Three Months Ended June 30, 2022 Compared to Three Months Ended June 30, 2021

Net operating revenues decreased to $2.9 billion for the three months ended June 30, 2022 compared to $3.0 billion for the three months ended June 30, 2021. Net operating revenues on a same-store basis from hospitals that were operated throughout both periods decreased $79 million, or 2.6%, during the three months ended June 30, 2022, as compared to the three months ended June 30, 2021. On a period-over-period basis, the decrease in net operating revenues was primarily attributable to decreased patient volumes, lower acuity of inpatient admissions and a decline in non-patient revenue, partially offset by increased reimbursement rates. Non-same-store net operating revenues increased $5 million during the three months ended June 30, 2022, in comparison to the prior year period. On a consolidated basis, inpatient admissions decreased by 3.4% and adjusted admissions decreased by 0.4% during the three months ended June 30, 2022 as compared to the three months ended June 30, 2021. On a same-store basis, net operating revenues per adjusted admission decreased 2.1%, while inpatient admissions decreased by 3.5% and adjusted admissions decreased by 0.5% for the three months ended June 30, 2022, compared to the three months ended June 30, 2021.

Operating costs and expenses, as a percentage of net operating revenues, increased from 89.6% during the three months ended June 30, 2021 to 95.9% during the three months ended June 30, 2022. Operating costs and expenses, excluding depreciation and amortization and impairment and (gain) loss on sale of businesses, as a percentage of net operating revenues, increased from 85.1% for the three months ended June 30, 2021 to 91.4% for the three months ended June 30, 2022. Salaries and benefits, as a percentage of net operating revenues, increased from 42.1% for the three months ended June 30, 2021 to 44.1% for the three months ended June 30, 2022, primarily due to wage increases driven by inflation and current competitive labor market conditions. Supplies, as a percentage of net operating revenues, remained consistent at 16.6% for the three months ended June 30, 2022 and 2021. Other operating expenses, as a percentage of net operating revenues, increased from 23.8% for the three months ended June 30, 2021 to 28.3% for the three months ended June 30, 2022, primarily due to higher rates for and greater utilization of contract labor. Lease cost and rent, as a percentage of net operating revenues, increased from 2.6% for the three months ended June 30, 2021 to 2.7% for the three months ended June 30, 2022. Pandemic relief funds, as a percentage of net operating revenues, were (0.3)% for the three months ended June 30, 2022, compared to less than (0.1)% for the three months ended June 30, 2021.

Depreciation and amortization, as a percentage of net operating revenues, increased to 4.5% for the three months ended June 30, 2022 from 4.4% for the three months ended June 30, 2021.

There was no impairment and (gain) loss on sale of businesses, net for the three months ended June 30, 2022, compared to impairment and (gain) loss on sale of businesses, net, of $2 million for the three months ended June 30, 2021, which related primarily to divestitures during the period.

Interest expense, net, decreased by $1 million to $218 million for the three months ended June 30, 2022 compared to $219 million for the three months ended June 30, 2021. This was primarily due to our debt refinancing activities in 2021.

There was no loss from early extinguishment of debt during the three months ended June 30, 2022. Loss from early extinguishment of debt of $8 million was recognized during the three months ended June 30, 2021, as a result of the refinancing of certain of our outstanding notes.

Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, decreased to less than (0.1)% for the three months ended June 30, 2022 from (0.1)% for the three months ended June 30, 2021, primarily due to the sale of our unconsolidated equity interests in Macon Healthcare, LLC during the three months ended September 30, 2021.

The net results of the above-mentioned changes resulted in (loss) income before income taxes decreasing $189 million to a loss of $(98) million for the three months ended June 30, 2022 from $91 million for the three months ended June 30, 2021.

Our provision for income taxes for the three months ended June 30, 2022 and 2021 was $200 million and $54 million, respectively, and the effective tax rates were (204.1)% and 59.3% for the three months ended June 30, 2022 and 2021, respectively. The increase in the provision for income taxes for the three months ended June 30, 2022 compared to the three months ended June 30, 2021 was primarily due to an increase in non-deductible interest as a result of a decline in projected adjusted taxable income for 2022 compared to 2021, compounded by an adverse change in the IRC Section 163(j) limit for deductible interest expense beginning in 2022. The difference in our effective tax rate for the three months ended June 30, 2022 compared to the three months ended June 30, 2021 was due to an increase in the provision for income taxes and reporting loss before income taxes in the current year period compared to income before income taxes in the prior year period.

Net (loss) income, as a percentage of net operating revenues, was (10.1)% for the three months ended June 30, 2022 compared to 1.2% for the three months ended June 30, 2021.

Net income attributable to noncontrolling interests as a percentage of net operating revenues remained consistent at 1.0% for the three months ended June 30, 2022 and 2021.

Net (loss) income attributable to Community Health Systems, Inc. stockholders was $(326) million for the three months ended June 30, 2022, compared to $6 million for the three months ended June 30, 2021.

Six Months Ended June 30, 2022 Compared to Six Months Ended June 30, 2021

Net operating revenues increased to $6.044 billion for the six months ended June 30, 2022 compared to $6.020 billion for the six months ended June 30, 2021. Net operating revenues on a same-store basis from hospitals that were operated throughout both periods increased $34 million, or 0.6%, during the six months ended June 30, 2022, as compared to the six months ended June 30, 2021. On a period-over-period basis, the increase in net operating revenues was attributable to increased reimbursement rates and outpatient service volume, partially offset by decreased inpatient volume, less favorable payor mix and a decline in non-patient revenue. Non-same-store net operating revenues decreased $10 million during the six months ended June 30, 2022, in comparison to the prior year period. On a consolidated basis, inpatient admissions decreased by 2.5% and adjusted admissions increased by 0.8% during the six months ended June 30, 2022 as compared to the six months ended June 30, 2021. On a same-store basis, net operating revenues per adjusted admission decreased 0.7%, while inpatient admissions decreased by 1.9% and adjusted admissions increased by 1.3% for the six months ended June 30, 2022, compared to the six months ended June 30, 2021.

Operating costs and expenses, as a percentage of net operating revenues, increased from 89.4% during the six months ended June 30, 2021 to 93.6% during the six months ended June 30, 2022. Operating costs and expenses, excluding depreciation and amortization and impairment and (gain) loss on sale of businesses, as a percentage of net operating revenues, increased from 84.5% for the six months ended June 30, 2021 to 89.2% for the six months ended June 30, 2022. Salaries and benefits, as a percentage of net operating revenues, increased from 42.7% for the six months ended June 30, 2021 to 43.4% for the six months ended June 30, 2022, primarily due to wage increases driven by inflation and current competitive labor market conditions. Supplies, as a percentage of net operating revenues, decreased from 16.5% for the six months ended June 30, 2021 to 16.3% for the six months ended June 30, 2022. Other operating expenses, as a percentage of net operating revenues, increased from 24.1% for the six months ended June 30, 2021 to 27.8% for the six months ended June 30, 2022, primarily due to higher rates for and greater utilization of contract labor. Lease cost and rent, as a percentage of net operating revenues remained consistent at 2.6% for the six months ended June 30, 2022 and 2021. Pandemic relief funds, as a percentage of net operating revenues, were (0.9)% for the six months ended June 30, 2022, compared to (1.4)% for the six months ended June 30, 2021.

Depreciation and amortization, as a percentage of net operating revenues, decreased to 4.3% for the six months ended June 30, 2022 from 4.5% for the six months ended June 30, 2021.

Impairment and (gain) loss on sale of businesses, net was expense of $6 million for the six months ended June 30, 2022, which related to a hospital held for sale, compared to $23 million for the six months ended June 30, 2021, which related primarily to divestitures during the period.

Interest expense, net, decreased by $14 million to $435 million for the six months ended June 30, 2022 compared to $449 million for the six months ended June 30, 2021. This was primarily due to our debt refinancing activities in 2021.

Loss from early extinguishment of debt of $5 million and $79 million was recognized during the six months ended June 30, 2022 and 2021, respectively, as a result of the refinancing of certain of our outstanding notes.

Equity in earnings of unconsolidated affiliates, as a percentage of net operating revenues, decreased to (0.1)% for the six months ended June 30, 2022 from (0.2)% for the six months ended June 30, 2021, primarily due to the sale of our unconsolidated equity interests in Macon Healthcare, LLC during the three months ended September 30, 2021.

The net results of the above-mentioned changes resulted in (loss) income before income taxes decreasing $170 million to a loss of $(45) million for the six months ended June 30, 2022 from income of $125 million for the six months ended June 30, 2021.

Our provision for income taxes for the six months ended June 30, 2022 and 2021 was $223 million and $123 million, respectively, and the effective tax rates were (495.6)% and 98.4% for the six months ended June 30, 2022 and 2021, respectively. The increase in the provision for income taxes for the six months ended June 30, 2022 compared to the six months ended June 30, 2021 was primarily due to an increase in non-deductible interest as a result of a decline in projected adjusted taxable income for 2022 compared to 2021, compounded by an adverse change in the IRC Section 163(j) limit for deductible interest expense beginning in 2022. The difference in our effective tax rate for the six months ended June 30, 2022 compared to the six months ended June 30, 2021 was due to an increase in the provision for income taxes and reporting loss before income taxes in the current year period compared to income before income taxes in the prior year period.

Net (loss) income, as a percentage of net operating revenues, was (4.4)% for the six months ended June 30, 2022 compared to less than 0.1% for the six months ended June 30, 2021.

Net income attributable to noncontrolling interests as a percentage of net operating revenues remained consistent at 1.0% for the six months ended June 30, 2022 and 2021.

Net loss attributable to Community Health Systems, Inc. stockholders was $(327) million for the six months ended June 30, 2022, compared to $(58) million for the six months ended June 30, 2021.

Liquidity and Capital Resources

Net cash provided by operating activities decreased $126 million, from approximately $280 million for the six months ended June 30, 2021, to approximately $154 million for the six months ended June 30, 2022. Cash paid for interest was $410 million during the six months ended June 30, 2022 compared to $304 million for the six months ended June 30, 2021. Cash paid for income taxes, net of refunds received, resulted in a net payment of $6 million and $1 million during the six months ended June 30, 2022 and 2021, respectively.

Net cash used in investing activities was approximately $237 million for the six months ended June 30, 2022, compared to approximately $255 million for the six months ended June 30, 2021, a decrease of $18 million. Net cash used in investing activities during the six months ended June 30, 2022 was primarily impacted by a decrease of $21 million in cash used for the purchase of property and equipment, an increase of $4 million in cash proceeds from the sale of property and equipment, a decrease of $2 million in cash used to purchase other investments, and a decrease of $1 million in cash used in the net impact of the purchase and sale of available-for-sale debt and equity securities. These decreases in cash used in investing activities were partially offset by an increase of $6 million in cash used to purchase investments in unconsolidated affiliates and a decrease of $4 million in cash proceeds from dispositions of hospitals and other ancillary operations.

Our net cash used in financing activities was approximately $78 million for the six months ended June 30, 2022, compared to approximately $451 million for the six months ended June 30, 2021, a decrease of $373 million. This was primarily due to the net effect of our debt repayments, refinancing activities, and cash paid for deferred financing costs and other debt-related costs during the six months ended June 30, 2022 and 2021.

Liquidity

Net working capital was approximately $1.0 billion at June 30, 2022 and $1.1 billion at December 31, 2021, respectively. Net working capital decreased by approximately $81 million between December 31, 2021 and June 30, 2022. The decrease is primarily due to the decrease in cash and cash equivalents as a result of cash paid for interest, deferred financing costs and contract labor as well as a decrease in patient accounts receivable, net, during the six months ended June 30, 2022, partially offset by an increase in prepaid expenses and taxes and decreases in accrued employee compensation and other accrued liabilities.

In addition to cash flows from operations, available sources of capital include amounts available under the asset-based loan (ABL) credit agreement, or the ABL Credit Agreement, as amended and restated on November 22, 2021, and anticipated access to public and private debt markets as well as proceeds from the disposition of hospitals or other investments such as our minority equity interests in various businesses, as applicable.

Pursuant to the ABL Credit Agreement, the lenders have extended to CHS/Community Health Systems, Inc., or CHS, a revolving asset-based loan facility, or the ABL Facility, in the maximum aggregate principal amount of $1.0 billion, subject to borrowing base capacity. At June 30, 2022, the available borrowing base under the ABL Facility was $978 million, of which $84 million was reserved for outstanding letters of credit and $894 million represented excess availability. Letters of credit were reduced during the six months ended June 30, 2022 by $19 million due to a reduction in an insurance-related letter of credit. We had no outstanding borrowings as of June 30, 2022. The issued letters of credit were primarily in support of potential insurance-related claims and certain bonds. Principal amounts outstanding under the ABL Facility, if any, will be due and payable in full on November 22, 2026.

2022 Financing Activity

On February 4, 2022, CHS completed a private offering of $1.535 billion aggregate principal amount of 5¼% Senior Secured Notes due May 15, 2030, or the 5¼% Senior Secured Notes due 2030. The proceeds of the offering were used to redeem the 6⅝% Senior Secured Notes due 2025 on February 4, 2022, and to pay related fees and expenses. The 5¼% Senior Secured Notes due 2030 bear interest at a rate of 5.250% per year payable semi-annually in arrears on May 15 and November 15, commencing on November 15, 2022.

Additional Liquidity Information

Our ability to meet the restricted covenants and financial ratios and tests in the ABL Facility and the indentures governing our outstanding notes 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 the ABL Facility and/or the indentures that govern our outstanding notes. Upon the occurrence of an event of default under the ABL Facility or indentures that govern our outstanding notes, all amounts outstanding under the ABL Facility and the indentures that govern our outstanding notes may become immediately due and payable and all commitments under the ABL Facility to extend further credit may be terminated.

As of June 30, 2022, approximately $32 million of our outstanding debt of $12.2 billion is due within the next 12 months.

As previously discussed, we may require an increased level of working capital if we experience extended billing and collection cycles resulting from ongoing negative economic conditions and/or factors arising from the COVID-19 pandemic, which may impact service mix, revenue mix, payor mix and patient volumes, as well as our ability to collect outstanding receivables. A material increase in the amount or deterioration in the collectability of accounts receivable will adversely affect our cash flows and results of operations, requiring an increased level of working capital.

We believe that internally generated cash flows and current levels of availability for additional borrowing under the ABL Facility, as well as our continued access to the capital markets, will be sufficient to finance acquisitions, capital expenditures, working capital requirements, and any debt repurchases or other debt repayments we may elect to make or be required to make through the next 12 months and the foreseeable future thereafter. Pandemic relief funds that we have received and may continue to receive through various federal, state and local stimulus or relief programs have been and will continue to be used according to applicable terms and conditions as reimbursement for lost revenues or incremental expenses attributable to COVID-19, including working capital requirements and capital expenditures. In addition, ongoing negative economic conditions and/or the COVID-19 pandemic have resulted in, and may continue to result in, significant disruptions of financial and capital markets, which could reduce our ability to access capital and negatively affect our liquidity in the future. Additionally, while we have received and may continue to receive pandemic relief funds and may continue to be able to utilize pandemic relief funds which have been received, as noted above, there is no assurance regarding the extent to which we will continue to benefit from these payments or other stimulus measures. Moreover, we do not currently expect to receive the same level of pandemic relief payments or benefits in future periods that we received or realized earlier in the pandemic.

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

There have been no material changes outside of the ordinary course of business to our upcoming cash obligations during the six months ended June 30, 2022 from those disclosed under “Capital Resources” in Management’s Discussion and Analysis of Financial Condition and Results of Operations in our Annual Report on Form 10-K filed with the SEC on February 17, 2022, or 2021 Form 10-K, except as discussed above related to debt refinancing activity during 2022.

Capital Resources

Cash expenditures for purchases of facilities and other related businesses were approximately $4 million for both of the six-month periods ended June 30, 2022 and 2021. Our expenditures for the six months ended June 30, 2022 and 2021 were primarily related to physician practices and other ancillary services.

Excluding the cost to construct replacement and de novo hospitals, our cash expenditures for routine capital for the six months ended June 30, 2022 totaled $144 million compared to $149 million for the six months ended June 30, 2021. These capital expenditures related primarily to the purchase of additional equipment, minor renovations and information systems infrastructure. Costs to construct replacement hospitals totaled $13 million and $34 million for the six months ended June 30, 2022 and 2021, respectively, primarily related to the construction of a replacement facility in Fort Wayne, Indiana. During the six months ended June 30, 2022 and 2021, we also had cash expenditures of $34 million and $29 million, respectively, that represent both planning and construction costs primarily for one de novo hospital in the Tucson, Arizona market. This de novo hospital was completed in the first half of 2022 and has 52 beds.

Pursuant to a hospital purchase agreement from our March 1, 2016 acquisition of Northwest Health - Starke, formerly known as Starke Hospital, we committed to build a replacement facility in Knox, Indiana. Construction of the replacement facility for Northwest Health - Starke is required to be completed within five years of the date we enter into a new lease with Starke County, Indiana, the hospital lessor, or in the event we do not enter into a new lease with Starke County, construction shall be completed by September 30, 2026. We have not entered into a new lease with the lessor for Northwest Health - Starke and currently anticipate completing

construction of the Northwest Health - Starke replacement facility in 2026. The estimated construction costs, including equipment costs, for the construction of this replacement facility in Knox, Indiana are currently estimated to be approximately $15 million.

Reimbursement, Legislative and Regulatory Changes

Ongoing legislative and regulatory efforts, and judicial interpretations, could reduce or otherwise adversely affect the payments we receive from Medicare and Medicaid and other payors. Within the statutory framework of the Medicare and Medicaid programs, there are substantial areas subject to administrative rulings, interpretations and discretion, and which are at times subject to court challenges, which may further affect payments made under those programs. Further, the federal and state governments might, in the future, reduce the funds available under those programs, require repayment of previously received funds or require more stringent utilization and quality reviews of hospital facilities. Additionally, there may be a continued rise in managed care programs and additional restructuring of the financing and delivery of healthcare in the United States. These events could cause our future financial results to be adversely impacted. We cannot estimate the impact of Medicare and Medicaid reimbursement changes that have been enacted or are under consideration. We cannot predict whether additional reimbursement reductions will be made or whether any such changes or other restructuring of the financing and delivery of healthcare would have a material adverse effect on our business, financial conditions, results of operations, cash flow, capital resources and liquidity.

Critical Accounting Policies

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

Critical accounting policies are defined as those policies that involve a significant level of estimation uncertainty and have had or are reasonably likely to have a material impact on the financial condition or results of operations of the registrant. We believe that our critical accounting policies are limited to those described below. The following information should be read in conjunction with our significant accounting policies included in Note 1 of the Notes to the Consolidated Financial Statements included under Part II, Item 8 of our 2021 Form 10-K.

Revenue Recognition

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

Due to the complexities involved in these estimates, actual payments we receive could be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs and managed care contracts differed by 1% at June 30, 2022 from our estimated reimbursement percentage, net income for the six months ended June 30, 2022 would have changed by approximately $87 million, and net accounts receivable at June 30, 2022 would have changed by $112 million. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net (loss) income by an insignificant amount for each of the three and six-month periods ended June 30, 2022 and 2021.

Patient Accounts Receivable

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

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

Patient accounts receivable can be impacted by the effectiveness of our collection efforts and, as described in our significant accounting policies included in Note 1 of the Notes to Condensed Consolidated Financial Statements included under Part I, Item 1 of this Form 10-Q, numerous factors may affect the net realizable value of accounts receivable. If the actual collection percentage differed by 1% at June 30, 2022 from our estimated collection percentage as a result of a change in expected recoveries, net income for the six months ended June 30, 2022 would have changed by $40 million, and net accounts receivable at June 30, 2022 would have changed by $51 million. We also continually review our overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net operating revenues, as well as by analyzing current period net revenue and admissions by payor classification, days revenue outstanding, the composition of self-pay receivables between pure self-pay patients and the patient responsibility portion of third-party insured receivables and the impact of recent acquisitions and dispositions.

Our policy is to write-off gross accounts receivable if the balance is under $10.00 or when such amounts are placed with outside collection agencies. We believe this policy accurately reflects our ongoing collection efforts and is consistent with industry practices. We had approximately $1.8 billion at June 30, 2022, and $2.2 billion at December 31, 2021, being pursued by various outside collection agencies. We expect to collect less than 4%, net of estimated collection fees, of the amounts being pursued by outside collection agencies. As these amounts have been written-off, they are not included in our accounts receivable. Collections on amounts previously written-off are recognized as a recovery of net operating revenues when received. However, we take into consideration estimated collections of these future amounts written-off in determining the implicit price concessions used to measure the transaction price for the applicable portfolio of patient accounts receivable.

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

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

Days revenue outstanding, adjusted for the impact of receivables for state Medicaid supplemental payment programs and divested facilities, was 58 days and 55 days at June 30, 2022 and December 31, 2021, respectively.

Total gross accounts receivable (prior to allowance for contractual adjustments and implicit price concessions) was approximately $16.0 billion and $16.2 billion as of June 30, 2022 and December 31, 2021, respectively. The approximate percentage of total gross accounts receivable (prior to allowance for contractual adjustments and implicit price concessions) summarized by aging categories is as follows:

As of June 30, 2022:

	% of Gross Receivables			
Payor	**0 - 90 Days**	**90 - 180 Days**	**180 - 365 Days**	**Over 365 Days**
Medicare	12%	—%	—%	—%
Medicaid	7%	1%	1%	1%
Managed Care and Other	33%	6%	4%	3%
Self-Pay	8%	5%	9%	10%

As of December 31, 2021:

Payor	% of Gross Receivables			
	0 - 90 Days	90 - 180 Days	180 - 365 Days	Over 365 Days
Medicare	12%	1%	—%	—%
Medicaid	7%	1%	1%	1%
Managed Care and Other	33%	5%	3%	2%
Self-Pay	8%	5%	9%	12%

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

	June 30, 2022	December 31, 2021
Insured receivables	68.4%	66.3%
Self-pay receivables	31.6	33.7
Total	100.0%	100.0%

The combined total at our hospitals and clinics for the estimated implicit price concessions for self-pay accounts receivable and allowances for other self-pay discounts and contractuals, as a percentage of gross self-pay receivables, was approximately 91% at both June 30, 2022 and December 31, 2021. If the receivables that have been written-off, but where collections are still being pursued by outside collection agencies, were included in both the allowances and gross self-pay receivables specified above, the percentage of combined allowances to total self-pay receivables would have been 93% at both June 30, 2022 and December 31, 2021.

Goodwill

Taking into account recent developments as discussed below, we believe that our accounting policies with respect to the impairment of goodwill and other intangibles currently constitutes a critical accounting policy. Goodwill represents the excess of the fair value of the consideration conveyed in an acquisition over the fair value of net assets acquired. Goodwill is evaluated for impairment annually and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. We performed our last annual goodwill impairment evaluation during the fourth quarter of 2021 using the October 31, 2021 measurement date, which indicated no impairment.

The determination of fair value in our goodwill impairment analysis is based on an estimate of fair value for the hospital operations reporting unit utilizing known and estimated inputs at the evaluation date. Some of those inputs include, but are not limited to, the most recent price of our common stock or fair value of our long-term debt, our recent financial results, estimates of future revenue and expense growth, estimated market multiples, expected capital expenditures, income tax rates, and costs of invested capital.

At June 30, 2022, we had approximately $4.2 billion of goodwill recorded, all of which resides at our hospital operations reporting unit. A detailed evaluation of potential impairment indicators was performed as of June 30, 2022, which specifically considered declines in the fair market value of our senior secured and unsecured notes and common stock during the six months ended June 30, 2022 as well as macroeconomic conditions and our recent financial results, including the effect of increased wage and contract labor expense. On the basis of available evidence, as of June 30, 2022, we concluded that the fair value of the reporting unit was not more likely than not reduced to an amount less than its carrying value.

Future estimates of fair value could be adversely affected if the actual outcome of one or more of the assumptions described above changes materially in the future, including a decline in or volatility of our stock price and the fair value of our long-term debt, lower than expected hospital volumes, higher market interest rates, increased operating costs or other adverse impacts on our financial results. Such changes impacting the calculation of our fair value could result in a material impairment charge in the future. Moreover, the recent developments described in the immediately preceding paragraph have increased our risk of future goodwill impairment, which could be material.

Professional Liability Claims

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

The net present value of the projected payments was discounted using a weighted-average risk-free rate of approximately 3.4% and 1.8% at June 30, 2022 and December 31, 2021, respectively. This liability is adjusted for new claims information in the period such information becomes known to us. Professional malpractice expense includes the losses resulting from professional liability claims and loss adjustment expense, as well as excess insurance premiums, and is presented within other operating expenses in the accompanying condensed consolidated statements of (loss) income.

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

For purposes of estimating our individual claim accruals, we utilize specific claim information, including the nature of the claim, the expected claim amount, the year in which the claim occurred and the laws of the jurisdiction in which the claim occurred. Once the case accruals for known claims are determined, information is stratified by loss layers and retentions, accident years, reported years and geography. Several actuarial methods are used against this data to produce estimates of ultimate paid losses and reserves for incurred but not reported claims. Each of these methods uses our company-specific historical claims data and other information. Company-specific data includes information regarding our business, including historical paid losses and loss adjustment expenses, historical and current case loss reserves, actual and projected hospital statistical data, a variety of hospital census information, employed physician information, professional liability retentions for each policy year, geographic information and other data. Significant assumptions are made on the basis of the aforementioned information in estimating reserves for incurred but not reported claims. A 1% change in assumptions for either severity or frequency as of June 30, 2022 would have increased or decreased the reserve between $10 million to $20 million.

Based on these analyses, we determine our estimate of the professional liability claims. The determination of management's estimate, including the preparation of the reserve analysis that supports such estimate, involves subjective judgment of management. Changes in reserve data or the trends and factors that influence reserve data may signal fundamental shifts in our future claim development patterns or may simply reflect single-period anomalies. Even if a change reflects a fundamental shift, the full extent of the change may not become evident until years later. Moreover, since our methods and models use different types of data and we select our liability from the results of all of these methods, we typically cannot quantify the precise impact of such factors on our estimates of the liability. Due to our standardized and consistent processes for handling claims and the long history and depth of our company-specific data, our methodologies have historically produced reliably determinable estimates of ultimate paid losses. Management considers any changes in the amount and pattern of its historical paid losses up through the most recent reporting period to identify any fundamental shifts or trends in claim development experience in determining the estimate of professional liability claims. However, due to the subjective nature of this estimate and the impact that previously unforeseen shifts in actual claim experience can have, future estimates of professional liability could be adversely impacted when actual paid losses develop unexpectedly based on assumptions and settlement events that were not previously known or anticipated.

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

retentions were $2 million per occurrence. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 and before June 1, 2014 are self-insured up to $5 million per claim. Substantially all claims reported on or after June 1, 2014 and before June 1, 2018 are self-insured up to $10 million per claim. Substantially all claims reported on or after June 1, 2018 are self-insured up to $15 million per claim. Management, on occasion, has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future.

Excess insurance for all hospitals has been purchased through commercial insurance companies and generally covers us for liabilities in excess of the self-insured retentions. The excess coverage consists of multiple layers of insurance, the sum of which totals up to $95 million per occurrence and in the aggregate for claims reported on or after June 1, 2003, up to $145 million per occurrence and in the aggregate for claims reported on or after January 1, 2008, up to $195 million per occurrence and in the aggregate for claims reported on or after June 1, 2010, and up to at least $216 million per occurrence and in the aggregate for claims reported on or after June 1, 2015. In addition, for integrated occurrence malpractice claims, there is an additional $50 million of excess coverage for claims reported on or after June 1, 2014 and an additional $75 million of excess coverage for claims reported on or after June 1, 2015 through June 1, 2020. The $75 million in integrated occurrence coverage will also apply to claims reported between June 1, 2020 and June 1, 2023 for events that occurred prior to June 1, 2020 but which were not previously known or reported. For certain policy years prior to June 1, 2014, if the first aggregate layer of excess coverage becomes fully utilized, then the self-insured retention will increase to $10 million per claim for any subsequent claims in that policy year until our total aggregate coverage is met. Beginning June 1, 2018, this drop-down provision in the excess policies attaches over the $15 million per claim self-insured retention.

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

There were no significant changes in our estimate of the reserve for professional liability claims during the six months ended June 30, 2022.

Income Taxes

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

The total amount of unrecognized benefit that would impact the effective tax rate, if recognized, was less than $1 million as of June 30, 2022. A total of less than $1 million of interest and penalties is included in the amount of liability for uncertain tax positions at June 30, 2022. It is our policy to recognize interest and penalties related to unrecognized benefits in our condensed consolidated statements of (loss) income as income tax expense.

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

Our federal income tax return for the 2018 tax year remains under examination by the Internal Revenue Service. We believe the result of this examination will not be material to our consolidated results of operations or consolidated financial position. In addition, we have extended our federal statute of limitations through December 31, 2023 for the tax period ended December 31, 2018.

FORWARD-LOOKING STATEMENTS

This Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, Section 21E of the Securities Exchange Act of 1934, as amended, and the Private Securities Litigation Reform Act of 1995 that involve risks and uncertainties. Statements that are predictive in nature, that depend upon or refer to future events or conditions or that include words such as “expects,” “anticipates,” “intends,” “plans,” “believes,” “estimates,” “thinks,” and similar expressions are forward-looking statements. These statements involve known and unknown risks, uncertainties, and other factors that may cause our actual results and performance to be materially different from any future results or performance expressed or implied by these forward-looking statements. A number of factors could affect the future results of the Company or the healthcare industry generally and could cause the Company’s expected results to differ materially from those expressed in this Form 10-Q. These factors include, among other things:

- developments related to COVID-19, including, without limitation, related to the length and severity of the pandemic; the volume of canceled or rescheduled procedures; and the spread of potentially more contagious and/or virulent forms of the virus, including variants of the virus for which currently available vaccines, treatments and tests may not be effective or authorized;
- uncertainty regarding the magnitude and timing of any future payments or benefits we may receive or realize under the CARES Act, the PPPHCE Act, the CAA, the ARPA and any other future stimulus measures related to COVID-19;
- general economic and business conditions, both nationally and in the regions in which we operate, including inflationary pressures that have significantly increased and may continue to significantly increase our expenses, the extremely competitive labor market and labor shortages, and supply chain shortages and disruptions, as well as the current and/or potential future adverse impact of such economic conditions and other factors on our net operating revenues (including our service mix, revenue mix, payor mix and/or patient volumes) and our ability to collect outstanding receivables;
- the impact of current or future federal and state health reform initiatives, including the Affordable Care Act, and the potential for changes to the Affordable Care Act, its implementation or its interpretation (including through executive orders and court challenges);
- the extent to and manner in which states support increases, decreases or changes in Medicaid programs, implement health insurance exchanges or alter the provision of healthcare to state residents through legislation, regulation or otherwise;
- the future and long-term viability of health insurance exchanges and potential changes to the beneficiary enrollment process;
- risks associated with our substantial indebtedness, leverage and debt service obligations, including our ability to refinance such indebtedness on acceptable terms or to incur additional indebtedness, and our ability to remain in compliance with debt covenants;
- demographic changes;
- changes in, or the failure to comply with, federal, state or local laws or governmental regulations affecting our business, including any such laws or governmental regulations which are adopted in connection with the COVID-19 pandemic;
- potential adverse impact of known and unknown legal, regulatory and governmental proceedings and other loss contingencies, including governmental investigations and audits, and federal and state false claims act litigation;
- our ability, where appropriate, to enter into and maintain provider arrangements with payors and the terms of these arrangements, which may be further affected by the increasing consolidation of health insurers and managed care companies and vertical integration efforts involving payors and healthcare providers;
- changes in, or the failure to comply with, contract terms with payors and changes in reimbursement policies or rates paid by federal or state healthcare programs or commercial payors;
- any security breaches, cyber-attacks, loss of data, other cybersecurity threats or incidents, and any actual or perceived failures to comply with legal requirements governing the privacy and security of health information or other regulated, sensitive or confidential information, or legal requirements regarding data privacy or data protection;
- any potential impairments in the carrying value of goodwill, other intangible assets, or other long-lived assets, or changes in the useful lives of other intangible assets;
- changes in inpatient or outpatient Medicare and Medicaid payment levels and methodologies;
- the effects related to the implementation of the sequestration spending reductions pursuant to both the Budget Control Act of 2011 and the Pay-As-You-Go Act of 2010 and the potential for future deficit reduction legislation;
- increases in the amount and risk of collectability of patient accounts receivable, including decreases in collectability which may result from, among other things, self-pay growth and difficulties in recovering payments for which patients are responsible, including co-pays and deductibles;

- the efforts of insurers, healthcare providers, large employer groups and others to contain healthcare costs, including the trend toward value-based purchasing;
- the impact of competitive labor market conditions and the shortage of experienced nurses, including in connection with our ability to hire and retain qualified nurses, physicians, other medical personnel and key management, and increased labor expenses as a result of such competitive labor market conditions, inflation and competition for such positions;
- any failure to obtain medical supplies or pharmaceuticals at favorable prices;
- liabilities and other claims asserted against us, including self-insured malpractice claims;
- competition;
- trends toward treatment of patients in less acute or specialty healthcare settings, including ambulatory surgery centers or specialty hospitals or via telehealth;
- changes in medical or other technology;
- changes in GAAP;
- the availability and terms of capital to fund any additional acquisitions or replacement facilities or other capital expenditures;
- our ability to successfully make acquisitions or complete divestitures, our ability to complete any such acquisitions or divestitures on desired terms or at all, the timing of the completion of any such acquisitions or divestitures, and our ability to realize the intended benefits from any such acquisitions or divestitures;
- the impact that changes in our relationships with joint venture or syndication partners could have on effectively operating our hospitals or ancillary services or in advancing strategic opportunities;
- our ability to successfully integrate any acquired hospitals and/or outpatient facilities, or to recognize expected synergies from acquisitions;
- the impact of seasonal severe weather conditions and climate change, as well as the timing and amount of insurance recoveries in relation to severe weather events;
- our ability to obtain adequate levels of insurance, including cyber, general liability, professional liability, and directors and officers liability insurance;
- timeliness of reimbursement payments received under government programs;
- effects related to pandemics, epidemics, or outbreaks of infectious diseases, including the coronavirus causing the disease known as COVID-19;
- any failure to comply with our obligations under license or technology agreements;
- challenging economic conditions in non-urban communities in which we operate;
- any developments with respect to the final auditing and reporting requirements of, or other adverse developments with respect to, the Corporate Integrity Agreement to which we are subject;
- the concentration of our revenue in a small number of states;
- our ability to realize anticipated cost savings and other benefits from our current strategic and operational cost savings initiatives;
- any changes in or interpretations of income tax laws and regulations; and
- the risk factors set forth in our 2021 Form 10-K and our other public filings with the SEC.

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

Item 3. ***Quantitative and Qualitative Disclosures about Market Risk***

During the six months ended June 30, 2022, there have been no material changes in the quantitative and qualitative disclosures set forth in Item 7A. Quantitative and Qualitative Disclosures about Market Risk in our 2021 Form 10-K.

Item 4. ***Controls and Procedures***

Our Chief Executive Officer and Chief Financial Officer, with the participation of other members of management, have evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e)) under the Securities and Exchange Act of 1934, as amended, as of the end of the period covered by this report. Based on such evaluations, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective (at the reasonable assurance level) to ensure that the information required to be included in this report has been recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms and to ensure that the information required to be included in this report was accumulated and communicated to management, including our Chief Executive Officer and Chief Financial Officer, to allow timely decisions regarding required disclosure.

There have been no changes in our internal control over financial reporting during the six months ended June 30, 2022 that have materially affected or are reasonably likely to materially affect our internal controls over financial reporting.

PART II OTHER INFORMATION

Item 1. *Legal Proceedings*

From time to time, we receive inquiries or subpoenas from state regulators, state Medicaid Fraud Control units, fiscal intermediaries, CMS, the U.S. Department of Justice and other government entities regarding various Medicare and Medicaid issues. In addition to the matters discussed below, we are currently responding to subpoenas and administrative demands concerning (a) certain emergency care services provided at one of our Texas hospitals and (b) billing for certain procedures provided to dual-eligible patients at one of our Arkansas hospitals. In addition, we are subject to other claims and lawsuits arising in the ordinary course of our business including lawsuits and claims related to billing and collection practices at our hospitals. Based on current knowledge, management does not believe that loss contingencies arising from pending legal, regulatory and governmental matters, including the matters described herein, will have a material adverse effect on the consolidated financial position or liquidity of the Company. However, in light of the inherent uncertainties involved in pending legal, regulatory and governmental matters, some of which are beyond our control, and the very large or indeterminate damages sought in some of these matters, an adverse outcome in one or more of these matters could be material to our results of operations or cash flows for any particular reporting period. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Additionally, qui tam or "whistleblower" actions initiated under the civil False Claims Act, or FCA, may be pending but placed under seal by the court to comply with the FCA's requirements for filing such suits. In September 2014, the Criminal Division of the U.S. Department of Justice announced that all qui tam cases will be shared with their Division to determine if a parallel criminal investigation should be opened. The Criminal Division has also frequently stated an intention to pursue corporations in criminal prosecutions. From time to time, we detect issues of non-compliance with Federal healthcare laws pertaining to claims submission and reimbursement practices and/or financial relationships with physicians. We avail ourselves of various mechanisms to address potential overpayments arising out of these issues, including repayment of claims, rebilling of claims, and participation in voluntary disclosure protocols offered by CMS and the Office of Inspector General. Participating in voluntary repayments and voluntary disclosure protocols can have the potential for significant settlement obligations or even enforcement action.

The following legal proceedings are described in detail because, although certain legal proceedings may not be required to be disclosed in this Part II, Item 1 under SEC rules, due to the nature of the business of the Company, we believe that the following discussion of these matters may provide useful information to security holders. This discussion does not include claims and lawsuits covered by medical malpractice, general liability or employment practices insurance and risk retention programs, none of which claims or lawsuits would in any event be required to be disclosed in this Part II, Item 1 under SEC rules.

Shareholder Litigation

Caleb Padilla, individually and on behalf of all others similarly situated v Community Health Systems, Inc., Wayne T. Smith, Larry Cash, and Thomas J. Aaron. This purported federal securities class action was filed in the United States District Court for the Middle District of Tennessee on May 30, 2019. It seeks class certification on behalf of purchasers of our common stock between February 20, 2017 and February 27, 2018 and alleges misleading statements resulted in artificially inflated prices for our common stock. On November 20, 2019, the District Court appointed Arun Bhattacharya and Michael Gaviria as lead plaintiffs in the case. The lead plaintiffs filed a consolidated class complaint on January 21, 2020. The Company filed a motion to dismiss the consolidated class complaint on March 23, 2020. That motion is pending. We believe this matter is without merit and are vigorously defending this case.

Padilla Derivative Litigation. Four purported shareholder derivative cases have been filed in two District Courts relating to the factual allegations in the Padilla litigation; three of these cases have been consolidated in *In re Community Health Systems, Inc. Shareholder Derivative Litigation* and are pending in the United States District Court for the District of Delaware; namely, *Faisal Hussain v. Wayne T. Smith, et al,* filed August 12, 2019; *Susheel Tanjavoor v. Wayne T. Smith, et al.,* filed August 29, 2019; and *Kevin Aronson v. Wayne T. Smith, et al*, filed April 29, 2020. The fourth case, *Roger Trombley v. Wayne T. Smith, et al,* filed August 20, 2019, is pending in the United States District Court for the Middle District of Tennessee. All four cases seek relief derivatively and on behalf of Community Health Systems, Inc. against certain Company officers and directors based on alleged breaches of fiduciary duty, unjust enrichment, and other acts related to certain Company disclosures in 2017 and 2018 regarding the Company's adoption of Accounting Standards Update 2014-09, which the Company adopted effective January 1, 2018. All four cases are stayed by court order until the United States District Court for the Middle District of Tennessee rules on the defendants' motion to dismiss in the *Padilla* action.

Qui Tam Litigation

U.S. ex rel Larry Bomar v. Bayfront HMA Medical Center, LLC, et al – On September 14, 2017, our former hospital in St. Petersburg, Florida received a civil investigative demand, or CID, from the United States Department of Justice for information concerning its historic participation in the Florida Low Income Pool Program. The Low Income Pool Program, or LIP, is a funding pool to support healthcare providers that provide uncompensated care to Florida residents who are uninsured or underinsured. The

CID sought documentation related to agreements between the hospital and Pinellas County. On June 13, 2019, an additional ten of our affiliated hospitals in Florida received CIDs related to the same subject matter, along with two CIDs addressed to our affiliated management company and the Parent Company. We cooperated fully with the investigation. On September 15, 2021, the United States District Court for the Middle District of Florida ordered the unsealing of this *qui tam* complaint, which contains allegations related to the information sought in the September 14, 2017 CID. Specifically, the relator claims our former hospital in St. Petersburg – Bayfront Medical Center St. Petersburg – along with other, unaffiliated hospitals violated the False Claims Act by allegedly making certain contributions to a non-profit entity for the purpose of receiving supplemental Medicaid funding. The United States has declined to intervene in the case. We filed a motion to dismiss on November 23, 2021. That motion is pending. We believe this matter is without merit and are vigorously defending this case.

Commercial Litigation and Other Lawsuits

Thomas Mason, MD, Steven Folstad, MD and Mid-Atlantic Emergency Medical Associates, PA v Health Management Associates, LLC f/k/a Health Management Associates, Inc., Mooresville Hospital Management Associates d/b/a Lake Norman Regional Medical Center, Statesville HMA, LLC d/b/a Davis Regional Medical Center, Envision Healthcare Corporation f/k/a Emergency Medical Services Corporation, Emcare Holdings, Inc., and Emergency Medical Services, LP. This alleged wrongful retaliation case is filed in the United States District Court for the Western District of North Carolina. The plaintiffs allege their agreements with the defendants were terminated in retaliation for plaintiffs' alleged refusal to admit patients unnecessarily to the defendant hospitals or otherwise perform unnecessary diagnostic testing. The allegations of the complaint relate to time periods prior to the hospitals' affiliation with the Company. The plaintiffs filed a Third Amended Complaint on April 26, 2019. The defendants filed motions to dismiss, which were granted in part and denied in part on September 5, 2019. We believe these claims are without merit and are vigorously defending this case.

Tower Health, f/k/a Reading Health System, et al v CHS/Community Health Systems, Inc., et al. This breach of contract action is pending in the United States District Court for the Eastern District of Pennsylvania. The plaintiffs allege breaches of an asset purchase agreement in connection with the sale of Pottstown Memorial Medical Center. The alleged breaches regard plaintiffs' contention that the defendants failed to disclose certain conditions related to the physical plant of the hospital, along with various other alleged breaches of the asset purchase agreement. The plaintiffs filed an amended complaint on July 22, 2019. Trial for this matter began May 3, 2021, and closed on October 5, 2021. The court has not issued a decision. We believe these claims are without merit and are vigorously defending this case.

Daniel H. Golden, as Litigation Trustee of the QHC Litigation Trust, and Wilmington Savings Fund Society, FSB, solely in its capacity as indenture trustee v Community Health Systems, Inc., et al. A complaint in this case was filed on October 25, 2021 in the United States Bankruptcy Court for the District of Delaware against various persons, including the Company, certain subsidiaries of the Company, certain former executive officers of the Company and Credit Suisse Securities (USA) LLC. Plaintiff Daniel H. Golden is the litigation trustee for a litigation trust which was formed under the plan of reorganization of Quorum Health Corporation, or QHC, and certain affiliated entities confirmed by order of the United States Bankruptcy Court for the District of Delaware wherein QHC and certain affiliated entities contributed various causes of action to such litigation trust. Plaintiff Wilmington Savings Fund Society is the indenture trustee for certain notes issued by QHC. The complaint seeks damages and other forms of recovery arising out of certain alleged actions taken by the Company and the other defendants in connection with the spin-off of QHC which was completed on April 29, 2016, and includes claims for unjust enrichment and for avoidance of certain transactions and payments by QHC to the Company connected with the spin-off, including the $1.21 billion special dividend paid by QHC to the Company as part of the spin-off transactions. We filed a motion to dismiss on January 14, 2022, and oral argument on that motion was heard on July 21, 2022. That motion is still pending. We believe these claims are without merit and will vigorously defend this case.

Item 1A. Risk Factors

There have been no material changes with regard to the risk factors previously disclosed in the 2021 Form 10-K.

Item 2. Unregistered Sale of Equity Securities and Use of Proceeds

The following table contains information about our purchases of common stock during the three months ended June 30, 2022.

Period	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (b)	Maximum Number of Shares That May Yet Be Purchased Under the Plans or Programs (b)
April 1, 2022 - April 30, 2022	—	$ —	—	—
May 1, 2022 - May 31, 2022	—	—	—	—
June 1, 2022 - June 30, 2022	4,850	5.00	—	—
Total	4,850	$ 5.00	—	—

(a) 4,850 shares were withheld to satisfy the payment of tax obligations related to the vesting of restricted stock awards.
(b) We had no publicly announced repurchase programs for shares of our common stock during the three months ended June 30, 2022.

The ABL Facility and the indentures governing each series of our outstanding notes restrict our subsidiaries from, among other matters, paying dividends and making distributions to us, which thereby limits our ability to pay dividends and/or repurchase stock. As of June 30, 2022, under the most restrictive test in these agreements (and subject to certain exceptions), we have approximately $300 million of capacity to pay permitted dividends and/or repurchase shares of stock or make other restricted payments.

Item 3. Defaults Upon Senior Securities

None.

Item 4. *Mine Safety Disclosures*

Not applicable.

Item 5. *Other Information*

None.

Item 6. *Exhibits*

No.		Description
31.1	*	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	*	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	**	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	**	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	*	The following financial information from our quarterly report on Form 10-Q for the quarter and six months ended June 30, 2022 and 2021, filed with the SEC on July 28, 2022, formatted in Inline Extensible Business Reporting Language: (i) the condensed consolidated statements of (loss) income for the three and six months ended June 30, 2022 and June 30, 2021, (ii) the condensed consolidated statements of comprehensive (loss) income for the three and six months ended June 30, 2022 and June 30, 2021, (iii) the condensed consolidated balance sheets at June 30, 2022 and December 31, 2021, (iv) the condensed consolidated statements of cash flows for the six months ended June 30, 2022 and June 30, 2021, and (v) the notes to the condensed consolidated financial statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	*	Cover Page Interactive Data File (formatted as Inline XBRL and contained in Exhibit 101).

---

* Filed herewith.
** Furnished herewith.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

COMMUNITY HEALTH SYSTEMS, INC.
(Registrant)

By: /s/ Tim L. Hingtgen
Tim L. Hingtgen
Director and
Chief Executive Officer

By: /s/ Kevin J. Hammons
Kevin J. Hammons
President and
Chief Financial Officer

By: /s/ Jason K. Johnson
Jason K. Johnson
Senior Vice President and
Chief Accounting Officer

Date: July 28, 2022

Exhibit 31.1

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

I, Tim L. Hingtgen, certify that:

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

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

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

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

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

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

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

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

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

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

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

/s/ Tim L. Hingtgen

Tim L. Hingtgen
Chief Executive Officer

Date: July 28, 2022

Exhibit 31.2

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

I, Kevin J. Hammons, certify that:

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

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

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

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

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

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

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

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

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

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

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

/s/ Kevin J. Hammons

Kevin J. Hammons
President and Chief Financial Officer

Date: July 28, 2022

Exhibit 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Community Health Systems, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2022, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Tim L. Hingtgen, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Tim L. Hingtgen

Tim L. Hingtgen
Chief Executive Officer

July 28, 2022

Exhibit 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Community Health Systems, Inc. (the “Company”) on Form 10-Q for the period ended June 30, 2022, as filed with the Securities and Exchange Commission on the date hereof (the “Report”), I, Kevin J. Hammons, President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Kevin J. Hammons

Kevin J. Hammons
President and Chief Financial Officer

July 28, 2022