COMMUNITY HEALTH SYSTEMS INC
Form 10-K
February 21, 2017
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UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the year ended December 31, 2016
OR
TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

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

COMMUNITY HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**13-3893191**
(State of incorporation)	*(IRS Employer Identification No.)*
4000 Meridian Boulevard	**37067**

Franklin, Tennessee *(Zip Code)*

(Address of principal executive offices)

Registrant s telephone number, including area code:

(615) 465-7000

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

Title of Each Class	**Name of Each Exchange on Which Registered**
Common Stock, $.01 par value	New York Stock Exchange
Stock Purchase Rights	New York Stock Exchange
Contingent Value Rights	The NASDAQ Stock Market LLC

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

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

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

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

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

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

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

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

The aggregate market value of the voting stock held by non-affiliates of the Registrant was $1,321,763,644. Market value is determined by reference to the closing price on June 30, 2016 of the Registrant s Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2016) have any non-voting

common stock outstanding. As of February 15, 2017, there were 113,849,339 shares of common stock, par value $.01 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Certain information required for Part III of this annual report is incorporated by reference to portions of the Registrant s definitive proxy statement for its 2017 annual meeting of stockholders to be filed with the Securities and Exchange Commission within 120 days after the end of the Registrant s fiscal year ended December 31, 2016.

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COMMUNITY HEALTH SYSTEMS, INC.

Year ended December 31, 2016

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

Overview of Our Company

We are one of the largest publicly-traded hospital companies in the United States and a leading operator of general acute care hospitals and outpatient facilities in communities across the country. We were originally founded in 1986 and were reincorporated in 1996 as a Delaware corporation. We provide healthcare services through the hospitals that we own and operate and affiliated businesses in non-urban and selected urban markets throughout the United States. As of December 31, 2016, we owned or leased 155 hospitals included in continuing operations, with an aggregate of 26,222 licensed beds, comprised of 152 general acute care hospitals and three stand-alone rehabilitation or psychiatric hospitals. These hospitals are geographically diversified across 21 states, with the majority of our hospitals located in regional networks or in close geographic proximity to one or more of our other hospitals. We also owned or leased three hospitals included in discontinued operations at December 31, 2016. We generate revenues by providing a broad range of general and specialized hospital healthcare services and outpatient services to patients in the communities in which we are located. Services provided through our hospitals and affiliated businesses include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric and rehabilitation services. We also provide additional outpatient services at urgent care centers, occupational medicine clinics, imaging centers, cancer centers, ambulatory surgery centers and home health and hospice agencies. An integral part of providing these services is our network of affiliated physicians at our hospitals and affiliated businesses. As of December 31, 2016, we employed approximately 3,000 physicians and an additional 1,000 licensed healthcare practitioners. Through our management and operation of these businesses, we provide standardization and centralization of operations across key business areas; strategic assistance to expand and improve services and facilities; implementation of patient safety and quality of care improvement programs and assistance in the recruitment of additional physicians and licensed healthcare practitioners to the markets in which our hospitals are located. In a number of our markets, we have partnered with local physicians or not-for-profit providers, or both, in the ownership of our facilities. The financial information for our reportable operating segments is presented in Note 15 of the Notes to our Consolidated Financial Statements included under Part II, Item 8 of this Annual Report on Form 10-K, or Form 10-K.

Our business strategy has historically included growth by acquisition. In this regard, we have generally targeted hospitals in growing, non-urban and selected urban healthcare markets for acquisition because of their favorable demographic and economic trends and competitive conditions. Because non-urban and suburban service areas have smaller populations, there are generally fewer hospitals and other healthcare service providers in these communities and generally a lower level of managed care presence in these markets. We believe that communities with smaller populations generally view the local hospital as an integral part of the community and support less direct competition for hospital-based services. Since 2007, we have substantially increased the size of our business and the number of hospitals we operate through the acquisitions of hospitals from Triad Hospitals, Inc., or Triad, and Health Management Associates, Inc., or HMA. Our growth strategy has also included developing or acquiring select physician practices, physician-owned ancillary service providers and other outpatient capabilities in markets where we already had a hospital presence. More recently, our efforts have focused on creating regional networks in select urban markets. We believe opportunities exist for skilled, disciplined operators to create networks between urban and non-urban hospitals while improving physician alignment in both markets and making the hospitals more attractive to managed care.

We have been implementing a portfolio rationalization and deleveraging strategy by divesting hospitals and non-hospital businesses that are attractive to strategic and other buyers. Generally, these businesses are not in one of our strategically beneficial service areas, are less complementary to our business strategy and/or have lower operating margins. More recently, in connection with our announced divestiture initiative, strategic buyers have made offers to

buy certain of our assets. Through consideration of these offers we have divested or may divest hospitals and non-hospital businesses when we find such offers to be attractive and in line with our operating strategy. In addition, we expect to return to our acquisition strategy when our portfolio rationalization and deleveraging strategy has been sufficiently completed.

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On January 27, 2014, we completed the acquisition of HMA for approximately $7.3 billion, including the assumption of approximately $3.8 billion of indebtedness, which is referred to in this report as the HMA merger. Additional details regarding the HMA merger are set forth in the Executive Overview section of Management s Discussion and Analysis of Financial Condition and Results of Operations under Part II, Item 7 of this Annual Report on Form 10-K.

On April 29, 2016, we completed a spin-off of 38 hospitals and Quorum Health Resources, LLC, or QHR (our subsidiary through which we provided management advisory and consulting services to non-affiliated general acute care hospitals located throughout the United States), into Quorum Health Corporation, or QHC, and distributed, on a pro rata basis, all of the shares of QHC common stock to our stockholders of record as of April 22, 2016. These stockholders received one share of QHC common stock for every four shares of our common stock held as of the record date plus cash in lieu of any fractional shares. The transaction was structured to be generally tax free to us and our stockholders. In recognition of the spin-off, we recorded a non-cash dividend of approximately $713 million during the year ended December 31, 2016, representing the net assets of QHC distributed to our stockholders. Following the spin-off, QHC became an independent public company with its common stock listed for trading under the symbol QHC on the New York Stock Exchange. Financial and statistical data reported in this Form 10-K include QHC operating results through the spin-off date. Same-store operating results and statistical data exclude information for the hospitals divested in the spin-off of QHC in the years ended December 31, 2016, and for the comparable periods in 2015 and 2014.

In connection with the spin-off, we entered into a separation and distribution agreement as well as certain ancillary agreements with QHC on April 29, 2016. These agreements allocate between QHC and us the various assets, employees, liabilities and obligations (including investments, property and employee benefits and tax-related assets and liabilities) that comprise the separate companies and govern certain relationships between, and activities of, QHC and us for a period of time after the spin-off.

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

As initially disclosed on September 19, 2016, with the assistance of advisors, we are exploring a variety of options with financial sponsors, as well as other potential alternatives. These discussions are ongoing. There can be no certainty that the exploration will result in any kind of transaction. We do not expect to make further public comment regarding these matters while the exploration process takes place unless and until we otherwise deem further public comment is appropriate or required.

In addition, our Board of Directors adopted a Stockholder Protection Rights Agreement on October 3, 2016. The Stockholder Protection Rights Agreement will not prevent our takeover, but may cause substantial dilution to a person or group that acquires 15% or more of our common stock, which may inhibit or render more difficult a merger, tender offer or other business combination involving us that is not supported by our Board of Directors. The Stockholder Protection Rights Agreement will expire on April 1, 2017.

Available Information

Our website address is www.chs.net and the investor relations section of our website is located at www.chs.net/investor-relations. We make available free of charge, through the investor relations section of our

website, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K as well as amendments to those reports, as soon as reasonably practical after they are filed with, or furnished to, the SEC. Our filings are also available to the public at the website maintained by the SEC, www.sec.gov.

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

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

Our Business Strategy

Our objective is to increase shareholder value by providing high-quality patient care using cost effective and efficient operations. The key elements of our business strategy to achieve this objective are to:

expand and strengthen regional networks,

increase revenue at our facilities,

increase productivity and operating efficiency,

improve patient safety and quality of care,

rationalize our portfolio through divestitures of hospitals and non-hospital businesses, and

grow through selective acquisitions.

Expand and Strengthen Regional Networks

We believe opportunities exist in select urban markets to create networks between urban hospitals and non-urban hospitals in order to expand the breadth of services offerings in the non-urban hospitals while improving alignment in these markets and making them more attractive to managed care.

Currently, 74 of our hospitals operate in 11 unique regional networks, which are comprised of one or more larger hospitals with smaller hospitals located in nearby communities. Within each regional network, we leverage the network s brand and local scale to expand our continuum of care, enhance access to our facilities, provide a more integrated service offering and reduce costs through increased operating efficiencies. Additionally, 34 of our hospitals operate in close geographic proximity to one or more of our other hospitals in 13 geographic areas. For these hospitals, we seek to develop or expand similar specialty services and outpatient services as our regional networks to yield high patient and physician satisfaction, improve revenue and gain operational efficiencies. As of December 31, 2016, we estimate that approximately 70% of our facilities are located in regional networks or are in close proximity to another CHS hospital.

Increase Revenue at Our Facilities

Overview. We are implementing a strategy to expand and rationalize service lines. We believe this focused, service line strategy facilitates better capital allocation, and drives volume, acuity and rate growth in desirable areas. In addition, we are expanding the medical services we provide through the recruitment of additional primary care physicians and specialists. We also work with local hospital boards, management teams and medical staffs to determine the number and type of additional physician specialties needed. In recent years, we have built through acquisitions and consolidation several major networks of affiliated hospitals in key states in which we operate. We believe these hospital networks allow us to provide more integrated services and maximize the usage of our strong physician base.

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Our initiatives to increase revenue include:

- recruiting and/or employing additional primary care physicians and specialists,
- expanding patient access points and the breadth of services offered at our hospitals, our affiliated businesses and in the communities in which we operate, through targeted capital expenditures and physician alignment to support the addition of more convenient or complex services, including orthopedics, cardiovascular services, urology and urgent care,
- providing the capital to invest in technology and the physical plant at our facilities, particularly in our emergency rooms, surgery departments, critical care departments and in diagnostic services, and
- executing select managed care contracts through a centrally managed review process.

Physician Recruiting. The primary method of adding or expanding medical services is the recruitment of new primary care physicians and specialists into the community. A core group of primary care physicians is necessary as an initial contact point for all local healthcare. The addition of specialists who offer services, including general surgery, obstetrics and gynecology, cardiovascular services, orthopedics and urology, completes the full range of medical and surgical services required to meet a community s core healthcare needs. At the time we acquire a hospital, and from time to time thereafter, we identify the healthcare needs of the community in which such hospital is located by analyzing demographic data and patient referral trends. As a result of this analysis, we are able to determine what we believe to be the optimum mix of primary care physicians and specialists. We employ recruiters at the corporate level to support the local hospital managers in their recruitment efforts. In some markets, we employ physicians, often acquiring their practice at the onset of the arrangement. We have increased the number of physicians affiliated with us through our recruiting and employment efforts. The percentage of recruited or employed physicians commencing practice with us that were specialists was over 70% in 2016. However, most of the physicians in our communities remain in private practice and are not our employees. We believe we have been successful in recruiting and employing physicians because of the practice opportunities afforded physicians in our markets, as well as lower managed care penetration as compared to larger urban areas.

Expansion of Services and Capital Investment. In an effort to better meet the healthcare needs of the communities we serve and to capture a greater portion of the healthcare spending in our markets, we have added a broad range of services to our facilities and, in certain markets, acquired physician practices to broaden our service offerings. These services range from various types of diagnostic equipment capabilities to additional and renovated emergency rooms, surgical and critical care suites and specialty services. We have concentrated our focus on expanding our service lines to those service offerings that we believe have the greatest growth potential, including orthopedics, neuroscience, cardiovascular care, women s health and cancer care. We have been able to expand these service lines through providing additional access points separate from the traditional hospital service location, the maximization of physician practice utilization, creation of free-standing emergency departments, joint venture partnerships with third-party urgent care, diagnostic, imaging and other retail service locations, expansion of outside diagnostic and surgery center locations, and advancing tele-health strategies. Focused initiatives in these areas are intended to provide quicker access to care in a lower cost setting, increase the number of patient transfer centers to better coordinate care, and implement digital health solutions to improve patient engagement and satisfaction. Some of these initiatives include:

expanding our orthopedic program and creating a more standardized process of orthopedic care;

expanding and renovating existing emergency rooms to improve service and reduce waiting times;

increasing the number of patient transfer centers to better coordinate care among our physicians, hospitals and outpatient centers. Transfer centers enable patients to be transported to facilities that provide the services they need in our hospitals; and

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leveraging digital tools to create virtual access points and improve our patient and physician experiences. These digital solutions use clinical protocols and analytics to drive patient outreach for scheduling appointments, assist with referral management to keep patients in-network when possible and provide post care follow-up, including treatment plans, health education, prescription reminders and prevention screening. We also have introduced a tool that enables patients to compare pricing for select outpatient services among our facilities and those of competitors in our markets.

In addition to these initiatives, we believe our investment in expanding our footprint through free-standing emergency departments, ambulatory surgery centers and urgent care centers will generate increased revenues and earnings from businesses with higher growth and operating margins. We believe that appropriate capital investments in our outpatient facilities combined with the development of our service capabilities will increase patient retention while providing an attractive return on investment.

We spent approximately $192 million on 93 major construction projects that were completed in 2016. These projects included new emergency rooms, cardiac catheterization laboratories, hospital additions and surgical suites as well as improvements to various diagnostic and other inpatient and outpatient service capabilities. We also employ a small group of clinical consultants at our corporate headquarters to assist the hospitals in their development of surgery, emergency, critical care, cardiovascular and hospitalist services. In addition to spending capital on expanding services at our existing hospitals, we also build replacement facilities in certain markets to better meet the healthcare needs in those communities. In 2015, we completed Grandview Medical Center, a replacement hospital in Birmingham, Alabama. Transfer of all operations to this new facility was completed on October 10, 2015. As part of an acquisition in 2012, we agreed to build a replacement hospital in York, Pennsylvania by July 2017. The total cost of the replacement hospital in York, Pennsylvania is estimated to be $125 million. In 2016, we spent $12 million on the construction project related to the York replacement hospital. In 2015, we spent $123 million on construction projects related to the Birmingham and York replacement hospitals.

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

Increase Productivity and Operating Efficiency

Overview. We focus on improving operating efficiency to enhance our operating margins. We seek to implement cost containment programs and adhere to operating philosophies that focus on standardizing and centralizing our methods of operation and management, including:

monitoring and enhancing productivity of our human resources,

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

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

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

In addition, each of our hospital management teams is supported by our centralized operational, reimbursement, regulatory and compliance expertise, as well as by our senior management team that has substantial industry knowledge and a proven track record of operations success in the hospital industry. Our chief executive officer and chief financial officer each have over 30 years of experience in the healthcare industry and have worked together since 1973. Our five division presidents have each worked at the Company for many years and average 21 years of experience in hospital and division executive roles. Additionally, we have recently made several key external hires to further strengthen our senior management team.

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

Billing and Collections. We have adopted standard policies and procedures with respect to billing and collections. We have also automated and standardized various components of the collection cycle, including statement and collection letters and the movement of accounts through the collection cycle. Upon completion of an acquisition, our management information systems team converts the hospital s existing information system to our standardized system. This enables us to quickly implement our business controls and cost containment initiatives. Additionally, we have consolidated local billing and collection functions into six centralized business offices and have completed the transition of our hospitals to this new system and have started to benefit from lower patient denials, underpayment recoveries and reduced operating expenses.

Physician Support. We support our newly recruited physicians to enhance their transition into our communities. All newly recruited physicians who enter into contracts with us participate in an online orientation that covers issues related to starting up or joining a practice. For our employed physicians, we are leveraging software solutions that monitor physician practice performance. We have also implemented programs to improve physician workflow, reduce physician turnover, optimize staffing at physician clinics and standardize onboarding processes.

Procurement and Materials Management. We have standardized and centralized our operations with respect to medical supplies, equipment and pharmaceuticals used in our hospitals. We have a participation agreement with HealthTrust Purchasing Group, L.P., or HealthTrust, a group purchasing organization, or GPO. HealthTrust contracts with certain vendors who supply a substantial portion of our medical supplies, equipment and pharmaceuticals. The current term of our agreement with HealthTrust expires in January 2018, with automatic renewal terms of one year unless either party terminates by giving notice of non-renewal.

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

Other Initiatives. We have also improved efficiency and productivity by implementing standard programs with respect to ancillary services in various areas, including emergency rooms, pharmacy, laboratory, imaging, home care, skilled nursing, centralized outpatient scheduling and health information management. Moreover, we have implemented initiatives intended to realize employee benefit savings on medical benefits, prescription services and high medical claims and to reduce

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overtime and use of temporary staffing to align with patient admissions. We work to identify and communicate best practices and monitor these improvements throughout the Company.

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

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

appropriate management of length of stay consistent with national standards and benchmarks,

reducing unnecessary utilization,

developing and implementing operational best practices,

discharge planning, and

compliance with all regulatory standards.

Our case management program integrates the functions of utilization review, discharge planning, assessment of medical necessity and resource management. Patients are assessed upon presentation to the hospital and throughout their course of care with ongoing reviews. Industry standard criteria are utilized in patient assessments, and discharge plans are adjusted according to patient needs. Cases are monitored to prevent delays in service or unnecessary utilization of resources. When a patient is ready for discharge, a case manager works with the patient s attending physician to evaluate and coordinate the patient s needs for continued care in the post-acute setting. Each hospital has the support of a physician advisor to act as a liaison to the medical staff and assist with all the activities of the program.

Improve Patient Safety and Quality of Care

Each of our hospitals is operated by a corporate board of directors that has established a local board of trustees, which includes members of the hospital s medical staff. The board of directors delegates certain matters to the board of trustees, including establishing policies concerning the hospital s medical, professional, and ethical practices, monitoring these practices, and responsibility for ensuring that these practices conform to legally required standards. We maintain quality assurance programs to support and monitor quality of care standards and to meet Medicare and Medicaid accreditation and regulatory requirements. Patient care evaluations and other quality of care assessment activities are reviewed and monitored continuously with comparison to regional and national benchmarks when available.

We maintain an emphasis on patient safety, the provision of quality care and improving clinical outcomes. We understand that high levels of quality are only achieved with a company-wide focus that embraces patient, physician

and employee satisfaction and continual, systematic clinical improvements. We believe that a focus on continuous improvement yields the best results for patients, reduces risk and improves revenue through achievement of quality measures. We have developed and implemented programs to support and monitor patient safety and quality of care that include:

- standardized data and benchmarks to monitor hospital performance and quality improvement efforts;
- recommended policies and procedures based on the best medical and scientific evidence as well as training on evidence-based tools for improving patient, physician and employee satisfaction;
- leveraging of technology and sharing of evidence-based clinical best practices;

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training programs for hospital management and clinical staff regarding regulatory and reporting requirements; and

implementation of specific leadership methods and error-prevention tools to create safer care environments for patients and staff.

As a result of these efforts, we have made significant progress in patient safety and clinical quality.

In 2011, we established a component patient safety organization, or PSO, which was listed by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality on January 11, 2012. We believe our PSO has assisted, and will continue to assist, us in improving patient safety at our hospitals. The PSO was recertified in 2014 through 2018.

Divestiture and Acquisition Strategy

Divestiture and Acquisition Criteria. Acquisitions have been a core part of our growth strategy historically. We have been implementing a portfolio rationalization and deleveraging strategy by divesting hospitals and non-hospital businesses that are attractive to strategic and other buyers. Generally, these businesses are not in one of our strategically beneficial service areas, are less complementary to our business strategy and/or have lower operating margins. In addition to the spin-off of the 38 facilities to QHC which was completed in April 2016 as noted above, in 2016 we divested two facilities and an 80% ownership interest in our home care division, which, as of December 31, 2016, owned and operated 74 licensed home care agencies and 15 licensed hospice agencies. For additional information regarding potential additional dispositions, see the Executive Overview of Management s Discussion and Analysis of Financial Condition and Results of Operations under Part II, Item 7 of this Form 10-K.

Although we are not actively pursuing hospital acquisition opportunities at this time, we have continued to invest capital strategically in selected physician practice and ancillary service locations that will enhance the service lines and patient access points for our existing hospitals. We intend to focus again on hospital acquisitions once our portfolio rationalization has been sufficiently completed, and, at that time return to a disciplined and targeted approach to hospital acquisitions and seek opportunities that are complementary to our existing markets or represent new markets that fit our operating criteria. At that time, we may pursue acquisition candidates that:

are located in a market that has a stable or growing population base,

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

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

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

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

In 2016 we acquired three hospitals located in Fayetteville, Arkansas; La Porte, Indiana and Knox, Indiana. We believe that our access to capital, reputation for providing quality care and ability to recruit physicians makes us an attractive partner for these communities. No hospital acquisitions closed during 2015.

On January 27, 2014, we completed the merger with HMA, which at the time of acquisition owned or leased 71 hospitals. In addition to the HMA hospitals, during 2014 we acquired four other hospitals located in Ocala, Florida; Sharon, Pennsylvania; Natchez, Mississippi; and Gaffney, South Carolina.

Acquisition Efforts. A key part of our strategy has involved establishing a broader presence in our states and markets of operation and expanding and strengthening our regional networks where appropriate. Apart from our

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acquisition of Triad hospitals in 2007 and HMA in 2014, most of the hospitals that we have acquired have been municipal or other not-for-profit hospitals. We believe that our access to capital, ability to recruit physicians and reputation for providing quality care make us an attractive partner for these communities. In addition, we have found that communities located in states where we already operate a hospital are more receptive to our acquiring their hospitals, because they are aware of our operating track record with respect to our other hospitals within the state.

At the time we have acquired a hospital, we may commit to an amount of capital expenditures, such as a replacement facility, renovations, or equipment over a specified period of time.

Pursuant to a hospital purchase agreement in effect as of December 31, 2016, we have committed to build replacement facilities in both La Porte, Indiana and Knox, Indiana by March 2021. Construction costs, including equipment costs, for the La Porte and Knox replacement facilities are currently estimated to be approximately $125 million and $15 million, respectively. No costs have been incurred to date on those facilities. Additionally, we are required to build a replacement facility in York, Pennsylvania by July 2017. Estimated construction costs, including equipment costs, are approximately $125 million for this replacement facility, of which approximately $17 million has been incurred to date. Under other purchase agreements in effect as of December 31, 2016, we have committed to spend $464 million, generally over a five to seven year period after acquisition, for costs such as capital improvements, equipment, selected leases and physician recruiting. Through December 31, 2016, we have incurred approximately $209 million related to these commitments.

Industry Overview

According to the Centers for Medicare & Medicaid Services, or CMS, national healthcare expenditures in 2016 are projected to have grown 4.8% to approximately $3.4 trillion. In addition, these CMS projections, published 2017, indicate that total U.S. healthcare spending will grow at an average annual rate of 5.9% for 2018 through 2019 and by an average of 5.8% annually from 2020 through 2025. However, these projections do not take into account initiatives, programs or other developments that may result from the 2016 federal elections, including any potential significant modifications to or repeal of the Affordable Care Act. CMS also projected that total U.S. healthcare annual expenditures will exceed $5.5 trillion by 2025, accounting for approximately 19.9% of the total U.S. gross domestic product. CMS expects healthcare spending to be largely influenced by changes in economic growth and population aging, and anticipates faster growth in medical prices.

Hospital services, the market within the healthcare industry in which we primarily operate, is the largest single category of healthcare expenditures. In 2016, hospital care expenditures are projected to have grown 4.9%, amounting to over $1 trillion. CMS estimates that the hospital services category will exceed $1.1 trillion in 2017, and projects growth in this category at an average of 5.5% annually from 2016 through 2025.

U.S. Hospital Industry. The U.S. hospital industry is broadly defined to include acute care, rehabilitation and psychiatric facilities that are either public (government owned and operated), not-for-profit private (religious or secular), or for-profit institutions (investor owned). According to the American Hospital Association, there are 4,800 community hospitals in the U.S. which are not-for-profit owned, investor owned, or state or local government owned. Of these hospitals, nearly 40% are located in non-urban communities. We believe that a majority of these hospitals are owned by not-for-profit or governmental entities. These facilities offer a broad range of healthcare services, including internal medicine, general surgery, cardiology, oncology, orthopedics, OB/GYN and emergency services. In addition, hospitals offer other ancillary services, including psychiatric, diagnostic, rehabilitation, home care and outpatient surgery services.

Urban vs. Non-Urban Hospitals. According to the U.S. Census Bureau, 19.3% of the U.S. population lives in communities designated as non-urban. In these non-urban communities, hospitals are typically the primary source of healthcare. In many cases a single hospital is the only provider of general healthcare services in these communities.

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

facility size and location,

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

a facility s ability to participate in GPOs, and

facility payor mix.

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

Hospital Industry Trends

Demographic Trends. According to the U.S. Census Bureau, in 2015, there were approximately 48 million Americans aged 65 or older in the U.S. comprising approximately 14.9% of the total U.S. population. By the year 2030, the number of Americans aged 65 or older is expected to climb to 72 million, or 19.3% of the total population. Due to the increasing life expectancy of Americans, the number of people aged 85 years and older is also expected to increase from 6 million in 2015 to 9 million by the year 2030. This increase in life expectancy will increase demand for healthcare services and, as importantly, the demand for innovative, more sophisticated means of delivering those services. Hospitals, as the largest category of care in the healthcare market, will be among those impacted most directly by this increase in demand. Based on data compiled for us, the populations of the service areas where our hospitals are located grew 4.6% from 2011 to 2016 and are expected to grow by 4.3% from 2016 to 2021. The number of people aged 65 or older in these service areas grew by 17.7% from 2011 to 2016 and is expected to grow by 17.4% from 2016 to 2021. People aged 65 or older comprised 17.1% of the total population in our service areas in 2016, yet they could comprise 19.3% of the total population in our service areas by 2021.

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

ample supply of available capital,

valuation levels,

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

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

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

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

changes to healthcare payment models that emphasize cost-effective delivery of service and quality of outcomes for the entire episode of care, and

regulatory changes.

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

Trends in Payment for Healthcare Services. As discussed in more detail in the Government Regulation section of this Form 10-K, the impact of healthcare reform legislation, combined with the growing financial and economic pressures on the healthcare industry, has resulted in challenges to traditional reimbursement trends. For example, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, collectively, the Affordable Care Act, has encouraged the adoption of new payment models that emphasize cost effective delivery of care and quality of outcomes. Although health insurance coverage has expanded, patients may face higher deductibles and increased co-payment requirements, which may result in greater write-offs of uncollectible amounts from those patients.

Shift to Outpatient Services. Because of the growing availability of stand-alone outpatient healthcare facilities and the increase in the services that are able to be provided at these locations, many individuals are seeking a broader range of services at outpatient facilities. This trend has contributed to an increase in outpatient services while inhibiting the growth of inpatient admissions.

Selected Operating Data

The following table sets forth operating statistics for our hospitals for each of the years presented, which are included in our continuing operations. Statistics for 2016 include a full year of operations for 152 hospitals and partial periods for three hospitals acquired during the year reflecting the operations of these hospitals following the completion of the acquisition. Statistics for 2015 include a full year of operations for 194 hospitals. Statistics for 2014 include a full year of operations for 127 hospitals and partial periods for 70 hospitals acquired during the year reflecting the operations of these hospitals following the completion of the acquisition. Statistics for hospitals included in discontinued operations are excluded from all periods presented.

	Year Ended December 31,		
	2016	2015	2014
	(Dollars in millions)		
Consolidated Data			
Number of hospitals (at end of period)	155	194	197
Licensed beds (at end of period)(1)	26,222	29,853	30,137
Beds in service (at end of period)(2)	23,229	26,312	27,000
Admissions(3)	857,412	940,292	924,557
Adjusted admissions(4)	1,867,348	2,038,103	1,969,770
Patient days(5)	3,832,104	4,175,214	4,091,183
Average length of stay (days)(6)	4.5	4.4	4.4
Occupancy rate (beds in service)(7)	43.1 %	43.3 %	43.8 %
Net operating revenues	$ 18,438	$ 19,437	$ 18,639
Net inpatient revenues as a % of net patient revenues before provision for bad debts	43.2 %	42.8 %	43.9 %
Net outpatient revenues as a % of net patient revenues before provision for bad debts	56.8 %	57.2 %	56.1 %

Net (loss) income attributable to Community Health Systems Inc. stockholders	$ (1,721)	$ 158	$ 92
Net (loss) income attributable to Community Health Systems Inc. stockholders as a % of net operating revenues	(9.3)%	0.8 %	0.5 %
Adjusted EBITDA(8)	$ 2,225	$ 2,670	$ 2,777
Adjusted EBITDA as a % of net operating revenues(8)	12.1 %	13.7 %	14.9 %
Liquidity Data			
Net cash flows provided by operating activities	$ 1,137	$ 921	$ 1,615

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	Year Ended December 31,		
	2016	2015	2014
	(Dollars in millions)		
Net cash flows provided by operating activities as a % of net operating revenues	6.2 %	4.7 %	8.7 %
Net cash flows provided by (used in) investing activities	$ 630	$ (1,051)	$ (4,351)
Net cash flows (used in) provided by financing activities	$ (1,713)	$ (195)	$ 2,872

	Year Ended December 31,		(Decrease) Increase
	2016	2015	
	(Dollars in millions)		
Same-Store Data(9)			
Admissions(3)	818,559	834,383	(1.9)%
Adjusted admissions(4)	1,773,093	1,782,134	(0.5)%
Patient days(5)	3,678,397	3,752,264	
Average length of stay (days)(6)	4.5	4.5	
Occupancy rate (beds in service)(7)	43.4 %	44.3 %	
Net operating revenues	$ 17,481	$ 17,248	1.4 %
Income from operations	$ 1,069	$ 1,498	(28.6)%
Income from operations as a % of net operating revenues	6.1 %	8.7 %	
Depreciation and amortization	$ 1,045	$ 1,030	
Equity in earnings of unconsolidated affiliates	$ (14)	$ (11)	

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

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

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

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

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

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

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

(8) EBITDA is a non-GAAP financial measure which consists of net (loss) income attributable to Community Health Systems, Inc. before interest, income taxes, depreciation and amortization. Adjusted EBITDA, also a non-GAAP financial measure, is EBITDA adjusted to add back net income attributable to noncontrolling interests and to exclude the effect of discontinued operations, loss from early extinguishment of debt, impairment and (gain) loss on sale of business, gain on sale of investments in unconsolidated affiliates, acquisition and integration expenses from the acquisition of HMA, expense incurred related to the spin-off of QHC, expense incurred related to the sale of a majority ownership interest in our home care division, expense related to government and other legal settlements and related costs, and (income) expense from fair value adjustments on the CVR agreement liability accounted for at fair value related to the HMA legal proceedings, and related legal expenses. We have from time to time sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. We believe that it is useful to present Adjusted EBITDA because it adds back the portion of EBITDA attributable to these third-party interests and clarifies for investors our portion of EBITDA generated by continuing

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operations. We now report Adjusted EBITDA as a measure of financial performance rather than as a liquidity measure. Adjusted EBITDA is a key measure used by our management to assess the operating performance of our hospital operations and to make decisions on the allocation of resources. Adjusted EBITDA is also used to evaluate the performance of our executive management team and is one of the primary targets used to determine short-term cash incentive compensation. In addition, our management utilizes Adjusted EBITDA in assessing our consolidated results of operations and operational performance and in comparing our results of operations between periods. We believe it is useful to provide investors and other users of our financial statements this performance measure to align with how management assesses our results of operations. Adjusted EBITDA also is comparable to a similar metric called Consolidated EBITDA, as defined in our senior secured credit facility, which is a key component in the determination of our compliance with some of the covenants under our senior secured credit facility (including our ability to service debt and incur capital expenditures), and is used to determine the interest rate and commitment fee payable under the senior secured credit facility (although Adjusted EBITDA does not include all of the adjustments described in the senior secured credit facility). For further discussion of Consolidated EBITDA and how that measure is utilized in the calculation of our debt covenants, see the Capital Resources section of Part II, Item 7 of this Form 10-K.

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

The following table reflects the reconciliation of adjusted EBITDA, as defined, to net (loss) income attributable to Community Health Systems, Inc. stockholders as derived directly from our Consolidated Financial Statements for the years ended December 31, 2016, 2015 and 2014 (in millions):

	Year Ended December 31,		
	2016	**2015**	**2014**
Net (loss) income attributable to Community Health Systems, Inc. stockholders	$ (1,721)	$ 158	$ 92
Adjustments:			
(Benefit from) provision for income taxes	(104)	116	82
Depreciation and amortization	1,100	1,172	1,106
Net income attributable to noncontrolling interests	95	101	111
Loss from discontinued operations	15	36	57
Amortization of software to be abandoned	-	-	75
Interest expense, net	962	973	972
Loss from early extinguishment of debt	30	16	73
Impairment and (gain) loss on sale of businesses, net	1,919	68	41
Gain on sale of investments in unconsolidated affiliates	(94)	-	-
Expenses related to the acquisition and integration of HMA	-	1	69
Expense from government and other legal settlements and related costs	16	4	105

(Income) expense from fair value adjustments and legal expenses related to cases covered by the CVR	(6)	8	(6)
Expenses related to the sale of a majority interest in home care division	1	-	-
Expenses related to the spin-off of Quorum Health Corporation	12	17	-
Adjusted EBITDA	$ 2,225	$ 2,670	$ 2,777

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(9) Same-store operating results and statistical data exclude information for the hospitals divested in the spin-off of QHC in both the year ended December 31, 2016 and the comparable periods in 2015 and 2014. Same-store operating results include former HMA hospitals for the periods from January 1 through December 31, 2016, 2015 and 2014, as if such hospitals were owned during each of these comparable periods. For all hospitals owned throughout both periods, the same-store operating results and statistical data reflects the indicated periods. The same-store information does not reflect the application of purchase accounting adjustments as if the HMA merger had been completed on January 1, 2014. Therefore, this information is not intended to present pro forma information prepared under the guidelines of Articles 3-05 and 11 of the SEC. However, management believes the information provides investors with useful information about the hospital admissions, adjusted admissions and net operating revenues had the HMA facilities been owned for the indicated periods. This same-store information for the hospitals acquired in the HMA merger for the period from January 1 through December 31, 2014 is non-GAAP financial information and may not be comparable to the information provided for the comparable 2015 period due to the aforementioned purchase accounting adjustments not having been applied. In addition, same-store comparisons exclude our hospitals that have previously been classified as discontinued operations for accounting purposes.

Sources of Revenue

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

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

The following table presents the approximate percentages of operating revenues, net of contractual allowances and discounts (but before provision for bad debts), by payor source for the periods indicated. The data for the years presented are not strictly comparable due to the effect that hospital acquisitions have had on these statistics.

	Year Ended December 31,		
	2016	**2015**	**2014**
Medicare	23.9 %	24.1 %	24.7 %
Medicaid	10.5	11.2	10.8
Managed Care and other third-party payors	53.4	52.4	51.5
Self-pay	12.2	12.3	13.0
Total	100.0 %	100.0 %	100.0 %

As reflected 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. The Affordable Care Act has increased the number of insured patients, particularly in states that have expanded Medicaid, which, in turn, has reduced the percentage of our revenues from self-pay patients. However, the outcome of the 2016 federal elections has cast considerable uncertainty on the future of the Affordable Care Act, and it is unclear whether the trend of increased coverage will continue. In addition, several private health insurers have withdrawn, or have announced their intent to withdraw, from the health insurance exchanges established pursuant to the Affordable Care Act, which may

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threaten the stability of those marketplaces. Legislation or regulation resulting from the repeal, replacement or amendment of the Affordable Care Act may result in payment reductions under the Medicare or Medicaid programs that could negatively impact our business.

Medicare is a federal program that provides medical insurance benefits to persons age 65 and over, some disabled persons, and persons with end-stage renal disease. Medicaid is a federal-state funded program, administered by the states, that provides medical benefits to individuals who would otherwise be unable to afford healthcare. All of our hospitals are certified as providers of Medicare and Medicaid services. Amounts received under the Medicare and Medicaid programs are generally significantly less than a hospital s customary charges for the services provided. Further, the Affordable Care Act imposes significant reductions in amounts the government pays healthcare providers and Medicare managed care plans. Since a substantial portion of our revenue comes from patients under Medicare and Medicaid programs, our ability to operate our business successfully in the future will depend in large measure on our ability to adapt to changes in these programs. The trend toward increased enrollment in Medicare managed care may adversely affect our operating revenue.

In addition to government programs, we are paid by private payors, which include insurance companies, HMOs, PPOs, other managed care companies and employers, and by patients directly. Blue Cross payors are included in the Managed Care and other third-party payors line in the above table. Patients are generally not responsible for any difference between customary hospital charges and amounts paid for hospital services by Medicare and Medicaid programs, insurance companies, HMOs, PPOs and other managed care companies, but are responsible for services not covered by these programs or plans, as well as for deductibles and co-insurance obligations of their coverage. The amount of these deductibles and co-insurance obligations has increased in recent years. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government or business payors. To further reduce their healthcare costs, an increasing number of insurance companies, HMOs, PPOs and other managed care companies negotiate discounted fee structures or fixed amounts for hospital services performed, rather than paying healthcare providers the amounts billed, and utilize structures such as narrow networks that restrict the providers that enrollees may utilize. We negotiate discounts with managed care companies, which are typically smaller than discounts under government programs. If an increased number of insurance companies, HMOs, PPOs and other managed care companies succeed in negotiating discounted fee structures or fixed amounts or if we are unable to participate in managed care networks serving our markets, our results of operations may be negatively affected. There can be no assurance that we will retain our existing reimbursement arrangements or that these third-party payors will not attempt to further reduce the rates they pay for our services. For more information on the payment programs on which our revenues depend, see Payment on page 22.

As of December 31, 2016, Florida, Texas, Pennsylvania and Indiana represented our only areas of significant geographic concentration. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by our hospitals in Florida (which became an area of geographic concentration in 2014 as a result of the HMA merger), as a percentage of consolidated operating revenues, were 14.1% in 2016, 13.6% in 2015 and 13.0% in 2014. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by our hospitals in Texas, as a percentage of consolidated operating revenues, were 11.4% in 2016, 11.1% in 2015 and 10.9% in 2014. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by our hospitals in Pennsylvania, as a percentage of consolidated operating revenues, were 11.2% in 2016, 10.6% in 2015 and 11.1% in 2014. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by our hospitals in Indiana, as a percentage of consolidated operating revenues, were 8.6% in 2016, 7.3% in 2015, and 7.6% in 2014.

Hospital revenues depend upon inpatient occupancy levels, the volume of outpatient procedures and the charges or negotiated payment rates for hospital services provided. Charges and payment rates for routine inpatient services vary

significantly depending on the type of service performed and the geographic location of

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the hospital. In recent years, we have experienced a significant increase in revenue received from outpatient services. We attribute this increase to:

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

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

Government Regulation

Overview. The healthcare industry is required to comply with extensive government regulation at the federal, state and local levels. Under these regulations, hospitals must meet requirements to be certified as hospitals and qualified to participate in government programs, including the Medicare and Medicaid programs. These requirements include those relating to the adequacy of medical care, equipment, personnel, operating policies and procedures; billing and coding for services; properly handling overpayments; classifications of levels of care provided; preparing and filing of cost reports; relationships with referral sources and referral recipients; maintenance of adequate records; hospital use; rate-setting; compliance with building codes; environmental protection; and privacy and security. There are also extensive laws and regulations governing a hospital s participation in these government programs. If we fail to comply with applicable laws and regulations, we may be subject to criminal penalties and civil sanctions, our hospitals could lose their licenses and we could lose our ability to participate in these government programs. Further, government regulations may change. If that happens, we may have to make changes in our facilities, equipment, personnel and services so that our hospitals remain certified as hospitals and qualified to participate in these programs. We believe that our hospitals are currently in substantial compliance with current federal, state and local regulations and standards. We cannot be certain that governmental officials responsible for enforcing these laws or whistleblowers will not assert that we are in violation of them or that such statutes or regulations will be interpreted by the courts in a manner consistent with our interpretation.

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

Healthcare Reform. Over the last decade, the U.S. Congress and certain state legislatures have introduced and passed a large number of proposals and legislation designed to make major changes in the healthcare system, including changes that increased access to health insurance. The most prominent of these recent efforts, the Affordable Care Act, affects how healthcare services are covered, delivered, and reimbursed. However, the future of the Affordable Care Act is uncertain following the 2016 federal elections. The newly elected presidential administration and certain members of Congress have stated their intent to repeal or make significant changes to the Affordable Care Act, its implementation or interpretation but have not yet agreed upon specific proposals for replacement reforms. In addition, a presidential executive order has been signed that directs agencies to minimize economic and regulatory burdens of the Affordable Care Act, but it is unclear how this will be implemented. The impact and timing of any potential repeal

of or changes to the Affordable Care Act and any alternative provisions on the healthcare industry is unknown.

The Affordable Care Act, as currently structured, mandates that substantially all U.S. citizens maintain health insurance coverage and increases health insurance coverage through a combination of public program expansion

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and private sector health insurance reforms. Expansion in public program coverage has been driven primarily by adjusting eligibility requirements for Medicaid coverage. A number of states opted out of the Medicaid expansion provisions, which they may do without losing federal funding. States that have opted out include Florida, Tennessee and Texas, where we operated a significant number of hospitals as of December 31, 2016. Some states that have opted out are evaluating options such as waiver plans to operate an alternative Medicaid expansion plan.

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

Substantial uncertainty remains regarding the ongoing net effect of the Affordable Care Act due to the results of the 2016 federal elections, the possibility of repeal or significant change to the Affordable Care Act following such elections, and other factors, including clarifications and modifications resulting from executive orders, the rule-making process, the outcome of court challenges, the development of agency guidance, whether and how many states ultimately decide to expand Medicaid coverage, the number of uninsured who elect to purchase health insurance coverage and budgetary issues at federal and state levels.

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

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

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

A section of the Social Security Act, known as the anti-kickback statute prohibits some business practices and relationships under Medicare, Medicaid and other federal healthcare programs. These practices include the payment, receipt, offer, or solicitation of remuneration of any kind in exchange for items or services that are reimbursed under most federal or state healthcare programs.

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

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failure of a particular activity to comply with the safe harbor regulations does not necessarily mean that the activity violates the anti-kickback statute; however, such failure may lead to increased scrutiny by government enforcement authorities.

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

payment of any incentive by the hospital when a physician refers a patient to the hospital,

use of free or significantly discounted office space or equipment for physicians in facilities usually located close to the hospital,

provision of free or significantly discounted billing, nursing, or other staff services,

free training for a physician s office staff, including management and laboratory techniques (but excluding compliance training),

guarantees which provide that, if the physician s income fails to reach a predetermined level, the hospital will pay any portion of the remainder,

low-interest or interest-free loans, or loans which may be forgiven if a physician refers patients to the hospital,

payment of the costs of a physician s travel and expenses for conferences,

payment of services which require few, if any, substantive duties by the physician, or payment for services in excess of the fair market value of the services rendered,

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

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

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

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

We have a variety of financial relationships with physicians who refer patients to our hospitals. Physicians own interests in a number of our facilities. Physicians may also own our stock. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases, management agreements and professional service agreements. We provide financial incentives to recruit physicians to relocate to communities served by our hospitals. These incentives include relocation, reimbursement for certain direct expenses, income guarantees and, in some cases, loans. Although we strive to comply with the anti-kickback statute, taking into account available guidance including the safe harbor regulations, we cannot assure you that regulatory authorities will not determine otherwise. If that happens, we could be subject to criminal and civil penalties and/or exclusion from participating in Medicare, Medicaid, or other government healthcare programs. Pursuant to the Bipartisan Budget Act of 2015, civil monetary penalties increased substantially in 2016, were further increased in 2017, and will continue to increase annually based on updates to the consumer price index.

The Social Security Act also includes a provision commonly known as the Stark Law. This law prohibits physicians from referring Medicare and Medicaid patients to healthcare entities in which they or any of their

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immediate family members have ownership interests or other financial arrangements. These types of referrals are commonly known as self referrals. There are ownership and compensation arrangement exceptions to the self-referral prohibition. One exception, known as the whole hospital exception, allows a physician to make a referral to a hospital if the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. Another exception allows a physician to refer patients to a healthcare entity in which the physician has an ownership interest if the entity is located in a rural area, as defined in the statute. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases and recruitment agreements. From time to time, the federal government has issued regulations which interpret the provisions included in the Stark Law.

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

Taking into account 2017 updates to such penalties, sanctions for violating the Stark Law include denial of payment, civil monetary penalties of up to $24,253 per claim submitted and exclusion from federal healthcare programs, and a penalty of up to $161,692 for a scheme intended to circumvent the Stark Law prohibitions. These civil monetary penalties will increase annually based on updates to the consumer price index.

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

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

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

precedent exists for the interpretation or enforcement of these state laws.

Our operations could be adversely affected by the failure of our arrangements to comply with the anti-kickback statute, the Stark Law, billing laws and regulations, current state laws or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the

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

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

When a defendant is determined by a court of law to be liable under the FCA, the defendant must pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $10,957 and $21,916 for each separate false claim, after taking into account 2017 updates to such penalties. These civil monetary penalties will increase annually based on updates to the consumer price index. Settlements entered into prior to litigation usually involve a less severe calculation of damages. The FCA also contains qui tam or whistleblower provisions, which allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. If the government intervenes in the action and prevails, the party filing the initial complaint may share in any settlement or judgment. If the government does not intervene in the action, the whistleblower plaintiff may pursue the action independently and may receive a larger share of any settlement or judgment. When a private party brings a qui tam action under the FCA, the defendant generally will not be made aware of the lawsuit until the government commences its own investigation or determines whether it will intervene. Every entity that receives at least $5 million annually in Medicaid payments must have written policies for all employees, contractors and agents providing detailed information about false claims, false statements and whistleblower protections under certain federal laws, including the FCA, and similar state laws.

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

Corporate Practice of Medicine; Fee-Splitting. Some states have laws that prohibit unlicensed persons or business entities, including corporations, from employing physicians. Some states also have adopted laws that prohibit direct or indirect payments to, or entering into fee-splitting arrangements with, physicians and unlicensed persons or business entities. Possible sanctions for violations of these restrictions include loss of a physician s license, civil and criminal penalties and rescission of business arrangements. These laws vary from state to state, are often vague and have

seldom been interpreted by the courts or regulatory agencies. We structure

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our arrangements with healthcare providers to comply with the relevant state law. However, we cannot provide assurance that governmental officials responsible for enforcing these laws will not assert that we, or transactions in which we are involved, are in violation of these laws. These laws may also be interpreted by the courts in a manner inconsistent with our interpretations.

Emergency Medical Treatment and Active Labor Act. The Emergency Medical Treatment and Active Labor Act imposes requirements as to the care that must be provided to anyone who comes to facilities providing emergency medical services seeking care before they may be transferred to another facility or otherwise denied care. Sanctions for failing to fulfill these requirements include exclusion from participation in Medicare and Medicaid programs and civil money penalties. These civil monetary penalties increased significantly in 2016, were further adjusted in 2017, and will be increased annually based on updates to the consumer price index. In addition, the law creates private civil remedies that enable an individual who suffers personal harm as a direct result of a violation of the law to sue the offending hospital for damages and equitable relief. A medical facility that suffers a financial loss as a direct result of another participating hospital s violation of the law also has a similar right. Although we believe that our practices are in compliance with the law, we can give no assurance that governmental officials responsible for enforcing the law will not assert we are in violation of this law.

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

Certificates of Need. The construction of new facilities, the acquisition of existing facilities and the addition of new services at our facilities may be subject to state laws that require prior approval by state regulatory agencies. These CON laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. As of December 31, 2016, we operated 83 hospitals in 12 states that have adopted CON laws for acute care facilities. If we fail to obtain necessary state approval, we will not be able to expand our facilities, complete acquisitions or add new services in these states. Violation of these state laws may result in the imposition of civil sanctions or the revocation of a hospital s licenses.

HIPAA Administrative Simplification and Privacy and Security Requirements. The Health Insurance Portability and Accountability Act of 1996, or HIPAA, requires the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. HHS has established electronic data transmission standards that all healthcare providers must use when submitting or receiving certain healthcare transactions electronically. In addition, HIPAA requires that each provider use a National Provider Identifier. All healthcare providers covered by HIPAA were required to transition to updated standard code sets for certain diagnoses and procedures, known as ICD-10 code sets, by October 1, 2015. We have transitioned all of our hospitals to the ICD-10 coding system. The Affordable Care Act requires the HHS to adopt standards for additional electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction.

As required by HIPAA, HHS has issued privacy and security regulations that extensively regulate the use and disclosure of individually identifiable health-related information and require covered entities, including health plans and most healthcare providers, to implement administrative, physical and technical practices to protect the security of individually identifiable health information that is electronically maintained or transmitted. Certain

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provisions of the security and privacy regulations apply to business associates (entities that handle identifiable health-related information on behalf of covered entities), and business associates are subject to direct liability for violation of the regulations. In addition, a covered entity may be subject to penalties as a result of a business associate violating HIPAA, if the business associate is found to be an agent of the covered entity. We have developed and utilize a HIPAA compliance plan as part of our effort to comply with HIPAA privacy and security requirements. The privacy regulations and security regulations have and will continue to impose significant costs on us in order to comply with these standards.

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

Violations of the HIPAA privacy and security regulations may result in criminal penalties and in civil penalties of up to $55,910 per violation for a maximum of $1,677,299 in a calendar year for violations of the same requirement. These penalties will increase annually based on updates to the consumer price index. HHS is required to perform compliance audits. In addition to enforcement by HHS, state attorneys general are authorized to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. HHS may resolve HIPAA violations through informal means, such as allowing a covered entity to implement a corrective action plan, but HHS has the discretion to move directly to impose monetary penalties and is required to impose penalties for violations resulting from willful neglect. Our facilities also are subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties. For example, the Federal Trade Commission uses its consumer protection authority to initiate enforcement actions in response to data breaches.

Payment

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

Payments for inpatient acute services are generally made pursuant to a prospective payment system, commonly known as PPS. Under PPS, our hospitals are paid a predetermined amount for each hospital discharge based on the patient s diagnosis. Specifically, each discharge is assigned to a diagnosis-related group, commonly known as a DRG, based upon the patient s condition and treatment during the relevant inpatient stay. Each DRG is assigned a payment rate using 100% of the national average cost per case and 100% of the severity-adjusted DRG weights. DRG payments are based on national averages and not on charges or costs specific to a hospital. Severity-adjusted DRGs more accurately reflect the costs a hospital incurs for caring for a patient and account more fully for the severity of each patient s condition. However, DRG payments are adjusted by a predetermined geographic adjustment factor assigned to the geographic area in which the hospital is located. While a hospital generally does not receive payment in addition to a DRG payment, hospitals may qualify for an outlier payment when the relevant patient s treatment costs are extraordinarily high and exceed a specified regulatory threshold.

The DRG payment rates are adjusted by an update factor on October 1 of each year, the beginning of the federal fiscal year. The index used to adjust the DRG payment rates, known as the market basket index, gives consideration to the inflation experienced by hospitals in purchasing goods and services. DRG payment rates were increased by the full

market basket index, for the federal fiscal years 2016 and 2017 by 2.4% and 2.7% respectively, subject to certain reductions. For federal fiscal year 2016, the DRG payment rates were reduced by

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0.8% for documentation and coding; reduced by 0.5% for the multi-factor productivity adjustment; and reduced by 0.2% in accordance with the Affordable Care Act. There was also a 0.2% downward adjustment to offset projected spending increases associated with admission and medical review criteria for inpatient services commonly known as the two midnight rule. For federal fiscal year 2017, the DRG payment rates were reduced by 1.5% for documentation and coding; reduced by 0.3% for the multi-factor productivity adjustment; and reduced by 0.75% in accordance with the Affordable Care Act. There is also a positive 0.8% adjustment to remove the effects of prior adjustments intended to offset projected spending increases associated with the two midnight rule. Under the rule, services to Medicare beneficiaries are only payable as inpatient hospital services when there is a reasonable expectation that the hospital care is medically necessary and will be required across two midnights, absent unusual circumstances. A 25% reduction to the market basket index occurs if patient quality data is not submitted, and a reduction of 75% of the market basket index update occurs for hospitals that fail to demonstrate meaningful use of certified electronic health records, or EHR, technology without receiving a hardship exception. Future legislation may decrease the rate of increase for DRG payments or even decrease such payment rates, but we are unable to predict the amount of any reduction or the effect that any reduction will have on us.

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

In addition, hospitals may qualify for Medicare disproportionate share payments when their percentage of low income patients exceeds specified regulatory thresholds. A majority of our hospitals qualify to receive Medicare disproportionate share payments. Medicare disproportionate share payments are reduced by 75% and earmarked for an uncompensated care payment pool, in accordance with the Affordable Care Act. The uncompensated care pool is further reduced each year by a formula that reflects reductions in the U.S. uninsured population that is under 65 years of age. Thus, the greater the level of coverage for the uninsured, the more the Medicare uncompensated care pool will be reduced. Each eligible hospital is then paid, out of the uncompensated care pool, an amount based upon its estimated cost of providing uncompensated care. At this time, we cannot predict an impact for this change. These Medicare disproportionate share and uncompensated care payments as a percentage of operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), were 1.0% and 1.2% for the years ended December 31, 2016 and 2015, respectively. Hospitals may also qualify for Medicaid disproportionate share payments when they qualify under the state established guidelines. These Medicaid disproportionate share payments as a percentage of operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), were 0.3% and 0.4% for the years ended December 31, 2016 and 2015, respectively.

We also receive Medicare reimbursement for outpatient services through a PPS. The outpatient conversion factor was increased 2.4% effective January 1, 2016; however, there was a 0.2% downward adjustment in accordance with the Affordable Care Act, a 0.5% downward productivity adjustment and a 2.0% downward adjustment to address what CMS views as inflated payments for laboratory tests packaged with payments for hospital outpatient services. The

outpatient conversion factor was increased 2.7% effective January 1, 2017;

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however, there was a 0.75% downward adjustment in accordance with the Affordable Care Act and a 0.3% downward productivity adjustment and other payment adjustments, for an estimated 1.65% increase. Taking into account these and other payment adjustments, CMS estimates the 2017 update will result in a 1.7% increase in outpatient PPS payments to hospitals. For fiscal year 2017, an additional 2.0% reduction applies to hospitals that do not submit required patient quality data. We are complying with this data submission requirement.

The Medicare reimbursement discussed above was reduced beginning in 2013 due to the Budget Control Act of 2011 that required across-the-board spending cuts to the federal budget, also known as sequestration. These sequestration cuts included reductions in payments for Medicare and other federally funded healthcare programs, including TRICARE. The cuts began on March 1, 2013, with the sequester-related Medicare reimbursement cuts beginning April 1, 2013. These reductions have been extended through 2025.

Payment under the Medicare program for physician services is based upon the Medicare Physician Fee Schedule, or MPFS, under which CMS has assigned a national relative value unit, or RVU, to most medical procedures and services that reflects the resources required to provide the services relative to all other services. Each RVU is calculated based on a combination of the time and intensity of work required, overhead expense attributable to the service, and malpractice insurance expense. These elements are each modified by a geographic adjustment factor to account for local practice costs and are then aggregated. MACRA provides for a 0.5% update to the MPFS for each calendar year through 2019. MACRA also requires the establishment of the Quality Payment Program, or QPP, a payment methodology intended to reward high-quality patient care. Beginning in 2017, physicians and certain other healthcare clinicians are required to participate in one of two QPP tracks. Under both tracks, performance data collected in 2017 will affect Medicare payments in 2019. CMS expects to transition increasing financial risk to providers as QPP evolves. Under the Advanced Alternative Payment Model, or Advanced APM, track, incentive payments are available based on participation in specific innovative payment models approved by CMS. Providers may earn a Medicare incentive payment and will be exempt from the reporting requirements and payment adjustments imposed under the Merit-Based Incentive Payment System, or MIPS, if the provider has sufficient participation in an Advanced APM. Alternatively, providers may participate in the MIPS track, under which physicians will receive performance-based payment incentives or payment reductions based on their performance with respect to clinical quality, resource use, clinical improvement activities, and meaningful use of EHR. MIPS will consolidate components of certain existing physician incentive programs.

In addition to changing Medicare physician payment methodology, MACRA extended the Medicare Inpatient Low Volume payment and Medicare Dependent Hospital programs to qualifying hospitals through September 30, 2017. If additional legislation is not passed to extend these Medicare hospital payment programs, we could experience a reduction in future reimbursement.

Medicaid. Most state Medicaid payments are made under a PPS or under programs which negotiate payment levels with individual hospitals. Medicaid is funded jointly by state and federal government. The federal government and many states are currently considering significantly reducing Medicaid funding, while at the same time expanding Medicaid benefits. Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from CMS and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Similar programs are also being considered by other states. We can provide no assurance that reductions to Medicaid funding will not have a material adverse effect on our consolidated results of operations. Further, the Affordable Care Act prohibits the use of federal funds under the Medicaid program to reimburse providers for medical services provided to treat HACs.

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

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

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

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

Medicare Administrative Contractors. CMS competitively bids the Medicare fiscal intermediary and Medicare carrier functions to Medicare Administrative Contractors, or MACs, in 12 jurisdictions. Each MAC is geographically assigned and serves both Part A and Part B providers within a given jurisdiction. Chain providers had the option of having all hospitals use one home office MAC, and we chose to do so. However, CMS has not converted all of our hospitals to one MAC and currently does not have an established date to accomplish the conversion. CMS periodically re-solicits bids, and the MAC servicing a geographic area can change as a result of the bid competition. MAC transition periods can impact claims processing functions and the resulting cash flow.

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

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

We maintain policies and procedures to respond to the RAC requests and payment denials. Payment recoveries resulting from RAC reviews and denials are appealable, and we pursue reversal of adverse determinations at

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appropriate appeal levels. Currently, there are significant delays in the assignment of new Medicare appeals to Administrative Law Judges. According to the Office of Medicare Hearings and Appeals, the average processing time in fiscal year 2016 was nearly two and a half years. HHS has finalized rules intended to streamline the process and improve efficiency, but has also stressed the need for additional funding. Thus, we may experience significant delays in appealing any RAC payment denials. To ease the backlog of appeals, CMS has made available an administrative settlement process for disputed claims, offering to pay 66% of the net allowable amount in exchange for a hospital s withdrawal of all medical claims appealed. We are participating in this settlement process. Depending upon the growth of RAC programs and our success in appealing claims in future periods, our cash flows and results of operations could be negatively impacted.

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

Bundled Payment Initiatives. The CMS Innovation Center is responsible for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for healthcare that create savings under the Medicare and Medicaid programs, while maintaining or improving quality of care. For example, providers participating in bundled payment initiatives accept accountability for costs and quality of care by agreeing to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care. By rewarding providers for increasing quality and reducing costs and penalizing providers if costs exceed a certain amount, bundled payment models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. The CMS Innovation Center has implemented a voluntary bundled payment program known as the Bundled Payment for Care Improvement, or BPCI, initiative. We are participating in BPCI initiatives in eleven of our markets. More recently, the CMS Innovation Center has established mandatory bundled payment programs for hospitals in selected geographic areas, including some of our hospitals. These mandatory initiatives focus on orthopedic and cardiac care.

Supply Contracts

In March 2005, we began purchasing items, primarily medical supplies, medical equipment and pharmaceuticals, under an agreement with HealthTrust, a GPO in which we are a noncontrolling partner. As of December 31, 2016, we had a 23.1% ownership interest in HealthTrust. By participating in this organization, we are able to procure items at competitively priced rates for our hospitals. There can be no assurance that our arrangement with HealthTrust will continue to provide the discounts that we have historically received.

Competition

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

reasonable.

In addition to the competition we face for acquisitions, we must also compete with other hospitals and healthcare providers for patients. The competition among hospitals and other healthcare providers for patients

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has intensified in recent years. The majority of our hospitals are located in non-urban service areas in which we are the sole provider of general acute care health services. Those hospitals in non-urban service areas face no direct competition because there are no other hospitals in their primary service areas. However, these hospitals face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in those service areas may travel to these other hospitals for a variety of reasons, including the need for services we do not offer or physician referrals. Patients who are required to seek services from these other hospitals may subsequently shift their preferences to those hospitals for services we do provide. Those hospitals in selected urban service areas may face competition from hospitals that are more established than our hospitals. Certain of these competing facilities offer services, including extensive medical research and medical education programs, which are not offered by our facilities. In addition, in certain markets where we operate, there are large teaching hospitals that provide highly specialized facilities, equipment and services that may not be available at our hospitals. We also face competition from other specialized care providers, including outpatient surgery, orthopedic, oncology and diagnostic centers. Some competitors are implementing physician alignment strategies, such as employing physicians, acquiring physician practice groups, and participating in ACOs, or other clinical integration models. We believe that we will continue to face increased competition in outpatient service models that become more integrated through acquisitions or partnerships between physicians, specialized care providers, and managed care payors.

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

The number and quality of the physicians on a hospital s staff is an important factor in a hospital s competitive position. Physicians decide whether a patient is admitted to the hospital and the procedures to be performed. Admitting physicians may be on the medical staffs of other hospitals in addition to those of our hospitals. We attempt to attract our physicians patients to our hospitals by offering quality services and facilities, convenient locations and state-of-the-art equipment. In addition, CMS publicizes on its Hospital Compare website data that hospitals submit in connection with Medicare reimbursement claims, including performance data related to quality measures and patient satisfaction surveys. Federal law provides for the future expansion of the number of quality measures that must be reported. Additional quality measures and other future trends toward clinical transparency may have a potential impact on our competitive position and patient volumes in ways that we are unable to predict. In addition, hospitals must either make public a list of their standard charges, or their policies for allowing the public to view a list of these charges in response to an inquiry.

Compliance Program

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

Our company-wide compliance program has been in place since 1997. Currently, the program s elements include leadership, management and oversight at the highest levels, a Code of Conduct, risk area specific policies and

procedures, employee education and training, an internal system for reporting concerns, auditing and monitoring programs and a means for enforcing the program s policies.

The compliance program continues to be expanded and developed to meet the industry s expectations and our needs. Specific written policies, procedures, training and educational materials and programs, as well as auditing

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and monitoring activities, have been prepared and implemented to address the functional and operational aspects of our business. Included within these functional areas are materials and activities for business sub-units, including laboratory, radiology, pharmacy, emergency, surgery, observation, home care, skilled nursing and clinics. Specific areas identified through regulatory interpretation and enforcement activities have also been addressed in our program. Claims preparation and submission, including coding, billing and cost reports, comprise the bulk of these areas. Financial arrangements with physicians and other referral sources, including compliance with the federal anti-kickback statute and the Stark Law, emergency department treatment and transfer requirements and other patient disposition issues, are also the focus of policy and training, standardized documentation requirements and review and audit. Another focus of the program is the interpretation and implementation of the HIPAA standards for privacy and security.

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

Corporate Integrity Agreement

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

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

- continuing the duties and activities of our Corporate Compliance Officer, Corporate Compliance Work Group, and Facility Compliance Officers and committees;
- maintaining our written Code of Conduct, which sets forth our commitment to full compliance with all statutes, regulations, and guidelines applicable to federal healthcare programs;
- maintaining our written policies and procedures addressing the operation of our Compliance Program, including adherence to medical necessity and admissions standards for inpatient hospital stays;
- continuing our general compliance training;
- providing specific training for appropriate personnel on billing, case management and clinical documentation;

engaging an independent third party to perform an annual review of our compliance with the CIA;

continuing our Confidential Disclosure Program and hotline to enable employees or others to disclose issues or questions regarding possible inappropriate policies or behavior;

enhancing our screening program to ensure that we do not hire or engage employees or contractors who are ineligible persons for federal healthcare programs;

reporting any material deficiency which resulted in an overpayment to us by a federal healthcare program; and

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submitting annual reports to the OIG which describe in detail the operations of our corporate Compliance Program for the past year.

Material, uncorrected violations of the CIA could lead to our suspension or disbarment from participation in Medicare, Medicaid and other federal and state healthcare programs and repayment obligations. In addition, we are subject to possible civil penalties for failure to substantially comply with the terms of the CIA, including stipulated penalties ranging from $1,000 to $2,500 per day. We are also subject to a stipulated penalty of $50,000 for each false certification made by us or on our behalf in connection with reports required under the CIA. The CIA increases the amount of information we must provide to the federal government regarding our healthcare practices and our compliance with federal regulations. The reports we provide in connection with the CIA could result in greater scrutiny by regulatory authorities. We believe our existing Compliance Program addresses compliance with the operational terms of the CIA.

Employees and Medical Staff

At December 31, 2016, we had approximately 120,000 employees, including approximately 24,000 part-time employees. References herein to employees refer to employees of our affiliates. We are subject to various state and federal laws that regulate wages, hours, benefits and other terms and conditions relating to employment. At December 31, 2016, certain employees at 23 of our hospitals are represented by various labor unions. It is likely that union organizing efforts will take place at additional hospitals in the future. We consider our employee relations to be good and have not experienced work stoppages that have materially, adversely affected our business or results of operations. Our hospitals, like most hospitals, have experienced rising labor costs. In some markets, nurse and medical support personnel availability has become a significant operating issue to healthcare providers. To address this challenge, we have implemented several initiatives to improve retention, recruiting, compensation programs and productivity.

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

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

Professional Liability Claims

As part of our business of owning and operating hospitals, we are subject to legal actions alleging liability on our part. To cover claims arising out of the operations of hospitals, we maintain professional malpractice liability insurance and

general liability insurance on a claims made basis in excess of those amounts for which we are self-insured, in amounts we believe to be sufficient for our operations. We also maintain umbrella liability coverage for claims which, due to their nature or amount, are not covered by our other insurance policies.

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However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. For a further discussion of our insurance coverage, see our discussion of professional liability claims in Management s Discussion and Analysis of Financial Condition and Results of Operations in Part II, Item 7 of this Form 10-K.

Environmental Matters

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

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

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

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

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

We have a significant amount of indebtedness, which is more fully described in the Capital Resources section of Management s Discussion and Analysis of Financial Condition and Results of Operations in Part II, Item 7 of this Form 10-K and the Notes to our Consolidated Financial Statements included under Part II, Item 8 of this Form 10-K. As of December 31, 2016, we had approximately $8.8 billion aggregate principal amount of senior secured indebtedness outstanding, and approximately $6.4 billion of senior unsecured indebtedness outstanding. A substantial amount of our outstanding indebtedness under our senior secured credit facility and outstanding notes is scheduled to mature at various dates beginning in December 2018 and through 2019. Our substantial leverage could have important consequences for you, including the following:

- it may limit our ability to refinance existing indebtedness or obtain additional debt or equity financing for working capital, capital expenditures, debt service requirements, acquisitions and general corporate or other purposes;

our ability to refinance our indebtedness on favorable terms, or at all, is dependent on (among other things) conditions in the credit and capital markets, which are beyond our control;

a substantial portion of our cash flows from operations will be dedicated to the payment of principal and interest on our indebtedness and will not be available for other purposes, including to fund our operations, capital expenditures, and future business opportunities;

the debt service requirements of our indebtedness could make it more difficult for us to satisfy our financial obligations;

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- some of our borrowings, including borrowings under our credit facility, accrue interest at variable rates, exposing us to the risk of increased interest rates;

- it may limit our ability to make strategic acquisitions or cause us to make certain divestitures;

- it may limit our ability to adjust to changing market conditions and place us at a competitive disadvantage compared to our competitors that are less leveraged; and

- it may increase our vulnerability in connection with adverse changes in general economic, industry or competitive conditions or government regulations or other adverse developments.

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

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

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

We may find it necessary or prudent to refinance certain of our outstanding indebtedness, the terms of which may not be favorable to us. Our ability to refinance our indebtedness on favorable terms, or at all, is directly affected by the then current general economic and financial conditions. In addition, our ability to incur secured indebtedness (which would generally enable us to achieve better pricing than the incurrence of unsecured indebtedness) depends in part on the value of our assets, which depends, in turn, on the strength of our cash flows and results of operations, and on economic and market conditions and other factors.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we could face substantial liquidity problems and may be forced to reduce or delay capital expenditures, sell assets or operations, seek additional capital or restructure or refinance our indebtedness. We cannot assure you that we would be able to take any of these actions, that these actions would be successful and permit us to meet our scheduled debt service obligations or that these actions would be permitted under the terms of our existing or future debt agreements, including our credit facility and the indentures governing our outstanding notes. For example, our credit facility and the indentures governing our outstanding notes restrict our ability to dispose of assets and use the proceeds from any dispositions. We may not be able to consummate those dispositions and any proceeds we receive may not be adequate to meet any debt service obligations then due.

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

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

incur, assume or guarantee additional indebtedness;

issue redeemable stock and preferred stock;

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repurchase capital stock;

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

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

create liens;

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

impair the security interests;

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

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

enter into transactions with affiliates; and

guarantee certain obligations.

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

A breach of any of these covenants could result in a default under our credit facility and the indentures governing our outstanding notes. Upon the occurrence of an event of default under our credit facility or the indentures governing our outstanding notes, all amounts outstanding under our credit facility and our outstanding notes may become immediately due and payable and all commitments under the credit facility to extend further credit may be terminated. The acceleration of any such indebtedness will result in an event of default under all of our other long-term indebtedness.

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

Our borrowings under our credit facility are at variable rates of interest and expose us to interest rate risk. If interest rates increase, our debt service obligations on the variable rate indebtedness would increase even though the amount borrowed remained the same, and our net income would decrease. Our interest expense, net, for the year ended December 31, 2016 was $ 962 million. For the year ended December 31, 2016, a fluctuation in interest rates of 1% on our variable rate debt that is not hedged by interest rate swaps would have resulted in a fluctuation in our interest expense of approximately $50 million.

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

We and our subsidiaries have the ability to incur substantial additional indebtedness in the future, subject to restrictions contained in our credit facilities and the indentures governing our outstanding notes. Our credit facility as well as a separate receivables facility provide for commitments and borrowings of up to approximately $8.2 billion in the aggregate, of which approximately $7.2 billion is outstanding at December 31, 2016. Our credit facility also gives us the ability to provide for one or more additional tranches of term loans and increases in our revolving credit facility in the aggregate principal amount of up to the greater of (x) $1.5 billion and (y) an amount such that our senior secured net leverage ratio would not exceed 4.50:1.00 without the consent of the existing lenders if specified criteria are satisfied. If new debt is added to our current debt levels, the related risks

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that we now face could be further exacerbated. For the 12-month period ended December 31, 2016, (a) the interest coverage ratio financial covenant in our credit facilities required the ratio of consolidated EBITDA, as defined, to consolidated interest expense to be greater than or equal to 2.00 to 1.00 and (b) the secured net leverage ratio financial covenant in our credit facilities limited the ratio of secured debt to consolidated EBITDA, as defined, to less than or equal to 4.50 to 1.00. We were in compliance with all such covenants at December 31, 2016, with an interest coverage ratio of approximately 2.43 to 1.00 and a secured net leverage ratio of approximately 3.96 to 1.00. If additional indebtedness is added to our current debt levels, the related risks that we currently face related to indebtedness as noted above could increase.

Failure to improve operations at certain hospitals acquired from HMA could adversely affect us.

We have achieved synergies from the HMA merger as a result of eliminating duplicate corporate functions and centralizing many support functions. However, we cannot be certain whether, and to what extent, additional operating improvements and efficiencies in connection with the HMA merger will be achieved in the future. In addition, operational improvement of some of the HMA hospitals has been more difficult to achieve than anticipated. Moreover, costs associated with HMA s legal proceedings and other loss contingencies may be greater than expected, and could exceed the amount of any reduction in payment under the contingent value rights, or CVRs, issued in the HMA merger to HMA stockholders.

In order to obtain the intended benefits of the merger, we must achieve additional efficiencies and improve operations at certain of the former HMA hospitals. Such operational improvement may be complex and the failure to do so efficiently and effectively may negatively affect earnings.

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

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

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

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

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

acquire additional hospitals on terms favorable to us.

In addition, many of the hospitals we have acquired have had lower operating margins than we do and operating losses incurred prior to the time we acquired them. Hospitals acquired in the future may have similar

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financial performance issues. In the past, we have experienced delays in improving the operating margins or effectively integrating the operations of certain acquired hospitals. In the future, if we are unable to improve the operating margins of acquired hospitals, operate them profitably, or effectively integrate their operations, our results of operations and business may be adversely affected.

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

If we are unable to complete divestitures that are currently contemplated, our results of operations and financial condition could be adversely affected.

As noted above, we have been implementing a portfolio rationalization and deleveraging strategy by divesting hospitals and non-hospital businesses that are attractive to strategic and other buyers. Generally, these businesses are not in one of our strategically beneficial service areas, are less complementary to our business strategy and/or have lower operating margins. However, there is no assurance that these contemplated dispositions will be completed, will be completed within our contemplated timeframe, or will be completed on terms favorable to us or on terms sufficient to allow us to achieve our deleveraging strategy. Additionally, the results of operations for these hospitals we plan to divest and the potential gains or losses on the sales of those businesses may adversely affect our profitability. Moreover, we may incur asset impairment charges related to divestitures that reduce our profitability.

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

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

State efforts to regulate the construction, acquisition or expansion of healthcare facilities could limit our ability to build or acquire additional healthcare facilities, renovate our facilities or expand the breadth of services we offer.

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

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

Many states have adopted legislation regarding the sale or other disposition of hospitals operated by municipal or not-for-profit entities. In some states that do not have specific legislation, the attorneys general have demonstrated an interest in these transactions under their general obligation to protect the use of charitable assets.

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These legislative and administrative efforts focus primarily on the appropriate valuation of the assets divested and the use of the proceeds of the sale by the non-profit seller. While these review and, in some instances, approval processes can add additional time to the closing of a hospital acquisition, we have not had any significant difficulties or delays in completing acquisitions. However, future state actions could seriously delay or even prevent our ability to acquire hospitals once we return to our acquisition strategy.

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

The healthcare industry is highly competitive among hospitals and other healthcare providers for patients, affiliations with physicians and acquisitions. The competition among hospitals and other healthcare providers for patients has intensified in recent years. However, the majority of our hospitals are located in non-urban service areas where we believe we are the sole provider of general acute care health services. As a result, the most significant competition our hospitals face typically comes from hospitals outside of our primary service areas, including hospitals in urban areas that provide more complex services. Patients in our primary service areas may travel to these other hospitals because of physician referrals or their need for services we do not offer, among other reasons. Patients who receive services from these other hospitals may subsequently shift their preferences to those hospitals for the services we provide. Competition for patients is also increasing among other healthcare providers, including outpatient surgery, orthopedic, oncology and diagnostic centers. Our hospitals and our competitors are implementing physician alignment strategies, such as acquiring physician practice groups, employing physicians and participating in ACOs or other clinical integration models, which may impact our competitive position.

At December 31, 2016, 59 of our hospitals competed with more than one other hospital in their respective primary service areas. In most markets in which we are not the sole provider of general acute care health services, our primary competitor is a municipal or not-for-profit hospital. These hospitals are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. They do not pay income or property taxes, and can make capital expenditures without paying sales tax. These financial advantages may better position these hospitals to maintain more modern and technologically upgraded facilities and equipment and offer services more specialized than those available at our hospitals. If our competitors are better able to attract patients with these offerings, we may experience an overall decline in patient volume.

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

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

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

We have a participation agreement with HealthTrust, a GPO. The current term of this agreement expires in January 2018, with automatic renewal terms of one year unless either party terminates by giving notice of non-renewal. GPOs attempt to obtain favorable pricing on medical supplies with manufacturers and vendors, sometimes by negotiating exclusive supply arrangements in exchange for discounts. To the extent these exclusive

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supply arrangements are challenged or deemed unenforceable, we could incur higher costs for our medical supplies obtained through HealthTrust. Further, costs of supplies and drugs may continue to increase due to market pressure from pharmaceutical companies and new product releases. Higher costs could continue to adversely impact our operating results. Also, there can be no assurance that our arrangement with HealthTrust will provide the discounts we expect to achieve.

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

At December 31, 2016, we had approximately $6.5 billion of goodwill recorded on our books. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, under GAAP, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired when events or changes in circumstances indicate that such carrying value may not be recoverable. GAAP requires us to test goodwill for impairment at least annually.

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

We performed our annual goodwill evaluation during the fourth quarter of 2016. While no impairment was indicated by this evaluation, the reduction in our fair value and the resulting goodwill impairment charge recorded during 2016 reduced the excess of fair value calculated in the step two analysis over the carrying value of our hospital operations reporting unit to an amount less than 1% of our carrying value. This minimal amount in the excess fair value over carrying value of our hospital operations reporting unit increases the risk that future declines in fair value could result in goodwill impairment.

The testing of goodwill for impairment requires us to make significant estimates about our future performance and cash flows, as well as other assumptions related to our cost of capital and other factors impacting our fair value models. These estimates can be affected by various factors, including changes in economic, industry or other market assumptions, changes in our business operations, estimates of future revenue and expenses, estimated marked multiples, expected capital expenditures, potential changes in our stock price and market capitalization, and the fair value of our long-term debt. Changes in these factors, or changes in our actual performance compared with our estimates of future projections, could affect our calculation of the fair value of our reporting units, which could result in a material impairment charge to goodwill and a material non-cash charge to earnings during the period in which the impairment is determined.

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

Our operations are capital intensive and require significant investment in long-lived assets, such as property, equipment and other long-lived intangible assets, including capitalized internal-use software. If one of our facilities experiences declining operating results or is adversely impacted by one or more of these risk factors, we may not be

able to recover the carrying value of those assets through our future operating cash flows. On an ongoing basis, we evaluate whether changes in future undiscounted cash flows reflect an impairment in the fair value of our long-lived assets. If the carrying value of our long-lived assets is impaired, we may incur a material non-cash charge to earnings.

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

In recent years, the U.S. Congress and certain state legislatures have introduced and passed a large number of proposals and legislation designed to make major changes in the healthcare system, including changes that increased access to health insurance. The most prominent of these efforts, the Affordable Care Act, affects how healthcare services are covered, delivered, and reimbursed. As currently structured, the Affordable Care Act mandates that substantially all U.S. citizens maintain health insurance coverage, expands health insurance coverage through a combination of public program expansion and private sector health insurance reforms, reduces Medicare reimbursement to hospitals, and promotes value-based purchasing. There are currently several public and private initiatives that aim to transition payment models from passive volume-based reimbursement to models that are tied to the quality and value of services.

The 2016 federal elections resulted in a new administration that, along with certain members of Congress, have stated their intent to repeal or make significant changes to the Affordable Care Act, its implementation and/or its interpretation. There is uncertainty regarding whether, when, and how the Affordable Care Act will be changed, what alternative provisions, if any, will be enacted, the timing of enactment and implementation of alternative provisions, and the impact of alternative provisions on providers as well as other healthcare industry participants. In addition, a presidential executive order has been signed that directs agencies to minimize economic and regulatory burdens of the Affordable Care Act, but it is unclear how this will be implemented. Further, Congress could eliminate or alter provisions beneficial to us while leaving in place provisions reducing our reimbursement. Government efforts to repeal or change the Affordable Care Act may have an adverse effect on our business, results of operations, cash flow, capital resources and liquidity.

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

In 2016, 34.4% of our operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), came from the Medicare and Medicaid programs. Federal healthcare expenditures continue to increase and state governments continue to face budgetary shortfalls as a result of current economic conditions and increasing Medicaid enrollment. As a result of such events and also pursuant to the Affordable Care Act, federal and state governments have made, and continue to make, significant changes in the Medicare and Medicaid programs, including reductions in reimbursement levels and supplemental payment programs like disproportionate share payments. Some of these changes have decreased, or could decrease, the amount of money we receive for our services relating to these programs.

In addition, government and commercial payors as well as other third parties from whom we receive payment for our services attempt to control healthcare costs by, for example, requiring hospitals to discount payments for their services in exchange for exclusive or preferred participation in their benefit plans, restricting coverage through utilization review, reducing coverage of inpatient services and shifting care to outpatient settings, requiring prior authorizations, and implementing alternative payment models. The ability of commercial payors to control healthcare costs using these measures may be enhanced by the increasing consolidation of insurance and managed care companies.

In 2016, 53.4% of our operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), came from commercial payors. Our contracts with payors require us to comply with a number of terms

related to the provision of services and billing for services. If we are unable to negotiate increased reimbursement rates, maintain existing rates or other favorable contract terms, effectively respond to payor cost controls or comply with the terms of our payor contracts, the payments we receive for our services may be reduced or we may be involved in disputes with payors and experience payment denials, both

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prospectively and retroactively. In addition, some individuals may move from existing coverage under health insurance plans with higher reimbursement rates for our services and lower co-pays and deductibles to plans, such as those purchased on the health insurance exchanges, that may provide for lower reimbursement for our services along with higher co-pays and deductibles or even exclusion of our hospitals and employed physicians from coverage.

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

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

We may be adversely affected by consolidation among health insurers.

In recent years, a number of health insurers have merged or increased efforts to consolidate with other payors as well as providers, in part, as a result of the insurance industry challenges resulting from the Affordable Care Act. Our ability to negotiate prices and favorable terms with health insurers in certain markets could be affected negatively as a result of this consolidation. Also, the shift toward value-based payment models could be accelerated if larger insurers find these models to be financially beneficial. We cannot predict whether we will be able to respond effectively to the impact of increased consolidation in the payor industry.

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

The healthcare industry is governed by laws and regulations at the federal, state and local government levels. These laws and regulations include standards addressing, among other issues, the adequacy of medical care, equipment, personnel, operating policies and procedures; billing and coding for services; properly handling overpayments; classification of levels of care provided; preparing and filing of cost reports; relationships with referral sources and referral recipients; maintenance of adequate records; compliance with building codes; environmental protection; and privacy and security. Examples of these laws include, but are not limited to, HIPAA, the Stark Law, the federal anti-kickback statute, the FCA, the Emergency Medical Treatment and Active Labor Act and similar state laws. If we fail to comply with applicable laws and regulations we could suffer civil sanctions and criminal penalties, including the loss of our operating licenses and our ability to participate in the Medicare, Medicaid and other federal and state healthcare programs.

In addition, there are heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment. Recent enforcement actions have focused on financial arrangements between hospitals and physicians, billing for services without adequately documenting medical necessity and billing for services outside the coverage guidelines for such services. Specific to our hospitals, we have received inquiries and subpoenas from various governmental agencies regarding these and other matters, and we are also subject to various claims and lawsuits relating to such matters. For a further discussion of these matters, see Legal Proceedings in Part I, Item 3 of this Form 10-K.

In the future, evolving interpretations or enforcement of these laws and regulations could subject our current practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel,

services, capital expenditure programs and operating expenses.

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

Physicians, hospitals and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability, or related legal theories. Even in states that have imposed caps on damages, litigants are seeking recoveries under new theories of liability that might not be subject to the caps on damages. Many of these actions involve large claims and significant defense costs. To protect us from the cost of these claims, we maintain claims made professional malpractice liability insurance and general liability insurance coverage in excess of those amounts for which we are self-insured. This insurance coverage is in amounts that we believe to be sufficient for our operations; however, our insurance coverage may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. Additionally, our insurance coverage does not cover all claims against us, such as fines, penalties, or other damage and legal expense payments resulting from qui tam lawsuits.

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

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

Material, uncorrected violations of the CIA could lead to our suspension or disbarment from participation in Medicare, Medicaid and other federal and state healthcare programs and repayment obligations. In addition, we are subject to possible civil penalties for failure to substantially comply with the terms of the CIA, including stipulated penalties ranging between $1,000 to $2,500 per day. We are also subject to a stipulated penalty of $50,000 for each false certification made by us or on our behalf, pursuant to the reporting provisions of the CIA. The CIA increases the amount of information we must provide to the federal government regarding our healthcare practices and our compliance with federal regulations. The reports we provide in connection with the CIA could result in greater scrutiny by regulatory authorities.

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

Our primary collection risks relate to uninsured patients and outstanding patient balances for which the primary insurance payor has paid some but not all of the outstanding balance, with the remaining outstanding balance (generally deductibles and co-payments) owed by the patient. Collections are impacted by the economic ability of patients to pay and the effectiveness of our collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage may affect our collection of accounts receivable and are considered in our estimates of accounts receivable collectability.

Since the implementation of the Affordable Care Act, our self-pay revenues as a percentage of total revenue have decreased, primarily resulting from a shift from self-pay to Medicaid and private insurers for a portion of our patient population, driven by the insurance coverage expansion provisions of the Affordable Care Act. However, the outcome of the 2016 federal elections has cast considerable uncertainty on the future of the Affordable Care Act. In addition, it

is difficult to predict the ultimate impact of the Affordable Care Act on the uninsured population and the percentage of our total revenue comprised of self-pay revenues because of, among other variables, uncertainty regarding the number and identity of states that ultimately choose to expand

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

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

While the U.S. economy as a whole has improved, improvement in many of the non-urban communities in which we operate has lagged behind the larger urban communities. In addition, the economies in the non-urban communities in which our hospitals primarily operate are often dependent on a small number of large employers, especially manufacturing or other facilities. These employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our hospitals for care. The failure of one or more large employers, or the closure or substantial reduction in the number of individuals employed at manufacturing or other facilities located in or near many of the non-urban communities in which our hospitals primarily operate, could cause affected employees to move elsewhere for employment or lose insurance coverage that was otherwise available to them. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may:

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

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

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

We derive a significant amount of our net operating revenues from governmental healthcare programs, primarily Medicare and Medicaid. The reimbursements due to us from those programs are subject to legislative and regulatory changes that can have a significant impact on our operating results. When delays occur in the implementation of regulations or passage of legislation, there is the potential for material increases or decreases in operating revenues to

be recognized in periods subsequent to when such related services were performed, resulting in the potential for an adverse effect on our consolidated financial position and consolidated results of operations.

If our adoption and utilization of electronic health record systems fails to achieve the required measures for meaningful use, our consolidated results of operations could be adversely affected.

As a result of the Health Information Technology for Economic and Clinical Health Act, or HITECH, eligible hospitals and healthcare professionals can receive incentive payments for their adoption and meaningful use of

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EHR technology. The incentive payments are available for a maximum period of five or six years, depending on the program. The implementation of EHR technology that meets the meaningful use criteria requires a significant capital investment, and we have and intend to continue to offset some of these costs by maximizing our receipt of incentive payments. Eligible hospitals and professionals that fail to demonstrate meaningful use of certified EHR technology and have not applied and qualified for a hardship exception are subject to reduced reimbursement from Medicare. Thus, if our hospitals and employed professionals are unable to comply with the meaningful use standards, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems (to the extent incentive payments remain available), and we could be subject to penalties that may have an adverse effect on our consolidated financial position and consolidated results of operations.

A cyber-attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

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

In spite of our security measures, there can be no assurance that we will not be subject to additional cyber-attacks or security breaches in the future. Such attacks or breaches could result in loss of protected health information or other data subject to privacy laws or disrupt our information technology systems or business. Additionally, growing cyber-security threats related to the use of ransomware and other malicious software threaten the access and utilization of critical information technology and data. We continue to prioritize cybersecurity and the development of practices and controls to protect our systems. Our ability to recover from a ransomware or other cyber-attack is dependent on these practices, including successful backup systems and other recovery procedures. As cyber-threats continue to evolve, we may be required to expend significant additional resources to continue to modify or enhance our protective measures or to investigate and remediate any information security vulnerabilities. If we are subject to cyber-attacks or security breaches in the future, this could have an adverse impact on our business, financial condition or results of operations.

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

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

shutdown or diversion of patients, by disrupting or delaying production and delivery of materials and products in the supply chain or by causing staffing shortages in our facilities. Although we have disaster plans in place and operate pursuant to infectious disease protocols, the potential impact of a pandemic, epidemic or outbreak of a contagious disease with respect to our markets or our facilities is difficult to predict and could adversely impact our business.

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

Although we employ some physicians, physicians are often not employees at our healthcare facilities at which they practice. The success of our healthcare facilities depends in part on the number and quality of the physicians on the medical staffs of our healthcare facilities, our ability to employ quality physicians, the admitting and utilization practices of employed and independent physicians, maintaining good relations with those physicians and controlling costs related to the employment of physicians. In many of the markets we serve, many physicians have admitting privileges at other healthcare facilities in addition to our healthcare facilities. Such physicians may terminate their affiliation with or employment by our healthcare facilities at any time. If we are unable to provide adequate support personnel or technologically advanced equipment and facilities that meet the needs of those physicians and their patients, they may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline.

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

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

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

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

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

The trend toward value-based purchasing of healthcare services is gaining momentum across the healthcare industry among both government and commercial payors. Generally, value-based purchasing initiatives tie payment to the quality and efficiency of care. For example, hospital payments may be negatively impacted by the occurrence of HACs. The 25% of hospitals with the worst national risk-adjusted HAC rates for all hospitals in the previous year receive a 1% reduction in their total Medicare payments. Medicare does not reimburse for care related to HACs. In addition, federal funds may not be used under the Medicaid program to reimburse providers for services provided to treat HACs. Hospitals that experience excess readmissions for designated conditions receive reduced payments for all

inpatient discharges. HHS also reduces Medicare inpatient hospital payments for all discharges by a required percentage and pools the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards. Further, Medicare and Medicaid require hospitals to report certain quality data to receive full reimbursement updates.

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HHS has indicated that it is particularly focused on tying Medicare payments to quality or value through alternative payment models, which generally aim to make providers attentive to the quality and cost of care they deliver to patients. Examples of alternative payment models include ACOs and bundled payment arrangements. HHS currently requires hospitals in certain geographic areas to participate in a bundled payment program for specified joint replacement procedures and will implement a mandatory program with a cardiac focus in 2017. HHS may increasingly establish similar mandatory programs. It is unclear whether alternative payment models will successfully coordinate care and reduce costs or whether they will decrease aggregate reimbursement. Several of the nation s largest commercial payors have also expressed an intent to increase reliance on value-based reimbursement arrangements. Further, many large commercial payors require hospitals to report quality data, and several commercial payors do not reimburse hospitals for certain preventable adverse events.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our revenues or our cost of operations, or both.

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

Our revenues are particularly sensitive to regulatory and economic changes in states in which we generate a significant portion of our revenues, including Florida, Pennsylvania, Texas, Indiana and Tennessee. Accordingly, any change in the current demographic, economic, competitive or regulatory conditions in these states could have an adverse effect on our business, financial condition or results of operations. Changes to the Medicaid programs in these states could also have an adverse effect on our business, financial condition, results of operations or cash flows. For example, the Texas Medicaid Waiver Program provides funding for uncompensated care and delivery system reform initiatives and allows Texas to continue receiving supplemental Medicaid reimbursement while expanding its Medicaid managed care program. CMS has extended the waiver through December 31, 2017. Texas has submitted an application to extend its Medicaid Waiver Program through September 30, 2019, but CMS has not yet issued a decision. We cannot predict whether the Texas Medicaid Waiver Program will be extended, continue in its current form or guarantee that revenues recognized from the program will not decrease.

In addition, some of our hospitals in Florida, Texas and other areas along the Gulf Coast are located in hurricane-prone areas. In the past, hurricanes have had a disruptive effect on the operations of our hospitals in Florida, Texas and other coastal states and the patient populations in those states. Our business activities could be harmed by a particularly active hurricane season or even a single storm, and the property insurance we obtain may not be adequate to cover losses from future hurricanes or other natural disasters.

The Company s Stockholder Protection Rights Agreement could delay or prevent a change in control of the Company, which could have a negative effect on the price of the Company s common stock.

The Board of Directors of the Company adopted a Stockholder Protection Rights Agreement on October 3, 2016. Under the terms of the Stockholder Protection Rights Agreement, any person (together with certain affiliated persons) that acquires 15% or more of the Company s common stock could suffer substantial dilution of its ownership interest in the Company through the issuance of a large amount of stock to shareholders other than the acquiring person.

Our Stockholder Protection Rights Agreement was adopted in order to prevent the accumulation of a potentially controlling block of the Company s common stock pending our exploration of potential strategic options and alternatives. However, our Stockholders Protection Rights Agreement may impede an attempt to acquire a significant

or controlling ownership interest in the Company, and may prevent or make more difficult takeovers or unsolicited corporate transactions involving the Company not supported by our Board of Directors, even if such a transaction were considered beneficial by some of our stockholders. The Stockholder Protection Rights Agreement will expire on April 1, 2017.

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There can be no assurance that our exploration of strategic alternatives will result in any transaction, and exploration of strategic alternatives may impact our ability to pursue other opportunities.

As initially disclosed on September 19, 2016, with the assistance of advisors, we are exploring a variety of options with financial sponsors, as well as other potential alternatives. These discussions are ongoing. There can be no certainty that the exploration will result in any kind of transaction. We do not expect to make further public comment regarding these matters while the exploration takes place unless and until we otherwise deem further public comment is appropriate or required. In addition, the process of exploring strategic alternatives has involved and may continue to involve the dedication of significant resources, including the time and attention of our management, and the incurrence of significant costs and expenses. Moreover, uncertainty regarding the possible outcome of our exploration of strategic alternatives may increase the challenge of recruiting and retaining talented and skilled personnel. It is also possible that potentially inaccurate market speculation regarding the outcome of the process may cause our stock to trade based on factors other than our financial and operating performance and prospects as a stand-alone company.

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

None

Item 2. ***Properties***

Corporate Headquarters

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

Hospitals

Our hospitals are general care hospitals offering a wide range of inpatient and outpatient medical services. These services generally include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric and rehabilitation services. In addition, some of our hospitals provide skilled nursing and home care services based on individual community needs.

For each of our hospitals owned or leased as of December 31, 2016, the following table shows its location, the date of its acquisition or lease inception and the number of licensed beds:

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Alabama				
South Baldwin Regional Medical Center	Foley	112	June, 2000	Leased
Grandview Medical Center	Birmingham	372	July, 2007	Owned
Flowers Hospital	Dothan	235	July, 2007	Owned
Medical Center Enterprise	Enterprise	131	July, 2007	Owned
Gadsden Regional Medical Center	Gadsden	346	July, 2007	Owned
Crestwood Medical Center	Huntsville	180	July, 2007	Owned
Stringfellow Memorial Hospital	Anniston	125	January, 2014	Leased

Alaska				
Mat-Su Regional Medical Center	Palmer	74	July, 2007	Owned
Arizona				
Western Arizona Regional Medical Center	Bullhead City	139	July, 2000	Owned
Northwest Medical Center	Tucson	300	July, 2007	Owned
Oro Valley Hospital	Oro Valley	146	July, 2007	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type			
Arkansas							
Northwest Health System							
Northwest Medical Center - Bentonville	Bentonville	128	July, 2007	Owned			
Northwest Medical Center - Springdale	Springdale	222	July, 2007	Owned			
Willow Creek Women s Hospital	Johnson	64	July, 2007	Owned			
Northwest Health Physician s Specialty Hospital	Fayetteville	21	April, 2016	Leased			
Siloam Springs Regional Hospital	Siloam Springs	73	February, 2009	Owned			
Medical Center of South Arkansas	El Dorado	166	April, 2009	Leased			
Sparks Regional Medical Center	Fort Smith	492	January, 2014	Owned			
Sparks Medical Center - Van Buren	Van Buren	103	January, 2014	Leased			
Florida							
Lake Wales Medical Center	Lake Wales	160	December, 2002	Owned			
North Okaloosa Medical Center	Crestview	110	March, 1996	Owned			
Bayfront Health Brooksville	Brooksville	120	January, 2014	Leased			
Bayfront Health Dade City	Dade City	120	January, 2014	Owned			
Bayfront Health Port Charlotte	Port Charlotte	254	January, 2014	Owned			
Bayfront Health Punta Gorda	Punta Gorda	208	January, 2014	Owned			
Bayfront Health St. Petersburg	St. Petersburg	480	January, 2014	Leased			
Bayfront Health Spring Hill	Spring Hill	124	January, 2014	Leased			
Heart of Florida Regional Medical Center	Davenport	193	January, 2014	Owned			
Highlands Regional Medical Center	Sebring	126	January, 2014	Enterprise Resource	$ 966	$ 569	70%

			Planning	
Supply Chain Management	4,082	3,769	8%	
Total license revenues	$ 5,048	$ 4,338	16%	

	Nine Months Ended January 31,		
	2016	2015	% Change
	(in thousands)		
Enterprise Resource Planning	$ 2,607	$ 1,824	43%
Supply Chain Management	12,880	9,894	30%
Total license revenues	$ 15,487	$ 11,718	32%

For the three and nine months ended January 31, 2016, license fee revenues increased 16% and 32%, respectively, when compared to the same periods in the prior year. While we expect a degree of quarterly fluctuation due to the timing of signing license fee agreements, our SCM and ERP segments experienced an increase in license fee close rates in the current quarter when compared

to the same period last year due to improvement in the overall capital spending environment and improved sales execution in closing

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transactions partly as a result of an increase in sales and marketing staff when compared to the same period last year. The SCM license fee revenue would have been higher in the current quarter by approximately $800,000 however these customer sales included hosting services which require the revenue recognition to be spread over the life of the contract due to the lack of VSOE.

Our SCM segment constituted 81% and 83% of total license fee revenues for the three and nine months ended January 31, 2016, respectively, compared to 87% and 84% for the three and nine months ended January 31, 2015, respectively. Our ERP business unit license fee revenues increased by 70% and 43% for the three and nine months ended January 31, 2016 when compared to the same periods in the prior year, primarily due to an increase in license fee sales to the apparel and retail industries due to improved sales execution and sales environment for those vertical industries.

The direct sales channel provided approximately 82% and 76% of license fee revenues for the three and nine months ended January 31, 2016, respectively, compared to approximately 77% and 71% of license fee revenues for the three and nine months ended January 31, 2015, respectively. The increase in the proportion of sales by our direct sales channel, which tends to target larger companies, for the current quarter when compared to the prior year period is primarily due to an increase in larger sales compared with the same time last year. In general, large and midsized companies do not require access to capital markets to fund expenditures to the same degree as do smaller companies. Thus, our indirect sales channel faces relatively greater challenges in the current economy, as the indirect channel tends to target smaller companies. For the three and nine months ended January 31, 2016, our margins after commissions on direct sales were approximately 84% and 86%, respectively, compared to 87% for the three and nine months ended January 31, 2015, respectively. For the three months ended January 31, 2016 compared to the same period in the prior year, our direct margins decreased due to the concentration (or mix) of sales staff achieving certain commission rate levels when compared to the same period last year. For the three and nine months ended January 31, 2016, our margins after commissions on indirect sales were approximately 46% and 50%, respectively, compared to 32% and 39% for the three and nine months ended January 31, 2015, respectively. The indirect channel margins increased for the three and nine months ended January 31, 2016 when compared to the same periods in the prior year due to the mix of value-added reseller (VAR) commission rates. These margin calculations include only commission expense for comparative purposes and do not include other costs of license fees such as amortization of capitalized software.

Services and Other Revenues

	Three Months Ended January 31,		
	2016	2015	% Change
	(in thousands)		
Enterprise Resource Planning	$ 998	$ 1,168	(15)%
Supply Chain Management	5,338	3,954	35%
IT Consulting	5,465	6,540	(16)%
Total services and other revenues	$ 11,801	$ 11,662	1%

	Nine Months Ended January 31,		
	2016	2015	% Change

	(in thousands)		
Enterprise Resource Planning	$ 3,362	$ 3,029	11%
Supply Chain Management	16,778	12,786	31%
IT Consulting	18,969	18,633	2%
Total services and other revenues	$ 39,109	$ 34,448	14%

For the three months ended January 31, 2016, services and other revenues increased by 1% when compared to the same period in the prior year, primarily due to an increase in services and other revenues from our SCM segment which was partially offset by decreases in our ERP and IT Consulting business segments . For the nine months ended January 31, 2016, services and other revenues increased by 14% when compared to the same period in the prior year, primarily due to an increase in services and other revenues from all our business segments. For the three and nine months ended January 31, 2016, services and other revenues from Logility (SCM) increased by 35% and 31%, respectively, when compared to the prior year periods. Logility services and other revenues increased due to an increase in project implementation work from higher license fee sales in the first half of fiscal 2016, which tend to increase services implementation revenue with a one to three quarter lag. For the three and nine months ended January 31, 2015, our ERP segment s revenues decreased 15% and increased 11%, respectively, when compared to the prior year periods. The decrease in the current quarter is due to timing of project work. For the three and nine months ended January 31, 2015, our IT Consulting segment s revenues decreased 16% and increased 2%, respectively, when compared to the prior year periods. The decrease in the current quarter was due to the completion of an IT project from one of our larger customer as a result of timing of project work. We expect the services revenue to increase sequentially in the fourth quarter of fiscal 2016 when compared to the current quarter.

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We have observed that there is a tendency for services and other revenues, other than from IT Consulting, to lag changes in license revenues by one to three quarters, as new licenses in one quarter often involve implementation and consulting services in subsequent quarters, for which we recognize revenues only as we perform those services.

Maintenance Revenues

	Three Months Ended January 31,		
	2016	2015	% Change
	(in thousands)		
Enterprise Resource Planning	$ 1,327	$ 1,260	5%
Supply Chain Management	8,919	8,579	4%
Total maintenance revenues	$ 10,246	$ 9,839	4%

	Nine Months Ended January 31,		
	2016	2015	% Change
	(in thousands)		
Enterprise Resource Planning	$ 3,906	$ 3,754	4%
Supply Chain Management	26,521	25,353	5%
Total maintenance revenues	$ 30,427	$ 29,107	5%

For the three and nine months ended January 31, 2016, maintenance revenues increased 4% and 5%, respectively, when compared to the same periods in the prior year due primarily to license fee sales in recent quarters and improved renewal rates in our SCM unit, which experienced a 4% and 5% increase in maintenance revenue for the three and nine months ended January 31, 2016, respectively, when compared to the same periods last year. Our legacy ERP unit experienced an increase of 5% and 4%, for the three and nine months ended January 31, 2016, respectively, when compared to the same periods in the prior year due to increased license fees in recent quarters and improved renewal rates. Logility accounted for 87% of total maintenance revenues for both the three- and nine-month periods ended January 31, 2016, respectively, compared to 87% of total maintenance revenues for both the three- and nine-month periods ended January 31, 2015. Typically, our maintenance revenues have had a direct relationship to current and historic license fee revenues, since new licenses are the potential source of new maintenance customers.

GROSS MARGIN

The following table provides both dollar amounts (in thousands) and percentage measures of gross margin:

	Three months ended January 31,				Nine months ended January 31,			
	2016		2015		2016		2015	
Gross margin on license fees	$ 3,202	63%	$ 2,349	54%	$ 9,712	63%	$ 6,230	53%
Gross margin on services and other	2,620	22%	2,870	25%	10,554	27%	9,318	27%
Gross margin on maintenance	7,785	76%	7,630	78%	23,555	77%	22,742	78%

Total gross margin	$ 13,607	50%	$ 12,849	50%	$ 43,821	52%	$ 38,290	51%

For the three and nine months ended January 31, 2016, total gross margin percentage was the essentially the same when compared to the same periods in the prior year.

Gross Margin on License Fees

License fee gross margin percentage for the three and nine months ended January 31, 2016 was 63% compared to 54% and 53% for the same periods in the prior year, respectively, due primarily to an increase in the license fee. License fee gross margin percentage tends to be directly related to the level of license fee revenues due to the relatively fixed cost of computer software amortization expense, amortization of acquired software and the sales mix between our direct and indirect channels.

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Gross Margin on Services and Other

For the three months ended January 31, 2016, the gross margin percentage on services and other revenues decreased three percentage points to 22% from 25% in the same period in the prior year, primarily due to a decrease in margins at our IT consulting and ERP business unit from a decrease services revenue from timing of project work. For the nine months ended January 31, 2016 and 2015, the gross margin percentage on services and other revenues were 27% for both periods. Services and other gross margin are directly related to the level of services and other revenues. The primary component of cost of services and other revenues is services staffing, which is relatively inelastic in the short term.

Gross Margin on Maintenance

Maintenance gross margin percentage for the three months ended January 31, 2016 declined by 2 percentage points when compared to the same periods in the prior year due to an increase in headcount. Maintenance gross margin percentage for the nine months ended January 31, 2016 were the same when compared to the same periods in the prior year. Maintenance gross margin normally is directly related to the level of maintenance revenues. The primary component of cost of maintenance revenue is maintenance staffing, which is relatively inelastic in the short term.

Expenses

	Three Months Ended January 31,				Nine Months Ended January 31,			
			% of Revenues				% of Revenues	
	2016	2015	2016	2015	2016	2015	2016	2015
	(in thousands)				(in thousands)			
Research and development	$ 3,012	$ 2,603	11%	10%	$ 8,177	$ 8,609	10%	11%
Sales and marketing	$ 5,269	$ 4,540	19%	18%	$ 15,967	$ 13,758	19%	18%
General and administrative	$ 2,740	$ 3,224	10%	12%	$ 9,807	$ 9,707	12%	13%
Amortization of acquisition-related intangible assets	$ 68	$ 107	0%	1%	$ 204	$ 299	0%	1%
Other (expense) income, net	$ (194)	$ (80)	1%	0%	$ 242	$ 715	0%	1%
Income tax expense (benefit)	$ 213	$ (546)	1%	(2)%	$ 3,072	$ 1,082	4%	2%

Research and Development

Gross product research and development costs include all non-capitalized and capitalized software development costs. A breakdown of the research and development costs is as follows:

	Three Months Ended (in thousands)		
	January 31, 2016	Percent Change	January 31, 2015
Total capitalized computer software development costs	$ 692	(21)%	$ 879
	19%		25%

Percentage of gross product research and development costs			
Total research and development expense	3,012	16%	2,603
Percentage of total revenues	11%		10%
Total research and development expense and capitalized computer software development costs	$ 3,704	6%	$ 3,482
Percentage of total revenues	14%		13%
Total amortization of capitalized computer software development costs *	$ 985	10%	$ 897

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	Nine Months Ended (in thousands)		
	January 31, 2016	Percent Change	January 31, 2015
Total capitalized computer software development costs	$ 2,681	55%	$ 1,725
Percentage of gross product research and development costs	25%		17%
Total research and development expense	8,177	(5)%	8,609
Percentage of total revenues	10%		11%
Total research and development expense and capitalized computer software development costs	$ 10,858	5%	$ 10,334
Percentage of total revenues	13%		14%
Total amortization of capitalized computer software development costs *	$ 2,936	9%	$ 2,691

* Included in cost of license fees

For the three and nine months ended January 31, 2016, gross product research and development costs increased when compared to the same periods in the previous fiscal year primarily due to an increased hiring in our SCM business unit. Capitalized software development costs decreased for the three months ended January 31, 2016 and increased for the nine months ended January 31, 2016 when compared to the same periods last year due to timing of capitalizable project work. We expect capitalized product development costs to increase as new projects reach technological feasibility and we expect capitalized software amortization expense to be relatively stable in coming quarters. Costs included in gross product development are salaries of product development personnel, hardware lease expense, computer software expense, telephone expense and rent.

Sales and Marketing

For the three and nine months ended January 31, 2016, sales and marketing expenses increased 16% when compared to the same periods a year ago primarily due to an increase in headcount, marketing related fees and sales commissions as a result of higher license fees. We generally include commissions on indirect sales in cost of sales.

General and Administrative and Provision for (Recovery of) Doubtful Accounts

For the three months ended January 31, 2016, the 15% decrease when compared to the same period last year was primarily due to recording a Research and Development State tax credit against withholding taxes of approximately $638,000 and to a lesser extent a decrease in the allowance for doubtful accounts. Based on current Georgia law and our historical research and development costs, in future fiscal years we expect this credit to be approximately $400,000 annually.

For the nine months ended January 31, 2016, the 1% increase compared to the same period last year was primarily due to an increase in variable compensation, general office expenses and audit related expenses. This increase was partially offset by a Research and Development state tax credit against withholding taxes of approximately $638,000 and to a lesser extent a decrease in the allowance for doubtful accounts.

At January 31, 2016, the total number of employees was 419, compared to 399 at January 31, 2015.

Operating Income/(Loss)

	Three Months Ended January 31,			Nine Months Ended January 31,		
	2016	2015	% Change	2016	2015	% Change
	(in thousands)			(in thousands)2		
Enterprise Resource Planning	$ (1,049)	$ (1,192)	12%	$ (3,394)	$ (3,792)	10%
Collaborative Supply Chain Management	3,393	3,064	11%	11,784	8,076	46%
IT Consulting	174	503	(65)%	1,276	1,633	(22)%
Total Operating Income	$ 2,518	$ 2,375	6%	$ 9,666	$ 5,917	63%

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Our ERP and corporate expense segment operating loss in the three months ended January 31, 2016 decreased from the same period in the prior year due to higher license fee and maintenance revenues partially offset by a decrease in services revenue. Our ERP and corporate expense segment operating loss decreased in the nine months ended January 31, 2016 due to higher license fee, services and maintenance revenues.

Our SCM segment s contribution to operating income increased by 11% and 46% for the three and nine months ended January 31, 2016 compared to same periods last year, primarily as a result of an increase overall revenues particularly the 8% and 30% increase in license fee revenues for the three and nine months ended January 31, 2016 compared to same periods last year, respectively.

Our IT consulting segment operating income decreased 65% and 22% for the three and nine months ended January 31, 2016, respectively, when compared to same periods last year as a result of higher revenue and improved cost management due to a decrease in revenue from the end of a large IT project ending during the quarter.

Other Income (Expense)

Other income is comprised of net interest and dividend income, rental income net of related depreciation expenses, exchange rate gains and losses, and realized and unrealized gains and losses from investments. For the three and nine months ended January 31, 2016, the decrease in other income was due primarily to higher unrealized losses on investments when compared to the same period last year.

This decrease was partially offset by: 1) lower exchange rate losses of approximately $128,000 and $303,000 for the three and nine months ended January 31, 2016 when compared to $262,000 and $455,000 for the three and nine months ended January 31, 2015, 2) an increase in interest income as a result of higher market yields and 3) higher rental income when compared to the same periods last year.

We recorded losses of approximately $703,000 and $1.2 million for the three and nine months ended January 31, 2016, respectively, from our trading securities portfolio. We recorded losses of approximately $364,000 and $381,000 for the three and nine months ended January 31, 2015, respectively, from our trading securities portfolio.

For the three and nine months ended January 31, 2016, our investments generated an annualized yield of approximately 2.01% and 1.87% respectively, compared to approximately 1.86% and 1.67% for the three and nine months ended January 31, 2015, respectively.

Income Taxes

We recognize deferred tax assets and liabilities based on the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their tax bases. We measure deferred tax assets and liabilities using statutory tax rates in effect in the year in which we expect the differences to reverse. We establish a deferred tax asset for the expected future benefit of net operating loss and credit carry-forwards. Under the Income Tax Topic of the FASB Accounting Standards Codification, we cannot recognize a deferred tax asset for the future benefit of our net operating losses, tax credits and temporary differences unless we can establish that it is more likely than not that the deferred tax asset would be realized. During the three months ended January 31, 2016, our effective tax rate was 9.2% compared to our effective tax rate of (23.8)% in the three months ended January 31, 2015. The current quarter included the extension of the research and development tax credit during the third quarter of fiscal 2016 which resulted in a catch-up credit adjustment for the period January 1, 2015 through December 31, 2015.

The effective tax rate for the current quarter is higher compared to the third quarter of fiscal 2015 due to the reversal of a FIN 48 Reserve ($973,000) in the third quarter of 2015, due to the lapse in the statute of limitations.

During the nine months ended January 31, 2016, our effective rate was 31.0% compared to our effective rate of 16.3% in the nine months ended January 31, 2015. We expect our effective rate will be between 31% and 34% during fiscal 2016.

Operating Pattern

We experience irregular fluctuations in quarterly operating results, caused primarily by changes in both the number and size of software license contracts received and delivered from quarter to quarter and our ability to recognize revenues in that quarter in accordance with our revenue recognition policies. We expect these fluctuations to continue.

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LIQUIDITY, CAPITAL RESOURCES AND FINANCIAL CONDITION

Sources and Uses of Cash

We have historically funded, and continue to fund, our operations and capital expenditures primarily with cash generated from operating activities. The changes in net cash that our operating activities provide generally reflect the changes in net earnings and non-cash operating items plus the effect of changes in operating assets and liabilities, such as investment trading securities, trade accounts receivable, trade accounts payable, accrued expenses and deferred revenue. We have no debt obligations or off-balance sheet financing arrangements, and therefore we used no cash for debt service purposes.

The following table shows information about our cash flows and liquidity positions during the nine months ended January 31, 2016 and 2015. You should read this table and the discussion that follows in conjunction with our condensed consolidated statements of cash flows contained in Item 1. Financial Statements in Part I of this report and in our Annual Report on Form 10-K for the fiscal year ended April 30, 2015.

	Nine Months Ended January 31,	
	2016	2015
	(in thousands)	
Net cash provided by operating activities	$ 8,465	$ 4,714
Net cash used in investing activities	(3,162)	(10,606)
Net cash used in financing activities	(6,996)	(8,888)
Net change in cash and cash equivalents	$ (1,693)	$ (14,780)

For the nine months ended January 31, 2016, the increase in cash provided by operating activities compared to the same period last year was due primarily to: 1) a decrease in purchases of trading securities, 2) an increase in net earnings, 3) an increase in accounts payable and other accruals compared to a decrease in the same period last year due to timing of payments, 4) a higher increase in the tax benefit of stock options exercised compared to the prior year due to the mix of options exercised, 5) higher stock-based compensation expense and 6) an increase in unrealized losses on investments compared to the same period last year.

This increase was partially offset by: 1) lower proceeds from the maturity and sales of trading securities, 2) a decrease in customer accounts receivable compared to an increase in the same period last year caused by the timing of closing customer sales and related collections, 3) a decrease in prepaid expenses and other assets compared to an increase in the same period last year due to the timing of purchases, 4) higher excess tax benefits from stock-based compensation compared to the prior year due to the mix of options exercised, and 5) a decrease in deferred revenues compared to an increase in the same period last year due to the timing of revenue recognition.

The decrease in cash used in investing activities when compared to the same period in the prior year was due primarily to the acquisition of MRI during the first quarter of fiscal 2015 and a decrease in purchases of property and equipment. The decrease was partially offset by an increase in capitalized computer software development costs due to the timing of project work.

The decrease in cash used in financing activities compared to the prior year was due primarily to: 1) a decrease in repurchases of the Company s common stock, 2) an increase in proceeds from exercise of stock options and 3) an increase in excess tax benefits from stock-based compensation. This was partially offset by an increase in dividends paid.

The following table shows net changes in total cash, cash equivalents, and investments, which is one measure management uses to view net total cash generated by our activities:

	As of January 31,	
	2016	2015
	(in thousands)	
Cash and cash equivalents	$ 42,962	$ 41,023
Short and long-term investments	31,363	29,973
Total cash and short and long-term investments	$ 74,325	$ 70,996
Net decrease in total cash and investments (nine months ended January 31)	$ (1,070)	$ (8,578)

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Our total activities used less cash and investments during the nine months ended January 31, 2016, when compared to the prior year period, due primarily to the changes in operating assets and liabilities noted above, the payment of quarterly dividends, the acquisition of MRI and repurchase of the Company s common stock.

Days Sales Outstanding in accounts receivable were 69 days as of January 31, 2016, compared to 62 days as of January 31, 2015. This increase is primarily due to the timing of collection activity. Our current ratio on January 31, 2016 was 2.3 to 1 and on January 31, 2015 was 2.2 to 1.

Our business in recent periods has generated positive cash flow from operations, excluding purchases and proceeds of sale of trading securities. For this reason, and because we had $74.3 million in cash and investments with no debt as of January 31, 2016, we believe that our sources of liquidity and capital resources will be sufficient to satisfy our presently anticipated requirements during at least the next twelve months for working capital, capital expenditures and other corporate needs. However, at some future date, we may need to seek additional sources of capital to meet our requirements. If such need arises, we may be required to raise additional funds through equity or debt financing. We do not currently have a bank line of credit. We can provide no assurance that bank lines of credit or other financing will be available on terms acceptable to us. If available, such financing may result in dilution to our shareholders or higher interest expense.

On December 17, 1997, our Board of Directors approved a resolution authorizing the repurchase of up to 1.5 million of our Class A Common Shares. On March 11, 1999, our Board of Directors approved a resolution authorizing us to repurchase an additional 700,000 shares for a total of up to 2.2 million of our Class A Common Shares. On August 19, 2002, our Board of Directors approved a resolution authorizing us to repurchase an additional 2.0 million shares for a total of up to 4.2 million of our Class A Common Shares. These repurchases have been and will be made through open market purchases at prevailing market prices. The timing of any repurchases will depend upon market conditions, the market price of our common stock and management s assessment of our liquidity and cash flow needs. As of January 31, 2016, under all repurchase plans previously authorized, including this most recent plan, we have repurchased a total of 4,576,166 shares of common stock at a cost of approximately $25.4 million.

CRITICAL ACCOUNTING POLICIES AND ESTIMATES

We have based the following discussion and analysis of financial condition and results of operations on our financial statements, which we have prepared in accordance with U.S. generally accepted accounting principles. The preparation of these financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Note 1 in the Notes to the Consolidated Financial Statements in our Annual Report on Form 10-K for the fiscal year ended April 30, 2015 describes the significant accounting policies that we have used in preparing our financial statements. On an ongoing basis, we evaluate our estimates, including, but not limited to those related to vendor specific objective evidence (VSOE), bad debts, capitalized software costs, goodwill, intangible asset impairment, stock-based compensation, income taxes and contingencies. We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Our actual results could differ materially from these estimates under different assumptions or conditions.

We believe the critical accounting policies listed below affect significant judgments and estimates used in the preparation of the financial statements.

Revenue Recognition. We recognize revenue in accordance with the Software Revenue Recognition Topic of FASB s Accounting Standards Codification. We recognize license revenues in connection with license agreements for standard proprietary software upon delivery of the software, provided we deem collection to be probable, the fee is fixed or determinable, there is evidence of an arrangement, and VSOE exists with respect to any undelivered elements of the arrangement. We generally bill maintenance fees annually in advance and recognize the resulting revenues ratably over the term of the maintenance agreement. We derive revenues from services which primarily include consulting, implementation, and training. We bill for these services primarily under time and materials arrangements and recognize fees as we perform the services. Deferred revenues represent advance payments or billings for software licenses, services, and maintenance billed in advance of the time we recognize revenues. We record revenues from sales of third-party products in accordance with Principal Agent Considerations within the Revenue Recognition Topic of the FASB s Accounting Standards Codification. Furthermore, we evaluate sales through our indirect channel on a case-by-case basis to determine whether the transaction should be recorded gross or net, including but not limited to assessing whether or not we 1) act as principal in the transaction, 2) take title to the products, 3) have risks and rewards of ownership, such as the risk of loss for collection, delivery, or returns, and 4) act as an agent or broker with compensation on a commission or fee basis. Accordingly, our sales through the DMI channel are typically recorded on a gross basis.

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Generally, our software products do not require significant modification or customization. Installation of the products is routine and is not essential to their functionality. Our sales frequently include maintenance contracts and professional services with the sale of our software licenses. We have established VSOE for our maintenance contracts and professional services. We determine fair value based upon the prices we charge to customers when we sell these elements separately. We defer maintenance revenues, including those sold with the initial license fee, based on VSOE, and recognize the revenue ratably over the maintenance contract period. We recognize consulting and training service revenues, including those sold with license fees, as we perform the services based on their established VSOE. We determine the amount of revenue we allocate to the licenses sold with services or maintenance using the residual method of accounting. Under the residual method, we allocate the total value of the arrangement first to the undelivered elements based on their VSOE and allocate the remainder to license fees.

Allowance for Doubtful Accounts. We maintain allowances for doubtful accounts for estimated losses resulting from the inability of customers to make required payments. If the financial condition of these customers were to deteriorate, resulting in an impairment of their ability to make payments, we may require additional allowances or we may defer revenue until we determine that collectability is probable. We specifically analyze accounts receivable and historical bad debts, customer creditworthiness, current economic trends and changes in customer payment terms when we evaluate the adequacy of the allowance for doubtful accounts.

Valuation of Long-Lived and Intangible Assets. In accordance with the Intangibles-Goodwill and Other Topic of the FASB s Accounting Standards Codification, we do not amortize goodwill and other intangible assets with indefinite lives. Our goodwill is subject to annual impairment tests, which require us to estimate the fair value of our business compared to the carrying value. The impairment reviews require an analysis of future projections and assumptions about our operating performance. Should such review indicate the assets are impaired, we would record an expense for the impaired assets.

In accordance with the Property, Plant, and Equipment Topic of the FASB s Accounting Standards Codification, long-lived assets, such as property and equipment and intangible assets, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability would be measured by a comparison of the carrying amount of an asset to the estimated undiscounted future cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, we recognize an impairment charge in the amount by which the carrying amount of the asset exceeds the fair value of the asset. The determination of estimated future cash flows, however, requires management to make estimates. Future events and changes in circumstances may require us to record a significant impairment charge in the period in which such events or changes occur. Impairment testing requires considerable analysis and judgment in determining results. If other assumptions and estimates were used in our evaluations, the results could differ significantly.

Annual tests or other future events could cause us to conclude that impairment indicators exist and that our goodwill is impaired. For example, if we had reason to believe that our recorded goodwill and intangible assets had become impaired due to decreases in the fair market value of the underlying business, we would have to take a charge to income for that portion of goodwill or intangible assets that we believed was impaired. Any resulting impairment loss could have a material adverse impact on our financial position and results of operations. At January 31, 2016, our goodwill balance was $18.7 million and our intangible assets with definite lives balance was approximately $2.1 million, net of accumulated amortization.

Valuation of Capitalized Software Assets. We capitalize certain computer software development costs in accordance with the Intangibles-Goodwill and Other Topic of the FASB s Accounting Standards Codification. Costs incurred internally to create a computer software product or to develop an enhancement to an existing product are charged to expense when incurred as research and development expense until technological feasibility for the respective product

is established. Thereafter, we capitalize all software development costs and report those costs at the lower of unamortized cost or net realizable value. Capitalization ceases when the product or enhancement is available for general release to customers. We make ongoing evaluations of the recoverability of our capitalized software projects by comparing the amount capitalized for each product to the estimated net realizable value of the product. If such evaluations indicate that the unamortized software development costs exceed the net realizable value, we write off the amount by which the unamortized software development costs exceed net realizable value. We amortize capitalized computer software development costs ratably based on the projected revenues associated with the related software or on a straight-line basis over three years, whichever method results in a higher level of amortization. Amortization of capitalized computer software development costs is included in the cost of license revenues in the condensed consolidated statements of operations.

Stock-Based Compensation. We estimate the value of options granted on the date of grant using the Black-Scholes option pricing model. Management s judgments and assumptions related to volatility, the expected term and the forfeiture rate are made in connection with the calculation of stock compensation expense. We periodically review all assumptions used in our stock option pricing model. Changes in these assumptions could have a significant impact on the amount of stock compensation expense.

Income Taxes. We provide for the effect of income taxes on our financial position and results of operations in accordance with the Income Tax Topic of the FASB s Accounting Standards Codification. Under this accounting guidance, income tax expense is recognized for the amount of income taxes payable or refundable for the current year and for the change in net deferred tax assets or liabilities resulting from events that are recorded for financial reporting purposes in a different reporting period than recorded in the

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tax return. Management must make significant assumptions, judgments and estimates to determine our current provision for income taxes and also our deferred tax assets and liabilities and any valuation allowance to be recorded against our net deferred tax asset. Our judgments, assumptions and estimates relative to the current provision for income tax take into account current tax laws, our interpretation of current tax laws, allowable deductions, and projected tax credits. Changes in tax law or our interpretation of tax laws could significantly impact the amounts provided for income taxes in our financial position and results of operations. Our assumptions, judgments and estimates relative to the value of our deferred tax assets take into account our expectations of the amount and category of future taxable income. Actual operating results and the underlying amount and category of income in future years, which could significantly increase tax expense, could render inaccurate our current assumptions, judgments and estimates of recoverable net deferred taxes.

Business Combinations and Intangible Assets Including Goodwill. We account for business combinations using the acquisition method of accounting and accordingly, the identifiable assets acquired and liabilities assumed are recorded based upon management s estimates of current fair values as of the acquisition date. The estimation process includes analyses based on income and market approaches. Goodwill represents the excess purchase price over the fair value of net assets, including the amount assigned to identifiable intangible assets. The goodwill generated is due in part to the synergies that are not included in the fair value of identifiable intangible assets. Goodwill recorded in an acquisition is assigned to applicable reporting units based on expected revenues. Identifiable intangible assets with finite lives are amortized over there useful lives. Amortization of current technology is recorded in Cost of Revenue-License and amortization of all other intangible assets is recorded in Amortization of acquisition-related intangibles. Acquisition-related costs, including advisory, legal, accounting, valuation and other costs, are expensed in general and administrative expenses in the periods in which the costs are incurred. The results of operations of acquired businesses are included in the consolidated financial statements from the acquisition date.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

Foreign Currency. In the three and nine months ended January 31, 2016, we generated approximately 19% and 18%, respectively, of our revenues outside the United States. We typically make international sales through our foreign subsidiaries or our Logility subsidiary and denominate those sales typically in U.S. Dollars, British Pounds Sterling or Euros. However, expenses incurred in connection with these sales are typically denominated in the local currencies. We recorded exchange rate losses of approximately $128,000 and $303,000 for the three and nine months ended January 31, 2016, respectively, compared to exchange rate losses of approximately $262,000 and $455,000 for the three and nine months ended January 31, 2015. We estimate that a 10% movement in foreign currency rates would have had the effect of creating up to a $346,000 exchange gain or loss for the nine months ended January 31, 2016. We have not engaged in any hedging activities.

Interest Rates and Other Market Risks. We have no debt, and therefore limit our discussion of interest rate risk to risk associated with our investment profile. We manage our interest rate risk by maintaining an investment portfolio of trading investments with high credit quality and relatively short average maturities. These instruments include, but are not limited to, money-market instruments, bank time deposits, and taxable and tax-advantaged variable rate and fixed rate obligations of corporations, municipalities, and national, state, and local government agencies, in accordance with an investment policy approved by our Board of Directors. These instruments are denominated in U.S. Dollars. The fair market value of these instruments as of January 31, 2016 was approximately $71.6 million compared to $69.0 million as of January 31, 2015.

We also hold cash balances in accounts with commercial banks in the United States and foreign countries. These cash balances represent operating balances only and are invested in short-term time deposits of the local bank. Such

operating cash balances held at banks outside the United States are denominated in the local currency and are minor.

Many of our investments carry a degree of interest rate risk. When interest rates fall, our income from investments in variable-rate securities declines. When interest rates rise, the fair market value of our investments in fixed-rate securities declines. In addition, our investments in equity securities are subject to stock market volatility. Due in part to these factors, our future investment income may fall short of expectations or we may suffer losses in principal if forced to sell securities, which have seen a decline in market value due to changes in interest rates. We attempt to mitigate risk by holding fixed-rate securities to maturity, but, if our liquidity needs force us to sell fixed-rate securities prior to maturity, we may experience a loss of principal.

Inflation. Although we cannot accurately determine the amounts attributable thereto, we have been affected by inflation through increased costs of employee compensation and other operational expenses. To the extent permitted by the marketplace for our products and services, we attempt to recover increases in costs by periodically increasing prices.

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Item 4. Controls and Procedures

Management s Report on Internal Control Over Financial Reporting

As of the end of the period covered by this report, our management evaluated the effectiveness of our disclosure controls and procedures (as such term is defined in Rule 13a-15(e) and 15d-15(e) under the Exchange Act) under the supervision and with the participation of our chief executive officer and chief financial officer. Based on and as of the date of such evaluation, the aforementioned officers have concluded that, as of the end of the period covered by this report, our disclosure controls and procedures were effective.

Our chief executive officer and chief financial officer, with the assistance of our Disclosure Committee, have conducted an evaluation of the effectiveness of our disclosure controls and procedures as of the end of the period covered by this quarterly report. We perform this evaluation on a quarterly basis so that the conclusions concerning the effectiveness of our disclosure controls and procedures can be reported in our Annual Report on Form 10-K and quarterly reports on Form 10-Q. Based on this evaluation, our chief executive officer and chief financial officer have concluded that our disclosure controls and procedures were effective as of the end of the period covered by this quarterly report.

Changes in Internal Control over Financial Reporting

There have not been any changes in our internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) during the fiscal quarter to which this report relates that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II OTHER INFORMATION

Item 1. Legal Proceedings

We are not currently involved in legal proceedings requiring disclosure under this item.

Item 1A. Risk Factors

In addition to the other information set forth in this report, you should carefully consider the risk factors disclosed in Item 1A, Risk Factors, of our Annual Report on Form 10-K for the fiscal year ended April 30, 2015. There have been no material changes to the risk factors as previously disclosed in such Annual Report on Form 10-K,

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

(a) Not applicable

(b) Not applicable

(c) The following table summarizes repurchases of our stock in the three months ended January 31, 2016:

Fiscal Period	Total Number of Shares Purchased	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs*
November 1, 2015 through November 30, 2015		$		958,787
December 1, 2015 through December 31, 2015				958,787
January 1, 2016 through January 31, 2016				958,787
Total Fiscal 2016 Third Quarter		$		958,787

* Our Board of Directors approved the above share purchase authority on August 19, 2002, when the Board approved a resolution authorizing us to repurchase up to 2.0 million shares of Class A common stock. This action was announced on August 22, 2002. The authorization has no expiration date.

Item 3. Defaults Upon Senior Securities

Not applicable.

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Item 4. Mine Safety Disclosures

Not applicable.

Item 5. Other Information

None.

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Item 6. Exhibits

Exhibit 3.1	Amended and Restated Articles of Incorporation, and amendments thereto (1)
Exhibit 3.2	Amended and Restated By-Laws dated May 18, 2009 (2)
Exhibits 31.1-31.2.	Rule 13a-14(a)/15d-14(a) Certifications
Exhibit 32.1.	Section 906 Certifications
Exhibit 101.INS	XBRL Instance Document.
Exhibit 101.SCH	XBRL Taxonomy Extension Schema Document.
Exhibit 101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
Exhibit 101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
Exhibit 101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
Exhibit 101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

(1) Incorporated by reference herein. Filed by the Company as an exhibit to its quarterly report filed on Form 10-Q for the quarter ended October 31, 1990.
(2) Incorporated by reference herein. Filed by the Company as an exhibit to its quarterly report filed on Form 10-Q for the quarter ended January 31, 2010.

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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.

AMERICAN SOFTWARE, INC.

Date: March 4, 2016

By: /s/ J. Michael Edenfield
J. Michael Edenfield
President, Chief Executive Officer, Director and Chief Operating Officer

Date: March 4, 2016

By: /s/ Vincent C. Klinges
Vincent C. Klinges
Chief Financial Officer

Date: March 4, 2016

By: /s/ Bryan L. Sell
Bryan L. Sell
Controller and Principal Accounting Officer