ORiGINAL 10-018

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

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HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Vista Lindenhurst Emergency Center		
Street Address: 1050 Red Oak Lane		
City and Zip Code: Lindenhurst 60046		
County: Lake	Health Service Area	Health Planning Area:

Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Waukegan Illinois Hospital Company, LLC, d/b/a Vista Medical Center - East
Address:	4000 Meridian Blvd., Franklin, TN 37067
Name of Registered Agent:	
Name of Chief Executive Officer:	Wayne Smith
CEO Address:	Same
Telephone Number:	615-465-7000

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Type of Ownership

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an Illinois certificate of good standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

Primary Contact
[Person to receive all correspondence or inquiries during the review period]

Name:	Anne M. Murphy
Title:	Partner
Company Name:	Holland & Knight
Address:	131 S. Dearborn Street, Chicago, IL 60603
Telephone Number:	312-578-6544
E-mail Address:	anne.murphy@hklaw.com
Fax Number:	312-578-6666

Additional Contact
[Person who is also authorized to discuss the application for permit]

Name:	
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

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Street Address: 1050 Red Oak Lane		
City and Zip Code: Lindenhurst 60046		
County: Lake	Health Service Area	Health Planning Area:

Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Community Health Systems, Inc.
Address:	400 Meridian Bldv., Franklin, TN 37067
Name of Registered Agent:	
Name of Chief Executive Officer:	Wayne Smith
CEO Address:	Same
Telephone Number:	615-465-7000

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Additional Contact
[Person who is also authorized to discuss the application for permit]

Name:	
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance]

Name:	Barbara Martin
Title:	President & CEO
Company Name:	Vista Health System
Address:	1324 N. Sheridan Road, Waukegan, IL 60085
Telephone Number:	847-360-4000
E-mail Address:	barbaramartin@chs.net
Fax Number:	847-360-4109

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Waukegan Illinois Hospital Company, LLC
Address of Site Owner:	4000 Meridian Blvd., Franklin, TN 37067
Street Address or Legal Description of Site:	Legal description attached.

APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name:	Waukegan Illinois Hospital Company, LLC, d/b/a Vista Medical Center - East
Address:	1324 N. Sheridan Road, Waukegan, IL 60085

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an Illinois certificate of good standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person who is related (as defined in Part 1130.140). If the related person is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format**. In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 **(http://www.idph.state.il.us/about/hfpb.htm)**.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT-5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
☒ Substantive	☐ Part 1120 Not Applicable
☐ Non-substantive	☐ Category A Project
	☒ Category B Project
	☐ DHS or DVA Project

2. Project Outline

In the chart below, indicate the proposed action(s) for each clinical service area involved by writing the number of beds, stations or key rooms involved:

Clinical Service Areas	Establish	Expand	Modernize	Discontinue	No. of Beds, Stations or Key Rooms
Medical/Surgical, Obstetric, Pediatric and Intensive Care					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
Open Heart Surgery					
Cardiac Catheterization					
In-Center Hemodialysis					
Non-Hospital Based Ambulatory Surgery					
General Long Term Care					
Specialized Long Term Care					
Selected Organ Transplantation					
Kidney Transplantation					
Subacute Care Hospital Model					
Post Surgical Recovery Care Center					
Children's Community-Based Health Care Center					
Community-Based Residential Rehabilitation Center					
Long Term Acute Care Hospital Bed Projects					
Clinical Service Areas Other Than Categories of Service:					
• Surgery					
• Ambulatory Care Services (organized as a service)					
• Diagnostic & Interventional Radiology/Imaging					
• Therapeutic Radiology					
• Laboratory					
• Pharmacy					
• Occupational Therapy					
• Physical Therapy					
• Major Medical Equipment					
Freestanding Emergency Center Medical Services	X				7 stations
Master Design and Related Projects					
Mergers, Consolidations and Acquisitions					

APPEND DOCUMENTATION AS ATTACHMENT-6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

3. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done **in State Board defined terms, NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The co-applicants propose the establishment of a 7-station (6 treatment rooms and 1 trauma room) freestanding emergency center (FEC) through the construction of an addition to a building on Vista Health System's Lindenhurst campus. That building currently houses an IDPH-licensed ASTC and a variety of other diagnostic (including imaging) and treatment services, and is supported by an FAA-approved heliport.

The proposed FEC will operate under the direction of Vista Medical Center-East's comprehensive emergency department, which serves as the only "resource hospital" for the Northern Lake County Emergency Medical Services System.

This is a "substantive" project, in that it is proposing the establishment of a new "category of service".

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-clinical components that are not related to the provision of health care, complete the second column of the table below. See 20 ILCS 3960 for definition of non-clinical. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds

USE OF FUNDS	CLINICAL	NON-CLINICAL	TOTAL
Preplanning Costs	$35,000	$14,000	$49,000
Site Survey and Soil Investigation	-	-	-
Site Preparation	$59,000	$34,000	93,000
Off Site Work	-	-	-
New Construction Contracts	$1,490,720	$860,992	2,351,712
Modernization Contracts	-	$92,160	$92,160
Contingencies	$97,405	$63,938	$161,343
Architectural/Engineering Fees	$142,900	$91,500	$234,400
Consulting and Other Fees	$ 218,996	$ 79,763	$ 298,759
Movable or Other Equipment (not in construction contracts)	$ 494,500	$162,469	$656,969
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$2,538,521	$1,398,822	$3,937,343
SOURCE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Cash and Securities	$2,538,521	$1,398,822	$3,937,343
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$2,538,521	$1,398,822	$3,937,343

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $__________
Fair Market Value: $__________

The project involves the establishment of a new facility or a new category of service
☒ Yes ☐ No

If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ 203,424.90.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary

☒ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): 12 months from issuance date of CON permit.

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON contingencies.
☒ Project obligation will occur after permit issuance.

State Agency Submittals

Are the following submittals up to date as applicable:
☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits

Cost Space Requirements

SEE ATTACHMENT - 8

Provide in the following format, the department/area GSF and cost. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
CLINICAL							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON CLINICAL							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Vista Medical Center - Eas **CITY:** Waukegan

REPORTING PERIOD DATES: From: January 1 to: December 31, 2009

Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	256	8,411	33,227	-	256
Obstetrics	29	2,113	4,304	-	29
Pediatrics	35	included	in med/surg.	-	35
Intensive Care	16	1,298	4,618	-	16
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	336	11,822	42,149	-	336

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Community Health Systems, Inc. * **in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.**

SIGNATURE	SIGNATURE
Rachel A. Seifert	Martin G. Schweinhart
PRINTED NAME	PRINTED NAME
Executive Vice President, Secretary and General Counsel	President
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 22nd day of March	Notarization: Subscribed and sworn to before me this 22nd day of March
Mary Ann Eckman	Mary Ann Eckman
Signature of Notary	Signature of Notary
Seal: MARY ANN ECKMAN STATE OF TENNESSEE NOTARY PUBLIC WILLIAMSON COUNTY My Commission Expires October 16 2011	Seal: MARY ANN ECKMAN STATE OF TENNESSEE NOTARY PUBLIC WILLIAMSON COUNTY My Commission Expires October 16 2011

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Waukegan Illinois Hospital Company, LLC d/b/a Vista Medical Center - East * **in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.**

SIGNATURE

Rachel A. Seifert
PRINTED NAME

Senior Vice President & Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22nd day of March

Mary Ann Eckman
Signature of Notary

Seal MARY ANN ECKMAN STATE OF TENNESSEE NOTARY PUBLIC WILLIAMSON COUNTY My Commission Expires October 16 2011

SIGNATURE

Barbara J. Martin
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 23 day of March, 2010

Signature of Notary

Seal "OFFICIAL SEAL" JAYLON HOLDEN Notary Public, State of Illinois My Commission Expires 06/25/11

*Insert EXACT legal name of the applicant

SECTION II. DISCONTINUATION

NOT APPLICABLE

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III. - PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 - Project Purpose, Background and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, certification and accreditation identification numbers, if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals.

For projects involving modernization, describe the conditions being upgraded. For facility projects, include statements of age and condition and regulatory citations. For equipment being replaced, include repair and maintenance records.

NOTE: The description of the "Purpose of the Project" should not exceed one page in length. Information regarding the "Purpose of the Project" will be included in the State Agency Report.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ALTERNATIVES

Document **ALL** of the alternatives to the proposed project:

Examples of alternative options include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation.

3) The applicant shall provide empirical evidence, including quantified outcome data, that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive.

2. If the gross square footage exceeds the GSF standards in Appendix B, justify the discrepancy by documenting one of the following::

    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

    c. The project involves the conversion of existing bed space that results in excess square footage.

APPEND DOCUMENTATION AS ATTACHMENT-13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B.

APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE. APPLICATION FORM.

UNFINISHED OR SHELL SPACE: NOT APPLICABLE

Provide the following information:

1. Total gross square footage of the proposed shell space;

2. The anticipated use of the shell space, specifying the proposed GSF tot be allocated to each department, area or function;

3. Evidence that the shell space is being constructed due to
    a. Requirements of governmental or certification agencies; or
    b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
    a. Historical utilization for the area for the latest five-year period for which data are available; and

b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES: NOT APPLICABLE

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION V. - MASTER DESIGN AND RELATED PROJECTS

NOT APPLICABLE

This Section is applicable only to proposed master design and related projects.

Criterion 1110.235(a) - System Impact of Master Design

Read the criterion and provide documentation that addresses the following:

1. The availability of alternative health care facilities within the planning area and the impact that the proposed project and subsequent related projects will have on the utilization of such facilities;

2. How the services proposed in future projects will improve access to planning area residents;

3. What the potential impact upon planning area residents would be if the proposed services were not replaced or developed; and

4. The anticipated role of the facility in the delivery system including anticipated patterns of patient referral, any contractual or referral agreements between the applicant and other providers that will result in the transfer of patients to the applicant's facility.

Criterion 1110.235(b) - Master Plan or Related Future Projects

Read the criterion and provide documentation regarding the need for all beds and services to be developed, and also, document the improvement in access for each service proposed. Provide the following:

1. The anticipated completion date(s) for the future construction or modernization projects; and

2. Evidence that the proposed number of beds and services is consistent with the need assessment provisions of Part 1100; or documentation that the need for the proposed number of beds and services is justified due to such factors, but not limited to:
3. limitation on government funded or charity patients that are expected to continue;

   a. restrictive admission policies of existing planning area health care facilities that are expected to continue;
   b. the planning area population is projected to exhibit indicators of medical care problems such as average family income below poverty levels or projected high infant mortality.

3. Evidence that the proposed beds and services will meet or exceed the utilization targets established in Part 1100 within two years after completion of the future construction of modernization project(s), based upon:

   a. historical service/beds utilization levels;
   b. projected trends in utilization (include the rationale and projection assumptions used in such
   c. projections);
   d. anticipated market factors such as referral patterns or changes in population characteristics (age, density, wellness) that would support utilization projections; and
   anticipated changes in delivery of the service due to changes in technology, care delivery techniques or physician availability that would support the projected utilization levels.

Criterion 1110.235(c) - Relationship to Previously Approved Master Design Projects

READ THE CRITERION which requires that projects submitted pursuant to a master design permit are consistent with the approved master design project. Provide the following documentation:

1. Schematic architectural plans for all construction or modification approved in the master design permit;
2. The estimated project cost for the proposed projects and also for the total construction/modification projects approved in the master design permit;
3. An item by item comparison of the construction elements (i.e. site, number of buildings, number of floors, etc.) in the proposed project to the approved master design project; and
4. A comparison of proposed beds and services to those approved under the master design permit.

APPEND DOCUMENTATION AS ATTACHMENT-17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

SECTION VI. MERGERS, CONSOLIDATIONS AND ACQUISITIONS/CHANGES OF OWNERSHIP

This Section is applicable to projects involving merger, consolidation or acquisition/change of ownership.

A. Criterion 1110.240(b), Impact Statement

Read the criterion and provide an impact statement that contains the following information:

1. Any change in the number of beds or services currently offered.
2. Who the operating entity will be.
3. The reason for the transaction.
4. Any anticipated additions or reductions in employees now and for the two years following completion of the transaction.
5. A cost-benefit analysis for the proposed transaction.

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

1. The current admission policies for the facilities involved in the proposed transaction.
2. The proposed admission policies for the facilities.
3. A letter from the CEO certifying that the admission policies of the facilities involved will not become more restrictive.

C. Criterion 1110.240(d), Health Care System

Read the criterion and address the following:

1. Explain what the impact of the proposed transaction will be on the other area providers.
2. List all of the facilities within the applicant's health care system and provide the following for each facility.
   a. the location (town and street address);
   b. the number of beds;
   c. a list of services; and
   d. the utilization figures for each of those services for the last 12 month period.
3. Provide copies of all present and proposed referral agreements for the facilities involved in this transaction.
4. Provide time and distance information for the proposed referrals within the system.
5. Explain the organization policy regarding the use of the care system providers over area providers.
6. Explain how duplication of services within the care system will be resolved.
7. Indicate what services the proposed project will make available to the community that are not now available.

APPEND DOCUMENTATION AS ATTACHMENT-18, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

1. This Section is applicable to all projects proposing establishment, expansion or modernization of **ALL categories of service that are subject to CON review**, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960], WITH THE EXCEPTION OF:
   - General Long Term Care;
   - Subacute Care Hospital Model;
   - Postsurgical Recovery Care Center Alternative Health Care Model;
   - Children's Community-Based Health Care Center Alternative Health Care Model; and
   - Community-Based Residential Rehabilitation Center Alternative Health Care Model.

   If the project involves any of the above-referenced categories of service, refer to " SECTION VIII.- Service Specific Review Criteria" for applicable review criteria, and submit all necessary documentation for each service involved..

2. READ THE APPLICABLE REVIEW CRITERIA FOR EACH OF THE CATEGORIES OF SERVICE INVOLVED. **[Refer to SECTION VIII regarding the applicable criteria for EACH action proposed, for EACH category of service involved.]**

3. **After identifying the applicable review criteria for each category of service involved (see the charts in Section VIII), provide the following information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:**

A. Planning Area Need - Formula Need Calculation:

1. **Complete the requested information for each category of service involved:**
   Refer to 77 Ill. Adm. Code 1100 for information concerning planning areas, bed/station/key room deficits and occupancy/utilization standards.

   Planning Area Not applicable.

Category of Service	No. of Beds/Stations/Key Rooms Proposed	HFSRB Inventory Need or Excess	Part 1100 Occupancy/Utilization Standard
Freestanding	7	N/A	2000/station
Emergency Center			

Using the formatting above:

2. Indicate the number of beds/stations/key rooms proposed for each category of service.

3. Document that the proposed number of beds/stations/key rooms is in conformance with the projected deficit specified in 77 Ill. Adm. Code 1100.

4. Document that the proposed number of beds/stations/key rooms will be in conformance with the applicable occupancy/utilization standard(s) specified in Ill. Adm. Code 1100.

B. Planning Area Need - Service to the Planning Area Residents:

1. If establishing or expanding beds/stations/key rooms, document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

2. If expanding an existing category of service, provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, document that at least 50% of the projected patient volume will be from residents of the

area.

3. If expanding an existing category of service, submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

APPEND DOCUMENTATION AS ATTACHMENT -19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

C. Service Demand - Establishment of Category of Service

Document "Historical Referrals" and **either** "Projected Referrals" or "Project Service Demand - Based on Rapid Population Growth" :

1. Historical Referrals
If the applicant is an existing facility, document the number of referrals for the last two years for each category of service, as formatted below:

EXAMPLE:

Year	CY or FY	Category of Service	Patient Origin by Zip Code	Name & Specialty of Referring Physician	Name & Location of Recipient Hospital
2008	CY	Medical/Surgical	62761 [Patient Initials]	Dr. Hyde	Wellness Hospital

2. Projected Referrals
An applicant proposing to establish a category of service or establish a new hospital shall submit physician referral letters containing ALL of the information outlined in Criterion 1110.530(b)(3)

3. Project Service Demand - Based on Rapid Population Growth

If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand must be determined, as specified in the Criterion titled "Project Service Demand - Based on Rapid Population Growth".

APPEND DOCUMENTATION AS ATTACHMENT-20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

D. Service Demand - Expansion of an Existing Category of Service NOT APPLICABLE

Document "Historical Service Demand" and **either** "Projected Referrals" or "Project Service Demand - Based on Rapid Population Growth" :

1. Historical Service Demand

Category of Service	Board Occupancy/Utilzation Standards	Year One Indicate CY or FY	Year Two Indicate CY or FY
	[Indicate standards for the planning area.]		

a. As formatted above, document that the average annual occupancy/utilization rate has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest two years;

b. If patients have been referred to other facilities in order to receive the subject services, provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient hospital, for each of the latest two years

2. Projected Referrals
An applicant proposing to establish a category of service or establish a new hospital shall submit physician referral letters containing ALL of the information outlined in subsection(b)(4) of the criteria for the subject service(s).

3. Projected Service Demand – Based on Rapid Population Growth

If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand must be determined, as specified in the criterion titled "Projected Service Demand-Based on Rapid Population Growth" of the criteria for the subject service(s).

APPEND DOCUMENTATION AS ATTACHMENT-21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

E. Service Accessibility - Service Restrictions

1. The applicant shall document that at least one of the factors listed in subsection (b)(5) of the criteria for subject service(s) exists in the planning area.

2. Provide documentation, as applicable, listed in subsection (b)(5) of the criteria for the subject service(s), concerning existing restrictions to service access:

APPEND DOCUMENTATION AS ATTACHMENT-22, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

F. Unnecessary Duplication/Maldistribution

1. Document that the project will not result in an unnecessary duplication, and provide the following information:

   a. A list of all zip code areas that are located, in total or in part, within 30 minutes normal travel time of the project's site;

   b. The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois); and

   c. The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provide the categories of bed service that are proposed by the project.

2. Document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as presented in subsection (c)(1) and (2) of the criteria for the subject service(s)..

3. Document that, within 24 months after project completion, the proposed project:

   A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

   B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

APPEND DOCUMENTATION AS ATTACHMENT-23, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Category of Service Modernization NOT APPLICABLE

1. Document that the inpatient beds areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, citing factors, as listed in subsection (d)(1) of the criteria for the subject service(s), but not limited to the reasons cited in the rule.

2. Provide the following documentation of the need for modernization:

   A. the most recent IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports;
   B. the most recent Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reports;

3. Include other documentation, as applicable to the factors cited above:

   A. Copies of maintenance reports;
   B. Copies of citations for life safety code violations; and
   C. Other pertinent reports and data.

4. Provide the annual occupancy/utilization for each category of service to be modernized, for each of the last three years.

APPEND DOCUMENTATION AS ATTACHMENT-24, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

H. Staffing Availability

1. For each category of service, document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met.

2. Provide the following documentation:

   a. The name and qualification of the person currently filling the position, if applicable; and
   b. Letters of interest from potential employees; and
   c. Applications filed for each position; and
   d. Signed contracts with the required staff; or
   e. A narrative explanation of how the proposed staffing will be achieved.

APPEND DOCUMENTATION AS ATTACHMENT-25, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE

APPLICATION FORM.

I. Performance Requirements

READ the subsection titled "Performance Requirements" for the subject service(s).

K. Assurances

Submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after project completion, the applicant will achieve and maintain the occupancy/utilization standards specified in 77 Ill. Adm Code 1100 for each category of service involved in the proposal.

APPEND DOCUMENTATION AS ATTACHMENT-26, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion and modernization). After identifying the applicable review criteria for each category of service involved , read the criteria and provide the required information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

A. Criterion 1110.530 - Medical/Surgical, Obstetric, Pediatric and Intensive Care NOT APPLICABLE

1. In addition to addressing the Category of Service Review Criteria for ALL category of service projects [SECTION VII], applicants proposing to establish, expand and/or modernize Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds	# to Establish	# to Expand	# to Modernize
☐ Medical/Surgical					
☐ Obstetric					
☐ Pediatric					
☐ Intensive Care					

3. READ the applicable review criteria outlined below:

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.530(b)(1) -	Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.530(b)(2) -	Planning Area Need - Service to Planning Area Residents	X	X	
1110.530(b)(3) -	Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.530(b)(4) -	Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.530(b)(5) -	Planning Area Need - Service Accessibility	X		
1110.530(c)(1) -	Unnecessary Duplication of Services	X		
1110.530(c)(2) -	Maldistribution			
1110.530(c)(3) -	Impact of Project on Other Area Providers	X		
1110.530(d)(1) -	Deteriorated Facilities			X
1110.530(d)(2) -	Documentation			X
1110.530(d)(3) -	Documentation Related to Cited Problems			X

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.530(d)(4) -	Occupancy			X
110.530(e) -	Staffing Availability	X	X	
1110.530(f) -	Performance Requirements	X	X	X
1110.530(g) -	Assurances	X	X	

B. Criterion 1110.630 - Comprehensive Physical Rehabilitation

NOT APPLICABLE

1. In addition to addressing the Category of Service Review Criteria for ALL category of service projects [SECTION VII], applicants proposing to establish, expand and/or modernize Comprehensive Physical Rehabilitation must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds	# to Establish	# to Expand	# to Modernize
☐ Comprehensive Physical Rehabilitation					

3. READ the applicable review criteria outlined below and **submit required documentation for the criterion printed below in bold:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.630(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.630(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.630(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.630(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.630(b)(5) - Planning Area Need - Service Accessibility	X		
1110.630(c)(1) - Unnecessary Duplication of Services	X		
1110.630(c)(2) - Maldistribution	X		
1110.630(c)(3) - Impact of Project on Other Area Providers	X		
1110.630(d)(1) - Deteriorated Facilities			X
1110.630(d)(2) - Documentation			X
1110.630(d)(3) - Documentation Related to Cited Problems			X
1110.630(d)(4) - Occupancy			X
1110.630(e(1) and (2) - Staffing	X	X	
1110.630(e)(2) - Personnel Qualifications	X		
1110.630(f) - Performance Requirements	X	X	X
1110.630(g) - Assurances	X	X	

APPEND DOCUMENTATION for "Personnel Qualifications", AS ATTACHMENT-27, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

C. Criterion 1110.730 - Acute Mental Illness and Chronic Mental Illness

NOT APPLICABLE

1. In addition to addressing the Category of Service Review Criteria for ALL category of service projects [SECTION VII], applicants proposing to establish, expand and/or modernize Acute/Chronic Mental Illness must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds	# to Establish	# to Expand	# to Modernize
☐ Acute Mental Illness					
☐ **Chronic Mental Illness**					

3. READ the applicable review criteria outlined below:

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.730(b)(1) -	Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.730(b)(2) -	Planning Area Need - Service to Planning Area Residents	X	X	
1110.730(b)(3) -	Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.730(b)(4) -	Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.730(b)(5) -	Planning Area Need - Service Accessibility	X		
1110.730(c)(1) -	Unnecessary Duplication of Services	X		
1110.730(c)(2) -	Maldistribution	X		
1110.730(c)(3) -	Impact of Project on Other Area Providers	X		
1110.730(d)(1) -	Deteriorated Facilities			X
1110.730(d)(2) -	Documentation			X
1110.730(d)(3) -	Documentation Related to Cited Problems			X
1110.730(d)(4) -	Occupancy			X
1110.730(e(1)) -	Staffing Availability	X	X	
1110.730(f) -	Performance Requirements	X	X	X
1110.730(g) -	Assurances	X	X	

D. Criterion 1110.930 - Neonatal Intensive Care

NOT APPLICABLE

This section is applicable to all projects proposing to add neonatal intensive care beds for which an exemption was not obtained.

1. **Criterion 1110.930(a), Staffing**

   Read the criterion and for those positions described under this criterion provide the following information:

   1. The name and qualifications of the person currently filling the job.
   2. Letters of interest from potential employees.
   3. Applications filed for each position.
   4. Signed contracts with the required staff.
   5. A detailed explanation of how you will fill the positions.

2. **Criterion 1110.930(b), Letter of Agreement**

   Read the criterion and provide the required letter of agreement.

3. **Criterion 1110.930(c), Need for Additional Beds**

   Read the criterion and provide the following information:

   a. The patient days and admissions for the affiliated center for each of the last two years; or

   b. An explanation as to why the existing providers of this service in the planning area cannot provide care to your projected caseload.

4. **Criterion 1110.930(d), Obstetric Service**

   Read the criterion and provide a detailed assessment of the obstetric service capability.

APPEND DOCUMENTATION AS ATTACHMENT-28, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

E. Criterion 1110.1230 - Open Heart Surgery

NOT APPLICABLE

This section is applicable to all projects proposing to establish the open heart surgery category of service.

1. Criterion 1110.1230(a), Peer Review

Read the criterion and submit a detailed explanation of your peer review program.

2. Criterion 1110.1230(b), Establishment of Open Heart Surgery

Read the criterion and provide the following information:

a. The number of cardiac catheterizations (patients) performed in the latest 12-month period for which data is available.
b. The number of patients referred for open heart surgery following cardiac catheterization at your facility, for each of the last two years.

3. Criterion 1110.1230(c), Unnecessary Duplication of Services

Read the criterion and address the following:

a. Contact all existing facilities within 90 minutes travel time of your facility which currently provide or are approved to provide open heart surgery to determine what the impact of the proposed project will be on their facility.
b. Provide a sample copy of the letter written to each of the facilities and include a list of the facilities sent letters.
c. Provide a copy of all of the responses received.

4. Criterion 1110.1230(d), Support Services

Read the criterion and indicate on a service by service basis which of the services listed in this criterion are available on a 24-hour inpatient basis and explain how any services not available on a 24 hour inpatient basis can be immediately mobilized for emergencies at all times.

5. Criterion 1110.1230(e), Staffing

Read the criterion and for those positions described under this criterion provide the following informati

a. The name and qualifications of the person currently filling the job.
b. Letters of interest from potential employees.
c. Application filed for a position.
d. Signed contracts with the required staff.
e. A detailed explanation of how you will fill the positions.

APPEND DOCUMENTATION AS ATTACHMENT-29, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

F. Criterion 1110.1330 - Cardiac Catheterization

NOT APPLICABLE

This section is applicable to all projects proposing to establish or modernize a cardiac catheterization category of service or to replace existing cardiac catheterization equipment.

1. **Criterion 1110.1330(a), Peer Review**

   Read the criterion and submit a detailed explanation of your peer review program.

2. **Criterion 1110.1330(b), Establishment or Expansion of Cardiac Catheterization Service**

   Read the criterion and, if applicable, submit the following information:

   a. A map (8 1/2" x 11") showing the location of the other hospitals within the planning area.

   b. The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.

   c. Provide the number of patients transferred directly from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years.

3. **Criterion 1110.1330(c), Unnecessary Duplication of Services**

   Read the criterion and, if applicable, submit the following information.

   a. Copies of the letter sent to all facilities within 90 minutes travel time which currently provide cardiac catheterization. This letter must contain a description of the proposed project and a request that the other facility quantify the impact of the proposal on its program.

   b. Copies of the responses received from the facilities to which the letter was sent.

4. **Criterion 1110.1330(d), Modernization of Existing Cardiac Catheterization Laboratories**

   Read the criterion and, if applicable, submit the number of cardiac catheterization procedures performed for the latest 12 months.

5. **Criterion 1110.1330(e), Support Services**

   Read the criterion and indicate on a service by service basis which of the listed services are available on a 24 hour basis and explain how any services not available on a 24 hour basis will be available when needed.

6. **Criterion 1110.1330(f), Laboratory Location**

   Read the criterion and, if applicable, submit line drawings showing the location of the proposed laboratories. If the laboratories are not in close proximity explain why.

7. **Criterion 1110.1330(g), Staffing**

   Read the criterion and submit a list of names and qualifications of those who will fill the positions detailed in this criterion. Also provide staffing schedules to show the coverage required by this criterion.

8. **Criterion 1110.1330(h), Continuity of Care**

Read the criterion and submit a copy of the fully executed written referral agreement(s).

9. Criterion 1110.1330(i), Multi-institutional Variance

Read the criterion and, if applicable, submit the following information:

a. A copy of a fully executed affiliation agreement between the two facilities involved.

b. Names and positions of the shared staff at the two facilities.

c. The volume of open heart surgeries performed for the latest 12-month period at the existing operating program.

d. A cost comparison between the proposed project and expansion at the existing operating program.

e. The number of cardiac catheterization procedures performed in the last 12 months at the operating program.

f. The number of catheterization laboratories at the operating program.

g. The projected cardiac catheterization volume at the proposed facility annually for the next 2 years.

h. The basis for the above projection.

APPEND DOCUMENTATION AS <u>ATTACHMENT-30,</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Criterion 1110.1430 - In-Center Hemodialysis

NOT APPLICABLE

1. In addition to addressing the Review Criteria for ALL category of service projects, applicants proposing to establish, expand and/or modernize In-Center Hemodialysis must submit the following information:

2. Indicate station capacity changes by Service: Indicate # of stations changed by action(s):

Category of Service	# Existing Stations	# Proposed Stations	# to Establish	# to Expand	# to Modernize
☐ In-Center Hemodialysis					

3. READ the applicable review criteria outlined below and **submit required documentation for the criteria printed below in bold:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.1430(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.1430(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.1430(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.1430(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.1430(b)(5) - Planning Area Need - Service Accessibility	X		
1110.1430(c)(1) - Unnecessary Duplication of Services	X		
1110.1430(c)(2) - Maldistribution	X		
1110.1430(c)(3) - Impact of Project on Other Area Providers	X		
1110.1430(d)(1) - Deteriorated Facilities			X
1110.1430(d)(2) - Documentation			X
1110.1430(d)(3) - Documentation Related to Cited Problems			X
1110.1430(e) - Staffing Availability	X	X	
1110.1430(f) - **Support Services**	X	X	X
1110.1430(g) - **Minimum Number of Stations**	X		
1110.1430(h) - **Continuity of Care**	X		
1110.1430(j) - Assurances	X	X	

4. Projects for relocation of a facility from one location in a planning area to another in the same planning area must address the requirements listed in subsection (a)(1) for the "Establishment of Services or Facilities", as well as the requirements in Section 1110.130 - "Discontinuation" and subsection 1110.1430(i) - "Relocation of Facilities".

APPEND DOCUMENTATION for "Support Services", Minimum Number of Stations" and Continuity of Care", AS ATTACHMENT-31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

H. Non-Hospital Based Ambulatory Surgery NOT APPLICABLE

This section is applicable to all projects proposing to establish or modernize a non-hospital based ambulatory surgical treatment center or to the addition of surgical specialties.

1. **Criterion 1110.1540(a), Scope of Services Provided**

   Read the criterion and complete the following:

   a. Indicate which of the following types of surgery are proposed:

_____Cardiovascular	_____Obstetrics/Gynecology	_____Plastic
_____Dermatology	_____Ophthalmoloy.	_____Podiatry
_____Gastroenterology	_____Oral/Maxillofacial	_____Thoracic
_____General/Other	_____Orthpaedic	_____Urology
_____Neurology	_____Otolaryngology	

   b. Indicate if the project will result in a _____ limited or _____ a multi-specialty ASTC.

2. **Criterion 1110.1540(b), Target Population**

   Read the criterion and provide the following:

   a. On a map (8 ½" x 11"), outline the intended geographic services area (GSA).

   b. Indicate the population within the GSA and how this number was obtained.

   c. Provide the travel time in all directions from the proposed location to the GSA borders and indicate how this travel time was determined.

3. **Criterion 1110.1540(c), Projected Patient Volume**

   Read the criterion and provide signed letters from physicians that contain the following:

   a. The number of referrals anticipated annually for each specialty.

   b. For the past 12 months, the name and address of health care facilities to which patients were referred, including the number of patients referred for each surgical specialty by facility.

   c. A statement that the projected patient volume will come from within the proposed GSA.

   d. A statement that the information in the referral letter is true and correct to the best of his or her belief.

4. **Criterion 1110.1540(d), Treatment Room Need Assessment**

   Read the criterion and provide:

   a. The number of procedure rooms proposed.

   b. The estimated time per procedure including clean-up and set-up time and the methodology used in arriving at this figure.

5. **Criterion 1110.1540(e), Impact on Other Facilities**

   Read the criterion and provide:

   a. A copy of the letter sent to area surgical facilities regarding the proposed project's impact on their workload. NOTE: This letter must contain: a description of the project including its size, cost, and projected workload; the location of the proposed project; and a request that the facility administrator indicate what the impact of the proposed project will be on the existing facility.

b. A list of the facilities contacted. NOTE: Facilities must be contacted by registered mail.

6. **Criterion 1110.1540(f), Establishment of New Facilities**

Read the criterion and provide:

a. A list of services that the proposed facility will provide that are not currently available in the GSA; or

b. Documentation that the existing facilities in the GSA have restrictive admission policies; or

c. For co-operative ventures,

    a. Patient origin data that documents the existing hospital is providing outpatient surgery services to the target population of the GSA, and

    b. The hospital's surgical utilization data for the latest 12 months, and

    c. Certification that the existing hospital will not increase its operating room capacity until such a time as the proposed project's operating rooms are operating at or above the target utilization rate for a period of twelve full months; and

    d. Certification that the proposed charges for comparable procedures at the ASTC will be lower than those of the existing hospital.

7. **Criterion 1110.1540(g), Charge Commitment**

Read the criterion and provide:

a. A complete list of the procedures to be performed at the proposed facility with the proposed charge shown for each procedure.

b. A letter from the owner and operator of the proposed facility committing to maintain the above charges for the first two years of operation.

8. **Criterion 1110.1540(h), Change in Scope of Service**

Read the criterion and, if applicable, document that existing programs do not currently provide the service proposed or are not accessible to the general population of the geographic area in which the facility is located.

APPEND DOCUMENTATION AS ATTACHMENT-32, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

I. Criterion 1110.1730 - General Long Term Care

NOT APPLICABLE

1. Applicants proposing to establish, expand and/or modernize General Long Term Care must submit the following information:

Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds	# to Establish	# to Expand	# to Modernize
☐ General Long Term Care					
☐					
☐					

2. READ the applicable review criteria outlined below and **SUBMIT ALL required information, as applicable to the project:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize	Continuum of Care- Establish or Expand	Defined Population Establish or Expand
1110.1730(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X				
1110.1730(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X			
1110.1730(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X				
1110.1730(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X			
1110.1730(b)(5) - Planning Area Need - Service Accessibility	X				
1110.1730(c)(1) - Description of Continuum of Care				X	
1110.1730(c)(2) - Components				X	
1110.1730(c)(3) - Documentation				X	
1110.1730(d)(1) - Description of Defined Population to be Served					X
1110.1730(d)(2) - Documentation of Need					X
1110.1730(d)(3) - Documentation Related to Cited Problems			X		
1110.1730(e)(1) - Unnecessary Duplication of Services	X				
1110.1730(e)(2) - Maldistribution	X				

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize	Continuum of Care- Establish or Expand	Defined Population Establish or Expand
1110.1730(e)(3) - Impact of Project on Other Area Providers	X				
1110.1730(f)(1) - Deteriorated Facilities			X		
1110.1730(f)(2) & (3) - Documentation			X		
1110.1730(f)(4) - Utilization			X		
1110.1730(g) - Staffing Availability	X	X		X	X
1110,1730(h) - Facility Size	X	X	X	X	X
1110.1730(i) - Community Related Functions	X		X	X	X
1110.1730(j) - Zoning	X		X	X	X
1110.1730(k) - Assurances	X	X		X	X

APPEND DOCUMENTATION AS INDICATED BELOW, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM:

APPLICABLE REVIEW CRITERIA	ATTACHMENT NUMBER
Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	33
Planning Area Need - Service to Planning Area Residents	34
Planning Area Need - Service Demand - Establishment of Category of Service	35
Planning Area Need - Service Demand - Expansion of Existing Category of Service	36
Planning Area Need - Service Accessibility	37
Description of Continuum of Care	38
Components	39
Documentation	40
Description of Defined Population to be Served	41
Documentation of Need	42
Documentation Related to Cited Problems	43
Unnecessary Duplication of Services	44
Maldistribution	45
Impact of Project on Other Area Providers	46
Deteriorated Facilities	47

J. Criterion 1110.1830 - Specialized Long Term Care

NOT APPLICABLE

This section is applicable to all projects proposing specialized long-term care services or beds.

1. **Criterion 1110.1830(b), Community Related Functions**

   Read the criterion and submit the following information:

   a. a description of the process used to inform and receive input from the public including those residents living in close proximity to the proposed facility's location;

   b. letters of support from social, social service and economic groups in the community;

   c. letters of support from municipal/elected officials who represent the area where the project is located.

2. **Criterion 1110.1830(c), Availability of Ancillary and Support Services**

   Read the criterion, which applies only to ICF/DD 16 beds and fewer facilities, and submit the following:

   a. a copy of the letter, sent by certified mail return receipt requested, to each of the day programs in the area requesting their comments regarding the impact of the project upon their programs and any response letters;

   b. a description of the public transportation services available to the proposed residents;

   c. a description of the specialized services (other than day programming) available to the residents;

   d. a description of the availability of community activities available to the facility's residents.

   e. documentation of the availability of community workshops.

3. **Criterion 1110.1830(d), Recommendation from State Departments**

   Read the criterion and submit a copy of the letters sent, including the date when the letters were sent, to the Departments of Human Services and Public Aid requesting these departments to indicate if the proposed project meets the department's planning objectives regarding the size, type, and number of beds proposed, whether the project conforms or does not conform to the department's plan, and how the project assists or hinders the department in achieving its planning objectives.

4. **Criterion 1110.1830(e), Long-term Medical Care for Children Category of Service**

Read the criterion and submit the following information:

   a. a map outlining the target area proposed to be served;

   b. the number of individuals age 0-18 in the target area and the number of individuals in the target area that require the type of care proposed, include the source documents for this estimate;

   c. any reports/studies that show the points of origin of past patients/residents admissions to the facility;

   d. describe the special programs or services proposed and explain the relationship of theses programs to the needs of the specialized population proposed to be served.

   e. indicate why the services in the area are insufficient to meet the needs of the area population;

f. documentation that the 90% occupancy target will be achieved within the first full year of

5. **Criterion 1110.1830(f), Zoning**

Read the criterion and provide a letter from an authorized zoning official that verifies appropriate zoning.

6. **Criterion 1110.1830(g), Establishment of Chronic Mental Illness**

Read the criterion and provide the following:

a. documentation of how the resident population has changed making the proposed project necessary.

b. indicate which beds will be closed to accommodate these additional beds.

c. the number of admissions for this type of care for each of the last two years.

7. **Criterion 1110.1830(i), Variance to Computed Bed Need for Establishment of Beds Developmentally Disabled Adults for Placement of Residents from DHS State Operated Beds**

Read this criterion and submit the following information:

a. documentation that all of the residents proposed to be served are now residents of a DHS facility;

b. documentation that each of the proposed residents has at least one interested family member who resides in the planning area or at least one interested family member that lives out of state but within 15 miles of the planning area boundary where the facility is or will be located;

c. if the above is not the case then you must document that the proposed resident has lived in a DHS operated facility within the planning area in which the proposed facility is to be located for more than 2 years and that the consent of the legal guardian has been obtained;

d. a letter from DHS indicating which facilities in the planning area have refused to accept referrals from the department and the dates of any refusals and the reasons cited for each refusal;

e. a copy of the letter (sent certified--return receipt requested) to each of the underutilized facilities in the planning area asking if they accept referrals from DHS-operated facilities, listing the dates of each past refusal of a referral, and requesting an explanation of the basis for each refusal;

f. documentation that each of the proposed relocations will save the State money;

g. a statement that the facility will only accept future referrals from an area DHS facility if a bed is available;

h. an explanation of how the proposed facility conforms with or deviates from the DHS comprehensive long range development plan for developmental disabilities services.

APPEND DOCUMENTATION AS ATTACHMENT-55, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

K. Criterion 1110.2330 - Selected Organ Transplantation

NOT APPLICABLE

This section is applicable to projects involving the establishment or modernization of the Selected Organ Transplantation service.

1. In addition to addressing the Category of Service Review Criteria for ALL category of service projects [SECTION VII], applicants proposing to establish or modernize Selected Organ Transplantation category of service must submit the following information:

2. Indicate changes by Service:

Indicate # of rooms changed by action(s):

Transplantation Type	# Existing Key Rooms	# Proposed Key Rooms	# to Establish	# to Modernize
☐				
☐				
☐				
☐				

3. READ the applicable review criteria outlined below and **submit required documentation for the criteria printed below in bold:**

APPLICABLE REVIEW CRITERIA	Establish	Modernize
1110.2330(b)(1) - Planning Area Need - 7 Ill. Adm. Code 1100 (formula calculation)	X	
1110.2330(b)(2) - Planning Area Need - Service to Planning Area Residents	X	
1110.2330(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X	
1110.2330(b)(4) - Planning Area Need - Service Accessibility	X	
1110.2330(c)(1) - Unnecessary Duplication of Services	X	
1110.2330(c)(2) - Maldistribution	X	
1110.2330(c)(3) - Impact of Project on Other Area Providers	X	
1110.2330(d)(1) - Deteriorated Facilities		X
1110.2330(d)(2) - Documentation		X
1110.2330(d)(3) - Documentation Related to Cited Problems		X
1110.2330(d)(4) - Utilization		X
1110.2330(e) - Staffing Availability	X	
1110.2330(f) - Surgical Staff	X	
1110.2330(g) - Collaborative Support	X	
1110.2330(h) - Support Services	X	

	1110.2330(i) - Performance Requirements	X	X	
	1110.2330(j) - Assurances	X	X	

APPEND DOCUMENTATION for "Surgical Staff", "Collaborative Support", and Support Services", AS ATTACHMENT-56, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

L. Criterion 1110.2430 - Kidney Transplantation

NOT APPLICABLE

This section is applicable to all projects involving the establishment of the kidney transplantation service.

1. In addition to addressing the Category of Service Review Criteria for ALL category of service projects [SECTION VII], applicants proposing to establish or modernize Selected Organ Transplantation category of service must submit the following information:

2. Indicate changes:

Indicate # of key rooms by action:

Category of Service	# Existing Key Rooms	# Proposed Key Rooms	# to Establish	# to Modernize
☐	-			

3. READ the applicable review criteria outlined below and **submit required documentation for the criteria printed below in bold:**

APPLICABLE REVIEW CRITERIA	Establish	Modernize
1110.2430(b)(1) - Planning Area Need - 7 Ill. Adm. Code 1100 (formula calculation)	X	
1110.2430(b)(2) - Planning Area Need - Service to Planning Area Residents	X	
1110.2430(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X	
1110.2430(b)(4) - Planning Area Need - Service Accessibility	X	
1110.2430(c)(1) - Unnecessary Duplication of Services	X	
1110.2430(c)(2) - Maldistribution	X	
1110.2430(c)(3) - Impact of Project on Other Area Providers	X	
1110.2430(d)(1) - Deteriorated Facilities		X
1110.2430(d)(2) - Documentation		X
1110.2430(d)(3) - Documentation Related to Cited Problems		X
1110.2430(d)(4) - Utilization		X
1110.2430(e) - Staffing Availability	X	
1110.2430(f) - Surgical Staff	X	
1110.2430(g) - Support Services	X	
1110.2430(h) - Performance Requirements	X	X
1110.2430(i) - Assurances	X	X

APPEND DOCUMENTATION for "Surgical Staff" and "Support Services", AS <u>ATTACHMENT-57,</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

M. Criterion 1110.2530 - Subacute Care Hospital Model

NOT APPLICABLE

This section is applicable to all projects proposing to establish a subacute care hospital model.

Subacute Care Hospital Model

1. Criterion 1110.2530(a), Distinct Unit

a. Provide a copy of the physical layout (an architectural schematic) of the subacute unit (include the room numbers) and describe the travel patterns to support services and patient and visitor access.

b. Provide a summary of shared services and staff and how costs for such will be allocated between the unit and the hospital or long-term care facility.

c. Provide a staffing plan with staff qualifications and explain how non-dedicated staffing services will be provided.

2. Criterion 1110.2530(b), Contractual Relationship

a. If the applicant is a licensed long-term care facility or a previously licensed general hospital the applicant must provide a copy of a contractual agreement (transfer agreement) with a general acute care hospital. Provide the travel time to the facility which signed the contract. Explain how the procedures for providing emergency care under this contract will work.

b. If the applicant is a licensed general hospital the applicant must document that its emergency capabilities continue to exist in accordance with the requirements of hospital licensure.

3. Rule 1110.2540(b), State Board Prioritization of Hospital Applications

Read this rule which applies only to hospital applications and provide the requested information as applicable.

a. Financial Support

Will the subacute care model provide the necessary financial support for the facility to provide continued acute care services? Yes___ No _____

If yes, submit the following information:

(1) projected two years of financial statements that exclude the financial impact of the subacute care hospital model as well as two years of projected financial statements which include the financial impact of the subacute care hospital model;

(2) the assumptions used in developing both sets of financial statements;

(3) a narrative description of the factors within the facility or the area which will prevent the facility from complying with the financial ratios within the next two years without the proposed project;

(4) a narrative explanation as to how the proposed project will allow you to meet the financial ratios;

(5) if the projected financial statements (which include the subacute impact) at the applicant facility fail to meet the Part 1120 financial ratios, provide a copy of a binding agreement with another institution which guarantees the financial viability of the subacute hospital model for a period of five years; and

(6) historical financial statements for each of the last three calendar years.

Subacute Care Hospital Model (continued)

b. Medically Underserved Area (as designated by the Department of Health and Human Services)

Is the facility located in a medically underserved area? Yes ☐ No ☐

If yes, provide a map showing the location of the medically underserved area and of the applicant facility.

c. Multi-Institutional System

Provide copies of all contractual agreements between your facility and any hospitals or long-term care facilities in your planning area which are within 60 minutes travel time of your facility which provide for exclusive best effort arrangements concerning transfer of patients between your two facilities. **Note: Best effort arrangement means the acute care facility will encourage and recommend to its medical staff that patients requiring subacute care will only be transferred to the applicant facility.**

d. Medicare/Medicaid

Provide the Medicare patient days and admissions, the Medicaid patient days and admissions, and the total patient days and admissions for the latest calendar or fiscal year (specify the dates).

e. Casemix and Utilization

Provide the following information:

(1) the number of admissions and patient days for each of the last five years for each of the following:

- Ventilator cases
- Head trauma cases
- Rehabilitation cases including spinal cord injuries
- Amputees
- Other orthopedic cases requiring subacute care (Specify diagnosis)
- Other complex diagnosis which included physiological monitoring on a continuous basis

(2) for multi-institutional systems provide the above information from each of the signatory facilities. If more than one signatory is involved, provide separate sheets for each one.

f. HMO/PPO Utilization

Provide the number of patient days at the applicant facility for the last 12 months being reimbursed through contractual relationships with preferred provider organizations or HMOs.

g. Staffing

Provide documentation that the following staff will be available for the subacute care hospital model. Documentation must consist of letters of interest from individuals for each of the positions. Indicate if any of the individuals who will fill these positions are presently employed at the applicant facility.

-Full-time medical director exclusively for the model
-Two or more full-time (FTEs) physical therapist
-One or more occupational therapists
-One or more speech therapists

4. Rule 1110.2540(c), State Board Prioritization-Long-Term Care Facilities

This rule applies to only to LTC facility applications. READ the criterion and submit the required information, as applicable.

Subacute Care Hospital Model (continued)

a. Exceptional Care

Has the applicant facility had an Exceptional Care Contract with the Illinois Department of Public Aid for at least two years in the past four years? Yes ____ No

If yes, provide copies of the Exceptional Care contract with the Illinois Department of Public Aid for each of the last four years.

b. Medically Underserved Area (as designated by the Department of Health and Human Services)

Is the facility located in a medically underserved area? Yes ☐ No ☐

If yes, provide a map showing the location of the medically underserved area and of the applicant facility.

c. Medicare/Medicaid

Provide the Medicare patient days and admissions, the Medicaid patient days and admissions, and the total patient days and admissions for the latest calendar or fiscal year (specify the dates).

d. Case Mix and Utilization

Provide the following information:

(1) the number of admissions and patient days for each of the last five years for each of the following:

- Ventilator cases
- Head trauma cases
- Rehabilitation cases including spinal cord injuries
- Amputees
- Other orthopedic cases requiring subacute care (Specify diagnosis)
- Other complex diagnoses which included physiological monitoring on a continuous basis

(2). for multi-institutional systems, provide the same information from each of the signatory facilities. If more than one signatory is involved, provide a separate sheet for each one.

e. HMO/PPO Utilization

Provide the number of patient days at the applicant facility for the last 12 months being reimbursed through contractual relationships with preferred provider organizations or HMO's.

f. Staffing

Provide documentation that the following staff will be available for the subacute care hospital model. Documentation shall consist of letters of interest from individuals for each of the positions. Indicate if any of the individuals who will fill the positions are currently employed by the applicant facility.

-Full-time medical director exclusively for the model
-Two or more full time (FTEs) physical therapists
-One or more occupational therapists

Subacute Care Hospital Model (continued)

-One or more speech therapists

g. Joint Commission on Accreditation of Healthcare Organizations

Is the applicant facility accredited by the Joint Commission? Yes ☐ No ☐ If yes, provide a copy of the latest Joint Commission letter of accreditation.

h. Multi-Institutional Arrangements

Provide copies of all contractual agreements between your facility and any hospitals or long-term care facilities in your planning area which are within 60 minutes travel time of your facility which provide for exclusive best effort arrangements concerning transfer of patients between your two facilities. **Note: Best effort arrangement means the referring facility will encourage and recommend to its medical staff that patients requiring subacute care will only be transferred to the applicant facility.**

5. **Section 1110.2540(d), State Board Prioritization of Previously Licensed Hospitals - Chicago**

This section must be completed only by applicants whose site was previously licensed as a hospital in Chicago. Provide the following information:

a. letters from health facilities establishing referral agreement for subacute hospital patients;

b. letters from physicians indicating that they will refer subacute patients to your proposed facility;

c. the number of admissions and patient days for each of the last five years for each of the following types of patients (this information must be provided from each referring facility):

- Ventilator cases
- Head trauma cases
- Rehabilitation cases including spinal cord injuries
- Amputees
- Other orthopedic cases requiring subacute care (Specify diagnosis)
- Other complex diagnoses which included physiological monitoring on a continuous basis.

APPEND DOCUMENTATION AS ATTACHMENT-58, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

N. Criterion 1110.2630 - Post Surgical Recovery Care Center

NOT APPLICABLE

This section is applicable to all projects proposing to establish a Postsurgical Recovery Care Center Alternative Health Care Model.

Post Surgical Recovery Care Center

1. Criterion 1110.2630(a), Need/Unit Size

Read the criterion and provide the following information:

a. the number of postsurgical recovery center beds proposed;

b. the anticipated number of patients who will utilize the facility; and

c. for each surgical referral site, for the latest 12 months:

1. the name of the surgical referral site;
2. the number of inpatient surgical cases that could have received postsurgical recovery services within the model if it had been available;
3. the number of the cases identified above expected to be referred to this model and the rationale therefore;
4. patient identification numbers for each patient;
5. ICD 9 Code or procedure type for each patient; and
6. the experienced length of stay for each patient.

2. Criterion 1110.2630(b), Staffing

Read the criterion and submit the following information:

a. A copy of the plans of the physical layout (design drawings) of the proposed facility. Indicate on these plans the manner by which the proposed area will be physically separate and identifiable from the remaining areas of the health care facility.

b. A detailed staffing plan identifying the number and type of staff positions dedicated to the model.

c. The name and qualifications of the proposed Medical Director including a signed commitment to the facility by that person stating a willingness to hold such a position.

d. Evidence that an on-call physician, licensed to practice medicine in all of its branches, can be physically present at the model within 15 minutes on a 24 hour per day seven day per week basis.

3. Criterion 1110.2630(c), Patient Mix

Read the criterion and provide the following information:

a. A listing of the types of surgical procedures that will require care in the postsurgical recovery model.

b. The anticipated number of admissions (for the first year of operation) for the following specialties:

General Surgery_____ Eyes-Ears-Nose-Throat _____ Obstetric/Gynecology ____
Orthopedic _____ Plastic Surgery _____ Ophthalmology ____
Urology_____ Gastroenterology _____ Other (specify) ____

c. The patient recovery care protocols including an explanation of how patient safety will be assured.

POSTSURGICAL RECOVERY CARE CENTER (continued)

4. **Criterion 1110.2630(d) Travel Time/Patient Transfer**

   Read the criterion and provide the following information:

   a. A map identifying all surgical referral sites for the proposed facility. Indicate distances in miles and travel times by medical transport between each of the surgical referral sites and the applicant facility. Indicate how the travel time was determined.

   b. Name of the person (and the position/title) who will have the responsibility for the transfer of patients from the surgical site to the postsurgical recovery center and copies of the protocols to be used in patient transfers to the Postsurgical Recovery Care Center from each surgical referral site.

5. **Criterion 1110.2630(e), On-Site Emergency Care**

   Read the criterion and provide the following information:

   a. All protocols established for the treatment of emergency patients and the applicant facility's requirements concerning staff training for emergency patient care.

   b. Provide documentation that a crash cart will be available on-site and that staff trained in cardiac defibrillation will be available at all times.

6. **Rule 1110.2640(b), State Board Review-Prioritization of Applications for Postsurgical Recovery Care Center Alternative Health Care Model**

   This rule applies to all applicants proposing to establish a Postsurgical Recovery Centers Alternative Health Care Model. Read the criterion and provide the following information:

   a. The name and population of the county in which the proposed facility will be located.

   b. Name the source of the population figures.

   c. Will the proposed facility be owned or operated by an existing hospital? Yes ☐ No

   d. Will the project be located within or attached to an existing facility? Yes ☐ No ☐
   If yes, give the name of the hospital or ASTC and date of initial license

   e. Will the proposed project be located in a Medically Underserved Area as designated by the Department of Health and Human Services? Yes ☐ No ☐ If yes, provide documentation that the facility is located in such an area.

   f. Provide total revenue, Medicare revenue, and Medicaid revenue for each surgical referral site.

   g. Provide a copy of the applicant facility's current accreditation letter if applicable.

APPEND DOCUMENTATION AS ATTACHMENT-59, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

O. Criterion 1110.2730 - Children's Community-Based Health Care Center

This section is applicable to all projects proposing to establish a Children's Respite Care Alternative Health Care Model.

A. Criterion 1110.2730(a), Admission Policy

Read the criterion and provide the following information:

1. Copies of all admission policies to be in effect at the proposed facility; and
2. Certification that no admission restrictions due to age, race, diagnosis, or source of payment will occur.

B. Criterion 1110.2730(b), Staffing

Read the criterion and provide the following information:

1. A detailed staffing plan for the proposed facility (unit) identifying the number and type of staff positions dedicated to the model;
2. The name and qualifications of the proposed Medical Director including a signed commitment to the facility by that person stating a willingness to hold such a position;
3. A job description for the medical director detailing the position responsibilities; and
4. Documentation as to how special staffing circumstances will be handled.

C. Criterion 1110.2730(c), Mandated Services

Read the criterion and provide a narrative explaining how the services required under the Alternative Health Care Delivery Act and referenced in Section 1110.2720(b) will be provided.

D. Criterion 1110.2730(d), Acute Care Backup

Read the criterion and provide the following information:

1. A signed referral agreement with an acute care facility for the referral of emergency patients;
2. A map identifying the location of the acute care facility; and
3. The travel time to the acute care facility from the applicant facility. Explain how the travel time was calculated.

E. Criterion 1110.2730(e), Patient Screening/Emergency Care

Read the criterion and provide the following information:

1. All protocols established for the screening of potential residents for the severity of medical conditions associated with the required care for the child;
2. Documentation that a care plan will be developed for each child admitted. Explain how this care plan will be developed; and
3. A narrative which explains how emergency situations will be handled.

F. Criterion 1110.2730(f), Education

Read the criterion and provide the following information:

1. Documentation that children who participate in educational programs will continue to receive such services during their stay at the facility; and

CHILDREN'S RESPITE CARE ALTERNATIVE HEALTH CARE MODEL (continued)

2. Identify the person or position who has the responsibility for maintaining these services and explain how the services will be provided.

G. Criterion 1110.2730(g), Age Specific Needs

Read the criterion and provide a narrative description of staff expertise as it pertains to the specific care needs required of the various age groups that will be admitted.

H. Rule 1110.2740(b)(2)(D),

Read the criterion and indicate if the proposed facility is located in a Health Professional Shortage Area as designated by the Department of Health and Human Services.
Yes ☐ No ☐

APPEND DOCUMENTATION AS ATTACHMENT-60, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

P. Community-Based Residential Rehabilitation Center

NOT APPLICABLE

This section is applicable to all projects proposing to establish a Community-based Residential Rehabilitation Center Alternative Health Care Model.

A. Criterion 1110.2830(a), Staffing

Read the criterion and provide the following information:

1. A detailed staffing plan that identifies the number and type of staff positions dedicated to the model and the qualifications for each position; and

2. How special staffing circumstances will be handled; and

3. The staffing patterns for the proposed center; and

4. The manner in which non-dedicated staff services will be provided.

B. Criterion 1110.2830(b), Mandated Service

Read the criterion and provide a narrative description documenting how the applicant will provide the minimum range of services required by the Alternative Health Care Delivery Act and specified in 1110.2820(b).

C. Criterion 1110.2830(c), Unit Size

Read the criterion and provide a narrative description that identifies the number and location of all beds in the model. Include the total number of beds for each residence and the total number of beds for the model.

D. Criterion 1110.2830(d), Utilization

Read the criterion and provide documentation that the target utilization for the model will be achieved by the second year of the model's operation. Include supporting information such as historical utilization trends, population growth, expansion of professional staff or programs, and the provision of new procedures that may increase utilization.

E. Criterion 1110.2830(e), Background of Applicant

Read the criterion and provide documentation that demonstrates the applicant's experience in providing the services required by the model. Provide evidence that the programs offered in the model have been accredited by the Commission on Accreditation of Rehabilitation Facilities as a Brain Injury Community-Integrative Program for at least three of the last five years.

APPEND DOCUMENTATION AS <u>ATTACHMENT-61,</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

Q. 1110.2930 - Long Term Acute Care Hospital

1. In addition to addressing the Category of Service Review Criteria for ALL category of service projects [SECTION VII], applicants proposing to establish, expand and/or modernize Long Term Acute Care Hospital Bed Projects must submit the following information:

2. Indicate the bed service(s) and capacity changes by Service: Indicate the # of beds by (action(s):

Category of Service	# Existing Beds	# Proposed Beds	# to Establish	# to Expand	# to Modernize
☐ LTACH					
☐ Intensive Care					
☐					

3. READ the applicable review criteria outlined below:

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.2930(b)(1) -	Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.2930(b)(2) -	Planning Area Need - Service to Planning Area Residents	X	X	
1110.2930(b)(3) -	Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.2930(b)(4) -	Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.2930(b)(5) -	Planning Area Need - Service Accessibility	X		
1110.2930(c)(1) -	Unnecessary Duplication of Services	X		
1110.2930(c)(2) -	Maldistribution	X		
1110.2930(c)(3) -	Impact of Project on Other Area Providers	X		
1110.2930(d)(1) -	Deteriorated Facilities			X
1110.2930(d)(2) -	Documentation			X
1110.2930(d)(3) -	Documentation Related to Cited Problems			X
1110.2930(d)(4) -	Occupancy			X
110.2930(e) -	Staffing Availability	X	X	
1110.2930(f) -	Performance Requirements	X	X	X
1110.2930(g) -	Assurances	X	X	

R. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

NOT APPLICABLE

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than Categories of Service must submit the following information:

2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms	# to Establish	# to Expand	# to Modernize
☐					
☐					
☐					

3. READ the applicable review criteria outlined below and SUBMIT all required information:

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
New Services or Facility or Equipment	(b) –	Need Determination – Establishment
Service Modernization	(c)(1) –	Deteriorated Facilities
		and/or
	(c)(2) –	Necessary Expansion
		PLUS
	(c)(3)(A) –	Utilization – Major Medical Equipment
		Or
	(c)(3)(B) –	Utilization – Service or Facility

APPEND DOCUMENTATION AS INDICATED BELOW, IN NUMERIC SEQUENCIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM:

APPLICABLE REVIEW CRITERIA	Attachment Number
Need Determination - Establishment	62
Service Demand	63
Referrals from Inpatient Base	64
Physician Referrals	65
Historical Referrals to Other Providers	66
Population Incidence	67
Impact of Project on Other Area Providers	68
Utilization	69
Deteriorated Facilities	70
Necessary Expansion	71
Utilization -Major Medical Equipment	72
Utilization - Service or Facility	73

S. Freestanding Emergency Center Medical Services

These criteria are applicable only to those projects or components of projects involving the freestanding emergency center medical services (FECMS) category of service.

A. Criterion 1110.3230 – ESTABLISHMENT OF FREESTANDING EMERGENCY CENTER (MEDICAL SERVICES

Read the criterion and provide the following information:

1. Utilization – Provide the projected number of patient visits per day for each treatment station in the FEC based upon 24-hour availability, including an explanation of how the projection was determined.

2. The identification of the municipality of the FEC and FECMS and the municipality's population as reported by the most recently available U.S. Census Bureau data.

3. The identification of the hospital that owns or controls the FEC and the distance of the proposed FEC from that hospital, including an explanation of how that distance was calculated.

4. The identification of the Resource Hospital affiliated with the FEC, the distance of the proposed FEC from that Resource Hospital, (including an explanation of how that distance was calculated), and identification of that Resource Hospital's EMS system, including certification of the hospital's Resource Hospital status.

5. Certification signed by two authorized representative(s) of the applicant entity(s) that they have reviewed, understand and plan to comply with both of the following requirements:
   A) The requirements of becoming a Medicare provider of freestanding emergency services; and
   B) The requirements of becoming licensed under the Emergency Medical Services Systems Act [210 ILCS 50/32.5].

6. Area Need; Service to Area Residents - Document the proposed service area and projected patient volume for the proposed FEC:
   A) Provide a map of the proposed service area, indicating the boundaries of the service area, and the total minutes travel time from the proposed site, indicating how the travel time was calculated.
   B) Provide a list of the projected patient volume for the proposed FEC, categorized by zip code. Indicate what percentage of this volume represents residents from the proposed FEC's service area.
   C) Provide either of the following:
      a) Provide letters from authorized representatives of hospitals, or other FEC facilities, that are part of the Emergency Medical Services System (EMSS) for the defined service area, that contain patient origin information by zip code, (each letter shall contain a certification by the authorized representative that the representations contained in the letter are true and correct. A complete set of the letters with original notarized signatures shall accompany the application for permit), or
      b) Patient origin information by zip code from independent data sources (e.g.,Illinois Hospital Association CompData or IDPH hospital discharge data), based upon the patient's legal residence, for patients receiving services in the existing service area's facilities' emergency departments (EDs), verifying that at least 50% of the ED patients

Freestanding Emergency Center Medical Services (continued)

served during the last 12-month period were residents of the service area.

7. Area Need; Service Demand – Historical Utilization
   A) Provide the annual number of ED patients that have received care at facilities that are located in the FEC's service area for the latest two-year period prior to submission of the application
   B) Provide the estimated number of patients anticipated to receive services at the proposed FEC, including an explanation of how the projection was determined.

8. Area Need; Service Accessibility - Document the following (using supporting documentation as specified in accordance with the requirements of 77 IAC 1110.3230(b)(4)(B) Supporting Documentation):
   i) The absence of the proposed ED service within the service area;
   ii) The area population and existing care system exhibit indicators of medical care problems,
   iii) All existing emergency services within the 30-minute normal travel time meet or exceed the utilization standard specified in 77 IAC 1100.

9. Unnecessary Duplication - Document that the project will not result in an unnecessary duplication by providing the following information:
   A) A list of all zip code areas (in total or in part) that are located within 30 minutes normal travel time of the project's site;
   B) The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois population); and
   C) The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provide emergency medical services.

10. Unnecessary Maldistribution - Document that the project will not result in maldistribution of services by documenting the following:
    A) Historical utilization (for the latest 12-month period prior to submission of the application) for existing ED departments within 30 minutes travel time of the applicant's site that is below the utilization standard established pursuant to 77 I AC 1100.800; or
    B) Insufficient population to provide the volume or caseload necessary to utilize the ED services proposed by the project at or above utilization standards.

11. Unnecessary Duplication/Maldistribution – Document that, within 24 months after project completion, the proposed project will not lower the utilization of other service area providers below, or further below, the utilization standards specified in 77 Ill. Adm. Code 1100 (using supporting documentation in accordance with the requirements of 77 IAC 1110.3230(c)(4)).

12. Staffing Availability - Document that a sufficient supply of personnel will be available to staff the service (in accordance with the requirements of 1110.3230(e)).

B. Criterion 1110.3230 – EXPANSION OF EXISTING FREESTANDING EMERGENCY CENTER MEDICAL SERVICES NOT APPLICABLE

Read the criterion and provide the following information:

1. The identification of the municipality of the FEC and FECMS and the municipality's population as reported by the most recently available U.S. Census Bureau data.

2. The identification of the hospital that owns or controls the FEC and the distance of the

Freestanding Emergency Center Medical Services (continued)

proposed FEC from that hospital, including an explanation of how that distance was calculated.

3. The identification of the Resource Hospital affiliated with the FEC, the distance of the proposed FEC from that Resource Hospital, (including an explanation of how that distance was calculated), and identification of that Resource Hospital's EMS system, including certification of the hospital's Resource Hospital status.

4. Provide copies of Medicare and EMS licensure, in addition to certification signed by two authorized representative(s) of the applicant entity(s), indicating that the existing FEC complies with both of the following requirements:
   A) The requirements of being a Medicare provider of freestanding emergency services; and
   B) The requirements of being licensed under the Emergency Medical Services Systems Act [210 ILCS 50/32.5].

5. Area Need; Service to Area Residents - Document the proposed service area and projected patient volume for the expanded FEC:
   A) Provide a map of the proposed service area, indicating the boundaries of the service area, and the total minutes travel time from the expanded FEC, indicating how the travel time was calculated.
   B) Provide a list of the historical (latest 12-month period) patient volume for the existing FEC, categorized by zip code, based on the patient's legal residence. Indicate what percentage of this volume represents residents from the existing FEC's service area, based on patient's legal residence.

6. Staffing Availability - Document that a sufficient supply of personnel will be available to staff the service (in accordance with the requirements of 1110.3230(e)).

C. Criterion 1110.3230 – MODERNIZATION OF EXISTING FREESTANDING EMERGENCY CENTER MEDICAL SERVICES) CATEGORY OF SERVICE NOT APPLICABLE

Read the criterion and provide the following information:

1. The historical number of visits (based on the latest 12-month period) for the existing FEC.

2. The identification of the municipality of the FEC and FECMS and the municipality's population as reported by the most recently available U.S. Census Bureau data.

3. The identification of the hospital that owns or controls the FEC and the distance of the proposed FEC from that hospital, including an explanation of how that distance was calculated.

4. The identification of the Resource Hospital affiliated with the FEC, the distance of the proposed FEC from that Resource Hospital, (including an explanation of how that distance was calculated), and identification of that Resource Hospital's EMS system, including certification of the hospital's Resource Hospital status.

5. Provide copies of Medicare and EMS licensure, in addition to certification signed by two authorized representative(s) of the applicant entity(s), indicating that the existing FEC complies with both of the following requirements:
   A) The requirements of being a Medicare provider of freestanding emergency services; and
   B) The requirements of being licensed under the Emergency Medical Services Systems Act [210 ILCS 50/32.5].

Freestanding Emergency Center Medical Services
(continued)

6. Category of Service Modernization - Document that the existing treatment areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to; high cost of maintenance, non-compliance with licensing or life safety codes, changes in standards of care, or additional space for diagnostic or therapeutic purposes. Documentation shall include the most recent IDPH Centers for Medicare and Medicaid Services (CMMS) Inspection reports, and Joint Commission on Accreditation of Healthcare Organizations reports. Other documentation shall include the following, as applicable to the factors cited in the application; copies of maintenance reports, copies of citations for life safety code violations, and other pertinent reports and data.

APPEND DOCUMENTATION AS ATTACHMENT-74, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

T. Financial Feasibility

This section is applicable to all projects subject to Part 1120.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

Does the applicant (or the entity that is responsible for financing the project or is responsible for assumin applicant's debt obligations in case of default) have a bond rating of "A" or better?
Yes ☐ No X.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXVI. **If no is indicated, submit the most recent three years' audited financial statements including the following:**

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

A. Criterion 1120.210(a), Financial Viability

1. Viability Ratios

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as: Community Health Systems, Inc.	**Category A or Category B (last three years)**			**Category B * (Projected)**
Enter Historical and/or Projected Years:	2007	2008	2009	2012
Current Ratio	1.76	1.73	1.83	over 1.5
Net Margin Percentage	0.43%	2.0%	2.01%	under 2.50%
Percent Debt to Total Capitalization	84%	84%	81%	under 75%
Projected Debt Service Coverage	1.84	2.00	2.04	under 2.0
Days Cash on Hand	49	34	35	15
Cushion Ratio	0.37	0.34	0.53	0-2

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

* Projected ratios not provided due to Securities and Exchange Commission Regulation fair disclosure requirements restricting Community Health Systems, Inc. as a publically traded company from making selective, forward-looking statements.

T. Financial Feasibility

This section is applicable to all projects subject to Part 1120.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

Does the applicant (or the entity that is responsible for financing the project or is responsible for assumin applicant's debt obligations in case of default) have a bond rating of "A" or better?
Yes ☐ No ☒.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXVI. **If no is indicated, submit the most recent three years' audited financial statements including the following:**

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

A. Criterion 1120.210(a), Financial Viability

1. Viability Ratios

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as: Waukegan IL. Hospital Co.	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:	2007	2008	2009	2012
Current Ratio	3.71	1.67	1.10	3.31
Net Margin Percentage	15.3%	14.7%	11.8%	19.2%
Percent Debt to Total Capitalization	at corporate	at corp.	at corp.	at corp.
Projected Debt Service Coverage	at corporate	at corp.	at corp.	at corp.
Days Cash on Hand	0	0	0	–
Cushion Ratio	at corporate	at corp.	at corp.	at corp.

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)
(continued)

B. Criterion 1120.210(b), Availability of Funds

If proof of an "A" or better bond rating has not been provided, read the criterion and document that sufficient resources are available to fund the project and related costs including operating start-up costs and operating deficits. Indicate the dollar amount to be provided from the following sources:

$2,751,207 Cash & Securities
Provide statements as to the amount of cash/securities available for the project. Identify any security, its value and availability of such funds. Interest to be earned or depreciation account funds to be earned on any asset from the date of application submission through project completion are also considered cash.

_______ Pledges
For anticipated pledges, provide a letter or report as to the dollar amount feasible showing the discounted value and any conditions or action the applicant would have to take to accomplish goal. The time period, historical fund raising experience and major contributors also must be specified.

_______ Gifts and Bequests
Provide verification of the dollar amount and identify any conditions of the source and timing of its use.

_______ Debt Financing (indicate type(s) ________________________)
For general obligation bonds, provide amount, terms and conditions, including any anticipated discounting or shrinkage) and proof of passage of the required referendum or evidence of governmental authority to issue such bonds;
For revenue bonds, provide amount, terms and conditions and proof of securing the specified amount;
For mortgages, provide a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated;
For leases, provide a copy of the lease including all terms and conditions of the lease including any purchase options.

_______ Governmental Appropriations
Provide a copy of the appropriation act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, provide a resolution or other action of the governmental unit attesting to such future funding.

_______ Grants
Provide a letter from the granting agency as to the availability of funds in terms of the amount, conditions, and time or receipt.

_______ Other Funds and Sources
Provide verification of the amount, terms and conditions, and type of any other funds that will be used for the project.

$2,751,207 TOTAL FUNDS AVAILABLE

C. Criterion 1120.210(c), Operating Start-up Costs

If proof of an "A" or better bond rating has not been provided, indicate if the project is classified as a Category B project that involves establishing a new facility or a new category of service? Yes ☒ No ☐. If yes is indicated, read the criterion and provide in the space below the amount of operating start-up costs (the same as reported in Section I of this application) and provide a description of the items or components that comprise the costs. Indicate the source and amount of the financial resources available to fund the operating start-up costs (including any initial operating deficit) and reference the documentation that verifies sufficient resources are available.

APPEND DOCUMENTATION AS ATTACHMENT 75, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

$203,424.90 in start-up costs is anticipated. Those costs will include 1 month of personnel-related expenses ($129,573), 2 months of supply costs ($41,366), 1 month of utilities ($2,799) and $20,000 of other costs.

U. Economic Feasibility

This section is applicable to all projects subject to Part 1120.

SECTION XXVI. REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON)

A. Criterion 1120.310(a), Reasonableness of Financing Arrangements

Is the project classified as a Category B project? Yes ☒ No ☐. If no is indicated this criterion is not applicable. If yes is indicated, has proof of a bond rating of "A" or better been provided? Yes ☐ No ☒. If yes is indicated this criterion is not applicable, go to item B. If no is indicated, read the criterion and address the following:

Are all available cash and equivalents being used for project funding prior to borrowing? ☒ Yes ☐ No

If no is checked, provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following:

1. a portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order that the current ratio does not fall below 2.0 times; or
2. borrowing is less costly than the liquidation of existing investments and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Criterion 1120.310(b), Conditions of Debt Financing NOT APPLICABLE - NO DEBT

Read the criterion and provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following as applicable:

1. The selected form of debt financing the project will be at the lowest net cost available or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term (years) financing costs, and other factors;
2. All or part of the project involves the leasing of equipment or facilities and the expenses incurred with such leasing are less costly than constructing a new facility or purchasing new equipment.

B. Criterion 1120.310(c), Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
	A	B	C	D	E	F	G	H	
Department (list below)	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. $ (A x C)	Mod. $ (B x E)	Total Cost (G + H)
Contingency									
TOTALS									
* Include the percentage (%) of space for circulation									

2. For each piece of major medical equipment included in the proposed project, the applicant must certify one of the following:

REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON) (continued)

a. that the lowest net cost available has been selected; or

b. that the choice of higher cost equipment is justified due to such factors as, but not limited to, maintenance agreements, options to purchase, or greater diagnostic or therapeutic capabilities.

3. List the items and costs included in preplanning, site survey, site preparation, off-site work, consulting, and other costs to be capitalized. If any project line item component includes costs attributable to extraordinary or unusual circumstances, explain the circumstances and provide the associated dollar amount. When fair market value has been provided for any component of project costs, submit documentation of the value in accordance with the requirements of Part 1190.40.

D. Criterion 1120.310(d), Projected Operating Costs

Read the criterion and provide in the space below the facility's projected direct annual operating costs (in current dollars per equivalent patient day or unit of service, as applicable) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. If the project involves a new category of service, also provide the annual operating costs for the service. Direct costs are the fully allocated costs of salaries, benefits, and supplies. Indicate the year for which the projected operating costs are provided.

E. Criterion 1120.310(e), Total Effect of the Project on Capital Costs

Is the project classified as a category B project? Yes ☒ No ☐. If no is indicated, go to item F. If yes is indicated, provide in the space below the facility's total projected annual capital costs as defined in Part 1120.130(f) (in current dollars per equivalent patient day) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. Indicate the year for which the projected capital costs are provided.

F. Criterion 1120.310(f), Non-patient Related Services NOT APPLICABLE

Is the project classified as a category B project and involve non-patient related services? Yes ☐ No ☐. If no is indicated, this criterion is not applicable. If yes is indicated, read the criterion and document that the project will be self-supporting and not result in increased charges to patients/residents or that increased charges are justified based upon such factors as, but not limited to, a cost benefit or other analysis that demonstrates the project will improve the applicant's financial viability.

APPEND DOCUMENTATION AS ATTACHMENT -76, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

For year 2012 of operation, the projected annual operating costs per treatment is $174.82, and the projected annual capital cost per treatment is $38.35.

SAFETY NET IMPACT STATEMENT that describes all of the following: NOT APPLICABLE

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service

APPEND DOCUMENTATION AS ATTACHMENT-77, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

File Number 0171523-2

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 20, 2005, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 2ND *day of* MARCH *A.D.* 2010 .

SEAL OF THE STATE OF ILLINOIS AUG. 26TH 1818

Authentication #: 1006101550

Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

File Number 6483-188-7

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

COMMUNITY HEALTH SYSTEMS, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MARCH 31, 2006, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* MARCH *A.D.* 2010 .

Authentication #: 1007402156

Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT - 1

66

File Number 0171523-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 20, 2005, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 2ND *day of* MARCH *A.D.* 2010 .

SEAL OF THE STATE OF ILLINOIS AUG. 26TH 1818

Authentication #: 1006101550

Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT - 2

EXHIBIT A
LEGAL DESCRIPTION

PARCEL 1: (WEST PARCEL)

PART OF THE NORTH 2276.00 FEET OF THE EAST HALF OF GOVERNMENT LOTS 1 AND 2 OF THE NORTHWEST QUARTER OF SECTION 3, TOWNSHIP 45 NORTH, RANGE 10, EAST OF THE THIRD PRINCIPAL MERIDIAN, BEING DESCRIBED AS FOLLOWS: COMMENCING AT THE NORTHEAST CORNER OF SAID EAST HALF OF GOVERNMENT LOT 2; THENCE SOUTH 00 DEGREES 40 MINUTES 54 SECONDS WEST ALONG THE EAST LINE THEREOF, 2276.08 FEET TO THE SOUTHEAST CORNER OF THE NORTH 2276.00 FEET OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2; THENCE NORTH 89 DEGREES 48 MINUTES 28 SECONDS WEST ALONG THE SOUTH LINE OF THE NORTH 2276.00 FEET OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2, A DISTANCE OF 598.95 FEET TO THE PLACE OF BEGINNING; THENCE NORTH 00 DEGREES 25 MINUTES 06 SECONDS EAST, 220.48 FEET; THENCE NORTHWESTERLY 74.18 FEET ALONG A NON-TANGENT CURVE TO THE RIGHT, HAVING A RADIUS OF 265.00 FEET, CHORD LENGTH OF 73.94 FEET AND BEARS NORTH 23 DEGREES 07 MINUTES 26 SECONDS WEST; THENCE NORTHWESTERLY 314.28 FEET ALONG A CURVE TO THE LEFT, HAVING A RADIUS OF 310.00 FEET, CHORD LENGTH OF 300.99 FEET AND BEARS NORTH 44 DEGREES 08 MINUTES 52 SECONDS WEST; THENCE SOUTH 45 DEGREES 06 MINUTES 49 SECONDS WEST, 22.36 FEET; THENCE NORTH 44 DEGREES 53 MINUTES 11 SECONDS WEST, 44.09 FEET; THENCE NORTHEASTERLY 416.69 FEET ALONG A NON-TANGENT CURVE TO THE LEFT, HAVING A RADIUS OF 570.00 FEET, CHORD LENGTH OF 407.47 FEET AND BEARS NORTH 25 DEGREES 09 MINUTES 59 SECONDS EAST; THENCE NORTHWESTERLY 227.63 FEET ALONG A CURVE TO THE LEFT HAVING A RADIUS OF 360.00 FEET, CHORD LENGTH OF 223.86 FEET AND BEARS NORTH 13 DEGREES 53 MINUTES 25 SECONDS WEST; THENCE NORTHWESTERLY 221.41 FEET ALONG A CURVE TO THE RIGHT, HAVING A RADIUS OF 425.00 FEET, CHORD LENGTH OF 218.91 FEET AND BEARS NORTH 17 DEGREES 04 MINUTES 48 SECONDS WEST; THENCE NORTHEASTERLY 154.92 FEET ALONG A CURVE TO THE LEFT HAVING A RADIUS OF 200.00 FEET, CHORD LENGTH OF 151.08 FEET AND BEARS NORTH 01 DEGREES 03 MINUTES 15 SECONDS EAST; THENCE NORTHEASTERLY 389.34 FEET ALONG A CURVE TO THE RIGHT, HAVING A RADIUS OF 245.00 FEET, CHORD LENGTH OF 349.65 FEET AND BEARS NORTH 24 DEGREES 23 MINUTES 20 SECONDS EAST; THENCE NORTH 69 DEGREES 54 MINUTES 53 SECONDS EAST, 149.28 FEET; THENCE NORTH 00 DEGREES 25 MINUTES 06 SECONDS EAST, 217.93 FEET TO THE SOUTHERLY RIGHT-OF-WAY LINE OF STATE ROUTE 132; THENCE NORTH 89 DEGREES 38 MINUTES 59 SECONDS WEST ALONG SAID SOUTHERLY RIGHT-OF-WAY LINE, 329.79 FEET; THENCE SOUTH 00 DEGREES 02 MINUTES 06 SECONDS WEST ALONG A JOG IN SAID SOUTHERLY RIGHT-OF-WAY LINE, 15.00 FEET; THENCE SOUTH 89 DEGREES 54 MINUTES 13 SECONDS EAST ALONG SAID RIGHT-OF-WAY LINE, 55.55 FEET; THENCE NORTHWESTERLY 343.68 FEET ALONG A CURVE TO THE LEFT, HAVING A RADIUS OF 49,055.70 FEET, CHORD LENGTH OF 343.68 FEET AND BEARS NORTH 89 DEGREES 53 MINUTES 45 SECONDS WEST TO A LINE 66.00 FEET EAST OF AND PARALLEL WITH THE WEST LINE OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2 OF THE NORTHWEST QUARTER OF SAID SECTION 3; THENCE SOUTH 00 DEGREES 53 MINUTES 19 SECONDS WEST ALONG SAID PARALLEL LINE, 277.07 FEET; THENCE SOUTH 89 DEGREES 48 MINUTES 28 SECONDS EAST PARALLEL WITH THE NORTH LINE OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2, A DISTANCE OF 14.00 FEET TO A LINE 80.00 FEET EAST OF AND PARALLEL WITH THE WEST LINE OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2; THENCE SOUTH 00 DEGREES 53 MINUTES 19 SECONDS WEST ALONG SAID PARALLEL LINE, 425.00 FEET TO A LINE 755.00 FEET SOUTH

CONTINUED ON NEXT PAGE

AND PARALLEL WITH THE NORTH LINE OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2; THENCE NORTH 89 DEGREES 48 MINUTES 28 SECONDS WEST ALONG SAID PARALLEL LINE, 80.00 FEET TO THE WEST LINE OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2; THENCE SOUTH 00 DEGREES 53 MINUTES 10 SECONDS WEST ALONG SAID WEST LINE 1521.17 FEET TO THE SOUTHWEST CORNER OF THE NORTH 2276.00 FEET OF SAID EAST HALF OF GOVERNMENT LOTS 1 AND 2; THENCE SOUTH 89 DEGREES 48 MINUTES 28 SECONDS EAST ALONG SAID SOUTH LINE, 735.14 FEET TO THE PLACE OF BEGINNING, IN LAKE COUNTY, ILLINOIS.

PARCEL 2:

INGRESS AND EGRESS EASEMENT FOR THE BENEFIT OF PARCEL 1 PURSUANT TO DECLARATION OF EASEMENTS AND COVENANTS DATED AS OF JUNE 27, 2006 AND RECORDED JUNE 29, 2006 AS DOCUMENT 6019319 BY VICTORY HEALTH SERVICES, AN ILLINOIS NOT FOR PROFIT CORPORATION OVER THAT PORTION OF THE LAND DESCRIBED IN EXHIBIT 'D' ATTACHED THERETO.

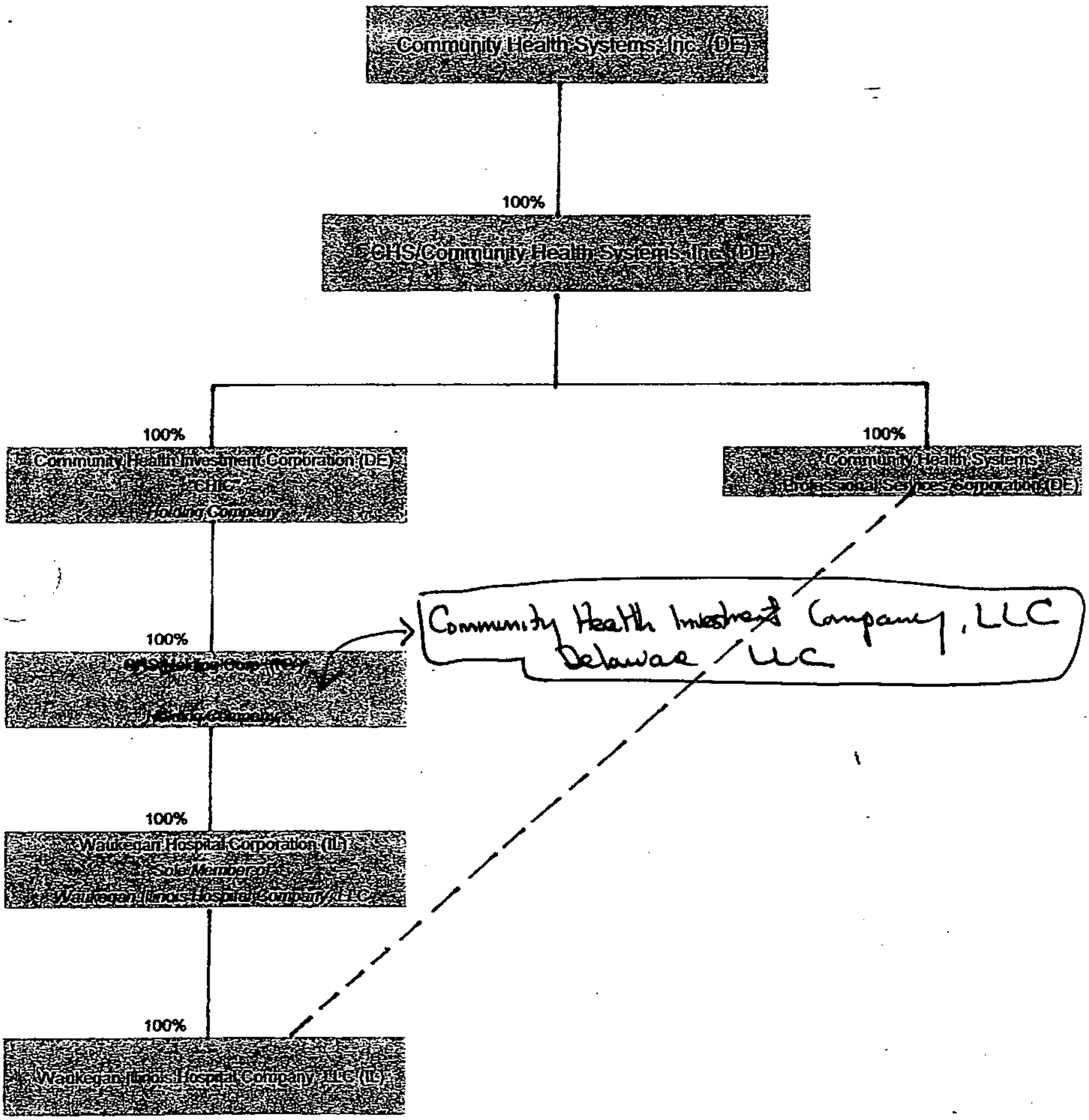
PARCEL 3:

DRIVEWAY EASEMENT FOR THE BENEFIT OF PARCEL 1 PURSUANT TO EASEMENT AND DEVELOPMENT AGREEMENT DATED NOVEMBER 25, 1997 AND RECORDED JUNE 2, 2006 AS DOCUMENT 6002626 BY AND BETWEEN VICTORY HEALTH SERVICES CORPORATION, AN ILLINOIS NOT-FOR-PROFIT CORPORATION JOHN W. GRIDLEY, AS TRUSTEE FOR THE JOHN W. GRIDLEY TRUST DATED MARCH 8, 1990, THE BOARD OF LIBRARY TRUSTEES OF THE LAKE VILLA PUBLIC LIBRARY DISTRICT.

Permanent Index Number: 06-03-100-044; 06-03-100-045; 06-03-100-046; 06-03-100-049; and 06-03-100-050

Commonly known as: 1050 Red Oak Lane, Lindenhurst, Illinois

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC



1172

Attachment [redacted]-3

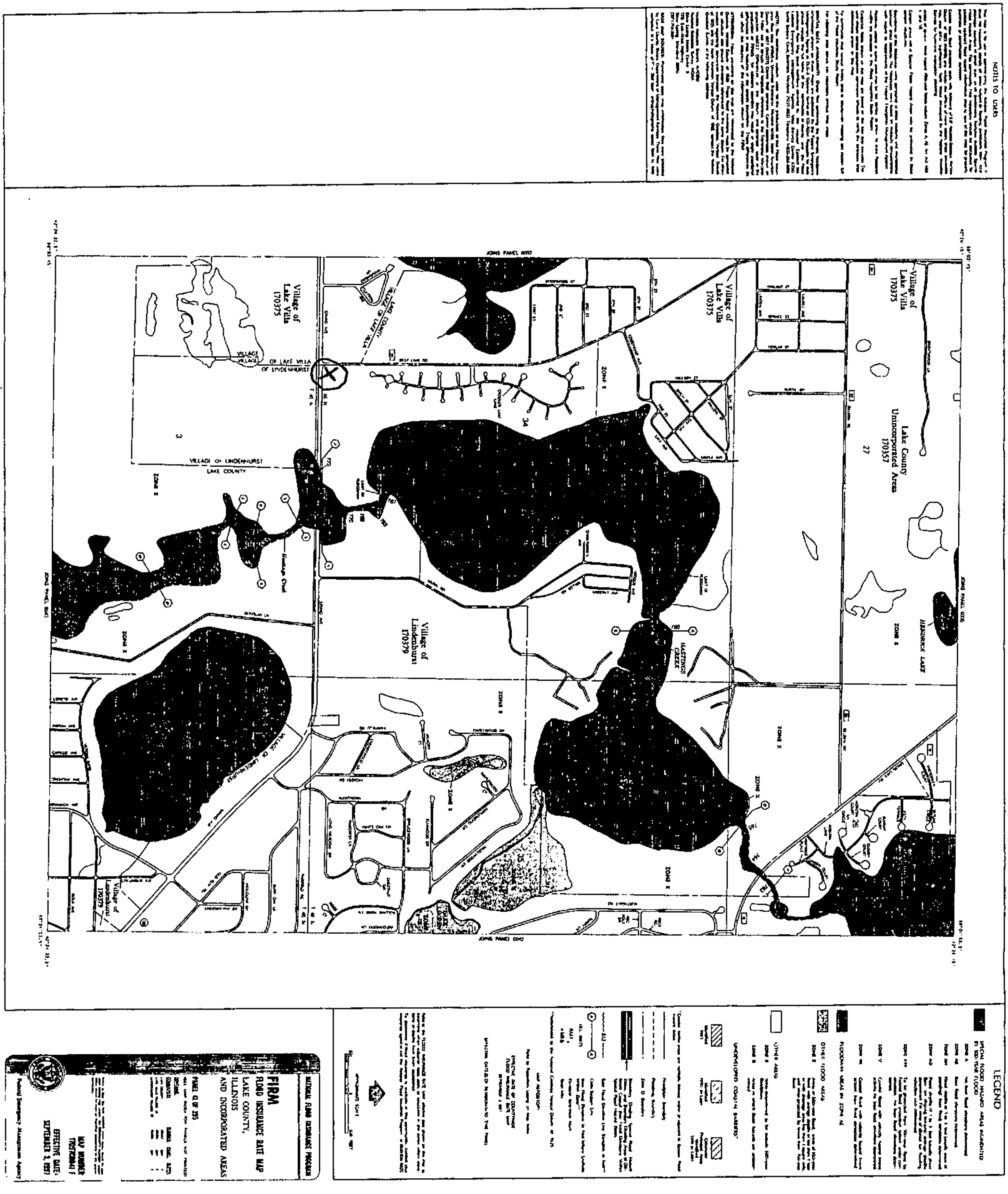
FLOOD PLAIN REQUIREMENTS

Attached is a flood plain map evidencing that the proposed project is not in a flood plain, and 2 additional Mapquest maps to help in identifying the proposed project location.

I, Barbara J. Martin, President and Chief Executive Officer of Vista Health System, certify that this project is not located in a flood plain.

Notwithstanding the above, and in accordance with the Flood Plain Rule under Executive Order #5 of 2006, there is no prohibition on the construction of a medical facility in a flood plain if it does not involve public funds, and this project will not involve the use of public funds.

Barbara J. Martin



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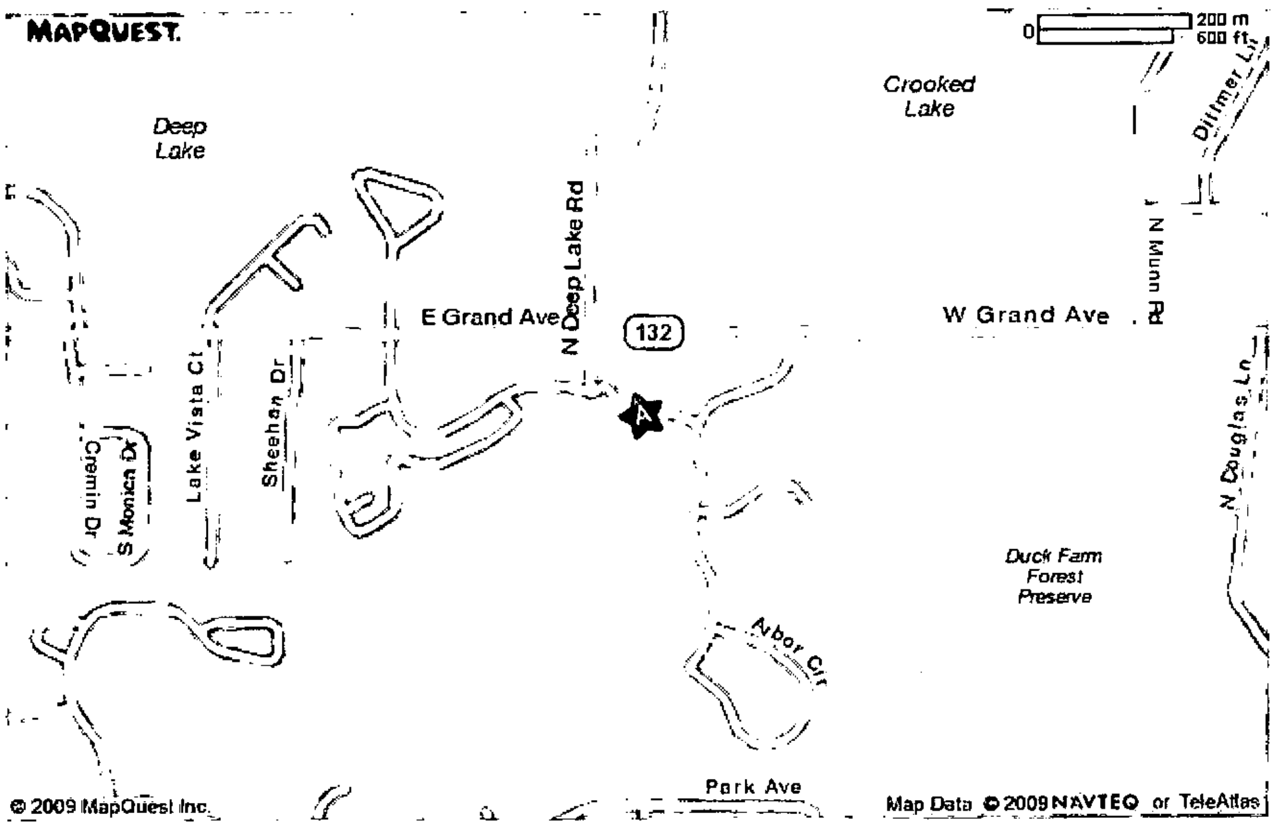
ATTACHMENT - 4

MAPQUEST.

Map of 1052 Red Oak Ln
Lindenhurst, IL 60046-4998

Notes



ATTACHMENT - 4

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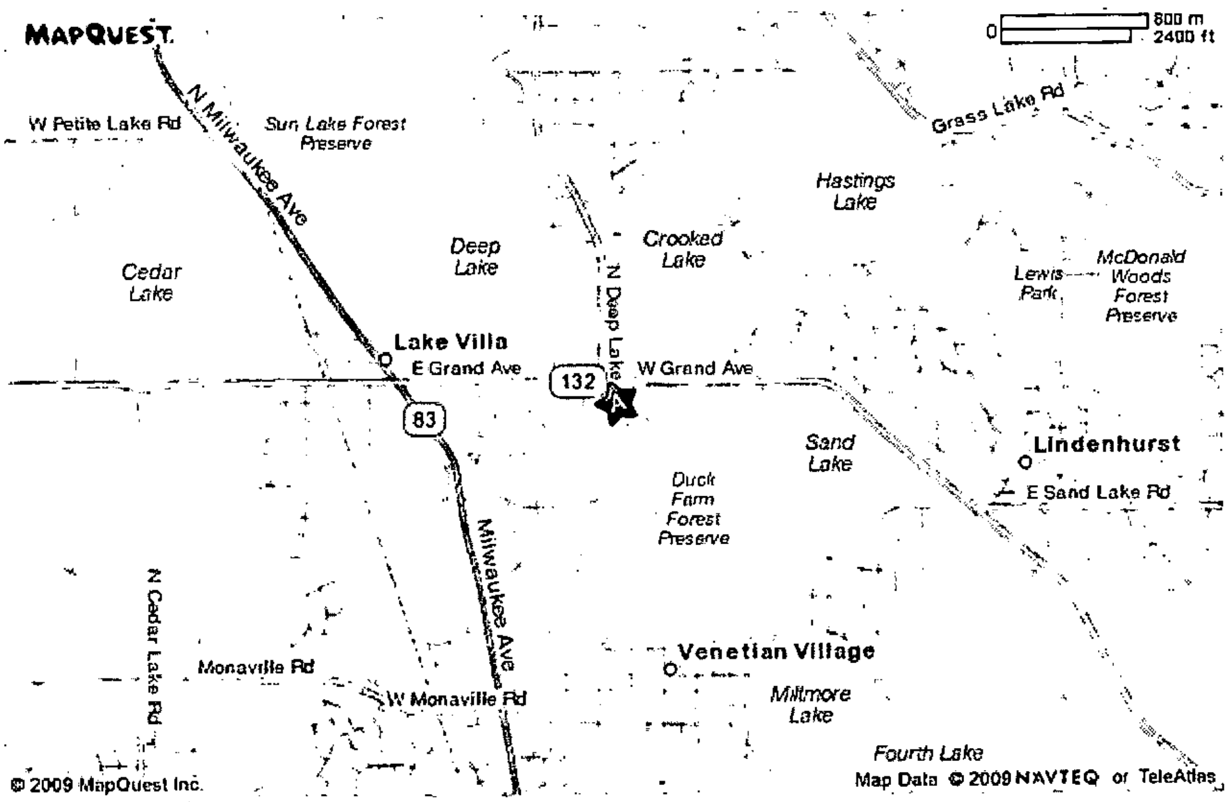
MAPQUEST.

Notes

Map of 1052 Red Oak Ln

Lindenhurst, IL 60046-4998



ATTACHMENT - 4

HISTORIC RESOURCE PRESERVATION ACT

Attached is a letter addressed to the Illinois Historic Preservation Agency ("Agency"), in which we ask that it provide its determination of the project's impact on historic resources.

Upon receipt of its determination, we will promptly provide it to Illinois Health Facilities and Services Review Board.

We are confident the Agency will determine in our favor, as evidenced by the attached letter dated 1/12/07 in regards to this same project.

Holland & Knight

131 South Dearborn Street | Chicago, IL 60603 | T 312.263.3600 | F 312.578.6666
Holland & Knight LLP | www.hklaw.com

Certified Article Number

7160 3820 3530 0678 8545
SENDERS RECORD

March 9, 2010

Debra Baer
312 263 3600

Certified Mail/Return Receipt Requested

Ms. Anne E. Haaker
Deputy State Historic Preservation Officer
Illinois Historic Preservation Agency
1 Old State Capitol Plaza
Springfield, IL 62701-1507

RE: Vista Health System ("**Vista**")
Proposed Establishment of Freestanding Emergency Center ("**FEC**")

Dear Ms. Haaker:

Our firm is in the process of developing a Certificate of Need application on behalf of Vista, to be filed with the Illinois Health Facilities Services and Review Board, and we need a determination as to whether this project will have an impact on historic resources.

The project proposes the establishment of a FEC through the construction of an addition to a building on Vista's Lindenhurst campus, located at 1052 Red Oak Lane, in Lindenhurst, Illinois.

I have enclosed photographs of the proposed site and a few maps for your review.

A letter from your office, confirming that the Preservation Act is not applicable to this project would be greatly appreciated.

Sincerely,

Debra Baer, Paralegal
w/enclosures

Illinois Historic
Preservation Agency

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • Voice (217) 782-4836
Teletypewriter Only (217) 524-7128
www.illinois-history.gov

Lake County
Lindenhurst
CON - New Construction, Lindenhurst Illinois Hospital Company
East Victory Drive
IHPA Log #002011107

January 12, 2007

Kristin Sculli
McGuireWoods LLP
77 W. Wacker Dr., Suite 4100
Chicago, IL 60601-1815

Dear Ms. Sculli:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or haeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact Andrew Heckenkamp, Manager, 1 Old State Capitol Plaza, Springfield, IL 62701, 217/782-8168.

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

Attachment [redacted]-5

PROJECT COSTS

Site Preparation ($93,000)
Estimate of costs associated with site development, including parking, driveway and exterior signage.

New Construction Contracts ($2,351,712)
Estimate of construction, including major medical and other fixed equipment, contractor's overhead and profit.

Modernization Contracts ($92,160)
Estimate of the cost associated with the renovation of the existing facility.

Contingencies ($161,343)
Allowance for any unanticipated construction and renovation-related expenses.

Architectural/Engineering Fees ($234,400)
Estimate of fees based on Capital Development Board norms for projects of this type involving both renovation and new construction.

Consulting and Other Fees ($298,759)
Estimate of costs associated with CON application development, IHFPRB review fee, IDPH plan review fee, municipal permits and inspections, construction-related insurance and miscellaneous costs.

Movable or Other Equipment ($656,969)
Estimate of the equipment cost associated with the establishment of a freestanding emergency center.

COST SPACE REQUIREMENTS

				Amount of Proposed GSF that is:		
Department	**Cost**	**Existing GSF**	**Proposed Total GSF**	**New**	**Remodeled**	**As Is**
Reviewable						
Emergency	$2,538,521.00			4,235		
TOTAL				4,235		
Non-Reviewable						
EMS Office	$94,316.00			112		
Public/General Circ.	$534,001.00			824	384	
Ambulance Garage	$770,505.00			1,510		
	$1,398,822.00			2,446		
PROJECT TOTAL	**$3,937,343.00**	**0**	**0**	**6,681**	**384**	**0**

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Division (#) V.P.	Hospital Name and Address Corporate Owner / State of Incorporation	Lic. Beds	Phone/ Fax No.	Speed Dial	Acctg Code	Executive Names	Executive Titles
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Abilene, Texas** Abilene Regional Medical Center 6250 Highway 83/84 Abilene, TX 79606 ARMC, L.P.(DE)	231	325-428-1000 325-428-1029	150	1628	Mike Murphy Bryan Bateman Ron Bennett Barbara Taylor Tonya Anderson	CEO COO CFO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Massillon, Ohio** Affinity Medical Center 875 Eighth Street, N.E. (P.O. Box 805) Massillon, OH 44648 DHSC, LLC	268	330-832-8761 330-837-6871	137	1902	Ron Bierman Jim Hutchinson Kathy Foltz Maureen Lowe	CEO CFO CNO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Las Vegas, New Mexico** Alta Vista Regional Hospital 104 Legion Drive Las Vegas, NM 87701 San Miguel Hospital Corporation (NM)	54	505-426-3500 505-454-9502	063	160	Richard Grogan Leonard Tapia Frank Almendarez Karen Brooks	CEO CFO CNO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Barstow, California** Barstow Community Hospital 555 South 7th Street Barstow, CA 92311 Hospital of Barstow, Inc. (DE)	56	760-256-1761 760-957-3048	022	115	Michael K. Stewart Carrie Howell Julia Vasquez Marilyn Clark Kennedy	CEO CFO Interim CNO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Berwick, Pennsylvania** Berwick Hospital Center 701 East 16th Street Berwick, PA 18603 Berwick Hospital Company, LLC (DE)	101	570-759-5000 570-759-3473	057	155	Ron Beer Diane Krowlikowski Joe McCullum Whitney Holloway Carolyn Diehl OPEN Jeff Bomboy	CEO ACEO CFO ACFO CNO ACNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Alpine, Texas** Big Bend Regional Medical Center 2600 Highway 118 North Alpine, TX 79830 Big Bend Hospital Corporation (TX)	25	432-837-3447 432-837-0330	001	158	Mike Ellis Tim Howard Kathy Degenstein-Gartman Trey McGraw	CEO CFO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Bluffton, Indiana** Bluffton Regional Medical Center 303 S. Main Street Bluffton, IN 46714 Bluffton Health System, LLC (DE)	79	260-919-3103 260-919-3201	139	1562	Tom Clark Larry DeBolt Brenda Tomson Vicki Hanselman John Martinsky	CEO CFO CNO COO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Coatesville, Pennsylvania** Brandywine Hospital 201 Reeceville Rd. Coatesville, PA 19320 Coatesville Hospital Corporation (PA)	243	610-383-8000 610-383-8360	066	167	Bryan Burklow Jill Tillman Mike Stephens Jeremy Graham Tammy Torres Mary Blanco	CEO ACEO CFO ACFO CNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Brownwood, Texas** Brownwood Regional Medical Center 1501 Burnet Drive (P.O. Box 760 / zip 76804) Brownwood, TX 76801 Brownwood Hospital L.P. (DE)	194	325-646-8541 325-646-5459	151	1570	Matt Maxfield Kyle Swift John Sharp Pam Craig Rae Smylie	CEO ACEO CFO CNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Leesville, Louisiana** Byrd Regional Hospital 1020 Fertitta Blvd. Leesville, LA 71446 National Healthcare of Leesville, Inc. (DE)	60	337-239-9041 337-239-5360	026	123	Roger C. LeDoux Robert Rupp Wendell Wilkes OPEN Beth Westerchil OPEN Angela Williams	CEO ACEO CFO ACFO CNO ACNO Quality Director

Division (#) V.P.	Hospital Name and Address Corporate Owner / State of Incorporation	Lic. Beds	Phone/ Fax No.	Speed Dial	Acctg Code	Executive Names	Executive Titles
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Carlsbad, New Mexico** Carlsbad Medical Center 2430 W. Pierce Carlsbad, NM 88220 Carlsbad Medical Center, LLC (DE)	127	575-887-4100 575-887-4256	115	1589	Janet Carbary Grant Trollope OPEN Carol Welch OPEN Billie Rutledge	CEO CFO ACFO CNO COO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Florence, South Carolina** Carolinas Hospital System 805 Pamplico Hwy Florence, SC 29505 QHG of South Carolina, Inc (SC)	372	843-674-5000 843-674-2519	116	1595	Jim O'Loughlin OPEN Brent White Gene Brattain Jeffrey Thomas Costa Cockfield Trish Carter-McLeod Eleanor Lynch Jodi Beauregard Donna Sullivan	CEO CFO Project CFO ACFO ACFO CNO ACNO Asst. Administrator COO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Cedar Park, Texas** Cedar Park Regional Medical Center 1401 Medical Parkway Cedar Park, TX 78613 Cedar Park Health System, L.P. (DE)	77	512-528-7000 512-259-9772	104	1521	OPEN Carol Schmoyer Erich Wallschlaeger Frances Lerma Angela Rafi	CEO Interim ACEO CFO CNO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Centre, Alabama** Cherokee Medical Center 400 Northwood Drive Centre, AL 35960 Centre Hospital Corporation (AL)	60	256-927-5531 256-927-1304	097	197	Jeff Noblin Zac Allen Angie Bennett Kathryn Lindsey	CEO CFO CNO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Cheraw, South Carolina** Chesterfield General Hospital Highway 9 West (P.O. Box 151) Cheraw, SC 29520 Chesterfield/Marlboro, L.P. (DE)	59	843-537-7881 843-320-3479	048	146	Paul Theriot Phillip Fouts Kari Snyder Julie Jordan	CEO CFO CNO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Philadelphia, Pennsylvania** Chestnut Hill Hospital 8835 Germantown Avenue Philadelphia, PA 19118 CHHS Hospital Company, LLC (DE)	164	215-248-8200 215-242-1022	091	191	Brooks Turkel Andrew Goldfrach Deb Konarski Teresa Kelly Sue Keown	CEO ACEO CFO CNO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Claremore, Oklahoma** Claremore Regional Hospital 1202 N. Muskogee Place Claremore, OK 74017 Claremore Regional Hospital, LLC (DE)	89	918-341-2556 918-342-3330	105	1821	David Chaussard Rodney Higgins Dava Baldridge Melissa Plummer	CEO CFO CNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Cleveland, Texas** Cleveland Regional Medical Center 300 E. Crockett Cleveland, TX 77327 Cleveland Regional Medical Center, L.P. (DE)	107	281-593-1811 281-432-4370	049	147	Cory Countryman Craig Morse Mike Cadoret OPEN	CEO CFO CNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**College Station, Texas** College Station Medical Center (P.O. Box 10000 / zip 77842) College Station, TX 77845 College Station Hospital, LP (DE)	141	979-764-5100 979-680-5366	140	1663	Tom Jackson Larry Rodgers Ben Cluff John Irby Sherri Welch Carol Bode	CEO COO CFO ACFO CNO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Huntsville, AL** Crestwood Medical Center One Hospital Drive SW Huntsville, AL 35801 Crestwood Healthcare, L.P. (DE)	150	256-429-4000 256-429-4615	124	1584	Pamela Hudson, M.D. Holt Smith Sherry Jones Martha Walls Brian Thomas Betty Grubb	CEO CFO ACFO CNO COO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Mt. Vernon, Illinois** Crossroads Community Hospital #8 Doctor's Park Road Mt. Vernon, IL 62864 National Healthcare of Mt. Vernon, Inc. (DE)	57	618-244-5500 618-244-5566	028	133	Ed Cunningham Brian Schneider Beth Horton Sam White	CEO CFO CNO Quality Director

Attachment 10

Division (#) V.P.	Hospital Name and Address Corporate Owner / State of Incorporation	Lic. Beds	Phone/ Fax No.	Speed Dial	Acctg Code	Executive Names	Executive Titles
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Oklahoma City, Oklahoma** Deaconess Hospital 5501 N. Portland Avenue Oklahoma City, OK 73112-2099 Deaconess Health System, LLC (DE)	313	405-604-6000 405-604-6153	152	1568	Cathryn Hibbs Charles Nasem Marty Bakos Jeremy Walker Chris McAuliffe OPEN Jennifer Langford	CEO COO CFO ACFO CNO ACNO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Spokane, Washington** Deaconess Medical Center 800 W. 5th Avenue Spokane, WA 99204 Spokane Washington Hospital Company, LLC (DE)	388	509-458-5800			Bill Gilbert Chad Campbell Dan Houghton Omar Garza Shelly Peterson Kay Lewis	CEO ACEO CFO ACFO CNO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Fort Payne, Alabama** DeKalb Regional Medical Center 200 Medical Center Drive P. O. Box 680778 Fort Payne, AL 35968 Fort Payne Hospital Corporation (AL)	134	256-845-3150 256-997-2512	096	198	Jeff Rains Darcy Craven Hugh Tobin Michael H. Johnson Marquita Johnson-Bailey Vicki Kay	CEO ACEO CFO ACFO CNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Victoria, Texas** DeTar Hospital North 101 Medical Drive Victoria, TX 77904 Victoria of Texas, L.P. (DE)	115	361-573-6100 361-788-2693	141	1611	Bill Blanchard George Parsley Don Hagan Laurence Bludeau Sammie Drehr Judy Hill Jean Herman	CEO COO CFO ACFO CNO ACNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Victoria, Texas** DeTar Hospital Navarro 506 E. San Antonio Street Victoria, TX 77901 Victoria of Texas, L.P. (DE)	193	361-575-7441 361-788-6114	142	1611	Bill Blanchard George Parsley Don Hagan Laurence Bludeau Sammie Drehr Jean Herman	CEO COO CFO ACFO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko	**Peru, Indiana** Dukes Memorial Hospital 275 West 12th Street Peru, IN 46970-1698 Dukes Health System, LLC (DE)	25	765-472-8000 765-473-8244	143	1768	Debra Close Cindy Vandenberg Melanie Heath Doris Timmins	CEO CFO CNO Quality Director
(5)Tom Miller Randy Cooper Mike Douzuk Gary Ladyko Cully Chapman	**Fort Wayne, Indiana** Dupont Hospital 2520 E. Dupont Road Fort Wayne, IN 46825 Dupont Hospital, LLC (DE)	131	260-416-3000 260-416-3300	144	1554	Mike Schatzlein, MD Erica Wehrmeister Craig Polkow Karra Heggen OPEN Theresa Herman, MD	CEO ACEO CFO CNO COO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Dyersburg, Tennessee** Dyersburg Regional Medical Center 400 Tickle Street Dyersburg, TN 38024 Dyersburg Hospital Corporation (TN)	225	731-285-2410 731-285-9545	079	0180	Russell Pigg Ben Youree Terri Warren Sallie Adkins Carrie Beld	CEO ACEO CFO CNO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Roswell, New Mexico** Eastern New Mexico Medical Center 405 West Country Club Road Roswell, NM 88201 Roswell Hospital Corporation (NM)	162	575-622-8170 575-624-8726	002	0151	Brad McGrath Leanne Hacker Maridel Acosta Troy Christenson Dona Townsend OPEN Shelda Adams	CEO CFO ACEO ACFO CNO ACNO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Easton, Pennsylvania** Easton Hospital 250 South 21st Street Easton, PA 18042-3892 Northampton Hospital Company, LLC (DE)	254	610-250-4000 610-250-4078	069	0169	Tim Trottier OPEN John McDowell OPEN James Washecka Robert Ehinger Linda Styles Karen Vadyak Christine Beige	CEO COO ACEO ACEO CFO ACFO ACFO CNO Quality Director

Division (#) V.P.	Hospital Name and Address Corporate Owner / State of Incorporation	Lic Beds	Phone/ Fax No.	Speed Dial	Acctg Code	Executive Names	Executive Titles
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Evanston, Wyoming** Evanston Regional Hospital 190 Arrowhead Drive Evanston, WY 82930 Evanston Hospital Corporation (WY)	42	307-789-3636 307-783-8167	006	0159	George Winn Jared Stimpson Darin Linford Cheri Willard	CEO CFO CNO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Fallbrook, California** Fallbrook Hospital 624 East Elder Fallbrook, CA 92028 Fallbrook Hospital Corporation (DE)	47	760-728-1191 760-728-0683	055	0153	Alex Villa Michael McHorney Janet Colvard Peggy Carroll	CEO CFO CNO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Blue Ridge, Georgia** Fannin Regional Hospital 2855 Old Highway 5, North Blue Ridge, GA 30513 Fannin Regional Hospital, Inc. (GA)	50	706-632-3711 706-632-7216	007	0102	Scott M. Smith Keith Newton Julia Barnett Cheryl Curtis	CEO CFO CNO Interim Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Dothan, Alabama** Flowers Hospital 4370 West Main Street Dothan, AL 36305 Triad of Alabama, LLC (DE)	235	334-794-5000 334-793-4613	126	1572	Suzanne Woods Talana Bell Renie Henslee Suzanne Woods Dan Cumbie Lori Lewis Amy Butler	Interim CEO CFO ACFO COO CNO ACNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Forrest City, Arkansas** Forrest City Medical Center 1601 Newcastle Road Forrest City, AR 72336 Forrest City Arkansas Hospital Company, LLC (AR)	118	870-261-0000 870-261-0405	095	0196	Brett Kinman Stephen Doherty Tanya Hughes Angie Vondran	CEO CFO CNO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Gadsden, Alabama** Gadsden Regional Medical Center 1007 Goodyear Avenue Gadsden, AL 35903 Gadsden Regional Medical Center, LLC (DE)	346	256-494-4000 256-494-4474	127	1585	Stephen Pennington Bill Keith Bryan McCauley Rodney Sisk Donna Nicholson OPEN Lisa Henderson	CEO COO CFO ACFO CNO ACNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Galesburg, Illinois** Galesburg Cottage Hospital 695 N. Kellogg St. Galesburg, IL 61401 Galesburg Hospital Corporation (IL)	173	309-343-8131 309-343-2393	089	0190	Ken Hutchenrider Rob Gasaway Irene Strejc Angie Cook Roni Benson	CEO CFO CNO ACNO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Clarksville, Tennessee** Gateway Medical Center 651 Dunlop Lane PO Box 31629 Clarksville, TN 37040 Clarksville Health System, G.P. (DE)	270	931-502-1000 931-502-1215	117	1553	Aaron Hazzard Corey Ewing Scott Pfister OPEN Fran Mackdanz Vickie Duncan	Interim CEO COO CFO ACFO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Granite City, Illinois** Gateway Regional Medical Center 2100 Madison Avenue Granite City, IL 62040 Granite City Illinois Hospital Company, LLC (IL)	382	618-798-3000 618-798-3724	072	0172	Damon Brown OPEN Ron Leazer OPEN Denise Fritz OPEN Janet Smith	CEO Assc CEO CFO ACFO CNO ACNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Ronceverte, West Virginia** Greenbrier Valley Medical Center 202 Maplewood Avenue (P.O. Box 497) Ronceverte, WV 24970 Greenbrier VMC, LLC (DE)	122	304-647-4411 304-647-6010	118	1878	Rob Followell Todd Jackson Joy Fergie Jeremy Barclay Vanessa Peters Paula Shrewsbury-Dowdy Barbara Frame-Cook	CEO ACEO CFO COO CNO ACNO Quality Director

Division (#) V.P.	Hospital Name and Address Corporate Owner / State of Incorporation	Lic. Beds	Phone/ Fax No.	Speed Dial	Acctg Code	Executive Names	Executive Titles
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Newport, Arkansas** Harris Hospital 1205 McLain Newport, AR 72112 National Healthcare of Newport, Inc. (DE)	133	870-523-8911 870-523-0225	030	0128	Claude "Chip" Camp Misty Gates Judy Haney Cheryl Mauldin	CEO CFO CNO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Brownsville, Tennessee** Haywood Park Community Hospital 2545 N. Washington Ave. Brownsville, TN 38012 Brownsville Hospital Corporation (TN)	62	731-772-4110 731-772-9428	078	0185	David Rasmussen Richard Read Steve Collins Yvette Sumler	CEO CFO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Marion, Illinois** Heartland Regional Medical Center 3333 West DeYoung Marion, IL 62959 Marion Hospital Corporation (IL)	92	618-998-7000 618-998-7449	047	0143	Philip Dionne Betty Scriber Loren Rials Eric Jost John Osgood Nancy McKransky	CEO COO CFO ACFO Interim CNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Helena, Arkansas** Helena Regional Medical Center 1801 Martin Luther King Drive / PO Box 788 Helena , AR 72342 Phillips Hospital Corporation (AR)	155	870-338-5800 870-816-3909	073	0176	Jim Sato Amy Rice OPEN Shanna Pryor Lana Thompson	CEO CFO ACFO CNO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Lexington, Tennessee** Henderson County Community Hospital 200 West Church St. Lexington, TN 38351 Lexington Hospital Corporation (TN)	45	731-968-3646 731-968-8113	081	0181	Holly Fowler-Clark Cliff Hendren Roy Boland Cheri Jowers	CEO CFO CNO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Shelbyville, Tennessee** Heritage Medical Center 2835 Hwy. 231N Shelbyville, TN 37160 Shelbyville Hospital Corporation (TN)	60	931-685-8252 931-685-8257	092	0192	Dan Buckner Jeremy Gray Alan Lovelace Pat Sweeton Jan Hibdon	CEO Asst. Administrator CFO CNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Hillsboro, Texas** Hill Regional Hospital 101 Circle Drive Hillsboro, TX 76645 NHCI of Hillsboro, Inc. (TX)	92	254-580-8500 254-582-2144	032	0134	Jan McClure Judy Culp Lorenda Lambert OPEN Cecily Bramlet	CEO CFO CNO ACNO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**West Grove, Pennsylvania** Jennersville Regional Hospital 1015 West Baltimore Pike West Grove, PA. 19390 West Grove Hospital Company, LLC (DE)	59	610-869-1000 610-869-1362	070	0170	Chuck Davis Brent Smith Sheila Bryson-Eckroade OPEN Dianna McCarthy	CEO CFO CNO ACEO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Jackson, Kentucky** Kentucky River Medical Center 540 Jetts Drive Jackson, KY 41339 Jackson Hospital Corporation (KY)	55	606-666-6000 606-666-6107	041	0140	Wayne Heatherly Mike Ackley Debbie Linkous Angela Kaye Willett	Interim CEO CFO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Warsaw, Indiana** Kosciusko Community Hospital 2101 East DuBois Drive Warsaw, IN 46580 Warsaw Health System, LLC (DE)	72	574-267-3200 574-372-7692	145	1556	Steve Miller Doug BeMent Joan Darr Judy Slone	CEO CFO CNO/COO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Greenville, Alabama** L.V. Stabler Memorial Hospital 29 L.V. Stabler Drive Greenville, AL 36037 Greenville Hospital Corporation (AL)	72	334-382-2671 334-382-0305	038	0122	Bobby Ginn Connie Nicholas Vann Windham Kimberli Weaver Nancy Smith	CEO ACEO CFO CNO Quality Director

Division (#) V.P.	Hospital Name and Address Corporate Owner / State of Incorporation	Lic. Beds	Phone/ Fax No.	Speed Dial	Acctg Code	Executive Names	Executive Titles
	Granbury, Texas						
(2)Michael Portacci	Lake Granbury Medical Center	83	817-573-2273	053	0149	David Orcutt	CEO
Dave Medley	1310 Paluxy Road		817-408-3038			Vicky Cha	ACEO
Tim Adams	Granbury, TX 76048					Jeff Casbeer	CFO
Mike Healey	Granbury Hospital Corporation (TX)					Shirley Graves	CNO
Mike Garfield						Joan Tracy	Chief Quality Director
	Lake Wales, Florida						
(1)David Miller	Lake Wales Medical Center	160	863-676-1433	077	0178	Michael Yungmann	CEO
Shan Carpenter	410 South 11th Street		863-676-9323			Eric LaChance	ACEO
Woody Fields	Lake Wales, FL 33853					Danny Warren	CFO
Eric Roach	Lake Wales Hospital Corporation (FL)					Lee Clack	CNO
Paul Smith						Diane Nizza	Quality Director
	Morristown, Tennessee						
(3)Marty Smith	Lakeway Regional Hospital	135	423-522-6000	008	0116	Priscilla Mills	CEO
Terry Fowler	726 McFarland Street		423-587-8548			OPEN	ACEO
Randy Cooper	Morristown, TN 37814					Alan Archbold	CFO
John McClellan	Hospital of Morristown, Inc. (TN)					Pam Johns	CNO
Neil Heatherly						Kristen Kilgore	Quality Director
	Laredo, Texas						
(2)Michael Portacci	Laredo Medical Center	326	956-796-5000	087	0189	Tim Schmidt	CEO
Dave Medley	1700 East Saunders		956-796-3173			John Ulbricht	COO
Tim Adams	Laredo, TX 78041					Derrick Cuenca	ACEO
Mike Healey	Laredo Texas Hospital Company, L.P. (TX)					Ed Romero	CFO
Mike Garfield						Noe Gutierrez	ACFO
						Pat Sullivan	CNO
						Robert Castaneda	ACNO
						Christine Boone	ACNO
						Christine Boone	Interim Quality Director
	Hobbs, New Mexico						
(4)Bill Hussey	Lea Regional Medical Center	250	575-492-5000	119	1597	Larry Payton	CEO
Stephanie Moore	5419 N. Lovington Hwy		575-492-5505			Steven Smith	CFO
Tim Puthoff	(P.O. Box 3000)					Melonie Ankerholz	CNO
Brad Cash	Hobbs, NM 88240					OPEN	COO
Tim Hingtgen	Lea Regional Hospital, LLC (DE)					Jolene Kleinsteuber	Quality Director
	Lock Haven, Pennsylvania						
(3)Marty Smith	Lock Haven Hospital	59	570-893-5000	074	0174	Cindy Segar-Miller	CEO
Terry Fowler	24 Cree Drive		570-893-5172			Paige Adkins	CFO
Randy Cooper	Lock Haven, PA 17745-2699					Margaret Kiss	CNO
John McClellan	Clinton Hospital Corporation (PA)					Kristin Sykes	ACFO
Neil Heatherly						Thomas Foster	Nursing Home
						Jacqui Conklin	Quality Director
	Longview, Texas						
(2)Michael Portacci	Longview Regional Medical Center	131	903-758-1818	107	1620	Jim Kendrick	CEO
Dave Medley	2901 N. Fourth Street		903-758-5167			Todd Johnson	CFO
Tim Adams	(P.O. Box 14000 / zip 75607)					Jill Bayless Berney	COO
Mike Healey	Longview, TX 75605					Stephanie Foster	CNO
Mike Garfield	Longview Medical Center, L.P. (DE)					Ann Huffman	Chief Quality Director
	Fort Wayne, Indiana						
(5)Tom Miller	Lutheran Hospital	471	260-435-7001	146	1525	Joe Dorko	CEO
Ron Shafer	7950 W. Jefferson Blvd.		260-435-7632			Michael McCullough	CFO
Mike Douzuk	Fort Wayne, IN 46804					Karen Springer	COO
Gary Ladyko	IOM Health System, L.P. (IN)					Diane Springer	CNO
Cully Chapman						Mary Ellen Brill	Quality Director
	McKenzie, Tennessee						
(3)Marty Smith	McKenzie Regional Hospital	45	731-352-5344	082	0182	Darrell Blaylock	CEO
Terry Fowler	161 Hospital Dr.		731-352-2733			Kevin Harvey	CFO
Randy Cooper	McKenzie, TN 38201					Penny Kirby	CNO
John McClellan	McKenzie Tennessee Hospital Company, LLC (DE)					Kim Ladd	Quality Director
Neil Heatherly							
	Springfield, Oregon						
(4)Bill Hussey	McKenzie-Willamette Medical Center	114	541-726-4401	154	1706	Maurine Cate	CEO
Stephanie Moore	1460 G Street		541-726-4540			Jason McLaughlin	CFO
Tim Puthoff	Springfield, OR 97477					Dale Koger	ACFO
Brad Cash	McKenzie-Willamette Regional Medical					OPEN	COO
Tim Hingtgen	Center Associates, LLC (DE)					Vivian Hoppe	CNO
						Margaret Silebi	Quality Director

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(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Selmer, Tennessee** McNairy Regional Hospital 705 Poplar Ave. Selmer, TN 38375 McNairy Hospital Corporation (TN)	45	731-645-3221 731-645-8275	083	0183	Pamela Roberts Meredith Jones Christy McDonald Jeni Crumby, RN	CEO CFO CNO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Bennettsville, South Carolina** Marlboro Park Hospital 1138 Cheraw Hwy (P.O. Box 738) Bennettsville, SC 29512 Chesterfield/Marlboro, L.P. (DE)	102	843-479-2881 843-479-5860	050	0144	Jeff Reece Troy Pickens Anita Crawford Candace Morton	CEO CFO CNO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Williamston, North Carolina** Martin General Hospital 310 S. McCaskey Road Williamston, NC 27892 Williamston Hospital Corporation (NC)	49	252-809-6179 252-809-6263	056	0154	Glenn Carney Kevin Randall OPEN Jo Anne Nance Susan Hyatt	CEO CFO ACFO CNO QMRC Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Spartanburg, South Carolina** Mary Black Health System 1700 Skylyn Drive Spartanburg, SC 29307 Mary Black Health System, LLC (DE)	209	864-573-3000 864-573-3277	108	1606	Doug Moyer Rich Meyer Christine Poplawski Chanda Flynn OPEN David Cope Nancy White	CEO CFO ACFO CNO ACEO COO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Palmer, Alaska** Mat-Su Regional Medical Center 2500 S. Woodworth Loop (P.O. Box 1687) Palmer, AK 99645 Mat-Su Valley Medical Center, LLC (AK)	74	907-861-6000 907-861-6559	153	1645	Tim Puthoff Gary Singer Michael Zielaskiewicz OPEN Lynn Gauthier	Interim CEO Interim CFO CNO COO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Enterprise, Alabama** Medical Center Enterprise 400 North Edwards Street Enterprise, AL 36330 QHG of Enterprise, Inc. (AL)	131	334-347-0584 334-347-2080	125	1590	Jeff Brannon Greg McGilvray Ann O'Neill Chad McCollough Lydia Rhodes	CEO CFO CNO ACNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**El Dorado, Arkansas** Medical Center of South Arkansas 700 W. Grove Street El Dorado, AR 71730 MCSA, LLC (AR)	166	870-863-2000 870-863-5442	147	1548	America Farrell Ben Casmer Ken Pannell Keitha Griffith Roseann Hodoba	CEO ACEO CFO CNO Chief Quality Director
(3)Marty Smith Terry Fowler John McClellan Neil Heatherly	**Salem, New Jersey** The Memorial Hospital of Salem County 310 Woodstown Road Salem, NJ 08079 Salem Hospital Corporation (NJ)	140	856-935-1000 856-935-3175	076	0173	Jim Angle Kelly Schirmer Don Bevers Pat Sherle Marla Maybrook	CEO ACEO CFO CNO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Mesquite, Nevada** Mesa View Regional Hospital 1299 Bertha Howe Avenue (P.O. Box 3540 / zip 89024-3540) Mesquite, NV 89027 MMC of Nevada, LLC (DE)	25	702-346-8040 702-346-7031	120	1531	Sue Conley Eric Hardy Josephine Sciacca Josephine Sciacca	CEO CFO CNO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Deming, New Mexico** Mimbres Memorial Hospital 900 W. Ash Street Deming, NM 88030 Deming Hospital Corporation (NM)	49	575-546-5800 575-543-6907	046	0142	Bill Quitmeyer Suzanne Hebert Gwenda McClure Charles Hickis	CEO CFO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko	**Moberly, Missouri** Moberly Regional Medical Center 1515 Union Avenue Moberly, MO 65270 Moberly Hospital Company, LLC (DE)	103	660-263-8400 660-269-3091	024	0118	Stephen Lunn Chris Jones Tracey Matheis Carla Bell Jennifer Dunkin	CEO ACEO CFO CNO Quality Director

Division (#) V.P.	Hospital Name and Address / Corporate Owner / State of Incorporation	Lic. Beds	Phone/ Fax No.	Speed Dial	Acctg Code	Executive Names	Executive Titles
	Tooele, Utah						
(4)Bill Hussey	Mountain West Medical Center	35	435-843-3600	012	0165	Kelly Duffin	CEO
Stephanie Moore	2055 N. Main		435-882-8770			Scott Banks	CFO
Tim Puthoff	Tooele, UT 84074-2794					Mike Sellers	CNO
Brad Cash	Tooele Hospital Corporation (UT)					Yvonne Nielson	Quality Director
Tim Hingtgen							
	Las Cruces, New Mexico						
(4)Bill Hussey	MountainView Regional Medical Center	168	575-556-7610	121	1892	Denten Park	CEO
Stephanie Moore	4311 East Lohman Avenue		575-556-7619			Gene Alexander	CFO
Tim Puthoff	Las Cruces, NM 88011					John Chaddock	ACFO
Brad Cash	Las Cruces Medical Center, LLC (DE)					Gayle Nash	Interim CNO
Tim Hingtgen						OPEN	COO
						Karen Anderson	Quality Director
	Corsicana, Texas						
(2)Michael Portacci	Navarro Regional Hospital	162	903-654-6800	122	1629	Xavier Villarreal	CEO
Dave Medley	3201 W. Highway 22		903-654-6955			Jerome Brooks	ACEO
Tim Adams	Corsicana, TX 75110					Marco Rodgriguez	CFO
Mike Healey	Navarro Hospital, L.P. (DE)					Robbin Odom	CNO
Mike Garfield						OPEN	Quality Director
	Crestview, Florida						
(1)David Miller	North Okaloosa Medical Center	110	850-689-8100	045	0141	David Sanders	CEO
Shan Carpenter	151 Redstone Avenue, S.E.		850-689-8484			Tonda Haigler	ACEO
Woody Fields	Crestview, FL 32539-6026					Jim Andrews	CFO
Eric Roach	Crestview Hospital Corporation (FL)					Steve Davis	ACFO
Paul Smith						Nina Perez	CNO
						Melinda Isphording	Quality Director
	Kirksville, Missouri						
(5)Tom Miller	Northeast Regional Medical Center	115	660-785-1000	065	0166	Bob Moore	CEO
Ron Shafer	315 S. Osteopathy		660-785-1110			Ranee Brayton	Assc CEO
Mike Douzuk	Kirksville, MO 63501					Tom Luebbering	CFO
Gary Ladyko	Kirksville Missouri Hospital Co., LLC (MO)					Cindy Carter	CNO
Cully Chapman						OPEN	ACNO
						Peggy Parks	Quality Director
	Ruston, Louisiana						
(2)Michael Portacci	Northern Louisiana Medical Center	159	318-254-2100	102	0126	Doug Sills	CEO
Dave Medley	401 East Vaughn Avenue		318-254-2728			James McClung	ACEO
Tim Adams	Ruston, LA 71270					Frank Malek	CFO
Mike Healey	Ruston Louisiana Hospital Company, LLC (DE)					Jan Thornton	CNO
Mike Garfield						Curtis Newton	ACNO
						Karin Jones	Quality Director
	Tucson, Arizona						
(4)Bill Hussey	Northwest Medical Center	300	520-742-9000	109	1730	Paul Kappelman	CEO
Stephanie Moore	6200 N. LaCholla Blvd.		520-469-8101			Farron Sneed	ACEO
Tim Puthoff	Tucson, AZ 85741					Andy Wills	ACEO
Brad Cash	Northwest Hospital, LLC (DE)					Ron Patrick	CFO
Tim Hingtgen						OPEN	ACFO
						Maurene Stricker	ACFO
						Janis Offret	CNO
						Julie Hunt	ACNO
						Norma Dykman	Quality Director
	Bentonville, Arkansas						
(2)Michael Portacci	Northwest Medical Center - Bentonville	128	479-553-1000	131	1516	Doug Arnold	CEO
Dave Medley	3000 Medical Center Pkwy.		479-553-1900			Hoyt "Tripp" Smith	COO
Tim Adams	Bentonville, AR 72712					Stanton Tait	CFO
Mike Healey	Northwest Arkansas Hospitals, LLC (DE)					Eddie Klein	Market CFO
Mike Garfield						Dwayne Eckley	ACFO
						Holly Holiman	CNO
						Michael Moorehead	ACNO
						Juli McWhorter	System Quality Director
	Springdale, Arkansas						
(2)Michael Portacci	Northwest Medical Center - Springdale	222	479-751-5711	132	1550	Doug Arnold	CEO
Dave Medley	609 W. Maple		479-757-2908			Lee Christenson	COO
Tim Adams	Springdale, AR 72764					Paul Storey	ACEO
Mike Healey	Northwest Arkansas Hospitals, LLC (DE)					Eddie Klein	Market CFO
Mike Garfield						Carin Lyne	CNO
						Robin Clark	Quality Director
						Juli McWhorter	System Quality Director
	Oro Valley, Arizona						
(4)Bill Hussey	Oro Valley Hospital	144	520-901-3500	110	1528	Shawn Strash	CEO
Stephanie Moore	1551 E. Tangerine Road		520-901-3525			Leonard Binkley	Interim CFO
Tim Puthoff	Oro Valley, AZ 85755					Deanna Martin	CNO
Brad Cash	Oro Valley Hospital, LLC (DE)					Patricia Rhoden	ACFO
Tim Hingtgen						Kirkpatrick (Kapua) Conley	ACEO
						Donna Zubay	Quality Director

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(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Fort Wayne, IN** The Orthopedic Hospital of Lutheran Health Network 700 Broadway Fort Wayne, IN 46802 Lutheran Musculoskeletal Center, LLC (DE)	39	260-435-2999 260-435-7632	160	1925	Joe Dorko Michael McCullough Shelly Miller Diane Springer Mary Ellen Brill	CEO CFO COO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Fulton, Kentucky** Parkway Regional Hospital 2000 Holiday Lane (P.O. Box 866) Fulton, KY 42041 Hospital of Fulton, Inc. (KY)	70	270-472-2522 270-472-8148	013	0112	Brenda Hamilton Dana Lawrence Libby Larkins Donna Hacker	CEO CFO CNO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Payson, Arizona** Payson Regional Medical Center 807 South Ponderosa Payson, AZ 85541 Payson Hospital Corporation (AZ)	44	928-474-3222 928-472-1295	044	0150	Chris Wolf OPEN Peter Finelli Hart Hintze Rebecca Nissila	CEO ACEO CFO CNO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Phoenixville, Pennsylvania** Phoenixville Hospital 140 Nutt Road Phoenixville, PA 19460 Phoenixville Hospital Company, LLC (DE)	196	610-983-1000 610-983-1488	090	0177	Steve Tullman Rich Galup Jacqueline Nalls Andrew Weitkamp Sarah Strzelecki Sue Reichenbach	CEO ACEO CFO ACFO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Oak Hill, West Virginia** Plateau Medical Center 430 Main Street Oak Hill, WV 25901 Oak Hill Hospital Corporation (WV)	25	304-469-8600 304-469-8605	075	0175	Chad Towner Heather (Carr) Hylton Randy Thompson Alison Suptic	CEO CFO CNO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Ponca City, Oklahoma** Ponca City Medical Center 1900 North 14th Street Ponca City, OK 74601 Kay County Oklahoma Hospital Company, LLC (OK)	140	580-765-3321 580-765-0341	098	0195	Andy Wachtel Nikia Beene Scott Bailey Jeanne Stara Carla Hobbs	CEO ACEO CFO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Valparaiso, Indiana** Porter 814 LaPorte Avenue Valparaiso, IN 46383 Porter Hospital, LLC (DE)	301	219-263-4600 219-263-4882	103	0137	Jonathan Nalli Bill Cummins Cheryl Harmon Taffy Arias Amy Hochstetler Rayanna Henderson	CEO COO CFO CNO ACFO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Pottstown, Pennsylvania** Pottstown Memorial Medical Center 1600 East High Street Pottstown, PA 19464 Pottstown Hospital Company, LLC (DE)	215	610-327-7000 610-327-7432	086	0187	John Kirby Scott Weiskittel Mike Zwetschkenbaum Sharif Omar Brian Balutanski Kim Jack Brian Barth Patricia Ball-Wozniak	CEO ACEO CFO COO ACFO CNO ACNO Chief Quality Officer
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Red Bud, Illinois** Red Bud Regional Hospital 325 Spring Street Red Bud, IL 62278 Red Bud Illinois Hospital Company, LLC (IL)	35	618-282-3831 618-282-6101	067	0168	Shane Watson David Jones Sue Odle Tammy Love	CEO CFO CNO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Jackson, Tennessee** Regional Hospital of Jackson 367 Hospital Blvd. Jackson, TN 38305 Jackson, Tennessee Hospital Company, LLC (TN)	154	731-661-2000 731-661-2187	080	0179	Steve Grubbs Dale Humphrey Richard Read Roseann Devault Jan Zimmer Yvetter Sumler	CEO ACEO CFO ACFO CNO Chief Quality Officer
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Vicksburg, Mississippi** River Region Health System 2100 Highway 61 North Vicksburg, MS 39183 Vicksburg Healthcare, LLC (DE)	372	601-883-5000 601-883-5197	123	1612	Vance Reynolds OPEN John Milazzo LaKesha Jimmerson Craig Fichter Linda Wymbs Wanda McClain Mary Jane Karnes	CEO COO CFO ACEO ACFO CNO ACNO Quality Director

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(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**San Angelo, Texas** San Angelo Community Medical Center 3501 Knickerbocker Road San Angelo, TX 76904 San Angelo Hospital, L.P. (DE)	171	325-949-9511 325-947-6550	155	1574	Brad Holland Emma Krabill Richard Ervin Susan Parker Cecil Jameson Irene Walter Becky Brandon	CEO ACEO CFO ACFO CNO ACNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Big Spring, Texas** Scenic Mountain Medical Center 1601 West Eleventh Place Big Spring, TX 79720 Big Spring Hospital Corporation (TX)	150	432-263-1211 432-263-0151	037	0135	Larry Rodgers OPEN Michael Ruff OPEN Judy Roever Amy Miramontes	Interim CEO ACEO CFO ACFO CNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Siloam Springs, AR** Siloam Springs Memorial Hospital 205 E. Jefferson Street Siloam Springs, AR 72761 Siloam Springs Arkansas Hospital Company, LLC (DE)	077	479-524-4141 479-549-2645	158	1511	Kevin Clement Jim Little Cindy Kugel Karen Lee	CEO CFO CNO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Cleveland, Tennessee** SkyRidge Medical Center 2305 Chambliss Avenue Cleveland, TN 37311 Cleveland Tennessee Hospital Company, LLC (DE)	351	423-559-6000 423-559-6653	094	193/127	Coleman Foss Lisa Childers Adam Portacci Bill Ziesmer Karla Stokes Bernadette DePrez Laura Franklin Jeanette Fetter	CEO ACEO Asst. Administrator CFO ACFO CNO / ACEO ACNO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Foley, Alabama** South Baldwin Regional Medical Center 1613 North McKenzie Street Foley, AL 36535 Foley Hospital Corporation (AL)	112	251-949-3400 251-943-7147	062	0164	Michael Neuendorf Chris Cosby Charles Coder Shea Brock Margaret Roley Sharon Dunkin	CEO ACEO CFO ACFO CNO Quality Director
(2)Michael Portacci Dave Medley Tim Adams Mike Healey Mike Garfield	**Jourdanton, Texas** South Texas Regional Medical Center 1905 Highway 97 E Jourdanton, TX 78026 Jourdanton Hospital Corporation (TX)	67	830-769-3515 830-769-5264	071	0171	Jim Resendez Jerry (Gerardo) Flores Gary Redmon Jerry (Gerardo) Flores Rita Castillo	CEO ACEO/CNO CFO CNO/ACEO Chief Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Franklin, Virginia** Southampton Memorial Hospital 100 Fairview Drive Franklin, VA 23851 Franklin Hospital Corporation (VA)	105	757-569-6100 757-569-6390	060	0162	David Fuller Kim Marks Steve Ramey Laurie Ross Lucy Drew	CEO ACEO CFO CNO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Tulsa, Oklahoma** SouthCrest Hospital 8801 S. 101st East Avenue Tulsa, OK 74133 SouthCrest, LLC (OK)	180	918-294-4000 918-294-4809	111	1880	Tony Young Kyle McCann Matt Romero Delores Copp Paige Treston Judy Dodson	CEO COO CFO CNO ACFO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Emporia, Virginia** Southern Virginia Regional Medical Center 727 North Main Street Emporia, VA 23847 Emporia Hospital Corporation (VA)	80	434-348-4400 434-348-4933	059	0157	Brit Phelps Michael Cotton Elizabeth Chaparro Anita Ivey	CEO CFO CNO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Petersburg, Virginia** Southside Regional Medical Center 200 Medical Park Blvd. Petersburg, VA 23805 Petersburg Hospital Company, LLC (VA)	300	804-765-5000 804-765-5948	085	0188	David Fikse Parkes Coggins Steve Embree Ed Sopiarz Christine Markowitz OPEN Phil Wright Mary Hicks Beverly Smith Ellen Buchanan Deanna Remmich	CEO ACEO CFO ACFO ACFO COO ACEO Director of Finance CNO Asst CNO Quality Director

Attachment 10

93C

Division (#) VP	Hospital Name and Address Corporate Owner / State of Incorporation	Lic. Beds	Phone/ Fax No.	Speed Dial	Acctg Code	Executive Names	Executive Titles
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Lancaster, South Carolina** Springs Memorial Hospital 800 W. Meeting Street Lancaster, SC 29720 Lancaster Hospital Corporation (DE)	231	803-286-1214 803-286-1367	042	0138	Doug Arbour Janice Dabney OPEN Nathan Crabdree Elmer Polite Karen Martin Judy Robinson	CEO ACEO COO CFO ACFO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Fort Wayne, Indiana** St. Joseph Hospital 700 Broadway Fort Wayne, IN 46802 St. Joseph Health System, LLC (DE)	191	260-425-3000 260-425-3222	148	1545	Dawn Rudolph Pam Hess Cheryl Rieves Brandon Haushalter Vickie Magurean Michelle Martin	CEO CFO CNO COO ACFO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper John McClellan Neil Heatherly	**Sunbury, Pennsylvania** Sunbury Community Hospital 350 N. Eleventh Street (P. O. Box 737) Sunbury, PA 17801 Sunbury Hospital Company, LLC (DE)	92	570-286-3333 570-286-3500	093	0194	Jeff Hunt Anthony Tortella Kathy Springman Susan Legros	CEO CFO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Louisa, Kentucky** Three Rivers Medical Center 2483 Highway 644 (P.O. Box 769) Louisa, KY 41230 Hospital of Louisa, Inc. (KY)	90	606-638-9451 606-638-9494	023	0117	Greg Kiser Adam Cruse Cathy Heston Betty Slone	CEO CFO CNO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Augusta, Georgia** Trinity Hospital of Augusta 2260 Wrightsboro Road Augusta, GA 30904 Augusta Hospital, LLC (DE)	231	706-481-7000 706-481-7599	N/A	1536	Jim Cruickshank Jason Studley Marc Nakagawa Jennifer Wehunt Robyn Stowell OPEN Dorothy Lowry	CEO ACEO CFO ACFO CNO COO Quality Director
(1)David Miller Shan Carpenter Woody Fields Eric Roach Paul Smith	**Birmingham, Alabama** Trinity Medical Center 800 Montclair Road Birmingham, AL 35213 Affinity Hospital, LLC (DE)	534	205-592-1000 205-592-5653	134	1583	Keith Granger Pat Trammell Julie Soekoro Brent White Kevin Cargill Andy Romine Pattie Ellis Sean Dardeau Bill Heburn Jane Northcutt	CEO ACEO CFO Project CFO ACFO CNO ACNO COO CDO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Anna, Illinois** Union County Hospital 517 North Main Anna, IL 62906 Anna Hospital Corporation (IL)	36	618-833-4511 618-833-8481	068	0125	Jim Farris Terry Paligo Jeanette Hook Toni Capel	CEO CFO CNO Quality Director
(4)Bill Hussey Stephanie Moore Tim Puthoff Brad Cash Tim Hingtgen	**Spokane Valley, Washington** Valley Hospital and Medical Center 12606 East Mission Avenue Spokane Valley, WA 99216 Spokane Valley Washington Hospital Company, LLC	123	509-924-6650			Dennis Barts Justin Voelker Lisa Noland Michaela Graff	CEO CFO CNO Quality Director
(5)Tom Miller Ron Shafer Mike Douzuk Gary Ladyko Cully Chapman	**Waukegan, Illinois** Vista Medical Center 1324 N. Sheridan Road Waukegan, IL 60085 Waukegan Illinois Hospital Company, LLC (IL)	407	847-360-3000 847-360-4109	100	0186	Barb Martin Joe Hurshe Steve Clark Marc Trznadel Eileen Barnes	CEO COO Interim CFO CNO Quality Director
(3)Marty Smith Terry Fowler Randy Cooper ohn McClellan Neil Heatherly	**Martin, Tennessee** Volunteer Community Hospital 161 Mt. Pelia Road Martin, TN 38237 Martin Hospital Corporation (TN)	100	731-587-4261 731-588-3209	084	0184	Steven Westenhofer John Conti Donna Barfield Lori Brown	CEO CFO CNO CQO

Division (#) V.P.	Hospital Name and Address Corporate Owner / State of Incorporation	Lic Beds	Phone/ Fax No.	Speed Dial	Acctg Code	Executive Names	Executive Titles
	Watsonville, California						
(4)Bill Hussey	Watsonville Community Hospital	106	831-724-4741	004	0152	Jae Dale	CEO
Stephanie Moore	75 Nielson Street		831-728-4758			OPEN	Assc CEO
Tim Puthoff	Watsonville, CA 95076					Mark Hoffman	CFO
Brad Cash	Watsonville Hospital Corporation (DE)					Sherri Stout	CNO
Tim Hingtgen						Lynne Langholz	Quality Director
	Weatherford, Texas						
(2)Michael Portacci	Weatherford Regional Medical Center	99	817-596-8751	101	0104	Donnie Romine	CEO
Dave Medley	713 E. Anderson Street		817-599-1148			Brady DuBois	ACEO
Tim Adams	Weatherford, TX 76086					Nancy Cooke	CFO
Mike Healey	Weatherford Texas Hospital Company, LLC (TX)					Donna Boone	CNO
Mike Garfield						Jeannette McCammack	Quality Director
	Hattiesburg, Mississippi						
(1)David Miller	Wesley Medical Center	211	601-268-8000	112	1633	Ron Seal	CEO
Shan Carpenter	5001 Hardy Street		601-268-5008			OPEN	CFO
Woody Fields	Hattiesburg, MS 39402					Charles Hester	Project CFO
Eric Roach	Wesley Health System, LLC (DE)					Susan Morgan	ACFO
Paul Smith						Andrea Brenn	CNO
						Travis Sisson	COO
						Betty Entrekin	Quality Director
	Bullhead City, Arizona						
(4)Bill Hussey	Western Arizona Regional Medical Center	139	928-763-2273	064	0163	Barry Schneider	CEO
Stephanie Moore	2735 Silver Creek Road		928-704-6785			Michael Morrical	COO
Tim Puthoff	Bullhead City, AZ 86442					Marty Brockman	CFO
Brad Cash	Bullhead City Hospital Corporation (AZ)					Kelly Ann Speckman	ACFO
Tim Hingtgen						Joanne Kimball	CNO
						Bridgette Haskins	ACNO
						Pat Timpe	Quality Director
	Johnson, Arkansas						
(2)Michael Portacci	Willow Creek Women's Hospital	64	479-684-3000	135	1551	Doug Arnold	CEO
Dave Medley	4301 Greathouse Springs Rd.		479-684-3113			Eddie Klein	Market CFO
Tim Adams	(P.O. Box 544)					Carol Gore	CNO
Mike Healey	Johnson, AR 72741					Juli McWhorter	Systerm Quality Director
Mike Garfield	Northwest Arkansas Hospitals, LLC (DE)						
	Wilkes - Barre, Pennsylvania						
(3)Marty Smith	Wilkes-Barre General Hospital	553	570-829-8111	159	1507	Cor Catena	CEO
Terry Fowler	575 North River Street		479-549-2645			John Fletcher	COO
Randy Cooper	Wilkes-Barre, PA 18764-0001					Roy Boyd	CFO
John McClellan	Wilkes-Barre Hospital Company, LLC (DE)					Jason Miller	CFO
Neil Heatherly						Mike Panisak	ACFO
						Bob Hoffman	CNO
						Joan Keis	Quality Director
	Lake Charles, Louisiana						
(2)Michael Portacci	Women & Children's Hospital	88	337-474-6370	113	1604	Rich Robinson	CEO
Dave Medley	4200 Nelson Road		337-475-4143			Dawn Johnson-Hatcher	CFO
Tim Adams	Lake Charles, LA 70605					Jobie James	ACFO
Mike Healey	Women & Children's Hospital, LLC (DE)					Chad French	ACEO
Mike Garfield						Charlene Warren	CNO
						Roman Jenks	ACNO
						Kathy Armentor	Quality Director
	Lufkin, Texas						
(2)Michael Portacci	Woodland Heights Medical Center	149	936-634-8311	157	1626	Casey Robertson	Interim CEO
Dave Medley	505 S. John Redditt Drive		936-637-8600			Casey Robertson	ACEO
Tim Adams	(P.O. Box 150610 / zip 75915)					Sam Minkowitz	CFO
Mike Healey	Lufkin, TX 75904					Cathy Busbee	CNO
Mike Garfield	Piney Woods Healthcare System, L.P. (DE)					Jannett Fowler	Quality Director
	Woodward, Oklahoma						
(4)Bill Hussey	Woodward Regional Hospital	87	580-256-5511	114	1712	Lavah Lowe	CEO
Stephanie Moore	900 17th Street		580-254-8418			Tom Earley	CFO
Tim Puthoff	Woodward, OK 73801					Steve Owens	CNO
Brad Cash	Woodward Health System, LLC (DE)					Karen Thomas	Quality Director
Tim Hingtgen							

State of Illinois 1927360

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of The State of Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/10	BGBD	0005397

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/09

BUSINESS ADDRESS

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC
D/B/A VISTA MEDICAL CENTER EAST
1324 NORTH SHERIDAN ROAD

WAUKEGAN IL 60085

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

State of Illinois 1927361

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/10	BGBD	0005405

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/09

BUSINESS ADDRESS

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC
D/B/A VISTA MEDICAL CENTER WEST
2615 WASHINGTON STREET

WAUKEGAN IL 60085

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ATTACHMENT - 10

State of Illinois 1938096

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/10	BGBD	7003115

FULL LICENSE

AMBUL SURGICAL TREAT CNTR

EFFECTIVE: 07/01/09

BUSINESS ADDRESS

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC
D/B/A VISTA SURGERY CENTER
1050 RED OAK LANE

LINDENHURST IL 60046

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 1938096

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LI

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/10	BGBD	7003115

FULL LICENSE

AMBUL SURGICAL TREAT CNTR

EFFECTIVE: 07/01/09

07/11/09

WAUKEGAN ILLINOIS HOSP COMP,LLC
D/B/A VISTA SURGERY CENTER
1050 RED OAK LANE
LINDENHURST IL 60046

FEE RECEIPT NO. 376

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ATTACHMENT - 10

The Joint Commission

October 2, 2008

Barbara Martin
CEO
Waukegan IL Hospital Company, LLC
1324 North Sheridan Road
Waukegan, IL 60085

Joint Commission ID #: 7442
Accreditation Activity: Evidence of Standards Compliance
Accreditation Activity Completed: 9/25/2008

Dear Mrs. Martin:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing

This accreditation cycle is effective beginning September 17, 2008. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 25 months.

Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

The following laboratory services have been surveyed under Joint Commission standards in accordance with the Clinical Laboratory Improvement Amendments of 1988 :

CLIA# 14D0666924 for the specialties and subspecialties of Bacteriology, Mycobacteriology, Mycology, Parasitology, Virology, Syphilis Serology, General Immunology, Routine Chemistry, Urinalysis, Endocrinology, Toxicology, Andrology, Coagulation, Hematology, Immunohematology(ABO Group and RH, Antibody Transfusion, Antibody Non-Transfusion, Antibody Identification, Compatibility Testing), Histopathology, Oral Pathology, Dermatopathology, Cytology and Tissue Banking.
CLIA# 14D0674690 for the specialties and subspecialties of Routine Chemistry, Toxicology and Hematology.
CLIA# 14D0961464 for the specialties and subspecialties of Routine Chemistry, Urinalysis, Coagulation and Hematology.
CLIA# 14D1050930 for the specialties and subspecialties of Routine Chemistry.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that the Joint Commission will keep the report confidential, except as required by law. To ensure that the Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

The Joint Commission

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

The Joint Commission

June 13, 2008

Virginia Mendoza, Registered Pharmacis
Director of Pharmacy
Waukegan Illinois Hospital Co., LLC
1050 Red Oak Lane
Lindenhurst, IL 60046

Joint Commission ID #: 352009
Accreditation Activity: Evidence of Standards Compliance
Accreditation Activity Completed: 6/13/2008

Dear Ms. Mendoza:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Ambulatory Health Care

This accreditation cycle is effective beginning April 23, 2008. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that the Joint Commission will keep the report confidential, except as required by law. To ensure that the Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Linda S. Murphy-Knoll

Linda S. Murphy-Knoll
Interim Executive Vice President
Division of Accreditation and Certification Operations

The Joint Commission

February 4, 2009

Barbara Martin
Chief Executive Officer
Waukegan IL Hospital Company, LLC
2615 Washington Street
Waukegan, IL 60085

Joint Commission ID #: 7441
Accreditation Activity: Evidence of Standards Compliance
Accreditation Activity Completed: 10/2/2008

Dear Mrs. Martin:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care
- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning July 25, 2008. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

ATTACHMENT - 10

The Joint Commission

March 17, 2009

Barbara Martin
Chief Executive Officer
Waukegan IL Hospital Company, LLC
2615 Washington Street
Waukegan, IL 60085

Joint Commission ID #: 7441
Program: Laboratory Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 03/17/2009

Dear Mrs. Martin:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing

This accreditation cycle is effective beginning March 16, 2009. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 25 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

The following laboratory services have been surveyed under Joint Commission standards in accordance with the Clinical Laboratory Improvement Amendments of 1988 :

CLIA# 14D1066835 for the specialties and subspecialties of Bacteriology, Parasitology, Virology, General Immunology, Routine Chemistry, Urinalysis, Endocrinology, Toxicology, Coagulation, Hematology and Immunohematology(ABO Group and RH).

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

The Joint Commission

September 9, 2009

Barbara Martin
CEO
Waukegan IL Hospital Company, LLC
1324 North Sheridan Road
Waukegan, IL 60085

Joint Commission ID #: 7442
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 09/09/2009

Dear Mrs. Martin:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning May 08, 2009. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

VISTA HEALTH SYSTEM

March 23, 2010

Illinois Health Facilities and Services Review Board
525 West Jefferson Street
Springfield, IL 62761

To Whom It May Concern:

Please be advised that two adverse actions have been taken by IDPH or CMMS against provider entities related to Community Health Systems, Inc. as discussed in the attached.

Further, the Illinois Health Facilities and Services Review Board, IDPH and their respective staffs are hereby granted authorization to access any records or documents necessary to verify the information submitted, including the records of Community Health Systems, Inc. and related licensed health care facilities concerning those facilities' licensure and certification.

Sincerely,

Barbara M. Martin
President and Chief Executive Officer

Notarized:

Barbara J. Martin, on March 23, 2010
did personally appear before me and
originally signed this document

By: ______________
Notary Public

"OFFICIAL SEAL"
JAYLON HOLDEN
Notary Public, State of Illinois
My Commission Expires 06/25/11

Red Bud, IL – Red Bud Regional Hospital

Based on an Illinois Department of Public Health survey that occurred on March 2009, the Centers for Medicare and Medicaid Services ("CMS") issued a notice in April 2009 that Red Bud Regional Hospital's Nursing Facility was out of compliance with three certification requirements. As a result, CMS imposed a Civil Money Penalty of $400 per day for each day of non-compliance which totaled $9,600. Although in the corrective action plan that was filed, the facility did not contest two of the allegations, it appealed the G level of the third allegation. Prior to hearing, the parties settled the matter for $8,160 in November 2009.

Marion, IL – Heartland Regional Medical Center

Based on an Illinois Department Public Health survey that occurred on September 2009, the Centers for Medicare and Medicaid Services ("CMS") issued a 23 day notice to terminate the facility's participating provider status. A Corrective Action Plan was submitted to CMS which was subsequently accepted.

Pursuant to a IDPH resurvey in October 2009, CMS indicated that was rescinding the 23 day notice of termination, however, it issued a 90 day notice of termination based on various life safety deficiencies. As result, a Corrective Action Plan was filed. Through a series of subsequent communications and surveys by IDPH, the facility received notice from CMS in March 2010 that the facility was in compliance with the conditions of participation and therefore, CMS was rescinding the 90 day notice of termination.

PURPOSE OF PROJECT

The purpose of the proposed project is to improve accessibility to emergency services for the residents of north-central and northwestern Lake County. Patients in need of emergency care, as opposed to "urgent" care, are most often transported to an emergency room by a rescue squad or ambulance. The three closest emergency rooms to Lindenhurst are located at Vista Medical Center-East, located 13.9 miles to the east southeast; Condell Medical Center, located 14.6 miles to the south southeast; and Northern Illinois Medical Center, 16.9 miles to the southwest.

The table below identifies the 2008 area ER utilization, as reported in the hospital's IDPH *Profiles*.

2008 Utilization of Emergency Departments located in the GSA

Hospital	Location	Visits (1)
Northern Illinois Medical Center	McHenry	38,938
Vista Medical Center - East	Waukegan	36,469
Vista Medical Center- West	Waukegan	12,018
Midwestern Regional Med. Ctr. (2)	Zion	5,244
Lake Forest Hospital	Lake Forest	33,690
Highland Park Hospital	Highland Park	26,251
Condell Medical Center	Libertyville	45,944
Advocate Good Shepherd Hospital	Barrington	32,840
		231,394

(1) per IDPH *Profiles*
(2) no longer accepts ambulances

The data presented above documents 231,394 visits during 2008, the most recent data available to the co-applicants. Effective May 1, 2008 Midwestern Regional Medical Center in Zion has ceased accepting ambulance transports to its emergency room, and its ER has been reduced to "stand-by" status.

CompDATA was used to calculate ED visits in the GSA for the two most recent years data was available: October 2007 - September 2008 (2008) and October 2008 - September 2009 (2009). We recognize the CompDATA shows different ED visit totals than does IDPH data for

2008. This may be based on different reporting methods, or the fact that the CompDATA calculation was not on a calendar year basis. CompDATA shows, for hospitals in the GSA, 186,355 total ED visits in 2008 and 205,894 total ED visits in 2009. Using CompDATA to conduct a zip code analysis, 139,127 ED visits in 2008 were by patients who reside in zip codes within the GSA, and 156,055 of the ED visits in 2009 were by patients who reside in zip codes within the GSA. Based on this, 74.6% of 2008 ED visits at hospitals in the GSA were by patients who resided within the GSA, and 75.8% of 2009 ED visits at hospitals in the GSA were by patients who resided within the GSA. Hospital-specific ED visits can be found in the attached CompDATA information.

Approximately 85% of the proposed FEC's patients are anticipated to come from the target population area (TPA) identified in said map, and which consists of that portion of Lake County located closer to the proposed site than to any existing hospital-based emergency department; ZIP code areas 60002 (Antioch), 60046 (Lindenhust/Lake Villa) and 60073 (Round Lake) and portions of five others. The vast majority of the remaining 15% of the anticipated patients will, it is believed, come from other parts of the GSA (and possibly from southern Wisconsin).

As this project relates to accessibility, restricted services exist, per Section 1110.3230, when one or more of three situations occur: 1) there are no emergency departments in the GSA; 2) the GSA exhibits indicators of medical care problems; or 3) all existing emergency services in the GSA meet or exceed the IDPH's utilization standard. Among the indicators of medical care problems identified in Section 1110.3230 is "...designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or Medically Underserved Population. Attached is documentation from the U.S. Department of Health and Human Services, showing three townships, all of which are located in the northeastern portion of the GSA, being identified as Health Professional Shortage Areas for primary medical care.

Lastly, attached is a letter from the Village of Lindenhurst endorsing the project.

9278899_v2

Case Trend Analysis

COMPdata

COMPdata Report: ER PATIENTS MARKET SHARE FOR ANNE ALL ZIPS

Reporting Period: 10/01/2007 THROUGH 09/30/2009

03/18/2010

Page 1

PROVIDER FACILITY	CASES 10/01/2008 - 09/30/2009	CASES 10/01/2007 - 09/30/2008	CASES % Change	CASES % Change	CASES % Change	SHARE 10/01/2008 - 09/30/2009	SHARE 10/01/2007 - 09/30/2008	SHARE % Change	SHARE % Change	SHARE % Change
ADVOCATE CONDELL MEDICAL CENTER	49,129	45,126	8.87			23.9	24.2	-1.46		
ADVOCATE GOOD SHEPHERD HOSPITAL	8,125	8,895	-8.66			3.9	4.8	-17.33		
CENTEGRA HOSPITAL - MCHENRY	36,390	30,153	20.69			17.7	16.2	9.23		
MIDWESTERN REGIONAL MEDICAL CENTER	4,468	420	963.81			2.2	0.2	864.44		
NORTHSHORE UNIVERSITY HEALTHSYSTEM HIGHL/	24,502	23,621	3.73			11.9	12.7	-6.11		
NORTHWESTERN LAKE FOREST HOSPITAL	33,469	34,271	-2.34			16.3	18.4	-11.61		
VISTA MEDICAL CENTER EAST	35,813	37,412	-4.27			17.4	20.1	-13.36		
VISTA MEDICAL CENTER WEST	13,998	6,458	116.75			6.8	3.5	96.22		
TOTAL:	205,894	186,356	10.48			100.0	100.0	115.00		

106B

Case Trend Analysis

ZIPS WITHIN THE GSA

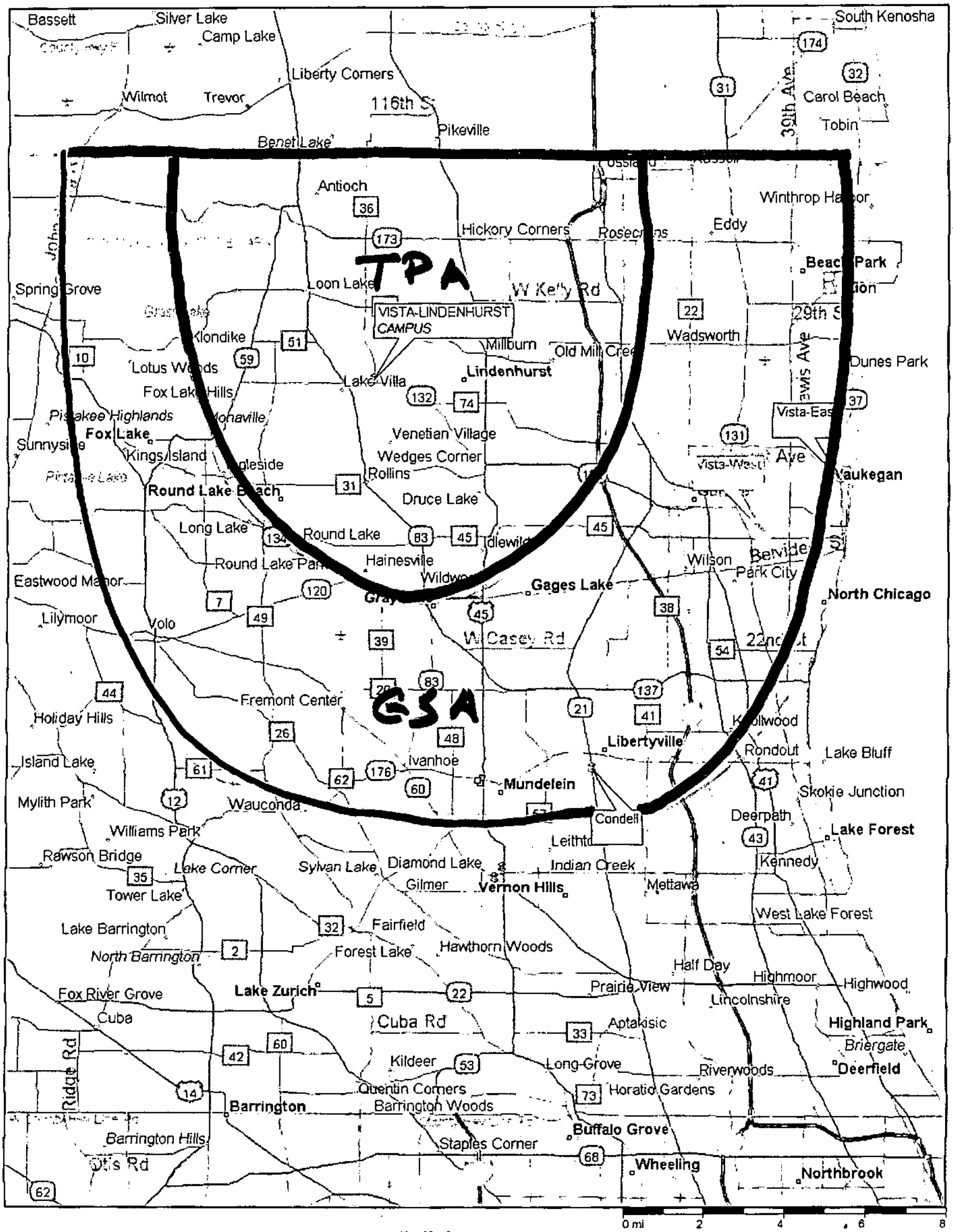
COMPdata

COMPdata Report: ER PATIENTS MARKET SHARE FOR ANNE
Reporting Period: 10/01/2007 THROUGH 09/30/2009

03/18/2010
Page 1

	CASES					SHARE				
PROVIDER FACILITY	10/01/2008 - 09/30/2009	10/01/2007 - 09/30/2008	% Change	% Change	% Change	10/01/2008 - 09/30/2009	10/01/2007 - 09/30/2008	% Change	% Change	% Change
ADVOCATE CONDELL MEDICAL CENTER	44,106	40,018	10.22			28.3	28.8	-1.74		
ADVOCATE GOOD SHEPHERD HOSPITAL	1,622	1,830	-11.37			1.0	1.3	-20.99		
CENTEGRA HOSPITAL - MCHENRY	22,661	18,166	24.74			14.5	13.1	11.21		
MIDWESTERN REGIONAL MEDICAL CENTER	3,718	279	1,232.62			2.4	0.2	1,085.08		
NORTHSHORE UNIVERSITY HEALTHSYSTEM HIGHL/	6,642	6,533	1.67			4.3	4.7	-9.37		
NORTHWESTERN LAKE FOREST HOSPITAL	29,604	30,502	-2.94			19.0	21.9	-13.47		
VISTA MEDICAL CENTER EAST	34,338	35,694	-3.80			22.0	25.7	-14.23		
VISTA MEDICAL CENTER WEST	13,364	6,105	118.90			8.6	4.4	95.17		
TOTAL:	156,055	139,127	12.17			100.0	100.0	141.46		

106 C



Streets98

ATTACHMENT - 11

Find Shortage Areas: HPSA by State & County

Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA Eligible for the Medicare Physician Bonus Payment
MUA/P by State & County

Criteria:

State: Illinois
County: Lake County
Date of Last Update: All Dates
HPSA Score (lower limit): 0

Discipline: Primary Medical Care
Metro: All
Status: Designated
Type: All

Results: 5 records found.
(Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee. They are not listed separately.)

HPSA Name	ID	Type	FTE	# Short	Score
097 - Lake County					
Lake County Community Health Department and Commun	117999176B	Comprehensive Health Center	1		7
Low Income - Waukegan/Zion/Benton	117999179C	Population Group	4	12	12
Benton Township		Minor Civil Division			
Waukogan Township		Minor Civil Division			
Zion Township		Minor Civil Division			

NEW SEARCH | MODIFY SEARCH CRITERIA

ATTACHMENT - 11

Village of Lindenhurst

2301 E. Sand Lake Road
Lindenhurst, Illinois 60046-8934

January 18, 2007

Jeffrey S. Mark
Executive Secretary
Illinois Department of Public Health
Health Facilities Planning Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Mr. Mark:

I am writing this letter on behalf of the Village of Lindenhurst to express its endorsement of Lindenhurst Illinois Hospital Company, LLC's application for a Certificate of Need from the Illinois Health Facilities Planning Board. On November 27, 2006, the Village Board of Lindenhurst unanimously passed a resolution whole-heartedly supporting Lindenhurst Illinois Hospital Company's proposal to build a new 215,000 square foot medical center in Lindenhurst.

The proposed site on which the new facility would be built is approximately 19 acres and is classified in the PUD-3 Planned Unit Development District. The proposed medical facility is a permitted use in this District. Once the certificate of need is granted and the required site plans and application for a building permit are submitted to us, we will proceed as quickly as possible with our review and approval process.

We look forward to working with Lindenhurst Illinois Hospital Company toward a successful completion of its proposed facility which we believe will fulfill our need for affordable health care for the residents of Lindenhurst and the surrounding community.

Sincerely,

THE VILLAGE OF LINDENHURST

James B. Stevens

James B. Stevens
Village Administrator

JBS/cs

ATTACHMENT - 11

Web Site: www.lindenhurstil.org E-mail: mail@lindenhurstil.org Phone: 847-356-8252 Fax: 847-356-8270

ALTERNATIVES

The purpose of this project is to improve accessibility to emergency services for the residents of north-central and northwestern Lake County. Current accessibility is not optimal for two reasons. The first reason is routine drive times that far exceed those identified by MapQuest due to an inadequate road system, high traffic volumes, two high traffic railroad lines running north-south through the County, and the dozens of lakes, making driving circuitous. Improving travel times through a re-design and expansion of the roadway system is both extraordinarily expensive, and beyond the control of the co-applicants. As such, it is not even considered as an alternative.

The first alternative considered is to do nothing, and continue to rely on area hospitals for the provision of emergency services. This alternative does not address the goal of the project as stated above, or that of the FEC legislation to improve accessibility to emergency medical services.

The second alternative is to rely on others to provide the service. While the Board approved in 2008 a FEC application submitted by Lake Forest Hospital for a similar facility in Grayslake, there remains a pressing need for our proposed FEC facility in Lindenhurst. The Grayslake site is not centrally-located to serve the north-central portion of the county as is the Lindenhurst site, and patients from Antioch and Lindenhurst would need to drive past our proposed site to get to the Lake Forest Hospital site. Last, and important to the type of service being proposed, only the Lindenhurst site has an FAA and IDOT-approved helipad in operation. This availability will be invaluable when transporting patients in need of inpatient care from the/any FEC to an acute care hospital.

The third alternative is to build the FEC on the Vista Lindenhurst campus, but as a freestanding facility. This alternative was dismissed because it was more costly, would require more square footage and would necessitate the duplication of the imaging facilities already housed in the building proposed to be expanded.

The fourth alternative is the proposed project, which, based on the fact that the Lindenhurst site is nearly 14 miles and 29 minutes from the closest full-service hospital, the availability of a helipad and the central location will provide a greater improvement in accessibility than alternatives one or two. In addition, the development of the FEC as an addition to an existing building in which a variety of services, including a broad scope of imaging services are already available, negates the need to duplicate those services.

The success of the project will be measured by shortened EMS transport time.

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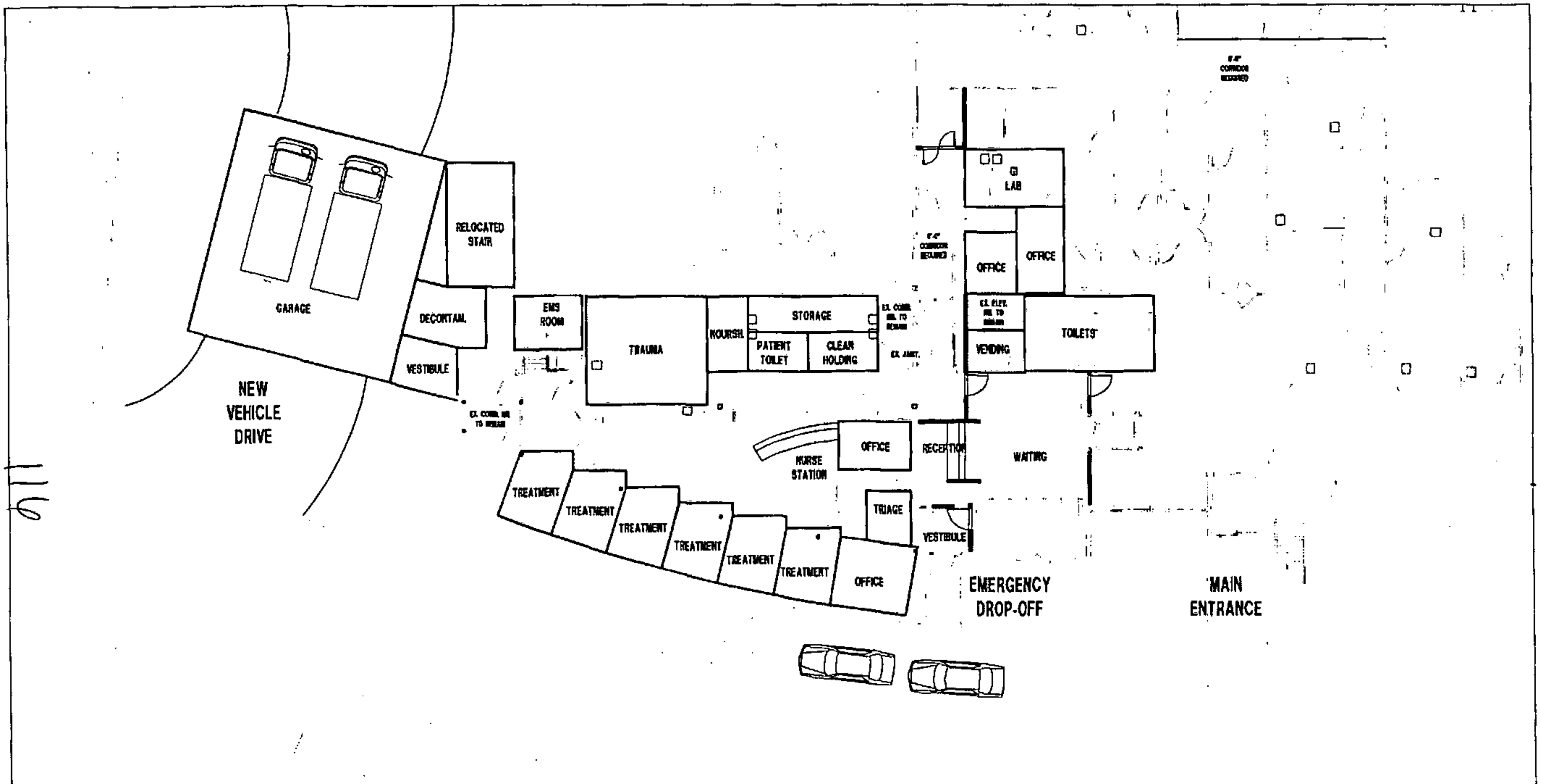
SUMMARY COMPARISON OF ALTERNATIVES

	Cost	Quality	Accessibility
Alternative 1 Do nothing	none	not applicable	inferior...would fail to provide improved access to emergency services
Alternative 2 Rely on others to provide service	none	not applicable	inferior...other proposed sites are not as centrally-located to the population to be served
Alternative 3 Develop FEC as a freestanding facility	approx $4.04M (30% over proposed)	identical	identical to selected project

SIZE

The IDPH has not developed a space "norm" for freestanding emergency centers. The proposed FEC will be developed in 4,235 GSF of newly-constructed space, or 605 GSF per treatment station, well within the "norm" for hospital-based emergency departments (744.6 GSF per station).

The space program for and design of the FEC were developed by Leget Architects, a firm well-versed in the design of health care facilities. A copy of the floor plan, depicting how the FEC will be developed as an addition to the existing structure, is attached.



PARTIAL FIRST FLOOR PLAN - OPTION 1A

1/16"=1'-0"

☐ TRAUMA ROOMS	☐ SUPPORT SPACES
☐ TREATMENT ROOMS	☐ RELOCATED ITEMS
☐ EMERGENCY SERVICE SPACES	

FREESTANDING EMERGENCY CENTER

LINDENHURST, ILLINOIS

9/11/07

HEALTH SYSTEM

LEGAT ARCHITECTS

116

SERVICE TO AREA RESIDENTS

The purpose of the proposed project is to improve accessibility to emergency services for the residents of north-central and northwestern Lake County. Patients in need of emergency care, as opposed to "urgent" care, are most often transported to an emergency room by a rescue squad or ambulance. The three closest emergency rooms to Lindenhurst are located at Vista Medical Center-East, located 13.9 miles to the east southeast; Condell Medical Center 14.6 miles to the south southeast; and Northern Illinois Medical Center, 16.9 miles to the southwest.

A simple proximity assessment identifies the residents of Zip Code areas 60002 (Antioch), 60046 (Lindenhurst/Lake Villa), 60073 (Round Lake) and portions of five other Zip Code areas as residing closer to the proposed Lindenhurst site than any of the existing emergency departments. This area is defined as the Target Population Area (TPA). As such, accessibility to emergency care services will clearly be improved for the TPA - which represents a sizable portion of the GSA - with the development of a freestanding emergency center in Lindenhurst; and the co-applicants believe that approximately 85% of the patients to be seen in the proposed freestanding emergency center will be residents of the TPA. Traditionally, need assessments prepared for Certificate of Need projects exclude out-of-state patients, and while the Lindenhurst site is located within six miles of the Wisconsin border, per past practices, Wisconsin residents have been excluded from the GSA population. However, it is anticipated that some patients using the emergency center will be Wisconsin residents. The vast majority of the remaining patients will come from the rest of the GSA.

The table below identifies the 2008 area ER utilization, as reported in the hospital's IDPH *Profiles*.

2008 Utilization of Emergency Departments located in the GSA

Hospital	Location	Visits (1)
Northern Illinois Medical Center	McHenry	38,938
Vista Medical Center - East	Waukegan	36,469
Vista Medical Center- West	Waukegan	12,018
Midwestern Regional Med. Ctr. (2)	Zion	5,244
Lake Forest Hospital	Lake Forest	33,690
Highland Park Hospital	Highland Park	26,251
Condell Medical Center	Libertyville	45,944
Advocate Good Shepherd Hospital	Barrington	32,840
		231,394

(1) per IDPH *Profiles*
(2) no longer accepts ambulances

The data presented above documents 231,394 visits during 2008, the most recent data available to the co-applicants. Effective May 1, 2008 Midwestern Regional Medical Center in Zion has ceased accepting ambulance transports to its emergency room, and its ER has been reduced to "stand-by" status. In addition, Midwestern does not participate in the IHA's CompDATA program, and therefore it is not known how many of that facility's ER patients have historically been GSA residents.

In 2007, CompDATA was used to identify the number of GSA residents seen in the GSA's emergency departments during 2006. That data indicated that 81,537 of the 219,971 ER patients treated in 2006 at Advocate Good Shepherd, Condell, Highland Park, Northern Illinois, Lake Forest, Vista-East and Vista-West were residents of a Zip Code area included in the GSA.

PLANNING AREA NEED

This project's planning area is identified on the attached map, and identified on that map the geographic service area (GSA), extending 30 minutes from the proposed site, in all directions, with the exception of to the north, at the Wisconsin state line. The perimeter of the GSA was identified, using 30-minute drive times, per MapQuest, adjusted consistent with the State Board's rules.

Approximately 85% of the proposed FEC's patients are anticipated to come from the target population area (TPA) identified in said map, and which consists of that portion of Lake County located to the proposed site than to any existing hospital-based emergency department; ZIP code areas 60002 (Antioch), 60046 (Lindenhust/Lake Villa) and 60073 (Round Lake) and portions of five others. The vast majority of the remaining 15% of the anticipated patients will, it is believed, come from other parts of the GSA (and possibly from southern Wisconsin).

The table below identifies the anticipated origin of the center's population:

		2009 Area ER Visits	Proposed FEC Mkt. Pen.	Projected FEC Visits
60002	Antioch	4,817	40%	1,927
60020	Fox Lake	2,747	20%	549
60030	Grayslake	6,664	10%	666
60031	Gurnee	7,668	10%	767
60041	Ingleside	2,460	20%	492
60046	Lindenhurst/Lake Villa	5,901	70%	4,131
60073	Round Lake	14,928	30%	4,478
60083	Wadsworth	1,715	30%	514
				13,523
		adj. for out-of-area (TPA) patients		.85
				15,909

Market Report

COMPdata

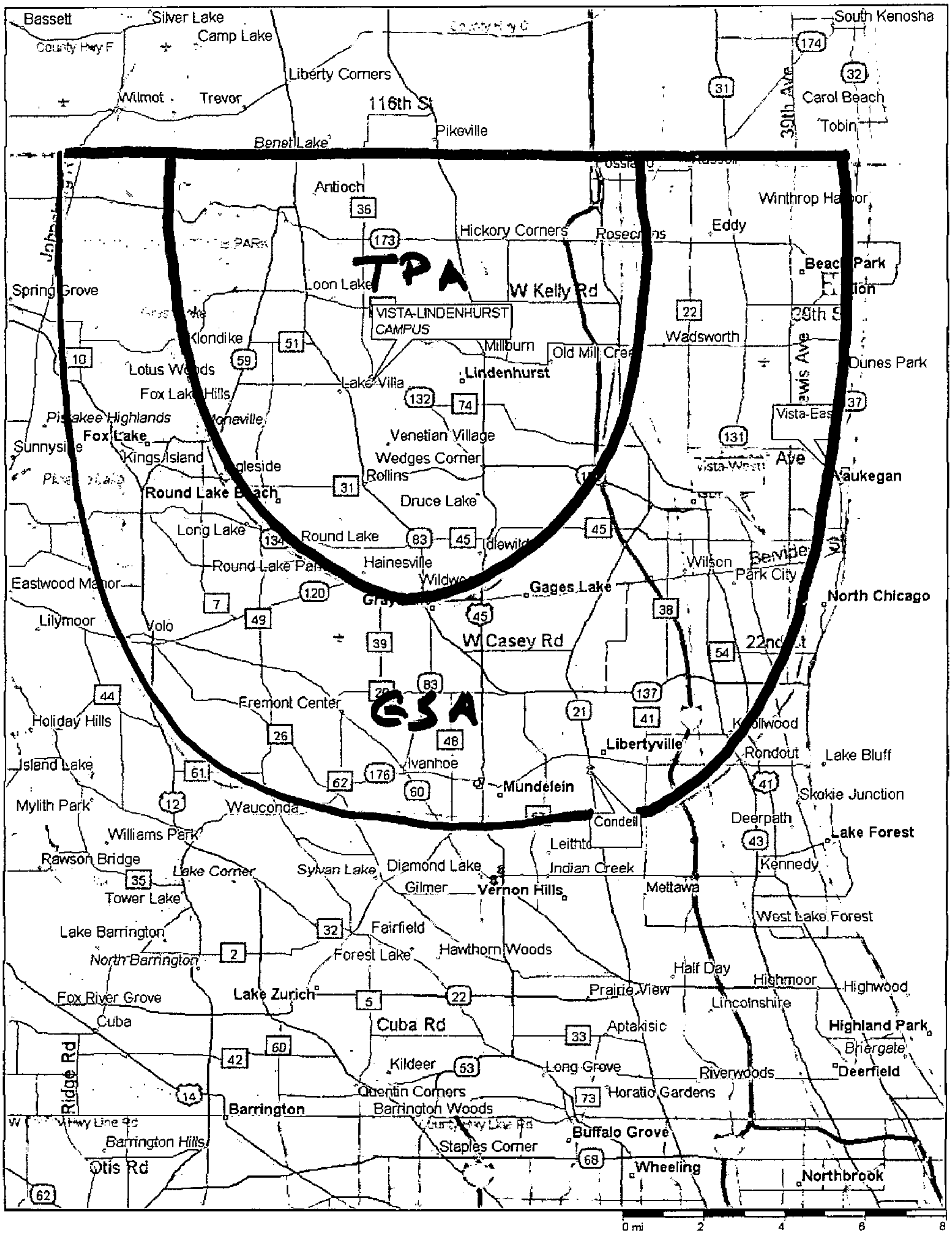
03/05/2010

COMPdata Report: ER PATIENTS MARKET SHARE - LAKE COUNTY

Reporting Period: 10/01/2008 THROUGH 09/30/2009

ZIP CODE - PATIENT	Cases	Market Share
60002 ANTIOCH	4,817	2.64
60010 BARRINGTON	4,572	2.51
60011 BARRINGTON	26	0.01
60015 DEERFIELD	5,426	2.98
60020 FOX LAKE	2,747	1.51
60030 GRAYSLAKE	6,664	3.66
60031 GURNEE	7,668	4.21
60035 HIGHLAND PARK	7,724	4.24
60037 FORT SHERIDAN	4	0.00
60040 HIGHWOOD	1,672	0.92
60041 INGLESIDE	2,460	1.35
60042 ISLAND LAKE	1,564	0.86
60044 LAKE BLUFF	2,335	1.28
60045 LAKE FOREST	4,712	2.59
60046 LAKE VILLA	5,901	3.24
60047 LAKE ZURICH	4,127	2.27
60048 LIBERTYVILLE	6,260	3.44
60049 LONG GROVE	28	0.02
60060 MUNDELEIN	9,407	5.17
60061 VERNON HILLS	5,729	3.15
60064 NORTH CHICAGO	9,140	5.02
60069 LINCOLNSHIRE	1,702	0.93
60073 ROUND LAKE	14,928	8.20
60075 RUSSELL	8	0.00
60079 WAUKEGAN	190	0.10
60083 WADSWORTH	1,715	0.94
60084 WAUCONDA	2,537	1.39
60085 WAUKEGAN	35,722	19.61
60086 NORTH CHICAGO	45	0.02
60087 WAUKEGAN	8,746	4.80
60088 GREAT LAKES	1,097	0.60
60089 BUFFALO GROVE	7,452	4.09
60092 LIBERTYVILLE	11	0.01
60096 WINTHROP HARBOR	1,322	0.73
60099 ZION	13,664	7.50
GRAND TOTAL:	182,122	

121



Streets98

ATTACHMENT - 19

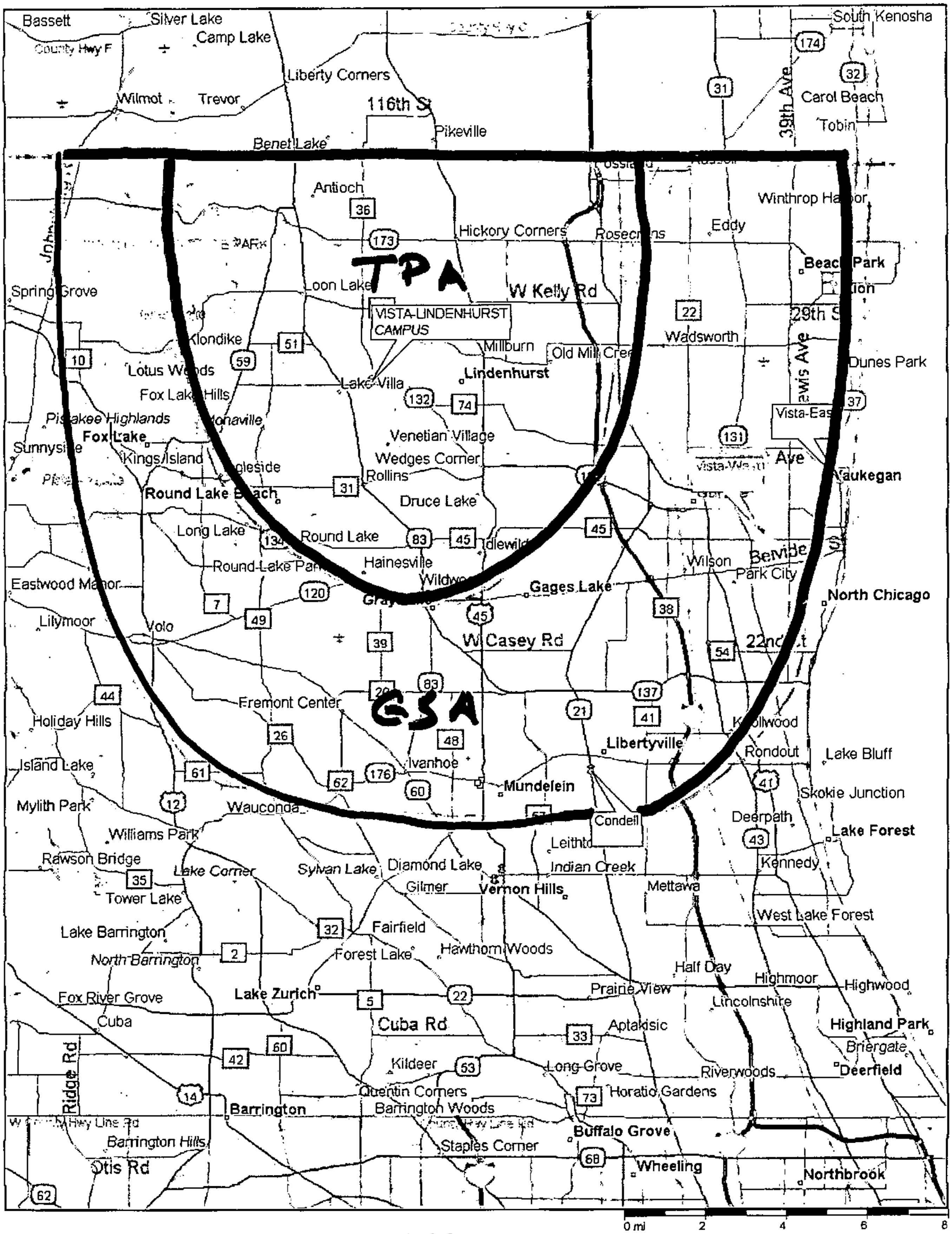
SERVICE DEMAND

Because of the nature of the proposed project, neither physician references or population growth demands are the reason for this project.

SERVICE ACCESSIBILITY

The purpose of this project is to improve the accessibility to emergency services for the residents of north-central and northwestern Lake County. The proposed service's geographic service area (GSA), as defined in Section 1110.3230 is identified on the attached map. That service area extends 30-minutes from the proposed site.

Restricted services exist, per Section 1110.3230, when one or more of three situations occur: 1) there are no emergency departments in the GSA; 2) the GSA exhibits indicators of medical care problems; or 3) all existing emergency services in the GSA meet or exceed the IDPH's utilization standard. Among the indicators of medical care problems identified in Section 1110.3230 is "...designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or Medically Underserved Population. Attached is documentation from the U.S. Department of Health and Human Services, showing three townships, all of which are located in the northeastern portion of the GSA, being identified as Health Professional Shortage Areas for primary medical care.



Streets98

ATTACHMENT - 22

HRSA U.S. Department of Health and Human Services
Health Resources and Services Administration

Find Shortage Areas: HPSA by State & County

Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA Eligible for the Medicare Physician Bonus Payment
MUA/P by State & County

Criteria:

State: Illinois
County: Lake County
Date of Last Update: All Dates
HPSA Score (lower limit): 0

Discipline: Primary Medical Care
Metro: All
Status: Designated
Type: All

Results: 5 records found.
(Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee. They are not listed separately.)

HPSA Name	ID	Type	FTE	# Short	Score
097 - Lake County					
Lake County Community Health Department and Commum	117999176B	Comprehensive Health Center	1		7
Low Income - Waukegan/Zion/Benton	117999179C	Population Group	4	12	12
Benton Township		Minor Civil Division			
Waukegan Township		Minor Civil Division			
Zion Township		Minor Civil Division			

NEW SEARCH | MODIFY SEARCH CRITERIA

ATTACHMENT - 22

UNNECESSARY DUPLICATION/MALDISTRIBUTION

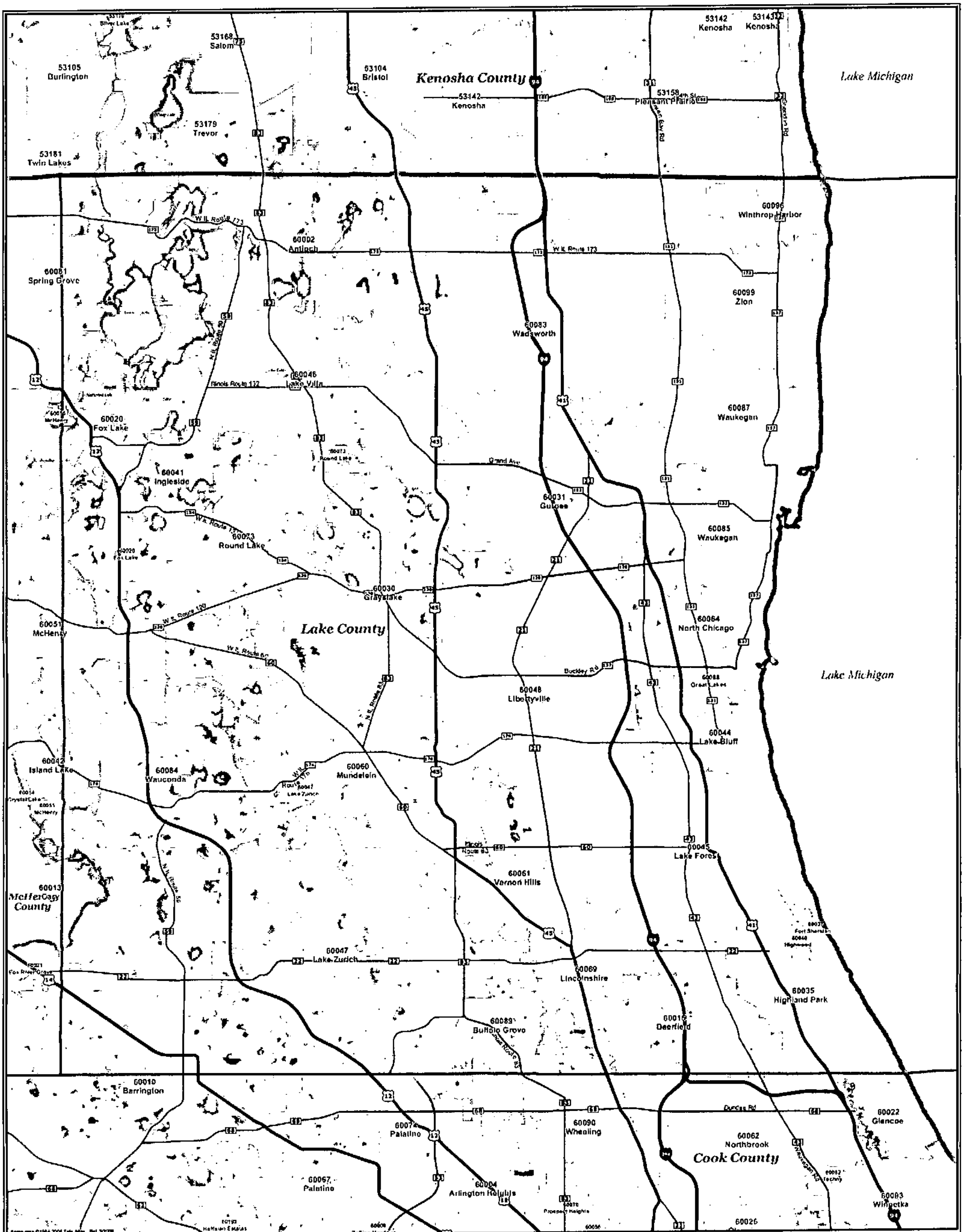
The IDPH-defined geographic service area (GSA) includes 22 Zip Code areas and their primary community, as follows:

60002	Antioch
60020	Fox Lake
60030	Grayslake
60031	Gurnee
60041	Ingleside
60044	Lake Bluff
60045	Lake Forest
60046	Lake Villa
60048	Libertyville
60060	Mundelein
60061	Vernon Hills
60064	North Chicago
60073	Round Lake
60079	Waukegan
60083	Wadsworth
60084	Wauconda
60085	Waukegan
60086	North Chicago
60087	Waukegan
60088	Great Lakes
60096	Winthrop Harbor
60099	Zion

In order to identify "the total population" of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois population), a representative of the co-applicants consulted with Michael Gibbs and Michael Mitchell of the IDPH staff and was directed to the U.S. Bureau of the Census ZIP code-specific population data. The cumulative 2000 population of the 22 Zip Code area identified above was 573,045 (it should be noted that the data did not include a population for Zip Code area 60051).

It should also be noted that while the proposed site is 29 minutes from the closest full-service hospital, a significant portion of the TPA (please see Attachment 22) is located in excess of 30 minutes from the closest hospital. As such, the proposed FEC will not be unnecessarily duplicating emergency department services and this project will not result in a mal-distribution of services; rather, accessibility will be improved.

The only provider of emergency department services (and accepting ambulances) located within 30 minutes of the proposed site are Condell Medical Center, which is located at 801 S. Milwaukee Avenue in Libertyville, Illinois, and Vista Medical center-West, which is located at 2615 Washington Street in Waukegan, Illinois. In addition, Lake Forest Hospital was recently approved to operate a FEC in Grayslake, Illinois.



County	ZIP Codes	ZIP Codes Lake County, IL	ATTACHMENT - 23	© Maponics (800) 762-5158 www.maponics.com

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A.

STAFFING

No unusual difficulties are anticipated with the staffing of the proposed FEC. As discussed in other portions of this document, the FEC will operate as an extension of the Level II trauma center at Vista Medical Center-East, and will likely attract its staff from the same general area, that being northern Lake County.

As noted, there is only one provider of emergency department services (and accepting ambulances) other than VMC-W located within a 30-minute drive of the proposed facility, that being Condell Medical Center.

Consistent with the requirements of Section 1110.3230, letters were sent to area hospitals (copies attached in Exhibit - 25) regarding vacancy rates, and their responses will be provided to the Board upon receipt.

VISTA
HEALTH
SYSTEM

March 8, 2010

ATTACHMENT - 25

Via Certified Mail-Return Receipt Requested
Skokie Hospital
Kristen Murtos, President
9600 Gross Point Road
Skokie, Illinois 60076

Dear Ms. Murtos:

Vista Medical Center East intends to file a Certificate of Need application, seeking approval to develop a Freestanding Emergency Center on Vista's Lindenhurst Campus.

Consistent with the proposed rules of the Illinois Health Facilities and Services Review Board, it would be appreciated if you could provide me with the following information in the form of a letter, to be sent to me within 15 days of your receipt of this request:

1. Has your emergency department experienced an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers subject to licensing by the Illinois Department of Financial and Professional Regulations?

2. How many treatment stations are located in your emergency department?

3. For each of the past 2 years, how many patients have been treated in your emergency department?

4. What impact do you believe this proposed project will have on the utilization of your emergency department?

Sincerely,

Barbara J. Martin
President & Chief Executive Officer

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Sent To Skokie Hospital
Street, Apt. No.; or PO Box No. 9600 Gross Point Rd.
City, State, ZIP+4 Skokie, IL 60076
PS Form 3800, August 2006 See Reverse for Instructions

Vista Medical Center East • Vista Medical Center West • Vist
Vista MRI Institute • Vista Imaging Center Vernon Hills • Vi
1324 North Sheridan Road, Waukegan, Il

VISTA
HEALTH
SYSTEM

March 8, 2010

ATTACHMENT - 25

Via Certified Mail-Return Receipt Requested
Centegra Health System
Michael S. Eesley, President & CEO
4201 Medical Center Drive
McHenry, Illinois 60050-8499

Dear Mr. Eesley:

Vista Medical Center East intends to file a Certificate of Need application, seeking approval to develop a Freestanding Emergency Center on Vista's Lindenhurst Campus.

Consistent with the proposed rules of the Illinois Health Facilities and Services Review Board, it would be appreciated if you could provide me with the following information in the form of a letter, to be sent to me within 15 days of your receipt of this request:

1. Has your emergency department experienced an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers subject to licensing by the Illinois Department of Financial and Professional Regulations?

2. How many treatment stations are located in your emergency department?

3. For each of the past 2 years, how many patients have been treated in your emergency department?

4. What impact do you believe this proposed project will have on the utilization of your emergency department?

Sincerely,

Barbara J. Martin
President & Chief Executive Officer

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Total Postage & Fees	$

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Sent To Centegra
Street, Apt. No.; or PO Box No. 4201 Medical Center Dr.
City, State, ZIP+4 McHenry IL 60050
PS Form 3800, August 2006 See Reverse for Instructions

VISTA
HEALTH
SYSTEM

March 8, 2010

ATTACHMENT - 25

Via Certified Mail-Return Receipt Requested
Westlake Hospital
Patricia Shehorn, EVP & CEO
1225 Lake Street
Melrose Park, Illinois 60160-4039

Dear Ms. Shehorn:

Vista Medical Center East intends to file a Certificate of Need application, seeking approval to develop a Freestanding Emergency Center on Vista's Lindenhurst Campus.

Consistent with the proposed rules of the Illinois Health Facilities and Services Review Board, it would be appreciated if you could provide me with the following information in the form of a letter, to be sent to me within 15 days of your receipt of this request:

1. Has your emergency department experienced an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers subject to licensing by the Illinois Department of Financial and Professional Regulations?

2. How many treatment stations are located in your emergency department?

3. For each of the past 2 years, how many patients have been treated in your emergency department?

4. What impact do you believe this proposed project will have on the utilization of your emergency department?

Sincerely,

Barbara J. Martin
President & Chief Executive Officer

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Street, Apt. No.; or PO Box No. 1225 Lake Street
City, State, ZIP+4 Melrose Park, IL 60160

PS Form 3800, August 2006 See Reverse for Instructions

VISTA
HEALTH
SYSTEM

March 8, 2010

ATTACHMENT - 25

Via Certified Mail-Return Receipt Requested
West Suburban Medical Center
Patricia Shehorn, EVP & CEO
3 Erie Court
Oak Park, Illinois 60302-2599

Dear Ms. Shehorn:

Vista Medical Center East intends to file a Certificate of Need application, seeking approval to develop a Freestanding Emergency Center on Vista's Lindenhurst Campus.

Consistent with the proposed rules of the Illinois Health Facilities and Services Review Board, it would be appreciated if you could provide me with the following information in the form of a letter, to be sent to me within 15 days of your receipt of this request:

1. Has your emergency department experienced an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers subject to licensing by the Illinois Department of Financial and Professional Regulations?

2. How many treatment stations are located in your emergency department?

3. For each of the past 2 years, how many patients have been treated in your emergency department?

4. What impact do you believe this proposed project will have on the utilization of your emergency department?

Sincerely,

Barbara J. Martin
President & Chief Executive Officer

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

Sent To West Suburban Medical Ctr.
Street, Apt. No.; or PO Box No. 3 Erie Court
City, State, ZIP+4 Oak Park IL 60302
PS Form 3800, August 2006 See Reverse for Instructions

VISTA
HEALTH
SYSTEM

ATTACHMENT - 25

March 8, 2010

Via Certified Mail-Return Receipt Requested
Midwestern Regional Medical Center
Anne Meisner, Chief Executive Officer
2520 Elisha Avenue
Zion, Illinois 60099

Dear Ms. Meisner:

Vista Medical Center East intends to file a Certificate of Need application, seeking approval to develop a Freestanding Emergency Center on Vista's Lindenhurst Campus.

Consistent with the proposed rules of the Illinois Health Facilities and Services Review Board, it would be appreciated if you could provide me with the following information in the form of a letter, to be sent to me within 15 days of your receipt of this request:

1. Has your emergency department experienced an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers subject to licensing by the Illinois Department of Financial and Professional Regulations?

2. How many treatment stations are located in your emergency department?

3. For each of the past 2 years, how many patients have been treated in your emergency department?

4. What impact do you believe this proposed project will have on the utilization of your emergency department?

Sincerely,

Barbara J. Martin
President & Chief Executive Officer

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Street, Apt. No.; or PO Box No. 2520 Elisha Ave
City, State, ZIP+4 Zion, IL 60099

PS Form 3800, August 2006 See Reverse for Instructions

VISTA
HEALTH
SYSTEM

March 8, 2010

ATTACHMENT - 25

Via Certified Mail-Return Receipt Requested
Highland Park Hospital
Jesse Peterson Hall, President
777 Park Avenue West
Highland Park, Illinois 60035-2497

Dear Mr. Hall:

Vista Medical Center East intends to file a Certificate of Need application, seeking approval to develop a Freestanding Emergency Center on Vista's Lindenhurst Campus.

Consistent with the proposed rules of the Illinois Health Facilities and Services Review Board, it would be appreciated if you could provide me with the following information in the form of a letter, to be sent to me within 15 days of your receipt of this request:

1. Has your emergency department experienced an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers subject to licensing by the Illinois Department of Financial and Professional Regulations?

2. How many treatment stations are located in your emergency department?

3. For each of the past 2 years, how many patients have been treated in your emergency department?

4. What impact do you believe this proposed project will have on the utilization of your emergency department?

Sincerely,

Barbara J. Martin
President & Chief Executive Officer

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Street, Apt. No.; or PO Box No. 777 Park Avenue West
City, State, ZIP+4 Highland Park IL 60035

PS Form 3800, August 2006 See Reverse for Instructions

VISTA
HEALTH
SYSTEM

March 8, 2010

ATTACHMENT - 25

Via Certified Mail-Return Receipt Requested
Condell Medical Center
Ann Errichetti, President
801 South Milwaukee Avenue
Libertyville, Illinois 60048-3199

Dear Ms. Errichetti:

Vista Medical Center East intends to file a Certificate of Need application, seeking approval to develop a Freestanding Emergency Center on Vista's Lindenhurst Campus.

Consistent with the proposed rules of the Illinois Health Facilities and Services Review Board, it would be appreciated if you could provide me with the following information in the form of a letter, to be sent to me within 15 days of your receipt of this request:

1. Has your emergency department experienced an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers subject to licensing by the Illinois Department of Financial and Professional Regulations?

2. How many treatment stations are located in your emergency department?

3. For each of the past 2 years, how many patients have been treated in your emergency department?

4. What impact do you believe this proposed project will have on the utilization of your emergency department?

Sincerely,

Barbara J. Martin
President & Chief Executive Officer

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Sent To Condell
Street, Apt. No.; or PO Box No. 801 S. Milwaukee
City, State, ZIP+4 Libertyville IL 60048

PS Form 3800, August 2006 See Reverse for Instructions

VISTA
HEALTH
SYSTEM

March 8, 2010

ATTACHMENT - 25

Via Certified Mail-Return Receipt Requested
University of Chicago Medical Center
Everett E. Vokes, M.D., Interim Dean & CEO
5841 South Maryland Avenue
Chicago, Illinois 60637-1470

Dear Mr. Vokes:

Vista Medical Center East intends to file a Certificate of Need application, seeking approval to develop a Freestanding Emergency Center on Vista's Lindenhurst Campus.

Consistent with the proposed rules of the Illinois Health Facilities and Services Review Board, it would be appreciated if you could provide me with the following information in the form of a letter, to be sent to me within 15 days of your receipt of this request:

1. Has your emergency department experienced an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers subject to licensing by the Illinois Department of Financial and Professional Regulations?

2. How many treatment stations are located in your emergency department?

3. For each of the past 2 years, how many patients have been treated in your emergency department?

4. What impact do you believe this proposed project will have on the utilization of your emergency department?

Sincerely,

Barbara J. Martin
President & Chief Executive Officer

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Street, Apt. No., or PO Box No. 5841 S Maryland Ave
City, State, ZIP+4 Chicago IL 60637-1470

VISTA
HEALTH
SYSTEM

March 8, 2010

ATTACHMENT - 25

Via Certified Mail-Return Receipt Requested
Lake Forest Hospital
Thomas J. McAfee, President & CEO
660 North Westmoreland Road
Lake Forest, Illinois 60045-9989

Dear Mr. McAfee:

Vista Medical Center East intends to file a Certificate of Need application, seeking approval to develop a Freestanding Emergency Center on Vista's Lindenhurst Campus.

Consistent with the proposed rules of the Illinois Health Facilities and Services Review Board, it would be appreciated if you could provide me with the following information in the form of a letter, to be sent to me within 15 days of your receipt of this request:

1. Has your emergency department experienced an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers subject to licensing by the Illinois Department of Financial and Professional Regulations?

2. How many treatment stations are located in your emergency department?

3. For each of the past 2 years, how many patients have been treated in your emergency department?

4. What impact do you believe this proposed project will have on the utilization of your emergency department?

Sincerely,

Barbara J. Martin
President & Chief Executive Officer

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Street, Apt. No.; or PO Box No. 660 N. Westmoreland Rd
City, State, ZIP+4 Lake Forest IL 60045

VISTA
HEALTH
SYSTEM

March 8, 2010

ATTACHMENT - 25

Via Certified Mail-Return Receipt Requested
Lake Forest Hospital FEC
Thomas J. McAfee, President & CEO
660 North Westmoreland Road
Lake Forest, Illinois 60045-9989

Dear Mr. McAfee:

Vista Medical Center East intends to file a Certificate of Need application, seeking approval to develop a Freestanding Emergency Center on Vista's Lindenhurst Campus.

Consistent with the proposed rules of the Illinois Health Facilities and Services Review Board, it would be appreciated if you could provide me with the following information in the form of a letter, to be sent to me within 15 days of your receipt of this request:

1. Has your emergency department experienced an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers subject to licensing by the Illinois Department of Financial and Professional Regulations?

2. How many treatment stations are located in your emergency department?

3. For each of the past 2 years, how many patients have been treated in your emergency department?

4. What impact do you believe this proposed project will have on the utilization of your emergency department?

Sincerely,

Barbara J. Martin
President & Chief Executive Officer

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Street, Apt. No.; or PO Box No. 660 N. Westmoreland Rd
City, State, ZIP+4 Lake Forest, IL 60045

VISTA
HEALTH
SYSTEM

March 15, 2010

Illinois Health Facilities and Services Review Board
525 West Jefferson Street
Springfield, IL 62761

Re: Vista Health System – CON application
Utilization Assurance

To Whom It May Concern:

A Certificate of Need Application has been filed for the establishment of a freestanding emergency center on Vista Health System's Lindenhurst, Illinois campus. Please be advised that it is our expectation and understanding that by the second year following the project's completion, the facility will be operating at the IHFSRB's target utilization level of 80%, and that it will, at minimum, maintain that level of utilization thereafter.

Sincerely,

Barbara J. Martin
President and Chief Executive Officer

Notarized:

Barbara J. Martin, on March 16, 2010
did personally appear before me and
originally signed this document

By: Gladys M Grant
Notary Public

"OFFICIAL SEAL"
GLADYS M GRANT
Notary Public, State of Illinois
My Commission Expires 8-4-10

Date: March 16, 2010

Attachment – 26

UTILIZATION

The IDPH-adopted utilization standard for freestanding emergency centers is 2,000 visits per treatment room.

Utilization was projected in a very conservative manner, including the following assumptions:

- utilization of emergency department services by area residents will remain at the 2009 level, even though a population increase will be realized.
- 100% of the FEC's patients will reside closer to the FEC than to a hospital-based emergency department (note: we used this calculation even though up to 15% of patients likely will come from other parts of the GSA).
- no more than 70% of the emergency services patients from any ZIP Code area will use the proposed FEC.

Based on the assumptions identified above, utilization during the second year of the proposed FEC's operation is projected to be 13,523 visits, supporting a "need" for the proposed seven treatment stations. The manner in which projected utilization was identified is presented in the table below.

		2009 Area ER Visits	Proposed FEC Mkt. Pen.	Projected FEC Visits
60002	Antioch	4,817	40%	1,927
60020	Fox Lake	2,747	20%	549
60030	Grayslake	6,664	10%	666
60031	Gurnee	7,668	10%	767
60041	Ingleside	2,460	20%	492
60046	Lindenhurst/Lake Villa	5,901	70%	4,131
60073	Round Lake	14,928	30%	4,478
60083	Wadsworth	1,715	30%	514
				13,523
		adj. for out-of-area (TPA) patients		.85
				15,909

The utilization projection identified above will not require the hiring of any physicians or other professionals that will refer patients to the FEC.

MUNICIPALITY

The proposed Freestanding Emergency Center (FEC) will be located on the Vista Health System campus in Lindenhurst, Illinois. The U.S. Bureau of the Census estimated Lindenhurst's 2006 population to be 14,632.

CONTROL HOSPITAL

Vista Medical Center-East is the resource hospital for the area's EMS program covering the northern portion of Lake County (North Lake County Emergency Medical Services System), and is located 13.9 miles (per MapQuest) to the east of the proposed freestanding emergency center. Vista Medical Center-East is designated as a Level II trauma center, and will "control" the proposed facility.

RESOURCE HOSPITAL

Vista Medical Center-East is the resource hospital for the area's EMS program covering the northern portion of Lake County (North Lake County Emergency Medical Services System), and is located 13.9 miles (per MapQuest) to the east of the proposed freestanding emergency center. Vista Medical Center-East is designated as a Level II trauma center, and will "control" the proposed facility.

Attached as certification of Vista Medical Center-East's status as the area's resource hospital is the identification of all IDPH-designated resource hospitals, as documented on the IDPH's web site.

NORTH LAKE COUNTY
EMS
SYSTEM

June 19, 2008,

Memo To: Jack Axel

From: David B. Edwards
EMS Administrative Director
North Lake County EMS System

RE: System Hospitals

This memo confirms that Vista Medical Center East and Vista Medical Center West are the only hospitals in the North Lake County Emergency Medical Services System which receives emergency and non-emergency patient transports from the field.

If you need additional information, please contact me at (847) 360-2319.

VISTA HEALTH SYSTEM

March 15, 2010

Illinois Health Facilities and Services Review Board
525 West Jefferson Street
Springfield, IL 62761

Re: Vista Health System – CON application
Medicare Participation/EMSS Act Requirements

To Whom It May Concern:

Vista Health System is proposing the establishment of a freestanding emergency center (FEC) on its Lindenhurst, Illinois campus. That facility will be operated in concert with the Level II Trauma Center located at Vista Medical Center East, and be under the "control" of Vista Medical Center East. Vista Medical Center East serves as the resource hospital for the North Lake County Emergency Medical Services System.

Further, we have reviewed and understand both the Medicare participation requirements and the licensing requirements established in the Emergency Medical Services Systems Act (210 ILCS 50/32.5), both in terms of design and operation.

It is Vista's intent that the proposed FEC becomes both Medicare-certified and licensed under the above-referenced Act.

Sincerely,

Barbara J. Martin
President and Chief Executive Officer

C. Marc Trznadel
Chief Nursing Officer

Notarized:

Barbara J. Martin, on March 16, 2010 did personally appear before me and originally sign this document.

By: Notary Public

Date: 3-16-2010

"OFFICIAL SEAL"
GLADYS M GRANT
Notary Public, State of Illinois
My Commission Expires 8-4-10

C. Marc Trznadel, on March 16, 2010 did personally appear before me and originally sign this document.

By: Notary Public

Date: 3-16-, 2010

"OFFICIAL SEAL"
GLADYS M GRANT
Notary Public, State of Illinois
My Commission Expires 8-4-10

Attachment – 74

SERVICE TO AREA RESIDENTS

The purpose of the proposed project is to improve accessibility to emergency services for the residents of north-central and northwestern Lake County. Patients in need of emergency care, as opposed to "urgent" care, are most often transported to an emergency room by a rescue squad or ambulance. The three closest emergency rooms to Lindenhurst are located at Vista Medical Center-East, located 13.9 miles to the east southeast; Condell Medical Center 14.6 miles to the south southeast; and Northern Illinois Medical Center, 16.9 miles to the southwest.

A simple proximity assessment identifies the residents of Zip Code areas 60002 (Antioch), 60046 (Lindenhurst/Lake Villa), 60073 (Round Lake) and portions of five other Zip Code areas as residing closer to the proposed Lindenhurst site than any of the existing emergency departments. This area is defined as the Target Population Area (TPA). As such, accessibility to emergency care services will clearly be improved for the TPA - which represents a sizable portion of the GSA - with the development of a freestanding emergency center in Lindenhurst; and the co-applicants believe that approximately 85% of the patients to be seen in the proposed freestanding emergency center will be residents of the TPA. Traditionally, need assessments prepared for Certificate of Need projects exclude out-of-state patients, and while the Lindenhurst site is located within six miles of the Wisconsin border, per past practices, Wisconsin residents have been excluded from the GSA population. However, it is anticipated that some patients using the emergency center will be Wisconsin residents. The vast majority of the remaining patients will come from the rest of the GSA.

The table below identifies the 2008 area ER utilization, as reported in the hospital's IDPH *Profiles*.

2008 Utilization of Emergency Departments located in the GSA

Hospital	Location	Visits (1)
Northern Illinois Medical Center	McHenry	38,938
Vista Medical Center - East	Waukegan	36,469
Vista Medical Center- West	Waukegan	12,018
Midwestern Regional Med. Ctr. (2)	Zion	5,244
Lake Forest Hospital	Lake Forest	33,690
Highland Park Hospital	Highland Park	26,251
Condell Medical Center	Libertyville	45,944
Advocate Good Shepherd Hospital	Barrington	32,840
		231,394

(1) per IDPH *Profiles*
(2) no longer accepts ambulances

The data presented above documents 231,394 visits during 2008, the most recent data available to the co-applicants. Effective May 1, 2008 Midwestern Regional Medical Center in Zion has ceased accepting ambulance transports to its emergency room, and its ER has been reduced to "stand-by" status.

CompDATA was used to calculate ED visits in the GSA for the two most recent years data was available: October 2007 - September 2008 (2008) and October 2008 - September 2009 (2009). We recognize the CompDATA shows different ED visit totals than does IDPH data for 2008. This may be based on different reporting methods, or the fact that the CompDATA calculation was not on a calendar year basis. CompDATA shows, for hospitals in the GSA, 186,355 total ED visits in 2008 and 205,894 total ED visits in 2009. Using CompDATA to conduct a zip code analysis, 139,127 ED visits in 2008 were by patients who reside in zip codes within the GSA, and 156,055 of the ED visits in 2009 were by patients who reside in zip codes within the GSA. Based on this, 74.6% of 2008 ED visits at hospitals in the GSA were by patients who resided within the GSA, and 75.8% of 2009 ED visits at hospitals in the GSA were by patients who resided within the GSA. Hospital-specific ED visits can be found in the attached CompDATA information.

Case Trend Analysis

COMPdata

COMPdata Report: ER PATIENTS MARKET SHARE FOR ANNE ALL ZIPS 03/18/2010

Reporting Period: 10/01/2007 THROUGH 09/30/2009

PROVIDER FACILITY	CASES 10/01/2008 09/30/2009	CASES 10/01/2007 09/30/2008	CASES % Change	CASES % Change	CASES % Change	SHARE 10/01/2008 09/30/2009	SHARE 10/01/2007 09/30/2008	SHARE % Change	SHARE % Change	SHARE % Change
ADVOCATE CONDELL MEDICAL CENTER	49,129	45,126	8.87			23.9	24.2	-1.46		
ADVOCATE GOOD SHEPHERD HOSPITAL	8,125	8,895	-8.66			3.9	4.8	-17.33		
CENTEGRA HOSPITAL - MCHENRY	36,390	30,153	20.69			17.7	16.2	9.23		
MIDWESTERN REGIONAL MEDICAL CENTER	4,468	420	963.81			2.2	0.2	864.44		
NORTHSHORE UNIVERSITY HEALTHSYSTEM HIGHL/	24,502	23,621	3.73			11.9	12.7	-6.11		
NORTHWESTERN LAKE FOREST HOSPITAL	33,469	34,271	-2.34			16.3	18.4	-11.61		
VISTA MEDICAL CENTER EAST	35,813	37,412	-4.27			17.4	20.1	-13.36		
VISTA MEDICAL CENTER WEST	13,998	6,459	116.75			6.8	3.5	96.22		
TOTAL:	205,894	186,356	10.48			100.0	100.0	115.00		

154B

Case Trend Analysis

COMPdata

ZIPS WITHIN THE GSA

COMPdata Report: ER PATIENTS MARKET SHARE FOR ANNE

Reporting Period: 10/01/2007 THROUGH 09/30/2009

03/18/2010

PROVIDER FACILITY	CASES 10/01/2008 09/30/2009	CASES 10/01/2007 09/30/2008	% Change	% Change	% Change	SHARE 10/01/2008 09/30/2009	SHARE 10/01/2007 09/30/2008	% Change	% Change	% Change
ADVOCATE CONDELL MEDICAL CENTER	44,106	40,018	10.22			28.3	28.8	-1.74		
ADVOCATE GOOD SHEPHERD HOSPITAL	1,622	1,830	-11.37			1.0	1.3	-20.99		
CENTEGRA HOSPITAL - MCHENRY	22,661	18,166	24.74			14.5	13.1	11.21		
MIDWESTERN REGIONAL MEDICAL CENTER	3,718	279	1,232.62			2.4	0.2	1,085.08		
NORTHSHORE UNIVERSITY HEALTHSYSTEM HIGHLI	6,642	6,533	1.67			4.3	4.7	-9.37		
NORTHWESTERN LAKE FOREST HOSPITAL	29,604	30,502	-2.94			19.0	21.9	-13.47		
VISTA MEDICAL CENTER EAST	34,338	35,694	-3.80			22.0	25.7	-14.23		
VISTA MEDICAL CENTER WEST	13,364	6,105	118.90			8.6	4.4	95.17		
TOTAL:	156,055	139,127	12.17			100.0	100.0	141.46		

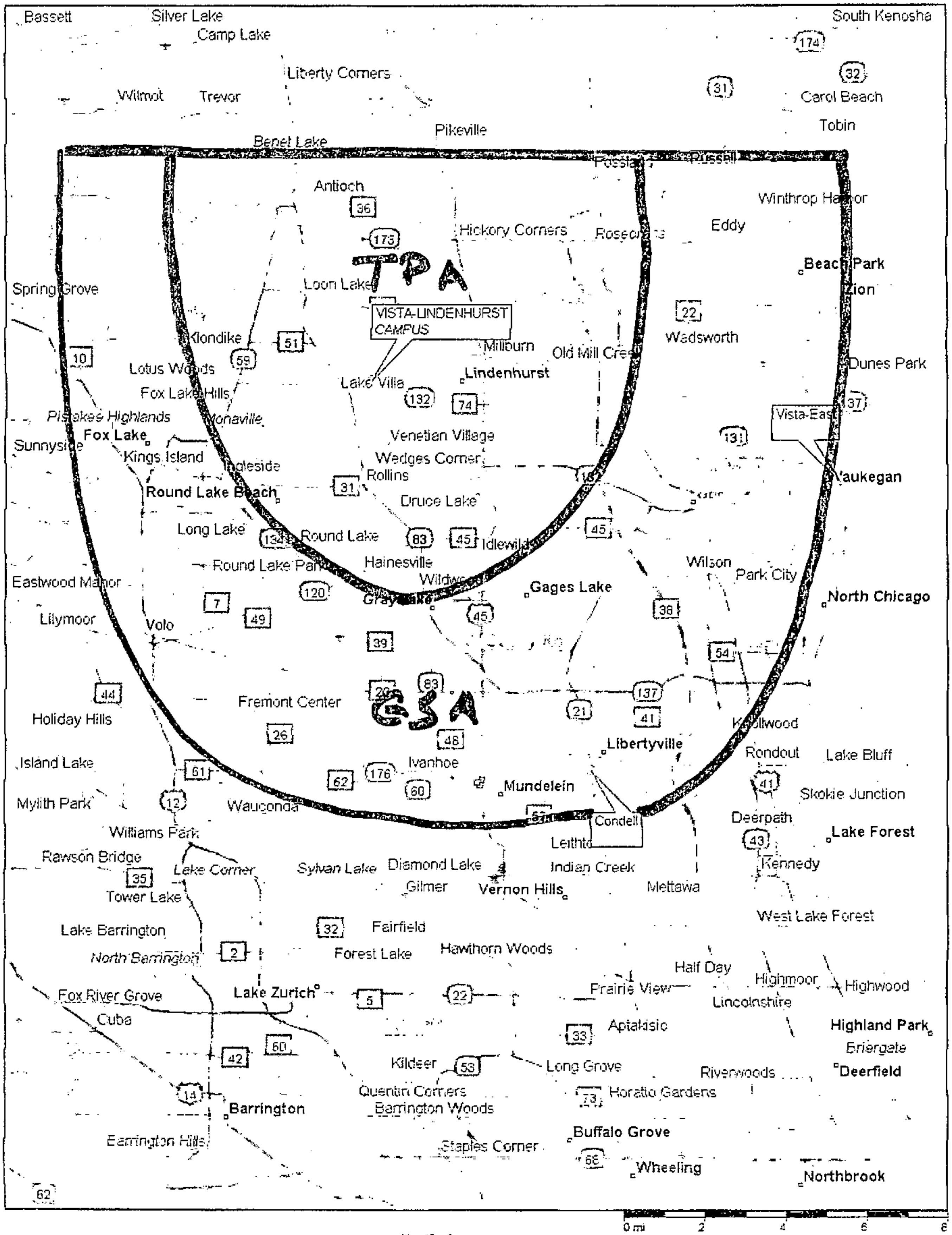
154C

LOCATION

The map in this Attachment – 74 grouping identifies the area from which the proposed freestanding emergency center (FEC) anticipates attracting patients, its target population area (TPA). The TPA is that portion of the geographic service area (GSA) that is located closer to the proposed FEC's site than to an existing emergency room. The GSA is defined by IHFPB rule as being the area located within a thirty-minute drive of the FEC. The GSA extends to the state border (as is common practice with CON projects) on the north, nearly to Lake Michigan on the east and into far northeastern McHenry County on the west.

Using the IHFPB's adjusted MapQuest drive time estimates, there are two hospitals that accept ambulances at their emergency departments located within the GSA: Vista Medical Center-West (23 minutes/12.34 miles to the east) and Condell Medical Center (29 minutes/14.6 miles to the south). It should be noted that Vista Medical Center-West (VMC-W) is the sister hospital to the co-applicant and operates in concert with VMC-E, with a shared management team. VMC-W does not provide inpatient medical/surgical, pediatric or obstetrics services, and the hospital's emergency department was kept open as part of Vista's commitment to the residents of the west side of Waukegan, upon the consolidation of medical/surgical services at VMC-E. Patients presenting themselves to the VMC-W emergency department (35-50 per day) needing non-psychiatric or rehabilitation (the only inpatient services provided at VMC-W) hospitalization are transferred to another hospital, often VMC-E. Area rescue squads transport patients to the VMC-W emergency department on a limited basis, typically not more than 3-5 per day.

This project does not involve inpatient services, and as such, the bed:population ratio is not applicable.


TPA
CSA
VISTA-LINDENHURST CAMPUS
Vista-East
Antioch
Lake Villa
Lindenhurst
Round Lake
Grayslake
Gages Lake
Libertyville
Mundelein
Wauconda
Waukegan
North Chicago
Zion
Lake Forest
Vernon Hills
Lake Zurich
Barrington
Buffalo Grove
Wheeling
Northbrook
Highland Park
Deerfield
0 mi 2 4 6 8

Streets98

VISTA
HEALTH SYSTEM

March 15, 2010

Illinois Health Facilities and Services Review Board
525 West Jefferson Street
Springfield, IL 62761

Re: Vista Health System – CON application
Emergency Department Patient Visits

To Whom It May Concern:

This letter is being provided in response to Review Criterion 1110.3230, and in support of Vista Medical Center's desire to establish a freestanding emergency center on its Lindenhurst campus.

Vista Medical Center-East and Vista Medical Center-West, both located in Waukegan, are part of the North Lake County Emergency Medical Services System (NLCEMSS).

During 2009, according to Illinois Hospital Association CompData, Vista Medical Center-East attracted 95.73% of its emergency department patients from the proposed freestanding emergency centers geographic service area (GSA); and Vista Medical Center-West attracted 95.32% of its emergency department patients from that area.

A patient origin analysis from each of the two hospital-based emergency departments is attached. That analysis identifies each zip code area included in the proposed facility's GSA.

This information is true and correct, to the best of my understanding.

Sincerely,

Barbara J. Martin
President & CEO

Notarized:

Barbara J. Martin, on March 16, 2010
did personally appear before me and
originally signed this document

By: Notary Public

"OFFICIAL SEAL"
GLADYS M GRANT
Notary Public, State of Illinois
My Commission Expires 8-4-10

Attachment – 74

Vista Medical Center
Emergency Department Patient Origin by Zip Code
2008-2009

Zip Code	City	VMC-East	VMC-West
60002	Antioch	1.81%	1.49%
60020	Fox Lake	0.17%	0.29%
60030	Grayslake	0.72%	1.26%
60031	Gurnee	3.00%	4.23%
60041	Ingleside	0.19%	0.28%
60044	Lake Bluff	0.10%	0.14%
60045	Lake Forest	0.03%	0.03%
60046	Lake Villa	1.22%	1.83%
60048	Libertyville	0.15%	0.34%
60060	Mundelein	0.20%	0.43%
60061	Vernon Hills	0.09%	0.19%
60064	North Chicago	9.31%	13.48%
60073	Round Lake	1.71%	2.28%
60079	Waukegan	0.17%	0.10%
60083	Wadsworth	1.38%	1.12%
60084	Wauconda	0.04%	0.08%
60085	Waukegan	47.43%	54.28%
60086	North Chicago	0.03%	0.16%
60087	Waukegan	11.36%	7.10%
60088	Great Lakes	0.13%	0.37%
60096	Winthrop Harbor	1.80%	0.81%
60099	Zion	18.78%	9.14%
	other	0.18%	0.57%
	Total	100.00%	100.00%

Market Report

COMPdata

COMPdata Report: ER PATIENTS MARKET SHARE - VISTA EAST AND WES

03/05/2010

Reporting Period: 10/01/2008 THROUGH 09/30/2009

Page 2

PROVIDER FACILITY / ZIP CODE - PATIENT	Cases	Market Share	Avg LOS	Days Total	Days Market Share	Charges Avg Charge	Avg Per Day	Avg Age
VISTA MEDICAL CENTER WEST								
60002 ANTIOCH	200	1.49						
60010 BARRINGTON	3	0.02						
60015 DEERFIELD	3	0.02						
60020 FOX LAKE	39	0.29						
60030 GRAYSLAKE	169	1.26						
60031 GURNEE	568	4.23						
60035 HIGHLAND PARK	33	0.25						
60040 HIGHWOOD	13	0.10						
60041 INGLESIDE	38	0.28						
60042 ISLAND LAKE	7	0.05						
60044 LAKE BLUFF	19	0.14						
60045 LAKE FOREST	4	0.03						
60046 LAKE VILLA	245	1.83						
60047 LAKE ZURICH	7	0.05						
60048 LIBERTYVILLE	45	0.34						
60049 LONG GROVE	1	0.01						
60060 MUNDELEIN	58	0.43						
60061 VERNON HILLS	25	0.19						
60064 NORTH CHICAGO	1,809	13.48						
60069 LINCOLNSHIRE	2	0.01						
60073 ROUND LAKE	306	2.28						
60079 WAUKEGAN	13	0.10						
60083 WADSWORTH	150	1.12						
60084 WAUCONDA	11	0.08						
60085 WAUKEGAN	7,285	54.28						
60086 NORTH CHICAGO	22	0.16						
60087 WAUKEGAN	953	7.10						
60088 GREAT LAKES	49	0.37						
60089 BUFFALO GROVE	8	0.06						
60096 WINTHROP HARBOR	109	0.81						
60099 ZION	1,226	9.14						
TOTAL FOR: VISTA MEDICAL CENTER WEST	13,420							
GRAND TOTAL:	47,766							

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Market Report

COMPdata

COMPdata Report: ER PATIENTS MARKET SHARE - VISTA EAST AND WES

03/05/2010

Page 1

Reporting Period: 10/01/2008 THROUGH 09/30/2009

PROVIDER FACILITY / ZIP CODE - PATIENT	Cases	Market Share	Days: Avg LOS	Days: Total	Days: Market Share	Charges: Avg Charge	Charges: Avg Per Day	Avg Age
VISTA MEDICAL CENTER EAST								
60002 ANTIOCH	620	1.81						
60010 BARRINGTON	3	0.01						
60015 DEERFIELD	3	0.01						
60020 FOX LAKE	57	0.17						
60030 GRAYSLAKE	248	0.72						
60031 GURNEE	1,029	3.00						
60035 HIGHLAND PARK	16	0.05						
60037 FORT SHERIDAN	1	0.00						
60040 HIGHWOOD	9	0.03						
60041 INGLESIDE	66	0.19						
60042 ISLAND LAKE	3	0.01						
60044 LAKE BLUFF	34	0.10						
60045 LAKE FOREST	11	0.03						
60046 LAKE VILLA	420	1.22						
60047 LAKE ZURICH	11	0.03						
60048 LIBERTYVILLE	50	0.15						
60060 MUNDELEIN	70	0.20						
60061 VERNON HILLS	31	0.09						
60064 NORTH CHICAGO	3,196	9.31						
60069 LINCOLNSHIRE	6	0.02						
60073 ROUND LAKE	588	1.71						
60075 RUSSELL	1	0.00						
60079 WAUKEGAN	57	0.17						
60083 WADSWORTH	473	1.38						
60084 WAUCONDA	13	0.04						
60085 WAUKEGAN	16,289	47.43						
60086 NORTH CHICAGO	12	0.03						
60087 WAUKEGAN	3,903	11.36						
60088 GREAT LAKES	45	0.13						
60089 BUFFALO GROVE	11	0.03						
60096 WINTHROP HARBOR	619	1.80						
60099 ZION	6,451	18.78						
TOTAL FOR: VISTA MEDICAL CENTER EAST	34,346							

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SERVICE DEMAND - HISTORICAL UTILIZATION

As noted elsewhere in this application, Condell Medical Center in Libertyville and Vista Medical Center-West in Waukegan are the only providers of emergency room services (and accepts ambulances) located within 30 minutes of the proposed FEC. Also as noted, VMC-W has a very limited inpatient program.

CompDATA was used to calculate ED visits in the GSA for the two most recent years data was available: October 2007 - September 2008 (2008) and October 2008 - September 2009 (2009). We recognize the CompDATA shows different ED visit totals than does IDPH data for 2008. This may be based on different reporting methods, or the fact that the CompDATA calculation was not on a calendar year basis. CompDATA shows, for hospitals in the GSA, 186,355 total ED visits in 2008 and 205,894 total ED visits in 2009. Using CompDATA to conduct a zip code analysis, 139,127 ED visits in 2008 were by patients who reside in zip codes within the GSA, and 156,055 of the ED visits in 2009 were by patients who reside in zip codes within the GSA. Based on this, 74.6% of 2008 ED visits at hospitals in the GSA were by patients who resided within the GSA, and 75.8% of 2009 ED visits at hospitals in the GSA were by patients who resided within the GSA. Hospital-specific ED visits can be found in the attached CompDATA information.

Utilization of the proposed FEC was projected in a very conservative manner, including the following assumptions:

- utilization of emergency department services by area residents will remain at the 2009 level, even though a population increase will be realized
- 100% of the FEC's patients will reside closer to the FEC than to a hospital-based emergency department
- no more than 70% of the emergency services patients from any Zip Code area will use the proposed FEC.

Based on the assumptions identified above, utilization during the second year of the proposed FEC's operation is projected to be 13,523 visits, supporting a "need" for the proposed seven treatment stations. The manner in which projected utilization was identified is presented in the table below. Allowing for a "ramp-up" period, utilization during the first year of operation is anticipated to be 60% of the second year's utilization, or 8,114 patient visits.

Case Trend Analysis

COMPdata

COMPdata Report: ER PATIENTS MARKET SHARE FOR ANNE ALL ZIPS 03/18/2010

Reporting Period: 10/01/2007 THROUGH 09/30/2009

PROVIDER FACILITY	CASES					SHARE				
	10/01/2008 09/30/2009	10/01/2007 09/30/2008	% Change	% Change	% Change	10/01/2008 09/30/2009	10/01/2007 09/30/2008	% Change	% Change	% Change
ADVOCATE CONDELL MEDICAL CENTER	49,129	45,128	8.87			23.9	24.2	-1.46		
ADVOCATE GOOD SHEPHERD HOSPITAL	8,125	8,895	-8.66			3.9	4.8	-17.33		
CENTEGRA HOSPITAL - MCHENRY	36,390	30,153	20.69			17.7	16.2	9.23		
MIDWESTERN REGIONAL MEDICAL CENTER	4,466	420	963.81			2.2	0.2	864.44		
NORTHSHORE UNIVERSITY HEALTHSYSTEM HIGHLI	24,502	23,621	3.73			11.9	12.7	-6.11		
NORTHWESTERN LAKE FOREST HOSPITAL	33,469	34,271	-2.34			16.3	18.4	-11.61		
VISTA MEDICAL CENTER EAST	35,813	37,412	-4.27			17.4	20.1	-13.36		
VISTA MEDICAL CENTER WEST	13,998	6,458	116.75			6.8	3.5	96.22		
TOTAL:	205,894	186,356	10.48			100.0	100.0	115.00		

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Case Trend Analysis

COMPdata

ZIPS WITHIN THE GSA

COMPdata Report: ER PATIENTS MARKET SHARE FOR ANNE

Reporting Period: 10/01/2007 THROUGH 09/30/2009

PROVIDER FACILITY	CASES 10/01/2008 - 09/30/2009	10/01/2007 - 09/30/2008	% Change	% Change	% Change	SHARE 10/01/2008 - 09/30/2009	10/01/2007 - 09/30/2008	% Change	% Change	% Change
ADVOCATE CONDELL MEDICAL CENTER	44,106	40,018	10.22			28.3	28.6	-1.74		
ADVOCATE GOOD SHEPHERD HOSPITAL	1,622	1,830	-11.37			1.0	1.3	-20.99		
CENTEGRA HOSPITAL - MCHENRY	22,661	18,166	24.74			14.5	13.1	11.21		
MIDWESTERN REGIONAL MEDICAL CENTER	3,718	279	1,232.62			2.4	0.2	1,085.08		
NORTHSHORE UNIVERSITY HEALTHSYSTEM HIGHU	6,642	6,533	1.67			4.3	4.7	-9.37		
NORTHWESTERN LAKE FOREST HOSPITAL	29,604	30,502	-2.94			19.0	21.9	-13.47		
VISTA MEDICAL CENTER EAST	34,338	35,694	-3.80			22.0	25.7	-14.23		
VISTA MEDICAL CENTER WEST	13,364	6,105	118.90			8.6	4.4	95.17		
TOTAL:	156,055	139,127	12.17			100.0	100.0	141.46		

161C

SERVICE ACCESSIBILITY

The purpose of this project is to improve the accessibility to emergency services for the residents of north-central and northwestern Lake County. The proposed service's geographic service area (GSA), as defined in Section 1110.3230 is identified on the map included in Attachment - 74. That service area extends 30-minutes from the proposed site.

Restricted services exist, per Section 1110.3230, when one or more of three situations occur: 1) there are no emergency departments in the GSA; 2) the GSA exhibits indicators of medical care problems; or 3) all existing emergency services in the GSA meet or exceed the IDPH's utilization standard. Among the indicators of medical care problems identified in Section 1110.3230 is "...designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or Medically Underserved Population. Attached is documentation from the U.S. Department of Health and Human Services, showing three townships, all of which are located in the northeastern portion of the GSA, being identified as Health Professional Shortage Areas for primary medical care.

Find Shortage Areas: HPSA by State & County

Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA Eligible for the Medicare Physician Bonus Payment
MUA/P by State & County

Criteria:

State: Illinois
County: Lake County
Date of Last Update: All Dates
HPSA Score (lower limit): 0

Discipline: Primary Medical Care
Metro: All
Status: Designated
Type: All

Results: 5 records found.
(Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee. They are not listed separately.)

HPSA Name	ID	Type	FTE	# Short	Score
097 - Lake County					
Lake County Community Health Department and Commun	117999176B	Comprehensive Health Center	1		7
Low Income - Waukegan/Zion/Benton	117999179C	Population Group	4	12	12
Benton Township		Minor Civil Division			
Waukegan Township		Minor Civil Division			
Zion Township		Minor Civil Division			

NEW SEARCH | MODIFY SEARCH CRITERIA

ATTACHMENT - 74

UNNECESSARY DUPLICATION/MALDISTRIBUTION

The IDPH-defined geographic service area (GSA) includes 22 Zip Code areas and their primary community, as follows:

60002	Antioch
60020	Fox Lake
60030	Grayslake
60031	Gurnee
60041	Ingleside
60044	Lake Bluff
60045	Lake Forest
60046	Lake Villa
60048	Libertyville
60060	Mundelein
60061	Vernon Hills
60064	North Chicago
60073	Round Lake
60079	Waukegan
60083	Wadsworth
60084	Wauconda
60085	Waukegan
60086	North Chicago
60087	Waukegan
60088	Great Lakes
60096	Winthrop Harbor
60099	Zion

In order to identify "the total population" of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois population), a representative of the co-applicants consulted with Michael Gibbs and Michael Mitchell of the IDPH staff and was directed to the U.S. Bureau of the Census ZIP code-specific population data. The cumulative 2000 population of the 22 Zip Code area identified above was 573,045 (it should be noted that the data did not include a population for Zip Code area 60051).

It should also be noted that while the proposed site is 29 minutes from the closest full-service hospital, a significant portion of the TPA (please see Attachment 22) is located in excess of 30 minutes from the closest hospital. As such, the proposed FEC will not be unnecessarily duplicating emergency department services and this project will not result in a mal-distribution of services; rather, accessibility will be improved.

The only provider of emergency department services located within 30 minutes of the proposed site are Condell Medical Center, which is located at 801 S. Milwaukee Avenue in Libertyville, Illinois, and Vista Medical center-West, which is located at 2615 Washington Street in Waukegan, Illinois. In addition, Lake Forest Hospital was recently approved to operate a FEC in Grayslake, Illinois.

MAL-DISTRIBUTION

The proposed project will not create a mal-distribution of services. Rather, this project will improve accessibility to emergency department services for the residents of the target population area, who, by definition, reside closer to the proposed site than to an existing service. This issue is most critical for those residing in the northern and western portions of the target population area (TPA), furthest from existing hospital-based emergency departments.

The anticipated TPA is a very small geographic area, but of sufficient population size to justify the proposed seven treatment stations, based on the following assumptions: 1) the population of the TPA will at least remain constant (very conservative), 2) the TPA's utilization rate will remain at its 2009 level of 193.87 visits/1,000, and 3) no more than 70% of emergency services patients from any TPA Zip Code will use the proposed FEC, and in each case will reside closer to the FEC than to a hospital-based emergency department.

The only providers of emergency department services (accepting ambulances) within a thirty-minute drive of the proposed site is Condell Medical Center in Libertyville and Vista Medical center-West in Waukegan. During 2008, 45,944 patients were treated in Condell's emergency department, and during 2008, 12,018 patient's were treated at VMC-W's emergency department.

STAFFING

No unusual difficulties are anticipated with the staffing of the proposed FEC. As discussed in other portions of this document, the FEC will operate as an extension of the Level II trauma center at Vista Medical Center-East, and will likely attract its staff from the same general area, that being northern Lake County.

As noted, there is only one provider of emergency department services (and accepting ambulances) other than VMC-W located within a 30-minute drive of the proposed facility, that being Condell Medical Center.

Consistent with the requirements of Section 1110.3230, letters were sent to area hospitals (copies attached in Exhibit - 25) regarding vacancy rates, and their responses will be provided to the Board upon receipt.

Morningstar® Document Research℠

FORM 10-K

COMMUNITY HEALTH SYSTEMS INC - CYH

Filed: February 29, 2008 (period: December 31, 2007)

Annual report which provides a comprehensive overview of the company for the past year

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, 2007

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 *(State of incorporation)*	**13-3893191** *(IRS Employer Identification No.)*
4000 Meridian Boulevard **Franklin, Tennessee** *(Address of principal executive offices)*	**37067** *(Zip Code)*

Registrant's telephone number, including area code:
(615) 465-7000

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

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, $.01 par value	New York Stock Exchange

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

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

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

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

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

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

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

The aggregate market value of the voting stock held by non-affiliates of the Registrant was $3,838,926,302. Market value is determined by reference to the closing price on June 30, 2007 of the Registrant's Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2007) have any non-voting common stock outstanding. As of February 1, 2008, there were 96,618,751 shares of common stock, par value $.01 per share.

outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required for Part III of this annual report is incorporated by reference from portions of the Registrant's definitive proxy statement for its 2008 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, 2007.

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FORM 10-K ANNUAL REPORT

COMMUNITY HEALTH SYSTEMS, INC.
Year ended December 31, 2007

PART I

Item 1. *BUSINESS OF COMMUNITY HEALTH SYSTEMS*

Overview of Our Company

We are the largest publicly traded operator of hospitals in the United States in terms of number of facilities and net operating revenues. We provide healthcare services through these hospitals that we own and operate in non-urban and selected urban markets throughout the United States. As of December 31, 2007, included in our continuing operations, are 115 hospitals that we owned, leased or operated. These hospitals are geographically diversified across 27 states, with an aggregate of 16,971 licensed beds. We generate revenues by providing a broad range of general and specialized hospital healthcare services to patients in the communities in which we are located. Services provided by our hospitals include, but are not limited to, general acute care services, emergency room services, general and specialty surgery, critical care, internal medicine, obstetrics and diagnostic services. As part of providing these services we also own, outright or through partnerships with physicians, physician practices, imaging centers, and ambulatory surgery centers. In addition to our hospitals and related businesses, we also own and operate home health agencies, including four home health agencies located in markets where we do not operate a hospital. Through our corporate ownership and operation of these businesses we provide: standardization and centralization of operations across key business areas; a strategic direction to expand and improve services and facilities at our hospitals; implementation of quality of care improvement programs; and assistance in the recruitment of additional physicians 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. Through our wholly-owned subsidiary, Quorum Health Resources, LLC ("QHR"), we also provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States.

Our strategy also includes growth by acquisition. We target hospitals in growing, non-urban and select urban healthcare markets for acquisition because of their favorable demographic and economic trends and competitive conditions. Because these service areas have smaller populations, there are generally fewer hospitals and other healthcare service providers in these communities and generally a lower level of managed care presence in these markets. We believe that smaller populations support less direct competition for hospital-based services. Also, we believe that these communities generally view the local hospital as an integral part of the community.

Effective July 25, 2007, we completed our acquisition of Triad Hospitals, Inc., or Triad. Of the 115 hospitals included in our continuing operations as of December 31, 2007, 43 of them were acquired as part of the acquisition of Triad. The acquisition of Triad also expanded our operations into five states where we previously did not own any facilities.

Available Information

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

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

We have included the Chief Executive Officer and the Chief Financial Officer certifications regarding the company's public disclosure required by Section 302 of the Sarbanes-Oxley Act of 2002 as Exhibits 31.1 and 31.2 of this report. We timely submitted to the New York Stock Exchange (the "NYSE") the 2007 Annual

CEO certification regarding our compliance with the NYSE's corporate governance listing standards as required by NYSE Rule 303A.

Our Business Strategy

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

- increase revenue at our facilities;
- improve profitability;
- improve quality; and
- grow through selective acquisitions.

Increase Revenue at Our Facilities

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

- recruiting additional primary care physicians and specialists;
- expanding the breadth of services offered at our hospitals through targeted capital expenditures to support the addition of more complex services, including orthopedics, cardiovascular services, and urology; and
- providing the capital to invest in technology and the physical plant at the facilities, particularly in our emergency rooms, surgery departments, critical care departments, and diagnostic services.

Physician Recruiting. The primary method of adding or expanding medical services is the recruitment of new physicians into the community. A core group of primary care physicians is necessary as an initial contact point for all local healthcare. The addition of specialists who offer services, including general surgery, OB/GYN, 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 by analyzing demographic data and patient referral trends. As a result of this analysis, we are able to determine what we believe to be the optimum mix of primary care physicians and specialists. We employ recruiters at the corporate level to support the local hospital managers in their recruitment efforts. We have increased the number of physicians affiliated with us through our recruiting efforts, net of turnover, by approximately 440 in 2007, 300 in 2006 and 290 in 2005. The percentage of recruited or other physicians commencing practice with us that were specialists was over 50% in 2007. Although in recent years we have begun employing more physicians, most of our physicians are in private practice in their communities and are not our employees. We have been successful in recruiting physicians because of the practice opportunities afforded physicians in our markets, as well as lower managed care penetration as compared to larger urban areas.

Emergency Room Initiatives. Given that over approximately 55% of our hospital admissions originate in the emergency room, we systematically take steps to increase patient flow in our emergency rooms as a means of optimizing utilization rates for our hospitals. Furthermore, the impression of our overall operations by our customers is substantially influenced by our emergency rooms since generally that is their first experience with our hospitals. The steps we take to increase patient flow in our emergency rooms include renovating and expanding our emergency room facilities, improving service and reducing waiting times, as well as publicizing our emergency room capabilities in the local community. We have expanded or renovated 13 of our emergency rooms during the past three years, including three in 2007. We have also implemented marketing campaigns that emphasize the speed, convenience, and quality of our emergency rooms to enhance each community's awareness of our emergency room services.

One component of upgrading our emergency rooms is the implementation of specialized computer software programs designed to assist physicians in making diagnoses and determining treatments. The software also benefits patients and hospital personnel by assisting in proper documentation of patient records and tracking patient flow. It enables our nurses to provide more consistent patient care and provides clear instructions to patients at time of discharge to help them better understand their treatments.

Expansion of Services. In an effort to better meet the healthcare needs of the communities we serve and to capture a greater portion of the healthcare spending in our markets, we have added a broad range of services to our facilities. These services range from various types of diagnostic equipment capabilities to additional and renovated emergency rooms, surgical and critical care suites and specialty services. For example, in 2007, we spent $61 million as a part of 35 major construction projects. This includes $15.1 million on 9 major construction projects which have been started at the hospitals acquired in the Triad acquisition. The 2007 projects included new emergency rooms, cardiac cathertization labs, intensive care units, hospital additions, and an ambulatory surgery center. These projects improved various diagnostic and other inpatient and outpatient service capabilities. We continue to believe that appropriate capital investments in our facilities combined with the development of our service capabilities will reduce the migration of patients to competing providers while providing an attractive return on investment. We also employ a small group of clinical consultants at our corporate headquarters to assist the hospitals in their development of surgery, emergency services, critical care and cardiovascular services. In conjunction with an interest in a joint venture that we acquired as part of the Triad acquisition, pursuant to the terms of the joint venture agreement, we built an acute care hospital in Cedar Park, Texas, which opened in December 2007. The joint venture partner is a not-for-profit entity. Since the Triad acquisition, we spent approximately $38.6 million in construction costs, including equipment related to this hospital. We estimate approximately $2 million will be spent in 2008 to complete this hospital.

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

Improve Profitability

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

- standardizing and centralizing our operations;
- optimizing resource allocation by utilizing our company-devised case and resource management program, which assists in improving clinical care and containing expenses;
- capitalizing on purchasing efficiencies through the use of company-wide standardized purchasing contracts and terminating or renegotiating specified vendor contracts;
- installing a standardized management information system, resulting in more efficient billing and collection procedures; and
- monitoring and enhancing productivity of our human resources.

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, which has an average of over 25 years of experience in the healthcare industry.

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

- *Billing and Collections.* We have adopted standard policies and procedures with respect to billing and collections. We have also automated and standardized various components of the collection cycle, including statement and collection letters and the movement of accounts through the collection cycle. Upon completion of an acquisition, our management information system 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.
- *Physician Support.* We support our newly recruited physicians to enhance their transition into our communities. We have implemented physician practice management seminars and training. We host these seminars bi-monthly. All newly recruited physicians are required to attend a three-day introductory seminar that covers issues involved in starting up a practice.
- *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. ("Health Trust"), a group purchasing organization ("GPO"). HealthTrust is the source for a substantial portion of our medical supplies, equipment and pharmaceuticals. This agreement extends to March 2010, 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 while maintaining the same level of quality and have shortened the time it takes us to complete these projects.
- *Other Initiatives.* We have also improved margins by implementing standard programs with respect to ancillary services in areas including emergency rooms, pharmacy, laboratory, imaging, home health, skilled nursing, centralized outpatient scheduling and health information management. We have reduced costs associated with these services by improving contract terms and standardizing information systems. We work to identify and communicate best practices and monitor these improvements throughout the Company.
- *Internal Controls Over Financial Reporting.* We have centralized many of our significant internal controls over financial reporting and standardized those other controls that are performed at our hospital locations. We continuously monitor compliance with and evaluate the effectiveness of our internal controls over financial reporting.

Case and Resource Management. Our case and resource management program is a company-devised program developed with the goal of improving clinical care and cost containment. The program focuses on:

- appropriately treating patients along the care continuum;
- reducing inefficiently applied processes, procedures and resources;
- developing and implementing standards for operational best practices; and
- using on-site clinical facilitators to train and educate care practitioners on identified best practices.

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Our case and resource management program integrates the functions of utilization review, discharge planning, overall clinical management, and resource management into a single effort to improve the quality and efficiency of care. Issues evaluated in this process include patient treatment, patient length of stay and utilization of resources.

Under our case and resource management program, patient care begins with a clinical assessment of the appropriate level of care, discharge planning, and medical necessity for planned services. Once a patient is admitted to the hospital, we conduct a review for ongoing medical necessity using appropriateness criteria. We reassess and adjust discharge plan options as the needs of the patient change. We closely monitor cases to prevent delayed service or inappropriate utilization of resources. Once the patient attains clinical improvement, we encourage the attending physician to consider alternatives to hospitalization through discussions with the facility's physician advisor. Finally, we refer the patient to the appropriate post-hospitalization resources.

Improve Quality

We have implemented various programs to ensure continuous improvement in the quality of care provided. We have developed training programs for all senior hospital management, chief nursing officers, quality directors, physicians and other clinical staff. We share information among our hospital management to implement best practices and assist in complying with regulatory requirements. We have standardized accreditation documentation and requirements. All hospitals conduct patient, physician, and staff satisfaction surveys to help identify methods of improving the quality of care.

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

Grow Through Selective Acquisitions

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

- have a service area population between 20,000 and 400,000 with a stable or growing population base;
- are the sole or primary provider of acute care services in the community;
- are located in an area with the potential for service expansion;
- are not located in an area that is dependent upon a single employer or industry; and
- have financial performance that we believe will benefit from our management's operating skills.

In each year since 1997, we have met or exceeded our acquisition goals. Occasionally, we have pursued acquisition opportunities outside of our specified criteria when such opportunities have had uniquely favorable characteristics. In addition to two hospitals acquired from local governmental entities in 2007, we also acquired Triad, which, at the time of our acquisition, owned and operated 50 hospitals in 17 states across the U.S., with 1 hospital in Ireland. Although we intend to meet our acquisition goal in 2008, by completing the previously announced acquisition of a two hospital system in Spokane, Washington, we do not anticipate actively pursuing acquisitions for the remainder of 2008 as we continue to concentrate on the integration of Triad. Beyond 2008, we intend on returning to our strategy of growing through selective acquisitions. We currently estimate that there are approximately 400 hospitals that meet our acquisition criteria. These hospitals are primarily owned by governmental, not-for-profit, or faith based agencies.

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

Acquisition Efforts. We have focused on identifying possible acquisition opportunities through expanding our internal acquisition group and working with a broad range of financial advisors who are active in the sale of hospitals, especially in the not-for-profit sector.

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

At the time we acquire a hospital, we may commit to an amount of capital expenditures, such as a replacement facility, renovations, or equipment over a specified period of time. As an obligation under hospital purchase agreements in effect as of December 31, 2007, we are required to build replacement facilities in Petersburg, Virginia, by August 2008, Clarksville, Tennessee by June 2009, Shelbyville, Tennessee by June 2009 and Valparaiso, Indiana by April 2011. Also, as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location. In conjunction with a joint venture agreement with a non-profit entity, we constructed an acute care hospital in Cedar Park, Texas, which opened in December 2007. Estimated construction costs, including equipment costs, are approximately $761.4 million for these five replacement hospitals and one de novo hospital of which approximately $362.1 million has been incurred to date (including costs incurred by Triad prior to our acquisition). In addition, other commitments under purchase agreements, which include amounts for costs such as capital improvements, equipment, selected leases and physician recruiting in effect as of December 31, 2007, obligate us to spend approximately $265.6 million through 2011.

Integration of Triad

We believe we can improve and grow the operations of the hospitals we acquired in the acquisition of Triad through our standardization and centralization strategies related to billing and collections, physician recruiting, emergency room initiatives, managed care contracting and our various improvement strategies, as previously discussed. We believe our objective of increasing shareholder value through this acquisition can be achieved through a combination of standardization of the information systems, the implementation of controls designed to enhance discipline over capital spending and synergies in overhead costs obtained through economies of scale.

Industry Overview

The Centers for Medicare and Medicaid Services, or CMS, reported that in 2006 total U.S. healthcare expenditures grew by 6.7% to $2.1 trillion. It projected total U.S. healthcare spending to grow by 6.6% in 2007, by an average of 7.0% annually from 2008 through 2010 and by 6.9% annually from 2011 through 2016. By these estimates, healthcare expenditures will account for approximately $4.1 trillion, or 19.6% of the total U.S. gross domestic product, by 2016.

Hospital services, the market in which we operate, is the largest single category of healthcare at 31% of total healthcare spending in 2006, or $648.2 billion, as reported by CMS. CMS projects the hospital services category to grow by at least 6.8% per year through 2016. It expects growth in hospital healthcare spending to continue due to the aging of the U.S. population and consumer demand for expanded medical services. As hospitals remain the primary setting for healthcare delivery, it expects hospital services to remain the largest category of healthcare spending.

U.S. Hospital Industry. The U.S. hospital industry is broadly defined to include acute care, rehabilitation, and psychiatric facilities that are either public (government owned and operated), not-for-profit private (religious or secular), or for-profit institutions (investor owned). According to the American Hospital Association, there are approximately 4,900 inpatient hospitals in the U.S. which are not-for-profit owned, investor owned, or state or local government owned. Of these hospitals, approximately 41% are located in non-urban communities. We believe that a majority of these hospitals are owned by not-for-profit or governmental entities. These facilities offer a broad range of healthcare services, including internal medicine, general surgery, cardiology, oncology, orthopedics, OB/GYN, and emergency services. In addition, hospitals also offer other ancillary services including psychiatric, diagnostic, rehabilitation, home health, and outpatient surgery services.

Urban vs. Non-Urban Hospitals

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

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

- facility size and location;
- facility ownership structure (i.e., tax-exempt or investor owned);
- a facility's ability to participate in group purchasing organizations; and
- facility payor mix.

We believe that non-urban hospitals are generally able to obtain higher operating margins than urban hospitals. Factors contributing to a non-urban hospital's margin advantage include fewer patients with complex medical problems, a lower cost structure, limited competition, and favorable Medicare payment provisions. Patients needing the most complex care are more often served by the larger and/or more specialized urban hospitals. A non-urban hospital's lower cost structure results from its geographic location, as well as the lower number of patients treated who need the most highly advanced services. Additionally, because non-urban hospitals are generally sole providers or one of a small group of providers in their markets, there is limited competition. This generally results in more favorable pricing with commercial payors. Medicare has special payment provisions for "sole community hospitals." Under present law, hospitals that qualify for this designation can receive higher reimbursement rates. As of December 31, 2007, 26 of our hospitals were "sole community hospitals." In addition, we believe that non-urban communities are generally characterized by a high level of patient and physician loyalty that fosters cooperative relationships among the local hospitals, physicians, employees and patients.

The type of third party responsible for the payment of services performed by healthcare service providers is also an important factor which affects hospital operating margins. These providers have increasingly exerted pressure on healthcare service providers to reduce the cost of care. The most active providers in this regard have been HMOs, PPOs, and other managed care organizations. The characteristics of non-urban markets make them less attractive to these managed care organizations. This is partly because the limited size of non-urban markets and their diverse, non-national employer bases minimize the ability of managed care organizations to achieve economies of scale as compared to economics of scale that can be achieved in many urban markets.

Hospital Industry Trends

Demographic Trends. According to the U.S. Census Bureau, there are presently approximately 37.3 million Americans aged 65 or older in the U.S. who comprise approximately 12.4% of the total

U.S. population. By the year 2030, the number of elderly is expected to climb to 71.5 million, or 20% of the total population. Due to the increasing life expectancy of Americans, the number of people aged 85 years and older is also expected to increase from 5.3 million to 9.6 million by the year 2030. This increase in life expectancy will increase demand for healthcare services and, as importantly, the demand for innovative, more sophisticated means of delivering those services. Hospitals, as the largest category of care in the healthcare market, will be among the main beneficiaries of this increase in demand. Based on data compiled for us, the populations of the service areas where our hospitals are located grew by 23.4% from 1990 to 2006 and are expected to grow by 6.1% from 2006 to 2010. The number of people aged 55 or older in these service areas grew by 34.4% from 1990 to 2006 and is expected to grow by 14.1% from 2006 to 2010.

Consolidation. During recent years a significant amount of private equity capital has been invested into the hospital industry. Also, in addition to our own acquisition of Triad in 2007, consolidation activity, primarily through mergers and acquisitions involving both for-profit and not-for-profit hospital systems is continuing. Reasons for this activity include:

- excess capacity of available capital;
- valuation levels;
- financial performance issues, including challenges associated with changes in reimbursement and collectability of self-pay revenue;
- the desire to enhance the local availability of healthcare in the community;
- the need and ability to recruit primary care physicians and specialists;
- the need to achieve general economies of scale and to gain access to standardized and centralized functions, including favorable supply agreements and access to malpractice coverage; and
- regulatory changes.

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 2007 include a full year of operations for 70 hospitals and partial periods for 45 hospitals. Statistics for 2006 include a full year of operations for 63 hospitals and partial periods for 7 hospitals acquired during the year. Statistics for 2005 include a full year of operations for 59 hospitals and partial periods for 4 hospitals acquired during the year less one hospital that was consolidated with another hospital we own in the same community. Hospitals which have been sold and hospitals which are classified as held for sale are excluded from all periods presented.

	Year Ended December 31,		
	2007	2006	2005
	(Dollars in thousands)		
Consolidated Data			
Number of hospitals (at end of period)	115	70	63
Licensed beds(1)	16,971	8,406	7,398
Beds in service(2)	14,604	6,753	5,986
Admissions(3)	463,212	307,964	275,044
Adjusted admissions(4)	848,707	570,969	508,037
Patient days(5)	1,941,887	1,264,256	1,140,605
Average length of stay (days)(6)	4.2	4.1	4.1
Occupancy rate (beds in service)(7)	52.4%	54.3%	54.4%
Net operating revenues	$ 7,127,494	$ 4,180,136	$ 3,576,117
Net inpatient revenues as a % of total net operating revenues	49.3%	50.0%	50.8%
Net outpatient revenues as a % of total net operating revenues	48.6%	48.8%	48.0%
Net Income	$ 30,289	$ 168,263	$ 167,544
Net Income as a % of total net operating revenues	0.4%	4.0%	4.7%
Liquidity Data			
Adjusted EBITDA(8)	$ 827,032	$ 564,339	$ 555,725
Adjusted EBITDA as a % of total net operating revenues(8)	11.6%	13.5%	15.5%
Net cash flows provided by operating activities	$ 687,738	$ 350,255	$ 411,049
Net cash flows provided by operating activities as a % of total net operating revenues	9.6%	8.4%	11.5%
Net cash flows used in investing activities	$ (7,498,858)	$ (640,257)	$ (327,272)
Net cash flows provided by (used in) financing activities	$ 6,903,428	$ 226,460	$ (62,167)

See pages 9 through 11 for footnotes.

	Year Ended December 31,		(Decrease) Increase
	2007	2006	
	(Dollars in thousands)		
Same-Store Data(9)			
Admissions(3)	434,317	439,056	(1.1)%
Adjusted admissions(4)	792,190	789,184	(0.4)%
Patient days(5)	1,824,399	1,872,581	
Average length of stay (days)(6)	4.2	4.3	
Occupancy rate (beds in service)(7)	52.6%	54.4%	
Net operating revenues	$ 6,571,528	$ 6,308,656	
Income from operations	$ 460,110	$ 550,519	
Income from operations as a% of net operating revenues	7.0%	8.7%	
Depreciation and amortization	$ 293,972	$ 279,485	
Equity in earnings of unconsolidated affiliates	$ 23,627	$ 20,105	

(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 percentages by dividing the average daily number of inpatients by the weighted average of beds in service.

(8) EBITDA consists of net income (loss) before interest, income taxes, depreciation and amortization. Adjusted EBITDA is EBITDA adjusted to exclude discontinued operations, loss from early extinguishment of debt and minority interest in earnings. We have from time to time sold minority interests in certain of our subsidiaries or acquired subsidiaries with existing minority interest ownership positions. We believe that it is useful to present adjusted EBITDA because it excludes the portion of EBITDA attributable to these third party interests and clarifies for investors our portion of EBITDA generated by continuing operations. We use adjusted EBITDA as a measure of liquidity. We have included this measure because we believe it provides investors with additional information about our ability to incur and service debt and make capital expenditures. Adjusted EBITDA is the basis for a key component in the determination of our compliance with some of the covenants under our senior secured credit facility, as well as 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).

Adjusted EBITDA is not a measurement of financial performance or liquidity under generally accepted accounting principles. It should not be considered in isolation or as a substitute for net income, operating income, cash flows from operating, investing or financing activities, or any other measure calculated in accordance with generally accepted accounting principles. The items excluded from adjusted EBITDA are significant components in understanding and evaluating financial performance and liquidity. Our calculation of adjusted EBITDA may not be comparable to similarly titled measures reported by other companies.

The following table reconciles adjusted EBITDA, as defined, to our net cash provided by operating activities as derived directly from our consolidated financial statements for the years ended December 31, 2007, 2006, and 2005 (in thousands):

	Year Ended December 31,		
	2007	2006	2005
Adjusted EBITDA	$ 827,032	$ 564,339	$ 555,725
Interest expense, net	(364,533)	(94,411)	(87,185)
Provision for income taxes	(43,003)	(110,152)	(119,804)
Deferred income taxes	(39,894)	(25,228)	9,889
Loss from operations of hospitals sold or held for sale	(11,067)	(6,873)	(8,737)
Income tax benefit on the non-cash impairment and loss on sale of hospitals	4,457	1,378	924
Depreciation and amortization of discontinued operations	16,365	9,485	8,900
Stock compensation expense	38,771	20,073	4,957
Excess tax benefits relating to stock based compensation	(1,216)	(6,819)	—
Other non-cash (income) expenses, net	19,017	500	740
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	131,300	(71,141)	(47,455)
Supplies, prepaid expenses and other current assets	(31,977)	(4,544)	(16,838)
Accounts payable, accrued liabilities and income taxes	125,959	52,151	84,956
Other	16,527	21,497	24,977
Net cash provided by operating activities	$ 687,738	$ 350,255	$ 411,049

(9) Includes former Triad hospital's data, as if they were owned August 1 through December 31, for both comparable periods and other acquired hospitals to the extent we operated them during comparable periods in both years.

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
- patient directly.

The following table presents the approximate percentages of net operating revenue received from Medicare, Medicaid, managed care, self-pay and other sources for the periods indicated. The data for the years presented are not strictly comparable due to the significant effect that hospital acquisitions have had on these statistics.

Net Operating Revenues by Payor Source	2007	2006	2005
Medicare	29.0%	30.4%	31.8%
Medicaid	10.3%	11.1%	11.2%
Managed Care and other third party payors	50.7%	46.7%	45.6%
Self-pay	10.0%	11.8%	11.4%
Total	100.0%	100.0%	100.0%

As shown above, we receive a substantial portion of our revenue from the Medicare and Medicaid programs. Other third party payors includes insurance companies for which we do not have insurance provider contracts, worker's compensation carriers, and non-patient service revenue, such as rental income and cafeteria sales.

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, which provides medical benefits to individuals who are 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. 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.

In addition to government programs, we are paid by private payors, which include insurance companies, HMOs, PPOs, other managed care companies, employers, and by patients directly. Blue Cross payors are included in "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 are negotiating discounted fee structures or fixed amounts for hospital services performed, rather than paying healthcare providers the amounts billed. We negotiate discounts with managed care companies, which are typically smaller than discounts under governmental programs. If an increased number of insurance companies, HMOs, PPOs, and other managed care companies succeed in negotiating discounted fee structures or fixed amounts, our results of operations may be negatively affected. For more information on the payment programs on which our revenues depend, see "Payment" on page 16.

As of December 31, 2007, Pennsylvania and Texas represented the only areas of geographic concentration. Net operating revenues as a percentage of consolidated net operating revenues generated in Pennsylvania were 13.1% in 2007, 22.0% in 2006 and 23.1% in 2005. Net operating revenues as a percentage of consolidated net operating revenues generated in Texas were 13.0% in 2007, 10.4% in 2006 and 11.6% in 2005.

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

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

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 relate to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, hospital use, rate-setting, compliance with building codes, and environmental protection laws. There are also extensive regulations governing a hospital's participation in these government programs. If we fail to comply with applicable laws and regulations, we can be subject to criminal penalties and civil sanctions, our hospitals can lose their licenses and we could lose our ability to participate in these government programs. In addition, 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 in substantial compliance with current federal, state, and local regulations and standards.

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 on Accreditation of Healthcare Organizations. This accreditation indicates that a hospital satisfies the applicable health and administrative standards to participate in Medicare and Medicaid programs.

Recent Changes. In recent years, numerous changes have been made in the oversight of health care providers to provide an increased emphasis on the linkage between quality of care criteria and payment levels. For example, hospital Medicare payments are now impacted by the hospital's accurate reporting of the basic elements of care provided to patients with certain diagnoses. The federal government, numerous states, and several managed care organizations have begun to initiate payment prohibitions for care associated with events considered preventable by the provider, such as falls, incorrect blood transfusion matching, and wrong site surgeries. As another indication of this trend and focus, the Joint Commission no longer gives numerical scores at scheduled triennial surveys; they now score hospitals and other accredited providers on a pass-fail basis based on unannounced surveys. Because hospitals no longer are able to prepare for a survey at a time certain, it is possible that there will be an increase in negative survey findings, which could lead to a loss of accreditation. Other provider types are facing similar changes in payment and quality oversight.

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

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of the fraud and abuse laws. Under HIPAA, 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.

Another law regulating the healthcare industry is a section of the Social Security Act, known as the "anti-kickback" statute. This law 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 program. Violations of the anti-kickback statute may be punished by criminal and civil fines, exclusion from federal healthcare programs, and damages up to three times the total dollar amount involved.

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. However, the failure of a particular activity to comply with the safe harbor regulations does not necessarily mean that the activity violates the anti-kickback statute.

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

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 believe that we have structured our arrangements with physicians in light of the "safe harbor" rules, 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.

The Social Security Act also includes a provision commonly known as the "Stark law." This law prohibits physicians from referring Medicare patients to healthcare entities in which they or any of their immediate family members have ownership interests or other financial arrangements. These types of referrals are commonly known as "self referrals." Sanctions for violating the Stark law include denial of payment, civil money penalties, assessments equal to twice the dollar value of each service, and exclusion from government payor programs. There are ownership and compensation arrangement exceptions to the self-referral prohibition. One 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. We strive to comply with the Stark law and regulations; however, the government may interpret the law and regulations differently. If we are found to have violated the Stark law or regulations, we could be subject to significant sanctions, including damages, penalties, and exclusion from federal health care programs.

Many states in which we operate also have adopted similar laws relating to financial relationships with physicians. Some of these state laws apply even if the payment for care does not come from the government. These statutes typically provide criminal and civil penalties as well as loss of licensure. While there is little precedent for the interpretation or enforcement of these state laws, we have attempted to structure our financial relationships with physicians and others in light of these laws. However, if we are found to have violated these state laws, it could result in the imposition of criminal and civil penalties as well as possible licensure revocation.

False Claims Act. Another trend in healthcare litigation is the increased use of the False Claims Act, or FCA. This law makes providers liable for, among other things, the knowing submission of a false claim for reimbursement by the federal government. The FCA has been used not only by the U.S. government, but also by individuals who bring an action on behalf of the government under the law's "qui tam" or "whistleblower" provisions and share in any recovery. When a private party brings a qui tam action under the FCA, it files the complaint with the court under seal, and the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation.

Civil liability under the FCA can be up to three times the actual damages sustained by the government plus civil penalties of up to $11,000 for each separate false claim submitted to the government. There are many potential bases for liability under the FCA. Although liability under the FCA arises when an entity knowingly submits a false claim for reimbursement, the FCA defines the term "knowingly" to include reckless disregard of the truth or falsity of the claim being submitted.

A number of states in which we operate have enacted state false claims legislation. These state false claims laws are generally modeled on the federal FCA, with similar damages, penalties, and qui tam enforcement provisions. An increasing number of healthcare false claims cases seek recoveries under both federal and state law.

Provisions in the Deficit Reduction Act of 2005 ("DRA") that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal FCA. Additionally, the DRA requires every entity that receives annual payments of at least $5 million from a state Medicaid plan to establish written policies for its employees that provide detailed information about federal and state false claims statutes and the whistleblower protections that exist under those laws. Both provisions of the DRA are expected to result in increased false claims litigation against health care providers. We have substantially complied with the written policy requirements.

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 or fee-splitting arrangements between physicians and unlicensed persons or business entities. Possible sanctions for violations of these restrictions include loss of a physician's license, civil and criminal penalties and rescission of business arrangements. These laws vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. We structure our arrangements with healthcare providers to comply with the relevant state law. However, we cannot assure you 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. In addition, the law creates private civil remedies which 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 or others will not assert we are in violation of these laws.

Healthcare Reform. The healthcare industry continues to attract much legislative interest and public attention. In recent years, an increasing number of legislative proposals have been introduced or proposed in Congress and in some state legislatures that would affect major changes in the healthcare system. Proposals that have been considered include cost controls on hospitals, insurance market reforms to increase the availability of group health insurance to small businesses, and mandatory health insurance coverage for employees. The costs of implementing some of these proposals could be financed, in part, by reductions in payments to healthcare providers under Medicare, Medicaid, and other government programs. We cannot predict the course of future healthcare legislation or other changes in the administration or interpretation of governmental healthcare programs and the effect that any legislation, interpretation, or change may have on us.

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 additional 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 certificate of need 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. We operate 59 hospitals in 15 states that have adopted certificate of need 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.

Privacy and Security Requirements of HIPAA. The Administrative Simplification Provisions of HIPAA require 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. We believe we are in compliance with these regulations.

The Administrative Simplification Provisions also require CMS to adopt standards to protect the security and privacy of health-related information. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. If we violate these regulations, we could be subject to monetary fines and penalties, criminal sanctions and civil causes of action. We have implemented and operate continuing employee education programs to reinforce operational compliance with policy and procedures which adhere to privacy regulations. The HIPAA security standards and privacy regulations serve similar purposes and overlap to a certain extent, but the security regulations relate more specifically to protecting the integrity, confidentiality and availability of electronic protected health information while it is in our custody or being transmitted to others. We believe we have established proper controls to safeguard access to protected health information.

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. For the federal fiscal year 2007 (i.e., the federal fiscal year beginning October 1, 2006), each

DRG was assigned a payment rate using 67% of the national average charge per case and 33% of the national average cost per case. For the federal fiscal year 2008, each DRG is assigned a payment rate using 67% of the national average cost per case and 33% of the national average charge per case and 50% of the change to severity adjusted DRG weights. Severity adjusted DRG's more accurately reflect the costs a hospital incurs for caring for a patient and accounts more fully for the severity of each patient's condition. For the federal fiscal year 2009, 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. 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 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 rates, known as the "market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. Under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, DRG payment rates were increased by the full "market basket index", for the federal fiscal years 2005, 2006, 2007 and 2008 or 3.3%, 3.7%, 3.4% and 3.3%, respectively. The Deficit Reduction Act of 2005 imposes a 2% reduction to the market basket index beginning in the federal fiscal year 2007, and thereafter, if patient quality data is not submitted. We intend to comply with this data submission requirement. Future legislation may decrease the rate of increase for DRG payments, but we are not able to predict the amount of any reduction or the effect that any reduction will have on us.

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. For the majority of our hospitals that qualify to receive Medicare disproportionate share payments, these payments were increased by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 effective April 1, 2004. These Medicare disproportionate share payments as a percentage of net operating revenues were 1.8% for the year ended December 31, 2007 and 2.1% for each of the two years ended December 31, 2006 and 2005.

Beginning August 1, 2000, we began receiving Medicare reimbursement for outpatient services through a PPS. Under the Balanced Budget Refinement Act of 1999, non-urban hospitals with 100 beds or less were held harmless through December 31, 2004 under this Medicare outpatient PPS. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 extended the hold harmless provision for non-urban hospitals with 100 beds or less and for non-urban sole community hospitals with more than 100 beds through December 31, 2005. The Deficit Reduction Act of 2005 extended the hold harmless provision for non-urban hospitals with 100 beds or less that are not sole community hospitals through December 31, 2008; however that Act reduced the amount these hospitals would receive in hold harmless payment by 5% in 2006, 10% in 2007 and 15% in 2008. Of our 115 hospitals in continuing operations at December 31, 2007, 31 qualified for this relief. The outpatient conversion factor was increased 3.3% effective January 1, 2005; however, coupled with adjustments to other variables within the outpatient PPS resulted in an approximate 4.8% to 5.2% net increase in outpatient PPS payments. The outpatient conversion factor was increased 3.7% effective January 1, 2006; however coupled with adjustments to other variables with the outpatient PPS, an approximate 2.2% to 2.6% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.4% effective January 1, 2007; however, coupled with adjustments to other variables with the outpatient PPS, an approximate 2.5% to 2.9% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.3% effective January 1, 2008; however, coupled with adjustments to other variables with outpatient PPS, an approximate 3.0% to 3.4% net increase in outpatient payments is expected to occur.

Skilled nursing facilities and swing bed facilities were historically paid by Medicare on the basis of actual costs, subject to limitations. The Balanced Budget Act of 1997 established a PPS for Medicare skilled nursing facilities and mandated that swing bed facilities must be incorporated into the skilled nursing facility PPS. For federal fiscal year 2005, skilled nursing facility PPS payment rates were increased by the full market basket of 2.8%. For federal fiscal year 2006, skilled nursing facility PPS payment rates were increased 3.1%; however coupled with adjustments to other variables within the skilled nursing facility PPS, an approximate 3.9% to

4.3% net increase in skilled nursing facility PPS payments occurred. Skilled nursing facility PPS rates were increased by the full SNF market basket index of 3.1% and 3.3% for the federal fiscal years 2007 and 2008, respectively.

The Department of Health and Human Services established a PPS for home health services effective October 1, 2000. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 implemented an 0.8% reduction to the market basket increase to the home health agency PPS per episodic payment rate effective April 1, 2004 and for the federal fiscal years 2005 and 2006, and increased Medicare payments by 5.0% to home health services provided in rural areas from April 1, 2004 through March 31, 2005. The Deficit Reduction Act of 2005 extended the 5.0% increase to home health services provided in rural areas for an additional year effective January 1, 2006 and froze home health agency payments for 2006 at 2005 levels. The home health agency PPS per episodic payment rate increased by 2.3% on January 1, 2005, 0% on January 1, 2006, and 3.3% on January 1, 2007. The home health agency PPS per episodic payment rate increased by 3% on January 1, 2008; however, coupled with adjustments to other variables with home health agency PPS, an approximate 1.5% to 1.9% net increase in home health agency payments is expected to occur.

Medicaid. Most state Medicaid payments are made under a PPS or under programs which negotiate payment levels with individual hospitals. Medicaid is currently 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. We can provide no assurance that reductions to Medicaid fundings will not have a material adverse effect on our results of operations.

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

Commercial Insurance. Our hospitals provide services to individuals covered by private healthcare insurance. Private insurance carriers 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. Commercial insurers are trying to limit the costs of hospital services by negotiating discounts, including PPS, which would reduce payments by commercial insurers to our hospitals. Reductions in payments for services provided by our hospitals to individuals covered by commercial insurers could adversely affect us.

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 minority partner. Triad was also a minority partner in HeathTrust and we acquired their ownership interest and contractual rights in the acquisition. As of December 31, 2007, we have a 19.3% ownership 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 we expect to achieve.

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 select 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 has intensified in recent years. Our hospitals are located in non-urban and selected urban service areas. 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 do 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.

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

The number and quality of the physicians on a hospital's staff is an important factor in a hospital's competitive advantage. 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.

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. 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.

Since its initial adoption, the compliance program continues to be expanded and developed to meet the industry's expectations and our needs. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring activities have been prepared and implemented to address the functional and operational aspects of our business. Included within these functional areas are materials and activities for business sub-units, including laboratory, radiology, pharmacy, emergency, surgery, observation, home health, 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 anti-kickback and Stark laws, 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, www.chs.net.

Employees

At December 31, 2007, we employed approximately 59,000 full-time employees and 23,200 part-time employees. Of these employees, approximately 2,600 are union members. We currently believe that our labor relations are good.

Professional Liability

As part of our business of owning and operating hospitals, we are subject to legal actions alleging liability on our part. To cover claims arising out of the operations of hospitals, we maintain professional malpractice liability insurance and general liability insurance on a claims made basis in excess of those amounts for which we are self-insured, in amounts we believe to be sufficient for our operations. We also maintain umbrella liability coverage for claims which, due to their nature or amount, are not covered by our other insurance policies. However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. For a further discussion of our insurance coverage, see our discussion of professional liability insurance claims in "Management's discussion and analysis of financial condition and results of operations."

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 waste products. Compliance with these laws and regulations is not expected 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.

Environmental Insurance for the Former Triad Hospitals

We are insured for both storage tank and pollution issues for the former Triad hospitals under one insurance policy. Our policy coverage is $2 million per occurrence with a $25,000 deductible and a $10 million annual aggregate.

Environmental Insurance for All Other Community Health Systems Hospitals

We are insured for onsite and offsite third party bodily injury, property damage and clean up costs including business interruption coverage for actual losses or rental value resulting from pollution issues. Our policy coverage for pollution is $3 million per occurrence with a $100,000 deductible and a $6 million annual aggregate.

We are insured for damages of personal property or environmental injury arising out of environmental impairment of both underground and above ground storage tanks for all of our hospitals (other than the former Triad hospitals). This policy also pays for the clean up resulting from storage tanks. Our policy coverage is $2 million per occurrence with a $25,000 deductible and a $5 million annual aggregate.

Item 1A. *Risk Factors*

The following risk factors could materially and adversely affect our future operating results and could cause actual results to differ materially from those predicted in the forward-looking statements we make about our business.

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

We are significantly leveraged. The chart below shows our level of indebtedness and other information as of December 31, 2007. In connection with the consummation of our acquisition of Triad, a $7.215 billion of senior secured financing under a new credit facility, or "New Credit Facility", was obtained by our wholly-owned subsidiary, CHS/Community Health Systems, Inc. or CHS. CHS also issued the 8.875% senior notes, of the "Notes", having an aggregate principal amount of $3.021 billion. Both the indebtedness under the New Credit Facility and the Notes are senior obligations of CHS and are guaranteed on a senior basis by us and by certain of our domestic subsidiaries. We used the net proceeds from the Notes offering and the net proceeds of the $6.065 billion term loans under the New Credit Facility to pay the consideration under the merger agreement with Triad, to refinance certain of our existing indebtedness and the indebtedness of Triad, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. As of December 31, 2007, a $750 million revolving credit facility and a $300 million delayed draw term loan facility are available to us for working capital and general corporate purposes under the New Credit Facility, with $36 million of the revolving credit facility being set aside for outstanding letters of credit.

Also, in connection with the consummation of the acquisition of Triad, we completed an early repayment of the $300 million aggregate principal amount of 6.5% Senior Subordinated Notes due 2012 through a cash tender offer and consent solicitation.

		As of December 31, 2007 ($ in millions)
Senior secured credit facility		
Term loans	$	5,965.0
Notes		3,021.3
Other		111.8
Total debt		9,098.1
Stockholder equity		1,710.8

As of December 31, 2007, our $3.750 billion notional amount of interest rate swap agreements represented approximately 63% of our variable rate debt. On a prospective basis, a 1% change in interest rates on the remaining unhedged variable rate debt existing as of December 31, 2007, would result in interest expense fluctuating approximately $22 million per year.

The New Credit Facility agreement and/or the Notes contain various covenants that limit our ability to take certain actions, including our ability to:

- incur, assume or guarantee additional indebtedness;
- issue redeemable stock and preferred stock;
- repurchase capital stock;
- make restricted payments, including paying dividends and making investments;
- redeem debt that is junior in right of payment to the notes;
- create liens;

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- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- enter into agreements that restrict dividends from subsidiaries;
- merge, consolidate, sell or otherwise dispose of substantial portions of our assets;
- enter into transactions with affiliates; and
- guarantee certain obligations.

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

A breach of any of these covenants could result in a default under our New Credit Facility and/or the Notes. Upon the occurrence of an event of default under our New Credit Facility or the Notes, all amounts outstanding under our New Credit Facility and the Notes may become due and payable and all commitments under the New Credit Facility to extend further credit may be terminated.

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

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

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

We may be able to incur substantial additional indebtedness in the future. The terms of the indenture governing the notes do not fully prohibit us from doing so. For example, under the indenture for the Notes, we may incur up to $7.815 billion pursuant to a credit facility or a qualified receivables transaction, less certain amounts repaid with the proceeds of asset dispositions. Our New Credit Facility provides for commitments of up to $7.115 billion in the aggregate. Our New Credit Facility also gives us the ability to provide for one or more additional tranches of term loans in aggregate principal amount of up to $600 million without the consent of the existing lenders if specified criteria are satisfied. If new debt is added to our current debt levels, the related risks that we now face could intensify.

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

An important part of our business strategy is to acquire two to four hospitals each year. However, not-for-profit hospital systems and other for-profit hospital companies generally attempt to acquire the same type of hospitals as we do. Some of these other purchasers have greater financial resources than we do. Our principal competitors for acquisitions have included Health Management Associates, Inc. and LifePoint

Hospitals, Inc. On some occasions, we also compete with Universal Health Services, Inc. In addition, some hospitals are sold through an auction process, which may result in higher purchase prices than we believe are reasonable. Therefore, we may not be able to acquire additional hospitals on terms favorable to us.

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

Many of the hospitals we have acquired, had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced temporary delays in improving the operating margins or effectively integrating the operations of these acquired hospitals. In the future, if we are unable to improve the operating margins of acquired hospitals, operate them profitably, or effectively integrate their operations, we may be unable to achieve our growth strategy. We acquired 50 hospitals in the Triad acquisition. In the past, we have not acquired this many hospitals at one time. We may experience delays or difficulties in improving the operating margins or effectively integrating the operations of these acquired hospitals.

Given the number of hospitals acquired, senior management may need to devote a significant amount of time to integration of the acquired hospitals, which may detract from the ability of senior management to execute our past acquisition strategy of attempting to acquire two to four hospitals each year. Except for a two hospital system, for which we currently have a definitive agreement to acquire, we do not anticipate acquiring more hospitals during 2008.

We may not be able to successfully integrate our acquisition of Triad or realize the potential benefits of the acquisition, which could cause our business to suffer.

We may not be able to combine successfully the operations of former Triad hospitals with our operations and, even if such integration is accomplished, we may never realize the potential benefits of the acquisition. The integration of former Triad hospitals with our operations requires significant attention from management and may impose substantial demands on our operations or other projects. In addition, Triad's corporate officers did not continue their employment with us. The integration of Triad also involves a significant capital commitment, and the return that we achieve on any capital invested may be less than the return that we would achieve on our other projects or investments. Any of these factors could cause delays or increased costs of combining former Triad hospitals with us; and could adversely affect our operations, financial results and liquidity.

Certain of Triad's joint venture partners have put or call rights, the exercise of which could affect our available cash and/or operating results. Triad entered into a number of joint venture transactions that entitle its joint venture partners to require Triad to purchase the partner's interest or to require Triad to sell its interest to the partner. The consideration provided for in these contracts may not be at an advantageous amount vis-à-vis the consideration paid for the Triad acquisition. If these rights are exercised, we may be required to make unanticipated payments, our operations at certain facilities may be adversely affected, or we may be required to divest certain facilities.

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

Hospitals that we acquire may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. Although we generally seek indemnification from prospective sellers covering these matters, we may nevertheless have material liabilities for past activities of acquired hospitals. In the case of the Triad acquisition, there was no indemnification provided given the fact that Triad was a public company and the acquisition was effective through a merger.

As a result of the Triad acquisition, on a consolidated basis, we are subject to all of the potential liabilities relating to the hospitals held by Triad, including liabilities relating to pending or threatened litigation matters, which, if adversely decided, could have a material adverse effect on our future results and operations.

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

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

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

Many states, including some where we have hospitals and others where we may in the future acquire hospitals, have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In other states that do not have specific legislation, the attorneys general have demonstrated an interest in these transactions under their general obligations to protect charitable assets from waste. 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 actions on the state level could seriously delay or even prevent our ability to acquire hospitals.

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

The hospital industry is highly competitive. In addition to the competition we face for acquisitions and physicians, we must also compete with other hospitals and healthcare providers for patients. The competition among hospitals and other healthcare providers for patients has intensified in recent years. Our hospitals are located in non-urban service areas. In approximately 65% of our markets, we are the sole provider of general healthcare services. In most of our other markets, the primary competitor is a not-for-profit hospital. These not-for-profit hospitals generally differ in each jurisdiction. However, our hospitals face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in our primary service areas may travel to these other hospitals for a variety of reasons. These reasons include physician referrals or the need for services we do not offer. Patients who seek services from these other hospitals may subsequently shift their preferences to those hospitals for the services we provide.

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

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

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

We have a five-year participation agreement with a GPO. This agreement extends to March 2010, with automatic renewal terms of one year, unless either party terminates by giving notice of non-renewal, which replaced a similar arrangement with another GPO. GPOs attempt to obtain favorable pricing on medical supplies with manufacturers and vendors who sometimes negotiate exclusive supply arrangements in exchange for the discounts they give. Recently some vendors who are not GPO members have challenged these exclusive supply arrangements. In addition, the U.S. Senate has held hearings with respect to GPOs and these exclusive supply arrangements. To the extent these exclusive supply arrangements are challenged or deemed unenforceable, we could incur higher costs for our medical supplies obtained through HealthTrust. These higher costs could cause our operating results to decline.

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

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

At December 31, 2007, we had approximately $4.248 billion of goodwill recorded on our books. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. If the carrying value of our goodwill is impaired, we may incur a material non-cash charge to earnings.

Risks related to our industry

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

In 2007, 39.3% of our net operating revenues came from the Medicare and Medicaid programs. In recent years, federal and state governments made significant changes in the Medicare and Medicaid programs, including the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Some of these changes have decreased the amount of money we receive for our services relating to these programs.

In recent years, Congress and some state legislatures have introduced an increasing number of other proposals to make major changes in the healthcare system including an increased emphasis on the linkage between quality of care criteria and payment levels such as the submission of patient quality data to the Secretary of Health and Human Services. In addition, CMS conducts ongoing reviews of certain state reimbursement programs. Federal funding for existing programs may not be approved in the future. Future federal and state legislation may further reduce the payments we receive for our services. For example, the Governor of the State of Tennessee implemented cuts in the second half of 2005 in TennCare by restricting eligibility and capping specified services.

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

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

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

In addition, there are heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment. The ongoing investigations relate to various referral, cost reporting, and billing practices, laboratory and home healthcare services, and physician ownership and joint ventures involving hospitals. The Department of Justice has alleged that we and three of our New Mexico hospitals have caused the state of New Mexico to submit improper claims for federal funds in violation of the Civil False Claims Act. See Item 3. Legal Proceedings.

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

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

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

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

In recent years, physicians, hospitals, and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability, or related legal theories. Even in states that have imposed caps on damages, litigants are seeking recoveries under new theories of liability that might not be subject to the caps on damages. Many of these actions involve large claims and significant defense costs. To protect us from the cost of these claims, we maintain professional malpractice liability insurance and general liability insurance coverage in excess of those amounts for which we are self-insured, in amounts that we believe to be sufficient for our operations. However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. The cost of malpractice and other professional liability insurance decreased in 2005 by 0.2%, increased in 2006 by 0.1% and decreased in 2007 by 0.1% as a percentage of net operating revenue. If these costs rise rapidly, our profitability could decline. For a further discussion of our insurance coverage, see our discussion of professional liability insurance claims in "Management's discussion and analysis of financial condition and results of operations."

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

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

This Report includes forward-looking statements which could differ from actual future results.

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

- general economic and business conditions, both nationally and in the regions in which we operate;
- our ability to successfully integrate any acquisitions or to recognize expected synergies from such acquisitions, including the recently acquired former Triad hospitals;
- risks associated with our substantial indebtedness, leverage and debt service obligations;
- demographic changes;
- existing governmental regulations and changes in, or the failure to comply with, governmental regulations;
- legislative proposals for healthcare reform;
- the impact of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which includes specific reimbursement changes for small urban and non-urban hospitals;
- potential adverse impact of known and unknown government investigations;
- our ability, where appropriate, to enter into managed care provider arrangements and the terms of these arrangements;
- changes in inpatient or outpatient Medicare and Medicaid payment levels;
- increases in the amount and risk of collectability of patient accounts receivable;
- increases in wages as a result of inflation or competition for highly technical positions and rising supply costs due to market pressure from pharmaceutical companies and new product releases;
- liabilities and other claims asserted against us, including self-insured malpractice claims;
- competition;
- our ability to attract and retain qualified personnel, key management, physicians, nurses and other healthcare workers;
- trends toward treatment of patients in less acute or specialty healthcare settings, including ambulatory surgery centers or specialty hospitals;
- changes in medical or other technology;
- changes in generally accepted accounting principles;
- the availability and terms of capital to fund additional acquisitions or replacement facilities;
- our ability to successfully acquire additional hospitals and complete the sale of hospitals held for sale;
- our ability to obtain adequate levels of general and professional liability insurance; and
- timeliness of reimbursement payments received under government programs.

Although we believe that these statements are based upon reasonable assumptions, we can give no assurance that our goals will be achieved. Given these uncertainties, prospective investors are cautioned not to place undue reliance on these forward-looking statements. These forward-looking statements are made as of the date of this filing. We assume no obligation to update or revise them or provide reasons why actual results may differ.

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

None

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Item 2. *Properties*

Corporate Headquarters

Pursuant to our lease agreement with a developer, construction was completed on our corporate headquarters, located in Franklin, Tennessee. In January 2007, we exercised our purchase option with the developer and acquired the building by purchasing the equity interests of the previous owner.

Hospitals

Our hospitals are general care hospitals offering a wide range of inpatient and outpatient medical services. These services generally include internal medicine, surgery, cardiology, oncology, orthopedics, OB/GYN, diagnostic and emergency room services, laboratory, radiology, respiratory therapy, physical therapy, and rehabilitation services. In addition, some of our hospitals provide skilled nursing and home health services based on individual community needs.

For each of our hospitals owned or leased as of December 31, 2007, including those twelve hospitals classified as held for sale and included in discontinued operations, 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				
Woodland Community Hospital	Cullman	100	October, 1994	Owned
Parkway Medical Center Hospital	Decatur	108	October, 1994	Owned
LV Stabler Memorial Hospital	Greenville	72	October, 1994	Owned
Hartselle Medical Center	Hartselle	150	October, 1994	Owned
South Baldwin Regional Center	Foley	112	June, 2000	Leased
Cherokee Medical Center	Centre	60	April, 2006	Owned
Dekalb Regional Medical Center	Fort Payne	134	April, 2006	Owned
Trinity Medical Center	Birmingham	560	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	150	July, 2007	Owned
Jacksonville Medical Center	Jacksonville	89	July, 2007	Owned
Alaska				
Mat-Su Regional Medical Center	Palmer	74	July, 2007	Owned
Arizona				
Payson Regional Medical Center	Payson	44	August, 1997	Leased
Western Arizona Regional Medical Center	Bullhead City	139	July, 2000	Owned
Northwest Medical Center	Tucson	300	July, 2007	Owned
Northwest Medical Center Oro Valley	Tucson	96	July, 2007	Owned
Arkansas				
Harris Hospital	Newport	133	October, 1994	Owned
Helena Regional Medical Center	Helena	155	March, 2002	Leased
Forrest City Medical Center	Forrest City	118	March, 2006	Leased
Northwest Medical Center — Bentonville	Bentonville	128	July, 2007	Owned
National Park Medical Center	Hot Springs	166	July, 2007	Owned
St. Mary's Regional Medical Center	Russellville	170	July, 2007	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Northwest Medical Center — Springdale	Springdale	252	July, 2007	Owned
California				
Barstow Community Hospital	Barstow	56	January, 1993	Leased
Fallbrook Hospital	Fallbrook	47	November, 1998	Operated(2)
Watsonville Community Hospital	Watsonville	106	September, 1998	Owned
Florida				
Lake Wales Medical Center	Lake Wales	154	December, 2002	Owned
North Okaloosa Medical Center	Crestview	110	March, 1996	Owned
Georgia				
Fannin Regional Hospital	Blue Ridge	50	January, 1986	Owned
Trinity Hospital of Augusta	Augusta	231	July, 2007	Owned
Illinois				
Crossroads Community Hospital	Mt. Vernon	55	October, 1994	Owned
Gateway Regional Medical Center	Granite City	406	January, 2002	Owned
Heartland Regional Medical Center	Marion	92	October, 1996	Owned
Red Bud Regional Hospital	Red Bud	31	September, 2001	Owned
Galesburg Cottage Hospital	Galesburg	173	July, 2004	Owned
Vista Medical Center East/West	Waukegan	407	July, 2006	Owned
Union County Hospital	Anna	25	November, 2006	Leased
Indiana				
Porter Hospital	Valparaiso	301	May, 2007	Owned
Bluffton Regional Medical Center	Bluffton	79	July, 2007	Owned
Dupont Hospital	Fort Wayne	122	July, 2007	Owned
Lutheran Hospital	Fort Wayne	471	July, 2007	Owned
St. Joseph's Hospital	Fort Wayne	191	July, 2007	Owned
Dukes Memorial Hospital	Peru	38	July, 2007	Owned
Kosciusko Community Hospital	Warsaw	72	July, 2007	Owned
Kentucky				
Parkway Regional Hospital	Fulton	70	May, 1992	Owned
Three Rivers Medical Center	Louisa	90	May, 1993	Owned
Kentucky River Medical Center	Jackson	55	August, 1995	Leased
Louisiana				
Byrd Regional Hospital	Leesville	60	October, 1994	Owned
Northern Louisiana Medical Center	Ruston	159	April, 2007	Leased
Women & Children's Hospital	Lake Charles	88	July, 2007	Owned
Mississippi				
Wesley Medical Center	Hattiesburg	211	July, 2007	Owned
River Region Health System	Vicksburg	341	July, 2007	Owned
Missouri				
Moberly Regional Medical Center	Moberly	103	November, 1993	Owned
Northeast Regional Medical Center	Kirksville	115	December, 2000	Leased
Mineral Area Regional Medical Center	Farmington	135	June, 2006	Owned
Nevada				

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Mesa View Regional Hospital	Mesquite	25	July, 2007	Owned
New Jersey				
Memorial Hospital of Salem County	Salem	140	September, 2002	Owned
New Mexico				
Mimbres Memorial Hospital	Deming	49	March, 1996	Owned
Eastern New Mexico Medical Center	Roswell	162	April, 1998	Owned
Northeastern Regional Hospital	Las Vegas	54	April, 2000	Owned
Carlsbad Medical Center	Carlsbad	112	July, 2007	Owned
Lea Regional Medical Center	Hobbs	234	July, 2007	Owned
Mountain View Regional Medical Center	Las Cruces	168	July, 2007	Owned
North Carolina				
Martin General Hospital	Williamston	49	November, 1998	Leased
Ohio				
Affinity Medical Center	Massillon	432	July, 2007	Owned
Oklahoma				
Ponca City Medical Center	Ponca City	140	May, 2006	Owned
Claremore Regional Hospital	Claremore	81	July, 2007	Owned
Deaconess Hospital	Oklahoma City	313	July, 2007	Owned
SouthCrest Hospital	Tulsa	180	July, 2007	Owned
Woodward Regional Hospital	Woodward	87	July, 2007	Owned
Oregon				
Willamette Valley Medical Center	McMinnville	80	July, 2007	Owned
McKenzie-Willamette Medical Center	Springfield	114	July, 2007	Owned
Pennsylvania				
Berwick Hospital	Berwick	101	March, 1999	Owned
Brandywine Hospital	Coatesville	175	June, 2001	Owned
Jennersville Regional Hospital	West Grove	59	October, 2001	Owned
Easton Hospital	Easton	254	October, 2001	Owned
Lock Haven Hospital	Lock Haven	59	August, 2002	Owned
Pottstown Memorial Medical Center	Pottstown	226	July, 2003	Owned
Phoenixville Hospital	Phoenixville	136	August, 2004	Owned
Chestnut Hill Hospital	Philadelphia	179	February, 2005	Owned
Sunbury Community Hospital	Sunbury	92	October, 2005	Owned
South Carolina				
Marlboro Park Hospital	Bennettsville	102	August, 1996	Leased
Chesterfield General Hospital	Cheraw	59	August, 1996	Leased
Springs Memorial Hospital	Lancaster	200	November, 1994	Owned
Carolinas Hospital System — Florence	Florence	420	July, 2007	Owned
Mary Black Memorial Hospital	Spartanburg	209	July, 2007	Owned
Tennessee				
Lakeway Regional Hospital	Morristown	135	May, 1993	Owned
White County Community Hospital	Sparta	60	October, 1994	Owned
Regional Hospital Of Jackson	Jackson	154	January, 2003	Owned

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Dyersburg Regional Medical Center	Dyersburg	225	January, 2003	Owned
Haywood Park Community Hospital	Brownsville	62	January, 2003	Owned
Henderson County Community Hospital	Lexington	45	January, 2003	Owned
McKenzie Regional Hospital	McKenzie	45	January, 2003	Owned
McNairy Regional Hospital	Selmer	45	January, 2003	Owned
Volunteer Community Hospital	Martin	100	January, 2003	Owned
Bedford County Medical Center	Shelbyville	104	July, 2005	Leased
Sky Ridge Medical Center	Cleveland	351	October, 2005	Owned
Gateway Medical Center	Clarksville	206	July, 2007	Owned
Texas				
Big Bend Regional Medical Center	Alpine	25	October, 1999	Owned
Cleveland Regional Medical Center	Cleveland	107	August, 1996	Leased
Scenic Mountain Medical Center	Big Spring	150	October, 1994	Owned
Hill Regional Hospital	Hillsboro	92	October, 1994	Owned
Lake Granbury Medical Center	Granbury	59	January, 1997	Owned
South Texas Regional Medical Center	Jourdanton	67	November, 2001	Owned
Laredo Medical Center	Laredo	326	October, 2003	Owned
Weatherford Regional Medical Center	Weatherford	99	November, 2006	Leased
Abilene Regional Medical Center	Abilene	231	July, 2007	Owned
Brownwood Regional Medical Center	Brownwood	196	July, 2007	Owned
College Station Medical Center	College Station	150	July, 2007	Owned
Navarro Regional Hospital	Corsicana	162	July, 2007	Owned
Presbyterian Hospital of Denton	Denton	255	July, 2007	Owned
Longview Regional Medical Center	Longview	131	July, 2007	Owned
Woodland Heights Medical Center	Lufkin	149	July, 2007	Owned
San Angelo Community Medical Center	San Angelo	171	July, 2007	Owned
DeTar Healthcare System	Victoria	308	July, 2007	Owned
Cedar Park Regional Medical Center	Cedar Park	77	December, 2007	Owned
Utah				
Mountain West Medical Center	Tooele	35	October, 2000	Owned
Virginia				
Southern Virginia Regional Medical Center	Emporia	80	March, 1999	Owned
Russell County Medical Center	Lebanon	78	September, 1986	Owned
Southampton Memorial Hospital	Franklin	105	March, 2000	Owned
Southside Regional Medical Center	Petersburg	408	August, 2003	Leased
West Virginia				
Plateau Medical Center	Oak Hill	25	July, 2002	Owned
Greenbrier Valley Medical Center	Ronceverte	122	July, 2007	Owned
Wyoming				
Evanston Regional Hospital	Evanston	42	November, 1999	Owned
Republic of Ireland				
Beacon Hospital	Sandyford, Dublin	122	July, 2007	Leased

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Total Licensed Beds at December 31, 2007		18,661		

(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) We operate this hospital under a lease-leaseback and operating agreement. We recognize all operating statistics, revenue and expenses associated with this hospital in our consolidated financial statements.

The following table lists the hospitals owned by joint venture entities in which we do not have a consolidating ownership interest, along with our percentage ownership interest in the joint venture entity as of December 31, 2007. Information on licensed beds was provided by the majority owner and manager of each joint venture. A subsidiary of HCA Inc. is the majority owner of Macon Healthcare LLC, a subsidiary of Universal Health Systems Inc. is the majority owner of Summerlin Hospital Medical Center LLC and Valley Health System LLC and the Share Foundation is the other 50% owner of MCSA LLC.

Joint Venture	Facility Name	City	State	Licensed Beds
Macon Healthcare LLC	Coliseum Medical Center (38%)	Macon	GA	250
Macon Healthcare LLC	Coliseum Psychiatric Center (38%)	Macon	GA	60
Macon Healthcare LLC	Macon Northside Hospital (38%)	Macon	GA	103
Summerlin Hospital Medical Center LLC	Summerlin Hospital Medical Center (26.1%)	Las Vegas	NV	281
Valley Health System LLC	Desert Springs Hospital (27.5%)	Las Vegas	NV	286
Valley Health System LLC	Valley Hospital Medical Center (27.5%)	Las Vegas	NV	404
Valley Health System LLC	Spring Valley Hospital Medical Center (27.5%)	Las Vegas	NV	210
Valley Health Systems LLC	Centennial Hills Medical Center (27.5%)	Las Vegas	NV	165
MCSA LLC	Medical Center of South Arkansas (50%)	El Dorado	AR	166

Item 3. ***Legal Proceedings***

From time to time, we receive various inquiries or subpoenas from state regulators, fiscal intermediaries, the Centers for Medicare and Medicaid Services and the Department of Justice regarding various Medicare and Medicaid issues. In addition, we are subject to other claims and lawsuits arising in the ordinary course of our business. We are not aware of any pending or threatened litigation that is not covered by insurance policies or reserved for in our financial statements or which we believe would have a material adverse impact on us; however, some pending or threatened proceedings against us may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Additionally, qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits.

Community Health Systems, Inc. Legal Proceedings

In May 1999, we were served with a complaint in *U.S. ex rel. Bledsoe v. Community Health Systems, Inc.*, subsequently moved to the Middle District of Tennessee, Case No. 2-00-0083. This qui tam action sought treble damages and penalties under the False Claims Act against us. The Department of Justice did not intervene in this action. The allegations in the amended complaint were extremely general, but involved

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Medicare billing at our White County Community Hospital in Sparta, Tennessee. By order entered on September 19, 2001, the U.S. District Court granted our motion for judgment on the pleadings and dismissed the case, with prejudice. The qui tam whistleblower (also referred to as a "relator") appealed the district court's ruling to the U.S. Court of Appeals for the Sixth Circuit. On September 10, 2003, the Sixth Circuit Court of Appeals rendered its decision in this case, affirming in part and reversing in part the district court's decision to dismiss the case with prejudice. The court affirmed the lower court's dismissal of certain of plaintiff's claims on the grounds that his allegations had been previously publicly disclosed. In addition, the appeals court agreed that, as to all other allegations, the relator had failed to include enough information to meet the special pleading requirements for fraud under the False Claims Act and the Federal Rules of Civil Procedure. However, the case was returned to the district court to allow the relator another opportunity to amend his complaint in an attempt to plead his fraud allegations with particularity. In May 2004, the relator in *U.S. ex rel. Bledsoe* filed an amended complaint alleging fraud involving Medicare billing at White County Community Hospital. We then filed a renewed motion to dismiss the amended complaint. On January 6, 2005, the District Court dismissed with prejudice the bulk of the relator's allegations. The only remaining allegations involve a small number of 1997-98 charges at White County. After further motion practice between the relator and the United States Government regarding the relator's right to participate in a previous settlement with the Company, the District Court again dismissed all claims in the case on December 13, 2005. On January 9, 2006, the relator filed a notice of appeal to the U.S. Court of Appeals for the Sixth Circuit and on September 6, 2007, the Court of Appeals issued its 25 page opinion affirming in part, reversing in part (and in doing so, reinstating a number of the allegations claimed by the relator), and remanding the case to the District Court for further proceedings. The relator has filed a motion for rehearing. That motion for rehearing was denied and we are in the process of evaluating our next steps with respect to this case.

In August 2004, we were served a complaint in *Arleana Lawrence and Robert Hollins v. Lakeview Community Hospital and Community Health Systems, Inc. (now styled Arleana Lawrence and Lisa Nichols vs. Eufaula Community Hospital, Community Health Systems, Inc., South Baldwin Regional Medical Center and Community Health Systems Professional Services Corporation)* in the Circuit Court of Barbour County, Alabama (Eufaula Division). This alleged class action was brought by the plaintiffs on behalf of themselves and as the representatives of similarly situated uninsured individuals who were treated at our Lakeview Hospital or any of our other Alabama hospitals. The plaintiffs allege that uninsured patients who do not qualify for Medicaid, Medicare or charity care are charged unreasonably high rates for services and materials and that we use unconscionable methods to collect bills. The plaintiffs seek restitution of overpayment, compensatory and other allowable damages and injunctive relief. In October 2005, the complaint was amended to eliminate one of the named plaintiffs and to add our management company subsidiary as a defendant. In November 2005, the complaint was again amended to add another plaintiff, Lisa Nichols and another defendant, our hospital in Foley, Alabama, South Baldwin Regional Medical Center. After a hearing held on June 13, 2007, on October 29, 2007 the Circuit Court ruled in favor of the plaintiffs' class action certification request. We disagree with that ruling and have pursued our automatic right of appeal to the Alabama Supreme Court. We are vigorously defending this case.

On March 3, 2005, we were served with a complaint in *Sheri Rix v. Heartland Regional Medical Center and Health Care Systems, Inc.* in the Circuit Court of Williamson County, Illinois. This alleged class action was brought by the plaintiff on behalf of herself and as the representative of similarly situated uninsured individuals who were treated at our Heartland Regional Medical Center. The plaintiff alleges that uninsured patients who do not qualify for Medicaid, Medicare or charity care are charged unreasonably high rates for services and materials and that we use unconscionable methods to collect bills. The plaintiff seeks recovery for breach of contract and the covenant of good faith and fair dealing, violation of the Illinois Consumer Fraud and Deceptive Practices Act, restitution of overpayment, and for unjust enrichment. The plaintiff class seeks compensatory and other damages and equitable relief. The Circuit Court Judge recently granted our motion to dismiss the case, but allowed the plaintiff to re-plead her case. The plaintiff elected to appeal the Circuit Court's decision in lieu of amending her case. Oral argument was heard on this case on January 9, 2008 and we await the ruling of the District Appellate Court. We are vigorously defending this case.

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On April 8, 2005, we were served with a first amended complaint, styled *Chronister, et al. v. Granite City Illinois Hospital Company, LLC d/b/a Gateway Regional Medical Center*, in the Circuit Court of Madison County, Illinois. The complaint seeks class action status on behalf of the uninsured patients treated at Gateway Regional Medical Center and alleges statutory, common law, and consumer fraud in the manner in which the hospital bills and collects for the services rendered to uninsured patients. The plaintiff seeks compensatory and punitive damages and declaratory and injunctive relief. Our motion to dismiss has been granted in part and denied in part and discovery has commenced. *Gateway Regional Medical Center v. Holman* is a companion case to the *Chronister* action, seeking counterclaim recovery on a collections case. *Holman* has been stayed pending the outcome of the *Chronister* action. We are vigorously defending these cases.

On February 10, 2006, we received a letter from the Civil Division of the Department of Justice requesting documents in an investigation they are conducting involving the Company. The inquiry relates to the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients. These programs are referred to by different names, including "intergovernmental payments," "upper payment limit programs," and "Medicaid disproportionate share hospital payments." The February 10th letter focused on our hospitals in 3 states: Arkansas, New Mexico, and South Carolina. On August 31, 2006, we received a follow up letter from the Department of Justice requesting additional documents relating to the programs in New Mexico and the payments to the Company's three hospitals in that state. We have provided the Department of Justice with the requested documents. In a letter dated October 4, 2007, the Civil Division notified us that, based on its investigation to date, it preliminarily believes that we and these three New Mexico hospitals have caused the State of New Mexico to submit improper claims for federal funds, in violation of the Civil False Claims Act. The DOJ asserted that these allegedly improper claims and payments began in 2000 and may be ongoing, but provided no information about the amount of any improper claims or the possible damages or penalties it make seek. After a meeting between us and the DOJ held in November 2007, by letter dated January 22, 2008, the Civil Division notified us that they continued to believe that the False Claims Act had been violated and had calculated that the three hospitals received ineligible federal participation payments from August 2000 to June 2006 of approximately $27.5 million. The Civil Division advised us that if they proceeded to trial, they would seek treble damages plus an appropriate penalty for each of the violations of the False Claims Act. Discussions are continuing with the Civil Division in an effort to resolve this matter. The Company continues to believe that it has not violated the Federal False Claims Act in the manner described in the government's letter of January 22, 2008.

In August 2006, our facility in Petersburg, Virginia (Southside Regional Medical Center) was notified of the pendency of a federal False Claims Act case styled *U.S. ex rel. Vuyyuru v. Jadhav et al.* filed in the Eastern District of Virginia. In addition to naming the hospital, Community Health Systems Professional Services Corporation, our management subsidiary, has also been named. The suit alleges that Dr. Jadhav, Southside Regional Medical Center, and other healthcare providers performed medically unnecessary procedures and billed federal healthcare programs and also alleges that the defendants defamed Dr. Vuyyuru in the process of terminating his medical staff privileges. Almost all of the allegations pre-date our acquisition of this facility and the seller's successor-in-interest has agreed to indemnify the Company and its affiliates. We believe that the allegations in this case are without merit and are vigorously defending the case. A motion to dismiss the case has been granted and the relator has appealed the ruling to the U.S. Court of Appeals for the Fourth Circuit.

On August 28, 2007, Texas Health Resources of Arlington, Texas, or THR, notified us of its decision to exercise a call right to acquire our 80% interest in the limited partnership that owns Presbyterian Hospital of Denton, Texas, together with certain land and buildings that we own in Denton (including rights under a lease for such land and buildings). We acquired these interests in connection with the Triad acquisition. This call right became exercisable under the terms of the limited partnership agreement by reasons of our acquisition of Triad. Shortly after we initiated efforts to set the purchase price, which is determined by various formulas set forth in the limited partnership agreement and related documents, THR filed suit in Texas state court seeking injunctive and declaratory relief to extend the 90-day closing date and to set the purchase price. We removed the case to Federal District Court and proceedings are underway in that court with respect to THR's renewed motions for relief. Pursuant to the limited partnership agreement, the closing was to occur on or before

November 26, 2007. The closing did not occur on November 26, 2007, as THR failed to properly tender adequate closing consideration. The case will proceed and trial is set for August 2008.

Triad Hospitals, Inc. Legal Proceedings

Triad, and its subsidiary, Quorum Health Resources, Inc. are defendants in a qui tam case styled *U.S. ex rel. Whitten vs. Quorum Health Resources, Inc. et al.*, which is pending in the Southern District of Georgia, Brunswick Division. Whitten, a long-term employee of a two hospital system in Brunswick and Camden, Georgia sued both his employer and Quorum Health Resources, Inc. and its predecessors, which had managed the facility from 1989 through September 2000; upon his termination of employment, Whitten signed a release and was paid $124,000. Whitten's original qui tam complaint was filed under seal in November 2002 and the case was unsealed in 2004. Whitten alleges various charging and billing infractions, including charging for routine equipment supplies and services not separately billable, billing for observation services that were not medically necessary or for which there was no physician order, billing labor and delivery patients for durable medical equipment that was not separately billable, inappropriate preparation of patients' histories and physicals, billing for cardiac rehabilitation services without physician supervision, performing outpatient dialysis without Medicare certification, and performing mental health services without the proper staff assignments. In October 2005, the district court granted Quorum's motion for summary judgment on the grounds that his claims were precluded under his severance agreement with the hospital, without reaching two other arguments made by Quorum, which included that a prior settlement agreement between the hospital and the federal government precluded the claims brought by Whitten as well as the doctrine of prior public disclosure. On appeal to the 11th Circuit Court of Appeals, the court reversed the findings of the district court regarding the severance agreement, but remanded the case to the district court for findings on Quorum's other two defenses. Limited discovery has been conducted and renewed motions by Quorum to dismiss the action and to stay further discovery were filed in September 2007. We await the district court's ruling on our motion to dismiss. We continue to believe that the relator's claims are without merit and will continue to vigorously defend this case.

In a case styled *U.S. ex rel. Bartlett vs. Quorum Health Resources, Inc., et al.*, pending in the Western District of Pennsylvania, Johnstown Division, the relator alleges in his second amended complaint, filed in January 2006 (the first amended complaint having been dismissed), alleges that Quorum conspired with an unaffiliated hospital to pay a illegal remuneration in violation of the anti-kickback statute and the Stark laws, thus causing false claims to be filed. A renewed motion to dismiss that was filed in March 2006 asserting that the second amended complaint did not cure the defects contained in the first amended complaint. In September 2006, the hospital and one of the other defendants affiliated with the hospital filed for protection under Chapter 11 of the federal bankruptcy code, which imposed an automatic stay on proceedings in the case. We believe that this case is without merit and should the stay be lifted, will continue to vigorously defend it.

Quorum is a defendant in a qui tam case styled *U.S. ex rel. Mosby vs. Quorum Health Resources, Inc., et al*, pending in the Western District of Mississippi, Western Division. Mosby was a long time medical records employee at a Quorum managed facility. She alleges wrongful termination for being a whistleblower and because of her race. Mosby's first amended complaint was filed in May 2003 and contains allegations of false claims related to non-allowable costs and cost reports. In October 2003, Quorum filed a motion to dismiss, asserting that Mosby's substantive allegations were lifted from the 1997 Alderson case filed in Tampa against Quorum, which was resolved in a settlement with the federal government in 2001. Without any predicate false claims being asserted, we believe that Mosby's retaliatory discharge allegations are unsupported. On January 16, 2008, at the request of the relator, with the joinder of the defendants, the district court dismissed the case.

Item 4. ***Submission of Matters to a Vote of Security Holders***

No matters were submitted to a vote of security holders during the fourth quarter of the year ended December 31, 2007.

PART II

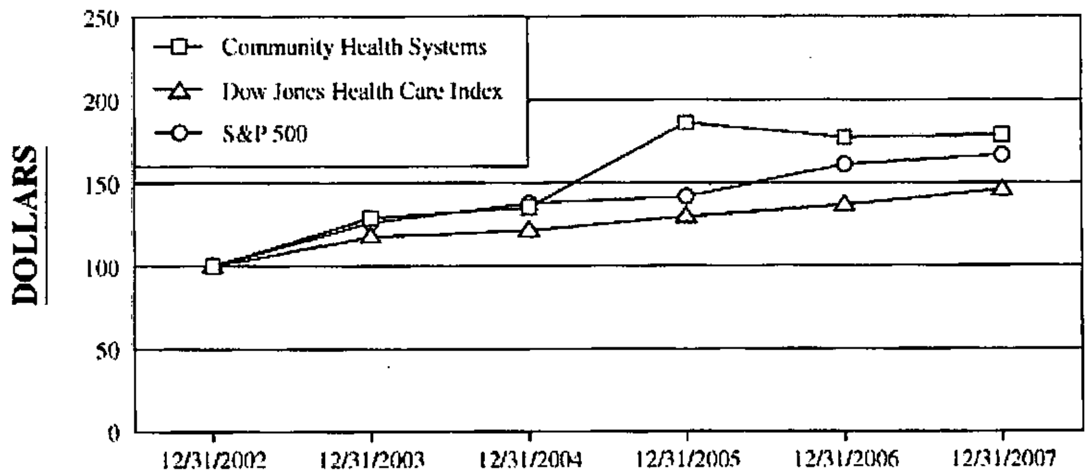
Item 5. *Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities*

We completed an initial public offering of our common stock on June 14, 2000. Our common stock began trading on June 9, 2000 and is listed on the New York Stock Exchange under the symbol CYH. At February 1, 2008, there were approximately 48 record holders of our common stock. The following table sets forth, for the periods indicated, the high and low sale prices per share of our common stock as reported by the New York Stock Exchange.

	High	Low
Year Ended December 31, 2006		
First Quarter	$ 39.96	$ 35.33
Second Quarter	38.39	34.94
Third Quarter	39.18	35.70
Fourth Quarter	37.26	31.00
Year Ended December 31, 2007		
First Quarter	$ 39.05	$ 33.28
Second Quarter	41.72	34.86
Third Quarter	44.50	30.39
Fourth Quarter	37.50	27.70

Corporate Performance Graph

The following graph sets forth the cumulative return of the Company's common stock during the five year period ended December 31, 2007, as compared to the cumulative return of the Standard & Poor's 500 Stock Index (S&P 500) and the cumulative return of the Dow Jones Healthcare Index. The graph assumes an initial investment of $100 in our common stock and in each of the foregoing indices and the reinvestment of dividends where applicable.



	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007
Community Health Systems	$ 100.00	$ 129.09	$ 135.41	$ 186.21	$ 177.37	$ 179.02
Dow Jones Health Care Index	$ 100.00	$ 117.77	$ 121.55	$ 129.90	$ 136.86	$ 146.12
S&P 500	$ 100.00	$ 126.38	$ 137.75	$ 141.88	$ 161.20	$ 166.89

We have not paid any cash dividends since our inception, and do not anticipate the payment of cash dividends in the foreseeable future. Our New Credit Facility limits our ability to pay dividends and/or repurchase stock to an amount not to exceed $400 million in the aggregate (but not in excess of $200 million unless we receive confirmation from Moody's and S&P that dividends or repurchases would not result in a downgrade, qualification or withdrawal of the then corporate credit rating). The indenture governing our Notes also limits our ability to pay dividends and/or repurchase stock. As of December 31, 2007, the amount of permitted dividends and/or stock repurchases permitted under the indenture was $348.7 million.

On December 13, 2006, we announced an open market repurchase program for up to five million shares of our common stock not to exceed $200 million in purchases. This purchase program commenced December 13, 2006 and will conclude at the earlier of three years or when the maximum number of shares have been repurchased. As of December 31, 2007, the Company has not repurchased any shares under this repurchase plan. This repurchase plan follows a prior repurchase plan for up to five million shares which concluded on November 8, 2006. We repurchased 5,000,000 shares at a weighted average price of $35.23 per share under this earlier program. We did not repurchase any shares of common stock during the year ended December 31, 2007.

On November 14, 2005, we elected to call for the redemption of $150 million in principal amount of our 4.25% Convertible Subordinated Notes due 2008 (the "2008 Notes") on December 14, 2005. At the conclusion of this call for redemption, $0.3 million in principal amount of the 2008 Notes were redeemed. Prior to the redemption date, $149.7 million of the 2008 Notes called for redemption, plus an additional $0.9 million of the 2008 Notes not called for redemption, were converted by the holders into an aggregate of 4,495,083 shares of our common stock.

On December 15, 2005, we elected to call for redemption all of the remaining outstanding 2008 Notes. As of December 15, 2005, there was $136.6 million in aggregate principal amount outstanding. On January 17, 2006, at the conclusion of the second call for redemption of 2008 Notes, $0.1 million in principal amount of the 2008 Notes were redeemed and $136.5 million of the 2008 Notes were converted by the holders into 4,074,510 shares of our common stock prior to the redemption date.

Item 6. *SELECTED FINANCIAL DATA*

The following table summarizes specified selected financial data and should be read in conjunction with our related Consolidated Financial Statements and accompanying Notes to Consolidated Financial Statements. The amounts shown below have been adjusted for discontinued operations.

Community Health Systems, Inc.
Five Year Summary of Selected Financial Data

	Year Ended December 31,				
	2007(1)	2006	2005	2004	2003
	(In thousands, except share and per share data)				
Consolidated Statement of Operations Data					
Net operating revenues	$ 7,127,494	$ 4,180,136	$ 3,576,117	$ 3,042,880	$ 2,514,817
Income from operations	485,685	385,057	398,463	332,767	282,475
Income from continuing operations	59,897	177,695	188,370	158,009	129,497
Net income	30,289	168,263	167,544	151,433	131,472
Earnings per common share — Basic:					
Income from continuing operations	$ 0.64	$ 1.87	$ 2.13	$ 1.65	$ 1.32
(Loss) Income on discontinued operations	(0.32)	(0.10)	(0.24)	(0.07)	0.02
Net Income	$ 0.32	$ 1.77	$ 1.89	$ 1.58	$ 1.34
Earnings per common share — Diluted:					
Income from continuing operations	$ 0.63	$ 1.85	$ 2.00	$ 1.58	$ 1.28
(Loss) Income on discontinued operations	(0.31)	(0.10)	(0.21)	(0.07)	0.02
Net Income	$ 0.32	$ 1.75	$ 1.79	$ 1.51	$ 1.30
Weighted-average number of shares outstanding					
Basic	93,517,337	94,983,646	88,601,168	95,643,733	98,391,849
Diluted(2)	94,642,294	96,232,910	98,579,977(4)	105,863,790(3)	108,094,956(3)
Cash and cash equivalents	$ 132,874	$ 40,566	$ 104,108	$ 82,498	$ 16,331
Total assets	13,493,643	4,506,579	3,934,218	3,632,608	3,350,211
Long-term obligations	10,334,904	2,207,623	1,932,238	2,030,258	1,601,558
Stockholders' equity	1,710,804	1,723,673	1,564,577	1,239,991	1,350,589

(1) Includes the results of operations of the former Triad hospitals from July 25, 2007, the date of acquisition.

(2) See Note 11 to the Consolidated Financial Statements, included in item 8 of this Form 10-K.

(3) Included 8,582,076 shares related to the convertible notes under the if-converted method of determining weighted average shares outstanding.

(4) Included 8,385,031 shares related to the convertible notes under the if-converted method of determining weighted average shares outstanding.

Item 7. *MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS*

You should read this discussion together with our consolidated financial statements and the accompanying notes to consolidated financial statements and "Selected Financial Data" included elsewhere in this Form 10-K.

Executive Overview

We are the largest publicly traded operator of hospitals in the United States and provide healthcare services through these hospitals that we own and operate in non-urban and selected urban markets. We generate revenue primarily by providing a broad range of general hospital healthcare services to patients in the communities in which we are located. Our hospital facilities included in continuing operations consist of 115 general acute care hospitals. In addition, we own four home health agencies, located in markets where we do not operate a hospital and through our wholly-owned subsidiary, QHR, we provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. We are paid for our services by governmental agencies, private insurers and directly by the patients we serve. Effective July 25, 2007, we completed our acquisition of Triad Hospitals Inc., or "Triad," for an aggregate consideration of $6.836 billion, including $1.686 billion of assumed indebtedness. In connection with this acquisition, one of our subsidiaries issued $3.021 billion principal amount of 8.875% senior notes due 2015 (the "Notes") and we entered into a new $7.215 billion credit facility (the "New Credit Facility") consisting of a $6.065 billion term loan, a $750 million revolving credit facility and a $400 million delayed draw term loan facility. The proceeds of these financings were used to pay the cash consideration under the merger agreement and to refinance substantially all of both the assumed indebtedness and our existing indebtedness and to pay related fees and expenses. The revolving credit facility and the delayed draw term loan facility remain available to us for future acquisitions, working capital, and general corporate purposes. The delayed draw term loan facility was subsequently reduced per our request to $300 million in the fourth quarter of 2007. We believe the acquisition of Triad will benefit us since it expanded the number of markets we serve, expanded our operations into five states where we previously did not operate, and reduced our concentration of credit risk in any one state. We also believe that synergies obtained from eliminating duplicate corporate functions and centralizing many support functions will allow us to improve Triad's margins. Subsequent to the acquisition of Triad, two of the former Triad hospitals were sold and 12 other hospitals, six of which were formerly owned by Triad, have been identified as available for sale. Accordingly, these hospitals have been classified in discontinued operations in the 2007 statement of income.

Since the Triad acquisition, we have not pursued additional acquisition targets, in order to focus on the integration of the Triad acquisition. We anticipate this focus on integration will continue throughout 2008. Through December 31, 2007, we have realized approximately $25 million of our estimated synergies related to this acquisition. We continue to believe our integration is on track and we anticipate fully recognizing all of the anticipated synergies.

In conjunction with our ongoing process of monitoring the net realizable value of our accounts receivable, as well as integrating the methodologies, data and assumptions used by the former Triad management, we performed various analyses including updating a review of historical cash collections. The acquisition of Triad also provided additional data and a comparative and larger population of data on which to base our estimates. The results of these analyses indicated a lower rate of collectability than had previously been indicated. Therefore, we have recorded an increase to both our contractual allowances and bad debt allowances. We believe this lower collectability is primarily the result of an increase in the number of patients qualifying for charity care, reduced enrollment in certain state Medicaid programs and an increase in the number of indigent non-resident aliens. The impact of this change in estimate reduced accounts receivable in the fourth quarter of 2007 by $166.4 million, reduced net operating revenues for 2007 by $96.3 million and increased the provision for bad debts as of December 31, 2007 by $70.1 million. The resulting impact, net of taxes is a decrease to income from continuing operations for 2007 of $105.4 million. Upon giving effect to this change in estimate, the aggregate of our allowance for doubtful accounts and other related allowances represents approximately 76% of self-pay accounts receivables at December 31, 2007, compared to 65% at December 31, 2006.

Self-pay revenues represented approximately 10.0% of our net operating revenues in 2007 compared 11.8% in 2006. The value of charity care services relative to total net operating revenues decreased to 5.0% in 2007 from 5.1% in 2006. Uninsured and underinsured patients continue to be an industry-wide issue, and we anticipate this trend will continue into the foreseeable future. However, we do not anticipate a significant amount of continuing deterioration in our self-pay business as evidenced by the lack of relative growth in business from self-pay patients over the prior year.

Operating results and statistical data for the year ended December 31, 2007, include comparative information for the operations of the acquired Triad hospitals from July 25, 2007, the date of its acquisition. Same-store operating results and statistical data include the hospitals acquired in the Triad acquisition as if they were owned August 1 through December 31 of both 2007 and 2006 and all other hospitals owned throughout both periods. For the year ended December 31, 2007, we generated $7.127 billion in net operating revenues, a growth of 70.5% over the year ended December 31, 2006, and $30.3 million of net income, a decrease of 82.0% over the year ended December 31, 2006. For the year ended December 31, 2007, admissions at hospitals owned throughout both periods decreased 1.1% and adjusted admissions increased 0.4%.

We believe there continues to be ample opportunity for growth in substantially all of our markets by decreasing the need for patients to travel outside their communities for health care services. Furthermore, we continue to strive to improve operating efficiencies and procedures in order to improve our profitability at all of our hospitals.

Acquisitions and Dispositions

On July 25, 2007, we completed our acquisition of Triad. Triad owned and operated 50 hospitals in 17 states as well as the Republic of Ireland in non-urban and middle market communities with a total of 9,585 licensed beds. Triad's subsidiary, QHR, acquired as part of the Triad acquisition, provides management and consulting services to independent hospitals. We acquired Triad for approximately $6.836 billion, including the assumption of $1.686 billion of existing indebtedness.

In addition to the Triad acquisition, effective April 1, 2007, we completed our acquisition of Lincoln General Hospital (157 licensed beds), located in Ruston, Louisiana. The total consideration for this hospital was approximately $48.7 million, of which $44.8 million was paid in cash and $3.9 million was assumed in liabilities.

Effective May 1, 2007, we completed our acquisition of Porter Memorial Hospital (301 licensed beds), located in Valparaiso, Indiana, with a satellite campus in Portage, Indiana and outpatient medical campuses located in Chesterton, Demotte, and Hebron, Indiana. As part of this acquisition, we agreed to construct a 225-bed replacement facility for the Valparaiso hospital by April 2011. The total consideration for Porter Memorial Hospital was approximately $110.1 million, of which $88.9 million was paid in cash and $21.2 million was assumed in liabilities.

Effective September 1, 2007, we sold our partnership interest in River West L.P., which owned and operated River West Medical Center (an 80 bed facility located in Plaquemine, Louisiana) to an affiliate of Shiloh Health Services, Inc. of Lubbock, Texas. The proceeds received from this sale were $0.3 million in cash.

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Effective October 31, 2007, we sold our 60% membership interest in Northeast Arkansas Medical Center, or NEA, a 104 bed facility in Jonesboro, Arkansas to Baptist Memorial Health Care ("Baptist"), headquartered in Memphis, Tennessee for $16.8 million in cash. In connection with this transaction, we also sold real estate and other assets previously leased by us to NEA to a subsidiary of Baptist. Proceeds received from this sale were $26.2 million in cash.

Effective November 30, 2007, we sold Barberton Citizens Hospital (312 licensed beds) located in Barberton, Ohio to Summa Health System of Akron, Ohio. The proceeds received from this sale were $53.8 million in cash.

Held for Sale

As of December 31, 2007, we have classified as held for sale 12 hospitals with an aggregate bed count of 1,690 licensed beds. Included in the 12 hospitals is Russell County Medical Center (78 licensed beds) located in Lebanon, Virginia, which was sold effective February 1, 2008, to Mountain States Health Alliance, headquartered in Johnson City, Tennessee, for $48.6 million in cash.

Sources of Revenue

The following table presents the approximate percentages of net operating revenue derived from Medicare, Medicaid, managed care and other third party payors, and self-pay for the periods indicated. The data for the years presented are not strictly comparable due to the significant effect that hospital acquisitions have had on these statistics.

	Year Ended December 31,		
	2007	2006	2005
Medicare	29.0%	30.4%	31.8%
Medicaid	10.3%	11.1%	11.2%
Managed care and other third party payors	50.7%	46.7%	45.6%
Self pay	10.0%	11.8%	11.4%
Total	100.0%	100.0%	100.0%

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-based reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual adjustments, which we deduct from gross revenues to arrive at net operating revenues. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual adjustments and report them in the periods that such adjustments become known. Adjustments related to final settlements or appeals that increased revenue were insignificant in the years ended December 31, 2007, 2006 and 2005. In the future, we expect the percentage of revenues received from the Medicare program to increase due to the general aging of the population.

The payment rates under the Medicare program for inpatient acute services are based on a prospective payment system, depending upon the diagnosis of a patient's condition. While these rates are indexed for inflation annually, the increases have historically been less than actual inflation. Reductions in the rate of increase in Medicare reimbursement may cause our net operating revenue growth to decline. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 provides a broad range of provider payment benefits; however, federal government spending in excess of federal budgetary provisions considered in passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 could result in future deficit spending for the Medicare system, which could cause future payments under the Medicare system to decline.

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In addition, specified managed care programs, insurance companies, and employers are actively negotiating the amounts paid to hospitals. The trend toward increased enrollment in managed care may adversely effect our net operating revenue growth.

Results of Operations

Our hospitals offer a variety of services involving a broad range of inpatient and outpatient medical and surgical services. These include orthopedics, cardiology, occupational medicine, diagnostic services, emergency services, rehabilitation treatment, and skilled nursing. The strongest demand for hospital services generally occurs during January through April and the weakest demand for these services occurs during the summer months. Accordingly, eliminating the effect of new acquisitions, our net operating revenues and earnings are historically highest during the first quarter and lowest during the third quarter.

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

	Year Ended December 31,		
	2007	2006	2005
	(Expressed as a percentage of net operating revenues)		
Consolidated(a)			
Net operating revenues	100.0	100.0	100.0
Operating expenses(b)	(88.8)	(86.5)	(84.5)
Depreciation and amortization	(4.4)	(4.3)	(4.4)
Income from operations	6.8	9.2	11.1
Interest expense, net	(5.1)	(2.2)	(2.4)
Loss from early extinguishment of debt	(0.4)	—	—
Minority interest in earnings	(0.3)	(0.1)	(0.1)
Equity in earnings of unconsolidated affiliates	0.4	—	—
Income from continuing operations before income taxes	1.4	6.9	8.6
Provision for income taxes	(0.6)	(2.6)	(3.3)
Income from continuing operations	0.8	4.3	5.3
Loss on discontinued operations	(0.4)	(0.3)	(0.6)
Net income	0.4	4.0	4.7

	Year Ended December 31,	
	2007	2006
	(Expressed in percentages)	
Percentage increase from prior year(a):		
Net operating revenues	70.5%	16.9%
Admissions	50.4	12.0
Adjusted admissions(c)	48.6	12.4
Average length of stay	2.4	—
Net Income(d)	(82.0)	0.4
Same-store percentage increase from prior year(a)(e):		
Net operating revenues	4.2%	7.5%
Admissions	(1.1)	1.2
Adjusted admissions(c)	0.4	1.0

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(a) Pursuant to Statement of Financial Accounting Standards ("SFAS") No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets," we have restated our 2006 and 2005 financial statements and statistical results to reflect the reclassification as discontinued operations of one hospital which was sold and five hospitals held for sale which were owned by us during these periods.

(b) Operating expenses include salaries and benefits, provision for bad debts, supplies, rent, and other operating expenses.

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

(d) Includes loss on discontinued operations.

(e) Includes former Triad hospitals during August through December of the comparable periods and other acquired hospitals to the extent we operated them during comparable periods in both years.

Year Ended December 31, 2007 Compared to Year Ended December 31, 2006

Net operating revenues increased by 70.5% to $7.127 billion in 2007, from $4.180 billion in 2006. This increase was net of a $96.3 million reduction to net operating revenues as a result of the change in estimate to increase contractual allowances recorded in the fourth quarter of 2007. $2.404 billion of this increase was contributed by hospitals acquired in the Triad acquisition that remain in continuing operations, $426.1 million was contributed by other recently acquired hospitals and $117.2 million, an increase of 2.8%, was contributed by hospitals that we owned throughout both periods. The increase from those hospitals that we owned throughout both periods was attributable to rate increases, payor mix, and acuity level of services provided.

On a consolidated basis inpatient admissions increased by 50.4% and adjusted admissions increased by 48.6%. With respect to consolidated admissions, approximately 35% were contributed from newly acquired hospitals, including those hospitals acquired from Triad, and 65% were contributed by hospitals we owned throughout both periods. On a same-store basis, which includes the hospitals acquired from Triad, as if we owned them from August 1 through December 31 of both periods, admissions decreased by 1.1% during the year ended December 31, 2007.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, increased from 86.5% in 2006 to 88.8% in 2007. Salaries and benefits, as a percentage of net operating revenues, increased from 39.8% in 2006 to 40.6% in 2007, primarily as a result of an increase in stock compensation expense, incurring duplicate salary costs related to the acquisition of Triad for certain corporate overhead positions not yet eliminated and an increase in the number of employed physicians. These increases have offset improvements realized at hospitals owned throughout both periods. Provision for bad debts, as a percentage of net revenues, increased from 12.4% in 2006 to 12.6% in 2007, due primarily to $70.1 million of additional bad debt expense recorded as a change in estimate to increase the allowance for doubtful accounts. Supplies, as a percentage of net operating revenues, increased from 11.7% in 2006 to 13.3% in 2007, primarily from the acquisition of hospitals from Triad whose higher acuity of services and lower purchasing program utilization resulted in higher supply costs than our other hospitals taken collectively and from other recent acquisitions for whom we have yet to fully integrate into our purchasing program, offsetting improvements at hospitals owned throughout both periods from greater utilization of and improved pricing under our purchasing program. Rent and other operating expenses, as a percentage of net operating revenues, decreased from 22.6% in 2006 to 22.3% in 2007, primarily as a result of the hospitals acquired from Triad having lower rent expense as a percentage of net operating revenues. As part of our acquisition of Triad, we acquired minority investments in certain joint ventures. These investments provided earnings of 0.4% of net operating revenues. Prior to the Triad acquisition, we did not have any material minority investments in joint ventures.

Income from continuing operations margin decreased from 4.3% in 2006 to 0.8% in 2007. Net income margins decreased from 4.0% in 2006 to 0.4% in 2007. The decrease in these margins is reflective of the impact of the net increase in expenses, as a percentage of net revenue, discussed above and the increase in interest expense and loss on early extinguishment of debt associated with the acquisition of Triad.

Depreciation and amortization increased from 4.3% of net operating revenues in 2006 to 4.4% of net operating revenues in 2007.

Interest expense, net, increased by $270.1 million from $94.4 million in 2006, to $364.5 million in 2007. An increase in the average debt balance in 2007 as compared to 2006 of $3.583 billion, due primarily to the additional borrowings to fund the Triad acquisition and repay our previous outstanding debt, accounted for a $247.7 million increase in interest expense. An increase in interest rates due to an increase in LIBOR during 2007, as compared to 2006, accounted for $22.4 million of the increase.

The net results of the above mentioned changes plus a $27.3 million loss from early extinguishment of debt incurred in connection with the financing of the Triad acquisition, resulted in income from continuing operations before income taxes decreasing $184.9 million from $287.8 million in 2006 to $102.9 million for 2007.

Provision for income taxes from continuing operations decreased from $110.2 million in 2006 to $43.0 million in 2007 due to the decrease in income from continuing operations before income taxes. Our effective tax rates were 41.8% and 38.3% for the years ended December 31, 2007 and 2006, respectively. The increase in our effective tax rate is primarily a result of an increase in valuation allowances. As a result of the additional interest expense expected to be incurred, we determined that certain of our state net operating losses will expire before being utilized and accordingly established appropriate valuation allowances.

Net income was $30.3 million in 2007 compared to $168.3 million for 2006, a decrease of 82%.

Year Ended December 31, 2006 Compared to Year Ended December 31, 2005

Net operating revenues increased by 16.9% to $4.180 billion in 2006, from $3.576 billion in 2005. Of the $604.0 million increase in net operating revenues, the hospitals we acquired in 2005 and 2006, which we did not own throughout both periods, contributed approximately $336.3 million, and hospitals we owned throughout both periods contributed approximately $267.7 million, an increase of 7.5%. The increase from hospitals that we owned throughout both periods was attributable to rate increase, payor mix and the acuity level of services provided, offset by a decrease in volume.

Inpatient admissions increased by 12.0%. Adjusted admissions increased by 12.4%. On a same-store basis, inpatient admissions increased by 1.2% and same-store adjusted admissions increased by 1.0%. Increases in admissions in 2006 were offset by 2006 having fewer flu and respiratory admissions than 2005 and a reduction in admissions from service closures and a change in the classification of one day stays from an inpatient admission to an outpatient procedure. With respect to consolidated admissions, approximately 10.8 percentage points of the increase in admissions were from newly acquired hospitals. On a same-store basis, net inpatient revenues increased by 6.0% and net outpatient revenues increased by 9.2%. Consolidated and same-store average length of stay remained unchanged at 4.1 days.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, increased from 84.5% in 2005 to 86.5% in 2006. Salaries and benefits, as a percentage of net operating revenues, increased from 39.7% in 2005 to 39.8% in 2006 as the impact of recent acquisitions, an increase in the number of employed physicians and the recognition of additional stock-based compensation from the adoption of SFAS No. 123(R) offset efficiencies gained since the prior year period. Provision for bad debts, as a percentage of net revenues, increased from 10.0% in 2005 to 12.4% in 2006 due to an increase in self-pay revenue and the $65.0 million change in estimate, recorded in the third quarter, which increased the provision for bad debt. Supplies, as a percentage of net operating revenues, decreased from 12.0% in 2005 to 11.7% in 2006. Rent and other operating expenses, as a percentage of net operating revenues, decreased from 22.7% in 2005 to 22.6% in 2006. Income from continuing operations margin decreased from 5.3% in 2005 to 4.3% in 2006. For hospitals that we owned throughout both periods, income from operations as a percentage of net operating revenues decreased from 10.9% in 2005 to 9.1% in 2006. The decrease in income from continuing operations, and income from operations on a same-store basis is primarily due to the increase in the provision for bad debts, offset by the improvements realized and efficiencies gained since the prior year at hospitals owned throughout both periods in the areas of salaries and benefits and supplies. Net income margins decreased from 4.7% in 2005 to 4.0% in 2006, as the decrease in income from continuing operations was offset by a decrease in both the loss on discontinued operations and the loss on sale and impairment of assets associated with those discontinued operations.

Depreciation and amortization decreased from 4.4% of net operating revenues for the year ended December 31, 2005 to 4.3% of net operating revenues for the year ended December 31, 2006.

Interest expense, net, increased by $7.2 million from $87.2 million in 2005, to $94.4 million in 2006. An increase in interest rates due to an increase in LIBOR during 2006, as compared to 2005 accounted for $14.8 million of the increase. This increase was offset by a decrease of $7.1 million as a result of a decrease in our average outstanding debt during 2006 as compared to 2005 and a decrease of $0.5 million related to the hospitals in discontinued operations.

Income from continuing operations before income taxes decreased $20.4 million from $308.2 million in 2005 to $287.8 million for 2006, primarily as a result of the change in estimate of the allowance for doubtful accounts which increased the provision for bad debt expense offset by other operating improvements.

Provision for income taxes from continuing operations decreased from $119.8 million in 2005 to $110.2 million in 2006 due to the decrease in income from continuing operations, before income taxes. Our effective tax rates were 38.3% and 38.8% for the years ended December 31, 2006 and 2005, respectively. The decrease in our effective tax rate is primarily a result of our current year growth in lower tax rate jurisdictions.

Net income was $168.3 million in 2006 compared to $167.5 million for 2005, an increase of 0.4%. The increase is due to the decrease in loss on discontinued operations in 2006 offset by the decrease in income from continuing operations.

Liquidity and Capital Resources

2007 Compared to 2006

Net cash provided by operating activities increased $337.4 million from $350.3 million for the year ended December 31, 2006 compared to $687.7 million for the year ended December 31, 2007. This increase is due to an increase in cash flow from changes in accounts receivable of $202.4 million, increases in cash flows from accounts payable, accrued liabilities and income taxes of $73.8 million, and an increase in non-cash expenses of $231.6 million, of which $143.8 million was related to depreciation. These cash flow increases were offset by decreases in cash flows from supplies, prepaid expenses and other current assets of $27.4 million, decreases in cash flows from other assets and liabilities of $5.0 million and a decrease in net income of $138.0 million.

The use of cash in investing activities increased $6.859 billion from $640.3 million in 2006 to $7.499 billion in 2007, as a result of the acquisition of Triad for $6.836 billion.

In 2007, our net cash provided by financing activities increased $6.677 billion from $226.5 million in 2006 to $6.903 billion in 2007 from our New Credit Facility and issuance of Notes in connection with the acquisition of Triad.

As described previously in our discussion of Liquidity and Capital Resources further and in Notes 6, 8 and 14 of the Notes to Consolidated Financial Statements, at December 31, 2007, we had certain cash obligations, which are due as follows *(in thousands)*:

	Total	2008	2009-2011	2012-2013	2014 and thereafter
Long Term Debt	$ 6,041,610	$ 14,743	$ 192,667	$ 127,214	$ 5,706,986
Senior Subordinated Notes	3,021,331	—	—	—	3,021,331
Interest on Bank Facility and Notes(1)	4,729,179	689,772	2,052,729	1,347,496	639,182
Capital Leases, including interest	47,009	9,290	13,915	5,503	18,301
Total Long-Term Debt	13,839,129	713,805	2,259,311	1,480,213	9,385,800
Operating Leases	768,703	146,084	307,484	120,638	194,497
Replacement Facilities and Other Capital Committments(2)	676,264	267,658	408,606	—	—
Open Purchase Orders(3)	211,119	211,119	—	—	—
Interpretation 48 obligations, including interest and penalties	17,530	1,754	15,776	—	—
Total	$ 15,512,745	$ 1,340,420	$ 2,991,177	$ 1,600,851	$ 9,580,297

(1) Estimate of interest payments assumes the interest rates at December 31, 2007 remain constant during the period presented for the New Credit Facility, which is variable rate debt. The interest rate used to calculate interest payments for the New Credit Facility was LIBOR as of December 31, 2007 plus the spread. The Notes are fixed at an interest rate of 8.875% per annum.

(2) Pursuant to purchase agreements in effect as of December 31, 2007 and where certificate of need approval has been obtained, we have commitments to build the following replacement facilities and the following capital commitments. As part of an acquisition in 2003, we agreed to build a replacement hospital in Petersburg, Virginia by August 2008. As part of an acquisition in 2005, we agreed to build a replacement hospital in Shelbyville, Tennessee by June 30, 2009. As required by an amendment to our lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location. As part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana by April 2011. In conjunction with the acquisition of Triad, we assumed the commitment to build a replacement hospital in Clarksville, Tennessee by June 2009 and a de novo hospital in Cedar Park, TX, which opened in December 2007. Construction costs, including equipment costs, for these five replacement facilities and one de novo hospital are currently estimated to be approximately $761.4 million of which approximately $362.1 million has been incurred to date including costs incurred by Triad prior to our acquisition. In addition as a part of an acquisition in 2004, we committed to spend $90 million in capital expenditures within eight years in Phoenixville, Pennsylvania, and as part of an acquisition in 2005 we committed to spend approximately $41 million within seven years related to capital expenditures at Chestnut Hill Hospital in Philadelphia, Pennsylvania.

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

As more fully described in Note 6 of the Notes to Consolidated Financial Statements at December 31, 2007, we had issued letters of credit primarily in support of potential insurance related claims and specified outstanding bonds of approximately $36 million.

Additional borrowings in 2007, offset by our redemption of $136.6 million of principal amount of convertible notes in 2006 along with net income for 2006, resulted in our debt as a percentage of total capitalization increasing from 53% at December 31, 2006 to 84% at December 31, 2007.

2006 Compared to 2005

Net cash provided by operating activities decreased by $60.7 million, from $411.0 million for the year ended December 31, 2005 to $350.3 million for the year ended December 31, 2006. This decrease in comparison to the prior year is primarily the result of an incremental build-up in accounts receivable from recently acquired hospitals of $23.7 million, cash paid for income taxes of $60.1 million in excess of amounts paid in the prior year period, and the change in cash flow presentation of the tax benefits from stock option exercises, associated with the adoption of SFAS No. 123(R), of $24.5 million. The increase in cash paid for income taxes in 2006 as compared to 2005 is primarily the result of the deferred nature of the deductibility for tax purposes, of the increase in bad debt expense from our change in estimate of our allowance for doubtful accounts and increase in stock-based compensation expense. Also, fewer stock options exercised in 2006 compared to 2005, reduced our deductions from taxable income. These decreases in cash flow were offset by an increase in depreciation expense of $22.6 million and an increase in stock-based compensation expense of $15.1 million, both of which are non-cash expenses, along with an increase of $3.5 million in other non-cash expenses. In addition, changes from all other operating assets and liabilities, primarily due to our management of our working capital, increased net cash flows by $6.4 million in 2006 as compared to 2005.

The use of cash in investing activities increased $313.0 million from $327.3 million in 2005 to $640.3 million in 2006. This increase is primarily the result of our increased acquisition activity which accounted for $226.2 million of the increase and the prior year cash used in investing activities being offset by $52.0 million proceeds from the sale of four hospitals, as opposed to in 2006 when we received proceeds of $0.8 million from the sale of one hospital and a nursing home.

In 2006, our net cash provided by financing activities increased $288.7 million to $226.5 million from a use of cash in 2005 of $62.2 million. This increase is primarily the result of our use of borrowings available under our Credit Agreement to fund hospital acquisitions, the repurchase of company stock, and the repayment of amounts previously borrowed under the revolving credit facility portions of our Credit Agreement.

During 2006, we repurchased 5,000,000 shares of our outstanding common stock at an aggregate cost of $176.3 million. Cash flow to fund these repurchases was derived from borrowings under our credit agreement. Considering the relatively low cost of funds available to us, we believe the use of these funds to repurchase outstanding shares provides an attractive return on investment.

Capital Expenditures

Cash expenditures for purchases of facilities were $7.018 billion in 2007, $384.6 million in 2006 and $158.4 million in 2005. Our expenditures in 2007 included $6.865 billion for the purchase of Triad, $133.7 million for the purchase of two additional hospitals, $3.4 million for the purchase of physician practices, $7.7 million for equipment to integrate acquired hospitals and $8.5 million for the settlement of acquired working capital. Our expenditures in 2006 included $334.5 million for the purchase of the eight hospitals acquired in 2006, $21.8 million for the purchase of three home health agencies and physician practices, $21.5 million for information systems and other equipment to integrate the hospitals acquired in 2006 and $6.8 million for the settlement of acquired working capital. Our capital expenditures in 2005 included $138.1 million for the purchase of five hospitals $10.7 million for the purchase of an ambulatory surgery center and physician practices and $9.6 million for information systems and other equipment to integrate the hospitals acquired in 2005.

Excluding the cost to construct replacement hospitals and a de novo hospital, our cash expenditures for routine capital for 2007 totaled $344.1 million compared to $207.7 million in 2006, and $185.6 million in 2005. Costs to construct replacement hospitals and a de novo hospital totaled $178.7 million in 2007, $16.8 million in 2006 and $2.8 million in 2005.

Pursuant to hospital purchase agreements in effect as of December 31, 2007, as part of the acquisition in August 2003 of the Southside Regional Medical Center in Petersburg, Virginia, we are required to build a replacement facility by August 2008. As part of an acquisition in 2005 of Bedford County Medical Center in Shelbyville, Tennessee, we are required to build a replacement facility by June 30, 2009. Also as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement facility at its Barstow Community Hospital in Barstow, California. As part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana by April 2011. In conjunction with the acquisition of Triad, we assumed the commitment to build a replacement hospital in Clarksville, Tennessee by June 2009 and a de novo hospital in Cedar Park, TX, which opened in December 2007. Estimated construction costs, including equipment costs, are approximately $761.4 million for these five replacement facilities and a de novo hospital. We expect total capital expenditures of approximately $775 to $800 million in 2008, including approximately $635 to $650 million for renovation, equipment purchases and IT conversion costs associated with the former Triad hospitals, (which includes amounts which are required to be expended pursuant to the terms of the hospital purchase agreements) and approximately $140 to $150 million for construction and equipment cost of the replacement hospitals.

Capital Resources

Net working capital was $1.105 billion at December 31, 2007 compared to $446.1 million at December 31, 2006, an increase of $658.9 million. The acquisition of Triad provided additional initial working capital of $721.3 million. An increase of cash of approximately $110.3 million and an increase of deferred taxes of $60.6 million also contributed to the increase in working capital. These increases were offset by increases in accrued liabilities for employee compensation of approximately $83.7 million and accrued interest of $146.7 million and the net reduction in working capital of all other assets and liabilities of $2.9 million.

On November 14, 2005, we elected to call for the redemption of $150 million in principal amount of our 4.25% Convertible Subordinated Notes due 2008 (the "2008 Notes"). At the conclusion of this call for redemption, $0.3 million in principal amount of the 2008 Notes were redeemed for cash and $149.7 million of the 2008 Notes called for redemption, plus an additional $0.9 million of the 2008 Notes, were converted by the holders into 4,495,083 shares of our common stock.

On December 15, 2005, we elected to call for redemption all of the remaining outstanding 2008 Notes. As of December 15, 2005, there was $136.6 million in aggregate principal amount outstanding. On January 17, 2006, at the conclusion of the second call for redemption of 2008 Notes, $0.1 million in principal amount of the 2008 Notes were redeemed for cash and $136.5 million of the 2008 Notes were converted by the holders into 4,074,510 shares of our common stock prior to the second redemption date.

In connection with the consummation of the Triad acquisition in July 2007, we obtained $7.215 billion of senior secured financing under a New Credit Facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The New Credit Facility consists of a $6.065 billion funded term loan facility with a maturity of seven years, a $300 million delayed draw term loan facility, reduced from $400 million with a maturity of seven years and a $750 million revolving credit facility with a maturity of six years. The revolving credit facility also includes a subfacility for letters of credit and a swingline subfacility. The New Credit Facility requires us to make quarterly amortization payments of each term loan facility equal to 0.25% of the initial outstanding amount of the term loans, if any, with the outstanding principal balance of each term loan facility payable on July 25, 2014.

The term loan facility must be prepaid in an amount equal to (1) 100% of the net cash proceeds of certain asset sales and dispositions by us and our subsidiaries, subject to certain exceptions and reinvestment rights, (2) 100% of the net cash proceeds of issuances of certain debt obligations or receivables based financing by us and our subsidiaries, subject to certain exceptions, and (3) 50%, subject to reduction to a lower percentage based on our leverage ratio (as defined in the New Credit Facility generally as the ratio of total debt on the date of determination to our EBITDA, as defined, for the four quarters most recently ended prior to such date), of excess cash flow (as defined) for any year, commencing in 2008, subject to certain exceptions.

Voluntary prepayments and commitment reductions are permitted in whole or in part, without premium or penalty, subject to minimum prepayment or reduction requirements.

The obligor under the New Credit Facility is CHS/Community Health Systems, Inc., or CHS, a wholly-owned subsidiary of Community Health Systems, Inc. All of our obligations under the New Credit Facility are unconditionally guaranteed by Community Health Systems, Inc. and certain existing and subsequently acquired or organized domestic subsidiaries. All obligations under the New Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of Community Health Systems, Inc., CHS and each subsidiary guarantor, including equity interests held by us or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries.

The loans under the New Credit Facility will bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at our option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus one-half of 1.0%, or (b) a reserve adjusted London interbank offered rate for dollars (Eurodollar rate (as defined)). The applicable percentage for term loans is 1.25% for Alternate Base Rate loans and 2.25% for Eurodollar rate loans. The applicable percentage for revolving loans will initially be 1.25% for Alternative Base Rate revolving loans and 2.25% for Eurodollar revolving loans, in each case subject to reduction based on our leverage ratio. Loans under the swingline subfacility bear interest at the rate applicable to Alternative Base Rate loans under the revolving credit facility.

We have agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to Eurodollar rate loans under the revolving credit facility times the maximum aggregate amount available to be drawn under all letters of credit outstanding under the subfacility for letters of credit. The issuer of any letter of credit issued under the subfacility for letters of credit will also receive a customary fronting fee and other customary processing charges. We are initially obligated to pay commitment fees of 0.50% per annum (subject to reduction based upon on our leverage ratio), on the unused portion of the revolving credit facility. For purposes of this calculation, swingline loans are not treated as usage of the revolving credit facility. We are also obligated to pay commitment fees of 0.50% per annum for the first six months after the close of the New Credit Facility, 0.75% per annum for the next three months thereafter and 1.0% per annum thereafter, in each case on the unused amount of the delayed draw term loan facility. We also paid arrangement fees on the closing of the New Credit Facility and will pay an annual administrative agent fee.

The New Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting our and our subsidiaries' ability to, among other things and subject to various exceptions, (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of our businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change our fiscal year. We and our subsidiaries are also required to comply with specified financial covenants (consisting of a leverage ratio and an interest coverage ratio) and various affirmative covenants.

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

As of December 31, 2007, there was approximately $1.050 billion of available borrowing capacity under our New Credit Facility, of which $36 million was set aside for outstanding letters of credit. We believe that these funds, along with internally generated cash and continued access to the bank credit and capital markets, will be sufficient to finance future acquisitions, capital expenditures and working capital requirements through the next 12 months and into the foreseeable future.

As of December 31, 2007, we are currently a party to the following interest rate swap agreements to limit the effect of changes in interest rates on a portion of our long-term borrowings. On each of these swaps, we received a variable rate of interest based on the three-month London Inter-Bank Offer Rate ("LIBOR"), in exchange for the payment by us of a fixed rate of interest. We currently pay, on a quarterly basis, a margin above LIBOR of 225 basis points for revolving credit and term loans under the New Credit Facility.

Swap #	Notional Amount (In 000's)	Fixed Interest Rate	Termination Date
1	100,000	4.0610%	May 30, 2008
2	100,000	2.4000%	June 13, 2008
3	100,000	3.5860%	August 29, 2008
4	100,000	3.9350%	June 6, 2009
5	100,000	4.3375%	November 30, 2009
6	100,000	4.9360%	October 4, 2010
7	100,000	4.7090%	January 24, 2011
8	300,000	5.1140%	August 8, 2011
9	100,000	4.7185%	August 19, 2011
10	100,000	4.7040%	August 19, 2011
11	100,000	4.6250%	August 19, 2011
12	200,000	4.9300%	August 30, 2011
13	200,000	4.4815%	October 26, 2011
14	200,000	4.0840%	December 3, 2011
15	250,000	5.0185%	May 30, 2012
16	150,000	5.0250%	May 30, 2012
17	200,000	4.6845%	September 11, 2012
18	125,000	4.3745%	November 23, 2012
19	75,000	4.3800%	November 23, 2012
20	150,000	5.0200%	November 30, 2012
21	100,000	5.0230%	May 30, 2013(1)
22	300,000	5.2420%	August 6, 2013
23	100,000	5.0380%	August 30, 2013(2)
24	100,000	5.0500%	November 30, 2013(3)
25	100,000	5.2310%	July 25, 2014
26	100,000	5.2310%	July 25, 2014
27	200,000	5.1600%	July 25, 2014
28	75,000	5.0405%	July 25, 2014
29	125,000	5.0215%	July 25, 2014

(1) This swap agreement becomes effective May 30, 2008, concurrent with the termination of agreement #1 listed above.

(2) This swap agreement becomes effective June 13, 2008, concurrent with the termination of agreement #2 listed above.

(3) This swap agreement becomes effective September 2, 2008, after the termination of agreement #3 listed above.

The swaps that were in effect prior to the Triad acquisition remain in effect after the refinancing for the Triad acquisition and will continue to be used to limit the effects of changes in interest rates on portions of our New Credit Facility.

The New Credit Facility and/or the Notes contain various covenants that limit our ability to take certain actions including; among other things, our ability to:

- incur, assume or guarantee additional indebtedness;
- issue redeemable stock and preferred stock;
- repurchase capital stock;
- make restricted payments, including paying dividends and making investments;
- redeem debt that is junior in right of payment to the notes;
- create liens without securing the notes;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- enter into agreements that restrict dividends from subsidiaries;
- merge, consolidate, sell or otherwise dispose of substantial portions of our assets;
- enter into transactions with affiliates; and
- guarantee certain obligations.

In addition, our New Credit Facility contains restrictive covenants and requires us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet these restricted covenants and financial ratios and tests can be affected by events beyond our control, and we cannot assure you that we will meet those tests. A breach of any of these covenants could result in a default under our New Credit Facility and/or the Notes. Upon the occurrence of an event of default under our New Credit Facility or the Notes, all amounts outstanding under our New Credit Facility and the Notes may become due and payable and all commitments under the New Credit Facility to extend further credit may be terminated.

We believe that internally generated cash flows, availability for additional borrowings under our New Credit Facility of $1.050 billion (consisting of a $750 million revolving credit facility and a $300 million delayed draw term loan facility) and our ability to add up to $300 million of borrowing capacity from receivable transactions (including securitizations) and continued access to the bank credit and capital markets will be sufficient to finance acquisitions, capital expenditures and working capital requirements through the next 12 months. We believe these same sources of cash flows, borrowings under our credit agreement as well as access to bank credit and capital markets will be available to us beyond the next 12 months and into the foreseeable future.

Off-balance sheet arrangements

Excluding the hospital whose lease terminated in conjunction with our sale of interests in the partnership holding the lease and whose operating results are included in discontinued operations, our consolidated operating results for the years ended December 31, 2007 and 2006, included $288.4 million and $255.7 million, respectively, of net operating revenue and $14.4 million and $13.3 million, respectively, of income from operations, generated from seven hospitals operated by us under operating lease arrangements. In accordance with accounting principles generally accepted in the United States of America, the respective assets and the future lease obligations under these arrangements are not recorded in our consolidated balance sheet. Lease payments under these arrangements are included in rent expense and totaled approximately $15.6 million and $14.4 million for the years ended December 31, 2007 and 2006, respectively. The current terms of these operating leases expire between June 2010 and December 2019, not including lease extension options. If we allow these leases to expire, we would no longer generate revenue nor incur expenses from these hospitals.

In the past, we have utilized operating leases as a financing tool for obtaining the operations of specified hospitals without acquiring, through ownership, the related assets of the hospital and without a significant outlay of cash at the front end of the lease. We utilize the same operating strategies to improve operations at those hospitals held under operating leases as we do at those hospitals that we own. We have not entered into any operating leases for hospital operations since December 2000.

As described more fully in Note 14 of the Notes to Consolidated Financial Statements, at December 31, 2007, we have certain cash obligations for replacement facilities and other construction commitments of $676.3 million and open purchase orders for $211.1 million.

Joint Ventures

We have sold minority interests in certain of our subsidiaries or acquired subsidiaries with existing minority interest ownership positions. The amount of minority interest in equity is included in other long-term liabilities and the minority interest in income or loss is recorded separately in the consolidated statements of income. Triad also implemented this strategy to a greater extent than we did. In conjunction with the acquisition of Triad, we acquired 19 hospitals containing minority ownership interests ranging from less than 1% to 35%. As of and for the years ended December 31, 2007 and 2006, the balance of minority interests included in long-term liabilities was $366.1 million and $23.6 million, respectively, and the amount of minority interest in earnings was $16.0 million and $2.8 million, respectively.

Reimbursement, Legislative and Regulatory Changes

Legislative and regulatory action has resulted in continuing change in the Medicare and Medicaid reimbursement programs which will continue to limit payment increases under these programs and in some cases implement payment decreases. Within the statutory framework of the Medicare and Medicaid programs, there are substantial areas subject to administrative rulings, interpretations, and discretion which may further affect payments made under those programs, and the federal and state governments might, in the future, reduce the funds available under those programs or require more stringent utilization and quality reviews of hospital facilities. Additionally, there may be a continued rise in managed care programs and future restructuring of the financing and delivery of healthcare in the United States. These events could cause our future financial results to decline.

Inflation

The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. In addition, our suppliers pass along rising costs to us in the form of higher prices. We have implemented cost control measures, including our case and resource management program, to curb increases in operating costs and expenses. We have generally offset increases in operating costs by increasing reimbursement for services, expanding services and reducing costs in other areas. However, we cannot predict our ability to cover or offset future cost increases.

Critical Accounting Policies

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

Critical accounting policies are defined as those that are reflective of significant judgments and uncertainties, and potentially result in materially different results under different assumptions and conditions. We believe that our critical accounting policies are limited to those described below. For a detailed discussion on the application of these and other accounting policies, see Note 1 in the Notes to the Consolidated Financial Statements.

Third Party Reimbursement

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. Excluding the former Triad hospitals, contractual allowances are automatically calculated and recorded through our internally developed "automated contractual allowance system". Within the automated system, actual Medicare DRG data, coupled with all payors' historical paid claims data, is utilized to calculate the contractual allowances. This data is automatically updated on a monthly basis. For the former Triad hospitals, contractual allowances are determined through a manual process wherein contractual allowance adjustments, regardless of payor or method of calculation, are reviewed and compared to actual payment experience. The methodology used is similar to the methodology used within our "automated contractual allowance system". The former Triad hospitals will be phased in to the "automated contractual allowance system". All hospital contractual allowance calculations are subjected to monthly review by management to ensure reasonableness and accuracy. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We record adjustments to the estimated billings in the periods that such adjustments become known. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in future periods as final settlements are determined. However, due to the complexities involved in these estimates, actual payments we receive could be different from the amounts we estimate and record. Contractual allowance adjustments related to final settlements or appeals increased net operating revenue by an insignificant amount in each of the years ended December 31, 2007, 2006 and 2005.

Allowance for Doubtful Accounts

Substantially all of our accounts receivable are related to providing healthcare services to our hospitals' patients. Collection of these accounts receivable is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and outstanding patient balances for which the primary insurance payor has paid some but not all of the outstanding balance, with the remaining outstanding balance (generally deductibles and co-payments) owed by the patient. At the point of service, for patients required to make a co-payment, we generally collect less than 15% of the related revenue. For all procedures scheduled in advance, our policy is to verify insurance coverage prior to the date of the procedure. Insurance coverage is not verified in advance of procedures for walk-in and emergency room patients.

Effective September 30, 2006, we began estimating the allowance for doubtful accounts by reserving a percentage of all self-pay accounts receivable without regard to aging category, based on collection history, adjusted for expected recoveries and, if present, anticipated changes in trends. For all other payor categories we began reserving 100% of all accounts aging over 365 days from the date of discharge. The percentage used to reserve for all self-pay accounts is based on our collection history. We believe that we collect substantially all of our third-party insured receivables which include receivables from governmental agencies. During the quarter ending December 31, 2007, in conjunction with our ongoing process of monitoring the net realizable value of our accounts receivable, as well as integrating the methodologies, data and assumptions used by the former Triad management, we performed various analyses including updating a review of historical cash collections. As a result of these analyses, we noted deterioration in certain key cash collection indicators. The acquisition of Triad also provided additional data and a comparative and larger population on which to base our estimates. As a result of the lower estimated collectability indicated by the updated analyses, we recorded an increase to our contractual reserves of $96.3 million and an increase to our allowance for doubtful accounts of approximately $70.1 million as of December 31, 2007. The resulting impact, net of taxes, is a decrease to income from continuing operations of $105.4 million. We believe this lower collectability is primarily the result of an increase in the number of patients qualifying for charity care, reduced enrollment in certain state Medicaid programs and an increase in the number of indigent non-resident aliens. 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 could affect our collection of accounts receivable. We also review our overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net revenue less provision for bad debts, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, and the impact of recent acquisitions and dispositions.

Our policy is to write-off gross accounts receivable if the balance is under $10.00 or when such amounts are placed with outside collection agencies. We believe this policy accurately reflects the ongoing collection efforts within the Company and is consistent with industry practices. We had approximately $1.5 billion and $0.8 billion at December 31, 2007 and December 31, 2006, respectively, being pursued by various outside collection agencies. We expect to collect less than 3%, net of estimated collection fees, of the amounts being pursued by outside collection agencies. As these amounts have been written-off, they are not included in our gross accounts receivable or our allowance for doubtful accounts. Collections on amounts previously written-off are recognized in income when received. However, we take into consideration estimated collections of these future amounts written-off in evaluating the reasonableness of our allowance for doubtful accounts.

Days revenue outstanding was 54 days at December 31, 2007 and 62 days at December 31, 2006. The change in estimate of our allowance for doubtful accounts reduced our days revenue outstanding by approximately 5 days. After giving effect to the change in estimate of our allowance for doubtful accounts, our target range for days revenue outstanding is 52 – 58 days.

Total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) was approximately $5.111 billion as of December 31, 2007 and approximately $2.274 billion as of December 31, 2006. The approximate percentage of total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) summarized by aging categories is as follows:

	As of December 31,		
	2007	2006	2005
0 – 60 days	61.2%	63.3%	63.7%
60 – 150 days	18.8%	17.7%	17.1%
151 – 360 days	15.8%	13.2%	6.5%
Over 360 days	4.2%	5.8%	12.7%
Total	100.0%	100.0%	100.0%

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

	As of December 31,		
	2007	2006	2005
Insured receivables	65.8%	66.0%	65.3%
Self-pay receivables	34.2%	34.0%	34.7%
Total	100.0%	100.0%	100.0%

On a combined basis, as a percentage of self-pay receivables, the combined total allowance for doubtful accounts, as reported in the consolidated financial statements, and related allowances for other self-pay discounts and contractuals, was approximately 76% at December 31, 2007, and 65% at December 31, 2006. The increase in the percentage of allowances as a percentage of self-pay receivables from December 31, 2006 to December 31, 2007, is due to the self-pay discounts assumed in the Triad acquisition as well as the change in estimate of the allowance for doubtful accounts and contractual allowances recorded in 2007.

Goodwill and Other Intangibles

Goodwill represents the excess of cost over the fair value of net assets acquired. Goodwill arising from business combinations is accounted for under the provisions of Statement of Financial Accounting Standards ("SFAS") No. 141 "Business Combinations" and SFAS No. 142 "Goodwill and Other Intangible Assets" and is not amortized. SFAS No. 142 requires goodwill to be evaluated for impairment at the same time every year and when an event occurs or circumstances change such that it is reasonably possible that an impairment may exist. We selected September 30th as our annual testing date.

The SFAS No. 142 goodwill impairment model requires a comparison of the book value of net assets to the fair value of the related operations that have goodwill assigned to them. If the fair value is determined to be less than book value, a second step is performed to compute the amount of the impairment. We estimated the fair values of the related operations using both a debt free discounted cash flow model as well as an adjusted EBITDA multiple model. These models are both based on our best estimate of future revenues and operating costs, and are reconciled to our consolidated market capitalization. The cash flow forecasts are adjusted by an appropriate discount rate based on our weighted average cost of capital. We performed our initial evaluation, as required by SFAS No. 142, during the first quarter of 2002 and the annual evaluation as of each succeeding September 30. No impairment has been indicated by these evaluations. In future periods, estimates used to conduct the impairment review, including revenue and profitability projections or fair values, could cause our analysis to indicate that our goodwill is impaired and result in a write-off of a portion or all of our goodwill.

Impairment or Disposal of Long-Lived Assets

In accordance with SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets", whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, we project the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

Professional Liability Insurance Claims

Professional Liability Insurance for Former Triad Hospitals

Substantially all of the professional and general liability risks of the acquired Triad hospitals are subject to a per occurrence deductible. Substantially all losses in periods prior to May 1999 are insured through a wholly-owned insurance subsidiary of HCA, Inc., or HCA, Triad's owner prior to that time, and excess loss policies maintained by HCA. HCA has agreed to indemnify the former Triad hospitals in respect of claims covered by such insurance policies arising prior to May 1999. After May 1999, the former Triad hospitals obtained insurance coverage on a claims incurred basis from HCA's wholly-owned insurance subsidiary with excess coverage obtained from other carriers that is subject to certain deductibles. Effective for claims incurred after December 31, 2006, Triad began insuring its claims from $1 million to $5 million through its wholly-owned captive insurance company, replacing the coverage provided by HCA. Substantially all claims reported on or after January 2007 are self-insured up to $10 million per claim. Excess insurance for all hospitals is purchased through commercial insurance companies generally after the self-insured amount covers up to $100 million per occurrence. The excess insurance for the former Triad hospitals is underwritten on a "claims-made basis." We accrue an estimated liability for its uninsured exposure and self-insured retention based on historical loss patterns and actuarial projections.

Professional Liability Insurance Claims for All Other Community Health Systems Hospitals

We accrue for estimated losses resulting from professional liability claims. The accrual, which includes an estimate for incurred but not reported claims, is based on historical loss patterns and actuarially determined projections and is discounted to its net present value using a weighted average risk-free discount rate of 4.1% and 4.6% in 2007 and 2006, respectively. To the extent that subsequent claims information varies from management's estimates, the liability is adjusted currently. Our insurance is underwritten on a "claims-made" basis. Prior to June 1, 2002 , substantially all of our professional and general liability risks were subject to a $0.5 million per occurrence deductible; for claims reported from June 1, 2002 through June 1, 2003, these deductibles were $2.0 million per occurrence. Additional coverage above these deductibles was purchased through captive insurance companies in which we had a 7.5% minority ownership interest in each and to which the premiums paid by us represented less than 8% of the total premium revenues of each captive insurance company. With the formation of our own wholly-owned captive insurance company in June 2003, we terminated our minority interest relationships in those entities. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 are self-insured up to $5 million per claim. Management on occasion has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals was purchased through commercial insurance companies and generally covers us for liabilities in excess of the self-insured amount and up to $100 million per occurrence for claims reported on or after June 1, 2003.

The following table represents the balance of our liability for the self-insured component of professional liability insurance claims and activity for each of the respective years listed (excludes premiums for insured coverage) (in thousands):

	Beginning of Year	Acquired Balance	Claims and Expenses Paid	Expense(1)	End of Year
2005	$ 63,849	$ —	$ 15,544	$ 40,066	$ 88,371
2006	88,371	—	34,464	50,254	104,161
2007	104,161	171,144	54,278	79,157	300,184

(1) Total expense, including premiums for insured coverage, was $53.6 million in 2005, $65.7 million in 2006 and $99.7 million in 2007.

Income Taxes

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

On January 1, 2007, we adopted the provisions of the FASB Interpretation No. 48, "Accounting for Uncertainty in Income Taxes." The total amount of unrecognized benefit that would affect the effective tax rate, if recognized, is approximately $5.7 million as of December 31, 2007. It is our policy to recognize interest and penalties accrued related to unrecognized benefits in our consolidated statement of operations as income tax expense. During the year ended December 31, 2007, we recorded approximately $2.4 million in liabilities and $0.6 million in interest and penalties related to prior state income tax returns through our income tax provision from continuing operations and which are included in our FASB Interpretation No. 48 liability at December 31, 2007. A total of approximately $1.8 million of interest and penalties is included in the amount of FASB Interpretation No. 48 liability at December 31, 2007. During the year ended December 31, 2007, we released $5.2 million plus accrued interest of $0.8 million of our FASB Interpretation No. 48 liability, as a result of the expiration of the statute of limitations pertaining to tax positions taken in prior years relative to legal settlements and $1.5 million relative to state tax positions. During the year ended December 31, 2007, our FASB Interpretation No. 48 liability decreased approximately $3.5 million due to an income tax examination settlement of the federal tax returns of the former Triad hospitals for the short taxable years ended April 27, 2001, June 30, 2001 and December 31, 2001, and the taxable years ended December 31, 2002 and 2003. The financial statement impact of this settlement impacted goodwill.

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Our unrecognized tax benefits consist primarily of state exposure items. We believe it is reasonably possible that approximately $1.1 million of our current unrecognized tax benefit may be recognized within the next twelve months as a result of a lapse of the statute of limitations and settlements with taxing authorities.

We or one of our subsidiaries file income tax returns in the U.S. federal jurisdiction and various state jurisdictions. With few exceptions, we are no longer subject to U.S. federal or state income tax examinations for years prior to 2003. During 2006, we agreed to a settlement at the Internal Revenue Service (the "IRS") Appeals Office with respect to the 2003 tax year. We have since received a closing letter with respect to the examination for that tax year. The settlement was not material to our results of operations or consolidated financial position.

The IRS has concluded an examination of the federal income tax returns of Triad for the short taxable years ended April 27, 2001, June 30, 2001 and December 31, 2001, and the taxable years ended December 31, 2002 and 2003. On May 10, 2006, the IRS issued an examination report with proposed adjustments. Triad filed a protest on June 9, 2006 and the matter was referred to the IRS Appeals Office. Representatives of the former Triad hospitals met with the IRS Appeals Office in April 2007 and reached a tentative settlement. Triad has since received a closing letter with respect to the examination for those tax years. The settlement was not material to our results of operations or consolidated financial position.

Recent Accounting Pronouncements

In September 2006, the FASB issued SFAS No. 157, " Fair Value Measurements" ("SFAS No. 157"), which defines fair value, provides a framework for measuring fair value, and expands the disclosures required for fair value measurements. SFAS No. 157 applies to other accounting pronouncements that require fair value measurement; it does not require any new fair value measurements. SFAS No. 157 is effective for fiscal years beginning after November 15, 2007, and is required to be adopted by us beginning in the first quarter of 2008. Although we will continue to evaluate the application of SFAS No. 157, management does not currently believe adoption will have a material impact on our consolidated results of operations or consolidated financial position.

In February 2007, the FASB issued SFAS No. 159, "The Fair Value Option for Financial Assets and Financial Liabilities — Including an Amendment of FASB Statement No. 115" ("SFAS No. 159"). SFAS No. 159 expands the use of fair value accounting but does not affect existing standards that require assets or liabilities to be carried at fair value. SFAS No. 159 permits an entity, on a contract-by-contract basis, to make an irrevocable election to account for certain types of financial instruments and warranty and insurance contracts at fair value, rather than historical cost, with changes in the fair value, whether realized or unrealized, recognized in earnings. SFAS No. 159 is effective for fiscal years beginning after November 15, 2007. We adopted SFAS No. 159 as of January 1, 2008. The adoption of this statement is not expected to have a material effect on our consolidated results of operations or consolidated financial position.

In December 2007, the FASB issued SFAS No. 141(R), "Business Combinations" ("SFAS No. 141(R)"). SFAS No. 141(R) replaces SFAS No. 141 and addresses the recognition and accounting for identifiable assets acquired, liabilities assumed, and noncontrolling interests in business combinations. This standard will require more assets and liabilities be recorded at fair value and will require expense recognition (rather than capitalization) of certain pre-acquisition costs. This standard will also require any adjustments to acquired deferred tax assets and liabilities occurring after the related allocation period to be made through earnings. Furthermore, this standard requires this treatment of acquired deferred tax assets and liabilities also be applied to acquisitions occurring prior to the effective date of this standard. SFAS No. 141(R) is effective for fiscal years beginning after December 15, 2008 and is required to be adopted prospectively with no early adoption permitted. We will begin applying SFAS No. 141(R) in the first quarter of 2009. We are currently assessing the potential impact that SFAS No. 141(R) will have on our consolidated results of operations and financial position.

In December 2007, the FASB issued SFAS No. 160, "Noncontrolling Interests in Consolidated Financial Statements" ("SFAS No. 160"). SFAS No. 160 addresses the accounting and reporting framework for noncontrolling ownership interests in consolidated subsidiaries of the parent. SFAS No. 160 also establishes disclosure requirements that clearly identify and distinguish between the interests of the parent company and the interests of the noncontrolling owners and that require minority ownership interests to be presented separately within equity in the consolidated financial statements. SFAS No. 160 is effective for fiscal years beginning after December 15, 2008, and will be adopted by us in the first quarter of 2009. We are currently assessing the potential impact that SFAS No. 160 will have on our consolidated results of operations and consolidated financial position.

Item 7A. *Quantitative and Qualitative Disclosures about Market Risk*

We are exposed to interest rate changes, primarily as a result of our New Credit Facility which bears interest based on floating rates. In order to manage the volatility relating to the market risk, we entered into interest rate swap agreements described under the heading "Liquidity and Capital Resources". We do not anticipate any material changes in our primary market risk exposures in 2008. We utilize risk management procedures and controls in executing derivative financial instrument transactions. We do not execute transactions or hold derivative financial instruments for trading purposes. Derivative financial instruments related to interest rate sensitivity of debt obligations are used with the goal of mitigating a portion of the exposure when it is cost effective to do so.

A 1% change in interest rates on variable rate debt in excess of that amount covered by interest rate swaps would have resulted in interest expense fluctuating approximately $14 million in 2007, $4 million for 2006 and $7 million for 2005.

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

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Community Health Systems, Inc.
Franklin, Tennessee

We have audited the accompanying consolidated balance sheets of Community Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 2007 and 2006, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2007. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Community Health Systems, Inc. and subsidiaries as of December 31, 2007 and 2006, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2007, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 2 to the consolidated financial statements, the Company adopted the fair value recognition provisions of Statement of Financial Accounting Standards No. 123 (Revised 2004), *Share Based Payment* effective January 1, 2006, which resulted in the Company changing the method in which it accounts for share-based compensation.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2007, based on the criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 28, 2008 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 28, 2008

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2007	2006	2005
	(In thousands, except share and per share data)		
Net operating revenues	$ 7,127,494	$ 4,180,136	$ 3,576,117
Operating costs and expenses:			
Salaries and benefits	2,894,977	1,661,619	1,421,145
Provision for bad debts	897,285	518,861	356,120
Supplies	944,768	487,778	429,846
Rent	155,566	91,943	82,257
Other operating expenses	1,432,998	855,596	731,024
Depreciation and amortization	316,215	179,282	157,262
Total operating costs and expenses	6,641,809	3,795,079	3,177,654
Income from operations	485,685	385,057	398,463
Interest expense, net of interest income of $8,181, $1,779, and $5,742 in 2007, 2006 and 2005, respectively	364,533	94,411	87,185
Loss from early extinguishment of debt	27,388	4	—
Minority interest in earnings	15,996	2,795	3,104
Equity in earnings of unconsolidated affiliates	(25,132)	—	—
Income from continuing operations before income taxes	102,900	287,847	308,174
Provision for income taxes	43,003	110,152	119,804
Income from continuing operations	59,897	177,695	188,370
Discontinued operations, net of taxes:			
Loss from operations of hospitals sold or held for sale	(11,067)	(6,873)	(8,737)
Net loss on sale of hospitals and partnership interests	(2,594)	(2,559)	(7,618)
Impairment of long-lived assets of hospitals held for sale	(15,947)	—	(4,471)
Loss on discontinued operations	(29,608)	(9,432)	(20,826)
Net income	$ 30,289	$ 168,263	$ 167,544
Earnings per common share — basic:			
Income from continuing operations	$ 0.64	$ 1.87	$ 2.13
Loss on discontinued operations	$ (0.32)	$ (0.10)	$ (0.24)
Net income	$ 0.32	$ 1.77	$ 1.89
Earnings per common share — diluted:			
Income from continuing operations	$ 0.63	$ 1.85	$ 2.00
Loss on discontinued operations	$ (0.31)	$ (0.10)	$ (0.21)
Net income	$ 0.32	$ 1.75	$ 1.79
Weighted average number of shares outstanding:			
Basic	93,517,337	94,983,646	88,601,168
Diluted	94,642,294	96,232,910	98,579,977

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

	December 31, 2007	December 31, 2006
	(In thousands, except share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 132,874	$ 40,566
Patient accounts receivable, net of allowance for doubtful accounts of $1,033,516 and $478,565 in 2007 and 2006, respectively	1,533,798	773,984
Supplies	262,903	113,320
Prepaid income taxes	99,417	—
Deferred income taxes	113,741	13,249
Prepaid expenses and taxes	70,339	32,385
Other current assets (including assets of hospitals held for sale of $118,893 at December 31, 2007)	339,826	47,880
Total current assets	2,552,898	1,021,384
Property and equipment:		
Land and improvements	460,501	163,988
Buildings and improvements	4,134,654	1,634,893
Equipment and fixtures	1,606,756	831,485
	6,201,911	2,630,366
Less accumulated depreciation and amortization	(689,337)	(643,789)
Property and equipment, net	5,512,574	1,986,577
Goodwill	4,247,714	1,336,525
Other assets, net of accumulated amortization of $100,556 and $92,921 in 2007 and 2006, respectively (including assets of hospitals held for sale of $417,120 at December 31, 2007)	1,180,457	162,093
Total assets	$ 13,493,643	$ 4,506,579
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Current maturities of long-term debt	$ 20,710	$ 35,396
Accounts payable	492,693	247,747
Current income taxes payable	—	7,626
Accrued liabilities:		
Employee compensation	403,598	162,188
Interest	153,832	7,122
Other (including liabilities of hospitals held for sale of $67,606 at December 31, 2007)	377,102	115,204
Total current liabilities	1,447,935	575,283
Long-term debt	9,077,367	1,905,781
Deferred income taxes	407,947	141,472
Other long-term liabilities	483,459	136,811
Minority interests in equity of consolidated subsidiaries	366,131	23,559
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $.01 par value per share, 100,000,000 shares authorized; none issued	—	—
Common stock, $.01 par value per share, 300,000,000 shares authorized; 96,611,085 shares issued and 95,635,536 shares outstanding at December 31, 2007 and 95,026,494 shares issued and 94,050,945 shares outstanding at December 31, 2006	966	950
Additional paid-in capital	1,240,308	1,195,947
Treasury stock, at cost, 975,549 shares at December 31, 2007 and 2006	(6,678)	(6,678)
Unearned stock compensation	—	—
Accumulated other comprehensive income	(81,737)	5,798
Retained earnings	557,945	527,656
Total stockholders' equity	1,710,804	1,723,673
Total liabilities and stockholders' equity	$ 13,493,643	$ 4,506,579

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

(In thousands, except share data)

	Common Stock Shares	Common Stock Amount	Additional Paid-in Capital	Treasury Stock Shares	Treasury Stock Amount	Unearned Stock Compensation	Accumulated Other Comprehensive Income (Loss)	Retained Earnings (Accumulated Deficit)	Total
BALANCE, December 31, 2004	88,591,733	$ 886	$ 1,047,888	(975,549)	$ (6,678)	$ —	$ 6,046	$ 191,849	$ 1,239,991
Comprehensive Income:									
Net income	—	—	—	—	—	—	—	167,544	167,544
Net change in fair value of interest rate swaps, net of tax expense of $5,019	—	—	—	—	—	—	8,923	—	8,923
Net change in fair value of available for sale securities							222	—	222
Total comprehensive income							9,145	167,544	176,689
Repurchases of common stock	(2,239,700)	(22)	(79,830)	—	—	—	—	—	(79,852)
Issuance of common stock in connection with the exercise of options	3,134,721	31	49,543	—	—	—	—	—	49,574
Issuance of common stock in connection with the conversion of convertible debt	4,495,083	44	148,576	—	—	—	—	—	148,620
Restricted stock grant	558,000	6	18,160	—	—	(18,160)	—	—	6
Tax benefit from exercise of options	—	—	24,453	—	—	—	—	—	24,453
Earned stock compensation	—	—	—	—	—	4,956	—	—	4,956
Miscellaneous	—	—	140	—	—	—	—	—	140
BALANCE, December 31, 2005	94,539,837	$ 945	$ 1,208,930	(975,549)	$ (6,678)	$ (13,204)	$ 15,191	$ 359,393	$ 1,564,577
Comprehensive Income:									
Net income	—	—	—	—	—	—	—	168,263	168,263
Net change in fair value of interest rate swaps, net of tax benefit of $931	—	—	—	—	—	—	(1,654)	—	(1,654)
Net change in fair value of available for sale securities	—	—	—	—	—	—	562	—	562
Total comprehensive income							(1,092)	168,263	167,171
Adjustment to adopt FASB statement No. 158, net of tax benefit of $5,465	—	—	—	—	—	—	(8,301)	—	(8,301)
Repurchases of common stock	(5,000,000)	(50)	(176,265)	—	—	—	—	—	(176,315)
Issuance of common stock in connection with the exercise of options	867,833	9	14,564	—	—	—	—	—	14,573
Issuance of common stock in connection with the conversion of convertible debt	4,074,510	41	137,157	—	—	—	—	—	137,198
Tax benefit from exercise of options	—	—	4,750	—	—	—	—	—	4,750
Share-based compensation	544,314	5	20,068	—	—	—	—	—	20,073
Reclassification of unearned stock compensation	—	—	(13,257)	—	—	13,204	—	—	(53)
BALANCE, December 31, 2006	95,026,494	$ 950	$ 1,195,947	(975,549)	$ (6,678)	$ —	$ 5,798	$ 527,656	$ 1,723,673
Comprehensive Income:									
Net income	—	—	—	—	—	—	—	30,289	30,289
Net change in fair value of interest rate swaps, net of tax benefit of $51,223	—	—	—	—	—	—	(91,063)	—	(91,063)
Net change in fair value of available for sale securities	—	—	—	—	—	—	237	—	237
Adjustment to pension liability, net of tax benefit of $496	—	—	—	—	—	—	3,291	—	3,291
Total comprehensive income							(87,535)	30,289	(57,246)
Issuance of common stock in connection with the exercise of options	321,535	3	8,362	—	—	—	—	—	8,365
Tax benefit from exercise of options	—	—	(2,760)	—	—	—	—	—	(2,760)
Share-based compensation	1,263,056	13	38,759	—	—	—	—	—	38,772
BALANCE, December 31, 2007	96,611,085	$ 966	$ 1,240,308	(975,549)	$ (6,678)	$ —	$ (81,737)	$ 557,945	$ 1,710,804

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2007	2006	2005
		(In thousands)	
Cash flows from operating activities:			
Net income	$ 30,289	$ 168,263	$ 167,544
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	332,580	188,771	166,162
Deferred income taxes	(39,894)	(25,228)	9,889
Stock compensation expense	38,771	20,073	4,957
Excess tax benefits relating to stock-based compensation	(1,216)	(6,819)	—
Loss on early extinguishment of debt	27,388	—	—
Minority interest in earnings	15,996	2,795	3,104
Impairment on hospital held for sale	19,044	—	6,718
Loss on sale of hospitals	3,954	3,937	6,295
Other non-cash expenses, net	19,017	500	740
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	131,300	(71,141)	(47,455)
Supplies, prepaid expenses and other current assets	(31,977)	(4,544)	(16,838)
Accounts payable, accrued liabilities and income taxes	125,959	52,151	84,956
Other	16,527	21,497	24,977
Net cash provided by operating activities	687,738	350,255	411,049
Cash flows from investing activities:			
Acquisitions of facilities and other related equipment	(7,018,048)	(384,618)	(158,379)
Purchases of property and equipment	(522,785)	(224,519)	(188,365)
Disposition of hospitals and other ancillary operations	109,996	750	51,998
Proceeds from sale of equipment	4,650	4,480	2,325
Increase in other non-operating assets	(72,671)	(36,350)	(34,851)
Net cash used in investing activities	(7,498,858)	(640,257)	(327,272)
Cash flows from financing activities:			
Proceeds from exercise of stock options	8,214	14,573	49,580
Stock buy-back	—	(176,316)	(79,853)
Deferred financing costs	(182,954)	(2,153)	(1,259)
Excess tax benefits relating to stock-based compensation	1,216	6,819	—
Redemption of convertible notes	—	(128)	(298)
Proceeds from minority investors in joint ventures	2,351	6,890	1,383
Redemption of minority investments in joint ventures	(1,356)	(915)	(3,242)
Distribution to minority investors in joint ventures	(6,645)	(3,220)	(1,939)
Borrowings under Credit Agreement	9,221,627	1,031,000	—
Repayments of long-term indebtedness	(2,139,025)	(650,090)	(26,539)
Net cash (used in) provided by financing activities	6,903,428	226,460	(62,167)
Net change in cash and cash equivalents	92,308	(63,542)	21,610
Cash and cash equivalents at beginning of period	40,566	104,108	82,498
Cash and cash equivalents at end of period	$ 132,874	$ 40,566	$ 104,108

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Business and Summary of Significant Accounting Policies

Business. Community Health Systems, Inc., through its subsidiaries (collectively the "Company"), owns, leases and operates acute care hospitals in non-urban and select urban markets. As of December 31, 2007, included in our continuing operations, the Company owned, leased or operated 115 hospitals, licensed for 16,971 beds in 27 states. Pennsylvania and Texas represent the only areas of geographic concentration. Net operating revenues generated by the Company's hospitals in Pennsylvania, as a percentage of consolidated net operating revenues, were 13.1% in 2007, 22.0% in 2006 and 23.1% in 2005. Net operating revenues generated by the Company's hospitals in Texas, as a percentage of consolidated net operating revenues, were 13.0% in 2007, 10.4% in 2006 and 11.6% in 2005.

Use of Estimates. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates under different assumptions or conditions.

Principles of Consolidation. The consolidated financial statements include the accounts of the Company, its subsidiaries, all of which are controlled by the Company through majority voting control, and variable interest entities for which the Company is the primary beneficiary. All significant intercompany accounts and transactions have been eliminated. Certain of the subsidiaries have minority stockholders. The amount of minority interest in equity is disclosed separately on the consolidated balance sheets and minority interest in earnings is disclosed separately on the consolidated statements of income.

Cost of Revenue. The majority of the Company's operating expenses are "cost of revenue" items. Operating costs that could be classified as general and administrative by the Company would include the Company's corporate office costs at the Company's Franklin, Tennessee and Plano, Texas offices, which were $133.4 million, $88.9 million and $67.5 million for the years ended December 31, 2007, 2006 and 2005, respectively. Included in these amounts is stock-based compensation of $38.8 million, $20.1 million and $5.0 million for the years ended December 31, 2007, 2006 and 2005, respectively.

Cash Equivalents. The Company considers highly liquid investments with original maturities of three months or less to be cash equivalents.

Supplies. Supplies, principally medical supplies, are stated at the lower of cost (first-in, first-out basis) or market.

Marketable Securites. The Company accounts for marketable securities in accordance with the provisions of Statement of Financial Accounting Standards ("SFAS") No. 115, "Accounting for Certain Investments in Debt and Equity Securities". The Company's marketable securities are classified as trading or available-for-sale. Available-for-sale securities are carried at fair value as determined by quoted market prices, with unrealized gains and losses reported as a separate component of stockholders' equity. Trading securities are reported at fair value with unrealized gains and losses included in earnings. Interest and dividends on securities classified as available-for-sale or trading are included in net revenue and were not material in all periods presented. Accumulated other comprehensive income included an unrealized gain of $0.2 million and $0.6 million at December 31, 2007 and December 31, 2006, respectively, related to these available-for-sale securities.

Property and Equipment. Property and equipment are recorded at cost. Depreciation is recognized using the straight-line method over the estimated useful lives of the land and improvements (2 to 15 years; weighted average useful life is 14 years), buildings and improvements (5 to 40 years; weighted average useful life is 24 years) and equipment and fixtures (4 to 18 years; weighted average useful life is 8 years). Costs capitalized as construction in progress were $457.5 million and $61.2 million at December 31, 2007 and 2006,

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

respectively. Expenditures for renovations and other significant improvements are capitalized; however, maintenance and repairs which do not improve or extend the useful lives of the respective assets are charged to operations as incurred. Interest capitalized in accordance with SFAS No. 34, "Capitalization of Interest Cost," was $19.0 million, $3.0 million and $2.1 million for the years ended December 31, 2007, 2006 and 2005, respectively. Net property and equipment additions included in accounts payable were $21.4 million, $16.9 million and $0.1 million for the years ended December 31, 2007, 2006 and 2005, respectively.

The Company also leases certain facilities and equipment under capital leases (see Notes 3 and 8). Such assets are amortized on a straight-line basis over the lesser of the term of the lease or the remaining useful lives of the applicable assets.

Goodwill. Goodwill represents the excess cost over the fair value of net assets acquired. Goodwill arising from business combinations is accounted for under the provisions of SFAS No. 141, "Business Combinations" ("SFAS No. 141"), and SFAS No. 142, "Goodwill and Other Intangible Assets" ("SFAS No. 142"), and is not amortized. SFAS No. 142 requires goodwill to be evaluated for impairment at the same time every year and when an event occurs or circumstances change such that it is reasonably possible that an impairment may exist. The Company has selected September 30th as its annual testing date.

Other Assets. Other assets consist of costs associated with the issuance of debt, which are included in interest expense over the life of the related debt using the effective interest method, and costs to recruit physicians to the Company's markets, which are deferred and amortized in amortization expense over the term of the respective physician recruitment contract, which is generally three years. Long-term assets held for sale at December 31, 2007 are also included in other assets.

Third-Party Reimbursement. Net patient service revenue is reported at the estimated net realizable amount from patients, third party payors and others for services rendered. Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems, provisions of cost-reimbursement and other payment methods. Approximately 39.3% of net operating revenues for the year ended December 31, 2007, 41.5% of net operating revenues for the year ended December 31, 2006 and 43.0% of net operating revenues for the year ended December 31, 2005, are related to services rendered to patients covered by the Medicare and Medicaid programs. Revenues from Medicare outlier payments are included in the amounts received from Medicare and are approximately 0.42% of net operating revenues for 2007, 0.44% of net operating revenues for 2006, and 0.47% for 2005. In addition, the Company is reimbursed by non-governmental payors using a variety of payment methodologies. Amounts received by the Company for treatment of patients covered by such programs are generally less than the standard billing rates. The differences between the estimated program reimbursement rates and the standard billing rates are accounted for as contractual adjustments, which are deducted from gross revenues to arrive at net operating revenues. These net operating revenues are an estimate of the net realizable value due from these payors. Final settlements under certain of these programs are subject to adjustment based on administrative review and audit by third parties. Adjustments to the estimated billings are recorded in the periods that such adjustments become known. Adjustments to previous program reimbursement estimates are accounted for as contractual allowance adjustments and reported in the periods in which final settlements are determined. Adjustments related to final settlements or appeals increased revenue by an insignificant amount in each of the years ended December 31, 2007, 2006 and 2005. Amounts due to third-party payors were $73 million as of December 31, 2007 and $55 million as of December 31, 2006 and are included in accrued liabilities-other in the accompanying consolidated balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 2005.

Net Operating Revenues. Net operating revenues are recorded net of provisions for contractual allowance of approximately $16.839 billion, $10.024 billion and $8.401 billion in 2007, 2006 and 2005, respectively. Net operating revenues are recognized when services are provided and are reported at the estimated net realizable amount from patients, third party payors and others for services rendered. Also

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

included in the provision for contractual allowance shown above is the value of administrative and other discounts provided to self-pay patients eliminated from net operating revenues which was $282.5 million, $100.3 million and $77.9 million for the years ended December 31, 2007, 2006 and 2005, respectively. In the ordinary course of business the Company renders services to patients who are financially unable to pay for hospital care. Included in the provision for contractual allowance shown above, is the value (at the Company's standard charges) of these services to patients who are unable to pay that is eliminated from net operating revenues when it is determined they qualify under the Company's charity care policy. The value of these services was $354.8 million, $214.2 million and $174.2 million for the years ended December 31, 2007, 2006 and 2005, respectively. In the fourth quarter of 2007, in conjunction with an analysis of the net realizable value of accounts receivable, which included updating the Company's analysis of historical cash collections, as well as conforming estimation methodologies with those of the former Triad hospitals, the Company revised its methodology whereby the Company has revised its estimate of contractual allowances for estimated amounts of self-pay accounts receivable that will ultimately qualify as charity care, or that will ultimately qualify for Medicaid, indigent care or other specific governmental reimbursement. Previous estimates of uncollectible amounts for such receivables were included in the Company's bad debt reserves for each period. The impact of these changes in estimates decreased net operating revenue approximately $96.3 million for the year ended December 31, 2007.

Allowance for Doubtful Accounts. Accounts receivable are reduced by an allowance for amounts that could become uncollectible in the future. Substantially all of the Company's receivables are related to providing healthcare services to its hospitals' patients.

The Company experienced a significant increase in self-pay volume and related revenue, combined with lower cash collections during the quarter ended September 30, 2006. The Company believes this trend reflected an increased collection risk from self-pay accounts, and as a result the Company performed a review and an alternative analysis of the adequacy of its allowance for doubtful accounts. Based on this review, the Company recorded a $65.0 million increase to its allowance for doubtful accounts to maintain an adequate allowance for doubtful accounts as of September 30, 2006. The Company believed that the increase in self-pay accounts is a result of current economic trends, including an increase in the number of uninsured patients, reduced enrollment under Medicaid programs such as Tenncare, and higher deductibles and co-payments for patients with insurance.

In conjunction with recording the $65.0 million increase to the allowance for doubtful accounts, the Company changed its methodology for estimating its allowance for doubtful accounts effective September 30, 2006, as follows: The Company reserved a percentage of all self-pay accounts receivable without regard to aging category, based on collection history adjusted for expected recoveries and, if present, other changes in trends. For all other payor categories the Company reserved 100% of all accounts aging over 365 days from the date of discharge. Previously, the Company estimated its allowance for doubtful accounts by reserving all accounts aging over 150 days from the date of discharge without regard to payor class. The Company believes its revised methodology provided a better approach to reflect changes in payor mix and historical collection patterns and to respond to changes in trends.

During the quarter ended December 31, 2007, in conjunction with the Company's ongoing process of monitoring the net realizable value of its accounts receivable, as well as integrating the methodologies, data and assumptions used by the former Triad management, the Company performed various analyses including updating a review of historical cash collections. As a result of these analyses, the Company noted a deterioration in certain key cash collection indicators. The acquisition of Triad also provided additional data and a comparative and larger population on which to base the Company's estimates. As a result of the lower estimated collectability indicated by the updated analyses, the Company has recorded an increase to its contractual reserves of $96.3 million (as described above) and an increase to its allowance for doubtful accounts as of December 31, 2007 of approximately $70.1 million. The Company believes this lower

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collectability is primarily the result of an increase in the number of patients qualifying for charity care, reduced enrollment in certain state Medicaid programs and an increase in the number of indigent non-resident aliens.

The Company believes the revised methodology provides a better approach to estimating changes in payor mix, continued increases in charity and indigent care as well as the monitoring of historical collection patterns. The revised accounting methodology and the adequacy of resulting estimates will continue to be reviewed by monitoring accounts receivable write-offs, monitoring cash collections as a percentage of trailing net revenues less provision for bad debts, monitoring historical cash collection trends, as well as analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, and the impact of recent acquisitions and dispositions.

Concentrations of Credit Risk. The Company grants unsecured credit to its patients, most of whom reside in the service area of the Company's facilities and are insured under third-party payor agreements. Because of the economic diversity of the Company's facilities and non-governmental third-party payors, Medicare represents the only significant concentration of credit risk from payors. Accounts receivable, net of contractual allowances, from Medicare were $302.1 million and $116.8 million as of December 31, 2007 and 2006, respectively, representing 11.8% and 9.3% of consolidated net accounts receivable, before allowance for doubtful accounts, as of December 31, 2007 and 2006, respectively.

Professional Liability Insurance Claims. The Company accrues for estimated losses resulting from professional liability. The accrual, which includes an estimate for incurred but not reported claims, is based on historical loss patterns and actuarially-determined projections and is discounted to its net present value. To the extent that subsequent claims information varies from management's estimates, the liability is adjusted currently.

Accounting for the Impairment or Disposal of Long-Lived Assets. In accordance with SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets" ("SFAS No. 144"), whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

Income Taxes. The Company accounts for income taxes under the asset and liability method, in which deferred income tax assets and liabilities are recognized for the tax consequences of "temporary differences" by applying enacted statutory tax rates applicable to future years to differences between the financial statement carrying amounts and the tax bases of existing assets and liabilities. The effect on deferred taxes of a change in tax rates is recognized in the consolidated statement of income during the period in which the tax rate change becomes law.

Comprehensive Income. Comprehensive income is the change in equity of a business enterprise during a period from transactions and other events and circumstances from non-owner sources.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Accumulated Other Comprehensive Income consists of the following (in thousands):

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Adjustment to Pension Liability	Accumulated Other Comprehensive Income
Balance as of December 31, 2005	$ 14,969	$ 222	$ —	$ 15,191
2006 Activity, net of tax	(1,654)	562	(8,301)	(9,393)
Balance as of December 31, 2006	$ 13,315	$ 784	$ (8,301)	$ 5,798
2007 Activity, net of tax	(91,063)	237	3,291	(87,535)
Balance as of December 31, 2007	$ (77,748)	$ 1,021	$ (5,010)	$ (81,737)

Segment Reporting. SFAS No. 131, "Disclosures About Segments of an Enterprise and Related Information" ("SFAS No. 131"), requires that a public company report annual and interim financial and descriptive information about its reportable operating segments. Operating segments, as defined, are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker in deciding how to allocate resources and in assessing performance. SFAS No. 131 allows aggregation of similar operating segments into a single reportable operating segment if the businesses have similar economic characteristics and are considered similar under the criteria established by SFAS No. 131.

Prior to the acquisition of Triad Hospitals, Inc. ("Triad"), the Company aggregated its operating segments into one reportable segment as all of its operating segments had similar services, had similar types of patients, operated in a consistent manner and had similar economic and regulatory characteristics. In connection with the Triad acquisition, certain aspects of the Company's organizational structure and the information that is reviewed by the chief operating decision maker have changed. As a result, management has determined that the Company now operates in three distinct operating segments, represented by the hospital operations (which includes our acute care hospitals and related healthcare entities that provide inpatient and outpatient health care services), the home health agencies operations (which provide outpatient care generally in the patient's home), and the hospital management services business (which provides executive management and consulting services to independent acute care hospitals). SFAS No. 131 requires (1) that financial information be disclosed for operating segments that meet a 10% quantitative threshold of the consolidated totals of net revenue, profit or loss, or total assets; and (2) that the individual reportable segments disclosed contribute at least 75% of total consolidated net revenue. Based on these measures, only the hospital operations segment meets the criteria as a separate reportable segment. Financial information for the home health agencies and management services segments do not meet the quantitative thresholds defined in SFAS No. 131 and are therefore combined with corporate into the all other reportable segment.

The financial information from prior years has been presented in Note 13 to reflect this change in the composition of our reportable operating segments.

Derivative Instruments and Hedging Activities. In accordance with SFAS No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133"), as amended, the Company records derivative instruments (including certain derivative instruments embedded in other contracts) on the consolidated balance sheet as either an asset or liability measured at its fair value. Changes in a derivative's fair value are recorded each period in earnings or other comprehensive income ("OCI"), depending on whether the derivative is designated and is effective as a hedged transaction, and on the type of hedge transaction. Changes in the fair value of derivative instruments recorded to OCI are reclassified to earnings in the period affected by the underlying hedged item. Any portion of the fair value of a derivative instrument determined to be ineffective under the standard is recognized in current earnings.

The Company has entered into several interest rate swap agreements subject to the scope of this pronouncement. See Note 6 for further discussion about the swap transactions.

New Accounting Pronouncements. In June 2006, the Financial Accounting Standards Board ("FASB") issued FASB Interpretation No. 48, "Accounting for Uncertainty in Income Taxes — an interpretation of FASB Statement No. 109" ("FIN 48"), which prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. FIN 48 also provides guidance on de-recognition, classification, interest and penalties, accounting in interim periods, disclosure and transition. FIN 48 is effective for fiscal years beginning after December 15, 2006. The Company adopted FIN 48 as of January 1, 2007. The adoption of this interpretation has not had a material effect on the Company's consolidated results of operations or consolidated financial position.

In September 2006, the FASB issued SFAS No. 157, " Fair Value Measurements" ("SFAS No. 157"), which defines fair value, provides a framework for measuring fair value, and expands the disclosures required for fair value measurements. SFAS No. 157 applies to other accounting pronouncements that require fair value measurement; it does not require any new fair value measurements. SFAS No. 157 is effective for fiscal years beginning after November 15, 2007, and is required to be adopted by the Company beginning in the first quarter of 2008. Although we will continue to evaluate the application of SFAS No. 157, management does not currently believe adoption will have a material impact on the Company's consolidated results of operations or consolidated financial position.

In February 2007, the FASB issued SFAS No. 159, "The Fair Value Option for Financial Assets and Financial Liabilities — Including an Amendment of FASB Statement No. 115" ("SFAS No. 159"). SFAS No. 159 expands the use of fair value accounting but does not affect existing standards that require assets or liabilities to be carried at fair value. SFAS No. 159 permits an entity, on a contract-by-contract basis, to make an irrevocable election to account for certain types of financial instruments and warranty and insurance contracts at fair value, rather than historical cost, with changes in the fair value, whether realized or unrealized, recognized in earnings. SFAS No. 159 is effective for fiscal years beginning after November 15, 2007. The Company adopted SFAS No. 159 as of January 1, 2008. The adoption of this statement is not expected to have a material effect on the Company's consolidated results of operations or consolidated financial position.

In December 2007, the FASB issued SFAS No. 141(R), "Business Combinations" ("SFAS No. 141(R)"). SFAS No. 141(R) replaces SFAS No. 141 and addresses the recognition and accounting for identifiable assets acquired, liabilities assumed, and noncontrolling interests in business combinations. This standard will require more assets and liabilities be recorded at fair value and will require expense recognition (rather than capitalization) of certain pre-acquisition costs. This standard also will require any adjustments to acquired deferred tax assets and liabilities occurring after the related allocation period to be made through earnings. Furthermore, this standard requires this treatment of acquired deferred tax assets and liabilities also be applied to acquisitions occurring prior to the effective date of this standard. SFAS No. 141(R) is effective for fiscal years beginning after December 15, 2008 and is required to be adopted prospectively with no early adoption permitted. SFAS No. 141(R) will be adopted by the Company in the first quarter of 2009. The Company is currently assessing the potential impact that SFAS No. 141(R) will have on its consolidated results of operations or financial position.

In December 2007, the FASB issued SFAS No. 160, "Noncontrolling Interests in Consolidated Financial Statements" ("SFAS No. 160"). SFAS No. 160 addresses the accounting and reporting framework for noncontrolling ownership interests in consolidated subsidiaries of the parent. SFAS No. 160 also establishes disclosure requirements that clearly identify and distinguish between the interests of the parent company and the interests of the noncontrolling owners and that require minority ownership interests be presented separately within equity in the consolidated financial statements. SFAS No. 160 is effective for fiscal years beginning after December 15, 2008, and will be adopted by the Company in the first quarter of 2009. The Company is currently assessing the potential impact that SFAS No. 160 will have on its consolidated results of operations or financial position.

Reclassifications. The Company disposed of one hospital in August 2007, disposed of one hospital in October 2007, disposed of one hospital in November 2007, and designated twelve hospitals as being held for sale in the fourth quarter of 2007. The operating results of those hospitals have been classified as discontinued operations on the consolidated statements of income for all periods presented. There is no effect on net income for all periods presented related to the reclassifications made for the discontinued operations. The presentation of certain other prior year amounts have been changed. These changes in presentation are immaterial to the Company's consolidated financial statements.

2. Accounting for Stock-Based Compensation

The Company adopted the provisions of SFAS No. 123(R), "Share-Based Payments" ("SFAS No. 123(R)") on January 1, 2006, electing to use the modified prospective method for transition purposes. The modified prospective method requires that compensation expense be recorded for all unvested stock options and share awards that subsequently vest or are modified, without restatement of prior periods. Prior to January 1, 2006, the Company accounted for stock-based compensation using the recognition and measurement principles of Accounting Principles Board Opinion No. 25, "Accounting for Stock Issued to Employees" and related interpretations ("APB No. 25"), and provided the pro-forma disclosure requirements of SFAS No. 123 "Accounting for Stock-Based Compensation" and SFAS No. 148 "Accounting for Stock-Based Compensation Transition and Disclosures — an Amendment of FASB Statement No. 123" ("SFAS No. 148"). Under APB No. 25, when the exercise price of the Company's stock was equal to the market price of the underlying stock on the date of grant, no compensation expense was recognized.

The pro-forma table below reflects net income and earnings per share had the Company applied the fair value recognition provisions of SFAS No. 123 for the year ended December 31, 2005, prior to the adoption of SFAS No. 123(R) (in thousands, except per share data):

		Year Ended December 31, 2005
Net Income:	$	167,544
Add: Stock-Based compensation expense recognized under APB No. 25, net of tax		3,493
Deduct: Total stock-based compensation under fair value based method for all awards, net of tax	$	14,232
Pro-forma net income	$	156,805
Net income per share:		
Basic — as reported	$	1.89
Basic — proforma	$	1.77
Diluted — as reported	$	1.79
Diluted — proforma	$	1.68

On September 22, 2005, the Compensation Committee of the Board of Directors of the Company approved an immediate acceleration of the vesting of unvested stock options awarded to employees and officers, including executive officers, on each of three grant dates, December 10, 2002, February 25, 2003, and May 22, 2003. Each of the grants accelerated had a three-year vesting period and would have otherwise become fully vested on their respective anniversary dates no later than May 22, 2006. All other terms and

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

conditions applicable to the outstanding stock option grants remain in effect. A total of 1,235,885 stock options, with a weighted exercise price of $20.26 per share, were accelerated.

The accelerated options were issued under the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan (the "2000 Plan"). No performance shares or units or incentive stock options have been granted under the 2000 Plan. Options granted to non-employee directors of the Company and restricted shares were not affected by this action. The Compensation Committee's decision to accelerate the vesting of the affected options was based primarily on the relatively short period of time until such stock options otherwise become fully vested making them no longer a significant motivator for retention and the fact the Company anticipated that up to approximately $3.8 million of compensation expense ($2.3 million, net of tax) associated with certain of these stock options would have otherwise been recognized in the first two quarters of 2006 pursuant to SFAS No. 123(R) would be avoided.

Since the Company accounted for its stock options prior to January 1, 2006 using the intrinsic value method of accounting prescribed in APB No. 25, the accelerated vesting did not result in the recognition of compensation expense in net income for the year ended December 31, 2005. However, in accordance with the disclosure requirements of SFAS No. 148, the pro-forma results presented in the table above include approximately $5.9 million ($3.6 million, net of tax) of compensation expense for the year ended December 31, 2005, resulting from the vesting acceleration.

Stock-based compensation awards are granted under the 2000 Plan. The 2000 Plan allows for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code as well as stock options which do not so qualify, stock appreciation rights, restricted stock, performance units and performance shares, phantom stock awards and share awards. Persons eligible to receive grants under the 2000 Plan include the Company's directors, officers, employees and consultants. To date, the options granted under the 2000 Plan are "nonqualified" stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date, except for options granted on July 25, 2007, which vests equally on the first two anniversaries of the award date. Options granted prior to 2005 have a 10 year contractual term and options granted in 2005, 2006 and 2007 have an 8 year contractual term. The exercise price of options granted to employees under the 2000 Plan were equal to the fair value of the Company's common stock on the option grant date. As of December 31, 2007, 5,849,771 shares of unissued common stock remain reserved for future grants under the 2000 Plan. The Company also has options outstanding under its Employee Stock Option Plan (the "1996 Plan"). These options are fully vested and exercisable and no additional grants of options will be made under the 1996 Plan.

The following table reflects the impact of total compensation expense related to stock-based equity plans under SFAS No. 123(R) for periods beginning January 1, 2006, and under APB No. 25 for the year ended December 31, 2005, on the reported operating results for the respective periods (in thousands, except per share data):

	Year Ended December 31,		
	2007	2006	2005
Effect on income from continuing operations before income taxes	$ (38,771)	$ (20,073)	$ (4,957)
Effect on net income	$ (23,541)	$ (12,762)	$ (3,493)
Effect on net income per share-diluted	$ (0.25)	$ (0.13)	$ (0.04)

SFAS No. 123(R) also requires the benefits of tax deductions in excess of the recognized tax benefit on compensation expense to be reported as a financing cash flow, rather than as an operating cash flow as required under APB No. 25 and related interpretations. This requirement reduced the Company's net operating cash flows and increased the Company's financing cash flows by $1.2 million and $6.8 million for the years

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ended December 31, 2007 and 2006. In addition, the Company's deferred compensation cost at December 31, 2005, of $13.2 million, arising from the issuance of restricted stock in 2005 and recorded as a component of stockholders' equity as required under APB No. 25, was reclassified into additional paid-in capital upon the adoption of SFAS No. 123(R).

At December 31, 2007, $80.4 million of unrecognized stock-based compensation expense from all outstanding unvested stock options and restricted stock is expected to be recognized over a weighted-average period of 18.4 months. There were no modifications to awards during 2007 or 2006.

The fair value of stock options was estimated using the Black Scholes option pricing model with the assumptions and weighted-average fair values during the years ended December 31, 2007 and 2006, as follows:

	Year Ended December 31,	
	2007	2006
Expected volatility	24.4%	24.2%
Expected dividends	0	0
Expected term	4 years	4 years
Risk-free interest rate	4.48%	4.67%

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

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

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

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Options outstanding and exercisable under the 1996 Plan and 2000 Plan as of December 31, 2007, and changes during each of the years in the three-year period ended December 31, 2007 were as follows (in thousands, except share and per share data):

	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (In Years)	Aggregate Intrinsic Value as of December 31, 2007
Outstanding at December 31, 2004	7,456,279	$ 18.03		
Granted	1,325,700	33.02		
Exercised	(3,134,721)	15.81		
Forfeited and cancelled	(276,984)	26.02		
Outstanding at December 31, 2005	5,370,274	22.63		
Granted	1,151,000	38.07		
Exercised	(865,833)	16.47		
Forfeited and cancelled	(172,913)	34.02		
Outstanding at December 31, 2006	5,482,528	26.48		
Granted	3,544,000	37.79		
Exercised	(295,854)	26.89		
Forfeited and cancelled	(291,659)	35.70		
Outstanding at December 31, 2007	8,439,015	$ 30.90	6.5 years	$ 57,992
Exercisable at December 31, 2007	4,024,138	$ 23.63	5.5 years	$ 53,726

The weighted-average grant date fair value of stock options granted during the year ended December 31, 2007 and 2006, was $10.24 and $10.38, respectively. The aggregate intrinsic value (the number of in-the-money stock options multiplied by the difference between the Company's closing stock price on the last trading day of the reporting period and the exercise price of the respective stock options) in the table above represents the amount that would have been received by the option holders had all option holders exercised their options on December 31, 2007. This amount changes based on the market value of the Company's common stock. The aggregate intrinsic value of options exercised during the year ended December 31, 2007 and 2006 was $3.5 million and $18.2 million, respectively. The aggregate intrinsic value of options vested and expected to vest approximates that of the outstanding options.

The Company has also awarded restricted stock under the 2000 Plan to various employees and its directors. The restrictions on these shares generally lapse in one-third increments on each of the first three anniversaries of the award date, except for restricted stock granted on July 25, 2007, which restrictions lapse equally on the first two anniversaries of the award date. Certain of the restricted stock awards granted to the Company's senior executives also contain a performance objective that must be met in addition to the vesting requirements. If the performance objective is not attained the awards will be forfeited in their entirety. Once the performance objective has been attained, restrictions will lapse in one-third increments on each of the first three anniversaries of the award date. Notwithstanding the above mentioned performance objectives and vesting requirements, the restrictions will lapse earlier in the event of death, disability, termination of employment by employer for reason other than for cause of the holder of the restricted stock or in the event of change in control of the Company. Restricted stock awards subject to performance standards are not considered outstanding for purposes of determining earnings per share until the performance objectives have been satisfied.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Restricted stock outstanding under the 2000 Plan as of December 31, 2007, and changes during each of the years in the three-year period ended December 31, 2007 were as follows:

	Shares	Weighted Average Fair Value
Unvested at December 31, 2004	—	$ —
Granted	563,000	32.37
Vested	—	—
Forfeited	(5,000)	32.37
Unvested at December 31, 2005	558,000	32.37
Granted	606,000	38.26
Vested	(185,975)	32.43
Forfeited	(8,334)	35.93
Unvested at December 31, 2006	969,691	36.05
Granted	1,392,000	38.70
Vested	(384,646)	35.47
Forfeited	(20,502)	36.73
Unvested at December 31, 2007	1,956,543	38.04

As of December 31, 2007, there was $50.3 million of unrecognized stock-based compensation expense related to unvested restricted stock expected to be recognized over a weighted-average period of 17.2 months.

Under the Director's Fee Deferral Plan, the Company's outside directors may elect to receive share equivalent units in lieu of cash for their director's fee. These units are held in the plan until the director electing to receive the share equivalent units retires or otherwise terminates his/her directorship with the Company. Share equivalent units are converted to shares of common stock of the Company at the time of distribution. The following table represents the amount of directors' fees which were deferred and the equivalent units into which they converted for each of the respective periods:

	Year Ended December 31,	
	2007	2006
Directors' fees earned and deferred into plan	$ 129,000	$ 177,500
Equivalent units	3,622.531	4,843.449

At December 31, 2007, there are a total of 13,408.532 units deferred in the plan with an aggregate fair value of $0.5 million, based on the closing market price of the Company's common stock at December 31, 2007 of $36.86.

3. Long-Term Leases, Acquisitions and Divestitures of Hospitals

Triad Acquisition

On July 25, 2007, the Company completed its acquisition of Triad. Triad owned and operated 50 hospitals in 17 states as well as the Republic of Ireland in non-urban and middle market communities. Immediately following the acquisition, on a combined basis the Company owned and operated 128 hospitals in 28 states as well as the Republic of Ireland. As of December 31, 2007, two hospitals acquired from Triad have been sold and six hospitals acquired from Triad were classified as held for sale. As a result of its acquisition of Triad, the Company also provides management and consulting services to independent hospitals, through its subsidiary, Quorum Health Resources, LLC, on a contract basis. The Company acquired Triad for approximately $6.836 billion, including the assumption of $1.686 billion of existing indebtedness. Prior to entering the merger agreement, Triad terminated an Agreement and Plan of Merger that it had entered into on February 4, 2007 (the "Prior Merger Agreement") with Panthera Partners, LLC, Panthera Holdco Corp. and Panthera Acquisition Corporation (collectively, "Panthera"). Concurrent with the termination of the Prior Merger Agreement and pursuant to the terms thereof, Triad paid a termination fee of $20 million and out-of-pocket expenses of $18.8 million to Panthera. The Company reimbursed Triad for the termination fee and the advance for expense reimbursement paid to Panthera. These amounts are included in the allocated purchase price of Triad.

In connection with the consummation of the acquisition of Triad, the Company obtained $7.215 billion of senior secured financing under a new credit facility (the "New Credit Facility") and its wholly-owned subsidiary CHS/Community Health Systems, Inc. ("CHS/Community Health") issued $3.021 billion aggregate principal amount of 8.875% senior notes due 2015 (the "Notes"). The Company used the net proceeds of $3.000 billion from the Notes offering and the net proceeds of $6.065 billion of term loans under the New Credit Facility to acquire the outstanding shares of Triad, to refinance certain of Triad's indebtedness and the Company's indebtedness, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. This New Credit Facility also provides an additional $750 million revolving credit facility and a $400 million delayed draw term loan facility for future acquisitions, working capital and general corporate purposes. As of December 31, 2007, the $400 million delayed draw term loan had been reduced to $300 million at the request of the Company.

The total cost of the Triad acquisition has been allocated to the assets acquired and liabilities assumed based upon their respective preliminary estimated fair values in accordance with SFAS No. 141. The purchase price represented a premium over the fair value of the net tangible and identifiable intangible assets acquired for reasons such as:

- strategically, Triad had operations in five states in which the Company previously had no operations;
- the combined company has smaller concentrations of credit risk through greater geographic diversification;
- many support functions will be centralized; and
- duplicate corporate functions will be eliminated.

The allocation process requires the analysis of acquired fixed assets, contracts, contractual commitments, and legal contingencies to identify and record the fair value of all assets acquired and liabilities assumed. Because of the significance of the transaction and proximity to the end of the current year, the values of certain assets and liabilities are based on preliminary valuations and are subject to adjustment as additional information is obtained. Such additional information includes, but is not limited to: valuations and physical counts of property and equipment, valuation of equity investments and intangible assets, valuation of contractual commitments, finalization of involuntary termination of employees, and review of open cost report settlement periods. The Company is also negotiating the termination of certain assumed contracts it deems unfavorable, such as various physician and service contracts. Under GAAP, the Company has up to twelve months from the closing of the acquisition to complete its valuations and complete contract terminations in order for these terminations to be considered in the allocation process. The Company expects to complete the allocation of the total cost of the Triad acquisition in the second quarter of 2008. Material adjustments to goodwill may result upon the completion of these matters.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Other Acquisitions

Effective April 1, 2007, the Company completed its acquisition of Lincoln General Hospital (157 licensed beds), located in Ruston, Louisiana. The total consideration for this hospital was approximately $48.7 million, of which $44.8 million was paid in cash and $3.9 million was assumed in liabilities. On May 1, 2007, the Company completed its acquisition of Porter Health, (301 licensed beds), located in Valparaiso, Indiana, with a satellite campus in Portage, Indiana and outpatient medical campuses located in Chesterton, Demotte, and Hebron, Indiana. As part of this acquisition, the Company has agreed to construct a 225-bed replacement facility for the Valparaiso hospital no later than April 2011. The total consideration for Porter Health was approximately $110.1 million, of which $88.9 million was paid in cash and $21.2 million was assumed in liabilities. The Company has estimated its purchase price allocation relating to these acquisitions resulting in approximately $1.5 million of goodwill being recorded. These allocations are preliminary pending, among other things, finalization of valuation of tangible and intangible assets. These acquisition transactions were accounted for using the purchase method of accounting. The allocation of the purchase price has been determined by the Company based upon available information and is subject to settling amounts related to purchased working capital and in some instances final appraisals. Adjustments to the purchase price allocation are not expected to be material.

During 2006, the Company acquired through 7 separate purchase transactions and three capital lease transactions, substantially all of the assets and working capital of eight hospitals and three home health agencies. On March 1, 2006, the Company acquired, through a combination of purchasing certain assets and entering into a capital lease for other related assets, Forrest City Hospital, a 118 bed hospital located in Forrest City, Arkansas. On April 1, 2006, the Company completed the acquisition of two hospitals from Baptist Health System, Birmingham, Alabama: Baptist Medical Center — DeKalb (134 beds) and Baptist Medical Center — Cherokee (60 beds). On May 1, 2006, the Company acquired Via Christi Oklahoma Regional Medical Center, a 140 bed hospital located in Ponca City, Oklahoma. On June 1, 2006, the Company acquired Mineral Area Regional Medical Center, a 135 bed hospital located in Farmington, Missouri. On June 30, 2006 the Company acquired Cottage Home Options, a home health agency and related business, located in Galesburg, Illinois. On July 1, 2006, the Company acquired the healthcare assets of Vista Health, which included Victory Memorial Hospital (336 beds) and St. Therese Medical Center (71 non-acute care beds), both located in Waukegan, Illinois. On September 1, 2006, the Company acquired Humble Texas Home Care, a home health agency located in Humble, Texas. On October 1, 2006, the Company acquired Helpsource Home Health, a home health agency located in Wichita Falls, Texas. On November 1, 2006 the Company acquired through two separate capital lease transactions, Campbell Memorial Hospital, a 99 bed hospital located in Weatherford, Texas and Union County Hospital, a 25 bed hospital located in Anna, Illinois. The aggregate consideration for these eight hospitals and three home health agencies totaled approximately $385.7 million, of which $353.8 million was paid in cash and $31.9 million was assumed in liabilities. Goodwill recognized in these transactions totaled $65.6 million, which is expected to be fully deductible for tax purposes.

During 2005, the Company acquired through four separate purchase transactions and one capital lease transaction, substantially all of the assets and working capital of five hospitals. On March 1, 2005, the Company acquired an 85% controlling interest in Chestnut Hill Hospital, a 222 bed hospital located in Philadelphia, Pennsylvania. On June 30, 2005, the Company acquired, through a capital lease, Bedford County Medical Center, a 104 bed hospital located in Shelbyville, Tennessee. On September 30, 2005, the Company acquired the assets of Newport Hospital and Clinic located in Newport, Arkansas. This facility, which was previously operated as an 83 bed acute care general hospital, was closed by its former owner simultaneous with this transaction. The operations of this hospital were consolidated with Harris Hospital, also located in Newport, which is owned and operated by a wholly owned subsidiary of the Company. On October 1, 2005, the Company acquired Sunbury Community Hospital, a 123 bed hospital located in Sunbury, Pennsylvania, and Bradley Memorial Hospital, a 251 bed hospital located in Cleveland, Tennessee. The aggregate consideration for the five hospitals totaled approximately $176 million, of which $138 million was paid in cash and

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

$38 million was assumed in liabilities. Goodwill recognized in these transactions totaled approximately $51 million, which is expected to be fully deductible for tax purposes.

The 2006 and 2005 acquisition transactions were accounted for using the purchase method of accounting. The final allocation of the purchase price for these acquisitions was determined by the Company within one year of the date of acquisition.

The table below summarizes the allocations of the purchase price (including assumed liabilities) for these acquisitions (in thousands):

	2007	2006	2005
Current assets	$ 1,675,392	$ 56,896	$ 19,144
Property and equipment	3,699,200	262,335	110,854
Goodwill and other intangibles	3,111,711	66,490	43,619
Liabilities	1,479,462	27,247	30,786

The operating results of the foregoing hospitals have been included in the consolidated statements of income from their respective dates of acquisition. The following pro forma combined summary of operations of the Company gives effect to using historical information of the operations of the hospitals purchased in 2007 and 2006 as if the acquisitions had occurred as of January 1, 2006 (in thousands except per share data):

	Year Ended December 31,	
	2007	2006
Pro forma net operating revenues	$ 9,623,221	$ 9,245,489
Pro forma net income (loss)	(95,598)	150,626
Pro forma net income per share:		
Basic	$ (1.02)	$ 1.59
Diluted	$ (1.01)	$ 1.57

Pro forma adjustments to net income (loss) include adjustments to depreciation and amortization expense, net of the related tax effect, based on the estimated fair value assigned to the long-lived assets acquired, and to interest expense, net of the related tax effect, assuming the increase in long-term debt used to fund the acquisitions had occurred as of January 1, 2006. The pro forma net income for the year ended December 31, 2007, includes a charge for the early extinguishment of debt of $27.3 million before taxes and $17.5 million after tax, or $0.19 per share (diluted). The pro forma results do not include transaction costs incurred by Triad prior to the date of acquisitions related to cost savings or other synergies that are anticipated as a result of this acquisition. These pro forma results are not necessarily indicative of the actual results of operations.

Discontinued Operations

Effective November 30, 2007, the Company sold Barberton Citizens Hospital (312 licensed beds) located in Barberton, Ohio to Summa Health System of Akron, Ohio. The proceeds from this sale were $53.8 million.

Effective October 31, 2007, the Company sold its 60% membership interest in Northeast Arkansas Medical Center ("NEA"), a 104 bed facility in Jonesboro, Arkansas to Baptist Memorial Health Care ("Baptist"), headquartered in Memphis, Tennessee for $16.8 million. In connection with this transaction, the Company also sold real estate and other assets to a subsidiary of Baptist for $26.2 million.

Effective September 1, 2007, the Company sold its partnership interest in River West L.P., which owned and operated River West Medical Center (an 80 bed facility located in Plaquemine, Louisiana) to an affiliate of Shiloh Health Services, Inc. of Lubbock, Texas. The proceeds from this sale were $0.3 million.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Effective March 18, 2006, the Company sold Highland Medical Center, a 123-bed facility located in Lubbock, Texas, to Shiloh Health Services, Inc. of Louisville, Kentucky. The proceeds from this sale were $0.5 million. This hospital had previously been classified as held for sale.

Effective January 31, 2005, the Company's lease of Scott County Hospital, a 99 bed facility located in Oneida, Tennessee, expired pursuant to its terms.

Effective March 31, 2005, the Company sold The King's Daughters Hospital, a 137 bed facility located in Greenville, Mississippi, to Delta Regional Medical Center, also located in Greenville, Mississippi. In a separate transaction, also effective March 31, 2005, the Company sold Troy Regional Medical Center, a 97 bed facility located in Troy, Alabama, Lakeview Community Hospital, a 74 bed facility located in Eufaula, Alabama and Northeast Medical Center, a 75 bed facility located in Bonham, Texas to Attentus Healthcare Company of Brentwood, Tennessee. The aggregate sales price for these four hospitals was approximately $52.0 million and was received in cash.

As of December 31, 2007, the Company had classified as held for sale 12 hospitals with an aggregate total of 1,690 licensed beds.

In connection with management's decision to sell the previously mentioned facilities and in accordance with SFAS No. 144, the Company has classified the results of operations of the above mentioned hospitals as discontinued operations in the accompanying consolidated statements of income.

Net operating revenues and loss reported for the fifteen hospitals in discontinued operations are as follows:

	Year Ended December 31,		
	2007	2006	2005
		(In thousands)	
Net operating revenues	$ 417,677	$ 189,734	$ 212,723
Loss from operations of hospitals sold or held for sale before income taxes	(14,735)	(10,694)	(13,395)
Loss on sale of hospitals and partnership interests	(3,954)	(3,938)	(6,295)
Impairment of long-lived assets of hospital held for sale	(19,044)	—	(6,718)
Loss from discontinued operations, before taxes	(37,733)	(14,632)	(26,408)
Income tax benefit	8,125	5,200	5,582
Loss from discontinued operations, net of tax	$ (29,608)	$ (9,432)	$ (20,826)

Included in the computation of the loss from discontinued operations, before taxes for the year ended December 31, 2007, is a write-off of $4.0 million of tangible assets and $0.1 million of goodwill for the partnership and membership interests sold and the two hospitals sold and an estimated impairment of $19.0 million on long-lived assets at the hospitals held for sale (see Note 4 Goodwill and Other Intangible Assets).

The computation of loss from discontinued operations, before taxes, for the year ended December 31, 2006, includes the net write-off of $4.4 million of tangible assets at the one hospital sold during the year ended December 31, 2006. Interest expense was allocated to discontinued operations based on estimated sales proceeds available for debt repayment.

The computation of loss from discontinued operations, before taxes, for the year ended December 31, 2005, includes the net write-off of $51.5 million of tangible assets and $17.1 million of goodwill of the four hospitals sold and one hospital designated as held for sale in the second quarter of 2005.

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The assets and liabilities of the hospitals held for sale as of December 31, 2007 are included in the accompanying consolidated balance sheet as follows (in thousands): current assets of $118,893, included in other current assets; net property and equipment of $331,139 and other long-term assets of $85,981, included in other assets; and current liabilities of $67,606, included in other accrued liabilities. The assets and liabilities of hospitals classified as held for sale at December 31, 2007 have not been reclassified as of December 31, 2006 in the accompanying consolidated balance sheet.

4. Goodwill and Other Intangible Assets

The changes in the carrying amount of goodwill are as follows (in thousands):

	Year Ended December 31,	
	2007	2006
Balance, beginning of year	$ 1,336,525	$ 1,259,816
Goodwill acquired as part of acquisitions during the year	2,912,392	67,550
Consideration adjustments and finalization of purchase price allocations for prior year's acquisitions	22,053	9,159
Goodwill related to hospital operations segment written off as part of disposals	(1,913)	—
Goodwill related to hospital operations segment assigned to disposal group classified as held for sale	(21,343)	—
Balance, end of year	$ 4,247,714	$ 1,336,525

SFAS No. 142 requires that goodwill be allocated to each identified reporting unit, which is defined as an operating segment or one level below the operating segment (referred to as a component of the entity). As a result of the change in the Company's operating segments as discussed in Note 1, management has re-evaluated the determination of our reporting units identified for allocation of goodwill in accordance with SFAS No. 142 and determined that the operating segments meet the criteria to be classified as reporting units. At September 30, 2007, goodwill, except for the amount related to the former Triad hospitals, was reallocated among the hospital operations and home health agencies operations reporting units. At December 31, 2007, the hospital operations reporting unit had $1.309 billion and the home health agencies reporting unit had $32.2 million of goodwill. No goodwill has been allocated to the hospital management services segment as of December 31, 2007 because that business relates entirely to the Triad acquisition. Goodwill related to the former Triad hospitals of $2.907 billion has not been allocated to the reporting unit level as of December 31, 2007 because the final purchase price allocation has not been completed (see Note 3).

The Company performed its annual goodwill evaluation, as required by SFAS No. 142 as of September 30, 2007, using the new segment and reporting units. No impairment was indicated by this evaluation. The Company will continue to perform its goodwill evaluation analysis as of September 30th.

Approximately $180.9 million of intangible assets were acquired during the year ended December 31, 2007. The gross carrying amount of the Company's other intangible assets was $194.6 million and $13.7 million as of December 31, 2007 and 2006, respectively, and the net carrying amount was $181.0 million and $7.4 million as of December 31, 2007 and 2006, respectively. Substantially all of the other intangible assets are finite lived and subject to amortization. Other intangible assets are included in other assets on the Company's consolidated balance sheets.

The weighted average amortization period for the intangible assets subject to amortization is approximately 8 years. There are no expected residual values related to these intangible assets. Amortization expense for these intangible assets was $2.7 million, $1.9 million and $1.3 million during the years ended December 31, 2007, 2006 and 2005, respectively. Amortization expense on intangible assets is estimated to be $14.8 million

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

in 2008, $13.9 million in 2009, $13.3 million in 2010, $11.9 million in 2011, $8.4 million in 2012 and $0.3 million thereafter.

5. Income Taxes

The provision for income taxes for income from continuing operations consists of the following (in thousands):

	Year Ended December 31, 2007	2006	2005
Current			
Federal	$ 27,416	$ 120,209	$ 101,371
State	11,411	13,555	12,746
	38,827	133,764	114,117
Deferred			
Federal	6,944	(21,793)	3,987
State	(2,768)	(1,819)	1,700
	4,176	(23,612)	5,687
Total provision for income taxes for income from continuing operations	$ 43,003	$ 110,152	$ 119,804

The following table reconciles the differences between the statutory federal income tax rate and the effective tax rate (dollars in thousands):

	Year Ended December 31, 2007		2006		2005	
	Amount	%	Amount	%	Amount	%
Provision for income taxes at statutory federal rate	$ 36,015	35.0%	$ 100,746	35.0%	$ 107,861	35.0%
State income taxes, net of federal income tax benefit	5,618	5.5	7,628	2.7	9,390	3.0
Change in valuation allowance	3,825	3.7	—	—	—	—
Federal and state tax credits	(2,625)	(2.6)	—	—	—	—
Other	170	0.2	1,778	0.6	2,553	0.8
Provision for income taxes and effective tax rate for income from continuing operations	$ 43,003	41.8%	$ 110,152	38.3%	$ 119,804	38.8%

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Deferred income taxes are based on the estimated future tax effects of differences between the financial statement and tax bases of assets and liabilities under the provisions of the enacted tax laws. Deferred income taxes as of December 31, consist of (in thousands):

	2007		2006	
	Assets	Liabilities	Assets	Liabilities
Net operating loss and credit carryforwards	$ 75,879	$ —	$ 26,709	$ —
Property and equipment	—	464,753	—	136,249
Self-insurance liabilities	100,642	—	35,607	—
Intangibles	—	139,757	—	101,569
Other liabilities	—	19,076	—	2,879
Long-term debt and interest	—	42,447	989	—
Accounts receivable	104,727	—	33,535	—
Accrued expenses	21,928	—	20,362	—
Other comprehensive income	58,933	—	—	1,952
Stock-Based compensation	54,464	—	6,353	—
Other	23,812	—	12,078	—
	440,385	666,033	135,633	242,649
Valuation allowance	(68,558)	—	(21,207)	—
Total deferred income taxes	$ 371,827	$ 666,033	$ 114,426	$ 242,649

Management believes that the net deferred tax assets will ultimately be realized, except as noted below. Management's conclusion is based on its estimate of future taxable income and the expected timing of temporary difference reversals. The Company has state net operating loss carry forwards of approximately $1.223 billion, which expire from 2008 to 2027. With respect to the deferred tax liability pertaining to intangibles, as included above, goodwill purchased in connection with certain of the Company's business acquisitions is amortizable for income tax reporting purposes. However, for financial reporting purposes, there is no corresponding amortization allowed with respect to such purchased goodwill.

The valuation allowance increased by $47.4 million and $0.1 million during the years ended December 31, 2007 and 2006, respectively. In addition to amounts previously discussed, the change in valuation allowance relates to a redetermination of the amount of, and realizability of, net operating losses in certain state and foreign income tax jurisdictions. In addition, as a result of the additional interest expense to be incurred resulting from the Triad acquisition, the Company determined that certain of its state net operating losses will expire before being utilized resulting in the recording of a valuation allowance of approximately $16.4 million. The results of this change in the valuation allowance impacted goodwill from the acquisition.

The Company adopted the provisions of FIN 48, on January 1, 2007. The total amount of unrecognized benefit that would affect the effective tax rate, if recognized, is approximately $5.7 million as of December 31, 2007. It is the Company's policy to recognize interest and penalties accrued related to unrecognized benefits in its statement of operations as income tax expense. During the year ended December 31, 2007, the Company recorded approximately $2.4 million in liabilities and $0.6 million in interest and penalties related to prior state income tax returns through its income tax provision from continuing operations and which are included in its FIN 48 liability at December 31, 2007. A total of approximately $1.8 million of interest and penalties is included in the amount of FIN 48 liability at December 31, 2007. During the year ended December 31, 2007, the Company released $5.2 million plus accrued interest of $0.8 million of its FIN 48 liability, as a result of the expiration of the statute of limitations pertaining to tax positions taken in prior years relative to legal settlements and $1.5 million relative to state tax positions. During the year ending December 31, 2007, the

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Company's FIN 48 liability decreased approximately $3.5 million due to an income tax examination settlement of the federal tax returns of the former Triad hospitals for the short taxable years ended April 27, 2001, June 30, 2001 and December 31, 2001, and the taxable years ended December 31, 2002 and 2003. The financial statement impact of this settlement impacted goodwill.

The Company's unrecognized tax benefits consist primarily of state exposure items. The Company believes that it is reasonably possible that approximately $1.1 million of its current unrecognized tax benefit may be recognized within the next twelve months as a result of a lapse of the statute of limitations and settlements with taxing authorities.

The following is a tabular reconciliation of the total amount of unrecognized tax benefit for the year ended December 31, 2007 (in thousands):

	Year Ended December 31, 2007
Unrecognized Tax Benefit at January 1, 2007	$ 10,510
Gross increases — purchase business combination	10,160
Gross increases — tax positions in current period	1,930
Gross increases — tax positions in prior period	1,820
Lapse of statute of limitations	(6,700)
Settlements	(2,840)
Unrecognized Tax Benefit at December 31, 2007	$ 14,880

The Company or one of its subsidiaries files income tax returns in the U.S. federal jurisdiction and various state jurisdictions. With few exceptions, the Company is no longer subject to U.S. federal or state income tax examinations for years prior to 2003. During 2006, the Company agreed to a settlement at the Internal Revenue Service (the "IRS") Appeals Office with respect to the 2003 tax year. The Company has since received a closing letter with respect to the examination for that tax year. The settlement was not material to the Company's results of operations or financial position.

The IRS has concluded an examination of the federal income tax returns of Triad for the short taxable years ended April 27, 2001, June 30, 2001 and December 31, 2001, and the taxable years ended December 31, 2002 and 2003. On May 10, 2006, the IRS issued an examination report with proposed adjustments. Triad filed a protest on June 9, 2006 and the matter was referred to the IRS Appeals Office. Representatives of the former Triad hospitals met with the IRS Appeals Office in April 2007 and reached a tentative settlement. Triad has since received a closing letter with respect to the examination for those tax years. The settlement was not material to the Company's results of operations or financial position.

The Company paid income taxes, net of refunds received, of $85.2 million, $128.1 million and $68.1 million during 2007, 2006, and 2005, respectively.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

6. Long-Term Debt

Long-term debt consists of the following (in thousands):

	As of December 31, 2007	As of December 31, 2006
Credit Facilities:		
Term loans	$ 5,965,000	$ 1,572,000
Revolving credit loans	—	—
Tax-exempt bonds	8,000	8,000
Senior subordinated notes	3,021,331	300,000
Capital lease obligations (see Note 8)	35,136	44,670
Other	68,610	16,507
Total debt	9,098,077	1,941,177
Less current maturities	(20,710)	(35,396)
Total long-term debt	$ 9,077,367	$ 1,905,781

Terminated Credit Facility and Notes

On August 19, 2004, the Company entered into a $1.625 billion senior secured credit facility with a consortium of lenders which was subsequently amended on December 16, 2004, July 8, 2005 and December 13, 2006 (the "Terminated Credit Facility"). The purpose of the Terminated Credit Facility was to refinance and replace the Company's previous credit agreement, repay specified other indebtedness, and fund general corporate purposes, including amending the credit facility to permit declaration and payment of cash dividends, to repurchase shares or make other distributions, subject to certain restrictions. The Terminated Credit Facility consisted of a $1.2 billion term loan that was due to mature in 2011 and a $425 million revolving credit facility that was due to mature in 2009. The First Incremental Facility Amendment, dated as of December 13, 2006, increased the Company's term loans by $400 million (the "Incremental Term Loan Facility") and also gave the Company the ability to add up to $400 million of additional term loans. The full amount of the Incremental Term Loan Facility was funded on December 13, 2006, and the proceeds were used to repay the full outstanding amount (approximately $326 million) of the revolving credit facility under the credit agreement and the balance was available to be used for general corporate purposes. The Company was able to elect from time to time an interest rate per annum for the borrowings under the term loan, including the incremental term loan, and revolving credit facility equal to (a) an alternate base rate, which would have been equal to the greatest of (i) the Prime Rate (as defined) in effect and (ii) the Federal Funds Effective Rate (as defined), plus 50 basis points, plus (1) 75 basis points for the term loan and (2) the Applicable Margin (as defined) for revolving credit loans or (b) the Eurodollar Rate (as defined) plus (1) 175 basis points for the term loan and (2) the Applicable Margin for Eurodollar revolving credit loans. The Company also paid a commitment fee for the daily average unused commitments under the revolving credit facility. The commitment fee was based on a pricing grid depending on the Applicable Margin for Eurodollar revolving credit loans and ranged from 0.250% to 0.500%. The commitment fee was payable quarterly in arrears and on the revolving credit termination date with respect to the available revolving credit commitments. In addition, the Company paid fees for each letter of credit issued under the credit facility.

On December 16, 2004, the Company issued $300 million 6 1/2% senior subordinated notes due 2012. On April 8, 2005, the Company exchanged these notes for notes having substantially the same terms as the outstanding notes, except the exchanged notes were registered under the Securities Act of 1933, as amended (the "1933 Act").

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

New Credit Facility and Notes

On July 25, 2007, the New Credit Facility was entered into with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The New Credit Facility consists of a $6.065 billion funded term loan facility with a maturity of seven years, a $400 million delayed draw term loan facility with a maturity of seven years and a $750 million revolving credit facility with a maturity of six years. The revolving credit facility also includes a subfacility for letters of credit and a swingline subfacility. As previously disclosed, in connection with the consummation of the acquisition of Triad, the Company used a portion of the net proceeds from its New Credit Facility and the Notes offering to repay its outstanding debt under the Terminated Credit Facility. The Company recorded a pre-tax write-off of approximately $13.9 million in deferred loan costs relative to the early extinguishment of the debt under the Terminated Credit Facility and incurred tender and solicitation fees of approximately $13.4 million on the early repayment of the Company's $300 million aggregate principal amount of 6 1/2% Senior Subordinated Notes due 2012 through a cash tender offer and consent solicitation.

The New Credit Facility requires the Company to make quarterly amortization payments of each term loan facility equal to 0.25% of the outstanding amount of the term loans, if any, with the outstanding principal balance payable on July 25, 2014.

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

The obligor under the New Credit Facility is CHS/Community Health. All of the obligations under the New Credit Facility are unconditionally guaranteed by the Company and certain existing and subsequently acquired or organized domestic subsidiaries. All obligations under the New Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of the Company, CHS/Community Health and each subsidiary guarantor, including equity interests held by the Company, CHS/Community Health or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries.

The loans under the New Credit Facility will bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at the Company's option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus one-half of 1.0%, or (b) a reserve adjusted London interbank offered rate for dollars (Eurodollar Rate) (as defined). The applicable percentage for term loans is 1.25% for Alternate Base Rate loans and 2.25% for Eurodollar rate loans. The applicable percentage for revolving loans is initially 1.25% for Alternate Base Rate revolving loans and 2.25% for Eurodollar revolving loans, in each case subject to reduction based on the Company's leverage ratio. Loans under the swingline subfacility bear interest at the rate applicable to alternative base rate loans under the revolving credit facility.

The Company has agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to Eurodollar rate loans under the revolving credit facility times the maximum aggregate amount available to be drawn under all letters of credit outstanding under the subfacility for letters of credit. The

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

issuer of any letter of credit issued under the subfacility for letters of credit will also receive a customary fronting fee and other customary processing charges. The Company is also obligated to pay commitment fees of 0.50% per annum (subject to reduction based upon the Company's leverage ratio) on the unused portion of the revolving credit facility. For purposes of this calculation, swingline loans are not treated as usage of the revolving credit facility. The Company is also obligated to pay commitment fees of 0.50% per annum for the first six months after the closing of the New Credit Facility, 0.75% per annum for the next three months thereafter and 1.0% per annum thereafter, in each case on the unused amount of the delayed draw term loan facility. The Company paid arrangement fees on the closing of the New Credit Facility and will pay an annual administrative agent fee.

The New Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting, subject to certain exceptions, the Company's and its subsidiaries' ability to, among other things (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of the Company's businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change the Company's fiscal year. The Company is also required to comply with specified financial covenants (consisting of a leverage ratio and an interest coverage ratio) and various affirmative covenants.

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

The Notes were issued by CHS/Community Health in connection with the Triad acquisition in the principal amount of $3.021 billion. These Notes will mature on July 15, 2015. The Notes bear interest at the rate of 8.875% per annum, payable semiannually in arrears on January 15 and July 15, commencing January 15, 2008. Interest on the Notes accrue from the date of original issuance. Interest will be calculated on the basis of 360-day year comprised of twelve 30-day months.

Except as set forth below, CHS/Community Health is not entitled to redeem the Notes prior to July 15, 2011.

On and after July 15, 2011, CHS/Community Health is entitled, at its option, to redeem all or a portion of the Notes upon not less than 30 nor more than 60 days notice, at the redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the 12-month period commencing on July 15 of the years set forth below:

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

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

In addition, any time prior to July 15, 2010, CHS/Community Health is entitled, at its option, on one or more occasions to redeem the Notes (which include additional Notes (the "Additional Notes"), if any which may be issued from time to time under the indenture under which the Notes were issued) in an aggregate principal amount not to exceed 35% of the aggregate principal amount of the Notes (which includes Additional Notes, if any) originally issued at a redemption price (expressed as a percentage of principal amount) of 108.875%, plus accrued and unpaid interest to the redemption date, with the Net Cash Proceeds (as defined) from one or more Public Equity Offerings (as defined) (provided that if the Public Equity Offering is an offering by the Company, a portion of the Net Cash Proceeds thereof equal to the amount required to redeem any such Notes is contributed to the equity capital of CHS/Community Health); provided, however, that:

1) at least 65% of such aggregate principal amount of Notes originally issued remains outstanding immediately after the occurrence of each such redemption (other than the Notes held, directly or indirectly, by the Company or its subsidiaries); and

2) each such redemption occurs within 90 days after the date of the related Public Equity Offering.

CHS/Community Health is entitled, at its option, to redeem the Notes, in whole or in part, at any time prior to July 15, 2011, upon not less than 30 or more than 60 days notice, at a redemption price equal to 100% of the principal amount of Notes redeemed plus the Application Premium (as defined), and accrued and unpaid interest, if any, as of the applicable redemption date.

Pursuant to a registration rights agreement entered into at the time of the issuance of the Notes, CHS/Community Health commenced an offer (the "Exchange Offer") on October 9, 2007, to exchange the Notes for new notes (the "Exchange Notes") having terms substantially identical in all material respects to the Notes (except that the Exchange Notes will be issued under a registration statement pursuant to the 1933 Act.) This registration statement was declared effective by the SEC on October 9, 2007. The Exchange Offer expired on November 13, 2007. The Exchange Offer was consummated on November 19, 2007.

As of December 31, 2007, the Company's availability for additional borrowings under its New Credit Facility was $1.050 billion (consisting of a $750 million revolving credit facility and a $300 million delayed draw term loan facility), of which $36 million was set aside for outstanding letters of credit. The Company also has the ability to add up to $300 million of borrowing capacity from receivable transactions (including securitizations) under the New Credit Facility which has not yet been accessed. The Company also has the ability to amend the New Credit Facility to provide for one or more tranches of term loans in an aggregate principal amount of $600 million, which the Company has not yet accessed. As of December 31, 2007, the Company's weighted-average interest rate under the New Credit Facility was 7.78%.

The Term Loans are scheduled to be paid with principal payments for future years as follows (in thousands):

	Term Loans
2008	$ —
2009	36,463
2010	60,650
2011	60,650
2012	60,650
Thereafter	5,746,587
Total	$ 5,965,000

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

As of December 31, 2007 and 2006, the Company had letters of credit issued, primarily in support of potential insurance related claims and certain bonds of approximately $36 million and $21 million, respectively.

Tax-Exempt Bonds. Tax-Exempt Bonds bore interest at floating rates, which averaged 3.69% and 3.51% during 2007 and 2006, respectively.

Senior Subordinated Notes. On December 16, 2004, the Company completed a private placement offering of $300 million aggregate principal amount of 6.5% senior subordinated notes due 2012. The senior subordinated notes were sold in an offering pursuant to Rule 144A and Regulation S under the 1933 Act. The senior subordinated notes when issued were registered under the 1933 Act or the securities laws of any state and may not be offered or sold in the United States absent registration or an applicable exemption from the registration requirements under the 1933 Act and any applicable state securities laws. On February 24, 2005, the Company filed a registration statement to exchange these notes for registered notes. This exchange was completed during the first quarter of 2005.

In connection with the consummation of the acquisition of Triad, the Company completed an early repayment of the $300 million aggregate principal amount of 61/2% Senior Subordinated Notes due 2012 through a cash tender offer and consent solicitation.

As previously described, in connection with the Triad acquisition, the Company issued $3.021 billion principal amount of Notes. These Notes bear interest at 8.875% interest and mature on July 15, 2015.

Other Debt. As of December 31, 2007, other debt consisted primarily of an industrial revenue bond, the mortgage obligation on the Company's corporate headquarters and other obligations maturing in various installments through 2017.

The Company is currently a party to 29 separate interest swap agreements with an aggregate notional amount of $4.050 billion, to limit the effect of changes in interest rates on a portion of the Company's long-term borrowings. On each of these swaps, the Company receives a variable rate of interest based on the three-month London Inter-Bank Offer Rate ("LIBOR") in exchange for the payment of a fixed rate of interest. The Company currently pays, on a quarterly basis, a margin above LIBOR of 225 basis points for revolver loans and term loans under the senior secured credit facility. See footnote 7 for additional information regarding these swaps.

As of December 31, 2007, the scheduled maturities of long-term debt outstanding, including capital leases for each of the next five years and thereafter are as follows (in thousands):

2008	$ 20,710
2009	53,887
2010	79,331
2011	70,316
2012	66,517
Thereafter	8,807,316
Total	$ 9,098,077

The Company paid interest of $218 million, $96 million and $90 million on borrowings during the years ended December 31, 2007, 2006 and 2005, respectively.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

7. Fair Values of Financial Instruments

The fair value of financial instruments has been estimated by the Company using available market information as of December 31, 2007 and 2006, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Company could realize in a current market exchange (in thousands):

	As of December 31,			
	2007		2006	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Assets:				
Cash and cash equivalents	$ 132,874	$ 132,874	$ 40,566	$ 40,566
Available-for-sale securities	8,352	8,352	7,620	7,620
Trading securities	38,075	38,075	17,714	17,714
Liabilities:				
Credit facilities	5,965,000	5,733,856	1,572,000	1,573,540
Tax-exempt bonds	8,000	8,000	8,000	8,000
Senior subordinated notes	3,021,331	3,074,204	300,000	295,500
Other debt	68,610	68,610	4,344	4,344

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

Available-for-sale securities. Estimated fair value is based on closing price as quoted in public markets.

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

Credit facilities. Estimated fair value is based on information from the Company's bankers regarding relevant pricing for trading activity among the Company's lending institutions.

Tax Exempt Bonds. The carrying amount approximates fair value as a result of the weekly interest rate reset feature of these publicly-traded instruments.

Senior Subordinated Notes. Estimated fair value is based on the average bid and ask price as quoted by the bank who served as underwriters in the sale of these notes.

Interest Rate Swaps. The fair value of interest rate swap agreements is the amount at which they could be settled, based on estimates obtained from the counterparty. The Company has designated the interest rate swaps as cash flow hedge instruments whose recorded value included in other long-term liabilities in the consolidated balance sheet approximates fair market value.

The Company assesses the effectiveness of its hedge instruments on a quarterly basis. For the years ended December 31, 2007 and 2006, the Company completed an assessment of the cash flow hedge instruments and determined the hedges to be highly effective. The Company has also determined that the ineffective portion of the hedges do not have a material effect on the Company's consolidated financial position, operations or cash flows. The counterparty to the interest rate swap agreements exposes the Company to credit risk in the event of non-performance. However, the Company does not anticipate non-performance by the counterparty. The Company does not hold or issue derivative financial instruments for trading purposes.

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

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Interest rate swaps consisted of the following at December 31, 2007:

Swap #	Notional Amount (In 000's)	Fixed Interest Rate	Termination Date	Fair Value (000's)
1	100,000	4.0610%	May 30, 2008	$ 234
2	100,000	2.4000%	June 13, 2008	989
3	100,000	3.5860%	August 29, 2008	493
4	100,000	3.9350%	June 6, 2009	(119)
5	100,000	4.3375%	November 30, 2009	(1,052)
6	100,000	4.9360%	October 4, 2010	(2,948)
7	100,000	4.7090%	January 24, 2011	(2,479)
8	300,000	5.1140%	August 8, 2011	(12,012)
9	100,000	4.7185%	August 19, 2011	(2,668)
10	100,000	4.7040%	August 19, 2011	(2,353)
11	100,000	4.6250%	August 19, 2011	(2,321)
12	200,000	4.9300%	August 30, 2011	(6,755)
13	200,000	4.4815%	October 26, 2011	(3,706)
14	200,000	4.0840%	December 3, 2011	(907)
15	250,000	5.0185%	May 30, 2012	(9,939)
16	150,000	5.0250%	May 30, 2012	(6,020)
17	200,000	4.6845%	September 11, 2012	(5,255)
18	125,000	4.3745%	November 23, 2012	(1,514)
19	75,000	4.3800%	November 23, 2012	(713)
20	150,000	5.0200%	November 30, 2012	(6,172)
21	100,000	5.0230%	May 30, 2013(1)	(4,043)
22	300,000	5.2420%	August 6, 2013	(15,970)
23	100,000	5.0380%	August 30, 2013(2)	(4,123)
24	100,000	5.0500%	November 30, 2013(3)	(3,871)
25	100,000	5.2310%	July 25, 2014	(5,423)
26	100,000	5.2310%	July 25, 2014	(4,440)
27	200,000	5.1600%	July 25, 2014	(9,965)
28	75,000	5.0405%	July 25, 2014	(3,213)
29	125,000	5.0215%	July 25, 2014	(5,217)

(1) This swap agreement becomes effective May 30, 2008, concurrent with the termination of agreement #1 listed above.

(2) This swap agreement becomes effective June 13, 2008, concurrent with the termination of agreement #2 listed above.

(3) This swap agreement becomes effective September 2, 2008, after the termination of agreement #3 listed above.

Assuming no change in December 31, 2007 interest rates, approximately $2.8 million will be recognized in earnings through interest expense during the year ending December 31, 2008 pursuant to the interest rate swap agreements. If interest rate swaps do not remain highly effective as a cash flow hedge, the derivatives' gains or losses reported through other comprehensive income will be reclassified into earnings.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

8. Leases

The Company leases hospitals, medical office buildings, and certain equipment under capital and operating lease agreements. During 2007, the Company entered into $10.8 million of capital leases and assumed $10.0 million of capital leases in the acquisition of the former Triad hospitals. All lease agreements generally require the Company to pay maintenance, repairs, property taxes and insurance costs. Commitments relating to noncancellable operating and capital leases for each of the next five years and thereafter are as follows (in thousands):

Year Ended December 31,	Operating(1)	Capital
2008	$ 146,084	$ 9,290
2009	124,159	5,854
2010	102,242	4,586
2011	81,083	3,475
2012	65,190	2,755
Thereafter	249,945	21,049
Total minimum future payments	$ 768,703	$ 47,009
Less imputed interest		(11,873)
		35,136
Less current portion		(5,967)
Long-term capital lease obligations		$ 29,169

(1) Minimum lease payments have not been reduced by minimum sublease rentals due in the future of $48.5 million.

Assets capitalized under capital leases as reflected in the accompanying consolidated balance sheets were $23.5 million of land and improvements, $140.1 million of buildings and improvements, and $61.8 million of equipment and fixtures as of December 31, 2007 and $19.2 million of land and improvements, $167.8 million of buildings and improvements and $52.4 million of equipment and fixtures as of December 31, 2006. The accumulated depreciation related to assets under capital leases was $79.9 million and $63.7 million as of December 31, 2007 and 2006, respectively. Depreciation of assets under capital leases is included in depreciation and amortization and amortization of debt discounts on capital lease obligations is included in interest expense in the consolidated statements of income.

9. Employee Benefit Plans

The Company maintains various benefit plans, including defined contribution plans, defined benefit plans and deferred compensation plans. The Company's defined contribution plans consist of one plan that covers substantially all corporate office employees and employees at the Company's hospitals and clinics owned prior to the acquisition of Triad. The other defined contribution plan covers substantially all employees at the former Triad hospitals, clinics and QHR. These plans are qualified under Section 401(k) of the Internal Revenue Code. Participants may contribute a portion of their compensation not exceeding a limit set annually by the Internal Revenue Service. These plans include a provision for the Company to match a portion of employee contributions. In addition, the plan covering the former Triad hospitals provides for a supplementary contribution, determined primarily as a percentage of participants' annual wages. The Company is required to maintain the former Triad plan, including this supplementary contribution benefit, through December 31, 2008. Total expense to the Company under the 401(k) plans was $39.8 million, $10.7 million and $8.8 million for the years ended December 31, 2007, 2006 and 2005, respectively.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

In 2007, the Company merged its three defined benefit, non-contributory pension plans, which covered certain employees at three of its hospitals, into one plan ("Pension plan"). The Pension plan provides benefits to covered individuals satisfying certain age and service requirements. Employer contributions to the Pension plan are in accordance with the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as amended. The Company expects to contribute $3.7 million to the Pension plan in fiscal 2008. The Company also provides an unfunded supplemental executive retirement plan ("SERP") for certain members of its executive management. The Company uses a December 31 measurement date for the benefit obligations and a January 1 measurement date for its net periodic costs for both the Pension plan and SERP. Variances from actuarially assumed rates will result in increases or decreases in benefit obligations, net periodic cost and funding requirements in future periods.

The Company's unfunded deferred compensation plans allow participants to defer receipt of a portion of their compensation. The liability under the deferred compensation plans was $59.4 million as of December 31, 2007 and $17.7 million as of December 31, 2006. The Company had trading securities either restricted or generally designated to pay benefits of the deferred compensation plans in the amounts of $38.1 million and $17.7 million as of December 31, 2007 and 2006, respectively, and available-for-sale securities either restricted or generally designated to pay benefits of the SERP in the amounts of $8.4 million and $7.6 million as of December 31, 2007 and 2006, respectively.

A summary of the benefit obligations and funded status for the Company's pension and SERP plans follows (in thousands):

	Pension Plans		SERP	
	2007	2006	2007	2006
Change in benefit obligation:				
Benefit obligation, beginning of year	$ 26,220	$ 27,467	$ 23,293	$ 22,280
Service cost	3,772	3,757	2,810	3,023
Interest cost	1,587	1,601	1,340	1,225
Plan amendment	—	(5,769)	—	—
Actuarial (gain)/loss	(2,812)	(792)	1,155	(3,235)
Benefits paid	(112)	(44)	—	—
Benefit obligation, end of year	28,655	26,220	28,598	23,293
Change in plan assets:				
Fair value of assets, beginning of year	13,670	12,452	—	—
Actual return on plan assets	834	1,262	—	—
Employer contributions	1,087	—	—	—
Benefits paid	(112)	(44)	—	—
Fair value of assets, end of year	15,479	13,670	—	—
Unfunded status	$ (13,176)	$ (12,550)	$ (28,598)	$ (23,293)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

A summary of the amounts recognized in the accompanying consolidated balance sheets follows (in thousands):

	Pension Plans		SERP	
	2007	2006	2007	2006
Noncurrent Asset	$ —	$ —	$ —	$ —
Current Liability	—	—	—	—
Noncurrent Liability	(13,176)	(12,550)	(28,598)	(23,293)
Net amount recognized in the consolidated balance sheets	$ (13,176)	$ (12,550)	$ (28,598)	$ (23,293)

A summary of the plans' benefit obligation in excess of the fair value of plan assets as of the end of the year follows (in thousands):

	Pension Plans		SERP	
	2007	2006	2007	2006
Projected benefit obligation	$ 28,655	$ 26,220	$ 28,598	$ 23,293
Accumulated benefit obligation	20,587	17,127	18,546	18,214
Fair value of plan assets	15,479	13,670	—	—

A summary of the weighted-average assumptions used by the Company to determine benefit obligations as of December 31 follows:

	Pension Plans		SERP	
	2007	2006	2007	2006
Discount Rate	6.55%	5.73% - 5.95%	6.00%	5.75%
Annual Salary Increases	4.00%	4.00% - 5.00%	5.00%	5.00%

A summary of the amounts recognized in Accumulated Other Comprehensive Income ("AOCI") due to the adoption of SFAS No. 158 "Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans — an amendment of SFAS No. 87, 88, 106 and 132(R)" ("SFAS No. 158") as of December 31, 2006 follows (in thousands):

	Pension Plans	SERP
	2006	2006
Amount recognized in AOCI prior to SFAS 158	$ —	$ —
Amount recognized in AOCI due to adoption of SFAS 158:		
Prior service cost (credit)	3,583	6,586
Net actuarial (gain) loss	141	2,937
Total amount recognized in AOCI	$ 3,724	$ 9,523

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

A summary of net periodic cost and other amounts recognized in Other Comprehensive Income follows (in thousands):

	Pension Plans			SERP		
	2007	2006	2005	2007	2006	2005
Service cost	$ 3,772	$ 3,757	$ 3,043	$ 2,810	$ 3,023	$ 2,113
Interest cost	1,586	1,601	1,364	1,339	1,225	846
Expected return on plan assets	(1,179)	(1,054)	(706)	—	—	—
Amortization of unrecognized prior service cost	689	1,336	1,336	884	884	884
Amortization of net (gain)/loss	(13)	—	(17)	60	407	55
Net periodic cost	4,855	5,640	5,020	5,093	5,539	3,898
Change in OCI	(3,142)	N/A	N/A	212	N/A	N/A
Total recognized in Net periodic cost and OCI	$ 1,713	$ 5,640	$ 5,020	$ 5,305	$ 5,539	$ 3,898

A summary of the expected amortization amounts to be included in net periodic cost for 2008 are as follows (in thousands):

	Pension Plans	SERP
Prior service cost	$ 689	$ 884
Actuarial (gain)/loss	—	122

A summary of the weighted-average assumptions used by the Company to determine net periodic cost follows:

	Pension Plans			SERP		
	2007	2006	2005	2007	2006	2005
Discount rate	5.94%	5.40% - 5.80%	6.00%	5.75%	5.50%	5.75%
Rate of compensation increase	4.00%	4.00% - 5.00%	4.00%	5.00%	5.00%	5.00%
Expected long term rate of return on assets	8.50%	8.50%	8.50%	N/A	N/A	N/A

The Company's weighted-average asset allocations by asset category for its pension plans as of the end of the year follows:

	Pension Plans		SERP	
	2007	2006	2007	2006
Equity securities	100%	100%	N/A	N/A
Debt securities	0%	0%	N/A	N/A
Total	100%	100%	N/A	N/A

The Company's pension plan assets are invested in mutual funds with an underlying investment allocation of 60% equity securities and 40% debt securities. The expected long-term rate of return for the Company's pension plan assets is based on current expected long-term inflation and historical rates of return on equities and fixed income securities, taking into account the investment policy under the plan. The expected long-term rate of return is weighted based on the target allocation for each asset category. Equity securities are expected to return between 8% and 12% and debt securities are expected to return between 4% and 7%. The Company expects its pension plan asset managers will provide a premium of approximately 0.5% to 1.5% per annum to the respective market benchmark indices.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The Company's investment policy related to its pension plans is to provide for growth of capital with a moderate level of volatility by investing in accordance with the target asset allocations stated above. The Company reviews its investment policy, including its target asset allocations, on a semi-annual basis to determine whether any changes in market conditions or amendments to its pension plans requires a revision to its investment policy.

The estimated future benefit payments reflecting future service as of the end of 2007 for the Company's pension and SERP plans follows (in thousands):

Years Ending	Pension Plans	SERP
2008	$ 271	$ —
2009	372	91
2010	438	91
2011	508	1,539
2012	651	1,591
2013 - 2016	4,611	14,019

10. Stockholders' Equity

Authorized capital shares of the Company include 400,000,000 shares of capital stock consisting of 300,000,000 shares of common stock and 100,000,000 shares of Preferred Stock. Each of the aforementioned classes of capital stock has a par value of $.01 per share. Shares of Preferred Stock, none of which are outstanding as of December 31, 2007 may be issued in one or more series having such rights, preferences and other provisions as determined by the Board of Directors without approval by the holders of common stock.

On January 14, 2006, the Company commenced an open market repurchase program for up to 5,000,000 shares of the Company's common stock, not to exceed $200 million in repurchases. Under this program, the Company repurchased the entire 5,000,000 shares at a weighted average price of $35.23. This program concluded on November 8, 2006 when the maximum number of shares had been repurchased. This repurchase plan followed a prior repurchase plan for up to 5,000,000 shares which concluded on January 13, 2006. The Company repurchased 3,029,700 shares at a weighted average price of $31.20 per share under this program. On December 13, 2006, the Company commenced another open market repurchase program for up to 5,000,000 shares of the Company's common stock not to exceed $200 million in repurchases. This program will conclude at the earlier of three years or when the maximum number of shares have been repurchased. As of December 31, 2007, the Company has not repurchased any shares under this program.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

11. Earnings Per Share

The following table sets forth the components of the numerator and denominator for the computation of basic and diluted income from continuing operations per share (in thousands, except share data):

	Year Ended December 31,		
	2007	2006	2005
Numerator:			
Numerator for basic earnings per share —			
Income from continuing operations available to common stockholders — basic	$ 59,897	$ 177,695	$ 188,370
Numerator for diluted earnings per share —			
Income from continuing operations	$ 59,897	$ 177,695	$ 188,370
Interest, net of tax, on 4.25% convertible notes	—	135	8,565
Income from continuing operations available to common stockholders — diluted	$ 59,897	$ 177,830	$ 196,935
Denominator:			
Weighted-average number of shares outstanding — basic	93,517,337	94,983,646	88,601,168
Effect of dilutive securities:			
Non-employee director options	2,957	11,825	11,715
Restricted Stock awards	227,200	140,959	115,411
Employee options	894,800	951,360	1,466,652
4.25% Convertible notes	—	145,120	8,385,031
Weighted-average number of shares outstanding — diluted	94,642,294	96,232,910	98,579,977
Dilutive securities outstanding not included in the computation of earning per share because their effect is antidilutive:			
Employee options	4,398,307	1,261,367	31,100

12. Equity Investments

The Company owns equity interests of 27.5% in four hospitals in Las Vegas, Nevada, and 26.1% in one hospital in Las Vegas, Nevada in which Universal Health Systems, Inc. owns the majority interest; an equity interest of 38.0% in a hospital in Macon, Georgia in which HCA Inc. owns the majority interest; and an equity interest of 50.0% in a hospital in El Dorado, Arkansas in which the SHARE Foundation, a not-for-profit foundation, owns the remaining 50.0%. These equity investments were acquired as part of the acquisition of Triad. The Company uses the equity method of accounting for its investments in these entities. The balance of the Company's investment in unconsolidated affiliates is $213.3 million at December 31, 2007, and is included in other assets in the accompanying consolidated balance sheet. Included in the Company's results of operations for the year ended December 31, 2007, is $25.1 million representing the Company's equity in pre-tax earnings from investments in unconsolidated affiliates for the period July 25, 2007 through December 31, 2007.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Summarized combined financial information for the years ended December 31, 2007 and 2006, for the unconsolidated entities in which the Company owns an equity interest is as follows (in thousands):

	December 31, 2007 (Unaudited)
Current assets	$ 226,458
Noncurrent assets	706,059
	$ 932,517
Current liabilities	$ 81,354
Noncurrent liabilities	3,079
Members' equity	848,084
	$ 932,517

	For the Year Ended December 31, 2007 2007 (Unaudited)
Revenues	$ 1,275,117
Net income	$ 160,802

13. Segment Information

Prior to the acquisition of Triad, the Company aggregated its operating segments into one reportable segment as all of its operating segments had similar services, had similar types of patients, operated in a consistent manner and had similar economic and regulatory characteristics. In connection with the Triad acquisition, management has re-evaluated the information that is reviewed by the chief operating decision maker and segment managers and has determined that the Company now operates in three distinct operating segments, represented by the hospital operations (which includes our acute care hospitals and related healthcare entities that provide acute and outpatient health care services), the home health agencies operations (which provide outpatient care generally at the patient's home), and our hospital management services business (which provides executive management services to non-affliated acute care hospitals). Only the hospital operations segment meets the criteria in SFAS No. 131 as a separate reportable segment. The financial information for the home health agencies and management services segment do not meet the quantitative thresholds defined in SFAS No. 131 and are combined into the corporate and all other reportable segment.

The accounting policies of the segments are the same as those described in the summary of significant accounting policies in Note 1. Expenditures for segment assets are reported on an accrual basis, which includes amounts that are reflected in accounts payable (See Note 1). Substantially all depreciation and amortization as reflected in the consolidated statements of income relates to the hospital operations segment.

The financial information from prior years has been presented to reflect this change in the composition of our reportable operating segments.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The distribution between reportable segments of our revenues, income from continuing operations before income taxes, expenditures for segment assets and total assets is summarized in the following tables (in thousands):

	For the Year Ended December 31,		
	2007	2006	2005
Revenues:			
Hospital operations	$ 6,965,152	$ 4,101,974	$ 3,516,856
Corporate and all other	162,342	78,162	59,261
	$ 7,127,494	$ 4,180,136	$ 3,576,117
Income from continuing operations before income taxes:			
Hospital operations	$ 256,274	$ 360,576	$ 360,263
Corporate and all other	(153,374)	(72,729)	(52,089)
	$ 102,900	$ 287,847	$ 308,174
Expenditures for segment assets:			
Hospital operations	$ 501,671	$ 232,500	$ 179,680
Corporate and all other	32,464	39,693	20,564
	$ 534,135	$ 272,193	$ 200,244

	December 31,	
	2007	2006
Total assets:		
Hospital operations	$ 12,176,957	$ 4,082,271
Corporate and all other	1,316,686	424,308
	$ 13,493,643	$ 4,506,579

14. Commitments and Contingencies

Construction Commitments. Pursuant to hospital purchase agreements in effect as of December 31, 2007, and where required certificate of need approval has been obtained, the Company is required to build the following replacement facilities. The Company has agreed, as part of the acquisition in 2003 of Southside Regional Medical Center in Petersburg, Virginia, to build a replacement facility with an aggregate estimated construction cost, including equipment, of approximately $145 million. Of this amount, approximately $98 million has been expended through December 31, 2007. The Company expects to spend approximately $44 million in replacement hospital construction and equipment costs related to this project in 2008. This project is required to be completed in 2008. The Company has agreed, as part of the acquisition in 2004 of Phoenixville Hospital in Phoenixville, Pennsylvania, to spend approximately $90 million in capital expenditures over eight years to develop and improve the hospital; of this amount approximately $25 million has been expended through December 2007. The Company expects to spend approximately $26 million of this commitment in 2008. The Company has agreed as part of the acquisition in 2005 of Chestnut Hill Hospital, in Philadelphia, Pennsylvania to spend approximately $41 million in capital expenditures over four years to develop and improve the hospital; of this amount approximately $13 million has been expended through December 2007. The Company expects to spend approximately $4 million of this commitment in 2008. As part of the acquisition in 2005 of Bedford County Medical Center in Shelbyville, Tennessee, the Company agreed to build a replacement facility with an aggregate estimated construction cost of approximately $35 million. Of this amount, approximately $19 million has been expended through December 31, 2007. The

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Company expects to spend approximately $16 million in replacement hospital construction costs related to this project in 2008. The project is required to be completed by June 30, 2009. As required by an amendment to a lease agreement entered into in 2005, the Company agreed to build a replacement facility at its Barstow, California location. Construction costs for this replacement facility are estimated to be approximately $60 million. Of this amount, approximately $2 million has been expended through December 31, 2007. The Company expects to spend approximately $3 million in replacement hospital construction and equipment costs related to this project in 2008. This project is required to be completed in 2011. The Company has agreed, as part of an acquisition in 2007, to build a replacement hospital in Valparaiso, Indiana with an aggregate estimated construction cost, including equipment costs, of approximately $210 million. Of this amount, an immaterial amount has been expended through December 31, 2007. The Company expects to spend approximately $5 million in replacement hospital construction and equipment costs related to this project in 2008. This project is required to be completed in 2011. As part of the Triad acquisition, the Company assumed the commitment to build a replacement hospital in Clarksville, Tennessee, with an aggregate estimated construction cost, including equipment costs, of approximately $201 million. Of this amount, approximately $133 million has been expended through December 31, 2007. The Company expects to spend approximately $68 million in replacement hospital construction and equipment costs related to this project in 2008. This project is required to be completed in 2009. Also, as part of the Triad acquisition, the Company assumed the commitment to build a de novo hospital in Cedar Park, Texas, with an aggregate estimated construction cost, including equipment costs, of approximately $113 million. Of this amount, approximately $111 million has been expended through December 31, 2007. The Company expects to spend approximately $2 million in replacement hospital construction and equipment costs related to this project in 2008. This project is required to be completed in 2008. Also in 2005, the Company entered into an agreement with a developer to build and lease to the Company new corporate headquarters. Construction of the new headquarters was completed in December 2006. In January 2007, the Company exercised a purchase option under that lease agreement and acquired the new headquarters by purchasing the equity interests of the previous owner for a purchase price of $34.9 million.

Physician Recruiting Commitments. As part of its physician recruitment strategy, the Company provides income guarantee agreements to certain physicians who agree to relocate to its communities and commit to remain in practice there. Under such agreements, the Company is required to make payments to the physicians in excess of the amounts they earned in their practice up to the amount of the income guarantee. These income guarantee periods are typically for 12 months. Such payments are recoverable by the Company from physicians who do not fulfill their commitment period, which is typically three years, to the respective community. At December 31, 2007, the maximum potential amount of future payments under these guarantees in excess of the liability recorded is $49.4 million.

Professional Liability Risks.

Professional Liability Insurance for Former Triad Hospitals

Substantially all of the professional and general liability risks of the acquired Triad hospitals are subject to a per occurrence deductible. Substantially all losses in periods prior to May 1999 are insured through a wholly-owned insurance subsidiary of HCA, Inc., or HCA, Triad's owner prior to that time, and excess loss policies maintained by HCA. HCA has agreed to indemnify the Triad hospitals in respect of claims covered by such insurance policies arising prior to May 1999. After May 1999, the Triad hospitals obtained insurance coverage on a "claims incurred" basis from HCA's wholly-owned insurance subsidiary with excess coverage obtained from other carriers that is subject to certain deductibles. Effective for claims incurred after December 31, 2006, Triad began insuring its claims from $1 million to $5 million through its wholly-owned captive insurance company, replacing the coverage provided by HCA. Substantially all claims reported on or after January 2007 are self-insured up to $10 million per claim. Excess insurance for all hospitals is purchased through commercial insurance companies and generally after the self-insured amount covers up to $100 million

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

per occurrence. The excess insurance for the Triad hospitals is underwritten on a "claims-made basis." The Company accrues an estimated liability for its uninsured exposure and self-insured retention based on historical loss patterns and actuarial projections.

Professional Liability Insurance Claims for All Other Community Health Systems Hospitals

The Company accrues for estimated losses resulting from professional liability claims. The accrual, which includes an estimate for incurred but not reported claims, is based on historical loss patterns and actuarially determined projections and is discounted to its net present value using a weighted average risk-free discount rate of 4.1% and 4.6% in 2007 and 2006, respectively. To the extent that subsequent claims information varies from management's estimates, the liability is adjusted currently. The Company's insurance is underwritten on a "claims-made" basis. Prior to June 1, 2002, substantially all of the Company's professional and general liability risks were subject to a $0.5 million per occurrence deductible; for claims reported from June 1, 2002 through June 1, 2003, these deductibles were $2.0 million per occurrence. Additional coverage above these deductibles was purchased through captive insurance companies in which the Company had a 7.5% minority ownership interest in each and to which the premiums paid by the Company represented less than 8% of the total premiums revenues of each captive insurance company. With the formation of the Company's own wholly-owned captive insurance company in June 2003, the Company terminated its minority interest relationships in those entities. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 are self-insured up to $5 million per claim. Management on occasion has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals was purchased through commercial insurance companies and generally covers the Company for liabilities in excess of the self-insured amount and up to $100 million per occurrence for claims reported on or after June 1, 2003.

The Company's estimated liability for the self-insured portion of professional and general liability claims was $300.2 million and $104.2 million as of December 31, 2007 and 2006, respectively. These estimated liabilities represent the present value of estimated future professional liability claims payments based on expected loss patterns using a weighted-average discount rate of 4.1% and 4.6% in 2007 and 2006, respectively. The weighted-average discount rate is based on an estimate of the risk-free interest rate for the duration of the expected claim payments. The estimated undiscounted claims liability was $321.5 million and $119.8 million as of December 31, 2007 and 2006, respectively.

Legal Matters. The Company is a party to other legal proceedings incidental to its business. In the opinion of management, any ultimate liability with respect to these actions will not have a material adverse effect on the Company's consolidated financial position, cash flows or results of operations.

In a letter dated October 4, 2007, the Civil Division of the Department of Justice notified the Company that, as a result of an investigation into the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients, it believes the Company and three of its New Mexico hospitals have caused the State of New Mexico to submit improper claims for federal funds in violation of the federal False Claims Act. In a letter dated January 22, 2008, the Civil Division notified the Company that based on its investigation, it has calculated that these three hospitals received ineligible federal participation payments from August 2000 to June 2006 of approximately $27.5 million. The Civil Division also advised the Company that were it to proceed to trial, it would seek treble damages plus an appropriate penalty for each of the violations of the False Claims Act. The Company continues to believe that it has not violated the False Claims Act, and is continuing discussions with the Civil Division in an effort to resolve this matter.

Other. The Company has entered into a definitive agreement to acquire Empire Health Services in Spokane, Washington. The health system includes two full-service acute care hospitals, Deaconess Medical Center (388

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

licensed beds) and Valley Hospital and Medical Center (123 licensed beds), and other outpatient and ancillary services. The transaction, subject to federal and state approvals, is expected to close in the third quarter of 2008.

15. Subsequent Events

Effective February 1, 2008, the Company sold Russell County Medical Center (78 licensed beds) located in Lebanon, Virginia to Mountain States Health Alliance, headquartered in Johnson City, Tennessee, for $48.6 million.

16. Quarterly Financial Data (Unaudited)

	Quarter				
	1st	2nd	3rd	4th	Total
	(In thousands, except share and per share data)				
Year ended December 31, 2007:					
Net operating revenues	$ 1,154,278	$ 1,197,865	$ 2,247,009	$ 2,528,342	$ 7,127,494
Income from continuing operations before taxes	93,121	87,114	31,371	(108,706)	102,900
Income from continuing operations	57,289	53,558	19,699	(70,649)	59,897
Loss on discontinued operations	(2,965)	205	(9,239)	(17,609)	(29,608)
Net income	54,324	53,763	10,460	(88,258)	30,289
Income from continuing operations per share:					
Basic	0.61	0.57	0.21	(0.75)	0.64
Diluted	0.61	0.57	0.21	(0.75)	0.63
Net income per share:					
Basic	0.58	0.57	0.11	(0.94)	0.32
Diluted	0.58	0.57	0.11	(0.94)	0.32
Weighted-average number of shares:					
Basic	93,402,545	93,518,991	93,651,645	93,664,355	93,517,337
Diluted	94,365,292	94,647,870	94,841,749	93,664,355	94,642,294
Year ended December 31, 2006:					
Net operating revenues	$ 986,073	$ 1,017,337	$ 1,072,199	$ 1,104,527	$ 4,180,136
Income from continuing operations before taxes	95,447	86,106	18,199	88,095	287,847
Income from continuing operations	58,484	52,963	11,344	54,904	177,695
Loss on discontinued operations	(4,446)	(594)	(3,103)	(1,289)	(9,432)
Net income	54,038	52,369	8,241	53,615	168,263
Income from continuing					

operations per share:					
Basic	0.61	0.55	0.12	0.59	1.87
Diluted	0.60	0.55	0.12	0.58	1.85
Net income per share:					
Basic	0.56	0.55	0.09	0.57	1.77
Diluted	0.55	0.54	0.09	0.57	1.75
Weighted-average number of shares:					
Basic	96,552,448	95,769,030	94,119,020	93,538,958	94,983,646
Diluted	98,209,271	96,870,315	95,258,771	94,644,589	96,232,910

Net operating revenues in the third and fourth quarter of the year ended December 31, 2007 include the results of operations of the former Triad hospitals and other operations subsequent to the acquisition date of July 25, 2007. Also, net operating revenues and income from continuing operations in the fourth quarter of the year ended December 31, 2007 give effect to the $96.3 million increase in contractual reserves and $70.1 million increase to the allowance for doubtful accounts resulting from management's analysis of the net realizable value of the Company's accounts receivable during the fourth quarter (see Note 1).

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

17. Supplemental Condensed Consolidating Financial Information

In connection with the consummation of the Triad acquisition, the Company obtained $7.215 billion of senior secured financing under the New Credit Facility and CHS/Community Health issued the Notes in the aggregate principal amount of $3.021 billion. The Notes are senior unsecured obligations of CHS/Community Health and are guaranteed on a senior basis by the Company and by certain of the Company's domestic subsidiaries. The Notes are fully and unconditionally guaranteed by the Company and certain of its current and future, direct and indirect, 100% owned domestic subsidiaries. Such guarantees are joint and several. The following condensed consolidating financial statements present the Company (as guarantor), CHS/Community Health (as the issuer), the subsidiary guarantors, the subsidiary non-guarantors and eliminations. This condensed consolidating financial information has been prepared and presented in accordance with SEC Regulation S-X Rule 3-10 "Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered".

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

December 31, 2007
Balance Sheet

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands, except for share data)			
			ASSETS			
Current assets						
Cash and cash equivalents	$ —	$ —	$ 114,075	$ 18,799	$ —	$ 132,874
Patient accounts receivable, net of allowance for doubtful accounts	—	—	954,106	579,692	—	1,533,798
Supplies	—	—	163,961	98,942	—	262,903
Deferred income taxes	113,741	—	—	—	—	113,741
Prepaid expenses and taxes	—	102	156,733	12,921	—	169,756
Other current assets	—	—	129,147	210,679	—	339,826
Total current assets	113,741	102	1,518,022	921,033	—	2,552,898
Property and equipment, net	—	—	3,667,487	1,845,087	—	5,512,574
Goodwill	96,671	—	2,162,601	1,988,442	—	4,247,714
Other assets, net of accumulated amortization	—	189,140	276,589	714,728	—	1,180,457
Net investment in subsidiaries	1,519,952	1,464,944	4,968,905	—	(7,953,801)	—
Total assets	$ 1,730,364	$ 1,654,186	$ 12,593,604	$ 5,469,290	$ (7,953,801)	$ 13,493,643
			LIABILITIES AND STOCKHOLDERS' EQUITY			
Current Liabilities						
Current maturities of long-term debt	$ —	$ —	$ 16,603	$ 4,107	$ —	$ 20,710
Accounts payable	—	19	276,503	216,171	—	492,693
Current income taxes payable	—	—	—	—	—	—
Deferred income taxes — current	—	—	—	—	—	—
Accrued liabilities						
Employee compensation	—	—	231,500	172,098	—	403,598
Interest payable (receivable)	—	153,085	8,042	(7,295)	—	153,832
Other	—	—	206,308	170,794	—	377,102
Total current liabilities	—	153,104	738,956	555,875	—	1,447,935
Long-term debt payable(receivable)	4	4,487,090	4,633,801	(43,528)	—	9,077,367
Deferred income taxes	407,947	—	—	—	—	407,947
Other long-term liabilities	(2,519)	121,482	188,316	176,180	—	483,459
Minority interests in equity of consolidated subsidiaries	—	—	13,491	352,640	—	366,131
Intercompany (receivable) payable	(385,872)	(4,627,439)	5,956,358	4,562,215	(5,505,262)	—
Stockholders' equity						
Preferred stock	—	—	—	—	—	—
Common stock	966	—	1	2	(3)	966
Additional paid-in capital	1,240,308	—	—	—	—	1,240,308
Treasury stock, at cost	(6,678)	—	—	—	—	(6,678)
Accumulated other comprehensive income	(81,737)	(81,737)	(3,990)	—	85,727	(81,737)
Retained earnings	557,945	1,601,686	1,066,671	(134,094)	(2,534,263)	557,945
Total stockholders' equity	1,710,804	1,519,949	1,062,682	(134,092)	(2,448,539)	1,710,804
Total liabilities and stockholders' equity	$ 1,730,364	$ 1,654,186	$ 12,593,604	$ 5,469,290	$ (7,953,801)	$ 13,493,643

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

December 31, 2006
Balance Sheet

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In thousands, except for share data)					
ASSETS						
Current assets:						
Cash and cash equivalents	$ —	$ —	$ 28,560	$ 12,006	$ —	$ 40,566
Patient accounts receivable, net of allowance for doubtful accounts	—	—	607,460	166,524	—	773,984
Supplies	—	—	87,688	25,632	—	113,320
Deferred income taxes	13,249	—	—	—	—	13,249
Prepaid expenses and taxes	—	—	31,586	799	—	32,385
Other current assets	—	—	25,827	22,053	—	47,880
Total current assets	13,249	—	781,121	227,014	—	1,021,384
Property and equipment, net	—	—	1,580,301	406,276	—	1,986,577
Goodwill	—	—	1,159,545	176,980	—	1,336,525
Other assets, net of accumulated amortization	—	20,804	123,413	17,876	—	162,093
Net investment in subsidiaries	1,085,218	1,071,903	420,246	—	(2,577,367)	—
Total assets	$ 1,098,467	$ 1,092,707	$ 4,064,626	$ 828,146	$ (2,577,367)	$ 4,506,579
LIABILITIES AND STOCKHOLDERS' EQUITY						
Current liabilities:						
Current maturities of long-term debt	$ —	$ 16,000	$ 20,065	$ (669)	$ —	$ 35,396
Accounts payable	—	—	201,340	46,407	—	247,747
Current income taxes payable	—	—	7,626	—	—	7,626
Accrued liabilities						
Employee compensation	—	—	127,620	34,568	—	162,188
Interest payable	867	5,866	316	73	—	7,122
Other	—	—	86,784	28,420	—	115,204
Total current liabilities	867	21,866	443,751	108,799	—	575,283
Long-term debt payable	300,000	1,556,000	24,942	24,839	—	1,905,781
Deferred income taxes	141,472	—	—	—	—	141,472
Other long-term liabilities	—	—	124,886	11,925	—	136,811
Minority interests in equity of consolidated subsidiaries	—	—	502	23,057	—	23,559
Intercompany (receivable) payable	(1,067,545)	(1,570,373)	2,403,385	709,118	(474,585)	—
Stockholders' equity:						
Preferred Stock						
Common Stock	950	—	1	2	(3)	950
Additional paid-in capital	1,195,947	—	—	—	—	1,195,947
Treasury stock, at cost	(6,678)	—	—	—	—	(6,678)
Accumulated other comprehensive income	5,798	5,798	(7,516)	—	1,718	5,798
Retained earnings	527,656	1,079,416	1,074,675	(49,594)	(2,104,497)	527,656
Total stockholders' equity	1,723,673	1,085,214	1,067,160	(49,592)	(2,102,782)	1,723,673
Total liabilities and stockholders' equity	$ 1,098,467	$ 1,092,707	$ 4,064,626	$ 828,146	$ (2,577,367)	$ 4,506,579

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2007
Statement of Income

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net Revenue	$ —	$ —	$ 4,932,207	$ 2,195,287	$ —	$ 7,127,494
Expenses and Costs:						
Salaries and benefits	—	—	1,896,340	998,637	—	2,894,977
Provision for bad debts	—	—	664,619	232,666	—	897,285
Supplies	—	—	628,922	315,846	—	944,768
Other operating expenses	—	—	960,095	472,903	—	1,432,998
Rent	—	—	91,836	63,730	—	155,566
Depreciation & amortization	—	—	218,722	97,493	—	316,215
	—	—	4,460,534	2,181,275	—	6,641,809
Income from operations	—	—	471,673	14,012	—	485,685
Interest expense, net	—	(160,144)	455,541	69,136		364,533
Loss from early extinguishment of debt	—	27,388	—	—	—	27,388
Minority interests in earnings	—	—	823	15,173	—	15,996
Equity in earnings of unconsolidated affiliates	(73,292)	59,464	74,773	—	(86,077)	(25,132)
Income from continuing operations before income taxes	73,292	73,292	(59,464)	(70,297)	86,077	102,900
Provision for income taxes	43,003	—	—	—	—	43,003
Income from continuing operations	30,289	73,292	(59,464)	(70,297)	86,077	59,897
Discontinued operations, net of taxes:						
Loss from operations of hospitals sold or held for sale	—	—	—	(11,067)	—	(11,067)
Net loss on sale of hospitals and partnership interests	—	—	—	(2,594)	—	(2,594)
Impairment of long-lived assets of hospitals held for sale	—	—	—	(15,947)	—	(15,947)
Loss on discontinued operations	—	—	—	(29,608)	—	(29,608)
Net income	$ 30,289	$ 73,292	$ (59,464)	$ (99,905)	$ 86,077	$ 30,289

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2006
Statement of Income

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net Revenue	$ —	$ —	$ 3,344,830	$ 835,306	$ —	$ 4,180,136
Operating costs and expenses:						
Salaries and benefits	—	—	1,278,676	382,943	—	1,661,619
Provision for bad debts	—	—	406,095	112,766	—	518,861
Supplies	—	—	390,147	97,631	—	487,778
Rent	—	—	64,544	27,399	—	91,943
Other operating expenses	—	—	658,746	196,850	—	855,596
Depreciation & amortization	—	—	147,885	31,397	—	179,282
Total operating costs and expenses	—	—	2,946,093	848,986	—	3,795,079
Income from operations	—	—	398,737	(13,680)	—	385,057
Interest expense, net	—	—	71,793	22,618	—	94,411
Loss from early extinguishment of debt	—	—	4	—	—	4
Minority interests in earnings	—	—	59	2,736	—	2,795
Equity in earnings of unconsolidated affiliates	(278,415)	(278,415)	53,778	—	503,052	—
Income from continuing operations before income taxes	278,415	278,415	273,103	(39,034)	(503,052)	287,847
Provision for income taxes	110,152	—	—	—	—	110,152
Income from continuing operations	168,263	278,415	273,103	(39,034)	(503,052)	177,695
Discontinued operations, net of taxes:						
Loss from operations of hospitals sold or held for sale	—	—	—	(6,873)	—	(6,873)
Loss on sale of hospitals and partnership interests	—	—	—	(2,559)	—	(2,559)
Loss on discontinued operations	—	—	—	(9,432)	—	(9,432)
Net income	$ 168,263	$ 278,415	$ 273,103	$ (48,466)	$ (503,052)	$ 168,263

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2005
Statement of Income

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net Revenue	$ —	$ —	$ 2,829,563	$ 746,554	$ —	$ 3,576,117
Expenses and Costs:						
Salaries and benefits	—	—	1,095,638	325,507	—	1,421,145
Provision for bad debts	—	—	278,743	77,377	—	356,120
Supplies	—	—	341,896	87,950	—	429,846
Other operating expenses	—	—	555,381	175,643	—	731,024
Rent	—	—	58,973	23,284	—	82,257
Depreciation & amortization	—	—	128,062	29,200	—	157,262
	—	—	2,458,693	718,961	—	3,177,654
Income from operations	—	—	370,870	27,593	—	398,463
Interest expense, net	—	(9)	67,927	19,267	—	87,185
Minority interests in earnings	—	—	129	2,975	—	3,104
Equity in earnings of unconsolidated affiliates	(287,348)	(287,499)	15,315	—	559,532	—
Income from continuing operations before income taxes	287,348	287,508	287,499	5,351	(559,532)	308,174
Provision for income taxes	119,804	—	—	—	—	119,804
Income from continuing operations	167,544	287,508	287,499	5,351	(559,532)	188,370
Discontinued operations, net of taxes:						
Loss from operations of hospitals sold or held for sale	—	—	—	(8,737)	—	(8,737)
Loss on sale of hospitals	—	—	—	(7,618)	—	(7,618)
Impairment of long-lived assets of hospitals held for sale	—	—	—	(4,471)	—	(4,471)
Loss on discontinued operations	—	—	—	(20,826)	—	(20,826)
Net income	$ 167,544	$ 287,508	$ 287,499	$ (15,475)	$ (559,532)	$ 167,544

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2007
Statement of Cash Flows

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Cash flows from operating activities						
Net income	$ 30,289	$ 73,292	$ (59,464)	$ (99,905)	$ 86,077	$ 30,289
Adjustments to reconcile net income to net cash provided by operating activities:						
Depreciation and amortization	—	—	218,723	113,857	—	332,580
Loss on early extinguishment of debt	—	27,388	—	—	—	27,388
Deferred income taxes	(39,894)	—	—	—	—	(39,894)
Stock compensation expense	38,771	—	—	—	—	38,771
Excess tax benefits relating to stock-based compensation	(1,216)	—	—	—	—	(1,216)
Minority interest in earnings	—	—	823	15,173	—	15,996
Impairment on hospital held for sale	—	—	—	19,044	—	19,044
Loss on sale of hospitals	—	—	—	3,954	—	3,954
Other non-cash expenses, net	—	16,996	1,546	475	—	19,017
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:						
Patient accounts receivable	—	—	234,448	(103,148)	—	131,300
Supplies, prepaid expenses and other current assets	—	5,400	(116,398)	79,021	—	(31,977)
Accounts payable, accrued liabilities and income taxes	103,484	198,461	(309,491)	133,505	—	125,959
Advances to subsidiaries, net of return on investment	246,938	(635,576)	1,461,443	(986,728)	(86,077)	—
Other	(87,934)	(12,225)	(724,503)	841,189	—	16,527
Net cash provided by(used in) operating activities	290,438	(326,264)	707,127	16,437	—	687,738
Cash flows from investing activities						
Acquisitions of facilities and other related equipment	—	(6,864,794)	(59,203)	(94,051)	—	(7,018,048)
Purchases of property and equipment	—	—	(366,069)	(156,716)	—	(522,785)
Sale of facilities	—	—	—	109,996	—	109,996
Proceeds from sale of equipment	—	—	591	4,059	—	4,650
Investment in other assets	—	(5,502)	(59,772)	(7,397)	—	(72,671)

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Net cash provided by (used in) investing activities	—	(6,870,296)	(484,453)	(144,109)	—	(7,498,858)
Cash flows from financing activities						
Proceeds from exercise of stock options	8,214	—	—	—	—	8,214
Stock buy-back	—	—	—	—	—	—
Deferred financing costs	—	(182,954)	—	—	—	(182,954)
Excess tax benefits relating to stock-based compensation	1,216	—	—	—	—	1,216
Redemption of convertible notes	—	—	—	—	—	—
Proceeds from minority investors in joint ventures	128	—	—	2,223	—	2,351
Redemption of minority investments in joint ventures	—	—	—	(1,356)	—	(1,356)
Distribution to minority investors in joint ventures	—	—	—	(6,645)	—	(6,645)
Borrowings under Credit Agreement	—	9,212,000	4,941	4,686	—	9,221,627
Repayments of long-term indebtedness	(299,996)	(1,832,486)	(142,100)	135,557	—	(2,139,025)
Net cash provided by (used in) financing activities	(290,438)	7,196,560	(137,159)	134,465	—	6,903,428
Net change in cash and cash equivalents	—	—	85,515	6,793	—	92,308
Cash and cash equivalents at beginning of period	—	—	28,560	12,006	—	40,566
Cash and cash equivalents at end of period	$ —	$ —	$ 114,075	$ 18,799	$ —	$ 132,874

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2006
Statement of Cash Flows

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Cash flows from operating activities:						
Net income	$ 168,263	$ 278,415	$ 273,103	$ (48,466)	$ (503,052)	$ 168,263
Adjustments to reconcile net income to net cash provided by operating activities:						
Deferred income taxes	(25,228)	—	—	—	—	(25,228)
Depreciation and amortization	—	—	147,885	40,886	—	188,771
Stock compensation expense	20,073	—	—	—	—	20,073
Excess tax benefits relating to stock-based compensation	(6,819)	—	—	—	—	(6,819)
Loss on early extinguishment of debt	—	—	—	—	—	—
Minority interest in earnings	—	—	59	2,736	—	2,795
Loss on sale of hospitals	—	—	—	3,937	—	3,937
Other non-cash expenses, net	—	—	427	73	—	500
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:						
Patient accounts receivable	—	—	(70,011)	(1,130)	—	(71,141)
Supplies, prepaid expenses and other current assets	—	—	(8,633)	4,089	—	(4,544)
Accounts payable, accrued liabilities and income taxes	4,935	1,358	71,161	(25,303)	—	52,151
Advances to subsidiaries, net of return on investment	4,977	(659,034)	49,448	101,557	503,052	—
Other	(11,149)	(7,739)	24,168	16,217	—	21,497
Net cash provided by (used in) operating activities	155,052	(387,000)	487,607	94,596	—	350,255
Cash flows from investing activities						
Acquisitions of facilities and other related equipment	—	—	(340,314)	(44,304)	—	(384,618)
Purchases of property and equipment	—	—	(176,070)	(48,449)	—	(224,519)
Proceeds from sale of equipment	—	—	102	4,378	—	4,480
Disposition of hospital and other ancillary operations	—	—	—	750	—	750
Increase in other assets	—	—	(20,420)	(15,930)	—	(36,350)
Net cash provided by (used in)	—	—	(536,702)	(103,555)	—	(640,257)

investing activities						
Cash flows from financing activities:						
Proceeds from exercise of stock options	14,573	—	—	—	—	14,573
Stock buy-back	(176,316)	—	—	—	—	(176,316)
Deferred financing costs	—	—	(2,153)	—	—	(2,153)
Excess tax benefits relating to stock-based compensation	6,819	—	—	—	—	6,819
Redemption of convertible notes	(128)	—	—	—	—	(128)
Proceeds from minority investors in joint ventures	—	—	—	6,890	—	6,890
Redemption of minority investments in joint ventures	—	—	(56)	(859)	—	(915)
Distribution to minority investors in joint ventures	—	—	—	(3,220)	—	(3,220)
Borrowings under Credit Agreement	—	1,031,000	—	—	—	1,031,000
Repayments of long-term indebtedness	—	(644,000)	(3,525)	(2,565)	—	(650,090)
Net cash provided by (used in) financing activities	(155,052)	387,000	(5,734)	246	—	226,460
Net change in cash and cash equivalents	—	—	(54,829)	(8,713)	—	(63,542)
Cash and cash equivalents at beginning of period	—	—	83,389	20,719	—	104,108
Cash and cash equivalents at end of period	$ —	$ —	$ 28,560	$ 12,006	$ —	$ 40,566

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2005
Statement of Cash Flows

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Cash flows from operating activities						
Net income	$ 167,544	$ 287,508	$ 287,499	$ (15,475)	$ (559,532)	$ 167,544
Adjustments to reconcile net income to net cash provided by operating activities:						
Depreciation and amortization	—	—	128,062	38,100	—	166,162
Loss on early extinguishment of debt	—	—	—	—	—	—
Deferred income taxes	9,889	—	—	—	—	9,889
Stock compensation expense	4,957	—	—	—	—	4,957
Excess tax benefits relating to stock-based compensation	—	—	—	—	—	—
Minority interest in earnings	—	—	129	2,975	—	3,104
Impairment on hospital held for sale	—	—	—	6,718	—	6,718
Loss on sale of hospitals	—	—	—	6,295	—	6,295
Other non-cash expenses, net	—	—	1,607	(867)	—	740
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:						
Patient accounts receivable	—	—	(38,917)	(8,538)	—	(47,455)
Supplies, prepaid expenses and other current assets	—	—	(18,462)	1,624	—	(16,838)
Accounts payable, accrued liabilities and income taxes	24,183	803	42,704	17,266	—	84,956
Advances to subsidiaries, net of return on investment	(183,330)	(271,514)	(99,433)	(5,255)	559,532	—
Other	7,328	(4,797)	30,187	(7,741)	—	24,977
Net cash provided by(used in) operating activities	30,571	12,000	333,376	35,102	—	411,049
Cash flows from investing activities						
Acquisitions of facilities and other related equipment	—	—	(125,493)	(32,886)	—	(158,379)
Purchases of property and equipment	—	—	(153,422)	(34,943)	—	(188,365)
Sale of facilities	—	—	(6,500)	58,498	—	51,998
Proceeds from sale of equipment	—	—	112	2,213	—	2,325
Investment in other assets	—	—	(22,444)	(12,407)	—	(34,851)

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Net cash provided by (used in) investing activities	—	—	(307,747)	(19,525)	—	(327,272)
Cash flows from financing activities						
Proceeds from exercise of stock options	49,580	—	—	—	—	49,580
Stock buy-back	(79,853)	—	—	—	—	(79,853)
Deferred financing costs	—	—	(1,259)	—	—	(1,259)
Excess tax benefits relating to stock-based compensation	—	—	—	—	—	—
Redemption of convertible notes	(298)	—	—	—	—	(298)
Proceeds from minority investors in joint ventures	—	—	—	1,383	—	1,383
Redemption of minority investments in joint ventures	—	—	—	(3,242)	—	(3,242)
Distribution to minority investors in joint ventures	—	—	—	(1,939)	—	(1,939)
Borrowings under Credit Agreement	—	—	—	—	—	—
Repayments of long-term indebtedness	—	(12,000)	(11,863)	(2,676)	—	(26,539)
Net cash provided by (used in) financing activities	(30,571)	(12,000)	(13,122)	(6,474)	—	(62,167)
Net change in cash and cash equivalents	—	—	12,507	9,103	—	21,610
Cash and cash equivalents at beginning of period	—	—	70,882	11,616	—	82,498
Cash and cash equivalents at end of period	$ —	$ —	$ 83,389	$ 20,719	$ —	104,108

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Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosure***

None

Item 9A. ***Controls and Procedures***

Our Chief Executive Officer and Chief Financial Officer, with the participation of other members of management, have evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a — 15(e) and 15d — 15(e)) under the Securities and Exchange Act of 1934, as amended, as of December 31, 2006. Based on such evaluations, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective (at the reasonable assurance level) to ensure that the information required to be included in this report has been recorded, processed, summarized and reported within the time periods specified in the Commission's rules and forms and to ensure that the information required to be included in this report was accumulated and communicated to management, including our Chief Executive Officer and Chief Financial Officer, to allow timely decisions regarding required disclosure.

As a result of the completion of the acquisition of Triad on July 25, 2007, our internal controls over financial reporting have changed. Since the Triad acquisition, we have started to analyze the systems of disclosure controls and procedures and internal controls over financial reporting of the former Triad hospitals and other operations acquired in the Triad acquisition and integrate them within our broader framework of controls. The Securities and Exchange Commission's rules require us to complete this process by the first anniversary of the acquisition. We plan to complete this evaluation and integration within the required time frame and report any changes in internal controls in our first annual report in which our assessment of the former Triad hospitals and other operations is to be included. Although we have not yet identified any material weaknesses in our disclosure controls and procedures or internal control over financial reporting as a result of this acquisition, there can be no assurance that a material weakness will not be identified in the course of this review.

There are no other changes in internal control over financial reporting that occurred during the period that have materially affected or are reasonably likely to materially affect our internal controls over financial reporting.

Item 9B. ***Other Information***

None

Management's Report on Internal Control over Financial Reporting

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States of America and include amounts based on management's estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the consolidated financial statements.

We are also responsible for establishing and maintaining adequate internal controls over financial reporting (as defined in Rule 13a — 15(f) under the Securities and Exchange Act of 1934, as amended). We maintain a system of internal controls that is designed to provide reasonable assurance as to the fair and reliable preparation and presentation of the consolidated financial statements, as well as to safeguard assets from unauthorized use or disposition.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Conduct. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit and Compliance Committee of the Board of Directors, which is composed solely of outside directors, meets periodically with members of management, the internal auditors and the independent registered public accounting firm to review and discuss internal control over financial reporting and accounting and financial reporting matters. The independent registered public accounting firm and internal auditors report to the Audit and Compliance Committee and accordingly have full and free access to the Audit and Compliance Committee at any time.

On July 25, 2007, we completed the acquisition of Triad and Triad's results of operations have been included in the consolidated financial statements since that date. As permitted by applicable rules, we have excluded the systems of disclosure controls and procedures and internal control over financial reporting of the former Triad hospitals and other operations acquired in the Triad acquisition from the scope of management's assessment of the effectiveness of internal control over financial reporting as of December 31, 2007. The former Triad hospitals and other operations represent approximately 40% of total assets as of December 31, 2007, and the results of operations from the former Triad hospitals and other operations represent approximately 34% of net revenue for the year ended December 31, 2007.

We conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. This evaluation included review of the documentation of controls, evaluation of the design effectiveness of controls, testing of the operating effectiveness of controls and a conclusion on this evaluation. We have concluded that our internal control over financial reporting was effective as of December 31, 2007, based on these criteria.

Deloitte & Touche LLP, an independent registered public accounting firm, has issued an attestation report on our internal control over financial reporting, which is included herein.

We do not expect that our disclosure controls and procedures or our internal controls will prevent all error and all fraud. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact there are resource constraints and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, within the Company have been detected.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Community Health Systems, Inc.
Franklin, Tennessee

We have audited the internal control over financial reporting of Community Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 2007, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. As described in Management's Report on Internal Control over Financial Reporting, management excluded from its assessment the internal control over financial reporting at Triad Hospitals, Inc. ("Triad"), which was acquired on July 25, 2007 and whose financial statements constitute approximately 40% of total assets and approximately 34% of net revenues of the consolidated financial statement amounts as of and for the year ended December 31, 2007. Accordingly, our audit did not include the internal control over financial reporting at Triad. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2007, based on the criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2007 of the Company and our report dated February 28, 2008 expressed an unqualified opinion on those consolidated financial statements and included an explanatory paragraph referring to the Company adopting the fair value recognition provisions of Statement of Financial Accounting Standards No. 123 (Revised 2004), *Share Based Payment* effective January 1, 2006.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 28, 2008

PART III

Item 10. *Directors and Executive Officers of the Company*

The information required by this Item is incorporated herein by reference from the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 20, 2008, under "Members of the Board of Directors," "Information About our Executive Officers," "Compliance with Exchange Act Section 16(A) Beneficial Ownership Reporting" and "Corporate Governance Principles and Board Matters."

Item 11. *Executive Compensation*

The information required by this Item is incorporated herein by reference from the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 20, 2008 under "Executive Compensation."

Item 12. *Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters*

The information required by this Item is incorporated herein by reference from the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 20, 2008 under "Security Ownership of Certain Beneficial Owners and Management."

Item 13. *Certain Relationships and Related Transactions*

The information required by this Item is incorporated herein by reference from the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 20, 2008 under "Certain Transactions."

Item 14. *Principal Accountant Fees and Services*

The information required by this Item is incorporated herein by reference from the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 20, 2008 under "Ratification of the Appointment of Independent Registered Public Accounting Firm."

PART IV

Item 15. *Exhibits and Financial Statement Schedules*

Item 15(a) 1. *Financial Statements*

Reference is made to the index of financial statements and supplementary data under Item 8 in Part II.

Item 15(a) 2. *Financial Statement Schedules*

The following financial statement schedule is filed as part of this Report at page 120 hereof:

Schedule II — *Valuation and Qualifying Accounts*

All other schedules are omitted since the required information is not present or is not present in amounts sufficient to require submission of the schedule, or because the information required is included in the consolidated financial statements and notes thereto.

Item 15(a)(3) and 15(c):

The following exhibits are either filed with this Report or incorporated herein by reference.

	Description
2.1	Agreement and Plan of Merger between the Registrant, FLCH Acquisition Corp. and Community Health Systems, Inc., dated on June 9, 1996 (incorporated by reference to Exhibit 2.1 to the Company's Registration Statement on Form S-1 (No. 333-31790))
2.2	Agreement and Plan of Merger, dated as of March 19, 2007, by and among Triad Hospitals, Inc., Community Health Systems, Inc. and FWCT-1 Acquisition Corporation (incorporated by reference to Exhibit 2.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed March 19, 2007 (No. 001-15925))
3.1	Form of Restated Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1 to the Company's Registration Statement on Form S-4 (No. 333-14627818))
3.2	Form of Restated By laws of the Registrant (incorporated by reference to Exhibit 3.2 to the Company's Registration Statement on Form S-4/A (333-14627818)
4.1	Form of Common Stock Certificate (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-1 (No. 333-31790))
4.2	Senior Notes Indenture, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., the Guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.3 to Community Health System Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
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4.4	Form of $8^{7}/^{8}$% Senior Note due 2015 (included in Exhibit 4.2)
4.5	Joinder to the Registration Rights Agreement dated as of July 25, 2007 (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.6	First Supplemental Indenture, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., Community Health Systems, Inc., Triad Healthcare Corporation, the other guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.4 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.7	First Supplemental Indenture relating to Community Health Systems, Inc.'s $6^{1}/^{2}$% Senior Subordinated Notes due 2012, dated as of July 24, 2007 by and among Community Health Systems, Inc. and U.S. Bank National Association (incorporated by reference to Exhibit 4.5 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.8	Second Supplemental Indenture relating to Triad's 7% Senior Notes due 2012, dated as of July 24, 2007, by and among Triad Hospitals Inc. and The Bank of New York Trust Company, N.A. (incorporated by reference to Exhibit 4.6 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.9	First Supplemental Indenture relating to the Triad's 7% Senior Subordinated Notes due 2013, dated as of July 24, 2007, by and among Triad Hospitals Inc. and The Bank of New York Trust Company, N.A (incorporated by reference to Exhibit 4.7 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
10.1	Credit Agreement, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the lender parties thereto and Credit Suisse, as Administrative Agent and Collateral Agent, Credit Suisse Securities (USA) LLC and Wachovia Capital Markets, LLC as Joint Bookrunner and Co-Lead Arrangers, Wachovia Bank, N.A. as Syndication Agent, JPMorgan Chase Bank and Merrill Lynch Capital Corporation as Co-Documentation Agents (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))

	Description
10.2	Guarantee and Collateral Agreement, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the Subsidiaries from time to time party hereto and Credit Suisse, as collateral agent (incorporated by reference to Exhibit 10.2 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
10.3	Joinder, dated as of July 25, 2007 to the Purchase Agreement dated as of June 27, 2007 (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
10.4	Form of outside director Stock Option Agreement (incorporated by reference to Exhibit 10.1 to the Company's Registration Statement on Form S-1 (No. 333-31790))
10.5	Form of Amendment No. 1 to the Director Stock Option Agreement (incorporated by reference to the Company's Registration Statement on Form S-8 (No. 333-10034977))
10.6	Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan, as amended and restated on February 23, 2005 (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed February 28, 2005 (No. 001-15925))
10.7	Form of Amendment No. 1 to the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan (incorporated by reference to Exhibit 99.1 to the Company's Current Report on Form 8-K dated December 20, 2005)
10.8	Form of Restricted Stock Award Agreement (Directors) (incorporated by reference to Exhibit 99.2 to the Company's Current Report on Form 8-K dated December 20, 2005)
10.9	Community Health Systems Deferred Compensation Plan Trust, Amended and Restated Effective February 26, 1999 (incorporated by reference to Exhibit 10.18 to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
10.10	Community Health Systems Deferred Compensation Plan, as amended effective October 1, 1993; January 1, 1994; January 1, 1998; April 1, 1999; July 1, 2000; and June 1, 2001 (incorporated by reference to Exhibit 10.19 to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
10.11	Community Health Systems, Inc. Director's Fees Deferral Plan (incorporated by reference to Exhibit 10.18 to the Company's Annual Report on Form 10-K for the year ended December 31, 2004)
10.12	Form of Restricted Stock Award Agreement (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed February 28, 2005 (No. 001-15925))
10.13	Form of Indemnification Agreement between the Registrant and its directors and executive officers (incorporated by reference to Exhibit 10.8 to the Company's Current Report on Form 8-K filed February 28, 2005 (No. 001-15925))
10.14	Community Health Systems, Inc. Supplemental Executive Retirement Plan (incorporated by reference to Exhibit 10.17 to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
10.15	Amendment No. 2 to the Community Health Systems, Inc. Supplemental Executive Retirement Plan dated December 10, 2002 (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed June 1, 2005 (No. 001-15925))
10.16	Supplemental Executive Retirement Plan Trust, dated June 1, 2005, by and between CHS/Community Health Systems, Inc., as grantor, and Wachovia Bank, N.A., as trustee (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K filed June 1, 2005 (No. 001-15925))
10.17	Participation Agreement entered into as of January 1, 2005, by and between Community Health Systems Professional Services Corporation and HealthTrust Purchasing Group, L.P. (incorporated by reference to Exhibit 10.19 to the Company's Annual Report on Form 10-K for the year ended December 31, 2004)
10.18	Form of Performance Based Restricted Stock Award Agreement between Registrant and its executive officers (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed March 3, 2006 (No. 001-15925))

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	Description
10.19	Form of Performance Based Restricted Stock Award Agreement, Part A (incorporated by reference to Exhibit 10.4 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
10.20	Form of Performance Based Restricted Stock Award Agreement, Part B (incorporated by reference to Exhibit 10.5 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
10.21	Form of Restricted Stock Award Agreement (incorporated by reference to Exhibit 10.6 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
21	List of subsidiaries*
23.1	Consent of Deloitte & Touche LLP*
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*

* Filed herewith.

Item 15(b):

SIGNATURES

Pursuant to the requirements of section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

COMMUNITY HEALTH SYSTEMS, INC.

By: /s/ Wayne T. Smith

Wayne T. Smith
Chairman of the Board,
President and Chief Executive Officer

February 28, 2008

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Name	Title	Date
/s/ WAYNE T. SMITH Wayne T. Smith	President and Chief Executive Officer and Director (principal executive officer)	02/28/2008
/s/ W. LARRY CASH W. Larry Cash	Executive Vice President, Chief Financial Officer and Director (principal financial officer)	02/28/2008
/s/ T. MARK BUFORD T. Mark Buford	Vice President and Corporate Controller (principal accounting officer)	02/28/2008
/s/ JOHN CLERICO John A. Clerico	Director	02/28/2008
/s/ DALE F. FREY Dale F. Frey	Director	02/28/2008
/s/ HARVEY KLEIN, M.D. Harvey Klein, M.D.	Director	02/28/2008
/s/ JOHN A. FRY John A. Fry	Director	02/28/2008
/s/ JULIA B. NORTH Julia B. North	Director	02/28/2008
/s/ H. MITCHELL WATSON, JR. H. Mitchell Watson, Jr.	Director	02/28/2008

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Community Health Systems, Inc.
Franklin, Tennessee

We have audited the consolidated financial statements of Community Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 2007 and 2006, and for each of the three years in the period ended December 31, 2007, and have issued our report thereon dated February 28, 2008 (included elsewhere in this Annual Report, such report expresses an unqualified opinion and includes an explanatory paragraph referring to the Company adopting the fair value recognition provisions of Statement of Financial Accounting Standards No. 123 (Revised 2004), *Share Based Payment* effective January 1, 2006). Our audits also included the financial statement schedule listed in Item 15 of this Annual Report. This consolidated financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, such consolidated financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 28, 2008

Community Health Systems, Inc. and Subsidiaries

Schedule II — Valuation and Qualifying Accounts

Description	Balance at Beginning of Year	Acquisitions and Dispositions	Charged to Costs and Expenses (In thousands)	Write-offs	Balance at End of Year
Year ended December 31, 2007 allowance for doubtful accounts	$ 478,565	$ 421,157	$ 897,285	$ (763,491)	$ 1,033,516
Year ended December 31, 2006 allowance for doubtful accounts	$ 346,024	$ 31,241	$ 547,781	$ (446,481)	$ 478,565
Year ended December 31, 2005 allowance for doubtful accounts	$ 286,094	$ —	$ 377,596	$ (317,666)	$ 346,024

Exhibit Index

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31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*

* Filed herewith.

Exhibit 21

Community Health Systems, Inc.
SUBSIDIARY LISTING

(*) Majority position held in an entity with physicians, non-profit entities or both
(#) Minority position held in a non-consolidating entity

5300 Grand Limited Partnership	
A Woman's Place, LLC	
Abilene Hospital, LLC	
Abilene Merger, LLC	
Affinity Health Systems, LLC*	
Affinity Hospital, LLC*	d/b/a Trinity Medical Center
Affinity Physician Services, LLC*	
Alaska Physician Services, LLC	
Alice Hospital, LLC	
Alice Surgeons, LLC	
Ambulance Services of Dyersburg, Inc.	
Ambulance Services of Forrest City, LLC	
Ambulance Services of Lexington, Inc.	
Ambulance Services of McKenzie, Inc.	
Ambulance Services of McNairy, Inc.	
American Health Facilities Development, LLC	
Anesthesiology Group of Hattiesburg, LLC	
Anna Clinic Corp.	
Anna Hospital Corporation	d/b/a Union County Hospital
APS Medical, LLC	
Arizona ASC Management, Inc.	
Arizona DH, LLC	
Arizona Medco, LLC	
Arkansas Healthcare System Limited Partnership#	
ARMC, LP	d/b/a Abilene Regional Medical Center
Arusha LLC*	
Augusta Health System, LLC*	
Augusta Hospital, LLC*	d/b/a Trinity Hospital of Augusta
Augusta Physician Services, LLC	
Barberton Health System, LLC	
Barberton Physician Services, LLC	

Barstow Healthcare Management, Inc.	
Beauco, LLC	
Beaumont Medical Center, L.P.	
Beaumont Regional, LLC	
Berwick Clinic Company, LLC	
Berwick Clinic Corp.	
Berwick Home Health Private Care, Inc.	
Berwick Hospital Company, LLC	d/b/a Berwick Hospital Center
Berwick Hospital Company, LLC	
Berwick Medical Professionals, P.C.	
BH Trans Company, LLC	
BH Trans Corporation	
Big Bend Hospital Corporation	d/b/a Big Bend Regional Medical Center
Big Spring Hospital Corporation	d/b/a Scenic Mountain Medical Center
Birmingham Holdings, LLC	
Bluffton Health System, LLC	d/b/a Bluffton Regional Medical Center
Bluffton Physician Services, LLC	
Brandywine Hospital Malpractice Assistance Fund, Inc.	
Brazos Medco, LLC	
Brazos Valley of Texas, L.P.	
Brazos Valley Surgical Center, LLC	
Broken Arrow Medical Group, LLC	
Brownsville Clinic Corp.	
Brownsville Hospital Corporation	d/b/a Haywood Park Community Hospital
Brownwood Hospital, L.P.	d/b/a Brownwood Regional Medical Center
Brownwood Medical Center, LLC	
Bullhead City Clinic Corp.	
Bullhead City Hospital Corporation*	d/b/a Western Arizona Regional Medical Center
Bullhead City Hospital Investment Corporation*	
Bullhead City Imaging Corporation	
BVSC, LLC	
Byrd Medical Clinic, Inc.	
Carlsbad Medical Center, LLC	d/b/a Carlsbad Medical Center
Carolina Surgery Center, LLC*	
Carolinas Medical Alliance, Inc.	

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Carolinas OB/GYN Medical Group, LLC	
Cedar Park Health System, L.P.*	d/b/a Cedar Park Regional Medical Center
Center for Adult Healthcare, LLC	
Central Alabama Physician Services, Inc.	
Central Arkansas Anesthesia Services, LLC	
Central Arkansas Pharmacy, LLC	
Central Arkansas Physician Services, LLC	
Central Arkansas Real Property, LLC	
Centre Clinic Corp.	
Centre Home Care Corporation	
Centre Hospital Corporation	d/b/a Cherokee Medical Center
Centre RHC Corp.	
Chesterfield Clinic Corp.	
Chesterfield/Marlboro, L.P.	d/b/a Marlboro Park Hospital; Chesterfield General Hospital
Chestnut Hill Clinic Company, LLC*	
Chestnut Hill Health System, LLC*	
CHHS ALF Company, LLC*	
CHHS Development Company, LLC*	
CHHS Holdings, LLC	
CHHS Hospital Company, LLC*	d/b/a Chestnut Hill Hospital
CHHS Rehab Company, LLC*	
CHS Kentucky Holdings, LLC	
CHS Pennsylvania Holdings, LLC	
CHS Realty Holdings I, Inc.	
CHS Realty Holdings II, Inc.	
CHS Realty Holdings Joint Venture	
CHS Virginia Holdings, LLC	
CHS/Community Health Systems, Inc.	
Claremore Anesthesia, LLC	
Claremore Diagnostic Center, LLC	
Claremore Internal Medicine, LLC	
Claremore Physicians, LLC	
Claremore Regional Hospital, LLC	d/b/a Claremore Regional Hospital
Clarksville Health System, G.P.*	d/b/a Gateway Health System
Clarksville Holdings, LLC	

Clarksville Imaging Center, LLC#	
Clarksville Physician Services, G.P.*	
Cleveland Clinic Corp.	
Cleveland Hospital Corporation	
Cleveland Medical Clinic, Inc.	
Cleveland PHO, Inc.	
Cleveland Regional Medical Center, L.P.	d/b/a Cleveland Regional Medical Center
Clinico, LLC	
Clinton County Health System, LLC	
Clinton Hospital Corporation	d/b/a Lock Haven Hospital
Coatesville Clinic Company, LLC	
Coatesville Hospital Corporation	d/b/a Brandywine Hospital
C-OK, LLC	
College Station Hospital, L.P.	d/b/a College Station Medical Center
College Station Medical Center, LLC	
College Station Merger, LLC	
Colonial Heights Imaging, LLC	
Community GP Corp.	
Community Health Care Partners, Inc.	
Community Health Investment Company, LLC	
Community Health Network, Inc.	
Community Health Systems Foundation	
Community Health Systems Professional Services Corporation	
Community Health Systems, Inc.	
Community Information Network, Inc.#	
Community Insurance Group, LTD.	
Community LP Corp.	
Consolidated Hospital Laundry Services, Inc.#	
Coronado Hospital, LLC	
Coronado Medical, LLC	
Cottage Home Options, L.L.C.	
Cottage Rehabilitation and Sports Medicine, L.L.C.#	
Coventry Clinic Company, LLC	
CP Hospital GP, LLC	

CPLP, LLC	
Crestview Hospital Corporation*	d/b/a North Okaloosa Medical Center
Crestview Professional Condominiums Association, Inc.*	
Crestview Surgery Center, L.P.	
Crestwood Healthcare, L.P.*	d/b/a Crestwood Medical Center
Crestwood Hospital LP, LLC	
Crestwood Hospital, LLC	
Crestwood Surgery Center, LLC*	
Crossroads Community Hospital Malpractice Assistance Fund, Inc.	
Crossroads Healthcare Management, LLC#	
Crossroads Physician Corp.	
CSDS, LLC	
CSMC, LLC	
CSRA Holdings, LLC	
Cullman County Medical Clinic, Inc.	
Cullman Hospital Corporation	
Cullman Surgery Venture Corp.	
Dallas Phy Service, LLC	
Dallas Physician Practice, L.P.	
Day Surgery, Inc.	
Deaconess Health System, LLC*	d/b/a Deaconess Hospital
Deaconess Holdings, LLC	
Deaconess Hospital Holdings, LLC	
Deaconess Metropolitan Physicians, LLC	
Deaconess Physician Services, LLC	
Deming Clinic Corporation	
Deming Hospital Corporation	d/b/a Mimbres Memorial Hospital
Denton ASC-GP, LLC	
Denton Surgery Center, L.P.*	
DeQueen Regional I, LLC	
Desert Hospital Holdings, LLC	
Detar Hospital, LLC	
DFW Physerv, LLC	

DHSC, LLC*	d/b/a Affinity Medical Center -- Doctors Campus; Affinity Medical Center -- Massillon
Diagnostic Imaging Management of Brandywine Valley, LLC	
Diagnostic Imaging of Brandywine Valley, LP	
Doctors Hospital Physician Services, LLC*	
Doctors Medical Center, LLC	
Doctors of Laredo, LLC	
Douglas Medical Center, LLC	
Dukes Health System, LLC	d/b/a Dukes Memorial Hospital
Dukes Physician Services, LLC	
Dupont Hospital, LLC*	d/b/a Dupont Hospital
Dyersburg Clinic Corp.	
Dyersburg Hospital Corporation	d/b/a Dyersburg Regional Medical Center
E.D. Clinics, LLC	
East Tennessee Clinic Corp.	
East Tennessee Health Systems, Inc.	
Easton Hospital Malpractice Assistance Fund, Inc.	
Edge Medical Clinic, Inc.	
Edwardsville Ambulatory Surgery Center, LLC*	
El Dorado Surgery Center, L.P.*	
EL Med, LLC	
Emporia Clinic Corp.	
Emporia Hospital Corporation	d/b/a Southern Virginia Regional Medical Center
Eufaula Clinic Corp.	
Eufaula Hospital Corporation	
Evanston Clinic Corp.	
Evanston Hospital Corporation	d/b/a Evanston Regional Hospital
Eye Institute of Southern Arizona, LLC	
Fairmont Health System, LLC	
Fallbrook Hospital Corporation	d/b/a Fallbrook Hospital
Family Home Care, Inc.	
Fannin Regional Hospital, Inc.	d/b/a Fannin Regional Hospital
Fannin Regional Orthopaedic Center, Inc.	
Farmington Clinic Company, LLC	
Farmington Hospital Corporation	

Farmington Missouri Hospital Company, LLC	d/b/a Mineral Area Regional Medical Center
Florence ASC Management, LLC	
Foley Clinic Corp.	
Foley Home Health Corporation	
Foley Hospital Corporation	d/b/a South Baldwin Regional Medical Center
Forrest City Arkansas Hospital Company, LLC	d/b/a Forrest City Medical Center
Forrest City Clinic Company, LLC	
Forrest City Hospital Corporation	
Fort Payne Clinic Corp.	
Fort Payne Home Care Corporation	
Fort Payne Hospital Corporation	d/b/a DeKalb Regional Medical Center
Fort Payne RHC Corp.	
Fort Wayne Cardiac Center, LLC#	
Fort Wayne Surgery Center, LLC*	
Frankfort Health Partner, Inc.	
Franklin Clinic Corp.	
Franklin Hospital Corporation	d/b/a Southampton Memorial Hospital
Gadsden Regional Medical Center, LLC	d/b/a Gadsden Regional Medical Center
Gadsden Regional Primary Care, LLC	
Galesburg Home Care Corporation	
Galesburg Hospital Corporation	d/b/a Galesburg Cottage Hospital
Galesburg In-Home Assistance, Inc.	
Garland Managed Care Organization, Inc.	
Gateway Malpractice Assistance Fund, Inc.	
Gateway Medical Services, Inc.	
GCMC, LLC	
GH Texas, LLC	
GHC Hospital, LLC	
Good Hope Health System, LLC	
Granbury Hospital Corporation	d/b/a Lake Granbury Medical Center
Granbury Texas Hospital Investment Corporation	
Granite City Clinic Corp.	
Granite City Hospital Corporation	
Granite City Illinois Hospital Company, LLC	d/b/a Gateway Regional Medical Center
Granite City Orthopedic Physicians Company, LLC	

Granite City Physicians Corp.

GRB Real Estate, LLC

Greenbrier Valley Anesthesia, LLC

Greenbrier Valley Emergency Physicians, LLC

Greenbrier VMC, LLC — d/b/a Greenbrier Valley Medical Center

Greenville Clinic Corp.

Greenville Hospital Corporation — d/b/a L. V. Stabler Memorial Hospital

GRMC Holdings, LLC

Gulf Coast Hospital, L.P.

Gulf Coast Medical Center, LLC

Hallmark Healthcare Company, LLC

Harris Managed Services, Inc.

Harris Medical Clinics, Inc.

Hartselle Physicians, Inc.

Hattiesburg ASC-GP, LLC

Haven Clinton Medical Associates, LLC

HDP DeQueen, LLC

HDP Woodland Heights, L.P.

HDP Woodland Property, LLC

HDPWH, LLC

Healdsburg of California, LLC

Healthcare of Forsyth County, Inc.

Healthsouth/Woodlands Surgery Center of Cullman, LLC#

HealthTrust Purchasing Group, L.P.#

Healthwest Holdings, Inc.

Heartland Malpractice Assistance Fund, Inc.

Heartland Regional Health System, LLC

Heartland Rural Healthcare, LLC

Heck, Mourning, Smith & Barnes Partnership#

Hefner Pointe Medical Associates, LLC#

HEH Corporation

Hidden Valley Medical Center, Inc.

Highland Health Systems, Inc.

HIH, LLC

Hill Regional Clinic Corp.	
Hill Regional Medical Group	
Hobbs Medco, LLC	
Hobbs Physician Practice, LLC	
Hood Medical Group	
Hood Medical Services, Inc.	
Hospital of Barstow, Inc.	d/b/a Barstow Community Hospital
Hospital of Beaumont, LLC	
Hospital of Fulton, Inc.	d/b/a Parkway Regional Hospital
Hospital of Louisa, Inc.	d/b/a Three Rivers Medical Center
Hospital of Morristown, Inc.	d/b/a Lakeway Regional Hospital
Hot Springs National Park Hospital Holdings, LLC*	d/b/a National Park Medical Center
Hot Springs Outpatient Surgery Center, G.P.#	
HTI Tucson Rehabilitation, Inc.	
Humble Texas Home Care Corporation	
Huntington Associates	
Huntington Beach Amdeco, LLC	
Imaging Diagnostic Center Partnership#	
INACTCO, Inc.	
In-Home Assistance, L.L.C.	
In-Home Medical Equipment Supplies and Services, Inc.	
Innovative Recoveries, LLC	
IOM Health System, L.P.	d/b/a Lutheran Hospital of Indiana
IRHC, LLC	
Jackson Hospital Corporation	d/b/a Kentucky River Medical Center
Jackson Hospital Corporation	
Jackson Physician Corp.	
Jackson, Tennessee Hospital Company, LLC	d/b/a Regional Hospital of Jackson
Jacksonville Medical Professional Services, LLC	
Jennersville Regional Hospital Malpractice Assistance Fund, Inc.	
Jonesboro Real Property, LLC	
Jourdanton Hospital Corporation	d/b/a South Texas Regional Medical Center
Kay County Clinic Company, LLC	
Kay County Hospital Corporation	

Kay County Oklahoma Hospital Company, LLC	d/b/a Ponca City Medical Center
Kensingcare, LLC	
Kentucky River Physician Corporation	
King's Daughters Malpractice Assistance Fund, Inc.	
Kirksville Academic Medicine, LLC	
Kirksville Clinic Corp.	
Kirksville Hospital Company, LLC	
Kirksville Missouri Hospital Company, LLC*	d/b/a Northeast Regional Medical Center
Knox Clinic Corp.	
Lake Area Physician Services, LLC	
Lake Area Surgicare, A Partnership in Commendam*	
Lake Wales Clinic Corp.	
Lake Wales Hospital Corporation*	d/b/a Lake Wales Medical Center
Lake Wales Hospital Investment Corporation*	
Lakeway Hospital Corporation	
Lancaster Clinic Corp.	
Lancaster Hospital Corporation	d/b/a Springs Memorial Hospital
Lancaster Imaging Center, LLC*	
Laredo Hospital, L.P.	
Laredo Texas Home Care Services Company, L.P.	
Laredo Texas Hospital Company, L.P.*	d/b/a Laredo Medical Center
Las Cruces ASC-GP, LLC	
Las Cruces Medical Center, LLC	d/b/a Mountain View Regional Medical Center
Las Cruces Physician Services, LLC	
Las Cruces Surgery Center, L.P.*	
Lea Regional Hospital, LLC	d/b/a Lea Regional Medical Center
Leesville Diagnostic Center, L.P.*	
Leesville Surgery Center, LLC*	
Lexington Clinic Corp.	
Lexington Hospital Corporation	d/b/a Henderson County Community Hospital
Lindenhurst Illinois Hospital Company, LLC	
Lithotripsy Providers of Alabama, LLC#	
Lock Haven Clinic Company, LLC	
Lock Haven Medical Professionals, P.C.	
Logan Hospital Corporation	

Logan, West Virginia Hospital Company, LLC	
Longview Medical Center, L.P.*	d/b/a Longview Regional Medical Center
Longview Merger, LLC	
LRH, LLC	
LS Psychiatric, LLC	
Lutheran Health Network CBO, LLC	
Lutheran Health Network of Indiana, LLC	
Lutheran Heart Alliance, LLC#	
Lutheran Medical Office Park, Phase II#	
Lutheran Musculoskeletal Center, LLC	
Lutheran/TRMA Network, LLC#	
Macon Healthcare, LLC#	
Madison Clinic Corp.	
Madison Hospital, LLC	
Malulani Health and Medical Center, LLC	
Marion Hospital Corporation	d/b/a Heartland Regional Medical Center
Marlboro Clinic Corp.	
Martin Clinic Corp.	
Martin Hospital Corporation	d/b/a Volunteer Community Hospital
Mary Black Health System LLC*	d/b/a Mary Black Memorial Hospital
Mary Black Medical Office Building Limited Partnership*	
Mary Black MOB II, L.P.*	
Mary Black Physician Services, LLC	
Mary Black Physicians Group, LLC	
Massillon Community Health System, LLC*	
Massillon Health System, LLC	
Mat-Su Regional ASC GP, LLC	
Mat-Su Regional Surgery Center, L.P.	
Mat-Su Valley II, LLC*	
Mat-Su Valley III, LLC*	
Mat-Su Valley Medical Center, LLC*	d/b/a Mat-Su Regional Medical Center
MCI Panhandle Surgical, L.P.	
McKenzie Clinic Corp.	
McKenzie Hospital Company, LLC	d/b/a McKenzie Regional Hospital

McKenzie Physician Services, LLC	
McKenzie Tennessee Hospital Company, LLC	
McKenzie-Willamette Regional Medical Center Associates, LLC*	d/b/a McKenzie-Willamette Medical Center
McNairy Clinic Corp.	
McNairy Hospital Corporation	d/b/a McNairy Regional Hospital
MCSA, LLC#	
Medical Center at Terrell, LLC	
Medical Center of Brownwood, LLC	
Medical Center of Sherman, LLC	
Medical Diagnostic Center Associates, LP#	
Medical Holdings, Inc.	
Medical Park Hospital, LLC	
Medical Park MSO, LLC	
MEDSTAT, LLC	
Memorial Hospital of Salem Malpractice Assistance Fund, Inc.	
Memorial Hospital, LLC	
Memorial Management, Inc.	
Mesa View Physical Rehabilitation, LLC#	
Mesa View PT, LLC	
MHS Ambulatory Surgery Center, Inc.	
Mid-America Health Partners, Inc.#	
Mid-Plains, LLC	
Mineral Area Pharmacy and Durable Medical Equipment, LLC	
Minot Health Services, Inc.	
Mission Bay Memorial Hospital, LLC	
Missouri Healthserv, LLC	
MMC of Nevada, LLC	d/b/a Mesa View Regional Hospital
Moberly Hospital Company, LLC	d/b/a Moberly Regional Medical Center
Moberly Hospital Company, LLC	
Moberly Medical Clinics, Inc.	
Moberly Physicians Corp.	
Mohave Imaging Center, LLC	

Morristown Clinic Corp.	
Morristown Professional Centers, Inc.	
Morristown Surgery Center, LLC	
MWMC Holdings, LLC*	
National Healthcare of Cleveland, Inc.	d/b/a SkyRidge Medical Center
National Healthcare of Cullman, Inc.	d/b/a Woodland Medical Center
National Healthcare of Decatur, Inc.	d/b/a Parkway Medical Center
National Healthcare of England Arkansas, Inc.	
National Healthcare of Hartselle, Inc.	d/b/a Hartselle Medical Center
National Healthcare of Holmes County, Inc.	
National Healthcare of Leesville, Inc.	d/b/a Byrd Regional Hospital
National Healthcare of Mt. Vernon, Inc.	d/b/a Crossroads Community Hospital
National Healthcare of Newport, Inc.	d/b/a Harris Hospital
National Park Physician Services, LLC	
National Park Real Property, LLC*	
Navarro Hospital, L.P.	d/b/a Navarro Regional Hospital
Navarro Regional, LLC	
NC-CSH, Inc.	
NC-DSH, Inc.	
NeuroSpine-Pain Surgery Center, LLC#	
NHCI of Hillsboro, Inc.	d/b/a Hill Regional Hospital
North Anaheim Surgicare, LLC	
North Okaloosa Clinic Corp.	
North Okaloosa Home Health Corp.	
North Okaloosa Medical Corp.*	
North Okaloosa Surgery Venture Corp.	
Northampton Clinic Company, LLC	
Northampton Home Care, LLC	
Northampton Hospital Company, LLC	d/b/a Easton Hospital
Northampton Hospital Company, LLC	
Northampton Physician Services Corp.	
Northeast Medical Center, L.P.	
Northwest Allied Physicians, LLC	
Northwest Arkansas Employees, LLC	

Northwest Arkansas Hospitals, LLC*	d/b/a Northwest Medical Center -- Bentonville; Northwest Medical Center -- Springdale; Willow Creek Women's Hospital
Northwest Benton County Physician Services, LLC	
Northwest Hospital, LLC	d/b/a Northwest Medical Center
Northwest Indiana Health System, LLC*	
Northwest Marana Hospital, LLC	
Northwest Medical Center CT/MRI at Marana, LLC#	
Northwest Physicians, LLC	
Northwest Rancho Vistoso Imaging Services, LLC	
Northwest Tucson ASC-GP, LLC	
Northwest Tucson Surgery Center, L.P.*	
NOV Holdings, LLC	
Novasys Health Network, L.L.C.#	
NPMC, Home Health, LLC	
NPMC, LLC	
NRH, LLC	
Oak Hill Clinic Corp.	
Oak Hill Hospital Corporation	d/b/a Plateau Medical Center
Odessa, LLC	
Ohio Sleep Disorders Centers, LLC#	
Oklahoma City ASC-GP, LLC	
Oklahoma City Surgery Center, L.P.	
Olive Branch Clinic Corp.	
Olive Branch Hospital, Inc.	
OPRMC, LLC	
Oregon Healthcorp, LLC	
Oro Valley Hospital, LLC	d/b/a Northwest Medical Center
Pacific East Division Office, L.P.	
Pacific Group ASC Division, Inc.	
Pacific Physicians Services, LLC	
Pacific West Division Office, LLC	
Pain Management Join Venture, L.L.P.#	
Palm Drive Hospital, L.P.	
Palm Drive Medical Center, LLC	
Palmer-Wasilla Health System, LLC	

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Palmetto Women's Care, LLC	
Pampa Hospital, L.P.	
Pampa Medical Center, LLC	
Panhandle Medical Center, LLC	
Panhandle Property, LLC	
Panhandle Surgical Hospital, L.P.	
Panhandle, LLC	
Parkway Medical Clinic, Inc.	
Parkway Regional Medical Clinic, Inc.	
Payson Healthcare Management, Inc.	
Payson Hospital Corporation	d/b/a Payson Regional Medical Center
PDMC, LLC	
Pecos Valley of New Mexico, LLC	
Peerless Healthcare, LLC	
Pennsylvania Hospital Company, LLC	
Pennsylvania Medical Professionals, P.C.	
Petersburg Clinic Company, LLC	
Petersburg Hospital Company, LLC	d/b/a Southside Regional Medical Center
Phillips & Coker OB-GYN, LLC	
Phillips Clinic Corp.	
Phillips Hospital Corporation	d/b/a Helena Regional Medical Center
Phoenix Amdeco, LLC	
Phoenix Surgical, LLC	
Phoenixville Clinic Company, LLC	
Phoenixville Hospital Company, LLC	d/b/a Phoenixville Hospital
Phoenixville Hospital Malpractice Assistance Fund, Inc.	
Physician Practice Support, Inc.	
Physicians and Surgeons Hospital of Alice, L.P.	
Physicians' Surgery Center of Florence, LLC	
Phys-Med, LLC	
Piney Woods Healthcare System, L.P.*	d/b/a Woodland Heights Medical Center
Plymouth Hospital Corporation	
Polk Medical Services, Inc.	
Ponca City Home Care Services, Inc.	

Porter Health Services, LLC	
Porter Hospital, LLC*	d/b/a Porter Hospital
Porter Physician Services, LLC	
Pottstown Clinic Company, LLC	
Pottstown Hospital Company, LLC	d/b/a Pottstown Memorial Medical Center
Pottstown Hospital Corporation	
Pottstown Imaging Company, LLC	
Pottstown Memorial Malpractice Assistance Fund, Inc.	
PremierCare of Arkansas, LLC#	
PremierCare Super PHO, LLC	
Premiere Care Hospital, LLC	
Primary Medical, LLC	
Procure Solutions, LLC	
Professional Account Services Inc.	
Psychiatric Services of Paradise Valley, LLC	
QHG Georgia Holdings, Inc.	
QHG Georgia, L.P.	
QHG of Barberton, Inc.	
QHG of Bluffton Company, LLC	
QHG of Clinton County, Inc.	
QHG of Enterprise, Inc.	d/b/a Medical Center Enterprise
QHG of Forrest County, Inc.	
QHG of Fort Wayne Company, LLC	
QHG of Hattiesburg, Inc.	
QHG of Jacksonville, Inc.	d/b/a Jacksonville Medical Center
QHG of Kenmare, Inc.	
QHG of Lake City, Inc.	
QHG of Massillon, Inc.	
QHG of Minot, Inc.	
QHG of Ohio, Inc.	
QHG of South Carolina, Inc.	d/b/a Carolinas Hospital System
QHG of Spartanburg, Inc.	
QHG of Springdale, Inc.	
QHG of Texas, Inc.	

QHG of Warsaw Company, LLC	
QHR International, LLC	
Quorum ELF, Inc.	
Quorum Health Resources, LLC	
Quorum Health Services, Inc.	
Red Bud Clinic Corp.	
Red Bud Hospital Corporation	
Red Bud Illinois Hospital Company, LLC	d/b/a Red Bud Regional Hospital
Redimed DeKalb, LLC#	
Regional Cancer Treatment Center, LP#	
Regional Hospital of Longview, LLC	
Rehab Hospital of Fort Wayne General Partnership	
River Region Medical Corporation	
River to River Heart Group, LLC	
River West Home Care, LLC	
Riverside MSO, LLC#	
Roswell Clinic Corp.	
Roswell Community Hospital Investment Corporation	
Roswell Hospital Corporation	d/b/a Eastern New Mexico Medical Center
Russell County Clinic Corp.	
Russell County Medical Center, Inc.	
Russellville Holdings, LLC	d/b/a St. Mary's Regional Medical Center
Ruston Clinic Company, LLC	
Ruston Hospital Corporation	
Ruston Louisiana Hospital Company, LLC	d/b/a Northern Louisiana Medical Center
SACMC, LLC	
Salem Clinic Corp.	
Salem Hospital Corporation	d/b/a The Memorial Hospital of Salem County
Salem Medical Professionals, P.C.	
Samaritan Surgicenters of Arizona II, LLC	
San Angelo Ambulatory Surgery Center, Ltd.#	
San Angelo Community Medical Center, LLC	
San Angelo Hospital, L.P.	d/b/a San Angelo Community Medical Center
San Angelo Medical, LLC	

San Diego Hospital, L.P.	
San Leandro, LLC	
San Leandro Hospital, L.P.	
San Leandro Medical Center, LLC	
San Leandro Surgery Center, Ltd.#	
San Miguel Clinic Corp.	
San Miguel Hospital Corporation	d/b/a Alta Vista Regional Hospital
Scenic Managed Services, Inc.	
Schuylkill Internal Medicine Associates, LLC	
SDH, LLC	
Searcy Holdings, LLC	
Sebastopol, LLC	
Senior Circle Association (not-for-profit)	
Shelbyville Clinic Corp.	
Shelbyville Hospital Corporation	d/b/a Bedford County Medical Center
Sherman Hospital, L.P.	
Sherman Medical Center, LLC	
Silsbee Doctors Hospital, L.P.	
Silsbee Medical Center, LLC	
Silsbee Texas, LLC	
Silver Creek MRI, LLC*	
SkyRidge Clinical Associates, LLC	
SLH, LLC	
SMMC Medical Group	
Software Sales Corp.	
South Alabama Managed Care Contracting, Inc.	
South Alabama Medical Management Services, Inc.	
South Alabama Physician Services, Inc.	
South Arkansas Clinic, LLC	
South Arkansas Physician Services, LLC#	
South Tulsa Medical Group, LLC	
SouthCrest Anesthesia Group, LLC	
SouthCrest Medical Group, LLC	
SouthCrest Surgery Center, L.P.*	
SouthCrest, L.L.C.	d/b/a SouthCrest Hospital

Southeast Alabama Maternity Center, LLC#	
Southern Chester County Medical Building I#	
Southern Chester County Medical Building II#	
Southern Illinois Medical Care Associates, LLC	
Southern Texas Medical Center, LLC	
Sparta Hospital Corporation	d/b/a White County Community Hospital
Spokane Valley Washington Hospital Company, LLC	
Spokane Washington Hospital Company, LLC	
Springdale/Bentonville ASC-GP, LLC	
Springdale/Bentonville Surgery Center, L.P.*	
Sprocket Medical Management, LLC	
St. Joseph Health System, LLC	d/b/a St. Joseph Health System
St. Joseph Medical Group, Inc.	
St. Mary's Physician Services, LLC	
St. Mary's Real Property, LLC	
Summerlin Hospital Medical Center, LLC#	
Summit Surgical Suites, LLC#	
Sunbury Clinic Company, LLC	
Sunbury Hospital Company, LLC*	d/b/a Sunbury Community Hospital
Surgical Center of Amarillo, LLC	
Surgical Center of Carlsbad, LLC	
Surgicare of Independence, Inc.	
Surgicare of San Leandro, Inc.	
Surgicare of Sherman, Inc.	
Surgicare of Southeast Texas I, LLC	
Surgicare of Victoria, Inc.	
Surgicare of Victoria, Ltd.	
Surgicare Outpatient Center of Lake Charles, Inc.	
Surgicenter of Johnson County, Inc.	
Surgicenters of America, Inc.	
TAC-SPC, Ltd.	
Tennyson Holdings, LLC	
Terrell Hospital, L.P.	
Terrell Medical Center, LLC	
The Intensive Resource Group, LLC	

The Surgery Center of Salem County, L.L.C.*	
The Vicksburg Clinic, LLC	
Three Rivers Medical Clinics, Inc.	
Timberland Medical Group	
Tooele Clinic Corp.	
Tooele Hospital Corporation	d/b/a Mountain West Medical Center
Triad Corporate Services, Limited Partnership	
Triad CSGP, LLC	
Triad CSLP, LLC	
Triad DeQueen Regional Medical Center, LLC	
Triad Healthcare Corporation	
Triad Healthcare System of Phoenix, L.P.	
Triad Holdings III, LLC	
Triad Holdings IV, LLC	
Triad Holdings V, LLC	
Triad Holdings VI, Inc.	
Triad Indiana Holdings, LLC	
Triad Nevada Holdings, LLC	
Triad of Alabama, LLC	d/b/a Flowers Hospital
Triad of Arizona (L.P.), Inc.	
Triad of Oregon, LLC	
Triad of Phoenix, Inc.	
Triad RC, Inc.	
Triad Texas, LLC	
Triad-Arizona I, Inc.	
Triad-ARMC, LLC	
Triad-Denton Hospital GP, LLC	
Triad-Denton Hospital, L.P.	
Triad-El Dorado, Inc.	
Triad-Medical Center at Terrell Subsidiary, LLC	
Triad-Medical Center of Sherman Subsidiary, LLC	
Triad-Navarro Regional Hospital Subsidiary, LLC	
Triad-South Tulsa Hospital Company, Inc.	
Triad-Willow Creek, LLC	
Tri-Irish, Inc.	

Tri-Shell 37 LLC	
Tri-World, LLC	
TROSCO, LLC	
Troy Hospital Corporation	
Trufor Pharmacy, LLC	
TTHR Limited Partnership*	d/b/a Presbyterian Hospital of Denton
Tucson Rehabilitation, LLC	
Tuscora Park Medical Specialists, LLC	
Valley Health System, LLC#	
Vanderbilt-Gateway Cancer Center, G.P.#	
VFARC, LLC	
VHC Holdings, LLC	
VHC Medical, LLC	
Vicksburg Healthcare, LLC	d/b/a River Region Medical Center
Vicksburg Surgical Center, LLC	
Victoria Functional Assessment & Restoration Ltd.	
Victoria Hospital, LLC	
Victoria of Texas, L.P.	d/b/a DeTar Hospital Navarro; DeTar Hospital North
Village Medical Center Associates, LLC	
Virginia Hospital Company, LLC	
VMF Medical, LLC	
Wagoner Community Hospital, LLC	
WAMC, LLC	
Warsaw Health System, LLC*	d/b/a Kosciusko Community Hospital
Washington Clinic Corp.	
Washington Hospital Corporation	
Washington Physician Corp.	
Watsonville Hospital Corporation	d/b/a Watsonville Community Hospital
Waukegan Clinic Corp.	
Waukegan Hospice Corp.	
Waukegan Hospital Corporation	
Waukegan Illinois Hospital Company, LLC	d/b/a Vista Medical Center East; Vista Medical Center West
Weatherford Hospital Corporation	
Weatherford Texas Hospital Company, LLC	d/b/a Weatherford Regional Medical Center

Webb Hospital Corporation	
Webb Hospital Holdings, LLC	
Wesley Health System, LLC	d/b/a Wesley Medical Center
Wesley HealthTrust, Inc.	
Wesley Physician Services, LLC	
West Anaheim Hospital, L.P.	
West Anaheim Medical Center, LLC	
West Anaheim, LLC	
West Grove Clinic Company, LLC	
West Grove Home Care, LLC	
West Grove Hospital Company, LLC	d/b/a Jennersville Regional Hospital
West Grove Hospital Company, LLC	
West Virginia MS, LLC	
Western Arizona Regional Home Health and Hospice, Inc.	
Western Illinois Kidney Center, L.L.C.#	
Wharton Medco, LLC	
White County Physician Services, Inc.	
WHMC, LLC	
Wichita Falls Texas Home Care Corporation	
Wichita Falls Texas Private Duty Corporation	
Willamette Community Medical Group, LLC	
Willamette Valley Clinics, LLC	
Willamette Valley Medical Center, LLC	d/b/a Willamette Valley Medical Center
Williamston Clinic Corp.	
Williamston Hospital Corporation	d/b/a Martin General Hospital
WM Medical, LLC	
Women & Children's Hospital, LLC	d/b/a Women & Children's Hospital
Women's Health Care Associates of Phoenixville, LLC	
Woodland Heights Medical Center, LLC	
Woodward Clinic Company, LLC	
Woodward Health System, LLC	d/b/a Woodward Hospital

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement No. 333-117697 on Form S-3 and in Registration Statement Nos. 333-100349, 333-61614, 333-44870, 333-107810, 333-121282, 333-121283 and 333-144525 on Form S-8 of our reports dated February 28, 2008, (which reports express an unqualified opinion and include an explanatory paragraph referring to the Company adopting the fair value recognition provisions of Statement of Financial Accounting Standards No. 123 (Revised 2004), *Share Based Payment* effective January 1, 2006) relating to the consolidated financial statements and financial statement schedule of Community Health Systems, Inc., and the effectiveness of Community Health Systems, Inc.'s internal control over financial reporting, appearing in this Annual Report on Form 10-K of Community Health Systems, Inc. for the year ended December 31, 2007.

/s/ DELOITTE & TOUCHE LLP

Nashville, Tennessee
February 28, 2008

Exhibit 31.1

I, Wayne T. Smith, certify that:

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

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

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

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

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

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

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

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

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

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

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

/s/ Wayne T. Smith

Wayne T. Smith
Chairman of the Board, President
and Chief Executive Officer

Date: February 28, 2008

Exhibit 31.2

I, W. Larry Cash, certify that:

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

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

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

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

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

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

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

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

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

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

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

/s/ W. Larry Cash

W. Larry Cash
Executive Vice President,
Chief Financial Officer and Director

Date: February 28, 2008

Exhibit Number 32.1

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

In connection with the Annual Report of Community Health Systems, Inc. (the "Company") on Form 10-K for the period ending December 31, 2007, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Wayne T. Smith, Chairman of the Board, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ WAYNE T. SMITH

Wayne T. Smith
Chairman of the Board, President and
Chief Executive Officer

February 28, 2008

Exhibit Number 32.2

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

In connection with the Annual Report of Community Health Systems, Inc. (the "Company") on Form 10-K for the period ending December 31, 2007, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, W. Larry Cash, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ W. LARRY CASH

W. Larry Cash
Executive Vice President, Chief Financial Officer and Director

February 28, 2008

FORM 10-K/A

COMMUNITY HEALTH SYSTEMS INC - CYH

Filed: December 22, 2008 (period: December 31, 2007)

Amendment to a previously filed 10-K

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

Form 10-K/A
Amendment No. 2

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the year ended December 31, 2007

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 *(State of incorporation)*	**13-3893191** *(IRS Employer Identification No.)*
4000 Meridian Boulevard **Franklin, Tennessee** *(Address of principal executive offices)*	**37067** *(Zip Code)*

Registrant's telephone number, including area code:
(615) 465-7000

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

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, $.01 par value	New York Stock Exchange

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

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

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

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

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

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

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

The aggregate market value of the voting stock held by non-affiliates of the Registrant was $3,838,926,302. Market value is determined by reference to the closing price on June 30, 2007 of the Registrant's Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2007) have any non-voting common stock outstanding. As of February 1, 2008, there were 96,618,751 shares of common stock, par value $.01 per share,

Attachment - 75

outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required for Part III of this annual report is incorporated by reference from portions of the Registrant's definitive proxy statement for its 2008 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, 2007.

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Community Health Systems, Inc.

Form 10-K/A

Year ended December 31, 2007

EXPLANATORY NOTE

The Company is filing this Amendment No. 2 to its Annual Report on Form 10-K/A for the year ended December 31, 2007 that was originally filed on February 29, 2008 and amended on April 4, 2008 (the "original Form 10-K") to conform Part II, Item 8 (Financial Statements and Supplementary Data) of the original Form 10-K to reflect revisions previously made in the Company's quarterly filings on Form 10-Q for the periods ended June 30, 2008 and September 30, 2008. This Amendment No. 2 will subsequently be incorporated by reference into a Registration Statement on Form S-3ASR. Absent the filing of a registration statement under the Securities Act of 1933, the revisions were deemed to be immaterial and would not otherwise have required an amendment to the original Form 10-K, and would have instead been reflected in the Company's Annual Report on Form 10-K for the year ending December 31, 2008.

Other than as specified above, this Amendment No. 2 on Form 10-K/A does not modify, update or affect any other disclosures or financial statements set forth in the original Form 10-K. Furthermore, this Amendment No. 2 on Form 10-K/A does not purport to provide a general update or discussion of any developments of the Company subsequent to the filing of the original Form 10-K. Accordingly, the original Form 10-K as amended by this Amendment No. 2 on Form 10-K/A, should be read in conjunction with the Company's filings made with the Securities and Exchange Commission subsequent to the date of the original Form 10-K.

On April 4, 2008, the Company filed Amendment No. 1 to its Annual Report on Form 10-K for the fiscal year ended December 31, 2007 to amend the Exhibit List set forth in Part IV, Item 15.

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

Index to Financial Statements

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Community Health Systems, Inc.
Franklin, Tennessee

We have audited the accompanying consolidated balance sheets of Community Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 2007 and 2006, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2007. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Community Health Systems, Inc. and subsidiaries as of December 31, 2007 and 2006, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2007, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 2 to the consolidated financial statements, the Company adopted the fair value recognition provisions of Statement of Financial Accounting Standards No. 123 (Revised 2004), *Share Based Payment* effective January 1, 2006, which resulted in the Company changing the method in which it accounts for share-based compensation.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2007, based on the criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 28, 2008 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 28, 2008
(December 19, 2008 as to the effects of the restatement discussed on Notes 1 and 17)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2007	2006	2005
	(In thousands, except share and per share data)		
Net operating revenues	$ 7,127,494	$ 4,180,136	$ 3,576,117
Operating costs and expenses:			
Salaries and benefits	2,894,977	1,661,619	1,421,145
Provision for bad debts	897,285	518,861	356,120
Supplies	944,768	487,778	429,846
Rent	155,566	91,943	82,257
Other operating expenses	1,432,998	855,596	731,024
Depreciation and amortization	316,215	179,282	157,262
Total operating costs and expenses	6,641,809	3,795,079	3,177,654
Income from operations	485,685	385,057	398,463
Interest expense, net of interest income of $8,181, $1,779, and $5,742 in 2007, 2006 and 2005, respectively	364,533	94,411	87,185
Loss from early extinguishment of debt	27,388	4	—
Minority interest in earnings	15,996	2,795	3,104
Equity in earnings of unconsolidated affiliates	(25,132)	—	—
Income from continuing operations before income taxes	102,900	287,847	308,174
Provision for income taxes	43,003	110,152	119,804
Income from continuing operations	59,897	177,695	188,370
Discontinued operations, net of taxes:			
Loss from operations of hospitals sold or held for sale	(11,067)	(6,873)	(8,737)
Net loss on sale of hospitals and partnership interests	(2,594)	(2,559)	(7,618)
Impairment of long-lived assets of hospitals held for sale	(15,947)	—	(4,471)
Loss on discontinued operations	(29,608)	(9,432)	(20,826)
Net income	$ 30,289	$ 168,263	$ 167,544
Earnings per common share — basic:			
Income from continuing operations	$ 0.64	$ 1.87	$ 2.13
Loss on discontinued operations	$ (0.32)	$ (0.10)	$ (0.24)
Net income	$ 0.32	$ 1.77	$ 1.89
Earnings per common share — diluted:			
Income from continuing operations	$ 0.63	$ 1.85	$ 2.00
Loss on discontinued operations	$ (0.31)	$ (0.10)	$ (0.21)
Net income	$ 0.32	$ 1.75	$ 1.79
Weighted average number of shares outstanding:			
Basic	93,517,337	94,983,646	88,601,168
Diluted	94,642,294	96,232,910	98,579,977

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

	December 31, 2007	December 31, 2006
	(In thousands, except share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 132,874	$ 40,566
Patient accounts receivable, net of allowance for doubtful accounts of $1,033,516 and $478,565 in 2007 and 2006, respectively	1,533,798	773,984
Supplies	262,903	113,320
Prepaid income taxes	99,417	—
Deferred income taxes	113,741	13,249
Prepaid expenses and taxes	70,339	32,385
Other current assets (including assets of hospitals held for sale of $118,893 at December 31, 2007)	339,826	47,880
Total current assets	2,552,898	1,021,384
Property and equipment:		
Land and improvements	463,373	163,988
Buildings and improvements	4,166,888	1,634,893
Equipment and fixtures	1,679,979	831,485
	6,310,240	2,630,366
Less accumulated depreciation and amortization	(797,666)	(643,789)
Property and equipment, net	5,512,574	1,986,577
Goodwill	4,247,714	1,336,525
Other assets, net of accumulated amortization of $100,556 and $92,921 in 2007 and 2006, respectively (including assets of hospitals held for sale of $362,546 at December 31, 2007)	1,180,457	162,093
Total assets	$ 13,493,643	$ 4,506,579
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Current maturities of long-term debt	$ 20,710	$ 35,396
Accounts payable	492,693	247,747
Current income taxes payable	—	7,626
Accrued liabilities:		
Employee compensation	403,598	162,188
Interest	153,832	7,122
Other (including liabilities of hospitals held for sale of $67,606 at December 31, 2007)	377,102	115,204
Total current liabilities	1,447,935	575,283
Long-term debt	9,077,367	1,905,781
Deferred income taxes	407,947	141,472
Other long-term liabilities	483,459	136,811
Minority interests in equity of consolidated subsidiaries	366,131	23,559
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $.01 par value per share, 100,000,000 shares authorized; none issued	—	—
Common stock, $.01 par value per share, 300,000,000 shares authorized; 96,611,085 shares issued and 95,635,536 shares outstanding at December 31, 2007 and 95,026,494 shares issued and 94,050,945 shares outstanding at December 31, 2006	966	950
Additional paid-in capital	1,240,308	1,195,947
Treasury stock, at cost, 975,549 shares at December 31, 2007 and 2006	(6,678)	(6,678)
Unearned stock compensation	—	—
Accumulated other comprehensive income	(81,737)	5,798
Retained earnings	557,945	527,656
Total stockholders' equity	1,710,804	1,723,673
Total liabilities and stockholders' equity	$ 13,493,643	$ 4,506,579

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Treasury Stock		Unearned Stock Compensation	Accumulated Other Comprehensive Income (Loss)	Retained Earnings (Accumulated Deficit)	Total
	Shares	Amount		Shares	Amount				
				(In thousands, except share data)					
BALANCE, December 31, 2004	88,591,733	$ 886	$ 1,047,888	(975,549)	$ (6,678)	$ —	$ 6,046	$ 191,849	$ 1,239,991
Comprehensive Income:									
Net income	—	—	—	—	—	—	—	167,544	167,544
Net change in fair value of interest rate swaps, net of tax expense of $5,019	—	—	—	—	—	—	8,923	—	8,923
Net change in fair value of available for sale securities							222	—	222
Total comprehensive income							9,145	167,544	176,689
Repurchases of common stock	(2,239,700)	(22)	(79,830)	—	—	—	—	—	(79,852)
Issuance of common stock in connection with the exercise of options	3,134,721	31	49,543	—	—	—	—	—	49,574
Issuance of common stock in connection with the conversion of convertible debt	4,493,083	44	148,576	—	—	—	—	—	148,620
Restricted stock grant	558,000	6	18,160	—	—	(18,160)	—	—	6
Tax benefit from exercise of options	—	—	24,453	—	—	—	—	—	24,453
Earned stock compensation	—	—	—	—	—	4,956	—	—	4,956
Miscellaneous	—	—	140	—	—	—	—	—	140
BALANCE, December 31, 2005	94,539,837	$ 945	$ 1,208,930	(975,549)	$ (6,678)	$ (13,204)	$ 15,191	$ 359,393	$ 1,564,577
Comprehensive Income:									
Net income	—	—	—	—	—	—	—	168,263	168,263
Net change in fair value of interest rate swaps, net of tax benefit of $931	—	—	—	—	—	—	(1,654)	—	(1,654)
Net change in fair value of available for sale securities	—	—	—	—	—	—	562	—	562
Total comprehensive income							(1,092)	168,263	167,171
Adjustment to adopt FASB statement No. 158, net of tax benefit of $5,465	—	—	—	—	—	—	(8,301)	—	(8,301)
Repurchases of common stock	(5,000,000)	(50)	(176,265)	—	—	—	—	—	(176,315)
Issuance of common stock in connection with the exercise of options	867,833	9	14,564	—	—	—	—	—	14,573
Issuance of common stock in connection with the conversion of convertible debt	4,074,510	41	137,157	—	—	—	—	—	137,198
Tax benefit from exercise of options	—	—	4,750	—	—	—	—	—	4,750
Share-based compensation	544,314	5	20,068	—	—	—	—	—	20,073
Reclassification of unearned stock compensation	—	—	(13,257)	—	—	13,204	—	—	(53)
BALANCE, December 31, 2006	95,026,494	$ 950	$ 1,195,947	(975,549)	$ (6,678)	$ —	$ 5,798	$ 527,656	$ 1,723,673
Comprehensive Income:									
Net income	—	—	—	—	—	—	—	30,289	30,289
Net change in fair value of interest rate swaps, net of tax benefit of $51,223	—	—	—	—	—	—	(91,063)	—	(91,063)
Net change in fair value of available for sale securities	—	—	—	—	—	—	237	—	237
Adjustment to pension liability, net of tax benefit of $496	—	—	—	—	—	—	3,291	—	3,291
Total comprehensive income							(87,535)	30,289	(57,246)
Issuance of common stock in connection with the exercise of options	321,535	3	8,362	—	—	—	—	—	8,365
Tax benefit from exercise of options	—	—	(2,760)	—	—	—	—	—	(2,760)
Share-based compensation	1,263,056	13	38,759	—	—	—	—	—	38,772
BALANCE, December 31, 2007	96,611,085	$ 966	$ 1,240,308	(975,549)	$ (6,678)	$ —	$ (81,737)	$ 557,945	$ 1,710,804

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2007	2006 (In thousands)	2005
Cash flows from operating activities:			
Net income	$ 30,289	$ 168,263	$ 167,544
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	332,580	188,771	166,162
Deferred income taxes	(39,894)	(25,228)	9,889
Stock compensation expense	38,771	20,073	4,957
Excess tax benefits relating to stock-based compensation	(1,216)	(6,819)	—
Loss on early extinguishment of debt	27,388	—	—
Minority interest in earnings	15,996	2,795	3,104
Impairment on hospital held for sale	19,044	—	6,718
Loss on sale of hospitals	3,954	3,937	6,295
Other non-cash expenses, net	19,017	500	740
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	131,300	(71,141)	(47,455)
Supplies, prepaid expenses and other current assets	(31,977)	(4,544)	(16,838)
Accounts payable, accrued liabilities and income taxes	125,959	52,151	84,956
Other	16,527	21,497	24,977
Net cash provided by operating activities	687,738	350,255	411,049
Cash flows from investing activities:			
Acquisitions of facilities and other related equipment	(7,018,048)	(384,618)	(158,379)
Purchases of property and equipment	(522,785)	(224,519)	(188,365)
Disposition of hospitals and other ancillary operations	109,996	750	51,998
Proceeds from sale of equipment	4,650	4,480	2,325
Increase in other non-operating assets	(72,671)	(36,350)	(34,851)
Net cash used in investing activities	(7,498,858)	(640,257)	(327,272)
Cash flows from financing activities:			
Proceeds from exercise of stock options	8,214	14,573	49,580
Stock buy-back	—	(176,316)	(79,853)
Deferred financing costs	(182,954)	(2,153)	(1,259)
Excess tax benefits relating to stock-based compensation	1,216	6,819	—
Redemption of convertible notes	—	(128)	(298)
Proceeds from minority investors in joint ventures	2,351	6,890	1,383
Redemption of minority investments in joint ventures	(1,356)	(915)	(3,242)
Distribution to minority investors in joint ventures	(6,645)	(3,220)	(1,939)
Borrowings under Credit Agreement	9,221,627	1,031,000	—
Repayments of long-term indebtedness	(2,139,025)	(650,090)	(26,539)
Net cash (used in) provided by financing activities	6,903,428	226,460	(62,167)
Net change in cash and cash equivalents	92,308	(63,542)	21,610
Cash and cash equivalents at beginning of period	40,566	104,108	82,498
Cash and cash equivalents at end of period	$ 132,874	$ 40,566	$ 104,108

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Business and Summary of Significant Accounting Policies

Business. Community Health Systems, Inc., through its subsidiaries (collectively the "Company"), owns, leases and operates acute care hospitals in non-urban and select urban markets. As of December 31, 2007, included in our continuing operations, the Company owned, leased or operated 115 hospitals, licensed for 16,971 beds in 27 states. Pennsylvania and Texas represent the only areas of geographic concentration. Net operating revenues generated by the Company's hospitals in Pennsylvania, as a percentage of consolidated net operating revenues, were 13.1% in 2007, 22.0% in 2006 and 23.1% in 2005. Net operating revenues generated by the Company's hospitals in Texas, as a percentage of consolidated net operating revenues, were 13.0% in 2007, 10.4% in 2006 and 11.6% in 2005.

Use of Estimates. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates under different assumptions or conditions.

Principles of Consolidation. The consolidated financial statements include the accounts of the Company, its subsidiaries, all of which are controlled by the Company through majority voting control, and variable interest entities for which the Company is the primary beneficiary. All significant intercompany accounts and transactions have been eliminated. Certain of the subsidiaries have minority stockholders. The amount of minority interest in equity is disclosed separately on the consolidated balance sheets and minority interest in earnings is disclosed separately on the consolidated statements of income.

Cost of Revenue. The majority of the Company's operating expenses are "cost of revenue" items. Operating costs that could be classified as general and administrative by the Company would include the Company's corporate office costs at the Company's Franklin, Tennessee and Plano, Texas offices, which were $133.4 million, $88.9 million and $67.5 million for the years ended December 31, 2007, 2006 and 2005, respectively. Included in these amounts is stock-based compensation of $38.8 million, $20.1 million and $5.0 million for the years ended December 31, 2007, 2006 and 2005, respectively.

Cash Equivalents. The Company considers highly liquid investments with original maturities of three months or less to be cash equivalents.

Supplies. Supplies, principally medical supplies, are stated at the lower of cost (first-in, first-out basis) or market.

Marketable Securites. The Company accounts for marketable securities in accordance with the provisions of Statement of Financial Accounting Standards ("SFAS") No. 115, "Accounting for Certain Investments in Debt and Equity Securities". The Company's marketable securities are classified as trading or available-for-sale. Available-for-sale securities are carried at fair value as determined by quoted market prices, with unrealized gains and losses reported as a separate component of stockholders' equity. Trading securities are reported at fair value with unrealized gains and losses included in earnings. Interest and dividends on securities classified as available-for-sale or trading are included in net revenue and were not material in all periods presented. Accumulated other comprehensive income included an unrealized gain of $0.2 million and $0.6 million at December 31, 2007 and December 31, 2006, respectively, related to these available-for-sale securities.

Property and Equipment. Property and equipment are recorded at cost. Depreciation is recognized using the straight-line method over the estimated useful lives of the land and improvements (2 to 15 years; weighted average useful life is 14 years), buildings and improvements (5 to 40 years; weighted average useful life is 24 years) and equipment and fixtures (4 to 18 years; weighted average useful life is 8 years). Costs capitalized as construction in progress were $457.5 million and $61.2 million at December 31, 2007 and 2006,

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

respectively. Expenditures for renovations and other significant improvements are capitalized; however, maintenance and repairs which do not improve or extend the useful lives of the respective assets are charged to operations as incurred. Interest capitalized in accordance with SFAS No. 34, "Capitalization of Interest Cost," was $19.0 million, $3.0 million and $2.1 million for the years ended December 31, 2007, 2006 and 2005, respectively. Net property and equipment additions included in accounts payable were $21.4 million, $16.9 million and $0.1 million for the years ended December 31, 2007, 2006 and 2005, respectively.

The Company also leases certain facilities and equipment under capital leases (see Notes 3 and 8). Such assets are amortized on a straight-line basis over the lesser of the term of the lease or the remaining useful lives of the applicable assets.

Goodwill. Goodwill represents the excess cost over the fair value of net assets acquired. Goodwill arising from business combinations is accounted for under the provisions of SFAS No. 141, "Business Combinations" ("SFAS No. 141"), and SFAS No. 142, "Goodwill and Other Intangible Assets" ("SFAS No. 142"), and is not amortized. SFAS No. 142 requires goodwill to be evaluated for impairment at the same time every year and when an event occurs or circumstances change such that it is reasonably possible that an impairment may exist. The Company has selected September 30th as its annual testing date.

Other Assets. Other assets consist of costs associated with the issuance of debt, which are included in interest expense over the life of the related debt using the effective interest method, and costs to recruit physicians to the Company's markets, which are deferred and amortized in amortization expense over the term of the respective physician recruitment contract, which is generally three years. Long-term assets held for sale at December 31, 2007 are also included in other assets.

Third-Party Reimbursement. Net patient service revenue is reported at the estimated net realizable amount from patients, third party payors and others for services rendered. Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems, provisions of cost-reimbursement and other payment methods. Approximately 39.3% of net operating revenues for the year ended December 31, 2007, 41.5% of net operating revenues for the year ended December 31, 2006 and 43.0% of net operating revenues for the year ended December 31, 2005, are related to services rendered to patients covered by the Medicare and Medicaid programs. Revenues from Medicare outlier payments are included in the amounts received from Medicare and are approximately 0.42% of net operating revenues for 2007, 0.44% of net operating revenues for 2006, and 0.47% for 2005. In addition, the Company is reimbursed by non-governmental payors using a variety of payment methodologies. Amounts received by the Company for treatment of patients covered by such programs are generally less than the standard billing rates. The differences between the estimated program reimbursement rates and the standard billing rates are accounted for as contractual adjustments, which are deducted from gross revenues to arrive at net operating revenues. These net operating revenues are an estimate of the net realizable value due from these payors. Final settlements under certain of these programs are subject to adjustment based on administrative review and audit by third parties. Adjustments to the estimated billings are recorded in the periods that such adjustments become known. Adjustments to previous program reimbursement estimates are accounted for as contractual allowance adjustments and reported in the periods in which final settlements are determined. Adjustments related to final settlements or appeals increased revenue by an insignificant amount in each of the years ended December 31, 2007, 2006 and 2005. Amounts due to third-party payors were $73 million as of December 31, 2007 and $55 million as of December 31, 2006 and are included in accrued liabilities-other in the accompanying consolidated balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 2005.

Net Operating Revenues. Net operating revenues are recorded net of provisions for contractual allowance of approximately $16.839 billion, $10.024 billion and $8.401 billion in 2007, 2006 and 2005, respectively. Net operating revenues are recognized when services are provided and are reported at the estimated net realizable amount from patients, third party payors and others for services rendered. Also included in the provision for contractual allowance shown above is the value of administrative and other discounts provided to self-pay patients eliminated from net operating revenues which was $282.5 million, $100.3 million and $77.9 million for the years ended December 31, 2007, 2006 and 2005, respectively. In the ordinary course of business the Company renders services to patients who are financially unable to pay for hospital care. Included in the provision for contractual allowance shown above, is the value (at the Company's standard charges) of these services to patients who are unable to pay that is eliminated from net operating revenues when it is determined they qualify under the Company's charity care policy. The value of these services was $354.8 million, $214.2 million and $174.2 million for the years ended December 31, 2007, 2006 and 2005, respectively. In the fourth quarter of 2007, in conjunction with an analysis of the net realizable value of accounts receivable, which included updating the Company's analysis of historical cash collections, as well as conforming estimation methodologies with those of the former Triad hospitals, the Company revised its methodology whereby the Company has revised its estimate of contractual allowances for estimated amounts of self-pay accounts receivable that will ultimately qualify as charity care, or that will ultimately qualify for Medicaid, indigent care or other specific governmental reimbursement. Previous estimates of uncollectible amounts for such receivables were included in the Company's bad debt reserves for each period. The impact of these changes in estimates decreased net operating revenue approximately $96.3 million for the year ended December 31, 2007.

Allowance for Doubtful Accounts. Accounts receivable are reduced by an allowance for amounts that could become uncollectible in the future. Substantially all of the Company's receivables are related to providing healthcare services to its hospitals' patients.

The Company experienced a significant increase in self-pay volume and related revenue, combined with lower cash collections during the quarter ended September 30, 2006. The Company believes this trend reflected an increased collection risk from self-pay accounts, and as a result the Company performed a review and an alternative analysis of the adequacy of its allowance for doubtful accounts. Based on this review, the Company recorded a $65.0 million increase to its allowance for doubtful accounts to maintain an adequate allowance for doubtful accounts as of September 30, 2006. The Company believed that the increase in self-pay accounts is a result of current economic trends, including an increase in the number of uninsured patients, reduced enrollment under Medicaid programs such as Tenncare, and higher deductibles and co-payments for patients with insurance.

In conjunction with recording the $65.0 million increase to the allowance for doubtful accounts, the Company changed its methodology for estimating its allowance for doubtful accounts effective September 30, 2006, as follows: The Company reserved a percentage of all self-pay accounts receivable without regard to aging category, based on collection history adjusted for expected recoveries and, if present, other changes in trends. For all other payor categories the Company reserved 100% of all accounts aging over 365 days from the date of discharge. Previously, the Company estimated its allowance for doubtful accounts by reserving all accounts aging over 150 days from the date of discharge without regard to payor class. The Company believes its revised methodology provided a better approach to reflect changes in payor mix and historical collection patterns and to respond to changes in trends.

During the quarter ended December 31, 2007, in conjunction with the Company's ongoing process of monitoring the net realizable value of its accounts receivable, as well as integrating the methodologies, data and assumptions used by the former Triad management, the Company performed various analyses including updating a review of historical cash collections. As a result of these analyses, the Company noted a deterioration in certain key cash collection indicators. The acquisition of Triad also provided additional data and a comparative and larger population on which to base the Company's estimates. As a result of the lower estimated collectability indicated by the updated analyses, the Company has recorded an increase to its contractual reserves of $96.3 million (as described above) and an increase to its allowance for doubtful accounts as of December 31, 2007 of approximately $70.1 million. The Company believes this lower

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

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collectability is primarily the result of an increase in the number of patients qualifying for charity care, reduced enrollment in certain state Medicaid programs and an increase in the number of indigent non-resident aliens.

The Company believes the revised methodology provides a better approach to estimating changes in payor mix, continued increases in charity and indigent care as well as the monitoring of historical collection patterns. The revised accounting methodology and the adequacy of resulting estimates will continue to be reviewed by monitoring accounts receivable write-offs, monitoring cash collections as a percentage of trailing net revenues less provision for bad debts, monitoring historical cash collection trends, as well as analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, and the impact of recent acquisitions and dispositions.

Concentrations of Credit Risk. The Company grants unsecured credit to its patients, most of whom reside in the service area of the Company's facilities and are insured under third-party payor agreements. Because of the economic diversity of the Company's facilities and non-governmental third-party payors, Medicare represents the only significant concentration of credit risk from payors. Accounts receivable, net of contractual allowances, from Medicare were $302.1 million and $116.8 million as of December 31, 2007 and 2006, respectively, representing 11.8% and 9.3% of consolidated net accounts receivable, before allowance for doubtful accounts, as of December 31, 2007 and 2006, respectively.

Professional Liability Insurance Claims. The Company accrues for estimated losses resulting from professional liability. The accrual, which includes an estimate for incurred but not reported claims, is based on historical loss patterns and actuarially-determined projections and is discounted to its net present value. To the extent that subsequent claims information varies from management's estimates, the liability is adjusted currently.

Accounting for the Impairment or Disposal of Long-Lived Assets. In accordance with SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets" ("SFAS No. 144"), whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

Income Taxes. The Company accounts for income taxes under the asset and liability method, in which deferred income tax assets and liabilities are recognized for the tax consequences of "temporary differences" by applying enacted statutory tax rates applicable to future years to differences between the financial statement carrying amounts and the tax bases of existing assets and liabilities. The effect on deferred taxes of a change in tax rates is recognized in the consolidated statement of income during the period in which the tax rate change becomes law.

Comprehensive Income. Comprehensive income is the change in equity of a business enterprise during a period from transactions and other events and circumstances from non-owner sources.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Accumulated Other Comprehensive Income consists of the following (in thousands):

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Adjustment to Pension Liability	Accumulated Other Comprehensive Income
Balance as of December 31, 2005	$ 14,969	$ 222	$ —	$ 15,191
2006 Activity, net of tax	(1,654)	562	(8,301)	(9,393)
Balance as of December 31, 2006	$ 13,315	$ 784	$ (8,301)	$ 5,798
2007 Activity, net of tax	(91,063)	237	3,291	(87,535)
Balance as of December 31, 2007	$ (77,748)	$ 1,021	$ (5,010)	$ (81,737)

Segment Reporting. SFAS No. 131, "Disclosures About Segments of an Enterprise and Related Information" ("SFAS No. 131"), requires that a public company report annual and interim financial and descriptive information about its reportable operating segments. Operating segments, as defined, are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker in deciding how to allocate resources and in assessing performance. SFAS No. 131 allows aggregation of similar operating segments into a single reportable operating segment if the businesses have similar economic characteristics and are considered similar under the criteria established by SFAS No. 131.

Prior to the acquisition of Triad Hospitals, Inc. ("Triad"), the Company aggregated its operating segments into one reportable segment as all of its operating segments had similar services, had similar types of patients, operated in a consistent manner and had similar economic and regulatory characteristics. In connection with the Triad acquisition, certain aspects of the Company's organizational structure and the information that is reviewed by the chief operating decision maker have changed. As a result, management has determined that the Company now operates in three distinct operating segments, represented by the hospital operations (which includes our acute care hospitals and related healthcare entities that provide inpatient and outpatient health care services), the home health agencies operations (which provide outpatient care generally in the patient's home), and the hospital management services business (which provides executive management and consulting services to independent acute care hospitals). SFAS No. 131 requires (1) that financial information be disclosed for operating segments that meet a 10% quantitative threshold of the consolidated totals of net revenue, profit or loss, or total assets; and (2) that the individual reportable segments disclosed contribute at least 75% of total consolidated net revenue. Based on these measures, only the hospital operations segment meets the criteria as a separate reportable segment. Financial information for the home health agencies and management services segments do not meet the quantitative thresholds defined in SFAS No. 131 and are therefore combined with corporate into the all other reportable segment.

The financial information from prior years has been presented in Note 13 to reflect this change in the composition of our reportable operating segments.

Derivative Instruments and Hedging Activities. In accordance with SFAS No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133"), as amended, the Company records derivative instruments (including certain derivative instruments embedded in other contracts) on the consolidated balance sheet as either an asset or liability measured at its fair value. Changes in a derivative's fair value are recorded each period in earnings or other comprehensive income ("OCI"), depending on whether the derivative is designated and is effective as a hedged transaction, and on the type of hedge transaction. Changes in the fair value of derivative instruments recorded to OCI are reclassified to earnings in the period affected by the underlying hedged item. Any portion of the fair value of a derivative instrument determined to be ineffective under the standard is recognized in current earnings.

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The Company has entered into several interest rate swap agreements subject to the scope of this pronouncement. See Note 6 for further discussion about the swap transactions.

New Accounting Pronouncements. In June 2006, the Financial Accounting Standards Board ("FASB") issued FASB Interpretation No. 48, "Accounting for Uncertainty in Income Taxes — an interpretation of FASB Statement No. 109" ("FIN 48"), which prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. FIN 48 also provides guidance on de-recognition, classification, interest and penalties, accounting in interim periods, disclosure and transition. FIN 48 is effective for fiscal years beginning after December 15, 2006. The Company adopted FIN 48 as of January 1, 2007. The adoption of this interpretation has not had a material effect on the Company's consolidated results of operations or consolidated financial position.

In September 2006, the FASB issued SFAS No. 157, " Fair Value Measurements" ("SFAS No. 157"), which defines fair value, provides a framework for measuring fair value, and expands the disclosures required for fair value measurements. SFAS No. 157 applies to other accounting pronouncements that require fair value measurement; it does not require any new fair value measurements. SFAS No. 157 is effective for fiscal years beginning after November 15, 2007, and is required to be adopted by the Company beginning in the first quarter of 2008. Although we will continue to evaluate the application of SFAS No. 157, management does not currently believe adoption will have a material impact on the Company's consolidated results of operations or consolidated financial position.

In February 2007, the FASB issued SFAS No. 159, "The Fair Value Option for Financial Assets and Financial Liabilities — Including an Amendment of FASB Statement No. 115" ("SFAS No. 159"). SFAS No. 159 expands the use of fair value accounting but does not affect existing standards that require assets or liabilities to be carried at fair value. SFAS No. 159 permits an entity, on a contract-by-contract basis, to make an irrevocable election to account for certain types of financial instruments and warranty and insurance contracts at fair value, rather than historical cost, with changes in the fair value, whether realized or unrealized, recognized in earnings. SFAS No. 159 is effective for fiscal years beginning after November 15, 2007. The Company adopted SFAS No. 159 as of January 1, 2008. The adoption of this statement is not expected to have a material effect on the Company's consolidated results of operations or consolidated financial position.

In December 2007, the FASB issued SFAS No. 141(R), "Business Combinations" ("SFAS No. 141(R)"). SFAS No. 141(R) replaces SFAS No. 141 and addresses the recognition and accounting for identifiable assets acquired, liabilities assumed, and noncontrolling interests in business combinations. This standard will require more assets and liabilities be recorded at fair value and will require expense recognition (rather than capitalization) of certain pre-acquisition costs. This standard also will require any adjustments to acquired deferred tax assets and liabilities occurring after the related allocation period to be made through earnings. Furthermore, this standard requires this treatment of acquired deferred tax assets and liabilities also be applied to acquisitions occurring prior to the effective date of this standard. SFAS No. 141(R) is effective for fiscal years beginning after December 15, 2008 and is required to be adopted prospectively with no early adoption permitted. SFAS No. 141(R) will be adopted by the Company in the first quarter of 2009. The Company is currently assessing the potential impact that SFAS No. 141(R) will have on its consolidated results of operations or financial position.

In December 2007, the FASB issued SFAS No. 160, "Noncontrolling Interests in Consolidated Financial Statements" ("SFAS No. 160"). SFAS No. 160 addresses the accounting and reporting framework for noncontrolling ownership interests in consolidated subsidiaries of the parent. SFAS No. 160 also establishes disclosure requirements that clearly identify and distinguish between the interests of the parent company and the interests of the noncontrolling owners and that require minority ownership interests be presented separately within equity in the consolidated financial statements. SFAS No. 160 is effective for fiscal years beginning after December 15, 2008, and will be adopted by the Company in the first quarter of 2009. The Company is currently assessing the potential impact that SFAS No. 160 will have on its consolidated results of operations or financial position.

Reclassifications. The Company disposed of one hospital in August 2007, disposed of one hospital in October 2007, disposed of one hospital in November 2007, and designated twelve hospitals as being held for sale in the fourth quarter of 2007. The operating results of those hospitals have been classified as discontinued operations on the consolidated statements of income for all periods presented. There is no effect on net income for all periods presented related to the reclassifications made for the discontinued operations. The presentation of gross property and equipment and accumulated depreciation and amortization at December 31, 2007 has been corrected to reflect certain assets acquired from Triad. This correction increased both gross property and equipment and accumulated depreciation and amortization by $108.3 million and did not impact the net balance of property and equipment as previously presented on the accompanying consolidated balance sheet. The correction to the parenthetical disclosure of assets of hospitals held for sale at December 31, 2007 on the accompanying consolidated balance sheet decreased the assets held for sale by $54.6 million and increased investments in unconsolidated affiliates by $54.6 million, related to those hospitals sold during the first quarter of 2008. This correction did not change the consolidated total of Other assets, net as presented in the accompanying consolidated balance sheet. Note 3 (Long-Term Leases, Acquisitions and Divestitures of Hospitals) and Note 12 (Equity Investments) were revised accordingly to reflect this correction. The presentation of certain other prior year amounts have been changed. These changes in presentation are immaterial to the Company's consolidated financial statements.

2. Accounting for Stock-Based Compensation

The Company adopted the provisions of SFAS No. 123(R), "Share-Based Payments" ("SFAS No. 123(R)") on January 1, 2006, electing to use the modified prospective method for transition purposes. The modified prospective method requires that compensation expense be recorded for all unvested stock options and share awards that subsequently vest or are modified, without restatement of prior periods. Prior to January 1, 2006, the Company accounted for stock-based compensation using the recognition and measurement principles of Accounting Principles Board Opinion No. 25, "Accounting for Stock Issued to Employees" and related interpretations ("APB No. 25"), and provided the pro-forma disclosure requirements of SFAS No. 123 "Accounting for Stock-Based Compensation" and SFAS No. 148 "Accounting for Stock-Based Compensation Transition and Disclosures — an Amendment of FASB Statement No. 123" ("SFAS No. 148"). Under APB No. 25, when the exercise price of the Company's stock was equal to the market price of the underlying stock on the date of grant, no compensation expense was recognized.

The pro-forma table below reflects net income and earnings per share had the Company applied the fair value recognition provisions of SFAS No. 123 for the year ended December 31, 2005, prior to the adoption of SFAS No. 123(R) (in thousands, except per share data):

		Year Ended December 31, 2005
Net Income:	$	167,544
Add: Stock-Based compensation expense recognized under APB No. 25, net of tax		3,493
Deduct: Total stock-based compensation under fair value based method for all awards, net of tax	$	14,232
Pro-forma net income	$	156,805
Net income per share:		
Basic — as reported	$	1.89
Basic — proforma	$	1.77
Diluted — as reported	$	1.79
Diluted — proforma	$	1.68

On September 22, 2005, the Compensation Committee of the Board of Directors of the Company approved an immediate acceleration of the vesting of unvested stock options awarded to employees and officers, including executive officers, on each of three grant dates, December 10, 2002, February 25, 2003, and May 22, 2003. Each of the grants accelerated had a three-year vesting period and would have otherwise become fully vested on their respective anniversary dates no later than May 22, 2006. All other terms and

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conditions applicable to the outstanding stock option grants remain in effect. A total of 1,235,885 stock options, with a weighted exercise price of $20.26 per share, were accelerated.

The accelerated options were issued under the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan (the "2000 Plan"). No performance shares or units or incentive stock options have been granted under the 2000 Plan. Options granted to non-employee directors of the Company and restricted shares were not affected by this action. The Compensation Committee's decision to accelerate the vesting of the affected options was based primarily on the relatively short period of time until such stock options otherwise become fully vested making them no longer a significant motivator for retention and the fact the Company anticipated that up to approximately $3.8 million of compensation expense ($2.3 million, net of tax) associated with certain of these stock options would have otherwise been recognized in the first two quarters of 2006 pursuant to SFAS No. 123(R) would be avoided.

Since the Company accounted for its stock options prior to January 1, 2006 using the intrinsic value method of accounting prescribed in APB No. 25, the accelerated vesting did not result in the recognition of compensation expense in net income for the year ended December 31, 2005. However, in accordance with the disclosure requirements of SFAS No. 148, the pro-forma results presented in the table above include approximately $5.9 million ($3.6 million, net of tax) of compensation expense for the year ended December 31, 2005, resulting from the vesting acceleration.

Stock-based compensation awards are granted under the 2000 Plan. The 2000 Plan allows for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code as well as stock options which do not so qualify, stock appreciation rights, restricted stock, performance units and performance shares, phantom stock awards and share awards. Persons eligible to receive grants under the 2000 Plan include the Company's directors, officers, employees and consultants. To date, the options granted under the 2000 Plan are "nonqualified" stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date, except for options granted on July 25, 2007, which vests equally on the first two anniversaries of the award date. Options granted prior to 2005 have a 10 year contractual term and options granted in 2005, 2006 and 2007 have an 8 year contractual term. The exercise price of options granted to employees under the 2000 Plan were equal to the fair value of the Company's common stock on the option grant date. As of December 31, 2007, 5,849,771 shares of unissued common stock remain reserved for future grants under the 2000 Plan. The Company also has options outstanding under its Employee Stock Option Plan (the "1996 Plan"). These options are fully vested and exercisable and no additional grants of options will be made under the 1996 Plan.

The following table reflects the impact of total compensation expense related to stock-based equity plans under SFAS No. 123(R) for periods beginning January 1, 2006, and under APB No. 25 for the year ended December 31, 2005, on the reported operating results for the respective periods (in thousands, except per share data):

	Year Ended December 31,		
	2007	2006	2005
Effect on income from continuing operations before income taxes	$ (38,771)	$ (20,073)	$ (4,957)
Effect on net income	$ (23,541)	$ (12,762)	$ (3,493)
Effect on net income per share-diluted	$ (0.25)	$ (0.13)	$ (0.04)

SFAS No. 123(R) also requires the benefits of tax deductions in excess of the recognized tax benefit on compensation expense to be reported as a financing cash flow, rather than as an operating cash flow as required under APB No. 25 and related interpretations. This requirement reduced the Company's net operating cash flows and increased the Company's financing cash flows by $1.2 million and $6.8 million for the years

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ended December 31, 2007 and 2006. In addition, the Company's deferred compensation cost at December 31, 2005, of $13.2 million, arising from the issuance of restricted stock in 2005 and recorded as a component of stockholders' equity as required under APB No. 25, was reclassified into additional paid-in capital upon the adoption of SFAS No. 123(R).

At December 31, 2007, $80.4 million of unrecognized stock-based compensation expense from all outstanding unvested stock options and restricted stock is expected to be recognized over a weighted-average period of 18.4 months. There were no modifications to awards during 2007 or 2006.

The fair value of stock options was estimated using the Black Scholes option pricing model with the assumptions and weighted-average fair values during the years ended December 31, 2007 and 2006, as follows:

	Year Ended December 31,	
	2007	2006
Expected volatility	24.4%	24.2%
Expected dividends	0	0
Expected term	4 years	4 years
Risk-free interest rate	4.48%	4.67%

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

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

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

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Options outstanding and exercisable under the 1996 Plan and 2000 Plan as of December 31, 2007, and changes during each of the years in the three-year period ended December 31, 2007 were as follows (in thousands, except share and per share data):

	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (In Years)	Aggregate Intrinsic Value as of December 31, 2007
Outstanding at December 31, 2004	7,456,279	$ 18.03		
Granted	1,325,700	33.02		
Exercised	(3,134,721)	15.81		
Forfeited and cancelled	(276,984)	26.02		
Outstanding at December 31, 2005	5,370,274	22.63		
Granted	1,151,000	38.07		
Exercised	(865,833)	16.47		
Forfeited and cancelled	(172,913)	34.02		
Outstanding at December 31, 2006	5,482,528	26.48		
Granted	3,544,000	37.79		
Exercised	(295,854)	26.89		
Forfeited and cancelled	(291,659)	35.70		
Outstanding at December 31, 2007	8,439,015	$ 30.90	6.5 years	$ 57,992
Exercisable at December 31, 2007	4,024,138	$ 23.63	5.5 years	$ 53,726

The weighted-average grant date fair value of stock options granted during the year ended December 31, 2007 and 2006, was $10.24 and $10.38, respectively. The aggregate intrinsic value (the number of in-the-money stock options multiplied by the difference between the Company's closing stock price on the last trading day of the reporting period and the exercise price of the respective stock options) in the table above represents the amount that would have been received by the option holders had all option holders exercised their options on December 31, 2007. This amount changes based on the market value of the Company's common stock. The aggregate intrinsic value of options exercised during the year ended December 31, 2007 and 2006 was $3.5 million and $18.2 million, respectively. The aggregate intrinsic value of options vested and expected to vest approximates that of the outstanding options.

The Company has also awarded restricted stock under the 2000 Plan to various employees and its directors. The restrictions on these shares generally lapse in one-third increments on each of the first three anniversaries of the award date, except for restricted stock granted on July 25, 2007, which restrictions lapse equally on the first two anniversaries of the award date. Certain of the restricted stock awards granted to the Company's senior executives also contain a performance objective that must be met in addition to the vesting requirements. If the performance objective is not attained the awards will be forfeited in their entirety. Once the performance objective has been attained, restrictions will lapse in one-third increments on each of the first three anniversaries of the award date. Notwithstanding the above mentioned performance objectives and vesting requirements, the restrictions will lapse earlier in the event of death, disability, termination of employment by employer for reason other than for cause of the holder of the restricted stock or in the event of change in control of the Company. Restricted stock awards subject to performance standards are not considered outstanding for purposes of determining earnings per share until the performance objectives have been satisfied.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Restricted stock outstanding under the 2000 Plan as of December 31, 2007, and changes during each of the years in the three-year period ended December 31, 2007 were as follows:

	Shares	Weighted Average Fair Value
Unvested at December 31, 2004	—	$ —
Granted	563,000	32.37
Vested	—	—
Forfeited	(5,000)	32.37
Unvested at December 31, 2005	558,000	32.37
Granted	606,000	38.26
Vested	(185,975)	32.43
Forfeited	(8,334)	35.93
Unvested at December 31, 2006	969,691	36.05
Granted	1,392,000	38.70
Vested	(384,646)	35.47
Forfeited	(20,502)	36.73
Unvested at December 31, 2007	1,956,543	38.04

As of December 31, 2007, there was $50.3 million of unrecognized stock-based compensation expense related to unvested restricted stock expected to be recognized over a weighted-average period of 17.2 months.

Under the Director's Fee Deferral Plan, the Company's outside directors may elect to receive share equivalent units in lieu of cash for their director's fee. These units are held in the plan until the director electing to receive the share equivalent units retires or otherwise terminates his/her directorship with the Company. Share equivalent units are converted to shares of common stock of the Company at the time of distribution. The following table represents the amount of directors' fees which were deferred and the equivalent units into which they converted for each of the respective periods:

	Year Ended December 31,	
	2007	2006
Directors' fees earned and deferred into plan	$ 129,000	$ 177,500
Equivalent units	3,622.531	4,843.449

At December 31, 2007, there are a total of 13,408.532 units deferred in the plan with an aggregate fair value of $0.5 million, based on the closing market price of the Company's common stock at December 31, 2007 of $36.86.

3. Long-Term Leases, Acquisitions and Divestitures of Hospitals

Triad Acquisition

On July 25, 2007, the Company completed its acquisition of Triad. Triad owned and operated 50 hospitals in 17 states as well as the Republic of Ireland in non-urban and middle market communities. Immediately following the acquisition, on a combined basis the Company owned and operated 128 hospitals in 28 states as well as the Republic of Ireland. As of December 31, 2007, two hospitals acquired from Triad have been sold and six hospitals acquired from Triad were classified as held for sale. As a result of its acquisition of Triad,

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

the Company also provides management and consulting services to independent hospitals, through its subsidiary, Quorum Health Resources, LLC, on a contract basis. The Company acquired Triad for approximately $6.836 billion, including the assumption of $1.686 billion of existing indebtedness. Prior to entering the merger agreement, Triad terminated an Agreement and Plan of Merger that it had entered into on February 4, 2007 (the "Prior Merger Agreement") with Panthera Partners, LLC, Panthera Holdco Corp. and Panthera Acquisition Corporation (collectively, "Panthera"). Concurrent with the termination of the Prior Merger Agreement and pursuant to the terms thereof, Triad paid a termination fee of $20 million and out-of-pocket expenses of $18.8 million to Panthera. The Company reimbursed Triad for the termination fee and the advance for expense reimbursement paid to Panthera. These amounts are included in the allocated purchase price of Triad.

In connection with the consummation of the acquisition of Triad, the Company obtained $7.215 billion of senior secured financing under a new credit facility (the "New Credit Facility") and its wholly-owned subsidiary CHS/Community Health Systems, Inc. ("CHS/Community Health") issued $3.021 billion aggregate principal amount of 8.875% senior notes due 2015 (the "Notes"). The Company used the net proceeds of $3.000 billion from the Notes offering and the net proceeds of $6.065 billion of term loans under the New Credit Facility to acquire the outstanding shares of Triad, to refinance certain of Triad's indebtedness and the Company's indebtedness, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. This New Credit Facility also provides an additional $750 million revolving credit facility and a $400 million delayed draw term loan facility for future acquisitions, working capital and general corporate purposes. As of December 31, 2007, the $400 million delayed draw term loan had been reduced to $300 million at the request of the Company.

The total cost of the Triad acquisition has been allocated to the assets acquired and liabilities assumed based upon their respective preliminary estimated fair values in accordance with SFAS No. 141. The purchase price represented a premium over the fair value of the net tangible and identifiable intangible assets acquired for reasons such as:

- strategically, Triad had operations in five states in which the Company previously had no operations;
- the combined company has smaller concentrations of credit risk through greater geographic diversification;
- many support functions will be centralized; and
- duplicate corporate functions will be eliminated.

The allocation process requires the analysis of acquired fixed assets, contracts, contractual commitments, and legal contingencies to identify and record the fair value of all assets acquired and liabilities assumed. Because of the significance of the transaction and proximity to the end of the current year, the values of certain assets and liabilities are based on preliminary valuations and are subject to adjustment as additional information is obtained. Such additional information includes, but is not limited to: valuations and physical counts of property and equipment, valuation of equity investments and intangible assets, valuation of contractual commitments, finalization of involuntary termination of employees, and review of open cost report settlement periods. The Company is also negotiating the termination of certain assumed contracts it deems unfavorable, such as various physician and service contracts. Under GAAP, the Company has up to twelve months from the closing of the acquisition to complete its valuations and complete contract terminations in order for these terminations to be considered in the allocation process. The Company expects to complete the allocation of the total cost of the Triad acquisition in the second quarter of 2008. Material adjustments to goodwill may result upon the completion of these matters.

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Other Acquisitions

Effective April 1, 2007, the Company completed its acquisition of Lincoln General Hospital (157 licensed beds), located in Ruston, Louisiana. The total consideration for this hospital was approximately $48.7 million, of which $44.8 million was paid in cash and $3.9 million was assumed in liabilities. On May 1, 2007, the Company completed its acquisition of Porter Health, (301 licensed beds), located in Valparaiso, Indiana, with a satellite campus in Portage, Indiana and outpatient medical campuses located in Chesterton, Demotte, and Hebron, Indiana. As part of this acquisition, the Company has agreed to construct a 225-bed replacement facility for the Valparaiso hospital no later than April 2011. The total consideration for Porter Health was approximately $110.1 million, of which $88.9 million was paid in cash and $21.2 million was assumed in liabilities. The Company has estimated its purchase price allocation relating to these acquisitions resulting in approximately $1.5 million of goodwill being recorded. These allocations are preliminary pending, among other things, finalization of valuation of tangible and intangible assets. These acquisition transactions were accounted for using the purchase method of accounting. The allocation of the purchase price has been determined by the Company based upon available information and is subject to settling amounts related to purchased working capital and in some instances final appraisals. Adjustments to the purchase price allocation are not expected to be material.

During 2006, the Company acquired through 7 separate purchase transactions and three capital lease transactions, substantially all of the assets and working capital of eight hospitals and three home health agencies. On March 1, 2006, the Company acquired, through a combination of purchasing certain assets and entering into a capital lease for other related assets, Forrest City Hospital, a 118 bed hospital located in Forrest City, Arkansas. On April 1, 2006, the Company completed the acquisition of two hospitals from Baptist Health System, Birmingham, Alabama: Baptist Medical Center — DeKalb (134 beds) and Baptist Medical Center — Cherokee (60 beds). On May 1, 2006, the Company acquired Via Christi Oklahoma Regional Medical Center, a 140 bed hospital located in Ponca City, Oklahoma. On June 1, 2006, the Company acquired Mineral Area Regional Medical Center, a 135 bed hospital located in Farmington, Missouri. On June 30, 2006 the Company acquired Cottage Home Options, a home health agency and related business, located in Galesburg, Illinois. On July 1, 2006, the Company acquired the healthcare assets of Vista Health, which included Victory Memorial Hospital (336 beds) and St. Therese Medical Center (71 non-acute care beds), both located in Waukegan, Illinois. On September 1, 2006, the Company acquired Humble Texas Home Care, a home health agency located in Humble, Texas. On October 1, 2006, the Company acquired Helpsource Home Health, a home health agency located in Wichita Falls, Texas. On November 1, 2006 the Company acquired through two separate capital lease transactions, Campbell Memorial Hospital, a 99 bed hospital located in Weatherford, Texas and Union County Hospital, a 25 bed hospital located in Anna, Illinois. The aggregate consideration for these eight hospitals and three home health agencies totaled approximately $385.7 million, of which $353.8 million was paid in cash and $31.9 million was assumed in liabilities. Goodwill recognized in these transactions totaled $65.6 million, which is expected to be fully deductible for tax purposes.

During 2005, the Company acquired through four separate purchase transactions and one capital lease transaction, substantially all of the assets and working capital of five hospitals. On March 1, 2005, the Company acquired an 85% controlling interest in Chestnut Hill Hospital, a 222 bed hospital located in Philadelphia, Pennsylvania. On June 30, 2005, the Company acquired, through a capital lease, Bedford County Medical Center, a 104 bed hospital located in Shelbyville, Tennessee. On September 30, 2005, the Company acquired the assets of Newport Hospital and Clinic located in Newport, Arkansas. This facility, which was previously operated as an 83 bed acute care general hospital, was closed by its former owner simultaneous with this transaction. The operations of this hospital were consolidated with Harris Hospital, also located in Newport, which is owned and operated by a wholly owned subsidiary of the Company. On October 1, 2005, the Company acquired Sunbury Community Hospital, a 123 bed hospital located in Sunbury, Pennsylvania, and Bradley Memorial Hospital, a 251 bed hospital located in Cleveland, Tennessee. The aggregate consideration for the five hospitals totaled approximately $176 million, of which $138 million was paid in cash and

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$38 million was assumed in liabilities. Goodwill recognized in these transactions totaled approximately $51 million, which is expected to be fully deductible for tax purposes.

The 2006 and 2005 acquisition transactions were accounted for using the purchase method of accounting. The final allocation of the purchase price for these acquisitions was determined by the Company within one year of the date of acquisition.

The table below summarizes the allocations of the purchase price (including assumed liabilities) for these acquisitions (in thousands):

	2007	2006	2005
Current assets	$ 1,675,392	$ 56,896	$ 19,144
Property and equipment	3,699,200	262,335	110,854
Goodwill and other intangibles	3,111,711	66,490	43,619
Liabilities	1,479,462	27,247	30,786

The operating results of the foregoing hospitals have been included in the consolidated statements of income from their respective dates of acquisition. The following pro forma combined summary of operations of the Company gives effect to using historical information of the operations of the hospitals purchased in 2007 and 2006 as if the acquisitions had occurred as of January 1, 2006 (in thousands except per share data):

	Year Ended December 31,	
	2007	2006
Pro forma net operating revenues	$ 9,623,221	$ 9,245,489
Pro forma net income (loss)	(95,598)	150,626
Pro forma net income per share:		
Basic	$ (1.02)	$ 1.59
Diluted	$ (1.01)	$ 1.57

Pro forma adjustments to net income (loss) include adjustments to depreciation and amortization expense, net of the related tax effect, based on the estimated fair value assigned to the long-lived assets acquired, and to interest expense, net of the related tax effect, assuming the increase in long-term debt used to fund the acquisitions had occurred as of January 1, 2006. The pro forma net income for the year ended December 31, 2007, includes a charge for the early extinguishment of debt of $27.3 million before taxes and $17.5 million after tax, or $0.19 per share (diluted). The pro forma results do not include transaction costs incurred by Triad prior to the date of acquisitions related to cost savings or other synergies that are anticipated as a result of this acquisition. These pro forma results are not necessarily indicative of the actual results of operations.

Discontinued Operations

Effective November 30, 2007, the Company sold Barberton Citizens Hospital (312 licensed beds) located in Barberton, Ohio to Summa Health System of Akron, Ohio. The proceeds from this sale were $53.8 million.

Effective October 31, 2007, the Company sold its 60% membership interest in Northeast Arkansas Medical Center ("NEA"), a 104 bed facility in Jonesboro, Arkansas to Baptist Memorial Health Care ("Baptist"), headquartered in Memphis, Tennessee for $16.8 million. In connection with this transaction, the Company also sold real estate and other assets to a subsidiary of Baptist for $26.2 million.

Effective September 1, 2007, the Company sold its partnership interest in River West L.P., which owned and operated River West Medical Center (an 80 bed facility located in Plaquemine, Louisiana) to an affiliate of Shiloh Health Services, Inc. of Lubbock, Texas. The proceeds from this sale were $0.3 million.

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Effective March 18, 2006, the Company sold Highland Medical Center, a 123-bed facility located in Lubbock, Texas, to Shiloh Health Services, Inc. of Louisville, Kentucky. The proceeds from this sale were $0.5 million. This hospital had previously been classified as held for sale.

Effective January 31, 2005, the Company's lease of Scott County Hospital, a 99 bed facility located in Oneida, Tennessee, expired pursuant to its terms.

Effective March 31, 2005, the Company sold The King's Daughters Hospital, a 137 bed facility located in Greenville, Mississippi, to Delta Regional Medical Center, also located in Greenville, Mississippi. In a separate transaction, also effective March 31, 2005, the Company sold Troy Regional Medical Center, a 97 bed facility located in Troy, Alabama, Lakeview Community Hospital, a 74 bed facility located in Eufaula, Alabama and Northeast Medical Center, a 75 bed facility located in Bonham, Texas to Attentus Healthcare Company of Brentwood, Tennessee. The aggregate sales price for these four hospitals was approximately $52.0 million and was received in cash.

As of December 31, 2007, the Company had classified as held for sale 12 hospitals with an aggregate total of 1,690 licensed beds.

In connection with management's decision to sell the previously mentioned facilities and in accordance with SFAS No. 144, the Company has classified the results of operations of the above mentioned hospitals as discontinued operations in the accompanying consolidated statements of income.

Net operating revenues and loss reported for the fifteen hospitals in discontinued operations are as follows:

	Year Ended December 31,		
	2007	2006	2005
		(In thousands)	
Net operating revenues	$ 417,677	$ 189,734	$ 212,723
Loss from operations of hospitals sold or held for sale before income taxes	(14,735)	(10,694)	(13,395)
Loss on sale of hospitals and partnership interests	(3,954)	(3,938)	(6,295)
Impairment of long-lived assets of hospital held for sale	(19,044)	—	(6,718)
Loss from discontinued operations, before taxes	(37,733)	(14,632)	(26,408)
Income tax benefit	8,125	5,200	5,582
Loss from discontinued operations, net of tax	$ (29,608)	$ (9,432)	$ (20,826)

Included in the computation of the loss from discontinued operations, before taxes for the year ended December 31, 2007, is a write-off of $4.0 million of tangible assets and $0.1 million of goodwill for the partnership and membership interests sold and the two hospitals sold and an estimated impairment of $19.0 million on long-lived assets at the hospitals held for sale (see Note 4 Goodwill and Other Intangible Assets).

The computation of loss from discontinued operations, before taxes, for the year ended December 31, 2006, includes the net write-off of $4.4 million of tangible assets at the one hospital sold during the year ended December 31, 2006. Interest expense was allocated to discontinued operations based on estimated sales proceeds available for debt repayment.

The computation of loss from discontinued operations, before taxes, for the year ended December 31, 2005, includes the net write-off of $51.5 million of tangible assets and $17.1 million of goodwill of the four hospitals sold and one hospital designated as held for sale in the second quarter of 2005.

The assets and liabilities of the hospitals held for sale as of December 31, 2007 are included in the accompanying consolidated balance sheet as follows (in thousands): current assets of $118,893, included in other current assets; net property and equipment of $331,139 and other long-term assets of $31,407, included in other assets; and current liabilities of $67,606, included in other accrued liabilities. The assets and liabilities of hospitals classified as held for sale at December 31, 2007 have not been reclassified as of December 31, 2006 in the accompanying consolidated balance sheet.

4. Goodwill and Other Intangible Assets

The changes in the carrying amount of goodwill are as follows (in thousands):

	Year Ended December 31, 2007	2006
Balance, beginning of year	$ 1,336,525	$ 1,259,816
Goodwill acquired as part of acquisitions during the year	2,912,392	67,550
Consideration adjustments and finalization of purchase price allocations for prior year's acquisitions	22,053	9,159
Goodwill related to hospital operations segment written off as part of disposals	(1,913)	—
Goodwill related to hospital operations segment assigned to disposal group classified as held for sale	(21,343)	—
Balance, end of year	$ 4,247,714	$ 1,336,525

SFAS No. 142 requires that goodwill be allocated to each identified reporting unit, which is defined as an operating segment or one level below the operating segment (referred to as a component of the entity). As a result of the change in the Company's operating segments as discussed in Note 1, management has re-evaluated the determination of our reporting units identified for allocation of goodwill in accordance with SFAS No. 142 and determined that the operating segments meet the criteria to be classified as reporting units. At September 30, 2007, goodwill, except for the amount related to the former Triad hospitals, was reallocated among the hospital operations and home health agencies operations reporting units. At December 31, 2007, the hospital operations reporting unit had $1.309 billion and the home health agencies reporting unit had $32.2 million of goodwill. No goodwill has been allocated to the hospital management services segment as of December 31, 2007 because that business relates entirely to the Triad acquisition. Goodwill related to the former Triad hospitals of $2.907 billion has not been allocated to the reporting unit level as of December 31, 2007 because the final purchase price allocation has not been completed (see Note 3).

The Company performed its annual goodwill evaluation, as required by SFAS No. 142 as of September 30, 2007, using the new segment and reporting units. No impairment was indicated by this evaluation. The Company will continue to perform its goodwill evaluation analysis as of September 30th.

Approximately $180.9 million of intangible assets were acquired during the year ended December 31, 2007. The gross carrying amount of the Company's other intangible assets was $194.6 million and $13.7 million as of December 31, 2007 and 2006, respectively, and the net carrying amount was $181.0 million and $7.4 million as of December 31, 2007 and 2006, respectively. Substantially all of the other intangible assets are finite lived and subject to amortization. Other intangible assets are included in other assets on the Company's consolidated balance sheets.

The weighted average amortization period for the intangible assets subject to amortization is approximately 8 years. There are no expected residual values related to these intangible assets. Amortization expense for these intangible assets was $2.7 million, $1.9 million and $1.3 million during the years ended December 31, 2007, 2006 and 2005, respectively. Amortization expense on intangible assets is estimated to be $14.8 million

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in 2008, $13.9 million in 2009, $13.3 million in 2010, $11.9 million in 2011, $8.4 million in 2012 and $0.3 million thereafter.

5. Income Taxes

The provision for income taxes for income from continuing operations consists of the following (in thousands):

	Year Ended December 31,		
	2007	2006	2005
Current			
Federal	$ 27,416	$ 120,209	$ 101,371
State	11,411	13,555	12,746
	38,827	133,764	114,117
Deferred			
Federal	6,944	(21,793)	3,987
State	(2,768)	(1,819)	1,700
	4,176	(23,612)	5,687
Total provision for income taxes for income from continuing operations	$ 43,003	$ 110,152	$ 119,804

The following table reconciles the differences between the statutory federal income tax rate and the effective tax rate (dollars in thousands):

	Year Ended December 31,					
	2007		2006		2005	
	Amount	%	Amount	%	Amount	%
Provision for income taxes at statutory federal rate	$ 36,015	35.0%	$ 100,746	35.0%	$ 107,861	35.0%
State income taxes, net of federal income tax benefit	5,618	5.5	7,628	2.7	9,390	3.0
Change in valuation allowance	3,825	3.7	—	—	—	—
Federal and state tax credits	(2,625)	(2.6)	—	—	—	—
Other	170	0.2	1,778	0.6	2,553	0.8
Provision for income taxes and effective tax rate for income from continuing operations	$ 43,003	41.8%	$ 110,152	38.3%	$ 119,804	38.8%

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Deferred income taxes are based on the estimated future tax effects of differences between the financial statement and tax bases of assets and liabilities under the provisions of the enacted tax laws. Deferred income taxes as of December 31, consist of (in thousands):

	2007		2006	
	Assets	Liabilities	Assets	Liabilities
Net operating loss and credit carryforwards	$ 75,879	$ —	$ 26,709	$ —
Property and equipment	—	464,753	—	136,249
Self-insurance liabilities	100,642	—	35,607	—
Intangibles	—	139,757	—	101,569
Other liabilities	—	19,076	—	2,879
Long-term debt and interest	—	42,447	989	—
Accounts receivable	104,727	—	33,535	—
Accrued expenses	21,928	—	20,362	—
Other comprehensive income	58,933	—	—	1,952
Stock-Based compensation	54,464	—	6,353	—
Other	23,812	—	12,078	—
	440,385	666,033	135,633	242,649
Valuation allowance	(68,558)	—	(21,207)	—
Total deferred income taxes	$ 371,827	$ 666,033	$ 114,426	$ 242,649

Management believes that the net deferred tax assets will ultimately be realized, except as noted below. Management's conclusion is based on its estimate of future taxable income and the expected timing of temporary difference reversals. The Company has state net operating loss carry forwards of approximately $1.223 billion, which expire from 2008 to 2027. With respect to the deferred tax liability pertaining to intangibles, as included above, goodwill purchased in connection with certain of the Company's business acquisitions is amortizable for income tax reporting purposes. However, for financial reporting purposes, there is no corresponding amortization allowed with respect to such purchased goodwill.

The valuation allowance increased by $47.4 million and $0.1 million during the years ended December 31, 2007 and 2006, respectively. In addition to amounts previously discussed, the change in valuation allowance relates to a redetermination of the amount of, and realizability of, net operating losses in certain state and foreign income tax jurisdictions. In addition, as a result of the additional interest expense to be incurred resulting from the Triad acquisition, the Company determined that certain of its state net operating losses will expire before being utilized resulting in the recording of a valuation allowance of approximately $16.4 million. The results of this change in the valuation allowance impacted goodwill from the acquisition.

The Company adopted the provisions of FIN 48, on January 1, 2007. The total amount of unrecognized benefit that would affect the effective tax rate, if recognized, is approximately $5.7 million as of December 31, 2007. It is the Company's policy to recognize interest and penalties accrued related to unrecognized benefits in its statement of operations as income tax expense. During the year ended December 31, 2007, the Company recorded approximately $2.4 million in liabilities and $0.6 million in interest and penalties related to prior state income tax returns through its income tax provision from continuing operations and which are included in its FIN 48 liability at December 31, 2007. A total of approximately $1.8 million of interest and penalties is included in the amount of FIN 48 liability at December 31, 2007. During the year ended December 31, 2007, the Company released $5.2 million plus accrued interest of $0.8 million of its FIN 48 liability, as a result of the expiration of the statute of limitations pertaining to tax positions taken in prior years relative to legal settlements and $1.5 million relative to state tax positions. During the year ending December 31, 2007, the

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Company's FIN 48 liability decreased approximately $3.5 million due to an income tax examination settlement of the federal tax returns of the former Triad hospitals for the short taxable years ended April 27, 2001, June 30, 2001 and December 31, 2001, and the taxable years ended December 31, 2002 and 2003. The financial statement impact of this settlement impacted goodwill.

The Company's unrecognized tax benefits consist primarily of state exposure items. The Company believes that it is reasonably possible that approximately $1.1 million of its current unrecognized tax benefit may be recognized within the next twelve months as a result of a lapse of the statute of limitations and settlements with taxing authorities.

The following is a tabular reconciliation of the total amount of unrecognized tax benefit for the year ended December 31, 2007 (in thousands):

	Year Ended December 31, 2007
Unrecognized Tax Benefit at January 1, 2007	$ 10,510
Gross increases — purchase business combination	10,160
Gross increases — tax positions in current period	1,930
Gross increases — tax positions in prior period	1,820
Lapse of statute of limitations	(6,700)
Settlements	(2,840)
Unrecognized Tax Benefit at December 31, 2007	$ 14,880

The Company or one of its subsidiaries files income tax returns in the U.S. federal jurisdiction and various state jurisdictions. With few exceptions, the Company is no longer subject to U.S. federal or state income tax examinations for years prior to 2003. During 2006, the Company agreed to a settlement at the Internal Revenue Service (the "IRS") Appeals Office with respect to the 2003 tax year. The Company has since received a closing letter with respect to the examination for that tax year. The settlement was not material to the Company's results of operations or financial position.

The IRS has concluded an examination of the federal income tax returns of Triad for the short taxable years ended April 27, 2001, June 30, 2001 and December 31, 2001, and the taxable years ended December 31, 2002 and 2003. On May 10, 2006, the IRS issued an examination report with proposed adjustments. Triad filed a protest on June 9, 2006 and the matter was referred to the IRS Appeals Office. Representatives of the former Triad hospitals met with the IRS Appeals Office in April 2007 and reached a tentative settlement. Triad has since received a closing letter with respect to the examination for those tax years. The settlement was not material to the Company's results of operations or financial position.

The Company paid income taxes, net of refunds received, of $85.2 million, $128.1 million and $68.1 million during 2007, 2006, and 2005, respectively.

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6. Long-Term Debt

Long-term debt consists of the following (in thousands):

	As of December 31, 2007	As of December 31, 2006
Credit Facilities:		
Term loans	$ 5,965,000	$ 1,572,000
Revolving credit loans	—	—
Tax-exempt bonds	8,000	8,000
Senior subordinated notes	3,021,331	300,000
Capital lease obligations (see Note 8)	35,136	44,670
Other	68,610	16,507
Total debt	9,098,077	1,941,177
Less current maturities	(20,710)	(35,396)
Total long-term debt	$ 9,077,367	$ 1,905,781

Terminated Credit Facility and Notes

On August 19, 2004, the Company entered into a $1.625 billion senior secured credit facility with a consortium of lenders which was subsequently amended on December 16, 2004, July 8, 2005 and December 13, 2006 (the "Terminated Credit Facility"). The purpose of the Terminated Credit Facility was to refinance and replace the Company's previous credit agreement, repay specified other indebtedness, and fund general corporate purposes, including amending the credit facility to permit declaration and payment of cash dividends, to repurchase shares or make other distributions, subject to certain restrictions. The Terminated Credit Facility consisted of a $1.2 billion term loan that was due to mature in 2011 and a $425 million revolving credit facility that was due to mature in 2009. The First Incremental Facility Amendment, dated as of December 13, 2006, increased the Company's term loans by $400 million (the "Incremental Term Loan Facility") and also gave the Company the ability to add up to $400 million of additional term loans. The full amount of the Incremental Term Loan Facility was funded on December 13, 2006, and the proceeds were used to repay the full outstanding amount (approximately $326 million) of the revolving credit facility under the credit agreement and the balance was available to be used for general corporate purposes. The Company was able to elect from time to time an interest rate per annum for the borrowings under the term loan, including the incremental term loan, and revolving credit facility equal to (a) an alternate base rate, which would have been equal to the greatest of (i) the Prime Rate (as defined) in effect and (ii) the Federal Funds Effective Rate (as defined), plus 50 basis points, plus (1) 75 basis points for the term loan and (2) the Applicable Margin (as defined) for revolving credit loans or (b) the Eurodollar Rate (as defined) plus (1) 175 basis points for the term loan and (2) the Applicable Margin for Eurodollar revolving credit loans. The Company also paid a commitment fee for the daily average unused commitments under the revolving credit facility. The commitment fee was based on a pricing grid depending on the Applicable Margin for Eurodollar revolving credit loans and ranged from 0.250% to 0.500%. The commitment fee was payable quarterly in arrears and on the revolving credit termination date with respect to the available revolving credit commitments. In addition, the Company paid fees for each letter of credit issued under the credit facility.

On December 16, 2004, the Company issued $300 million 61/2% senior subordinated notes due 2012. On April 8, 2005, the Company exchanged these notes for notes having substantially the same terms as the outstanding notes, except the exchanged notes were registered under the Securities Act of 1933, as amended (the "1933 Act").

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New Credit Facility and Notes

On July 25, 2007, the New Credit Facility was entered into with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The New Credit Facility consists of a $6.065 billion funded term loan facility with a maturity of seven years, a $400 million delayed draw term loan facility with a maturity of seven years and a $750 million revolving credit facility with a maturity of six years. The revolving credit facility also includes a subfacility for letters of credit and a swingline subfacility. As previously disclosed, in connection with the consummation of the acquisition of Triad, the Company used a portion of the net proceeds from its New Credit Facility and the Notes offering to repay its outstanding debt under the Terminated Credit Facility. The Company recorded a pre-tax write-off of approximately $13.9 million in deferred loan costs relative to the early extinguishment of the debt under the Terminated Credit Facility and incurred tender and solicitation fees of approximately $13.4 million on the early repayment of the Company's $300 million aggregate principal amount of 6 1/2% Senior Subordinated Notes due 2012 through a cash tender offer and consent solicitation.

The New Credit Facility requires the Company to make quarterly amortization payments of each term loan facility equal to 0.25% of the outstanding amount of the term loans, if any, with the outstanding principal balance payable on July 25, 2014.

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

The obligor under the New Credit Facility is CHS/Community Health. All of the obligations under the New Credit Facility are unconditionally guaranteed by the Company and certain existing and subsequently acquired or organized domestic subsidiaries. All obligations under the New Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of the Company, CHS/Community Health and each subsidiary guarantor, including equity interests held by the Company, CHS/Community Health or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries.

The loans under the New Credit Facility will bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at the Company's option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus one-half of 1.0%, or (b) a reserve adjusted London interbank offered rate for dollars (Eurodollar Rate) (as defined). The applicable percentage for term loans is 1.25% for Alternate Base Rate loans and 2.25% for Eurodollar rate loans. The applicable percentage for revolving loans is initially 1.25% for Alternate Base Rate revolving loans and 2.25% for Eurodollar revolving loans, in each case subject to reduction based on the Company's leverage ratio. Loans under the swingline subfacility bear interest at the rate applicable to alternative base rate loans under the revolving credit facility.

The Company has agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to Eurodollar rate loans under the revolving credit facility times the maximum aggregate amount available to be drawn under all letters of credit outstanding under the subfacility for letters of credit. The

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

issuer of any letter of credit issued under the subfacility for letters of credit will also receive a customary fronting fee and other customary processing charges. The Company is also obligated to pay commitment fees of 0.50% per annum (subject to reduction based upon the Company's leverage ratio) on the unused portion of the revolving credit facility. For purposes of this calculation, swingline loans are not treated as usage of the revolving credit facility. The Company is also obligated to pay commitment fees of 0.50% per annum for the first six months after the closing of the New Credit Facility, 0.75% per annum for the next three months thereafter and 1.0% per annum thereafter, in each case on the unused amount of the delayed draw term loan facility. The Company paid arrangement fees on the closing of the New Credit Facility and will pay an annual administrative agent fee.

The New Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting, subject to certain exceptions, the Company's and its subsidiaries' ability to, among other things (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of the Company's businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change the Company's fiscal year. The Company is also required to comply with specified financial covenants (consisting of a leverage ratio and an interest coverage ratio) and various affirmative covenants.

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

The Notes were issued by CHS/Community Health in connection with the Triad acquisition in the principal amount of $3.021 billion. These Notes will mature on July 15, 2015. The Notes bear interest at the rate of 8.875% per annum, payable semiannually in arrears on January 15 and July 15, commencing January 15, 2008. Interest on the Notes accrue from the date of original issuance. Interest will be calculated on the basis of 360-day year comprised of twelve 30-day months.

Except as set forth below, CHS/Community Health is not entitled to redeem the Notes prior to July 15, 2011.

On and after July 15, 2011, CHS/Community Health is entitled, at its option, to redeem all or a portion of the Notes upon not less than 30 nor more than 60 days notice, at the redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the 12-month period commencing on July 15 of the years set forth below:

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

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

In addition, any time prior to July 15, 2010, CHS/Community Health is entitled, at its option, on one or more occasions to redeem the Notes (which include additional Notes (the "Additional Notes"), if any which may be issued from time to time under the indenture under which the Notes were issued) in an aggregate principal amount not to exceed 35% of the aggregate principal amount of the Notes (which includes Additional Notes, if any) originally issued at a redemption price (expressed as a percentage of principal amount) of 108.875%, plus accrued and unpaid interest to the redemption date, with the Net Cash Proceeds (as defined) from one or more Public Equity Offerings (as defined) (provided that if the Public Equity Offering is an offering by the Company, a portion of the Net Cash Proceeds thereof equal to the amount required to redeem any such Notes is contributed to the equity capital of CHS/Community Health); provided, however, that:

1) at least 65% of such aggregate principal amount of Notes originally issued remains outstanding immediately after the occurrence of each such redemption (other than the Notes held, directly or indirectly, by the Company or its subsidiaries); and

2) each such redemption occurs within 90 days after the date of the related Public Equity Offering.

CHS/Community Health is entitled, at its option, to redeem the Notes, in whole or in part, at any time prior to July 15, 2011, upon not less than 30 or more than 60 days notice, at a redemption price equal to 100% of the principal amount of Notes redeemed plus the Application Premium (as defined), and accrued and unpaid interest, if any, as of the applicable redemption date.

Pursuant to a registration rights agreement entered into at the time of the issuance of the Notes, CHS/Community Health commenced an offer (the "Exchange Offer") on October 9, 2007, to exchange the Notes for new notes (the "Exchange Notes") having terms substantially identical in all material respects to the Notes (except that the Exchange Notes will be issued under a registration statement pursuant to the 1933 Act.) This registration statement was declared effective by the SEC on October 9, 2007. The Exchange Offer expired on November 13, 2007. The Exchange Offer was consummated on November 19, 2007.

As of December 31, 2007, the Company's availability for additional borrowings under its New Credit Facility was $1.050 billion (consisting of a $750 million revolving credit facility and a $300 million delayed draw term loan facility), of which $36 million was set aside for outstanding letters of credit. The Company also has the ability to add up to $300 million of borrowing capacity from receivable transactions (including securitizations) under the New Credit Facility which has not yet been accessed. The Company also has the ability to amend the New Credit Facility to provide for one or more tranches of term loans in an aggregate principal amount of $600 million, which the Company has not yet accessed. As of December 31, 2007, the Company's weighted-average interest rate under the New Credit Facility was 7.78%.

The Term Loans are scheduled to be paid with principal payments for future years as follows (in thousands):

	Term Loans
2008	$ —
2009	36,463
2010	60,650
2011	60,650
2012	60,650
Thereafter	5,746,587
Total	$ 5,965,000

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

As of December 31, 2007 and 2006, the Company had letters of credit issued, primarily in support of potential insurance related claims and certain bonds of approximately $36 million and $21 million, respectively.

Tax-Exempt Bonds. Tax-Exempt Bonds bore interest at floating rates, which averaged 3.69% and 3.51% during 2007 and 2006, respectively.

Senior Subordinated Notes. On December 16, 2004, the Company completed a private placement offering of $300 million aggregate principal amount of 6.5% senior subordinated notes due 2012. The senior subordinated notes were sold in an offering pursuant to Rule 144A and Regulation S under the 1933 Act. The senior subordinated notes when issued were registered under the 1933 Act or the securities laws of any state and may not be offered or sold in the United States absent registration or an applicable exemption from the registration requirements under the 1933 Act and any applicable state securities laws. On February 24, 2005, the Company filed a registration statement to exchange these notes for registered notes. This exchange was completed during the first quarter of 2005.

In connection with the consummation of the acquisition of Triad, the Company completed an early repayment of the $300 million aggregate principal amount of 61/2% Senior Subordinated Notes due 2012 through a cash tender offer and consent solicitation.

As previously described, in connection with the Triad acquisition, the Company issued $3.021 billion principal amount of Notes. These Notes bear interest at 8.875% interest and mature on July 15, 2015.

Other Debt. As of December 31, 2007, other debt consisted primarily of an industrial revenue bond, the mortgage obligation on the Company's corporate headquarters and other obligations maturing in various installments through 2017.

The Company is currently a party to 29 separate interest swap agreements with an aggregate notional amount of $4.050 billion, to limit the effect of changes in interest rates on a portion of the Company's long-term borrowings. On each of these swaps, the Company receives a variable rate of interest based on the three-month London Inter-Bank Offer Rate ("LIBOR") in exchange for the payment of a fixed rate of interest. The Company currently pays, on a quarterly basis, a margin above LIBOR of 225 basis points for revolver loans and term loans under the senior secured credit facility. See footnote 7 for additional information regarding these swaps.

As of December 31, 2007, the scheduled maturities of long-term debt outstanding, including capital leases for each of the next five years and thereafter are as follows (in thousands):

2008	$ 20,710
2009	53,887
2010	79,331
2011	70,316
2012	66,517
Thereafter	8,807,316
Total	$ 9,098,077

The Company paid interest of $218 million, $96 million and $90 million on borrowings during the years ended December 31, 2007, 2006 and 2005, respectively.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

7. Fair Values of Financial Instruments

The fair value of financial instruments has been estimated by the Company using available market information as of December 31, 2007 and 2006, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Company could realize in a current market exchange (in thousands):

	As of December 31,			
	2007		2006	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Assets:				
Cash and cash equivalents	$ 132,874	$ 132,874	$ 40,566	$ 40,566
Available-for-sale securities	8,352	8,352	7,620	7,620
Trading securities	38,075	38,075	17,714	17,714
Liabilities:				
Credit facilities	5,965,000	5,733,856	1,572,000	1,573,540
Tax-exempt bonds	8,000	8,000	8,000	8,000
Senior subordinated notes	3,021,331	3,074,204	300,000	295,500
Other debt	68,610	68,610	4,344	4,344

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

Available-for-sale securities. Estimated fair value is based on closing price as quoted in public markets.

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

Credit facilities. Estimated fair value is based on information from the Company's bankers regarding relevant pricing for trading activity among the Company's lending institutions.

Tax Exempt Bonds. The carrying amount approximates fair value as a result of the weekly interest rate reset feature of these publicly-traded instruments.

Senior Subordinated Notes. Estimated fair value is based on the average bid and ask price as quoted by the bank who served as underwriters in the sale of these notes.

Interest Rate Swaps. The fair value of interest rate swap agreements is the amount at which they could be settled, based on estimates obtained from the counterparty. The Company has designated the interest rate swaps as cash flow hedge instruments whose recorded value included in other long-term liabilities in the consolidated balance sheet approximates fair market value.

The Company assesses the effectiveness of its hedge instruments on a quarterly basis. For the years ended December 31, 2007 and 2006, the Company completed an assessment of the cash flow hedge instruments and determined the hedges to be highly effective. The Company has also determined that the ineffective portion of the hedges do not have a material effect on the Company's consolidated financial position, operations or cash flows. The counterparty to the interest rate swap agreements exposes the Company to credit risk in the event of non-performance. However, the Company does not anticipate non-performance by the counterparty. The Company does not hold or issue derivative financial instruments for trading purposes.

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

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Interest rate swaps consisted of the following at December 31, 2007:

Swap #	Notional Amount (In 000's)	Fixed Interest Rate	Termination Date	Fair Value (000's)
1	100,000	4.0610%	May 30, 2008	$ 234
2	100,000	2.4000%	June 13, 2008	989
3	100,000	3.5860%	August 29, 2008	493
4	100,000	3.9350%	June 6, 2009	(119)
5	100,000	4.3375%	November 30, 2009	(1,052)
6	100,000	4.9360%	October 4, 2010	(2,948)
7	100,000	4.7090%	January 24, 2011	(2,479)
8	300,000	5.1140%	August 8, 2011	(12,012)
9	100,000	4.7185%	August 19, 2011	(2,668)
10	100,000	4.7040%	August 19, 2011	(2,353)
11	100,000	4.6250%	August 19, 2011	(2,321)
12	200,000	4.9300%	August 30, 2011	(6,755)
13	200,000	4.4815%	October 26, 2011	(3,706)
14	200,000	4.0840%	December 3, 2011	(907)
15	250,000	5.0185%	May 30, 2012	(9,939)
16	150,000	5.0250%	May 30, 2012	(6,020)
17	200,000	4.6845%	September 11, 2012	(5,255)
18	125,000	4.3745%	November 23, 2012	(1,514)
19	75,000	4.3800%	November 23, 2012	(713)
20	150,000	5.0200%	November 30, 2012	(6,172)
21	100,000	5.0230%	May 30, 2013(1)	(4,043)
22	300,000	5.2420%	August 6, 2013	(15,970)
23	100,000	5.0380%	August 30, 2013(2)	(4,123)
24	100,000	5.0500%	November 30, 2013(3)	(3,871)
25	100,000	5.2310%	July 25, 2014	(5,423)
26	100,000	5.2310%	July 25, 2014	(4,440)
27	200,000	5.1600%	July 25, 2014	(9,965)
28	75,000	5.0405%	July 25, 2014	(3,213)
29	125,000	5.0215%	July 25, 2014	(5,217)

(1) This swap agreement becomes effective May 30, 2008, concurrent with the termination of agreement #1 listed above.

(2) This swap agreement becomes effective June 13, 2008, concurrent with the termination of agreement #2 listed above.

(3) This swap agreement becomes effective September 2, 2008, after the termination of agreement #3 listed above.

Assuming no change in December 31, 2007 interest rates, approximately $2.8 million will be recognized in earnings through interest expense during the year ending December 31, 2008 pursuant to the interest rate swap agreements. If interest rate swaps do not remain highly effective as a cash flow hedge, the derivatives' gains or losses reported through other comprehensive income will be reclassified into earnings.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

8. Leases

The Company leases hospitals, medical office buildings, and certain equipment under capital and operating lease agreements. During 2007, the Company entered into $10.8 million of capital leases and assumed $10.0 million of capital leases in the acquisition of the former Triad hospitals. All lease agreements generally require the Company to pay maintenance, repairs, property taxes and insurance costs. Commitments relating to noncancellable operating and capital leases for each of the next five years and thereafter are as follows (in thousands):

Year Ended December 31,	Operating(1)	Capital
2008	$ 146,084	$ 9,290
2009	124,159	5,854
2010	102,242	4,586
2011	81,083	3,475
2012	65,190	2,755
Thereafter	249,945	21,049
Total minimum future payments	$ 768,703	$ 47,009
Less imputed interest		(11,873)
		35,136
Less current portion		(5,967)
Long-term capital lease obligations		$ 29,169

(1) Minimum lease payments have not been reduced by minimum sublease rentals due in the future of $48.5 million.

Assets capitalized under capital leases as reflected in the accompanying consolidated balance sheets were $23.5 million of land and improvements, $140.1 million of buildings and improvements, and $61.8 million of equipment and fixtures as of December 31, 2007 and $19.2 million of land and improvements, $167.8 million of buildings and improvements and $52.4 million of equipment and fixtures as of December 31, 2006. The accumulated depreciation related to assets under capital leases was $79.9 million and $63.7 million as of December 31, 2007 and 2006, respectively. Depreciation of assets under capital leases is included in depreciation and amortization and amortization of debt discounts on capital lease obligations is included in interest expense in the consolidated statements of income.

9. Employee Benefit Plans

The Company maintains various benefit plans, including defined contribution plans, defined benefit plans and deferred compensation plans. The Company's defined contribution plans consist of one plan that covers substantially all corporate office employees and employees at the Company's hospitals and clinics owned prior to the acquisition of Triad. The other defined contribution plan covers substantially all employees at the former Triad hospitals, clinics and QHR. These plans are qualified under Section 401(k) of the Internal Revenue Code. Participants may contribute a portion of their compensation not exceeding a limit set annually by the Internal Revenue Service. These plans include a provision for the Company to match a portion of employee contributions. In addition, the plan covering the former Triad hospitals provides for a supplementary contribution, determined primarily as a percentage of participants' annual wages. The Company is required to maintain the former Triad plan, including this supplementary contribution benefit, through December 31, 2008. Total expense to the Company under the 401(k) plans was $39.8 million, $10.7 million and $8.8 million for the years ended December 31, 2007, 2006 and 2005, respectively.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

In 2007, the Company merged its three defined benefit, non-contributory pension plans, which covered certain employees at three of its hospitals, into one plan ("Pension plan"). The Pension plan provides benefits to covered individuals satisfying certain age and service requirements. Employer contributions to the Pension plan are in accordance with the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as amended. The Company expects to contribute $3.7 million to the Pension plan in fiscal 2008. The Company also provides an unfunded supplemental executive retirement plan ("SERP") for certain members of its executive management. The Company uses a December 31 measurement date for the benefit obligations and a January 1 measurement date for its net periodic costs for both the Pension plan and SERP. Variances from actuarially assumed rates will result in increases or decreases in benefit obligations, net periodic cost and funding requirements in future periods.

The Company's unfunded deferred compensation plans allow participants to defer receipt of a portion of their compensation. The liability under the deferred compensation plans was $59.4 million as of December 31, 2007 and $17.7 million as of December 31, 2006. The Company had trading securities either restricted or generally designated to pay benefits of the deferred compensation plans in the amounts of $38.1 million and $17.7 million as of December 31, 2007 and 2006, respectively, and available-for-sale securities either restricted or generally designated to pay benefits of the SERP in the amounts of $8.4 million and $7.6 million as of December 31, 2007 and 2006, respectively.

A summary of the benefit obligations and funded status for the Company's pension and SERP plans follows (in thousands):

	Pension Plans		SERP	
	2007	2006	2007	2006
Change in benefit obligation:				
Benefit obligation, beginning of year	$ 26,220	$ 27,467	$ 23,293	$ 22,280
Service cost	3,772	3,757	2,810	3,023
Interest cost	1,587	1,601	1,340	1,225
Plan amendment	—	(5,769)	—	—
Actuarial (gain)/loss	(2,812)	(792)	1,155	(3,235)
Benefits paid	(112)	(44)	—	—
Benefit obligation, end of year	28,655	26,220	28,598	23,293
Change in plan assets:				
Fair value of assets, beginning of year	13,670	12,452	—	—
Actual return on plan assets	834	1,262	—	—
Employer contributions	1,087	—	—	—
Benefits paid	(112)	(44)	—	—
Fair value of assets, end of year	15,479	13,670	—	—
Unfunded status	$ (13,176)	$ (12,550)	$ (28,598)	$ (23,293)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

A summary of the amounts recognized in the accompanying consolidated balance sheets follows (in thousands):

	Pension Plans		SERP	
	2007	2006	2007	2006
Noncurrent Asset	$ —	$ —	$ —	$ —
Current Liability	—	—	—	—
Noncurrent Liability	(13,176)	(12,550)	(28,598)	(23,293)
Net amount recognized in the consolidated balance sheets	$ (13,176)	$ (12,550)	$ (28,598)	$ (23,293)

A summary of the plans' benefit obligation in excess of the fair value of plan assets as of the end of the year follows (in thousands):

	Pension Plans		SERP	
	2007	2006	2007	2006
Projected benefit obligation	$ 28,655	$ 26,220	$ 28,598	$ 23,293
Accumulated benefit obligation	20,587	17,127	18,546	18,214
Fair value of plan assets	15,479	13,670	—	—

A summary of the weighted-average assumptions used by the Company to determine benefit obligations as of December 31 follows:

	Pension Plans		SERP	
	2007	2006	2007	2006
Discount Rate	6.55%	5.73% - 5.95%	6.00%	5.75%
Annual Salary Increases	4.00%	4.00% - 5.00%	5.00%	5.00%

A summary of the amounts recognized in Accumulated Other Comprehensive Income ("AOCI") due to the adoption of SFAS No. 158 "Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans — an amendment of SFAS No. 87, 88, 106 and 132(R)" ("SFAS No. 158") as of December 31, 2006 follows (in thousands):

	Pension Plans	SERP
	2006	2006
Amount recognized in AOCI prior to SFAS 158	$ —	$ —
Amount recognized in AOCI due to adoption of SFAS 158:		
Prior service cost (credit)	3,583	6,586
Net actuarial (gain) loss	141	2,937
Total amount recognized in AOCI	$ 3,724	$ 9,523

A summary of net periodic cost and other amounts recognized in Other Comprehensive Income follows (in thousands):

	Pension Plans			SERP		
	2007	2006	2005	2007	2006	2005
Service cost	$ 3,772	$ 3,757	$ 3,043	$ 2,810	$ 3,023	$ 2,113
Interest cost	1,586	1,601	1,364	1,339	1,225	846
Expected return on plan assets	(1,179)	(1,054)	(706)	—	—	—
Amortization of unrecognized prior service cost	689	1,336	1,336	884	884	884
Amortization of net (gain)/loss	(13)	—	(17)	60	407	55
Net periodic cost	4,855	5,640	5,020	5,093	5,539	3,898
Change in OCI	(3,142)	N/A	N/A	212	N/A	N/A
Total recognized in Net periodic cost and OCI	$ 1,713	$ 5,640	$ 5,020	$ 5,305	$ 5,539	$ 3,898

A summary of the expected amortization amounts to be included in net periodic cost for 2008 are as follows (in thousands):

	Pension Plans	SERP
Prior service cost	$ 689	$ 884
Actuarial (gain)/loss	—	122

A summary of the weighted-average assumptions used by the Company to determine net periodic cost follows:

	Pension Plans			SERP		
	2007	2006	2005	2007	2006	2005
Discount rate	5.94%	5.40% - 5.80%	6.00%	5.75%	5.50%	5.75%
Rate of compensation increase	4.00%	4.00% - 5.00%	4.00%	5.00%	5.00%	5.00%
Expected long term rate of return on assets	8.50%	8.50%	8.50%	N/A	N/A	N/A

The Company's weighted-average asset allocations by asset category for its pension plans as of the end of the year follows:

	Pension Plans		SERP	
	2007	2006	2007	2006
Equity securities	100%	100%	N/A	N/A
Debt securities	0%	0%	N/A	N/A
Total	100%	100%	N/A	N/A

The Company's pension plan assets are invested in mutual funds with an underlying investment allocation of 60% equity securities and 40% debt securities. The expected long-term rate of return for the Company's pension plan assets is based on current expected long-term inflation and historical rates of return on equities and fixed income securities, taking into account the investment policy under the plan. The expected long-term rate of return is weighted based on the target allocation for each asset category. Equity securities are expected to return between 8% and 12% and debt securities are expected to return between 4% and 7%. The Company expects its pension plan asset managers will provide a premium of approximately 0.5% to 1.5% per annum to the respective market benchmark indices.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The Company's investment policy related to its pension plans is to provide for growth of capital with a moderate level of volatility by investing in accordance with the target asset allocations stated above. The Company reviews its investment policy, including its target asset allocations, on a semi-annual basis to determine whether any changes in market conditions or amendments to its pension plans requires a revision to its investment policy.

The estimated future benefit payments reflecting future service as of the end of 2007 for the Company's pension and SERP plans follows (in thousands):

Years Ending	Pension Plans	SERP
2008	$ 271	$ —
2009	372	91
2010	438	91
2011	508	1,539
2012	651	1,591
2013 - 2016	4,611	14,019

10. Stockholders' Equity

Authorized capital shares of the Company include 400,000,000 shares of capital stock consisting of 300,000,000 shares of common stock and 100,000,000 shares of Preferred Stock. Each of the aforementioned classes of capital stock has a par value of $.01 per share. Shares of Preferred Stock, none of which are outstanding as of December 31, 2007 may be issued in one or more series having such rights, preferences and other provisions as determined by the Board of Directors without approval by the holders of common stock.

On January 14, 2006, the Company commenced an open market repurchase program for up to 5,000,000 shares of the Company's common stock, not to exceed $200 million in repurchases. Under this program, the Company repurchased the entire 5,000,000 shares at a weighted average price of $35.23. This program concluded on November 8, 2006 when the maximum number of shares had been repurchased. This repurchase plan followed a prior repurchase plan for up to 5,000,000 shares which concluded on January 13, 2006. The Company repurchased 3,029,700 shares at a weighted average price of $31.20 per share under this program. On December 13, 2006, the Company commenced another open market repurchase program for up to 5,000,000 shares of the Company's common stock not to exceed $200 million in repurchases. This program will conclude at the earlier of three years or when the maximum number of shares have been repurchased. As of December 31, 2007, the Company has not repurchased any shares under this program.

11. Earnings Per Share

The following table sets forth the components of the numerator and denominator for the computation of basic and diluted income from continuing operations per share (in thousands, except share data):

	Year Ended December 31,		
	2007	2006	2005
Numerator:			
Numerator for basic earnings per share —			
Income from continuing operations available to common stockholders — basic	$ 59,897	$ 177,695	$ 188,370
Numerator for diluted earnings per share —			
Income from continuing operations	$ 59,897	$ 177,695	$ 188,370
Interest, net of tax, on 4.25% convertible notes	—	135	8,565
Income from continuing operations available to common stockholders — diluted	$ 59,897	$ 177,830	$ 196,935
Denominator:			
Weighted-average number of shares outstanding — basic	93,517,337	94,983,646	88,601,168
Effect of dilutive securities:			
Non-employee director options	2,957	11,825	11,715
Restricted Stock awards	227,200	140,959	115,411
Employee options	894,800	951,360	1,466,652
4.25% Convertible notes	—	145,120	8,385,031
Weighted-average number of shares outstanding — diluted	94,642,294	96,232,910	98,579,977
Dilutive securities outstanding not included in the computation of earning per share because their effect is antidilutive:			
Employee options	4,398,307	1,261,367	31,100

12. Equity Investments

The Company owns equity interests of 27.5% in four hospitals in Las Vegas, Nevada, and 26.1% in one hospital in Las Vegas, Nevada in which Universal Health Systems, Inc. owns the majority interest; an equity interest of 38.0% in a hospital in Macon, Georgia in which HCA Inc. owns the majority interest; and an equity interest of 50.0% in a hospital in El Dorado, Arkansas in which the SHARE Foundation, a not-for-profit foundation, owns the remaining 50.0%. These equity investments were acquired as part of the acquisition of Triad. The Company uses the equity method of accounting for its investments in these entities. The balance of the Company's investment in unconsolidated affiliates is $267.8 million at December 31, 2007, and is included in other assets in the accompanying consolidated balance sheet. Included in the Company's results of operations for the year ended December 31, 2007, is $25.1 million representing the Company's equity in pre-tax earnings from investments in unconsolidated affiliates for the period July 25, 2007 through December 31, 2007.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Summarized combined financial information for the years ended December 31, 2007 and 2006, for the unconsolidated entities in which the Company owns an equity interest is as follows (in thousands):

	December 31, 2007 (Unaudited)
Current assets	$ 226,458
Noncurrent assets	706,059
	$ 932,517
Current liabilities	$ 81,354
Noncurrent liabilities	3,079
Members' equity	848,084
	$ 932,517

	For the Year Ended December 31, 2007 2007 (Unaudited)
Revenues	$ 1,275,117
Net income	$ 160,802

13. Segment Information

Prior to the acquisition of Triad, the Company aggregated its operating segments into one reportable segment as all of its operating segments had similar services, had similar types of patients, operated in a consistent manner and had similar economic and regulatory characteristics. In connection with the Triad acquisition, management has re-evaluated the information that is reviewed by the chief operating decision maker and segment managers and has determined that the Company now operates in three distinct operating segments, represented by the hospital operations (which includes our acute care hospitals and related healthcare entities that provide acute and outpatient health care services), the home health agencies operations (which provide outpatient care generally at the patient's home), and our hospital management services business (which provides executive management services to non-affliated acute care hospitals). Only the hospital operations segment meets the criteria in SFAS No. 131 as a separate reportable segment. The financial information for the home health agencies and management services segment do not meet the quantitative thresholds defined in SFAS No. 131 and are combined into the corporate and all other reportable segment.

The accounting policies of the segments are the same as those described in the summary of significant accounting policies in Note 1. Expenditures for segment assets are reported on an accrual basis, which includes amounts that are reflected in accounts payable (See Note 1). Substantially all depreciation and amortization as reflected in the consolidated statements of income relates to the hospital operations segment.

The financial information from prior years has been presented to reflect this change in the composition of our reportable operating segments.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The distribution between reportable segments of our revenues, income from continuing operations before income taxes, expenditures for segment assets and total assets is summarized in the following tables (in thousands):

	For the Year Ended December 31, 2007	2006	2005
Revenues:			
Hospital operations	$ 6,965,152	$ 4,101,974	$ 3,516,856
Corporate and all other	162,342	78,162	59,261
	$ 7,127,494	$ 4,180,136	$ 3,576,117
Income from continuing operations before income taxes:			
Hospital operations	$ 256,274	$ 360,576	$ 360,263
Corporate and all other	(153,374)	(72,729)	(52,089)
	$ 102,900	$ 287,847	$ 308,174
Expenditures for segment assets:			
Hospital operations	$ 501,671	$ 232,500	$ 179,680
Corporate and all other	32,464	39,693	20,564
	$ 534,135	$ 272,193	$ 200,244

	December 31, 2007	2006
Total assets:		
Hospital operations	$ 12,176,957	$ 4,082,271
Corporate and all other	1,316,686	424,308
	$ 13,493,643	$ 4,506,579

14. Commitments and Contingencies

Construction Commitments. Pursuant to hospital purchase agreements in effect as of December 31, 2007, and where required certificate of need approval has been obtained, the Company is required to build the following replacement facilities. The Company has agreed, as part of the acquisition in 2003 of Southside Regional Medical Center in Petersburg, Virginia, to build a replacement facility with an aggregate estimated construction cost, including equipment, of approximately $145 million. Of this amount, approximately $98 million has been expended through December 31, 2007. The Company expects to spend approximately $44 million in replacement hospital construction and equipment costs related to this project in 2008. This project is required to be completed in 2008. The Company has agreed, as part of the acquisition in 2004 of Phoenixville Hospital in Phoenixville, Pennsylvania, to spend approximately $90 million in capital expenditures over eight years to develop and improve the hospital; of this amount approximately $25 million has been expended through December 2007. The Company expects to spend approximately $26 million of this commitment in 2008. The Company has agreed as part of the acquisition in 2005 of Chestnut Hill Hospital, in Philadelphia, Pennsylvania to spend approximately $41 million in capital expenditures over four years to develop and improve the hospital; of this amount approximately $13 million has been expended through December 2007. The Company expects to spend approximately $4 million of this commitment in 2008. As part of the acquisition in 2005 of Bedford County Medical Center in Shelbyville, Tennessee, the Company agreed to build a replacement facility with an aggregate estimated construction cost of approximately $35 million. Of this amount, approximately $19 million has been expended through December 31, 2007. The

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Company expects to spend approximately $16 million in replacement hospital construction costs related to this project in 2008. The project is required to be completed by June 30, 2009. As required by an amendment to a lease agreement entered into in 2005, the Company agreed to build a replacement facility at its Barstow, California location. Construction costs for this replacement facility are estimated to be approximately $60 million. Of this amount, approximately $2 million has been expended through December 31, 2007. The Company expects to spend approximately $3 million in replacement hospital construction and equipment costs related to this project in 2008. This project is required to be completed in 2011. The Company has agreed, as part of an acquisition in 2007, to build a replacement hospital in Valparaiso, Indiana with an aggregate estimated construction cost, including equipment costs, of approximately $210 million. Of this amount, an immaterial amount has been expended through December 31, 2007. The Company expects to spend approximately $5 million in replacement hospital construction and equipment costs related to this project in 2008. This project is required to be completed in 2011. As part of the Triad acquisition, the Company assumed the commitment to build a replacement hospital in Clarksville, Tennessee, with an aggregate estimated construction cost, including equipment costs, of approximately $201 million. Of this amount, approximately $133 million has been expended through December 31, 2007. The Company expects to spend approximately $68 million in replacement hospital construction and equipment costs related to this project in 2008. This project is required to be completed in 2009. Also, as part of the Triad acquisition, the Company assumed the commitment to build a de novo hospital in Cedar Park, Texas, with an aggregate estimated construction cost, including equipment costs, of approximately $113 million. Of this amount, approximately $111 million has been expended through December 31, 2007. The Company expects to spend approximately $2 million in replacement hospital construction and equipment costs related to this project in 2008. This project is required to be completed in 2008. Also in 2005, the Company entered into an agreement with a developer to build and lease to the Company new corporate headquarters. Construction of the new headquarters was completed in December 2006. In January 2007, the Company exercised a purchase option under that lease agreement and acquired the new headquarters by purchasing the equity interests of the previous owner for a purchase price of $34.9 million.

Physician Recruiting Commitments. As part of its physician recruitment strategy, the Company provides income guarantee agreements to certain physicians who agree to relocate to its communities and commit to remain in practice there. Under such agreements, the Company is required to make payments to the physicians in excess of the amounts they earned in their practice up to the amount of the income guarantee. These income guarantee periods are typically for 12 months. Such payments are recoverable by the Company from physicians who do not fulfill their commitment period, which is typically three years, to the respective community. At December 31, 2007, the maximum potential amount of future payments under these guarantees in excess of the liability recorded is $49.4 million.

Professional Liability Risks.

Professional Liability Insurance for Former Triad Hospitals

Substantially all of the professional and general liability risks of the acquired Triad hospitals are subject to a per occurrence deductible. Substantially all losses in periods prior to May 1999 are insured through a wholly-owned insurance subsidiary of HCA, Inc., or HCA, Triad's owner prior to that time, and excess loss policies maintained by HCA. HCA has agreed to indemnify the Triad hospitals in respect of claims covered by such insurance policies arising prior to May 1999. After May 1999, the Triad hospitals obtained insurance coverage on a "claims incurred" basis from HCA's wholly-owned insurance subsidiary with excess coverage obtained from other carriers that is subject to certain deductibles. Effective for claims incurred after December 31, 2006, Triad began insuring its claims from $1 million to $5 million through its wholly-owned captive insurance company, replacing the coverage provided by HCA. Substantially all claims reported on or after January 2007 are self-insured up to $10 million per claim. Excess insurance for all hospitals is purchased through commercial insurance companies and generally after the self-insured amount covers up to $100 million

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

per occurrence. The excess insurance for the Triad hospitals is underwritten on a "claims-made basis." The Company accrues an estimated liability for its uninsured exposure and self-insured retention based on historical loss patterns and actuarial projections.

Professional Liability Insurance Claims for All Other Community Health Systems Hospitals

The Company accrues for estimated losses resulting from professional liability claims. The accrual, which includes an estimate for incurred but not reported claims, is based on historical loss patterns and actuarially determined projections and is discounted to its net present value using a weighted average risk-free discount rate of 4.1% and 4.6% in 2007 and 2006, respectively. To the extent that subsequent claims information varies from management's estimates, the liability is adjusted currently. The Company's insurance is underwritten on a "claims-made" basis. Prior to June 1, 2002, substantially all of the Company's professional and general liability risks were subject to a $0.5 million per occurrence deductible; for claims reported from June 1, 2002 through June 1, 2003, these deductibles were $2.0 million per occurrence. Additional coverage above these deductibles was purchased through captive insurance companies in which the Company had a 7.5% minority ownership interest in each and to which the premiums paid by the Company represented less than 8% of the total premiums revenues of each captive insurance company. With the formation of the Company's own wholly-owned captive insurance company in June 2003, the Company terminated its minority interest relationships in those entities. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 are self-insured up to $5 million per claim. Management on occasion has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals was purchased through commercial insurance companies and generally covers the Company for liabilities in excess of the self-insured amount and up to $100 million per occurrence for claims reported on or after June 1, 2003.

The Company's estimated liability for the self-insured portion of professional and general liability claims was $300.2 million and $104.2 million as of December 31, 2007 and 2006, respectively. These estimated liabilities represent the present value of estimated future professional liability claims payments based on expected loss patterns using a weighted-average discount rate of 4.1% and 4.6% in 2007 and 2006, respectively. The weighted-average discount rate is based on an estimate of the risk-free interest rate for the duration of the expected claim payments. The estimated undiscounted claims liability was $321.5 million and $119.8 million as of December 31, 2007 and 2006, respectively.

Legal Matters. The Company is a party to other legal proceedings incidental to its business. In the opinion of management, any ultimate liability with respect to these actions will not have a material adverse effect on the Company's consolidated financial position, cash flows or results of operations.

In a letter dated October 4, 2007, the Civil Division of the Department of Justice notified the Company that, as a result of an investigation into the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients, it believes the Company and three of its New Mexico hospitals have caused the State of New Mexico to submit improper claims for federal funds in violation of the federal False Claims Act. In a letter dated January 22, 2008, the Civil Division notified the Company that based on its investigation, it has calculated that these three hospitals received ineligible federal participation payments from August 2000 to June 2006 of approximately $27.5 million. The Civil Division also advised the Company that were it to proceed to trial, it would seek treble damages plus an appropriate penalty for each of the violations of the False Claims Act. The Company continues to believe that it has not violated the False Claims Act, and is continuing discussions with the Civil Division in an effort to resolve this matter.

Other. The Company has entered into a definitive agreement to acquire Empire Health Services in Spokane, Washington. The health system includes two full-service acute care hospitals, Deaconess Medical Center (388

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

licensed beds) and Valley Hospital and Medical Center (123 licensed beds), and other outpatient and ancillary services. The transaction, subject to federal and state approvals, is expected to close in the third quarter of 2008.

15. Subsequent Events

Effective February 1, 2008, the Company sold Russell County Medical Center (78 licensed beds) located in Lebanon, Virginia to Mountain States Health Alliance, headquartered in Johnson City, Tennessee, for $48.6 million.

16. Quarterly Financial Data (Unaudited)

	Quarter				
	1st	2nd	3rd	4th	Total
	(In thousands, except share and per share data)				
Year ended December 31, 2007:					
Net operating revenues	$ 1,154,278	$ 1,197,865	$ 2,247,009	$ 2,528,342	$ 7,127,494
Income from continuing operations before taxes	93,121	87,114	31,371	(108,706)	102,900
Income from continuing operations	57,289	53,558	19,699	(70,649)	59,897
Loss on discontinued operations	(2,965)	205	(9,239)	(17,609)	(29,608)
Net income	54,324	53,763	10,460	(88,258)	30,289
Income from continuing operations per share:					
Basic	0.61	0.57	0.21	(0.75)	0.64
Diluted	0.61	0.57	0.21	(0.75)	0.63
Net income per share:					
Basic	0.58	0.57	0.11	(0.94)	0.32
Diluted	0.58	0.57	0.11	(0.94)	0.32
Weighted-average number of shares:					
Basic	93,402,545	93,518,991	93,651,645	93,664,355	93,517,337
Diluted	94,365,292	94,647,870	94,841,749	93,664,355	94,642,294
Year ended December 31, 2006:					
Net operating revenues	$ 986,073	$ 1,017,337	$ 1,072,199	$ 1,104,527	$ 4,180,136
Income from continuing operations before taxes	95,447	86,106	18,199	88,095	287,847
Income from continuing operations	58,484	52,963	11,344	54,904	177,695
Loss on discontinued operations	(4,446)	(594)	(3,103)	(1,289)	(9,432)
Net income	54,038	52,369	8,241	53,615	168,263
Income from continuing					

operations per share:					
Basic	0.61	0.55	0.12	0.59	1.87
Diluted	0.60	0.55	0.12	0.58	1.85
Net income per share:					
Basic	0.56	0.55	0.09	0.57	1.77
Diluted	0.55	0.54	0.09	0.57	1.75
Weighted-average number of shares:					
Basic	96,552,448	95,769,030	94,119,020	93,538,958	94,983,646
Diluted	98,209,271	96,870,315	95,258,771	94,644,589	96,232,910

Net operating revenues in the third and fourth quarter of the year ended December 31, 2007 include the results of operations of the former Triad hospitals and other operations subsequent to the acquisition date of July 25, 2007. Also, net operating revenues and income from continuing operations in the fourth quarter of the year ended December 31, 2007 give effect to the $96.3 million increase in contractual reserves and $70.1 million increase to the allowance for doubtful accounts resulting from management's analysis of the net realizable value of the Company's accounts receivable during the fourth quarter (see Note 1).

17. Supplemental Condensed Consolidating Financial Information

In connection with the consummation of the Triad acquisition in July, 2007, the Company obtained $7.215 billion of senior secured financing under the New Credit Facility and CHS issued the Notes in the aggregate principal amount of $3.021 billion. The Notes are senior unsecured obligations of CHS and are guaranteed on a senior basis by the Company and by certain existing and subsequently acquired or organized 100% owned domestic subsidiaries.

The Notes are fully and unconditionally guaranteed on a joint and several basis. The following condensed consolidating financial statements present the Company (as parent guarantor), CHS (as the issuer), the subsidiary guarantors, the subsidiary non-guarantors and eliminations. These supplemental condensed consolidating financial statements have been prepared and presented in accordance with SEC Regulation S-X Rule 3-10 "Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered".

The presentation of intercompany balances and allocated income tax expense in the Company's previously issued supplemental condensed consolidating financial statements is being corrected as follows:

- Intercompany receivables and payables are presented gross in the supplemental consolidating balance sheets; the intercompany balances were previously reported net as "intercompany (receivable) payable". In addition, a portion of the intercompany (receivable) payable was netted against "long-term debt payable (receivable)" of the Issuer and other guarantors.
- Cash flows from intercompany transactions are presented in cash flows from financing activities, as changes in intercompany balances with affiliates, net; these cash flows were previously reported in cash flows from operating activities as "advances to subsidiaries, net of return of investment" and "other" operating cash flows.
- Income tax expense is allocated from the parent guarantor to the income producing operations (other guarantors and non-guarantors) and the Issuer through shareholders' equity; income tax expense was previously allocated entirely to the Parent Guarantor, which is the tax paying entity. As this approach represents an allocation, the income tax expense allocation is considered non-cash for statement of cash flow purposes.
- Interest expense, net has been presented to reflect net interest expense and interest income from outstanding long-term debt and intercompany balances; these interest expense and interest income amounts were previously netted within certain subsidiaries.

The Company's intercompany activity consists primarily of daily cash transfers for purposes of cash management, the allocation of certain expenses and expenditures paid for by the parent on behalf of its subsidiaries, and the push down of investment in its subsidiaries. The Company's subsidiaries generally do not purchase services from one another and therefore the intercompany transactions do not represent revenue generating transactions. All intercompany transactions eliminate in consolidation. Therefore, the aforementioned corrections do not impact the Company's consolidated balance sheet, consolidated statement of income or consolidated statement of cash flows for any period presented. Management believes the effects of these corrections are not material to the Company's previously issued consolidated financial statements.

The following tables disclose the impact of these corrections on each of the respective line items of the supplemental condensed consolidating financial statements as of and for the periods ending December 31, 2007, 2006 and 2005 (in thousands).

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
Condensed Consolidating Balance Sheet As of December 31, 2007						
As reported						
Prepaid expenses and taxes	$ —	$ 102	$ 156,733	$ 12,921	$ —	$ 169,756
Total current assets	113,741	102	1,518,022	921,033	—	2,552,898
Intercompany receivables (non-current)	—	—	—	—	—	—
Goodwill	96,671	—	2,162,601	1,988,442	—	4,247,714
Net investment in subsidiaries	1,519,952	1,464,944	4,968,905	—	(7,953,801)	—
Total Assets	1,730,364	1,654,186	12,593,604	5,469,290	(7,953,801)	13,493,643
Long-term debt	4	4,487,090	4,633,801	(43,528)	—	9,077,367
Intercompany payables (non-current)	(385,872)	(4,627,439)	5,956,358	4,562,215	(5,505,262)	—
Other long-term liabilities	(2,519)	121,482	188,316	176,180	—	483,459
Additional paid-in capital	1,240,308	—	—	—	—	1,240,308
Retained earnings	557,945	1,601,686	1,066,671	(134,094)	(2,534,263)	557,945
Total stockholders' equity	1,710,804	1,519,949	1,062,682	(134,092)	(2,448,539)	1,710,804
Total liabilities and stockholders' equity	1,730,364	1,654,186	12,593,604	5,469,290	(7,953,801)	13,493,643
As adjusted(1)						
Prepaid expenses and taxes	99,417	102	57,316	12,921	—	169,756
Total current assets	213,158	102	1,418,605	921,033	—	2,552,898
Intercompany receivables (non-current)	1,085,684	9,129,859	18,854,467	884,296	(29,954,306)	—
Goodwill	—	—	2,259,113	1,988,601	—	4,247,714
Net investment in subsidiaries	957,750	4,168,316	2,485,035	—	(7,611,101)	—
Total Assets	2,256,592	13,487,417	28,961,296	6,353,745	(37,565,407)	13,493,643
Long-term debt	4	8,987,090	62,792	27,481	—	9,077,367
Intercompany payables (non-current)	137,837	3,267,993	27,008,767	5,378,021	(35,792,618)	—
Other long-term liabilities	—	121,482	188,316	173,661	—	483,459
Additional paid-in capital	1,240,308	434,505	398,338	—	(832,843)	1,240,308
Retained earnings	557,945	604,980	554,624	(133,935)	(1,025,669)	557,945
Total stockholders' equity	1,710,804	957,748	948,974	(133,933)	(1,772,789)	1,710,804
Total liabilities and stockholders' equity	2,256,592	13,487,417	28,961,296	6,353,745	(37,565,407)	13,493,643
Condensed Consolidating Statement of Cash Flows For the year ended December 31, 2007						
As reported						
Net cash provided by (used in) operating activities	290,438	(326,264)	707,127	16,437	—	687,738
Changes in intercompany balances with affiliates, net	—	—	—	—	—	—
Net cash provided by (used in) financing activities	(290,438)	7,196,560	(137,159)	134,465	—	6,903,428
As adjusted(1)						
Net cash provided by (used in) operating activities	(85,881)	141,137	417,930	214,552	—	687,738
Changes in intercompany balances with affiliates, net	376,319	(468,160)	360,206	(268,365)	—	—
Net cash provided by (used in) financing activities	85,881	6,728,400	152,038	(62,891)	—	6,903,428
Condensed Consolidating Statement of Income For the year ended December 31, 2007						
As reported						
Interest expense, net	—	(160,144)	455,541	69,136	—	364,533
Equity in earnings of unconsolidated affiliates	(73,292)	59,464	74,773	—	(86,077)	(25,132)
Income (loss) from continuing operations before income taxes	73,292	73,292	(59,464)	(70,297)	86,077	102,900

Provision for income taxes	43,003	—	—	—	—	43,003
Income (loss) from continuing operations	30,289	73,292	(59,464)	(70,297)	86,077	59,897
Net income	$ 30,289	$ 73,292	$ (59,464)	$ (99,905)	$ 86,077	$ 30,289

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
As adjusted(1)						
Interest expense, net	$ —	$ 67,495	$ 227,902	$ 69,136	$ —	$ 364,533
Equity in earnings of unconsolidated affiliates	(30,289)	(114,008)	43,066	—	76,099	(25,132)
Income (loss) from continuing operations before income taxes	30,289	19,125	199,880	(70,295)	(76,099)	102,900
Provision for income taxes	—	(11,164)	83,550	(29,383)	—	43,003
Income (loss) from continuing operations	30,289	30,289	116,330	(40,912)	(76,099)	59,897
Net income	$ 30,289	$ 30,289	$ 116,330	$ (70,520)	$ (76,099)	$ 30,289

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
Condensed Consolidating Balance Sheet As of December 31, 2006						
As reported						
Intercompany receivables (non-current)	$ —	$ —	$ —	$ —	$ —	$ —
Net investment in subsidiaries	1,085,218	1,071,903	420,246	—	(2,577,367)	—
Total Assets	1,098,467	1,092,707	4,064,626	828,146	(2,577,367)	4,506,579
Current income taxes payable	—	—	7,626	—	—	7,626
Total current liabilities	867	21,866	443,751	108,799	—	575,283
Long-term debt	300,000	1,556,000	24,942	24,839	—	1,905,781
Intercompany payables (non-current)	(1,067,545)	(1,570,373)	2,403,385	709,118	(474,585)	—
Additional paid-in capital	1,195,947	—	—	—	—	1,195,947
Retained earnings	527,656	1,079,416	1,074,675	(49,594)	(2,104,497)	527,656
Total stockholders' equity	1,723,673	1,085,214	1,067,160	(49,592)	(2,102,782)	1,723,673
Total liabilities and stockholders' equity	1,098,467	1,092,707	4,064,626	828,146	(2,577,367)	4,506,579
As adjusted(1)						
Intercompany receivables (non-current)	1,360,530	5,620,834	5,590,489	275,417	(12,847,270)	—
Net investment in subsidiaries	975,063	1,650,140	415,506	—	(3,040,709)	—
Total Assets	2,348,842	7,291,778	9,650,375	1,103,563	(15,887,979)	4,506,579
Current income taxes payable	7,626	—	—	—	—	7,626
Total current liabilities	8,493	21,866	436,125	108,799	—	575,283
Long-term debt	300,000	1,556,000	24,942	24,839	—	1,905,781
Intercompany payables (non-current)	175,204	4,738,853	8,083,418	984,535	(13,982,010)	—
Additional paid-in capital	1,195,947	371,227	375,072	—	(746,299)	1,195,947
Retained earnings	527,656	598,034	612,946	(49,594)	(1,161,386)	527,656
Total stockholders' equity	1,723,673	975,059	980,502	(49,592)	(1,905,969)	1,723,673
Total liabilities and stockholders' equity	2,348,842	7,291,778	9,650,375	1,103,563	(15,887,979)	4,506,579
Condensed Consolidating Statement of Cash Flows For the year ended December 31, 2006						
As reported						
Net cash provided by (used in) operating activities	155,052	(387,000)	487,607	94,596	—	350,255
Changes in intercompany balances with affiliates, net	—	—	—	—	—	—
Net cash provided by (used in) financing activities	(155,052)	387,000	(5,734)	246	—	226,460
As adjusted(1)						
Net cash provided by (used in) operating activities	(151,205)	(20,514)	522,332	(358)	—	350,255
Changes in intercompany balances with affiliates, net	306,257	(366,486)	(34,725)	94,954	—	—
Net cash provided by (used in) financing activities	151,205	20,514	(40,459)	95,200	—	226,460
Condensed Consolidating Statement of Income For the year ended December 31, 2006						
As reported						
Interest expense, net	—	—	71,793	22,618	—	94,411
Equity in earnings of unconsolidated affiliates	(278,415)	(278,415)	53,778	—	503,052	—
	278,415	278,415	273,103	(39,034)	(503,052)	287,847

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Income (loss) from continuing operations before income taxes						
Provision for income taxes	110,152	—	—	—	—	110,152
Income (loss) from continuing operations	168,263	278,415	273,103	(39,034)	(503,052)	177,695
Net income	168,263	278,415	273,103	(48,466)	(503,052)	168,263
As adjusted(1)						
Interest expense, net	—	14,130	57,663	22,618	—	94,411
Equity in earnings of unconsolidated affiliates	(168,263)	(191,759)	38,829	—	321,193	—
Income (loss) from continuing operations before income taxes	168,263	177,629	302,182	(39,034)	(321,193)	287,847
Provision for income taxes	—	9,366	115,736	(14,950)	—	110,152
Income (loss) from continuing operations	168,263	168,263	186,446	(24,084)	(321,193)	177,695
Net income	$ 168,263	$ 168,263	$ 186,446	$ (33,516)	$ (321,193)	$ 168,263

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
Condensed Consolidating Statement of Cash Flows						
For the year ended December 31, 2005						
As reported						
Net cash provided by (used in) operating activities	$ 30,571	$ 12,000	$ 333,376	$ 35,102	$ —	$ 411,049
Changes in intercompany balances with affiliates, net	—	—	—	—	—	—
Net cash provided by (used in) financing activities	(30,571)	(12,000)	(13,122)	(6,474)	—	(62,167)
As adjusted(1)						
Net cash provided by (used in) operating activities	(67,739)	(38,924)	469,028	48,684	—	411,049
Changes in intercompany balances with affiliates, net	98,310	50,924	(135,652)	(13,582)	—	—
Net cash provided by (used in) financing activities	67,739	38,924	(148,774)	(20,056)	—	(62,167)
Condensed Consolidating Statement of Income						
For the year ended December 31, 2005						
As reported						
Interest expense, net	—	(9)	67,927	19,267	—	87,185
Equity in earnings of unconsolidated affiliates	(287,348)	(287,499)	15,315	—	559,532	—
Income (loss) from continuing operations before income taxes	287,348	287,508	287,499	5,351	(559,532)	308,174
Provision for income taxes	119,804	—	—	—	—	119,804
Income (loss) from continuing operations	167,544	287,508	287,499	5,351	(559,532)	188,370
Net income	167,544	287,508	287,499	(15,475)	(559,532)	167,544
As adjusted(1)						
Interest expense, net	—	34,930	32,988	19,267	—	87,185
Equity in earnings of unconsolidated affiliates	(167,544)	(195,805)	17,143	—	346,206	—
Income (loss) from continuing operations before income taxes	167,544	160,875	320,610	5,351	(346,206)	308,174
Provision for income taxes	—	(6,669)	124,397	2,076	—	119,804
	167,544	167,544	196,213	3,275	(346,206)	188,370

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Income (loss) from continuing operations											
Net income	$	167,544	$	167,544	$	196,213	$	(17,551)	$	(346,206)	$ 167,544

(1) Includes effects of reclassification for discontinued operations and for conforming corrections as applied to other periods presented.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

December 31, 2007
Balance Sheet

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands, except for share data)			
			ASSETS			
Current assets:						
Cash and cash equivalents	$ —	$ —	$ 114,075	$ 18,799	$ —	$ 132,874
Patient accounts receivable, net of allowance for doubtful accounts	—	—	954,106	579,692	—	1,533,798
Supplies	—	—	163,961	98,942	—	262,903
Deferred income taxes	113,741	—	—	—	—	113,741
Prepaid expenses and taxes	99,417	102	57,316	12,921	—	169,756
Other current assets	—	—	129,147	210,679	—	339,826
Total current assets	213,158	102	1,418,605	921,033	—	2,552,898
Intercompany receivable	1,085,684	9,129,859	18,854,467	884,296	(29,954,306)	—
Property and equipment, net	—	—	3,667,487	1,845,087	—	5,512,574
Goodwill	—	—	2,259,113	1,988,601	—	4,247,714
Other assets, net of accumulated amortization	—	189,140	276,589	714,728	—	1,180,457
Net investment in subsidiaries	957,750	4,168,316	2,485,035	—	(7,611,101)	—
Total assets	$ 2,256,592	$ 13,487,417	$ 28,961,296	$ 6,353,745	$ (37,565,407)	$ 13,493,643
			LIABILITIES AND STOCKHOLDERS' EQUITY			
Current liabilities:						
Current maturities of long-term debt	$ —	$ —	$ 16,603	$ 4,107	$ —	$ 20,710
Accounts payable	—	19	276,503	216,171	—	492,693
Current income taxes payable	—	—	—	—	—	—
Deferred income taxes — current	—	—	—	—	—	—
Accrued liabilities						
Employee compensation	—	—	231,500	172,098	—	403,598
Interest payable (receivable)	—	153,085	8,042	(7,295)	—	153,832
Other	—	—	206,308	170,794	—	377,102
Total current liabilities	—	153,104	738,956	555,875	—	1,447,935
Long-term debt payable	4	8,987,090	62,792	27,481	—	9,077,367
Intercompany payable	137,837	3,267,993	27,008,767	5,378,021	(35,792,618)	—
Deferred income taxes	407,947	—	—	—	—	407,947
Other long-term liabilities	—	121,482	188,316	173,661	—	483,459
Minority interests in equity of consolidated subsidiaries	—	—	13,491	352,640	—	366,131
Stockholders' equity						
Preferred stock	—	—	—	—	—	—
Common stock	966	—	1	2	(3)	966
Additional paid-in capital	1,240,308	434,505	398,338	—	(832,843)	1,240,308
Treasury stock, at cost	(6,678)	—	—	—	—	(6,678)
Accumulated other comprehensive income	(81,737)	(81,737)	(3,989)	—	85,726	(81,737)
Retained earnings	557,945	604,980	554,624	(133,935)	(1,025,669)	557,945
Total stockholders' equity	1,710,804	957,748	948,974	(133,933)	(1,772,789)	1,710,804
Total liabilities and stockholders' equity	$ 2,256,592	$ 13,487,417	$ 28,961,296	$ 6,353,745	$ (37,565,407)	$ 13,493,643

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

December 31, 2006
Balance Sheet

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands, except for share data)			
			ASSETS			
Current assets:						
Cash and cash equivalents	$ —	$ —	$ 28,560	$ 12,006	$ —	$ 40,566
Patient accounts receivable, net of allowance for doubtful accounts	—	—	607,460	166,524	—	773,984
Supplies	—	—	87,688	25,632	—	113,320
Deferred income taxes	13,249	—	—	—	—	13,249
Prepaid expenses and taxes	—	—	31,586	799	—	32,385
Other current assets	—	—	25,827	22,053	—	47,880
Total current assets	13,249	—	781,121	227,014	—	1,021,384
Intercompany receivable	1,360,530	5,620,834	5,590,489	275,417	(12,847,270)	—
Property and equipment, net	—	—	1,580,301	406,276	—	1,986,577
Goodwill	—	—	1,159,545	176,980	—	1,336,525
Other assets, net of accumulated amortization	—	20,804	123,413	17,876	—	162,093
Net investment in subsidiaries	975,063	1,650,140	415,506	—	(3,040,709)	—
Total assets	$ 2,348,842	$ 7,291,778	$ 9,650,375	$ 1,103,563	$ (15,887,979)	$ 4,506,579
			LIABILITIES AND STOCKHOLDERS' EQUITY			
Current liabilities:						
Current maturities of long-term debt	$ —	$ 16,000	$ 20,065	$ (669)	$ —	$ 35,396
Accounts payable	—	—	201,340	46,407	—	247,747
Current income taxes payable	7,626	—	—	—	—	7,626
Accrued liabilities						
Employee compensation	—	—	127,620	34,568	—	162,188
Interest payable	867	5,866	316	73	—	7,122
Other	—	—	86,784	28,420	—	115,204
Total current liabilities	8,493	21,866	436,125	108,799	—	575,283
Long-term debt payable	300,000	1,556,000	24,942	24,839	—	1,905,781
Intercompany payable	175,204	4,738,853	8,083,418	984,535	(13,982,010)	—
Deferred income taxes	141,472	—	—	—	—	141,472
Other long-term liabilities	—	—	124,886	11,925	—	136,811
Minority interests in equity of consolidated subsidiaries	—	—	502	23,057	—	23,559
Stockholders' equity:						
Preferred stock	950	—	1	2	(3)	950
Common stock						
Additional paid-in capital	1,195,947	371,227	375,072	—	(746,299)	1,195,947
Treasury stock, at cost	(6,678)	—	—	—	—	(6,678)
Accumulated other comprehensive income (loss)	5,798	5,798	(7,517)	—	1,719	5,798
Retained earnings	527,656	598,034	612,946	(49,594)	(1,161,386)	527,656
Total stockholders' equity	1,723,673	975,059	980,502	(49,592)	(1,905,969)	1,723,673
Total liabilities and stockholders' equity	$ 2,348,842	$ 7,291,778	$ 9,650,375	$ 1,103,563	$ (15,887,979)	$ 4,506,579

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2007
Statement of Income

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net operating revenues	$ —	$ —	$ 4,932,207	$ 2,195,287	$ —	$ 7,127,494
Operating costs and expenses:						
Salaries and benefits	—	—	1,896,340	998,637	—	2,894,977
Provision for bad debts	—	—	664,619	232,666	—	897,285
Supplies	—	—	628,922	315,846	—	944,768
Other operating expenses	—	—	960,096	472,902	—	1,432,998
Rent	—	—	91,836	63,730	—	155,566
Depreciation and amortization	—	—	218,723	97,492	—	316,215
Total operating costs and expenses	—	—	4,460,536	2,181,273	—	6,641,809
Income from operations	—	—	471,671	14,014	—	485,685
Interest expense, net	—	67,495	227,902	69,136		364,533
Loss from early extinguishment of debt	—	27,388	—	—	—	27,388
Minority interest in earnings	—	—	823	15,173	—	15,996
Equity in earnings of unconsolidated affiliates	(30,289)	(114,008)	43,066	—	76,099	(25,132)
Income (loss) from continuing operations before income taxes	30,289	19,125	199,880	(70,295)	(76,099)	102,900
Provision for income taxes	—	(11,164)	83,550	(29,383)	—	43,003
Income from continuing operations	30,289	30,289	116,330	(40,912)	(76,099)	59,897
Discontinued operations, net of taxes:						
Loss from operations of hospitals sold or held for sale	—	—	—	(11,067)	—	(11,067)
Net loss on sale of hospitals and partnership interests, net	—	—	—	(2,594)	—	(2,594)
Impairment of long-lived assets of hospitals held for sale	—	—	—	(15,947)	—	(15,947)
Loss on discontinued operations	—	—	—	(29,608)	—	(29,608)
Net income	$ 30,289	$ 30,289	$ 116,330	$ (70,520)	$ (76,099)	$ 30,289

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2006
Statement of Income

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net operating revenues	$ —	$ —	$ 3,344,830	$ 835,306	$ —	$ 4,180,136
Operating costs and expenses:						
Salaries and benefits	—	—	1,278,676	382,943	—	1,661,619
Provision for bad debts	—	—	406,095	112,766	—	518,861
Supplies	—	—	390,147	97,631	—	487,778
Rent	—	—	64,544	27,399	—	91,943
Other operating expenses	—	—	658,746	196,850	—	855,596
Depreciation and amortization	—	—	147,885	31,397	—	179,282
Total operating costs and expenses	—	—	2,946,093	848,986	—	3,795,079
Income from operations	—	—	398,737	(13,680)	—	385,057
Interest expense, net	—	14,130	57,663	22,618	—	94,411
Loss from early extinguishment of debt	—	—	4	—	—	4
Minority interest in earnings	—	—	59	2,736	—	2,795
Equity in earnings of unconsolidated affiliates	(168,263)	(191,759)	38,829	—	321,193	—
Income (loss) from continuing operations before income taxes	168,263	177,629	302,182	(39,034)	(321,193)	287,847
Provision for income taxes	—	9,366	115,736	(14,950)	—	110,152
Income from continuing operations	168,263	168,263	186,446	(24,084)	(321,193)	177,695
Discontinued operations, net of taxes:						
Loss from operations of hospitals sold or held for sale	—	—	—	(6,873)	—	(6,873)
Loss on sale of hospitals and partnership interests, net	—	—	—	(2,559)	—	(2,559)
Loss on discontinued operations	—	—	—	(9,432)	—	(9,432)
Net income	$ 168,263	$ 168,263	$ 186,446	$ (33,516)	$ (321,193)	$ 168,263

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2005
Statement of Income

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net operating revenues	$ —	$ —	$ 2,829,563	$ 746,554	$ —	$ 3,576,117
Operating costs and expenses:						
Salaries and benefits	—	—	1,095,638	325,507	—	1,421,145
Provision for bad debts	—	—	278,743	77,377	—	356,120
Supplies	—	—	341,896	87,950	—	429,846
Other operating expenses	—	—	555,381	175,643	—	731,024
Rent	—	—	58,973	23,284	—	82,257
Depreciation and amortization	—	—	128,062	29,200	—	157,262
Total operating costs and expenses	—	—	2,458,693	718,961	—	3,177,654
Income from operations	—	—	370,870	27,593	—	398,463
Interest expense, net	—	34,930	32,988	19,267	—	87,185
Minority interest in earnings	—	—	129	2,975	—	3,104
Equity in earnings of unconsolidated affiliates	(167,544)	(195,805)	17,143	—	346,206	—
Income from continuing operations before income taxes	167,544	160,875	320,610	5,351	(346,206)	308,174
Provision for income taxes	—	(6,669)	124,397	2,076	—	119,804
Income from continuing operations	167,544	167,544	196,213	3,275	(346,206)	188,370
Discontinued operations, net of taxes:						
Loss from operations of hospitals sold or held for sale	—	—	—	(8,737)	—	(8,737)
Loss on sale of hospitals, net	—	—	—	(7,618)	—	(7,618)
Impairment of long-lived assets of hospitals held for sale	—	—	—	(4,471)	—	(4,471)
Loss on discontinued operations	—	—	—	(20,826)	—	(20,826)
Net income	$ 167,544	$ 167,544	$ 196,213	$ (17,551)	$ (346,206)	$ 167,544

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2007
Statement of Cash Flows

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Cash flows from operating activities						
Net cash provided by(used in) operating activities	(85,881)	141,137	417,930	214,552	—	687,738
Cash flows from investing activities						
Acquisitions of facilities and other related equipment	—	(6,864,035)	(59,203)	(94,810)	—	(7,018,048)
Purchases of property and equipment	—	—	(366,069)	(156,716)	—	(522,785)
Sale of facilities	—	—	—	109,996	—	109,996
Proceeds from sale of equipment	—	—	591	4,059	—	4,650
Investment in other assets	—	(5,502)	(59,772)	(7,397)	—	(72,671)
Net cash provided by (used in) investing activities	—	(6,869,537)	(484,453)	(144,868)	—	(7,498,858)
Cash flows from financing activities						
Proceeds from exercise of stock options	8,214	—	—	—	—	8,214
Stock buy-back	—	—	—	—	—	—
Deferred financing costs	—	(182,954)	—	—	—	(182,954)
Excess tax benefits relating to stock-based compensation	1,216	—	—	—	—	1,216
Redemption of convertible notes	—	—	—	—	—	—
Proceeds from minority investors in joint ventures	128	—	—	2,223	—	2,351
Redemption of minority investments in joint ventures	—	—	—	(1,356)	—	(1,356)
Distribution to minority investors in joint ventures	—	—	—	(6,645)	—	(6,645)
Changes in intercompany balances with affiliates, net	376,319	(468,160)	360,206	(268,365)	—	—
Borrowings under Credit Agreement	—	9,212,000	(66,068)	75,695	—	9,221,627
Repayments of long-term indebtedness	(299,996)	(1,832,486)	(142,100)	135,557	—	(2,139,025)
Net cash provided by (used in) financing	85,881	6,728,400	152,038	(62,891)	—	6,903,428

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activities						
Net change in cash and cash equivalents	—	—	85,515	6,793	—	92,308
Cash and cash equivalents at beginning of period	—	—	28,560	12,006	—	40,566
Cash and cash equivalents at end of period	$ —	$ —	$ 114,075	$ 18,799	$ —	$ 132,874

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2006
Statement of Cash Flows

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Cash flows from operating activities:						
Net cash provided by (used in) operating activities	(151,205)	(20,514)	522,332	(358)	—	350,255
Cash flows from investing activities						
Acquisitions of facilities and other related equipment	—	—	(340,314)	(44,304)	—	(384,618)
Purchases of property and equipment	—	—	(176,070)	(48,449)	—	(224,519)
Proceeds from sale of equipment	—	—	102	4,378	—	4,480
Disposition of hospital and other ancillary operations	—	—	—	750	—	750
Increase in other assets	—	—	(20,420)	(15,930)	—	(36,350)
Net cash provided by (used in) investing activities	—	—	(536,702)	(103,555)	—	(640,257)
Cash flows from financing activities:						
Proceeds from exercise of stock options	14,573	—	—	—	—	14,573
Stock buy-back	(176,316)	—	—	—	—	(176,316)
Deferred financing costs	—	—	(2,153)	—	—	(2,153)
Excess tax benefits relating to stock-based compensation	6,819	—	—	—	—	6,819
Redemption of convertible notes	(128)	—	—	—	—	(128)
Proceeds from minority investors in joint ventures	—	—	—	6,890	—	6,890
Redemption of minority investments in joint ventures	—	—	(56)	(859)	—	(915)
Distribution to minority investors in joint ventures	—	—	—	(3,220)	—	(3,220)
Changes in intercompany balances with affiliates, net	306,257	(366,486)	(34,725)	94,954	—	—
Borrowings under Credit Agreement	—	1,031,000	—	—	—	1,031,000
Repayments of long-term indebtedness	—	(644,000)	(3,525)	(2,565)	—	(650,090)
Net cash provided by (used in) financing activities	151,205	20,514	(40,459)	95,200	—	226,460
Net change in cash and cash equivalents	—	—	(54,829)	(8,713)	—	(63,542)
Cash and cash equivalents at beginning of period	—	—	83,389	20,719	—	104,108
Cash and cash	$ —	$ —	$ 28,560	$ 12,006	$ —	$ 40,566

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equivalents at end of period						

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Year Ended December 31, 2005
Statement of Cash Flows

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Cash flows from operating activities						
Net cash provided by(used in) operating activities	(67,739)	(38,924)	469,028	48,684	—	411,049
Cash flows from investing activities						
Acquisitions of facilities and other related equipment	—	—	(125,493)	(32,886)	—	(158,379)
Purchases of property and equipment	—	—	(153,422)	(34,943)	—	(188,365)
Sale of facilities	—	—	(6,500)	58,498	—	51,998
Proceeds from sale of equipment	—	—	112	2,213	—	2,325
Investment in other assets	—	—	(22,444)	(12,407)	—	(34,851)
Net cash provided by (used in) investing activities	—	—	(307,747)	(19,525)	—	(327,272)
Cash flows from financing activities						
Proceeds from exercise of stock options	49,580	—	—	—	—	49,580
Stock buy-back	(79,853)	—	—	—	—	(79,853)
Deferred financing costs	—	—	(1,259)	—	—	(1,259)
Excess tax benefits relating to stock-based compensation	—	—	—	—	—	—
Redemption of convertible notes	(298)	—	—	—	—	(298)
Proceeds from minority investors in joint ventures	—	—	—	1,383	—	1,383
Redemption of minority investments in joint ventures	—	—	—	(3,242)	—	(3,242)
Distribution to minority investors in joint ventures	—	—	—	(1,939)	—	(1,939)
Change in intercompany balances with affiliates, net	98,310	50,924	(135,652)	(13,582)	—	—
Borrowings under Credit Agreement	—	—	—	—	—	—
Repayments of long-term indebtedness	—	(12,000)	(11,863)	(2,676)	—	(26,539)
Net cash provided by (used in) financing activities	67,739	38,924	(148,774)	(20,056)	—	(62,167)
Net change in cash and cash equivalents	—	—	12,507	9,103	—	21,610
Cash and cash equivalents at beginning of period	—	—	70,882	11,616	—	82,498
Cash and cash equivalents at end of period	$ —	$ —	$ 83,389	$ 20,719	$ —	104,108

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

Item 15(a)(1). Financial Statements

Reference is made to the index of financial statements and supplementary data previously filed as a part of the Annual Report under Item 8 in Part II.

Item 15(a)(2). Financial Statement Schedules

The following financial statement schedule was previously filed as a part of the Annual Report:

Schedule II — Valuation and Qualifying Accounts

All other schedules have been omitted since the required information is not present or is not present in amounts sufficient to require submission of the schedule, or because the information required is included in the consolidated financial statements and notes thereto.

Item 15(a)(3) and 15(c):

The following exhibits are either filed with this Report or incorporated herein by reference.

	Description
23.1	Consent of Deloitte & Touche LLP*
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*

* Filed herewith.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities and Exchange Act of 1934, the registrant has duly caused this Form 10-K/A to be signed on its behalf by the undersigned, thereunto duly authorized.

COMMUNITY HEALTH SYSTEMS, INC.
(Registrant)

By: /s/ Wayne T. Smith
Wayne T. Smith
Chairman of the Board,
President and Chief Executive Officer
(principal executive officer)

By: /s/ W. Larry Cash
W. Larry Cash
Executive Vice President, Chief Financial Officer and Director
(principal financial officer)

By: /s/ T. Mark Buford
T. Mark Buford
Vice President and Corporate Controller
(principal accounting officer)

Date: December 22, 2008

Exhibit Index

	Description
23.1	Consent of Deloitte & Touche LLP*
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*

* Filed herewith.

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement No. 333-117697 on Form S-3 and in Registration Statement Nos. 333-100349, 333-61614, 333-44870, 333-107810, 333-121282, 333-121283 and 333-144525 on Form S-8 of our report dated February 26, 2008 (December 19, 2008 as to the effects of the restatement discussed in Notes 1 and 17) relating to the consolidated financial statements of Community Health Systems, Inc. (which report expresses an unqualified opinion and includes an explanatory paragraph referring to the to the adoption of a new accounting principle in 2006), appearing in the Annual Report on Form 10-K/A (Amendment No. 2) of Community Health Systems, Inc. for the year ended December 31, 2007.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
December 19, 2008

Exhibit 31.1

I, Wayne T. Smith, certify that:

1. I have reviewed this annual report on Form 10-K/A of Community Health Systems, Inc.;

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

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

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

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

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

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

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

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

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

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

/s/ Wayne T. Smith

Wayne T. Smith
Chairman of the Board, President
and Chief Executive Officer

Date: December 22, 2008

Exhibit 31.2

I, W. Larry Cash, certify that:

1. I have reviewed this annual report on Form 10-K/A of Community Health Systems, Inc.;

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

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

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

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

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

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

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

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

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

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

/s/ W. Larry Cash

W. Larry Cash
Executive Vice President,
Chief Financial Officer and Director

Date: December 22, 2008

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

In connection with the Annual Report of Community Health Systems, Inc. (the "Company") on Form 10-K/A for the period ending December 31, 2007, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Wayne T. Smith, Chairman of the Board, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ WAYNE T. SMITH

Wayne T. Smith
Chairman of the Board, President and
Chief Executive Officer

December 22, 2008

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

In connection with the Annual Report of Community Health Systems, Inc. (the "Company") on Form 10-K/A for the period ending December 31, 2007, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, W. Larry Cash, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ W. LARRY CASH

W. Larry Cash
Executive Vice President, Chief Financial Officer and Director

December 22, 2008

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FORM 10-K

COMMUNITY HEALTH SYSTEMS INC - CYH

Filed: February 27, 2009 (period: December 31, 2008)

Annual report which provides a comprehensive overview of the company for the past year

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, 2008

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 *(State of incorporation)*	**13-3893191** *(IRS Employer Identification No.)*
4000 Meridian Boulevard **Franklin, Tennessee** *(Address of principal executive offices)*	**37067** *(Zip Code)*

Registrant's telephone number, including area code:
(615) 465-7000

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

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, $.01 par value	New York Stock Exchange

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

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

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

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

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

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

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

The aggregate market value of the voting stock held by non-affiliates of the Registrant was $3,198,044,909. Market value is determined by reference to the closing price on June 30, 2008 of the Registrant's Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2008) have any non-voting common stock outstanding. As of February 1, 2009, there were 91,507,617 shares of common stock, par value $.01 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required for Part III of this annual report is incorporated by reference from portions of the Registrant's definitive proxy statement for its 2009 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, 2008.

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FORM 10-K ANNUAL REPORT

COMMUNITY HEALTH SYSTEMS, INC.
Year ended December 31, 2008

PART I

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

Overview of Our Company

We are the largest publicly traded operator of hospitals in the United States in terms of number of facilities and net operating revenues. We were incorporated in 1996 as a Delaware corporation. We provide healthcare services through these hospitals that we own and operate in non-urban and selected urban markets throughout the United States. As of December 31, 2008, included in our continuing operations, are 118 hospitals that we owned or leased. These hospitals are geographically diversified across 28 states, with an aggregate of 17,245 licensed beds. We generate revenues by providing a broad range of general and specialized hospital healthcare services to patients in the communities in which we are located. Services provided by our hospitals include, but are not limited to, general acute care services, emergency room services, general and specialty surgery, critical care, internal medicine, obstetrics and diagnostic services. As part of providing these services we also own, outright or through partnerships with physicians, physician practices, imaging centers, and ambulatory surgery centers. Through our corporate ownership and operation of these businesses we provide: standardization and centralization of operations across key business areas; a strategic direction to expand and improve services and facilities at our hospitals; implementation of quality of care improvement programs; and assistance in the recruitment of additional physicians to the markets in which our hospitals are located. In a number of our markets, we have partnered with local physicians or not-for-profit providers, or both, in the ownership of our facilities. In addition to our hospitals and related businesses, we also own and operate home care agencies, including two home care agencies located in markets where we do not operate a hospital. Through our wholly-owned subsidiary, Quorum Health Resources, LLC, or QHR, we also provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. The home care agencies and the hospital management services businesses constitute operating segments that are not considered reportable segments since they do not meet the quantitative thresholds defined in Statement of Financial Accounting Standards, or SFAS, No. 131, "Disclosures about Segments of an Enterprise and Related Information." The financial information for our reportable operating segments is presented in Note 14 of the Notes to our Consolidated Financial Statements included under Item 8 of this Report.

Our strategy has also included growth by acquisition. We target hospitals in growing, non-urban and select urban healthcare markets for acquisition because of their favorable demographic and economic trends and competitive conditions. Because these service areas have smaller populations, there are generally fewer hospitals and other healthcare service providers in these communities and generally a lower level of managed care presence in these markets. We believe that smaller populations support less direct competition for hospital-based services. Also, we believe that these communities generally view the local hospital as an integral part of the community.

Effective July 25, 2007, we completed our acquisition of Triad Hospitals, Inc., or Triad. Triad owned and operated 50 hospitals with 49 hospitals located in 17 states in non-urban and middle market communities and one hospital located in the Republic of Ireland. At December 31, 2008, 41 of the 50 hospitals acquired from Triad remain in our continuing operations. The acquisition of Triad also expanded our operations into five states where we previously did not own any facilities.

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

Available Information

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

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

We have included the Chief Executive Officer and the Chief Financial Officer certifications regarding the company's public disclosure required by Section 302 of the Sarbanes-Oxley Act of 2002 as Exhibits 31.1 and 31.2 of this report. We timely submitted to the New York Stock Exchange, or NYSE, the 2008 Annual CEO certification regarding our compliance with the NYSE's corporate governance listing standards as required by NYSE Rule 303A.

Our Business Strategy

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

- increase revenue at our facilities;
- improve profitability;
- improve quality; and
- grow through selective acquisitions.

Increase Revenue at Our Facilities

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

- recruiting additional primary care physicians and specialists;
- expanding the breadth of services offered at our hospitals through targeted capital expenditures to support the addition of more complex services, including orthopedics, cardiovascular services, and urology; and
- providing the capital to invest in technology and the physical plant at the facilities, particularly in our emergency rooms, surgery departments, critical care departments, and diagnostic services.

Physician Recruiting. The primary method of adding or expanding medical services is the recruitment of new physicians into the community. A core group of primary care physicians is necessary as an initial contact point for all local healthcare. The addition of specialists who offer services, including general surgery, OB/GYN, 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 by analyzing demographic data and patient referral trends. As a result of this analysis, we are able to determine what we believe to be the optimum mix of primary care physicians and specialists. We employ recruiters at the corporate level to support the local hospital managers in their recruitment efforts. We have increased the number of physicians affiliated with us through our recruiting efforts, net of turnover, by approximately 686 in 2008, 440 in 2007 and 300 in 2006. The percentage of recruited or other physicians commencing practice with us that were specialists was over 50% in 2008. Although in recent years we have begun employing more physicians, most of our physicians are in private practice in their communities and are not our employees. We have been successful in recruiting physicians because of the practice opportunities afforded physicians in our markets, as well as lower managed care penetration as compared to larger urban areas.

Emergency Room Initiatives. Approximately 55% of our hospital admissions originate in the emergency room. Therefore, we systematically take steps to increase patient flow in our emergency rooms as a means of optimizing utilization rates for our hospitals. Furthermore, the impression of our overall operations by our customers is substantially influenced by our emergency rooms since generally that is their first experience with our hospitals. The steps we take to increase patient flow in our emergency rooms include renovating and expanding our emergency room facilities, improving service and reducing waiting times, as well as publicizing our emergency room capabilities in the local community. We have expanded or renovated 13 of our emergency rooms during the past three years, including four in 2008. We have also implemented marketing campaigns that emphasize the speed, convenience, and quality of our emergency rooms to enhance each community's awareness of our emergency room services.

One component of upgrading our emergency rooms is the implementation of specialized computer software programs designed to assist physicians in making diagnoses and determining treatments. The software also benefits patients and hospital personnel by assisting in proper documentation of patient records and tracking patient flow. It enables our nurses to provide more consistent patient care and provides clear instructions to patients at time of discharge to help them better understand their treatments.

Expansion of Services. In an effort to better meet the healthcare needs of the communities we serve and to capture a greater portion of the healthcare spending in our markets, we have added a broad range of services to our facilities. These services range from various types of diagnostic equipment capabilities to additional and renovated emergency rooms, surgical and critical care suites and specialty services. For example, in 2008, we spent $108.7 million as a part of 27 major construction projects. The 2008 projects included new emergency rooms, cardiac cathertization labs, intensive care units, hospital additions, and ambulatory surgery centers. These projects improved various diagnostic and other inpatient and outpatient service capabilities. We continue to believe that appropriate capital investments in our facilities combined with the development of our service capabilities will reduce the migration of patients to competing providers while providing an attractive return on investment. We also employ a small group of clinical consultants at our corporate headquarters to assist the hospitals in their development of surgery, emergency services, critical care and cardiovascular services. In addition to spending capital on expanding services at our existing hospitals, we also build replacement facilities to better meet the healthcare needs of our communities. In 2008, three replacement hospitals were completed and opened: one in Clarksville, Tennessee (June 2008), one in Shelbyville, Tennessee (July 2008) and one in Petersburg, Virginia (August 2008). We spent approximately $374 million on these three replacement hospitals which includes expenditures by Triad prior to our acquisition of Triad.

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

Improve Profitability

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

- standardizing and centralizing our operations;
- optimizing resource allocation by utilizing our company-devised case and resource management program, which assists in improving clinical care and containing expenses;
- capitalizing on purchasing efficiencies through the use of company-wide standardized purchasing contracts and terminating or renegotiating specified vendor contracts;
- installing a standardized management information system, resulting in more efficient billing and collection procedures; and
- monitoring and enhancing productivity of our human resources.

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, which has an average of over 25 years of experience in the healthcare industry.

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

- *Billing and Collections.* We have adopted standard policies and procedures with respect to billing and collections. We have also automated and standardized various components of the collection cycle, including statement and collection letters and the movement of accounts through the collection cycle. Upon completion of an acquisition, our management information system 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.
- *Physician Support.* We support our newly recruited physicians to enhance their transition into our communities. We have implemented physician practice management seminars and training. We host these seminars bi-monthly. All newly recruited physicians are required to attend a three-day introductory seminar that covers issues involved in starting up a practice.
- *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., HealthTrust, a group purchasing organization, or GPO. HealthTrust is the source for a substantial portion of our medical supplies, equipment and pharmaceuticals. This agreement extends to March 2010, 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 while maintaining the same level of quality and have shortened the time it takes us to complete these projects.
- *Other Initiatives.* We have also improved margins by implementing standard programs with respect to ancillary services in areas including emergency rooms, pharmacy, laboratory, imaging, home care, skilled nursing, centralized outpatient scheduling and health information management. We have reduced costs associated with these services by improving contract terms and standardizing information systems. We work to identify and communicate best practices and monitor these improvements throughout the Company.

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

Case and Resource Management. Our case and resource management program is a company-devised program developed with the goal of improving clinical care and cost containment. The program focuses on:

- appropriately treating patients along the care continuum;
- reducing inefficiently applied processes, procedures and resources;
- developing and implementing standards for operational best practices; and
- using on-site clinical facilitators to train and educate care practitioners on identified best practices.

Our case and resource management program integrates the functions of utilization review, discharge planning, overall clinical management, and resource management into a single effort to improve the quality and efficiency of care. Issues evaluated in this process include patient treatment, patient length of stay and utilization of resources.

Under our case and resource management program, patient care begins with a clinical assessment of the appropriate level of care, discharge planning, and medical necessity for planned services. Once a patient is admitted to the hospital, we conduct a review for ongoing medical necessity using appropriateness criteria. We reassess and adjust discharge plan options as the needs of the patient change. We closely monitor cases to prevent delayed service or inappropriate utilization of resources. Once the patient attains clinical improvement, we encourage the attending physician to consider alternatives to hospitalization through discussions with the facility's physician advisor. Finally, we refer the patient to the appropriate post-hospitalization resources.

Improve Quality

We have implemented various programs to ensure continuous improvement in the quality of care provided. We have developed training programs for all senior hospital management, chief nursing officers, quality directors, physicians and other clinical staff. We share information among our hospital management to implement best practices and assist in complying with regulatory requirements. We have standardized accreditation documentation and requirements. All hospitals conduct patient, physician, and staff satisfaction surveys to help identify methods of improving the quality of care.

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

Grow Through Selective Acquisitions

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

- have a service area population between 20,000 and 400,000 with a stable or growing population base;
- are the sole or primary provider of acute care services in the community;
- are located in an area with the potential for service expansion;
- are not located in an area that is dependent upon a single employer or industry; and
- have financial performance that we believe will benefit from our management's operating skills.

In each year since 1997, we have met or exceeded our acquisition goals. Occasionally, we have pursued acquisition opportunities outside of our specified criteria when such opportunities have had uniquely favorable characteristics. In addition to two hospitals acquired from local governmental entities in 2007, we also acquired Triad, which, at the time of our acquisition, owned and operated 50 hospitals with 49 hospitals located in 17 states across the U.S. and one hospital located in the Republic of Ireland. Since our acquisition of Triad's 50 hospital portfolio in July, 2007, we have primarily focused our efforts on integrating those hospitals, as opposed to pursuing further acquisition opportunities. In the fourth quarter of 2008, we completed an acquisition of a two hospital system located in Spokane, Washington, an acquisition we had been pursuing, and for which we were awaiting government approval, for almost a year. In 2009, in light of the current economic conditions, we intend to proceed cautiously with our acquisition strategy, anticipating closing on only two acquisitions during the year. One of these two anticipated acquisitions closed on February 1, 2009.

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

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

At the time we acquire a hospital, we may commit to an amount of capital expenditures, such as a replacement facility, renovations, or equipment over a specified period of time. As an obligation under a hospital purchase agreement in effect as of December 31, 2008, we are required to build a replacement facility in Valparaiso, Indiana by April 2011. Also, as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location. Estimated construction costs, including equipment costs, are approximately $269.0 million for these two replacement hospitals, of which approximately $8.5 million has been incurred to date. In addition, other commitments under purchase agreements in effect as of December 31, 2008, obligate us to spend approximately $266.8 million through 2013, for costs such as capital improvements, equipment, selected leases and physician recruiting.

Industry Overview

The Centers for Medicare and Medicaid Services, or CMS, reported that in 2007 total U.S. healthcare expenditures grew by 6.1% to $2.2 trillion. CMS also projected total U.S. healthcare spending to grow by 6.6% in 2008 and by an average of 6.7% annually from 2009 through 2017. By these estimates, healthcare expenditures will account for approximately $4.3 trillion, or 19.5% of the total U.S. gross domestic product, by 2017.

Hospital services, the market in which we operate, is the largest single category of healthcare at 30% of total healthcare spending in 2007, or $696.5 billion, as reported by CMS. CMS projects the hospital services category to grow by at least 6.4% per year through 2017. It expects growth in hospital healthcare spending to continue due to the aging of the U.S. population and consumer demand for expanded medical services. As hospitals remain the primary setting for healthcare delivery, CMS expects hospital services to remain the largest category of healthcare spending.

U.S. Hospital Industry. The U.S. hospital industry is broadly defined to include acute care, rehabilitation, and psychiatric facilities that are either public (government owned and operated), not-for-profit private (religious or secular), or for-profit institutions (investor owned). According to the American Hospital Association, there are approximately 4,900 inpatient hospitals in the U.S. which are not-for-profit owned, investor owned, or state or local government owned. Of these hospitals, approximately 41% are located in non-urban communities. We believe that a majority of these hospitals are owned by not-for-profit or governmental entities. These facilities offer a broad range of healthcare services, including internal medicine, general surgery, cardiology, oncology, orthopedics, OB/GYN, and emergency services. In addition, hospitals also offer other ancillary services including psychiatric, diagnostic, rehabilitation, home care, and outpatient surgery services.

Urban vs. Non-Urban Hospitals

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

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

- facility size and location;
- facility ownership structure (i.e., tax-exempt or investor owned);
- a facility's ability to participate in group purchasing organizations; and
- facility payor mix.

We believe that non-urban hospitals are generally able to obtain higher operating margins than urban hospitals. Factors contributing to a non-urban hospital's margin advantage include fewer patients with complex medical problems, a lower cost structure, limited competition, and favorable Medicare payment provisions. Patients needing the most complex care are more often served by the larger and/or more specialized urban hospitals. A non-urban hospital's lower cost structure results from its geographic location, as well as the lower number of patients treated who need the most highly advanced services. Additionally, because non-urban hospitals are generally sole providers or one of a small group of providers in their markets, there is limited competition. This generally results in more favorable pricing with commercial payors. Medicare has special payment provisions for "sole community hospitals." Under present law, hospitals that qualify for this designation can receive higher reimbursement rates. As of December 31, 2008, 25 of our hospitals were "sole community hospitals." In addition, we believe that non-urban communities are generally characterized by a high level of patient and physician loyalty that fosters cooperative relationships among the local hospitals, physicians, employees and patients.

The type of third party responsible for the payment of services performed by healthcare service providers is also an important factor which affects hospital operating margins. These providers have increasingly exerted pressure on healthcare service providers to reduce the cost of care. The most active providers in this regard have been HMOs, PPOs, and other managed care organizations. The characteristics of non-urban markets make them less attractive to these managed care organizations. This is partly because the limited size of non-urban markets and their diverse, non-national employer bases minimize the ability of managed care organizations to achieve economics of scale as compared to economics of scale that can be achieved in many urban markets.

Hospital Industry Trends

Demographic Trends. According to the U.S. Census Bureau, there are presently approximately 37.9 million Americans aged 65 or older in the U.S. who comprise approximately 12.6% of the total U.S. population. By the year 2030, the number of elderly is expected to climb to 72.1 million, or 19.3% of the total population. Due to the increasing life expectancy of Americans, the number of people aged 85 years and older is also expected to increase from 5.5 million to 8.7 million by the year 2030. This increase in life expectancy will increase demand for healthcare services and, as importantly, the demand for innovative, more sophisticated means of delivering those services. Hospitals, as the largest category of care in the healthcare market, will be among the main beneficiaries of this increase in demand. Based on data compiled for us, the populations of the service areas where our hospitals are located grew by 24.9% from 1990 to 2007 and are expected to grow by 6.2% from 2007 to 2012. The number of people aged 65 or older in these service areas grew by 24.4% from 1990 to 2007 and is expected to grow by 10.5% from 2007 to 2012.

Consolidation. During recent years a significant amount of private equity capital has been invested into the hospital industry. Also, in addition to our own acquisition of Triad in 2007, consolidation activity, primarily through mergers and acquisitions involving both for-profit and not-for-profit hospital systems is continuing. Reasons for this activity include:

- excess capacity of available capital;
- valuation levels;
- financial performance issues, including challenges associated with changes in reimbursement and collectability of self-pay revenue;
- the desire to enhance the local availability of healthcare in the community;
- the need and ability to recruit primary care physicians and specialists;
- the need to achieve general economies of scale and to gain access to standardized and centralized functions, including favorable supply agreements and access to malpractice coverage; and
- regulatory changes.

As a result of recent changes in the global economic conditions, we anticipate seeing a decline in the trend of consolidation activity, including mergers and acquisitions.

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 2008 include a full year of operations for 116 hospitals and partial periods for two hospitals acquired during the year. Statistics for 2007 include a full year of operations for 70 hospitals and partial periods for 45 hospitals acquired during the year. Statistics for 2006 include a full year of operations for 63 hospitals and partial periods for seven hospitals acquired during the year. Hospitals which have been sold and hospitals which are classified as held for sale are excluded from all periods presented.

	Year Ended December 31, 2008	2007	2006
	(Dollars in thousands)		
Consolidated Data			
Number of hospitals (at end of period)	118	115	70
Licensed beds (at end of period)(1)	17,245	16,716	8,406
Beds in service (at end of period)(2)	15,063	14,446	6,753
Admissions(3)	663,328	459,046	307,964
Adjusted admissions(4)	1,196,602	842,368	570,969
Patient days(5)	2,808,247	1,923,547	1,264,256
Average length of stay (days)(6)	4.2	4.2	4.1
Occupancy rate (beds in service)(7)	52.0%	52.2%	54.3%
Net operating revenues	$ 10,840,098	$ 7,063,775	$ 4,180,136
Net inpatient revenues as a % of total net operating revenues	50.3%	49.2%	50.0%
Net outpatient revenues as a % of total net operating revenues	47.5%	48.8%	48.8%
Net Income	$ 218,304	$ 30,289	$ 168,263
Net Income as a % of total net operating revenues	2.0%	0.4%	4.0%
Liquidity Data			
Adjusted EBITDA(8)	$ 1,524,723	$ 814,980	$ 564,339
Adjusted EBITDA as a % of total net operating revenues(8)	14.1%	11.7%	13.5%
Net cash flows provided by operating activities	$ 1,057,281	$ 687,738	$ 350,255
Net cash flows provided by operating activities as a % of total net operating revenues	9.8%	9.7%	8.4%
Net cash flows used in investing activities	$ (665,471)	$ (7,498,858)	$ (640,257)
Net cash flows provided by (used in) financing activities	$ (304,029)	$ 6,903,428	$ 226,460

See pages 10 and 11 for footnotes.

	Year Ended December 31, 2008	2007	(Decrease) Increase
	(Dollars in thousands)		
Same-Store Data(9)			
Admissions(3)	651,211	638,635	2.0%
Adjusted admissions(4)	1,174,600	1,149,284	2.2%
Patient days(5)	2,754,336	2,763,735	
Average length of stay (days)(6)	4.2	4.3	
Occupancy rate (beds in service)(7)	52.1%	52.8%	
Net operating revenues	$ 10,620,627	$ 9,962,447	6.6%
Income from operations	$ 981,365	$ 621,983	57.8%
Income from operations as a % of net operating revenues	9.2%	6.2%	
Depreciation and amortization	$ 487,637	$ 446,254	
Equity in earnings of unconsolidated affiliates	$ 42,064	$ 48,796	

(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 of beds in service.

(8) EBITDA consists of net income (loss) before interest, income taxes, depreciation and amortization. Adjusted EBITDA is EBITDA adjusted to exclude discontinued operations, loss from early extinguishment of debt and minority interest in earnings. We have from time to time sold minority interests in certain of our subsidiaries or acquired subsidiaries with existing minority interest ownership positions. We believe that it is useful to present adjusted EBITDA because it excludes the portion of EBITDA attributable to these third party interests and clarifies for investors our portion of EBITDA generated by continuing operations. We use adjusted EBITDA as a measure of liquidity. We have included this measure because we believe it provides investors with additional information about our ability to incur and service debt and make capital expenditures. Adjusted EBITDA is the basis for a key component in the determination of our compliance with some of the covenants under our senior secured credit facility, as well as 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).

Adjusted EBITDA is not a measurement of financial performance or liquidity under generally accepted accounting principles. It should not be considered in isolation or as a substitute for net income, operating income, cash flows from operating, investing or financing activities, or any other measure calculated in accordance with generally accepted accounting principles. The items excluded from adjusted EBITDA are significant components in understanding and evaluating financial performance and liquidity. Our calculation of adjusted EBITDA may not be comparable to similarly titled measures reported by other companies.

The following table reconciles adjusted EBITDA, as defined, to our net cash provided by operating activities as derived directly from our consolidated financial statements for the years ended December 31, 2008, 2007, and 2006 (in thousands):

	Year Ended December 31,		
	2008	2007	2006
Adjusted EBITDA	$ 1,524,723	$ 814,980	$ 564,339
Interest expense, net	(651,925)	(361,773)	(94,411)
Provision for income taxes	(129,479)	(41,828)	(110,152)
Deferred income taxes	159,870	(39,894)	(25,228)
Income (loss) from operations of hospitals sold or held for sale	5,316	(8,884)	(6,873)
Income tax (expense) benefit on the non-cash impairment and (gain) loss on sale of hospitals	(6,357)	5,298	1,378
Depreciation and amortization of discontinued operations	7,609	21,458	9,485
Stock compensation expense	52,105	38,771	20,073
Excess tax benefits relating to stock based compensation	(1,278)	(1,216)	(6,819)
Other non-cash (income) expenses, net	3,577	19,017	500
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	(57,437)	131,300	(71,141)
Supplies, prepaid expenses and other current assets	(34,711)	(31,977)	(4,544)
Accounts payable, accrued liabilities and income taxes	119,596	125,959	52,151
Other	65,672	16,527	21,497
Net cash provided by operating activities	$ 1,057,281	$ 687,738	$ 350,255

(9) Includes former Triad hospital's data, as if we owned them as of January 1, 2007 (acquisition date was July 25, 2007) and other acquired hospitals to the extent we operated them during comparable periods in both years. We have restated our 2008 and 2007 financial statements and statistical results to reflect the reclassification in 2008 of one hospital owned by us during these periods, which is held for sale, to discontinued operations.

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
- patient directly.

The following table presents the approximate percentages of net operating revenue received from Medicare, Medicaid, managed care, self-pay and other sources for the periods indicated. The data for the years presented are not strictly comparable due to the significant effect that hospital acquisitions have had on these statistics.

Net Operating Revenues by Payor Source	2008	2007	2006
Medicare	27.5%	29.0%	30.4%
Medicaid	9.1%	10.3%	11.1%
Managed Care and other third party payors	52.7%	50.7%	46.7%
Self-pay	10.7%	10.0%	11.8%
Total	100.0%	100.0%	100.0%

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

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, which provides medical benefits to individuals who are 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. 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.

In addition to government programs, we are paid by private payors, which include insurance companies, HMOs, PPOs, other managed care companies, employers, and by patients directly. Blue Cross payors are included in "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 are negotiating discounted fee structures or fixed amounts for hospital services performed, rather than paying healthcare providers the amounts billed. We negotiate discounts with managed care companies, which are typically smaller than discounts under governmental programs. If an increased number of insurance companies, HMOs, PPOs, and other managed care companies succeed in negotiating discounted fee structures or fixed amounts, our results of operations may be negatively affected. For more information on the payment programs on which our revenues depend, see "Payment" on page 17.

As of December 31, 2008, Indiana and Texas represented the only areas of geographic concentration. Net operating revenues as a percentage of consolidated net operating revenues generated in Indiana were 11.0% in 2008 and 7.7% in 2007. Net operating revenues as a percentage of consolidated net operating revenues generated in Texas were 13.4% in 2008, 13.0% in 2007 and 10.4% in 2006. As a result of our growth and expansion of services in other states, Pennsylvania no longer represents an area of geographic concentration, which it did as of December 31, 2007.

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

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

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 relate to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, hospital use, rate-setting, compliance with building codes, and environmental protection laws. There are also extensive regulations governing a hospital's participation in these government programs. If we fail to comply with applicable laws and regulations, we can be subject to criminal penalties and civil sanctions, our hospitals can lose their licenses and we could lose our ability to participate in these government programs. In addition, 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 in substantial compliance with current federal, state, and local regulations and standards.

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 on Accreditation of Healthcare Organizations. This accreditation indicates that a hospital satisfies the applicable health and administrative standards to participate in Medicare and Medicaid programs.

Healthcare Reform. The healthcare industry continues to attract much legislative interest and public attention. In recent years, an increasing number of legislative proposals have been introduced or proposed in Congress and in some state legislatures that would affect major changes in the healthcare system. The Obama administration has stated as a top priority its desire to reform the U.S. health care system with the goal of providing affordable, accessible health care for all Americans. Proposals that have been considered include cost controls on hospitals, insurance market reforms to increase the availability of group health insurance to small businesses, and mandatory health insurance coverage for employees. The "American Recovery and Reinvestment Act of 2009" has been signed into law providing for a temporary increase in the federal matching assistance percentage (FMAP), a temporary increase in federal Medicaid DSH allotments, subsidization of health insurance premiums (COBRA) for up to nine months, and grants and loans for infrastructure and incentive payments for providers who adopt and use health information technology. The costs of implementing this law and other proposals could be financed, in part, by reductions in payments to healthcare providers under Medicare, Medicaid, and other government programs. We cannot predict the course of future healthcare legislation, other changes the administration may seek to implement regarding healthcare or interpretations by the administration of existing governmental healthcare programs and the effect that any legislation change or interpretation may have on us.

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

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of the fraud and abuse laws. Under HIPAA, 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.

Another law regulating the healthcare industry is a section of the Social Security Act, known as the "anti-kickback" statute. This law 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 program. Violations of the anti-kickback statute may be punished by criminal and civil fines, exclusion from federal healthcare programs, and damages up to three times the total dollar amount involved.

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. However, the failure of a particular activity to comply with the safe harbor regulations does not necessarily mean that the activity violates the anti-kickback statute.

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

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 believe that we have structured our arrangements with physicians in light of the "safe harbor" rules, 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.

The Social Security Act also includes a provision commonly known as the "Stark law." This law prohibits physicians from referring Medicare patients to healthcare entities in which they or any of their immediate family members have ownership interests or other financial arrangements. These types of referrals are commonly known as "self referrals." Sanctions for violating the Stark law include denial of payment, civil money penalties, assessments equal to twice the dollar value of each service, and exclusion from government payor programs. There are ownership and compensation arrangement exceptions to the self-referral prohibition. One 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. We strive to comply with the Stark law and regulations; however, the government may interpret the law and regulations differently. If we are found to have violated the Stark law or regulations, we could be subject to significant sanctions, including damages, penalties, and exclusion from federal health care programs.

Many states in which we operate also have adopted similar laws relating to financial relationships with physicians. Some of these state laws apply even if the payment for care does not come from the government. These statutes typically provide criminal and civil penalties as well as loss of licensure. While there is little precedent for the interpretation or enforcement of these state laws, we have attempted to structure our financial relationships with physicians and others in light of these laws. However, if we are found to have violated these state laws, it could result in the imposition of criminal and civil penalties as well as possible licensure revocation.

False Claims Act. Another trend in healthcare litigation is the increased use of the False Claims Act, or FCA. This law makes providers liable for, among other things, the knowing submission of a false claim for reimbursement by the federal government. The FCA has been used not only by the U.S. government, but also by individuals who bring an action on behalf of the government under the law's "qui tam" or "whistleblower" provisions and share in any recovery. When a private party brings a qui tam action under the FCA, it files the complaint with the court under seal, and the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation.

Civil liability under the FCA can be up to three times the actual damages sustained by the government plus civil penalties of up to $11,000 for each separate false claim submitted to the government. There are many potential bases for liability under the FCA. Although liability under the FCA arises when an entity knowingly submits a false claim for reimbursement, the FCA defines the term "knowingly" to include reckless disregard of the truth or falsity of the claim being submitted.

A number of states in which we operate have enacted state false claims legislation. These state false claims laws are generally modeled on the federal FCA, with similar damages, penalties, and qui tam enforcement provisions. An increasing number of healthcare false claims cases seek recoveries under both federal and state law.

Provisions in the Deficit Reduction Act of 2005, or DRA, that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal FCA. Additionally, the DRA requires every entity that receives annual payments of at least $5 million from a state Medicaid plan to establish written policies for its employees that provide detailed information about federal and state false claims statutes and the whistleblower protections that exist under those laws. Both provisions of the DRA are expected to result in increased false claims litigation against health care providers. We have substantially complied with the written policy requirements.

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 or fee-splitting arrangements between physicians and unlicensed persons or business entities. Possible sanctions for violations of these restrictions include loss of a physician's license, civil and criminal penalties and rescission of business arrangements. These laws vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. We structure our arrangements with healthcare providers to comply with the relevant state law. However, we cannot assure you 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. In addition, the law creates private civil remedies which 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 or others will not assert we are in violation of these laws.

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 additional 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 certificate of need 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, 2008, we operated 54 hospitals in 16 states that have adopted certificate of need 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.

Privacy and Security Requirements of HIPAA. The Administrative Simplification Provisions of HIPAA require 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. We believe we are in compliance with these regulations.

The Administrative Simplification Provisions also require CMS to adopt standards to protect the security and privacy of health-related information. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. If we violate these regulations, we could be subject to monetary fines and penalties, criminal sanctions and civil causes of action. We have implemented and operate continuing employee education programs to reinforce operational compliance with policy and procedures which adhere to privacy regulations. The HIPAA security standards and privacy regulations serve similar purposes and overlap to a certain extent, but the security regulations relate more specifically to protecting the integrity, confidentiality and availability of electronic protected health information while it is in our custody or being transmitted to others. We believe we have established proper controls to safeguard access to protected health information.

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. For the federal fiscal year 2008 (i.e., the federal fiscal year beginning October 1, 2007), each DRG was assigned a payment rate using 67% of the national average cost per case and 33% of the national average charge per case and 50% of the change to severity adjusted DRG weights. Severity adjusted DRG's more accurately reflect the costs a hospital incurs for caring for a patient and accounts more fully for the severity of each patient's condition. For the federal fiscal year 2009, 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. 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 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 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 2006, 2007, 2008 and 2009 or 3.7%, 3.4%, 3.3% and 3.6%, respectively. The Deficit Reduction Act of 2005 imposes a two percentage point reduction to the market basket index beginning October 1, 2007, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement. Future legislation may decrease the rate of increase for DRG payments, but we are not able to predict the amount of any reduction or the effect that any reduction will have on us.

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. For the majority of our hospitals that qualify to receive Medicare disproportionate share payments, these payments were increased by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 effective April 1, 2004. These Medicare disproportionate share payments as a percentage of net operating revenues were 1.8%, 1.8% and 2.1% for the years ended December 31, 2008, 2007 and 2006, respectively.

Beginning August 1, 2000, we began receiving Medicare reimbursement for outpatient services through a PPS. Under the Balanced Budget Refinement Act of 1999, non-urban hospitals with 100 beds or less were held harmless through December 31, 2004 under this Medicare outpatient PPS. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 extended the hold harmless provision for non-urban hospitals with 100 beds or less and for non-urban sole community hospitals with more than 100 beds through December 31, 2005. The Deficit Reduction Act of 2005 extended the hold harmless provision for non-urban hospitals with 100 beds or less that are not sole community hospitals through December 31, 2008; however, that Act reduced the amount these hospitals would receive in hold harmless payment by 5% in 2006, 10% in 2007 and 15% in 2008. Of our 118 hospitals in continuing operations at December 31, 2008, 31 qualified for this relief. The Medicare Improvements for Patients and Providers Act extends the hold harmless provision for non-urban hospitals with 100 beds or less, including non-urban sole community hospitals, through December 31, 2009, at 85% of the hold harmless amount. Of our 118 hospitals in continuing operations at December 31, 2008, 44 will qualify for this relief. The outpatient conversion factor was increased 3.7%

effective January 1, 2006; however, coupled with adjustments to other variables within the outpatient PPS resulted in an approximate 2.2% to 2.6% net increase in outpatient PPS payments. The outpatient conversion factor was increased 3.4% effective January 1, 2007; however, coupled with adjustments to other variables with the outpatient PPS, an approximate 2.5% to 2.9% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.3% effective January 1, 2008; however, coupled with adjustments to other variables with the outpatient PPS, an approximate 3.0% to 3.4% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.6% effective January 1, 2009; however, coupled with adjustments to other variables with outpatient PPS, an approximate 3.5% to 3.9% net increase in outpatient payments is expected to occur. The Medicare Improvements and Extension Act of the Tax Relief and Health Care Act of 2006 imposes a two percentage point reduction to the market basket index beginning January 1, 2009, and each year thereafter, if patient quality data is not submitted. We intend to comply with this data submission requirement.

Skilled nursing facilities and swing bed facilities were historically paid by Medicare on the basis of actual costs, subject to limitations. The Balanced Budget Act of 1997 established a PPS for Medicare skilled nursing facilities and mandated that swing bed facilities must be incorporated into the skilled nursing facility PPS. For federal fiscal year 2006, skilled nursing facility PPS payment rates were increased by the full market basket of 3.1%; however coupled with adjustments to other variables within the skilled nursing facility PPS, an approximate 3.9% to 4.3% net increase in skilled nursing facility PPS payments occurred. Skilled nursing facility PPS rates were increased by the full SNF market basket index of 3.1%, 3.3% and 3.4% for the federal fiscal years 2007, 2008 and 2009, respectively.

The Department of Health and Human Services established a PPS for home health services (i.e. home care) effective October 1, 2000. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 implemented a 0.8% reduction to the market basket increase to the home health agency PPS per episodic payment rate effective April 1, 2004 and for the federal fiscal years 2005 and 2006, and increased Medicare payments by 5.0% to home health services provided in rural areas from April 1, 2004 through March 31, 2005. The Deficit Reduction Act of 2005 extended the 5.0% increase to home health services provided in rural areas for an additional year effective January 1, 2006 and froze home health agency payments for 2006 at 2005 levels. The home health agency PPS per episodic payment rate increased by 0% on January 1, 2006 and 3.3% on January 1, 2007. The home health agency PPS per episodic payment rate increased by 3% on January 1, 2008; however, coupled with adjustments to other variables with home health agency PPS, an approximate 1.5% to 1.9% net increase in home health agency payments occurred. The home health agency PPS per episodic payment rate increased by 2.9% on January 1, 2009; however, coupled with adjustments to other variables with home health agency PPS, an approximate 0.2% net increase in home health agency payments is expected to occur. The Deficit Reduction Act of 2005 imposes a two percentage point reduction to the market basket index beginning January 1, 2007, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement.

Medicaid. Most state Medicaid payments are made under a PPS or under programs which negotiate payment levels with individual hospitals. Medicaid is currently 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. We can provide no assurance that reductions to Medicaid fundings will not have a material adverse effect on our consolidated results of operations.

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

Commercial Insurance. Our hospitals provide services to individuals covered by private healthcare insurance. Private insurance carriers 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. Commercial insurers are trying to limit the costs of hospital services by negotiating discounts, including PPS, which would reduce payments by commercial insurers to our hospitals. Reductions in payments for services provided by our hospitals to individuals covered by commercial insurers could adversely affect us.

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 minority partner. Triad was also a minority partner in HeathTrust and we acquired their ownership interest and contractual rights in the acquisition. As of December 31, 2008, we have a 17.0% 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 we expect to achieve.

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 select 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 has intensified in recent years. Our hospitals are located in non-urban and selected urban service areas. 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 do 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.

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

The number and quality of the physicians on a hospital's staff is an important factor in a hospital's competitive advantage. 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.

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. 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.

Since its initial adoption, the compliance program continues to be expanded and developed to meet the industry's expectations and our needs. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring activities have been prepared and implemented to address the functional and operational aspects of our business. Included within these functional areas are materials and activities for business sub-units, including laboratory, radiology, pharmacy, emergency, surgery, observation, home care, skilled nursing, and clinics. Specific areas identified through regulatory interpretation and enforcement activities have also been addressed in our program. Claims preparation and submission, including coding, billing, and cost reports, comprise the bulk of these areas. Financial arrangements with physicians and other referral sources, including compliance with anti-kickback and Stark laws, 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_conduct.html.

Employees

At December 31, 2008, we employed approximately 55,579 full-time employees and 22,755 part-time employees. Of these employees, approximately 2,010 are union members. We currently believe that our labor relations are good.

Professional Liability Claims

As part of our business of owning and operating hospitals, we are subject to legal actions alleging liability on our part. To cover claims arising out of the operations of hospitals, we maintain professional malpractice liability insurance and general liability insurance on a claims made basis in excess of those amounts for which we are self-insured, in amounts we believe to be sufficient for our operations. We also maintain umbrella liability coverage for claims which, due to their nature or amount, are not covered by our other insurance policies. However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. For a further discussion of our insurance coverage, see our discussion of professional liability claims in "Management's Discussion and Analysis of Financial Condition and Results of Operations."

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 waste products. Compliance with these laws and regulations is not expected 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 $2 million per occurrence with a $25,000 deductible and a $10 million annual aggregate. This policy also provides pollution legal liability coverage for the former Triad hospitals.

Under a separate insurance policy, we are insured for onsite and offsite third party bodily injury, property damage and clean up costs including business interruption insurance coverage for actual losses or rental value resulting from pollution issues for all of our hospitals other than the former Triad hospitals. This policy coverage for pollution legal liability is $3 million per occurrence with a $100,000 deductible and a $6 million annual aggregate.

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

The following risk factors could materially and adversely affect our future operating results and could cause actual results to differ materially from those predicted in the forward-looking statements we make about our business.

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

We are significantly leveraged. The chart below shows our level of indebtedness and other information as of December 31, 2008. In connection with the consummation of our acquisition of Triad in July 2007, $7.215 billion senior secured financing under a new credit facility, or "New Credit Facility", was obtained by our wholly-owned subsidiary, CHS/Community Health Systems, Inc. or CHS. CHS also issued 8.875% senior notes, or the "Notes", having an aggregate principal amount of $3.021 billion. Both the indebtedness under the New Credit Facility and the Notes are senior obligations of CHS and are guaranteed on a senior basis by us and by certain of our domestic subsidiaries. We used the net proceeds from the Notes offering and the net proceeds of the $6.065 billion term loans under the New Credit Facility to pay the consideration under the merger agreement with Triad, to refinance certain of our existing indebtedness and the indebtedness of Triad, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. As of December 31, 2008, a $750 million revolving credit facility and $200 million of our delayed draw term loan facility are available to us for working capital and general corporate purposes under the New Credit Facility, with $93.6 million of the revolving credit facility being set aside for outstanding letters of credit. During the fourth quarter of 2008, $100 million of the delayed draw term loan had been drawn down by us, reducing the delayed draw term loan availability from $300 million to $200 million at December 31, 2008. In January 2009, we drew down the remaining $200 million of the delayed draw term loan.

Also, in connection with the consummation of the acquisition of Triad, we completed an early repayment of the $300 million aggregate principal amount of 6.5% Senior Subordinated Notes due 2012 through a cash tender offer and consent solicitation.

		As of December 31, 2008 ($ in millions)
Senior secured credit facility		
Term loans	$	5,965.9
Notes		2,910.8
Other		90.7
Total debt		8,967.4
Stockholder equity		1,672.9

The following table shows the ratio of earnings to fixed charges for the periods indicated:

	Year Ended December 31,				
	2004	2005	2006	2007	2008
Ratio of earnings to fixed charges(1)	3.87 x	3.79 x	3.37 x	1.22 x	1.47 x

(1) There are no shares of preferred stock outstanding.

As of December 31, 2008, our $5.350 billion notional amount of interest rate swap agreements represented approximately 89.7% of our variable rate debt. On a prospective basis, a 1% change in interest rates on the remaining unhedged variable rate debt existing as of December 31, 2008, would result in interest expense fluctuating approximately $6.2 million per year.

The New Credit Facility and/or the Notes contain various covenants that limit our ability to take certain actions, including our ability to:

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

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

The counterparty to the interest rate swap agreements exposes us to credit risk in the event of non-performance. However, at December 31, 2008, we do not anticipate non-performance by the counterparty due to the net settlement feature of the agreements and our liability position with respect to all of our counterparties.

A breach of any of these covenants could result in a default under our New Credit Facility and/or the Notes. Upon the occurrence of an event of default under our New Credit Facility or the Notes, all amounts outstanding under our New Credit Facility and the Notes may become due and payable and all commitments under the New Credit Facility to extend further credit may be terminated.

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

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

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

We may be able to incur substantial additional indebtedness in the future. The terms of the indenture governing the Notes do not fully prohibit us from doing so. For example, under the indenture for the Notes, we may incur up to $7.815 billion pursuant to a credit facility or a qualified receivables transaction, less certain amounts repaid with the proceeds of asset dispositions. Our New Credit Facility provides for commitments of up to $7.115 billion in the aggregate. Our New Credit Facility also gives us the ability to provide for one or more additional tranches of term loans in aggregate principal amount of up to $600 million without the consent of the existing lenders if specified criteria are satisfied. If new debt is added to our current debt levels, the related risks that we now face could intensify.

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

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

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

Many of the hospitals we have acquired, had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced temporary delays in improving the operating margins or effectively integrating the operations of these acquired hospitals. In the future, if we are unable to improve the operating margins of acquired hospitals, operate them profitably, or effectively integrate their operations, we may be unable to achieve our growth strategy. We acquired 50 hospitals in the Triad acquisition. In the past, we have not acquired this many hospitals at one time. We may still experience delays or difficulties in improving the operating margins or the operations of these acquired hospitals.

We may not be able to successfully integrate our acquisition of Triad or realize the potential benefits of the acquisition, which could cause our business to suffer.

We may not be able to combine successfully the operations of former Triad hospitals with our operations and, even if such integration is accomplished, we may never realize the potential benefits of the acquisition. The integration of former Triad hospitals with our operations requires significant attention from management and may impose substantial demands on our operations or other projects. In addition, Triad's corporate officers did not continue their employment with us. The integration of Triad also involves a significant capital commitment, and the return that we achieve on any capital invested may be less than the return that we would achieve on our other projects or investments. Any of these factors could cause delays or increased costs of combining former Triad hospitals with us; and could adversely affect our operations, financial results and liquidity.

Certain of Triad's joint venture partners have put or call rights, the exercise of which could affect our available cash and/or operating results. Triad entered into a number of joint venture transactions that entitle its joint venture partners to require Triad to purchase the partner's interest or to require Triad to sell its interest to the partner. The consideration provided for in these contracts may not be at an advantageous amount vis-à-vis the consideration paid for the Triad acquisition. If these rights are exercised, we may be required to make unanticipated payments, our operations at certain facilities may be adversely affected, or we may be required to divest certain facilities.

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

Hospitals that we acquire may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. Although we generally seek indemnification from prospective sellers covering these matters, we may nevertheless have material liabilities for past activities of acquired hospitals. In the case of the Triad acquisition, there was no indemnification provided given the fact that Triad was a public company and the acquisition was effective through a merger.

As a result of the Triad acquisition, on a consolidated basis, we are subject to all of the potential liabilities relating to the hospitals held by Triad, including liabilities relating to pending or threatened litigation matters, which, if adversely decided, could have a material adverse effect on our future results, operations and liquidity.

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

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

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

Many states, including some where we have hospitals and others where we may in the future acquire hospitals, have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In other states that do not have specific legislation, the attorneys general have demonstrated an interest in these transactions under their general obligations to protect charitable assets from waste. 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 actions on the state level could seriously delay or even prevent our ability to acquire hospitals.

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

The hospital industry is highly competitive. In addition to the competition we face for acquisitions and physicians, we must also compete with other hospitals and healthcare providers for patients. The competition among hospitals and other healthcare providers for patients has intensified in recent years. Our hospitals are located in non-urban service areas. In approximately 65% of our markets, we are the sole provider of general healthcare services. In most of our other markets, the primary competitor is a not-for-profit hospital. These not-for-profit hospitals generally differ in each jurisdiction. However, our hospitals face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in our primary service areas may travel to these other hospitals for a variety of reasons. These reasons include physician referrals or the need for services we do not offer. Patients who seek services from these other hospitals may subsequently shift their preferences to those hospitals for the services we provide.

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

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

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

We have a five-year participation agreement with a GPO. This agreement extends to March 2010, with automatic renewal terms of one year, unless either party terminates by giving notice of non-renewal. GPOs attempt to obtain favorable pricing on medical supplies with manufacturers and vendors who sometimes negotiate exclusive supply arrangements in exchange for the discounts they give. To the extent these exclusive supply arrangements are challenged or deemed unenforceable, we could incur higher costs for our medical supplies obtained through HealthTrust. These higher costs could cause our operating results to decline.

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

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

At December 31, 2008, we had approximately $4.166 billion of goodwill recorded on our books. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. If the carrying value of our goodwill is impaired, we may incur a material non-cash charge to earnings.

The current turmoil in the financial markets and weakness in macroeconomic conditions globally continue to be challenging and we cannot be certain of the duration of these conditions and their potential impact on our stock price performance. If a further decline in our market capitalization and other factors resulted in the decline in our fair value, it is reasonably likely that a goodwill impairment assessment prior to the next annual review, in the fourth quarter of 2009, would be necessary. If such an assessment is required, an impairment of goodwill may be recognized. A non-cash goodwill impairment charge would have the effect of decreasing our earnings or increasing our losses in the period the impairment is recognized. The amount of such effect on earnings and losses is dependent on the size of the impairment charge.

Risks related to our industry

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

In 2008, 36.6% of our net operating revenues came from the Medicare and Medicaid programs. In recent years, federal and state governments made significant changes in the Medicare and Medicaid programs, including the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Some of these changes have decreased the amount of money we receive for our services relating to these programs.

In recent years, Congress and some state legislatures have introduced an increasing number of other proposals to make major changes in the healthcare system including an increased emphasis on the linkage between quality of care criteria and payment levels such as the submission of patient quality data to the Secretary of Health and Human Services. In addition, CMS conducts ongoing reviews of certain state reimbursement programs. Federal funding for existing programs may not be approved in the future. Future federal and state legislation may further reduce the payments we receive for our services. The Obama administration has stated as a top priority its desire to reform the U.S. healthcare system with the goal of providing affordable, accessible health care for all Americans. Proposals that have been considered include cost controls on hospitals, insurance market reforms to increase the availability of group health insurance to small businesses, and mandatory health insurance coverage for employees. The "American Recovery and Reinvestment Act of 2009" has been signed into law providing for a temporary increase in the federal matching assistance percentage (FMAP), a temporary increase in federal Medicaid DSH allotments, subsidization of health insurance premiums (COBRA) for up to nine months, and grants and loans for infrastructure and incentive payments for providers who adopt and use health information technology. The costs of implementing this law and other proposals could be financed, in part, by reductions in payments to healthcare providers under Medicare, Medicaid, and other government programs. We cannot predict the course of future healthcare legislation, other changes the administration may seek to implement regarding healthcare or interpretations by the administration of existing governmental healthcare programs and the effect that any legislation change or interpretation may have on us.

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

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

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

In addition, there are heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment. The ongoing investigations relate to various referral, cost reporting, and billing practices, laboratory and home care services, and physician ownership and joint ventures involving hospitals. For example, the Department of Justice has alleged that we and three of our New Mexico hospitals have caused the state of New Mexico to submit improper claims for federal funds in violation of the Civil False Claims Act. For a further discussion of this matter, see "Legal Proceedings."

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

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

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

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

In recent years, physicians, hospitals, and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability, or related legal theories. Even in states that have imposed caps on damages, litigants are seeking recoveries under new theories of liability that might not be subject to the caps on damages. Many of these actions involve large claims and significant defense costs. To protect us from the cost of these claims, we maintain professional malpractice liability insurance and general liability insurance coverage in excess of those amounts for which we are self-insured, in amounts that we believe to be sufficient for our operations. However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. The cost of malpractice and other professional liability insurance increased in 2006 by 0.1%, decreased in 2007 by 0.1% and decreased in 2008 by 0.2% as a percentage of net operating revenue. If these costs rise rapidly, our profitability could decline. For a further discussion of our insurance coverage, see our discussion of professional liability insurance claims in "Management's Discussion and Analysis of Financial Condition and Results of Operations."

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

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

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

This Report includes forward-looking statements which could differ from actual future results.

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

- general economic and business conditions, both nationally and in the regions in which we operate;
- our ability to successfully integrate any acquisitions or to recognize expected synergies from such acquisitions, including facilities acquired from Triad;
- risks associated with our substantial indebtedness, leverage and debt service obligations;
- demographic changes;
- changes in, or the failure to comply with, governmental regulations;
- legislative proposals for healthcare reform;

- potential adverse impact of known and unknown government investigations and Civil False Claims Act litigation;
- our ability, where appropriate, to enter into or maintain managed care provider arrangements and the terms of these arrangements;
- changes in inpatient or outpatient Medicare and Medicaid payment levels;
- increases in the amount and risk of collectability of patient accounts receivable;
- increases in wages as a result of inflation or competition for highly technical positions and rising supply costs due to market pressure from pharmaceutical companies and new product releases;
- liabilities and other claims asserted against us, including self-insured malpractice claims;
- competition;
- our ability to attract and retain, without significant employment costs, qualified personnel, key management, physicians, nurses and other healthcare workers;
- trends toward treatment of patients in less acute or specialty healthcare settings, including ambulatory surgery centers or specialty hospitals;
- changes in medical or other technology;
- changes in GAAP;
- the availability and terms of capital to fund additional acquisitions or replacement facilities;
- our ability to successfully acquire additional hospitals and complete the sale of hospitals held for sale;
- our ability to obtain adequate levels of general and professional liability insurance; and
- timeliness of reimbursement payments received under government programs.

Although we believe that these statements are based upon reasonable assumptions, we can give no assurance that our goals will be achieved. Given these uncertainties, prospective investors are cautioned not to place undue reliance on these forward-looking statements. These forward-looking statements are made as of the date of this filing. We assume no obligation to update or revise them or provide reasons why actual results may differ.

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 internal medicine, surgery, cardiology, oncology, orthopedics, OB/GYN, diagnostic and emergency room services, laboratory, radiology, respiratory therapy, physical therapy, 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, 2008, including the two hospitals classified as held for sale and included in discontinued operations, 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				
LV Stabler Memorial Hospital	Greenville	72	October, 1994	Owned
South Baldwin Regional Medical Center	Foley	112	June, 2000	Leased
Cherokee Medical Center	Centre	60	April, 2006	Owned
Dekalb Regional Medical Center	Fort Payne	134	April, 2006	Owned
Trinity Medical Center	Birmingham	560	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	150	July, 2007	Owned
Alaska				
Mat-Su Regional Medical Center	Palmer	74	July, 2007	Owned
Arizona				
Payson Regional Medical Center	Payson	44	August, 1997	Leased
Western Arizona Regional Medical Center	Bullhead City	139	July, 2000	Owned
Northwest Medical Center	Tucson	300	July, 2007	Owned
Northwest Medical Center Oro Valley	Oro Valley	144	July, 2007	Owned
Arkansas				
Harris Hospital	Newport	133	October, 1994	Owned
Helena Regional Medical Center	Helena	155	March, 2002	Leased
Forrest City Medical Center	Forrest City	118	March, 2006	Leased
Northwest Medical Center — Bentonville	Bentonville	128	July, 2007	Owned
Northwest Medical Center — Springdale	Springdale	222	July, 2007	Owned
Willow Creek Women's Hospital(2)	Johnson	64	July, 2007	Owned
California				
Barstow Community Hospital	Barstow	56	January, 1993	Leased
Fallbrook Hospital	Fallbrook	47	November, 1998	Operated(3)
Watsonville Community Hospital	Watsonville	106	September, 1998	Owned
Florida				
Lake Wales Medical Center	Lake Wales	154	December, 2002	Owned
North Okaloosa Medical Center	Crestview	110	March, 1996	Owned
Georgia				
Fannin Regional Hospital	Blue Ridge	50	January, 1986	Owned
Trinity Hospital of Augusta	Augusta	231	July, 2007	Owned
Illinois				
Crossroads Community Hospital	Mt. Vernon	55	October, 1994	Owned
Gateway Regional Medical Center	Granite City	416	January, 2002	Owned
Heartland Regional Medical Center	Marion	92	October, 1996	Owned
Red Bud Regional Hospital	Red Bud	31	September, 2001	Owned
Galesburg Cottage Hospital	Galesburg	173	July, 2004	Owned

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Vista Medical Center East/West	Waukegan	407	July, 2006	Owned
Union County Hospital	Anna	25	November, 2006	Leased
Indiana				
Porter Hospital	Valparaiso	301	May, 2007	Owned
Bluffton Regional Medical Center	Bluffton	79	July, 2007	Owned
Dupont Hospital	Fort Wayne	131	July, 2007	Owned
Lutheran Hospital	Fort Wayne	432	July, 2007	Owned
St. Joseph's Hospital	Fort Wayne	191	July, 2007	Owned
Dukes Memorial Hospital	Peru	25	July, 2007	Owned
Kosciusko Community Hospital	Warsaw	72	July, 2007	Owned
Lutheran Musculoskeletal Center(4)	Fort Wayne	39	July, 2007	Owned
Kentucky				
Parkway Regional Hospital	Fulton	70	May, 1992	Owned
Three Rivers Medical Center	Louisa	90	May, 1993	Owned
Kentucky River Medical Center	Jackson	55	August, 1995	Leased
Louisiana				
Byrd Regional Hospital	Leesville	60	October, 1994	Owned
Northern Louisiana Medical Center	Ruston	159	April, 2007	Leased
Women & Children's Hospital	Lake Charles	88	July, 2007	Owned
Mississippi				
Wesley Medical Center	Hattiesburg	211	July, 2007	Owned
River Region Health System	Vicksburg	341	July, 2007	Owned
Missouri				
Moberly Regional Medical Center	Moberly	103	November, 1993	Owned
Northeast Regional Medical Center	Kirksville	115	December, 2000	Leased
Nevada				
Mesa View Regional Hospital	Mesquite	25	July, 2007	Owned
New Jersey				
Memorial Hospital of Salem County	Salem	140	September, 2002	Owned
New Mexico				
Mimbres Memorial Hospital	Deming	49	March, 1996	Owned
Eastern New Mexico Medical Center	Roswell	162	April, 1998	Owned
Alta Vista Regional Hospital	Las Vegas	54	April, 2000	Owned
Carlsbad Medical Center	Carlsbad	112	July, 2007	Owned
Lea Regional Medical Center	Hobbs	234	July, 2007	Owned
Mountain View Regional Medical Center	Las Cruces	168	July, 2007	Owned
North Carolina				
Martin General Hospital	Williamston	49	November, 1998	Leased
Ohio				
Affinity Medical Center	Massillon	432	July, 2007	Owned
Oklahoma				
Ponca City Medical Center	Ponca City	140	May, 2006	Owned
Claremore Regional Hospital	Claremore	81	July, 2007	Owned

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Deaconess Hospital	Oklahoma City	313	July, 2007	Owned
SouthCrest Hospital	Tulsa	180	July, 2007	Owned
Woodward Regional Hospital	Woodward	87	July, 2007	Owned
Oregon				
McKenzie-Willamette Medical Center	Springfield	114	July, 2007	Owned
Pennsylvania				
Berwick Hospital	Berwick	101	March, 1999	Owned
Brandywine Hospital	Coatesville	175	June, 2001	Owned
Jennersville Regional Hospital	West Grove	59	October, 2001	Owned
Easton Hospital	Easton	254	October, 2001	Owned
Lock Haven Hospital	Lock Haven	59	August, 2002	Owned
Pottstown Memorial Medical Center	Pottstown	226	July, 2003	Owned
Phoenixville Hospital	Phoenixville	138	August, 2004	Owned
Chestnut Hill Hospital	Philadelphia	164	February, 2005	Owned
Sunbury Community Hospital	Sunbury	92	October, 2005	Owned
South Carolina				
Marlboro Park Hospital	Bennettsville	102	August, 1996	Leased
Chesterfield General Hospital	Cheraw	59	August, 1996	Leased
Springs Memorial Hospital	Lancaster	231	November, 1994	Owned
Carolinas Hospital System — Florence	Florence	420	July, 2007	Owned
Mary Black Memorial Hospital	Spartanburg	209	July, 2007	Owned
Tennessee				
Lakeway Regional Hospital	Morristown	135	May, 1993	Owned
Regional Hospital Of Jackson	Jackson	154	January, 2003	Owned
Dyersburg Regional Medical Center	Dyersburg	225	January, 2003	Owned
Haywood Park Community Hospital	Brownsville	62	January, 2003	Owned
Henderson County Community Hospital	Lexington	45	January, 2003	Owned
McKenzie Regional Hospital	McKenzie	45	January, 2003	Owned
McNairy Regional Hospital	Selmer	45	January, 2003	Owned
Volunteer Community Hospital	Martin	100	January, 2003	Owned
Heritage Medical Center	Shelbyville	60	July, 2005	Owned
Sky Ridge Medical Center	Cleveland	351	October, 2005	Owned
Gateway Medical Center	Clarksville	270	July, 2007	Owned
Texas				
Big Bend Regional Medical Center	Alpine	25	October, 1999	Owned
Cleveland Regional Medical Center	Cleveland	107	August, 1996	Leased
Scenic Mountain Medical Center	Big Spring	150	October, 1994	Owned
Hill Regional Hospital	Hillsboro	92	October, 1994	Owned
Lake Granbury Medical Center	Granbury	59	January, 1997	Owned
South Texas Regional Medical Center	Jourdanton	67	November, 2001	Owned
Laredo Medical Center	Laredo	326	October, 2003	Owned
Weatherford Regional Medical Center	Weatherford	99	November, 2006	Leased
Abilene Regional Medical Center	Abilene	231	July, 2007	Owned

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Brownwood Regional Medical Center	Brownwood	196	July, 2007	Owned
College Station Medical Center	College Station	150	July, 2007	Owned
Navarro Regional Hospital	Corsicana	162	July, 2007	Owned
Presbyterian Hospital of Denton	Denton	255	July, 2007	Owned
Longview Regional Medical Center	Longview	131	July, 2007	Owned
Woodland Heights Medical Center	Lufkin	149	July, 2007	Owned
San Angelo Community Medical Center	San Angelo	171	July, 2007	Owned
DeTar Healthcare System	Victoria	308	July, 2007	Owned
Cedar Park Regional Medical Center	Cedar Park	77	December, 2007	Owned
Utah				
Mountain West Medical Center	Tooele	35	October, 2000	Owned
Virginia				
Southern Virginia Regional Medical Center	Emporia	80	March, 1999	Owned
Southampton Memorial Hospital	Franklin	105	March, 2000	Owned
Southside Regional Medical Center	Petersburg	300	August, 2003	Owned
Washington				
Deaconess Medical Center	Spokane	388	October, 2008	Owned
Valley Hospital and Medical Center	Spokane Valley	123	October, 2008	Owned
West Virginia				
Plateau Medical Center	Oak Hill	25	July, 2002	Owned
Greenbrier Valley Medical Center	Ronceverte	122	July, 2007	Owned
Wyoming				
Evanston Regional Hospital	Evanston	42	November, 1999	Owned
Total Licensed Beds at December 31, 2008		17,932		

(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) In 2008, we segregated this entity from Northwest Medical Center — Bentonville for reporting purposes.

(3) We operate this hospital under a lease-leaseback and operating agreement. We recognize all operating statistics, revenue and expenses associated with this hospital in our consolidated financial statements.

(4) In 2008, we segregated this entity from Lutheran Hospital for reporting purposes.

The real property of substantially all of our wholly-owned hospitals are encumbered by mortgages under the New Credit Facility.

The following table lists the hospitals owned by joint venture entities in which we do not have a consolidating ownership interest, along with our percentage ownership interest in the joint venture entity as of December 31, 2008. Information on licensed beds was provided by the majority owner and manager of each joint venture. A subsidiary of HCA Inc. is the majority owner of Macon Healthcare LLC, a subsidiary of Universal Health Systems Inc. is the majority owner of Summerlin Hospital Medical Center LLC and Valley Health System LLC and the Share Foundation is the other 50% owner of MCSA LLC.

Joint Venture	Facility Name	City	State	Licensed Beds
Macon Healthcare LLC	Coliseum Medical Center (38%)	Macon	GA	250
Macon Healthcare LLC	Coliseum Psychiatric Center (38%)	Macon	GA	60
Macon Healthcare LLC	Coliseum Northside Hospital (38%)	Macon	GA	103
Summerlin Hospital Medical Center LLC	Summerlin Hospital Medical Center (26.1%)	Las Vegas	NV	281
Valley Health System LLC	Desert Springs Hospital (27.5%)	Las Vegas	NV	286
Valley Health System LLC	Valley Hospital Medical Center (27.5%)	Las Vegas	NV	404
Valley Health System LLC	Spring Valley Hospital Medical Center (27.5%)	Las Vegas	NV	210
Valley Health System LLC	Centennial Hills Medical Center (27.5%)	Las Vegas	NV	165
MCSA LLC	Medical Center of South Arkansas (50%)	El Dorado	AR	166

Item 3. *Legal Proceedings*

From time to time, we receive various inquiries or subpoenas from state regulators, fiscal intermediaries, the Centers for Medicare and Medicaid Services and the Department of Justice regarding various Medicare and Medicaid issues. In addition, we are subject to other claims and lawsuits arising in the ordinary course of our business. We are not aware of any pending or threatened litigation that is not covered by insurance policies or reserved for in our financial statements or which we believe would have a material adverse impact on us; however, some pending or threatened proceedings against us may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Additionally, qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits.

Community Health Systems, Inc. Legal Proceedings

In May 1999, we were served with a complaint in U.S. ex rel. Bledsoe v. Community Health Systems, Inc., subsequently moved to the Middle District of Tennessee, Case No. 2-00-0083. This qui tam action sought treble damages and penalties under the False Claims Act against us. The Department of Justice did not intervene in this action. The allegations in the amended complaint were extremely general, but involved Medicare billing at our White County Community Hospital in Sparta, Tennessee. By order entered on September 19, 2001, the U.S. District Court granted our motion for judgment on the pleadings and dismissed the case, with prejudice. The qui tam whistleblower (also referred to as a "relator") appealed the district court's ruling to the U.S. Court of Appeals for the Sixth Circuit. On September 10, 2003, the Sixth Circuit Court of Appeals rendered its decision in this case, affirming in part and reversing in part the district court's decision to dismiss the case with prejudice. The court affirmed the lower court's dismissal of certain of plaintiff's claims on the grounds that his allegations had been previously publicly disclosed. In addition, the appeals court agreed that, as to all other allegations, the relator had failed to include enough information to meet the special pleading requirements for fraud under the False Claims Act and the Federal Rules of Civil

Procedure. However, the case was returned to the district court to allow the relator another opportunity to amend his complaint in an attempt to plead his fraud allegations with particularity. In May 2004, the relator in U.S. ex rel. Bledsoe filed an amended complaint alleging fraud involving Medicare billing at White County Community Hospital. We then filed a renewed motion to dismiss the amended complaint. On January 6, 2005, the District Court dismissed with prejudice the bulk of the relator's allegations. The only remaining allegations involve a small number of charges from 1997 and 1998 at White County. After further motion practice between the relator and the United States Government regarding the relator's right to participate in a previous settlement with the Company, the District Court again dismissed all claims in the case on December 13, 2005. On January 9, 2006, the relator filed a notice of appeal to the U.S. Court of Appeals for the Sixth Circuit and on September 6, 2007, the Court of Appeals issued its opinion affirming in part, reversing in part (and in doing so, reinstating a number of the allegations claimed by the relator), and remanding the case to the District Court for further proceedings. The relator filed a motion for rehearing. That motion for rehearing was denied. The relator amended his complaint to conform to the decision of the Court of Appeals and we filed an answer. A case management conference was held August 18, 2008. The parties have exchanged initial written discovery. Relator has recently filed a pleading stating "Relator Sean Bledsoe has a potentially fatal brain tumor that has severely affected Relator's long-term and short-term memory..." The court has now ordered that a mandatory settlement conference be stayed until Relator and wife can be deposed. We will continue to vigorously defend this case.

In August 2004, we were served a complaint in Arleana Lawrence and Robert Hollins v. Lakeview Community Hospital and Community Health Systems, Inc. (now styled Arleana Lawrence and Lisa Nichols vs. Eufaula Community Hospital, Community Health Systems, Inc., South Baldwin Regional Medical Center and Community Health Systems Professional Services Corporation) in the Circuit Court of Barbour County, Alabama (Eufaula Division). This alleged class action was brought by the plaintiffs on behalf of themselves and as the representatives of similarly situated uninsured individuals who were treated at our Lakeview Hospital or any of our other Alabama hospitals. The plaintiffs allege that uninsured patients who do not qualify for Medicaid, Medicare or charity care are charged unreasonably high rates for services and materials and that we use unconscionable methods to collect bills. The plaintiffs seek restitution of overpayment, compensatory and other allowable damages and injunctive relief. In October 2005, the complaint was amended to eliminate one of the named plaintiffs and to add our management company subsidiary as a defendant. In November 2005, the complaint was again amended to add another plaintiff, Lisa Nichols and another defendant, our hospital in Foley, Alabama, South Baldwin Regional Medical Center. After a hearing held on June 13, 2007, on October 29, 2007 the Circuit Court ruled in favor of the plaintiffs' class action certification request. On summary judgment, the Circuit Court dismissed the case against Community Health Systems, Inc. only. All other parties remain. We disagree with the certification ruling and pursued our automatic right of appeal to the Alabama Supreme Court. Briefs have now been filed and oral argument requested. We are vigorously defending this case.

On March 3, 2005, we were served with a complaint in Sheri Rix v. Heartland Regional Medical Center and Health Care Systems, Inc. in the Circuit Court of Williamson County, Illinois. This alleged class action was brought by the plaintiff on behalf of herself and as the representative of similarly situated uninsured individuals who were treated at our Heartland Regional Medical Center. The plaintiff alleges that uninsured patients who do not qualify for Medicaid, Medicare or charity care are charged unreasonably high rates for services and materials and that we use unconscionable methods to collect bills. The plaintiff seeks recovery for breach of contract and the covenant of good faith and fair dealing, violation of the Illinois Consumer Fraud and Deceptive Practices Act, restitution of overpayment, and for unjust enrichment. The plaintiff class seeks compensatory and other damages and equitable relief. The Circuit Court Judge granted our motion to dismiss the case, but allowed the plaintiff to re-plead her case. The plaintiff elected to appeal the Circuit Court's decision in lieu of amending her case. Oral argument was heard on this case on January 9, 2008. On June 16, 2008, the Appellate Court upheld the dismissal of the consumer fraud claim but reversed dismissal of the contract claim. We filed a Petition for Leave of Appeal to the Illinois Supreme Court which was denied. The case has now been remanded and we are evaluating our position concerning discovery and possible dispositive motions. We are vigorously defending this case.

On April 8, 2005, we were served with a first amended complaint, styled Chronister, et al. v. Granite City Illinois Hospital Company, LLC d/b/a Gateway Regional Medical Center, in the Circuit Court of Madison County, Illinois. The complaint seeks class action status on behalf of the uninsured patients treated at Gateway Regional Medical Center and alleges statutory, common law, and consumer fraud in the manner in which the hospital bills and collects for the services rendered to uninsured patients. The plaintiff seeks compensatory and punitive damages and declaratory and injunctive relief. Our motion to dismiss has been granted in part and denied in part and discovery has commenced. Gateway Regional Medical Center v. Holman is a companion case to the Chronister action, seeking counterclaim recovery on a collections case. Holman has been stayed pending the outcome of the Chronister action. We have refiled our motion to dismiss in light of subsequent favorable Illinois Appellate court decisions on the consumer fraud issues. We are vigorously defending these cases.

On February 10, 2006, we received a letter from the Civil Division of the Department of Justice requesting documents in an investigation they are conducting involving the Company. The inquiry relates to the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients. These programs are referred to by different names, including "intergovernmental payments," "upper payment limit programs," and "Medicaid disproportionate share hospital payments." The February 10th letter focused on our hospitals in 3 states: Arkansas, New Mexico, and South Carolina. On August 31, 2006, we received a follow up letter from the Department of Justice requesting additional documents relating to the programs in New Mexico and the payments to the Company's three hospitals in that state. We have provided the Department of Justice with the requested documents. In a letter dated October 4, 2007, the Civil Division notified us that, based on its investigation to date, it preliminarily believes that we and these three New Mexico hospitals have caused the State of New Mexico to submit improper claims for federal funds, in violation of the Civil False Claims Act. The DOJ asserted that these allegedly improper claims and payments began in 2000 and may be ongoing, but provided no information about the amount of any improper claims or the possible damages or penalties it may seek. After a meeting between us and the DOJ held in November 2007, by letter dated January 22, 2008, the Civil Division notified us that they continued to believe that the False Claims Act had been violated and had calculated that the three hospitals received ineligible federal participation payments from August 2000 to June 2006 of approximately $27.5 million. The Civil Division advised us that if they proceeded to trial, they would seek treble damages plus an appropriate penalty for each of the violations of the False Claims Act. Discussions are continuing with the Civil Division in an effort to resolve this matter. On May 28, 2008, we received a letter from the Office of the U.S. Attorney for the state of New Mexico requesting additional information. The Company responded to and subsequently met with the government on October 30, 2008 and in January 2009 we provided additional information. We continue to believe that we have not violated the Federal False Claims Act in the manner described in the government's letter of January 22, 2008. However, in February 2009 we were informed by the Department of Justice that it intends to pursue litigation in this matter.

In August 2006, our facility in Petersburg, Virginia (Southside Regional Medical Center) was notified of the pendency of a federal False Claims Act case styled U.S. ex rel. Vuyyuru v. Jadhav et al. filed in the Eastern District of Virginia. In addition to naming the hospital, Community Health Systems Professional Services Corporation, our management subsidiary, has also been named. The suit alleges that Dr. Jadhav, Southside Regional Medical Center, and other healthcare providers performed medically unnecessary procedures and billed federal healthcare programs and also alleges that the defendants defamed Dr. Vuyyuru in the process of terminating his medical staff privileges. Almost all of the allegations pre-date our acquisition of this facility and the seller's successor-in-interest has agreed to indemnify the Company and its affiliates. A motion to dismiss the case has been granted and the relator's appeal of the ruling to the U.S. Court of Appeals for the Fourth Circuit was denied. We will no longer refer to this case in future filings unless there is further litigation.

On August 28, 2007, Texas Health Resources of Arlington, Texas, or THR, notified us of its decision to exercise a call right to acquire our 80% interest in the limited partnership that owns Presbyterian Hospital of Denton, Texas, together with certain land and buildings that we own in Denton (including rights under a lease for such land and buildings). We acquired these interests in connection with the Triad acquisition. This call right became exercisable under the terms of the limited partnership agreement by reasons of our acquisition of Triad. Shortly after we initiated efforts to set the purchase price, which is determined by various formulas set forth in the limited partnership agreement and related documents, THR filed suit in Texas state court seeking injunctive and declaratory relief to extend the 90-day closing date and to set the purchase price. We removed the case to Federal District Court. Pursuant to the limited partnership agreement, the closing was to occur on or before November 26, 2007. The closing did not occur on November 26, 2007, as THR failed to properly tender adequate closing consideration. The case proceeded with discovery and motions. On February 12, 2009, the parties announced the execution of a settlement agreement, pursuant to which we will transfer our partnership interests on or before March 31, 2009 to THR or an affiliate. We will no longer refer to this case in future filings.

On June 12, 2008, two of our hospitals received letters from the U.S. Attorney's Office for the Western District of New York requesting documents in an investigation they are conducting into billing practices with respect to kyphoplasty procedures performed during the period January 1, 2002, through June 9, 2008. On September 16, 2008, one of our hospitals in South Carolina also received an inquiry. Kyphoplasty is a surgical spine procedure that returns a compromised vertebrae (either from trauma or osteoporotic disease process) to its previous height, reducing or eliminating severe pain. We have been informed that similar investigations have been initiated at unaffiliated facilities in Alabama, South Carolina, Indiana and other states. We believe that this investigation is related to a recent qui tam settlement between the same U.S. Attorney's office and the manufacturer and distributor of the Kyphon product, which is used in performing the kyphoplasty procedure. We are cooperating with the investigation by collecting and producing material responsive to the requests. At this early stage, we do not have sufficient information to determine whether our hospitals have engaged in inappropriate billing for kyphoplasty procedures. We are continuing to evaluate and discuss this matter with the government.

Triad Hospitals, Inc. Legal Proceedings

Triad, and its subsidiary, Quorum Health Resources, Inc. are defendants in a qui tam case styled *U.S. ex rel. Whitten vs. Quorum Health Resources, Inc. et al.*, which is pending in the Southern District of Georgia, Brunswick Division. Whitten, a long-term employee of a two hospital system in Brunswick and Camden, Georgia sued both his employer and Quorum Health Resources, Inc. and its predecessors, which had managed the facility from 1989 through September 2000; upon his termination of employment, Whitten signed a release and was paid $124,000. Whitten's original qui tam complaint was filed under seal in November 2002 and the case was unsealed in 2004. Whitten alleges various charging and billing infractions, including charging for routine equipment supplies and services not separately billable, billing for observation services that were not medically necessary or for which there was no physician order, billing labor and delivery patients for durable medical equipment that was not separately billable, inappropriate preparation of patients' histories and physicals, billing for cardiac rehabilitation services without physician supervision, performing outpatient dialysis without Medicare certification, and performing mental health services without the proper staff assignments. In October 2005, the district court granted Quorum's motion for summary judgment on the grounds that his claims were precluded under his severance agreement with the hospital, without reaching two other arguments made by Quorum, which included that a prior settlement agreement between the hospital and the federal government precluded the claims brought by Whitten as well as the doctrine of prior public disclosure. On appeal to the 11th Circuit Court of Appeals, the court reversed the findings of the district court regarding the severance agreement, but remanded the case to the district court for findings on Quorum's other two defenses. Limited discovery has been conducted and renewed motions by Quorum to dismiss the action and to stay further discovery were filed in September 2007. On August 5, 2008, our motion to dismiss was denied. Discovery is continuing and a motion for summary judgment will be filed. The pre-trial order is due March 13, 2009 and any trial would be anticipated for May 2009. We continue to believe that the relator's claims are without merit and will continue to vigorously defend this case.

In a case styled U.S. ex rel. Bartlett vs. Quorum Health Resources, Inc., et al., pending in the Western District of Pennsylvania, Johnstown Division, the relator alleges in his second amended complaint, filed in January 2006 (the first amended complaint having been dismissed), that Quorum conspired with an unaffiliated hospital to pay an illegal remuneration in violation of the anti-kickback statute and the Stark laws, thus causing false claims to be filed. A renewed motion to dismiss that was filed in March 2006 asserting that the second amended complaint did not cure the defects contained in the first amended complaint. In September 2006, the hospital and one of the other defendants affiliated with the hospital filed for protection under Chapter 11 of the federal bankruptcy code, which imposed an automatic stay on proceedings in the case. Relators entered into a settlement agreement with the hospital, subject to confirmation of the hospital's reorganization plan. The District Court conducted a status conference on January 30, 2009 and has indicated it will convene another conference with the Bankruptcy Court in the near future. We believe that this case is without merit and should the stay be lifted, will continue to vigorously defend it.

Item 4. *Submission of Matters to a Vote of Security Holders*

No matters were submitted to a vote of security holders during the fourth quarter of the year ended December 31, 2008.

PART II

Item 5. *Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities*

We completed an initial public offering of our common stock on June 14, 2000. Our common stock began trading on June 9, 2000 and is listed on the New York Stock Exchange under the symbol CYH. At February 2, 2009, there were approximately 46 record holders of our common stock. The following table sets forth, for the periods indicated, the high and low sale prices per share of our common stock as reported by the New York Stock Exchange.

	High	Low
Year Ended December 31, 2007		
First Quarter	$ 39.05	$ 33.28
Second Quarter	41.72	34.86
Third Quarter	44.50	30.39
Fourth Quarter	37.50	27.70
Year Ended December 31, 2008		
First Quarter	$ 36.85	$ 29.79
Second Quarter	40.05	32.40
Third Quarter	36.81	28.24
Fourth Quarter	28.38	10.47

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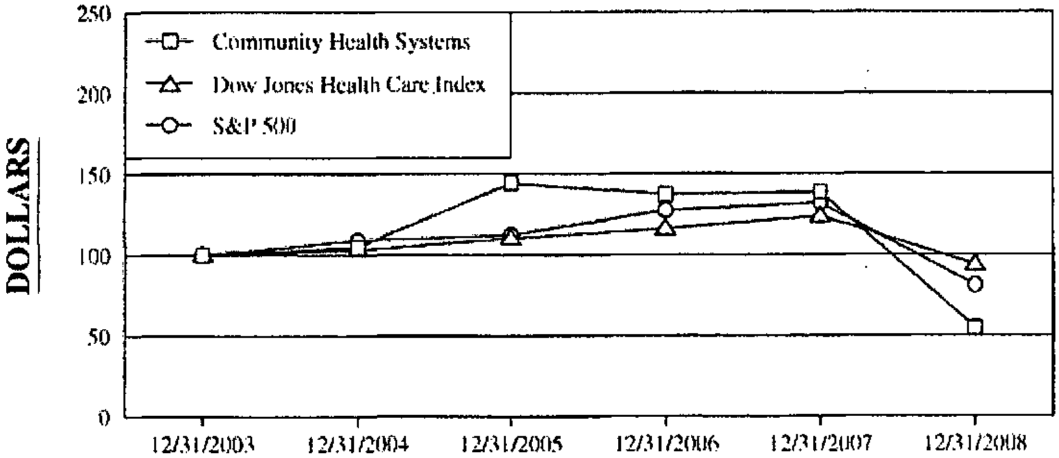
Corporate Performance Graph

The following graph sets forth the cumulative return of the Company's common stock during the five year period ended December 31, 2008, as compared to the cumulative return of the Standard & Poor's 500 Stock Index (S&P 500) and the cumulative return of the Dow Jones Healthcare Index. The graph assumes an initial investment of $100 in our common stock and in each of the foregoing indices and the reinvestment of dividends where applicable.



	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
Community Health Systems	$ 100.00	$ 104.89	$ 144.24	$ 137.40	$ 138.68	$ 54.85
Dow Jones Health Care Index	$ 100.00	$ 103.21	$ 110.30	$ 116.20	$ 124.07	$ 93.95
S&P 500	$ 100.00	$ 108.99	$ 112.26	$ 127.55	$ 132.06	$ 81.23

We have not paid any cash dividends since our inception, and do not anticipate the payment of cash dividends in the foreseeable future. Our New Credit Facility limits our ability to pay dividends and/or repurchase stock to an amount not to exceed $400 million in the aggregate (but not in excess of $200 million unless we receive confirmation from Moody's and S&P that dividends or repurchases would not result in a downgrade, qualification or withdrawal of the then corporate credit rating). The indenture governing our Notes also limits our ability to pay dividends and/or repurchase stock. As of December 31, 2008, the amount of permitted dividends and/or stock repurchases permitted under the indenture was $399 million.

The following table contains information about our purchases of common stock during the three months ended December 31, 2008:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans(a)	Maximum Number of Shares that May Yet be Purchased Under the Plans or Programs(a)
October 1, 2008 — October 31, 2008	2,500,000	$ 20.73	2,500,000	1,983,000
November 1, 2008 — November 30, 2008	1,319,609	11.75	1,319,609	663,391
December 1, 2008 — December 31, 2008	450,000	12.43	450,000	213,391
Total	4,269,609	17.08	4,269,609	213,391

(a) On December 13, 2006, we commenced an open market repurchase program for up to 5,000,000 shares of our common stock not to exceed $200 million in purchases. This purchase program will conclude at the earlier of three years or when the maximum number of shares have been repurchased. During the year ended December 31, 2008, we repurchased 4,786,609 shares, which is the cumulative number of shares repurchased under this program, at a weighted-average price of $18.80 per share. This repurchase plan follows a prior repurchase plan for up to five million shares which concluded on November 8, 2006. We repurchased 5,000,000 shares at a weighted average price of $35.23 per share under this earlier program.

Item 6. *Selected Financial Data*

The following table summarizes specified selected financial data and should be read in conjunction with our related Consolidated Financial Statements and accompanying Notes to Consolidated Financial Statements. The amounts shown below have been adjusted for discontinued operations. We have restated our 2008 and 2007 financial statements to reflect the reclassification in 2008 of one hospital owned by us during these periods, which is held for sale, to discontinued operations.

Community Health Systems, Inc.
Five Year Summary of Selected Financial Data

	Year Ended December 31,				
	2008	2007(1)	2006	2005	2004
	(In thousands, except share and per share data)				
Consolidated Statement of Operations Data					
Net operating revenues	$ 10,840,098	$ 7,063,775	$ 4,180,136	$ 3,576,117	$ 3,042,880
Income from operations	983,574	478,726	385,057	398,463	332,767
Income from continuing operations	206,658	57,714	177,695	188,370	158,009
Net income	218,304	30,289	168,263	167,544	151,433
Earnings per common share — Basic:					
Income from continuing operations	$ 2.21	$ 0.62	$ 1.87	$ 2.13	$ 1.65
Income (Loss) on discontinued operations	0.13	(0.30)	(0.10)	(0.24)	(0.07)
Net Income	$ 2.34	$ 0.32	$ 1.77	$ 1.89	$ 1.58
Earnings per common share — Diluted:					
Income from continuing operations	$ 2.19	$ 0.61	$ 1.85	$ 2.00	$ 1.58
Income (Loss) on discontinued operations	0.13	(0.29)	(0.10)	(0.21)	(0.07)
Net Income	$ 2.32	$ 0.32	$ 1.75	$ 1.79	$ 1.51
Weighted-average number of shares outstanding					
Basic	93,371,782	93,517,337	94,983,646	88,601,168	95,643,733
Diluted(2)	94,288,829	94,642,294	96,232,910	98,579,977(4)	105,863,790(3)
Cash and cash equivalents	$ 220,655	$ 132,874	$ 40,566	$ 104,108	$ 82,498
Total assets	13,818,254	13,493,643	4,506,579	3,934,218	3,632,608
Long-term obligations	10,611,419	10,334,904	2,207,623	1,932,238	2,030,258
Stockholders' equity	1,672,865	1,710,804	1,723,673	1,564,577	1,239,991

(1) Includes the results of operations of the former Triad hospitals from July 25, 2007, the date of acquisition.

(2) See Note 12 to the Consolidated Financial Statements, included in item 8 of this Form 10-K.

(3) Included 8,582,076 shares related to the convertible notes under the if-converted method of determining weighted average shares outstanding.

(4) Included 8,385,031 shares related to the convertible notes under the if-converted method of determining weighted average shares outstanding.

Item 7. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

You should read this discussion together with our consolidated financial statements and the accompanying notes to consolidated financial statements and "Selected Financial Data" included elsewhere in this Form 10-K.

Executive Overview

We are the largest publicly traded operator of hospitals in the United States in terms of number of facilities and net operating revenues. We provide healthcare services through these hospitals that we own and operate in non-urban and selected urban markets. We generate revenue primarily by providing a broad range of general hospital healthcare services to patients in the communities in which we are located. We currently have 118 general acute care hospitals included in continuing operations. In addition, we own four home care agencies, located in markets where we do not operate a hospital and through our wholly-owned subsidiary, Quorum Health Resources, LLC ("QHR"), we provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. We are paid for our services by governmental agencies, private insurers and directly by the patients we serve.

Since our acquisition of Triad on July 25, 2007 and throughout most of 2008, we have focused our efforts toward integrating the former Triad hospitals and realigning our hospital portfolio. As such we have put less effort toward the pursuit of additional acquisitions. During this time we have sold seven of the hospitals acquired from Triad and seven hospitals owned by us prior to our acquisition of Triad. These hospitals have been classified in discontinued operations for the years ended December 31, 2008, 2007 and 2006 to the extent the hospitals were owned by us during the respective periods. Two additional hospitals acquired from Triad have been classified as held for sale and are also included in discontinued operations during the respective periods of our ownership.

During 2008, with the exception of acquiring the outstanding minority interests in two of our hospitals, our only hospital acquisition was a two hospital system located in Spokane, Washington, an acquisition we had been pursuing and for which we were awaiting government approval since 2007.

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

As a result of our current levels of cash, available borrowing capacity, long term outlook on our debt repayments and our continued projection of our ability to generate cash flows, we do not anticipate a significant impact on our ability to invest the necessary capital in our business over the next twelve months. However, we do believe it to be prudent that we pursue our strategy of acquiring hospitals very cautiously and therefore we anticipate only completing two acquisitions in 2009. On February 1, 2009, we completed one of our anticipated acquisitions for 2009 with the acquisition of Siloam Springs Memorial Hospital (74 licensed beds), located in Siloam Springs, Arkansas, from the City of Siloam Springs.

In the quarter ended June 30, 2008, we were informed that we would not receive the full amount of previously estimated reimbursements under certain Indiana Medicaid programs. The reductions are due partly to the state not receiving a federal waiver for one of its programs and partly as a result of changes to its disproportionate share program which were different from what had previously been communicated to us. This represents an approximately $8.0 million reduction in expected payments from these programs on an annual basis.

Self-pay revenues represented approximately 10.7% of our net operating revenues in 2008 compared to 10.0% in 2007. The value of charity care services relative to total net operating revenues decreased to 3.5% in 2008 from 4.6% in 2007. Uninsured and underinsured patients continue to be an industry-wide issue, and we anticipate this trend will continue into the foreseeable future. However, we do not anticipate a significant amount of continuing deterioration resulting from our self-pay business as evidenced by the lack of relative growth in business from self-pay patients over the prior year.

Operating results and statistical data for the year ended December 31, 2008, include comparative information for the operations of the acquired Triad hospitals from July 25, 2007, the date of acquisition. Same-store operating results and statistical data include the hospitals acquired in the Triad acquisition as if they were owned by us from January 1 through July 24, 2007 and all other hospitals as owned throughout both periods. For the year ended December 31, 2008, we generated $10.840 billion in net operating revenues, a growth of 53.5% over the year ended December 31, 2007, and $218.3 million of net income, an increase of 620.7% over the year ended December 31, 2007. For the year ended December 31, 2008, admissions at hospitals owned throughout both periods increased 2.0% and adjusted admissions increased 2.2%.

We believe there continues to be ample opportunity for growth in substantially all of our markets by decreasing the need for patients to travel outside their communities for health care services. Furthermore, we continue to strive to improve operating efficiencies and procedures in order to improve our profitability at all of our hospitals.

Acquisitions and Dispositions

Effective November 14, 2008, we acquired from Willamette Community Health Solutions all of its joint venture interest in MWMC Holdings, LLC, which indirectly owns and operates McKenzie-Willamette Medical Center of Springfield, Oregon. This acquisition resulted from a put right held by Willamette Community Health Solutions in connection with the 2003 transaction establishing the joint venture. The purchase price for this minority interest was $22.7 million in cash. Physicians affiliated with Oregon Healthcare Resources, Inc. continue to own a minority interest in the hospital.

Effective October 1, 2008, we completed the acquisition of Deaconess Medical Center (388 licensed beds) and Valley Hospital and Medical Center (123 licensed beds) located in Spokane, Washington, from Empire Health Services. The total consideration for these two hospitals was approximately $182.6 million, of which $149.2 million was paid in cash and $33.4 million was assumed in liabilities.

Effective June 30, 2008, we acquired the remaining 35% equity interest in Affinity Health Systems, LLC, which indirectly owns and operates Trinity Medical Center (560 licensed beds) in Birmingham, Alabama, from Baptist Health Systems, Inc. of Birmingham, Alabama ("Baptist"), giving us 100% ownership of that facility. The purchase price for this minority interest was $51.5 million in cash and the cancellation of a promissory note issued by Baptist to Affinity Health Systems, LLC in the original principal amount of $32.8 million.

Effective March 1, 2008, we sold Woodland Medical Center (100 licensed beds) located in Cullman, Alabama; Parkway Medical Center (108 licensed beds) located in Decatur, Alabama; Hartselle Medical Center (150 licensed beds) located in Hartselle, Alabama; Jacksonville Medical Center (89 licensed beds) located in Jacksonville, Alabama; National Park Medical Center (166 licensed beds) located in Hot Springs, Arkansas; St. Mary's Regional Medical Center (170 licensed beds) located in Russellville, Arkansas; Mineral Area Regional Medical Center (135 licensed beds) located in Farmington, Missouri; Willamette Valley Medical

Center (80 licensed beds) located in McMinnville, Oregon; and White County Community Hospital (60 licensed beds) located in Sparta, Tennessee, to Capella Healthcare, Inc., headquartered in Franklin, Tennessee. The proceeds from this sale were $315 million in cash.

Effective February 21, 2008, we sold THI Ireland Holdings Limited, a private limited company incorporated in the Republic of Ireland, which leased and managed the operations of Beacon Medical Center (122 licensed beds) located in Dublin, Ireland, to Beacon Medical Group Limited, headquartered in Dublin, Ireland. The proceeds from this sale were $1.5 million in cash.

Effective February 1, 2008, we sold Russell County Medical Center (78 licensed beds) located in Lebanon, Virginia to Mountain States Health Alliance, headquartered in Johnson City, Tennessee. The proceeds from this sale were $48.6 million in cash.

As of December 31, 2008, we had two hospitals classified as held for sale and included in discontinued operations.

Sources of Revenue

The following table presents the approximate percentages of net operating revenue derived from Medicare, Medicaid, managed care and other third party payors, and self-pay for the periods indicated. The data for the years presented are not strictly comparable due to the significant effect that hospital acquisitions have had on these statistics.

	Year Ended December 31,		
	2008	2007	2006
Medicare	27.5%	29.0%	30.4%
Medicaid	9.1%	10.3%	11.1%
Managed care and other third party payors	52.7%	50.7%	46.7%
Self pay	10.7%	10.0%	11.8%
Total	100.0%	100.0%	100.0%

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-based reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual adjustments, which we deduct from gross revenues to arrive at net operating revenues. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual adjustments and report them in the periods that such adjustments become known. Adjustments related to final settlements were insignificant to both net operating revenue and net income in the years ended December 31, 2008, 2007 and 2006. In the future, we expect the percentage of revenues received from the Medicare program to increase due to the general aging of the population.

The payment rates under the Medicare program for inpatient acute services are based on a prospective payment system, depending upon the diagnosis of a patient's condition. These rates are indexed for inflation annually, although the increases have historically been less than actual inflation. Reductions in the rate of increase in Medicare reimbursement may cause our net operating revenue growth to decline.

In addition, specified managed care programs, insurance companies, and employers are actively negotiating the amounts paid to hospitals. The trend toward increased enrollment in managed care may adversely effect our net operating revenue growth.

Results of Operations

Our hospitals offer a variety of services involving a broad range of inpatient and outpatient medical and surgical services. These include orthopedics, cardiology, occupational medicine, diagnostic services, emergency services, rehabilitation treatment, home care and skilled nursing. The strongest demand for hospital services generally occurs during January through April and the weakest demand for these services occurs during the summer months. Accordingly, eliminating the effect of new acquisitions, our net operating revenues and earnings are historically highest during the first quarter and lowest during the third quarter.

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

	Year Ended December 31,		
	2008	2007	2006
	(Expressed as a percentage of net operating revenues)		
Consolidated(a):			
Net operating revenues	100.0	100.0	100.0
Operating expenses(b)	(86.3)	(88.9)	(86.5)
Depreciation and amortization	(4.6)	(4.4)	(4.3)
Income from operations	9.1	6.7	9.2
Interest expense, net	(6.0)	(5.1)	(2.2)
Loss from early extinguishment of debt	—	(0.4)	—
Minority interest in earnings	(0.4)	(0.2)	(0.1)
Equity in earnings of unconsolidated affiliates	0.4	0.4	—
Income from continuing operations before income taxes	3.1	1.4	6.9
Provision for income taxes	(1.2)	(0.6)	(2.6)
Income from continuing operations	1.9	0.8	4.3
Income (loss) on discontinued operations, net of tax	0.1	(0.4)	(0.3)
Net income	2.0	0.4	4.0

	Year Ended December 31,	
	2008	2007
	(Expressed in percentages)	
Percentage increase from prior year(a):		
Net operating revenues	53.5%	69.0%
Admissions	44.5	49.1
Adjusted admissions(c)	42.1	47.5
Average length of stay	—	2.4
Net Income(d)	620.7	(82.0)
Same-store percentage increase from prior year(a)(e):		
Net operating revenues	6.6%	4.2%
Admissions	2.0	(1.1)
Adjusted admissions(c)	2.2	0.3

(a) Pursuant to SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets," we have restated our 2008 and 2007 financial statements to reflect the reclassification in 2008 of one hospital owned by us during these periods, which is held for sale, to discontinued operations. Our statistical results have also been restated to reflect the aforementioned reclassification.

(b) Operating expenses include salaries and benefits, provision for bad debts, supplies, rent, and other operating expenses.

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

(d) Includes income (loss) on discontinued operations.

(e) Includes former Triad hospitals during the comparable periods and other acquired hospitals to the extent we operated them during comparable periods in both years.

Year Ended December 31, 2008 Compared to Year Ended December 31, 2007

Net operating revenues increased by 53.5% to $10.840 billion in 2008, from $7.064 billion in 2007. On a combined basis, the hospitals acquired in the Triad acquisition and growth from those hospitals owned throughout both periods contributed $3.557 billion of the increase and $219 million was contributed by other hospitals acquired in 2008. On a same-store basis, including the former Triad hospitals as if they were owned by us as of January 1, 2007, this represents an increase in same-store net revenue of 6.6%. The increase from hospitals that we owned throughout both periods was attributable to volume increases, rate increases, payor mix and the acuity level of services provided.

On a consolidated basis inpatient admissions increased by 44.5% and adjusted admissions increased by 42.1%. With respect to consolidated admissions, approximately 50.5% were contributed from newly acquired hospitals, including those hospitals acquired from Triad, and 49.5% were contributed by hospitals we owned throughout both periods. On a same-store basis, which includes the hospitals acquired from Triad, as if we owned them both years, admissions increased by 2.0% during the year ended December 31, 2008.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, decreased from 88.9% in 2007 to 86.3% in 2008. Salaries and benefits, as a percentage of net operating revenues, decreased from 40.7% in 2007 to 39.9% in 2008, primarily as a result of efficiency improvements realized at hospitals owned throughout both periods. These improvements were partially offset by an increase in the number of employed physicians as well as an increase in salaries for certain IT employees who were previously treated as leased employees with related expense previously being included in other operating expense. Provision for bad debts, as a percentage of net revenues, decreased from 12.5% in 2007 to 11.2% in 2008, due primarily to $70.1 million of additional bad debt expense recorded as a change in estimate to increase the allowance for doubtful accounts in 2007. Supplies, as a percentage of net operating revenues, increased from 13.2% in 2007 to 14.0% in 2008, primarily the result of the acquisition of the former Triad hospitals whose higher acuity of services resulted in higher supply costs than our other hospitals taken collectively, offsetting improvements from greater utilization of and improved pricing under our purchasing program. Rent and other operating expenses, as a percentage of net operating revenues, decreased from 22.5% in 2007 to 21.2% in 2008, primarily as a result of the hospitals acquired from Triad having lower rent expense as a percentage of net operating revenues. As part of our acquisition of Triad, we acquired minority ownership interests in several hospitals. Our percentage of ownership interests in these joint ventures provided earnings of 0.4% of net operating revenues during both of the years ended December 31, 2008 and 2007. Prior to the Triad acquisition, we did not have any material minority investments in joint ventures.

Income from continuing operations margin increased from 0.8% in 2007 to 1.9% in 2008. Net income margins increased from 0.4% in 2007 to 2.0% in 2008. The increase in these margins is reflective of the impact of the net decrease in expenses, as a percentage of net revenue, discussed above.

Depreciation and amortization increased from 4.4% of net operating revenues in 2007 to 4.6% of net operating revenues in 2008.

Interest expense, net, increased by $290.1 million from $361.8 million in 2007, to $651.9 million in 2008. The primary reason for the increase in interest expense is the increase in our average outstanding debt during the year ended December 31, 2008, as compared to the year ended December 31, 2007, resulting in an additional $299.2 million of interest expense. Interest expense for the year ended December 31, 2008 includes a full year of interest expense from borrowings under our New Credit Facility and the issuance of Notes in connection with the acquisition of Triad in 2007. Since 2008 was a leap year, one additional day in the year resulted in $1.8 million of the increase in interest expense. A decrease in our effective interest rate during the year ended December 31, 2008, as compared to the year ended December 31, 2007, resulted in a decrease in interest expense of $10.9 million.

The net results of the above mentioned changes resulted in income from continuing operations before income taxes increasing $236.6 million from $99.5 million in 2007 to $336.1 million for 2008.

Provision for income taxes from continuing operations increased from $41.8 million in 2007 to $129.5 million in 2008 due to the increase in income from continuing operations before income taxes. Our effective tax rates were 38.5% and 41.8% for the years ended December 31, 2008 and 2007, respectively. The decrease in our effective tax rate is primarily a result of a decrease in our effective state tax rate.

Net income was $218.3 million in 2008 compared to $30.3 million for 2007, an increase of 620.7%. The increase in net income is reflective of the impact of the net decrease in expenses discussed above, including the effect of the change in estimate that increased bad debt expense in 2007.

Year Ended December 31, 2007 Compared to Year Ended December 31, 2006

Net operating revenues increased by 69.0% to $7.064 billion in 2007, from $4.180 billion in 2006. This increase was net of a $96.3 million reduction to net operating revenues as a result of the change in estimate to increase contractual allowances recorded in the fourth quarter of 2007. On a combined basis, the hospitals acquired in the Triad acquisition and growth from those hospitals owned throughout both periods contributed $2.458 billion of that increase and $426 million was contributed by other hospitals acquired in 2007. On a same-store basis, including the former Triad hospitals during the comparable periods, this represents an increase in same-store net revenue of 4.2%. The increase from hospitals that we owned throughout both periods was attributable to volume increases, rate increases, payor mix and the acuity level of services provided.

On a consolidated basis inpatient admissions increased by 49.1% and adjusted admissions increased by 47.5%. With respect to consolidated admissions, approximately 34% were contributed from newly acquired hospitals, including those hospitals acquired from Triad, and 66% were contributed by hospitals we owned throughout both periods. On a same-store basis, which includes the hospitals acquired from Triad, as if we owned them from August 1 through December 31 of both periods, admissions decreased by 1.1% during the year ended December 31, 2007.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, increased from 86.5% in 2006 to 88.9% in 2007. Salaries and benefits, as a percentage of net operating revenues, increased from 39.8% in 2006 to 40.7% in 2007, primarily as a result of an increase in stock compensation expense, incurring duplicate salary costs related to the acquisition of Triad for certain corporate overhead positions not yet eliminated and an increase in the number of employed physicians. These increases have offset improvements realized at hospitals owned throughout both periods. Provision for bad debts, as a percentage of net revenues, increased from 12.4% in 2006 to 12.5% in 2007, due primarily to $70.1 million of additional bad debt expense recorded as a change in estimate to increase the allowance for doubtful accounts. Supplies, as a percentage of net operating revenues, increased from 11.7% in 2006 to 13.2% in 2007, primarily from the acquisition of hospitals from Triad whose higher acuity of services and lower purchasing program utilization resulted in higher supply costs than our other hospitals taken collectively and from other recent acquisitions for which we have yet to fully integrate into our purchasing program, offsetting improvements at hospitals owned throughout both periods from greater utilization of and improved pricing under our purchasing program. Rent and other operating expenses, as a percentage of net operating revenues, decreased from 22.6% in 2006 to 22.5% in 2007, primarily as a result of the hospitals acquired from Triad having lower rent expense as a percentage of net operating revenues. As part of our acquisition of Triad, we acquired minority ownership interests in several hospitals. These investments provided earnings of 0.4% of net operating revenues during the year ended December 31, 2007. Prior to the Triad acquisition, we did not have any material minority investments in joint ventures.

Income from continuing operations margin decreased from 4.3% in 2006 to 0.8% in 2007. Net income margins decreased from 4.0% in 2006 to 0.4% in 2007. The decrease in these margins is reflective of the impact of the net increase in expenses, as a percentage of net revenue, discussed above and the increase in interest expense and loss on early extinguishment of debt associated with the acquisition of Triad.

Depreciation and amortization increased from 4.3% of net operating revenues in 2006 to 4.4% of net operating revenues in 2007.

Interest expense, net, increased by $267.4 million from $94.4 million in 2006, to $361.8 million in 2007. An increase in the average debt balance in 2007 as compared to 2006 of $3.583 billion, due primarily to the additional borrowings to fund the Triad acquisition and repay our previous outstanding debt, accounted for a $245.9 million increase in interest expense. An increase in interest rates due to an increase in LIBOR during 2007, as compared to 2006, accounted for $21.5 million of the increase.

The net results of the above mentioned changes plus a $27.3 million loss from early extinguishment of debt incurred in connection with the financing of the Triad acquisition, resulted in income from continuing operations before income taxes decreasing $188.3 million from $287.8 million in 2006 to $99.5 million for 2007.

Provision for income taxes from continuing operations decreased from $110.2 million in 2006 to $41.8 million in 2007 due to the decrease in income from continuing operations before income taxes. Our effective tax rates were 41.8% and 38.3% for the years ended December 31, 2007 and 2006, respectively. The increase in our effective tax rate is primarily a result of an increase in valuation allowances. As a result of the additional interest expense expected to be incurred, we determined that certain of our state net operating losses will expire before being utilized and accordingly established appropriate valuation allowances.

Net income was $30.3 million in 2007 compared to $168.3 million for 2006, a decrease of 82%. The decrease in net income is reflective of the impact of the net increase in expenses discussed above, including the effect of the change in estimate that increased bad debt expense in 2007.

Liquidity and Capital Resources

2008 Compared to 2007

Net cash provided by operating activities increased $369.5 million from $687.7 million for the year ended December 31, 2007 to $1.057 billion for the year ended December 31, 2008. This increase is due to an increase in cash flow from net income of $188.0 million, increases in cash flows from other assets of $29.1 million and a net increase in non-cash expenses of $350.2 million, of which $174.1 million was related to depreciation and $199.8 million related to deferred income taxes. These cash flow increases were offset by decreases in cash flows from supplies, prepaid expenses and other current assets of $2.7 million, accounts receivable of $188.7 million and accounts payable, accrued liabilities and income taxes of $6.4 million. The decrease in income taxes was primarily a result of a prior year prepaid tax position which was used to offset taxes owed during the current year.

The use of cash in investing activities decreased $6.833 billion from $7.499 billion in 2007 to $665.5 million in 2008, as a result of the acquisition occurring in 2007. The purchase of property and equipment in 2008 increased $169.4 million from $522.8 million in 2007 to $692.2 million in 2008. This increase reflects the increased number of hospitals owned by us after the acquisition of Triad. We anticipate being able to fund future routine capital expenditures with cash flows generated from operations.

In 2008, our net cash provided by financing activities decreased $7.207 billion from $6.903 billion in 2007 to a net cash used in financing activities of $304.0 million in 2008, primarily due to borrowings under our New Credit Facility and issuance of Notes in connection with the acquisition of Triad in 2007. During the fourth quarter of 2008, $100 million of delayed draw term loans had been drawn by us.

In 2008, we used $90.0 million for the repurchase of 4,786,609 shares of our outstanding common stock on the open market. We believed this to be a prudent use of cash as a result of the severely depressed stock price under the current economic conditions. Our New Credit Facility limits our ability to pay dividends and/

or repurchase stock to an amount not to exceed $400 million in the aggregate (but not in excess $200 million unless we receive confirmation from Moody's and S&P that dividends or repurchases would not result in a downgrade, qualification or withdrawal of the then corporate credit rating). The indenture governing our Notes also limits our ability to pay dividends and/or repurchase stock. As of December 31, 2008, the amount of permitted dividends and/or stock repurchases permitted under the indenture was $399 million.

With the exception of some small principal payments of our term loans under our New Credit Facility, representing less than 1% of the outstanding balance each year through 2013, the term loans under our New Credit Facility mature in 2014 and our Notes are not due until 2015. We believe this five to six year period before final maturity allows sufficient time for the current financial environment to improve and permits us to make favorable changes, including refinancing, to our debt structure. Furthermore, we do not anticipate the need to use funds currently available under our New Credit Facility for purposes of funding our operations, although these funds could be used for the purpose of making further acquisitions or for restructuring our existing debt. Furthermore, we anticipate we will remain in compliance with our debt covenants and thus it would not be necessary to exercise the cures available to us in our existing debt agreements.

As described in Notes 6, 9 and 15 of the Notes to Consolidated Financial Statements, at December 31, 2008, we had certain cash obligations, which are due as follows *(in thousands)*:

	Total	2009	2010-2012	2013-2014	2015 and thereafter
Long Term Debt	$ 6,015,529	$ 22,730	$ 148,787	$ 5,821,263	$ 22,749
Senior Notes	2,910,831	—	—	—	2,910,831
Interest on Bank Facility and Notes(1)	2,947,815	487,993	1,454,945	864,943	139,934
Capital Leases, including interest	58,972	10,589	16,553	5,865	25,965
Total Long-Term Debt	11,933,147	521,312	1,620,285	6,692,071	3,099,479
Operating Leases	842,523	159,954	339,486	137,514	205,569
Replacement Facilities and Other Capital Committments(2)	527,320	110,683	383,615	18,022	15,000
Open Purchase Orders(3)	93,257	93,257	—	—	—
Financial Interpretation No. 48 obligations, including interest and penalties	18,211	6,454	11,757	—	—
Total	$ 13,414,458	$ 891,660	$ 2,355,143	$ 6,847,607	$ 3,320,048

(1) Estimate of interest payments assumes the interest rates at December 31, 2008 remain constant during the period presented for the New Credit Facility, which is variable rate debt. The interest rate used to calculate interest payments for the New Credit Facility was LIBOR as of December 31, 2008 plus the spread. The Notes are fixed at an interest rate of 8.875% per annum.

(2) Pursuant to purchase agreements in effect as of December 31, 2008 and where certificate of need approval has been obtained, we have commitments to build the following replacement facilities and the following capital commitments. As required by an amendment to our lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location by November 2012. As part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana by April 2011. Construction costs, including equipment costs, for these two replacement facilities are currently estimated to be approximately $269.0 million of which approximately $8.5 million has been incurred to date. In addition as a part of an acquisition in 2004, we committed to spend $90.0 million in capital expenditures within eight years in Phoenixville, Pennsylvania, and as part of an acquisition in 2005, we committed to spend approximately $64 million within seven years and an additional $15 million with no set completion

date related to capital expenditures at Chestnut Hill Hospital in Philadelphia, Pennsylvania. As of December 31, 2008, we have incurred to date approximately $53.6 million and $17.0 million for the capital expenditures at Phoenixville, Pennsylvania and Chestnut Hill, Pennsylvania, respectively. As part of an acquisition in 2008, we committed to spend $100.0 million within five years related to capital expenditures at Deaconess Hospital and Valley Hospital and Medical Center, both in Spokane, Washington. As of December 31, 2008, we have incurred to date approximately $11.3 million related to this commitment.

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

As more fully described in Note 6 of the Notes to Consolidated Financial Statements at December 31, 2008, we had issued letters of credit primarily in support of potential insurance related claims and specified outstanding bonds of approximately $93.6 million.

Our debt as a percentage of total capitalization remained consistent at 84% for both December 31, 2008 and 2007.

2007 Compared to 2006

Net cash provided by operating activities increased $337.4 million from $350.3 million for the year ended December 31, 2006 compared to $687.7 million for the year ended December 31, 2007. This increase is due to an increase in cash flow from changes in accounts receivable of $202.4 million, increases in cash flows from accounts payable, accrued liabilities and income taxes of $73.8 million, and an increase in non-cash expenses of $231.6 million, of which $143.8 million was related to depreciation. These cash flow increases were offset by decreases in cash flows from supplies, prepaid expenses and other current assets of $27.4 million, decreases in cash flows from other assets and liabilities of $5.0 million and a decrease in net income of $138.0 million.

The use of cash in investing activities increased $6.859 billion from $640.3 million in 2006 to $7.499 billion in 2007, as a result of the acquisition of Triad for $6.836 billion.

In 2007, our net cash provided by financing activities increased $6.677 billion from $226.5 million in 2006 to $6.903 billion in 2007 from our New Credit Facility and issuance of Notes in connection with the acquisition of Triad.

Capital Expenditures

Cash expenditures for purchases of facilities were $161.9 million in 2008, $7.018 billion in 2007 and $384.6 million in 2006. Our expenditures in 2008 included $149.1 million for the purchase of two hospitals and $12.8 million for the purchase of physician practices and a home care agency. Our expenditures in 2007 included $6.865 billion for the purchase of Triad, $133.7 million for the purchase of two additional hospitals, $3.4 million for the purchase of physician practices, $7.7 million for equipment to integrate acquired hospitals and $8.5 million for the settlement of acquired working capital. Our expenditures in 2006 included $334.5 million for the purchase of the eight hospitals acquired in 2006, $21.8 million for the purchase of three home care agencies and physician practices, $21.5 million for information systems and other equipment to integrate the hospitals acquired in 2006 and $6.8 million for the settlement of acquired working capital.

Excluding the cost to construct replacement hospitals and a de novo hospital, our cash expenditures for routine capital for 2008 totaled $569.4 million compared to $344.1 million in 2007, and $207.7 million in 2006. Costs to construct replacement hospitals and a de novo hospital totaled $122.8 million in 2008, $178.7 million in 2007 and $16.8 million in 2006.

Pursuant to hospital purchase agreements in effect as of December 31, 2008, as part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana by April 2011. Also as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement facility at Barstow Community Hospital in Barstow, California. Estimated construction costs, including equipment costs, are approximately $269 million for these two replacement facilities. We expect total capital expenditures of approximately $600 to $650 million in 2009 (which includes amounts which are required to be expended pursuant to the terms of hospital purchase agreements), including approximately $593 to $640 million for renovation and equipment cost and approximately $7 to $10 million for construction and equipment cost of the replacement hospitals.

Capital Resources

Net working capital was $1.071 billion at December 31, 2008 compared to $1.105 billion at December 31, 2007, a decrease of $34 million. This decrease in working capital is due to increases in accounts payable of $16.4 million and accrued liabilities of $21.6 million, decreases in other current assets of approximately $100.1 million and deferred income taxes of $21.9 million and the net reduction in all other working capital assets and liabilities of $15.1 million. This decrease in working capital was offset by an increase in working capital attributable to the acquisition of Deaconess Medical Center and Valley Hospital and Medical Center, which provided additional working capital of $17.7 million at December 31, 2008. In addition, an increase in cash of $85.3 million and accounts receivable of $38.1 million also offset the decrease in working capital.

In connection with the consummation of the Triad acquisition in July 2007, we obtained $7.215 billion of senior secured financing under a New Credit Facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The New Credit Facility consists of a $6.065 billion funded term loan facility with a maturity of seven years, a $300 million delayed draw term loan facility (reduced from $400 million) with a maturity of seven years and a $750 million revolving credit facility with a maturity of nine years. During the fourth quarter of 2008, $100 million of the delayed draw term loan had been drawn down by us reducing the delayed draw term loan availability to $200 million at December 31, 2008. In January 2009, we drew down the remaining $200 million of the delayed draw term loan. The revolving credit facility also includes a subfacility for letters of credit and a swingline subfacility. The New Credit Facility requires us to make quarterly amortization payments of each term loan facility equal to 0.25% of the initial outstanding amount of the term loans, if any, with the outstanding principal balance of each term loan facility payable on July 25, 2014.

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

The obligor under the New Credit Facility is CHS/Community Health Systems, Inc., or CHS, a wholly-owned subsidiary of Community Health Systems, Inc. All of our obligations under the New Credit Facility are unconditionally guaranteed by Community Health Systems, Inc. and certain existing and subsequently acquired or organized domestic subsidiaries. All obligations under the New Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of Community Health Systems, Inc., CHS and each subsidiary guarantor, including equity interests held by us or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries.

The loans under the New Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at our option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus one-half of 1.0%, or (b) a reserve adjusted London interbank offered rate for dollars (Eurodollar rate) (as defined). The applicable percentage for term loans is 1.25% for Alternate Base Rate loans and 2.25% for Eurodollar rate loans. The applicable percentage for revolving loans was initially 1.25% for Alternate Base Rate revolving loans and 2.25% for Eurodollar revolving loans, in each case subject to reduction based on our leverage ratio. Loans under the swingline subfacility bear interest at the rate applicable to Alternate Base Rate loans under the revolving credit facility.

We have agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to Eurodollar rate loans under the revolving credit facility times the maximum aggregate amount available to be drawn under all letters of credit outstanding under the subfacility for letters of credit. The issuer of any letter of credit issued under the subfacility for letters of credit will also receive a customary fronting fee and other customary processing charges. We were initially obligated to pay commitment fees of 0.50% per annum (subject to reduction based upon on our leverage ratio), on the unused portion of the revolving credit facility. For purposes of this calculation, swingline loans are not treated as usage of the revolving credit facility. With respect to the delayed draw term loan facility, we were also obligated to pay commitment fees of 0.50% per annum for the first nine months after the close of the New Credit Facility and 0.75% per annum for the next three months thereafter. Thereafter, we are obligated to pay a commitment fee of 1.0% per annum. In each case, the commitment fee is based on the unused amount of the delayed draw term loan facility. We also paid arrangement fees on the closing of the New Credit Facility and pay an annual administrative agent fee.

The New Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting our and our subsidiaries' ability to, among other things and subject to various exceptions, (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of our businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change our fiscal year. We and our subsidiaries are also required to comply with specified financial covenants (consisting of a leverage ratio and an interest coverage ratio) and various affirmative covenants.

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

As of December 31, 2008, there was approximately $950 million of available borrowing capacity under our New Credit Facility, of which $93.6 million was set aside for outstanding letters of credit and $200 million was available under the delayed draw term loan facility (which was borrowed in January 2009). We believe that these funds, along with internally generated cash and continued access to the bank credit and capital markets, will be sufficient to finance future acquisitions, capital expenditures and working capital requirements through the next 12 months and into the foreseeable future.

During the year ended December 31, 2008, we repurchased on the open market and cancelled $110.5 million of principal amount of the Notes. This resulted in a net gain from early extinguishment of debt of $2.5 million with an after-tax impact of $1.6 million.

As of December 31, 2008, we are currently a party to the following interest rate swap agreements to limit the effect of changes in interest rates on a portion of our long-term borrowings. On each of these swaps, we received a variable rate of interest based on the three-month London Inter-Bank Offer Rate ("LIBOR"), in exchange for the payment by us of a fixed rate of interest. We currently pay, on a quarterly basis, a margin above LIBOR of 225 basis points for revolving credit and term loans under the New Credit Facility.

Swap #	Notional Amount (In 000's)	Fixed Interest Rate	Termination Date	Fair Value (In 000's)
1	$ 100,000	3.9350%	June 6, 2009	$ (975)
2	100,000	4.3375%	November 30, 2009	(2,147)
3	200,000	2.8800%	September 17, 2010	(3,846)
4	100,000	4.9360%	October 4, 2010	(5,632)
5	100,000	4.7090%	January 24, 2011	(6,327)
6	300,000	5.1140%	August 8, 2011	(25,737)
7	100,000	4.7185%	August 19, 2011	(7,645)
8	100,000	4.7040%	August 19, 2011	(7,609)
9	100,000	4.6250%	August 19, 2011	(7,408)
10	200,000	4.9300%	August 30, 2011	(16,510)
11	200,000	3.0920%	September 18, 2011	(7,118)
12	100,000	3.0230%	October 23, 2011	(3,432)
13	200,000	4.4815%	October 26, 2011	(14,788)
14	200,000	4.0840%	December 3, 2011	(12,949)
15	100,000	3.8470%	January 4, 2012	(5,908)
16	100,000	3.8510%	January 4, 2012	(5,919)
17	100,000	3.8560%	January 4, 2012	(5,934)
18	200,000	3.7260%	January 8, 2012	(11,150)
19	200,000	3.5065%	January 16, 2012	(9,924)
20	250,000	5.0185%	May 30, 2012	(25,375)
21	150,000	5.0250%	May 30, 2012	(15,337)
22	200,000	4.6845%	September 11, 2012	(19,262)
23	100,000	3.3520%	October 23, 2012	(5,080)
24	125,000	4.3745%	November 23, 2012	(10,932)
25	75,000	4.3800%	November 23, 2012	(6,668)
26	150,000	5.0200%	November 30, 2012	(16,905)
27	100,000	5.0230%	May 30, 2013	(12,247)
28	300,000	5.2420%	August 6, 2013	(40,561)
29	100,000	5.0380%	August 30, 2013	(12,762)
30	50,000	3.5860%	October 23, 2013	(3,297)
31	50,000	3.5240%	October 23, 2013	(3,160)
32	100,000	5.0500%	November 30, 2013	(13,262)
33	200,000	2.0700%	December 19, 2013	161
34	100,000	5.2310%	July 25, 2014	(15,376)
35	100,000	5.2310%	July 25, 2014	(15,376)
36	200,000	5.1600%	July 25, 2014	(30,033)
37	75,000	5.0405%	July 25, 2014	(10,809)
38	125,000	5.0215%	July 25, 2014	(17,895)

The New Credit Facility and/or the Notes contain various covenants that limit our ability to take certain actions including; among other things, our ability to:

- incur, assume or guarantee additional indebtedness;
- issue redeemable stock and preferred stock;
- repurchase capital stock;
- make restricted payments, including paying dividends and making investments;
- redeem debt that is junior in right of payment to the notes;
- create liens without securing the notes;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- enter into agreements that restrict dividends from subsidiaries;
- merge, consolidate, sell or otherwise dispose of substantial portions of our assets;
- enter into transactions with affiliates; and
- guarantee certain obligations.

In addition, our New Credit Facility contains restrictive covenants and requires us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet these restricted covenants and financial ratios and tests can be affected by events beyond our control, and we cannot assure you that we will meet those tests. A breach of any of these covenants could result in a default under our New Credit Facility and/or the Notes. Upon the occurrence of an event of default under our New Credit Facility or the Notes, all amounts outstanding under our New Credit Facility and the Notes may become due and payable and all commitments under the New Credit Facility to extend further credit may be terminated.

We believe that internally generated cash flows, availability for additional borrowings under our New Credit Facility of $950 million (consisting of a $750 million revolving credit facility and $200 million of our delayed draw term loan facility) and our ability to add up to $300 million of borrowing capacity from receivable transactions (including securitizations) and continued access to the bank credit and capital markets will be sufficient to finance acquisitions, capital expenditures and working capital requirements through the next 12 months. We believe these same sources of cash flows, borrowings under our credit agreement as well as access to bank credit and capital markets will be available to us beyond the next 12 months and into the foreseeable future. On December 22, 2008, we filed a universal automatic shelf registration statement on Form S-3ASR that will permit us, from time to time, in one or more public offerings, to offer debt securities, common stock, preferred stock, warrants, depositary shares, or any combination of such securities. The shelf registration statement will also permit our subsidiary, CHS, to offer debt securities that would be guaranteed by us, from time to time in one or more public offerings. The terms of any such future offerings would be established at the time of the offering.

Off-balance sheet arrangements

Excluding the hospital whose lease terminated in conjunction with our sale of interests in the partnership holding the lease and whose operating results are included in discontinued operations, our consolidated operating results for the years ended December 31, 2008 and 2007, included $282.0 million and $275.6 million, respectively, of net operating revenue and $18.4 million and $22.7 million, respectively, of income from operations, generated from seven hospitals operated by us under operating lease arrangements. In accordance with accounting principles generally accepted in the United States of America, the respective assets and the future lease obligations under these arrangements are not recorded in our consolidated balance sheet. Lease payments under these arrangements are included in rent expense and totaled approximately $16.7 million and $15.2 million for the years ended December 31, 2008 and 2007, respectively. The current terms of these operating leases expire between June 2010 and December 2019, not including lease extension options. If we allow these leases to expire, we would no longer generate revenue nor incur expenses from these hospitals.

In the past, we have utilized operating leases as a financing tool for obtaining the operations of specified hospitals without acquiring, through ownership, the related assets of the hospital and without a significant outlay of cash at the front end of the lease. We utilize the same operating strategies to improve operations at those hospitals held under operating leases as we do at those hospitals that we own. We have not entered into any operating leases for hospital operations since December 2000.

As described more fully in Note 15 of the Notes to Consolidated Financial Statements, at December 31, 2008, we have certain cash obligations for replacement facilities and other construction commitments of $527.3 million and open purchase orders for $93.3 million.

Joint Ventures

We have sold minority interests in certain of our subsidiaries or acquired subsidiaries with existing minority interest ownership positions. Triad implemented this strategy to a greater extent than we did, and in conjunction with the acquisition of Triad, we acquired 19 hospitals containing minority ownership interests ranging from less than 1% to 35%. As of December 31, 2008, 22 of our hospitals were owned by physician joint ventures, of which one also had a non-profit entity as a partner. In addition, five other hospitals had non-profit entities as partners. During 2008, we sold minority interests in six of our hospitals for total consideration of $80.0 million. These minority interest positions represent ownership positions in the hospitals ranging from less than 1% to 40%. Effective June 30, 2008, we acquired the remaining 35% equity interest in Affinity Health Systems, LLC which indirectly owns and operates Trinity Medical Center (560 licensed beds) in Birmingham, Alabama, from Baptist, giving us 100% ownership of that facility. The purchase price to acquire this interest was $51.5 million in cash and the cancellation of a promissory note issued by Baptist to Affinity Health Systems, LLC in the original principal amount of $32.8 million. Effective November 14, 2008, we acquired from Willamette Community Health Solutions all of its joint venture interest in MWMC Holdings, LLC, which indirectly owns and operates McKenzie-Willamette Medical Center of Springfield, Oregon. This acquisition resulted from a put right held by Willamette Community Health Solutions in connection with the 2003 transaction establishing the joint venture. The purchase price to acquire this interest was $22.7 million in cash. Physicians affiliated with Oregon Health Resources, Inc. continue to own a minority interest in the hospital. Minority interests in equity of consolidated subsidiaries was $325.2 million and $366.1 million as of December 31, 2008 and December 31, 2007, respectively, and the amount of minority interest in earnings was $40.1 million and $15.2 million for the years ended December 31, 2008 and 2007, respectively.

Reimbursement, Legislative and Regulatory Changes

Legislative and regulatory action has resulted in continuing change in the Medicare and Medicaid reimbursement programs which will continue to limit payment increases under these programs and in some cases implement payment decreases. Within the statutory framework of the Medicare and Medicaid programs, there are substantial areas subject to administrative rulings, interpretations, and discretion which may further affect payments made under those programs, and the federal and state governments might, in the future, reduce the funds available under those programs or require more stringent utilization and quality reviews of hospital facilities. Additionally, there may be a continued rise in managed care programs and future restructuring of the financing and delivery of healthcare in the United States. These events could cause our future financial results to decline.

Inflation

The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. In addition, our suppliers pass along rising costs to us in the form of higher prices. We have implemented cost control measures, including our case and resource management program, to curb increases in operating costs and expenses. We have generally offset increases in operating costs by increasing reimbursement for services, expanding services and reducing costs in other areas. However, we cannot predict our ability to cover or offset future cost increases.

Critical Accounting Policies

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

Critical accounting policies are defined as those that are reflective of significant judgments and uncertainties, and potentially result in materially different results under different assumptions and conditions. We believe that our critical accounting policies are limited to those described below. For a detailed discussion on the application of these and other accounting policies, see Note 1 in the Notes to the Consolidated Financial Statements.

Third Party Reimbursement

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. Contractual allowances are automatically calculated and recorded through our internally developed "automated contractual allowance system." Within the automated system, excluding the former Triad hospitals, actual Medicare DRG data, coupled with all payors' historical paid claims data, is utilized to calculate the contractual allowances. This data is automatically updated on a monthly basis. For the former Triad hospitals, regardless of payor or method of calculation, contractual allowances are determined through a process wherein contractual allowance adjustments are reviewed and compared to actual payment experience. All hospital contractual allowance calculations are subjected to monthly review by management to ensure reasonableness and accuracy. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. The process of estimating contractual allowances requires us to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification and historical paid claims data. Due to the complexities involved in these estimates, actual payments we receive could be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs and managed care contracts differed by 1% from our estimated reimbursement percentage, net income for the year ended December 31, 2008 would have changed by approximately $24.1 million, and net accounts receivable would have changed by $39.1 million. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements were insignificant to both net operating revenue and net income in each of the years ended December 31, 2008, 2007 and 2006.

Allowance for Doubtful Accounts

Substantially all of our accounts receivable are related to providing healthcare services to our hospitals' patients. Collection of these accounts receivable is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and outstanding patient balances for which the primary insurance payor has paid some but not all of the outstanding balance, with the remaining outstanding balance (generally deductibles and co-payments) owed by the patient. At the point of service, for patients required to make a co-payment, we generally collect less than 15% of the related revenue. For all procedures scheduled in advance, our policy is to verify insurance coverage prior to the date of the procedure. Insurance coverage is not verified in advance of procedures for walk-in and emergency room patients.

We estimate the allowance for doubtful accounts by reserving a percentage of all self-pay accounts receivable without regard to aging category, based on collection history, adjusted for expected recoveries and, if present, anticipated changes in trends. For all other payor categories we reserve 100% of all accounts aging over 365 days from the date of discharge. The percentage used to reserve for all self-pay accounts is based on our collection history. We believe that we collect substantially all of our third-party insured receivables which include receivables from governmental agencies. During the quarter ended December 31, 2007, in conjunction with our ongoing process of monitoring the net realizable value of our accounts receivable, as well as integrating the methodologies, data and assumptions used by the former Triad management, we performed various analyses including updating a review of historical cash collections. As a result of these analyses, we noted deterioration in certain key cash collection indicators.

The primary key cash collection indicator that experienced deterioration during the fourth quarter of 2007 was "cash receipts as a percentage of net revenue less bad debts." This indicator decreased to the lowest percentage experienced by us since the quarter ended September 30, 2006. Further analysis indicated the primary causes of this deterioration were a continuing increase in the volume of indigent non-resident aliens, an increase in the number of patients qualifying for charity care and a greater than expected impact of the removal of participants from TennCare (Tennessee's state provided Medicaid program) which increased the number of uninsured patients with limited financial means receiving care at our eight Tennessee hospitals. During the fourth quarter of 2007, due to the deteriorating cash collections and the desire to standardize processes with those of the former Triad hospitals, we undertook a detailed programming effort to develop data around the deteriorating classes of accounts receivable needed to update its historical cash collections percentages as well as enable it to estimate how much of certain self-pay categories ultimately convert to Medicaid, charity and indigent programs. Triad's processes for establishing contractual allowances and allowances for bad debts related to accounts classified as Medicaid — pending, charity — pending and indigent non-resident alien included inputs and assumptions based on the historical percentage of these accounts which ultimately qualified for specific government programs or for write-off as charity care.

We used these new inputs and assumptions regarding Medicaid — pending, charity — pending, and indigent non-resident alien in conjunction with the new data developed in the fourth quarter of 2007 as described above to evaluate the reliability of accounts receivable and to revise our estimate of contractual allowances for estimated amounts of self-pay accounts receivable that will ultimately qualify as charity care, or that will ultimately qualify for Medicaid, indigent care or other specific governmental reimbursement, resulting in an increase to our contractual reserves of $96.3 million as of December 31, 2007. Previous estimates of uncollectible amounts for such receivables were included in our bad debt reserves for each period.

Furthermore, in updating the historical collection statistics of all our hospitals, we also took into account a detailed study of the historical collection information for the hospitals acquired from Triad. The updated collection statistics of the hospitals acquired from Triad also showed subsequent deterioration in cash collections similar to those experienced by the other hospitals that we own. Therefore, we also standardized the processes for calculating the allowance for doubtful accounts of the hospitals acquired from Triad to that of our other hospitals which, along with the allowance percentages determined from the new collection data, resulted in the recording of an additional $70.1 million of allowance for bad debts as of December 31, 2007.

The resulting impact of the above, net of taxes, for the year ended December 31, 2007 was a decrease to income from continuing operations of $105.4 million. We believe this lower collectability was primarily the result of an increase in the number of patients qualifying for charity care, reduced enrollment in certain state Medicaid programs and an increase in the number of indigent non-resident aliens. 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 could affect our collection of accounts receivable. The process of estimating the allowance for doubtful accounts requires us to estimate the collectability of self-pay accounts receivable, which is primarily based on our collection history, adjusted for expected recoveries and, if available, anticipated changes in collection trends. Significant change in payor mix, business office operations, economic conditions, trends in federal and state governmental healthcare coverage or other third party payors could affect our estimates of accounts receivable collectability. If the actual collection percentage differed by 1% from our estimated collection percentage as a result of a change in expected recoveries, net income for the year ended December 31, 2008 would have changed by $11.5 million, and net accounts receivable would have changed by $18.7 million. We also continually review our overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net revenue less provision for bad debts, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, and the impact of recent acquisitions and dispositions.

Our policy is to write-off gross accounts receivable if the balance is under $10.00 or when such amounts are placed with outside collection agencies. We believe this policy accurately reflects our ongoing collection efforts and is consistent with industry practices. We had approximately $1.5 billion at December 31, 2008 and 2007, being pursued by various outside collection agencies. We expect to collect less than 3%, net of estimated collection fees, of the amounts being pursued by outside collection agencies. As these amounts have been written-off, they are not included in our gross accounts receivable or our allowance for doubtful accounts. Collections on amounts previously written-off are recognized as a reduction to bad debt expense when received. However, we take into consideration estimated collections of these future amounts written-off in evaluating the reasonableness of our allowance for doubtful accounts.

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

Patient accounts receivable from our hospitals represent approximately 95% of our total consolidated accounts receivable.

Days revenue outstanding was 53 days at December 31, 2008 and 54 days at December 31, 2007. Our target range for days revenue outstanding is from 52 to 58 days.

Total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) was approximately $5.458 billion as of December 31, 2008 and approximately $4.692 billion as of December 31, 2007. The approximate percentage of total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) summarized by aging categories is as follows:

	As of December 31, 2008	As of December 31, 2007
0 – 60 days	59.8%	61.2%
60 – 150 days	19.0%	18.8%
151 – 360 days	16.2%	15.3%
Over 360 days	5.0%	4.7%
Total	100.0%	100.0%

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

	As of December 31, 2008	As of December 31, 2007
Insured receivables	67.0%	66.7%
Self-pay receivables	33.0%	33.3%
Total	100.0%	100.0%

For the hospital segment, the combined total of the allowance for doubtful accounts and related allowances for other self-pay discounts and contractuals, as a percentage of gross self-pay receivables, was approximately 80% at December 31, 2008 and 79% at December 31, 2007. If the receivables that have been written-off, but where collections are still being pursued by outside collection agencies, were included in both the allowances and gross self-pay receivables specified above, the percentage of combined allowances to total self-pay receivables would have been approximately 88% at December 31, 2008 and 89% at December 31, 2007.

Goodwill and Other Intangibles

Goodwill represents the excess of cost over the fair value of net assets acquired. Goodwill arising from business combinations is accounted for under the provisions of Statement of Financial Accounting Standards (SFAS) No. 141 "Business Combinations" and SFAS No. 142, "Goodwill and Other Intangible Assets" and is not amortized. SFAS 142 requires goodwill to be evaluated for impairment at the same time every year and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. SFAS No. 142 requires a two-step method for determining goodwill impairment. Step one is to compare the fair value of the reporting unit with the unit's carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit's goodwill with the carrying value of the reporting unit's goodwill. We have selected September 30th as our annual testing date.

We estimate the fair value of the related reporting units using both a discounted cash flow model as well as an EBITDA multiple model. These models are both based on our best estimate of future revenues and operating costs and are reconciled to our consolidated market capitalization. The cash flow forecasts are adjusted by an appropriate discount rate based on our weighted average cost of capital. Historically our valuation models did not fully capture the fair value of our business as a whole, as they did not consider the increased consideration a potential acquirer would be required to pay, in the form of a control premium, in order to gain sufficient ownership to set policies, direct operations and control management decisions. However, because our models have indicated value significantly in excess of the carrying amount of assets in our reporting units, the additional value from a control premium was not a determining factor in the outcome of step one of our impairment assessment.

As indicated above, in addition to the annual impairment analysis, we are required to evaluate goodwill for impairment whenever an event occurs or circumstances change such that it is more likely than not that an impairment may exist. In light of this requirement, we have considered whether the decline in our market capitalization between September 30, 2008 and December 31, 2008 has, more likely than not, resulted in the existence of an impairment and have concluded that the decline in our market capitalization did not, more likely than not, result in the existence of an impairment. In making this conclusion, we gave consideration to the valuation of hospitals in which we sold equity interests during periods subsequent to September 30, 2008, currently proposed hospital equity sale transactions, our proposed purchase price for a hospital which we anticipate closing on the acquisition in the first half of 2009, the increase in our stock price since December 31, 2008 and our average stock price over the trailing 3 month, 6 month and 1 year periods. We also considered the fact that the decline in our stock price has not been related to a decline in our operating performance and that any near term credit tightening within the financial markets could be overcome by us through the substantial amount of cash flows being generated by us, as well as, the borrowing capacity available to us through our existing credit facilities. The current turmoil in the financial markets and weakness in macroeconomic conditions globally continue to be challenging and we cannot be certain of the duration of these conditions and their potential impact on our stock price performance. If a further decline in our market capitalization and other factors resulted in the decline in our fair value, it is reasonably likely that a goodwill impairment assessment prior to the next annual review, in the fourth quarter of 2009, would be necessary. If such an assessment is required, an impairment of goodwill may be recognized. A non-cash goodwill impairment charge would have the effect of decreasing our earnings or increasing our losses in the period the impairment is recognized. The amount of such effect on earnings and losses is dependent on the size of the impairment charge. Such a change, however, would be a non-cash charge and therefore would not impact our compliance with covenants contained in our New Credit Facility.

Impairment or Disposal of Long-Lived Assets

In accordance with SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets", whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, we project the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

Professional Liability Claims

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

The net present value of the projected payments was discounted using a weighted-average risk-free rate of 2.6%, 4.1% and 4.6% in 2008, 2007 and 2006, respectively. This liability is adjusted for new claims information in the period such information becomes known to us. Professional malpractice expense includes the losses resulting from professional liability claims and loss adjustment expense, as well as paid excess insurance premiums, and is presented within other operating expenses in the accompanying consolidated statements of income.

Our processes for obtaining and analyzing claims and incident data are standardized across all of our hospitals and have been consistent for many years. We monitor the outcomes of the medical care services that we provide and for each reported claim, we obtain various information concerning the facts and circumstances related to that claim. In addition, we routinely monitor current key statistics and volume indicators in our assessment of utilizing historical trends. The average lag period between claim occurrence and payment of a final settlement is between 4 and 5 years, although the facts and circumstances of individual claims could result in the timing of such payments being different from this average. Since claims are paid promptly after settlement with the claimant is reached, settled claims represent less than 1.0% of the total liability at the end of any period.

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

Based on these analyses we determine our estimate of the professional liability claims. The determination of management's estimate, including the preparation of the reserve analysis that supports such estimate, involves subjective judgment of the management. Changes in reserving data or the trends and factors that influence reserving data may signal fundamental shifts in our future claim development patterns or may simply reflect single-period anomalies. Even if a change reflects a fundamental shift, the full extent of the change

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

Although we have not historically maintained and presented our claims data in this manner, we are providing the following table to present the amounts of our accrual for professional liability claims and approximate amounts of our activity for each of the respective years listed (excludes premiums for excess insurance coverage) (in thousands):

	Year Ended December 31,		
	2008	2007	2006
Accrual for professional liability claims, January 1	$ 300,184	$ 104,161	$ 88,371
Liability acquired through acquisition:			
Gross liability acquired	—	197,453	—
Discount of liability acquired	—	(26,309)	—
Discounted liability acquired	—	171,144	—
Expense (income) related to(1):			
Current accident year	110,010	73,039	43,441
Prior accident years	(15,826)	7,158	3,146
Expense (income) from discounting	11,499	(1,040)	3,667
Total incurred loss and loss expense	105,683	79,157	50,254
Paid claims and expenses related to:			
Current accident year	(688)	(701)	(574)
Prior accident years	(54,600)	(53,577)	(33,890)
Total paid claims and expenses	(55,288)	(54,278)	(34,464)
Accrual for professional liability claims, December 31	$ 350,579	$ 300,184	$ 104,161

(1) Total expense, including premiums for insured coverage, was $65.7 million in 2006, $99.7 million in 2007 and $130.4 million in 2008.

The increase in current accident year claims expense in each respective year from 2006 to 2008 is consistent with the increase in net operating revenues during the respective periods. Income/expense related to prior accident years reflects changes in estimates resulting from the filing of claims for prior year incidents, claim settlements, updates from litigation, and our ongoing investigation of open claims. Expense/income from discounting reflects the changes in the weighted-average risk-free interest rate used and timing of estimated payments for discounting in each respective year.

We are primarily self-insured for these claims; however, we obtain excess insurance that transfers the risk of loss to a third-party insurer for claims in excess of our self-insured retentions. Our excess insurance is underwritten on a claims-made basis. For claims reported prior to June 1, 2002, substantially all of our professional and general liability risks were subject to a $0.5 million per occurrence self-insured retention and for claims reported from June 1, 2002 through June 1, 2003, these self-insured retentions were $2.0 million per occurrence. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 are self-insured up to $5 million per claim. Management on occasion has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals has been purchased through commercial insurance companies and generally covers us for liabilities in excess of the self-insured retentions and up to $100 million per occurrence for claims reported on or after June 1, 2003 and up to $150 million per occurrence for claims occurred and reported after January 1, 2008.

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

Income Taxes

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

On January 1, 2007, we adopted the provisions of the FASB Interpretation No. 48, "Accounting for Uncertainty in Income Taxes." The total amount of unrecognized benefit that would affect the effective tax rate, if recognized, is approximately $10.5 million as of December 31, 2008. It is our policy to recognize interest and penalties accrued related to unrecognized benefits in our consolidated statement of operations as income tax expense. During the year ended December 31, 2008, we decreased liabilities by approximately $0.8 million and recorded $0.2 million in interest and penalties related to prior state income tax returns through our income tax provision from continuing operations and which are included in our FASB Interpretation No. 48 liability at December 31, 2008. A total of approximately $1.2 million of interest and penalties is included in the amount of FASB Interpretation No. 48 liability at December 31, 2008. During the year ended December 31, 2008, we released $7.5 million for income taxes and $1.8 million for accrued interest of our FASB Interpretation No. 48 liability, as a result of the expiration of the statute of limitations pertaining to tax positions taken in prior years relative to state tax positions.

We believe it is reasonably possible that approximately $5.3 million of our current unrecognized tax benefit may be recognized within the next twelve months as a result of a lapse of the statute of limitations and settlements with taxing authorities.

We or one of our subsidiaries file income tax returns in the U.S. federal jurisdiction and various state jurisdictions. We have extended the federal statute of limitations for Triad for the tax periods ended December 31, 1999, December 31, 2000, April 30, 2001, June 30, 2001, December 31, 2001, December 31, 2002 and December 31, 2003. With few exceptions, we are no longer subject to state income tax examinations for years prior to 2003. During 2007, we agreed to a settlement with the Internal Revenue Service, or IRS, Appeals Office with respect to the 2003 tax year. We have since received a closing letter with respect to the examination for that tax year. The settlement was not material to our results of operations or consolidated financial position.

The IRS has concluded an examination of the federal income tax returns of Triad for the short taxable years ended April 27, 2001, June 30, 2001 and December 31, 2001, and the taxable years ended December 31, 2002 and 2003. On May 10, 2006, the IRS issued an examination report with proposed adjustments. Triad filed a protest on June 9, 2006 and the matter was referred to the IRS Appeals Office. Representatives of the former Triad hospitals met with the IRS Appeals Office in April 2007 and reached a tentative settlement. Triad has since received a closing letter with respect to the examination for those tax years. The settlement was not material to our results of operations or consolidated financial position. In December 2008, we were notified by the IRS of its intent to examine the federal tax return of Triad for the tax periods ended December 31, 2005 and ended July 25, 2007. We believe the results of this examination will not be material to our results of operations or consolidated financial position.

Recent Accounting Pronouncements

In September 2006, the FASB issued SFAS No. 157, "Fair Value Measurements" ("SFAS No. 157"), which defines fair value, provides a framework for measuring fair value, and expands disclosures required for fair value measurements. SFAS No. 157 applies to other accounting pronouncements that require fair value measurement; it does not require any new fair value measurements. SFAS No. 157 is effective for fiscal years beginning after November 15, 2007, and was adopted by us as of January 1, 2008. The adoption of this statement has not had a material effect on our consolidated results of operations or consolidated financial position.

In February 2007, the FASB issued SFAS No. 159, "The Fair Value Option for Financial Assets and Financial Liabilities — Including an Amendment of FASB Statement No. 115" ("SFAS No. 159"). SFAS No. 159 expands the use of fair value accounting but does not affect existing standards that require assets or liabilities to be carried at fair value. SFAS No. 159 permits an entity, on a contract-by-contract basis, to make an irrevocable election to account for certain types of financial instruments and warranty and insurance contracts at fair value, rather than historical cost, with changes in the fair value, whether realized or unrealized, recognized in earnings. SFAS No. 159 is effective for fiscal years beginning after November 15, 2007. We adopted SFAS No. 159 as of January 1, 2008 and did not elect to re-measure any assets or liabilities. The adoption of this statement has not had a material effect on our consolidated results of operations or consolidated financial position.

In December 2007, the FASB issued SFAS No. 141(R), "Business Combinations" ("SFAS No. 141(R)"). SFAS No. 141(R) replaces SFAS No. 141 and addresses the recognition and accounting for identifiable assets acquired, liabilities assumed, and noncontrolling interests in business combinations. This standard will require more assets and liabilities to be recorded at fair value and will require expense recognition (rather than capitalization) of certain pre-acquisition costs. This standard will also require any adjustments to acquired deferred tax assets and liabilities occurring after the related allocation period to be made through earnings. Furthermore, this standard requires this treatment of acquired deferred tax assets and liabilities also to be applied to acquisitions occurring prior to the effective date of this standard. SFAS No. 141(R) is effective for fiscal years beginning after December 15, 2008 and is required to be adopted prospectively with no early adoption permitted. We will begin applying SFAS No. 141(R) in the first quarter of 2009. We do not currently have on our consolidated balance sheet any material deferred costs related to prospective acquisitions that would be required to be expensed upon the adoption of SFAS No. 141(R). Any outstanding deferred costs will be expensed in 2009 for any acquisitions that are not closed by December 31, 2008. Furthermore, the impact of SFAS No. 141(R) on our consolidated results of operations and consolidated financial position in future periods will be largely dependent on the number of acquisitions we pursue; however, it is not anticipated at this time that such impact will be material.

In December 2007, the FASB issued SFAS No. 160, "Noncontrolling Interests in Consolidated Financial Statements" ("SFAS No. 160"). SFAS No. 160 addresses the accounting and reporting framework for noncontrolling ownership interests in consolidated subsidiaries of the parent. SFAS No. 160 also establishes disclosure requirements that clearly identify and distinguish between the interests of the parent company and the interests of the noncontrolling owners and that require minority ownership interests to be presented separately within equity in the consolidated financial statements. SFAS No. 160 is effective for fiscal years beginning after December 15, 2008, and will be adopted by us in the first quarter of 2009. We are currently assessing the potential impact that SFAS No. 160 will have on our consolidated results of operations and consolidated financial position.

In February 2008, the FASB issued FASB Statement of Position No. 157-2, "Effective Date of FASB Statement No. 157" ("FSP 157-2"). FSP 157-2 deferred the effective date of the provisions of SFAS No. 157 for all non-financial assets and non-financial liabilities to fiscal years beginning after November 15, 2008, and will be adopted by us in the first quarter of 2009. We are currently assessing the potential impact of SFAS No. 157 for non-financial assets and non-financial liabilities on our consolidated results of operations and consolidated financial position.

In March 2008, the FASB issued SFAS No. 161, "Disclosures about Derivative Instruments and Hedging Activities" ("SFAS No. 161"). SFAS No. 161 expands the disclosure requirements for derivative instruments and for hedging activities in order to provide additional understanding of how an entity uses derivative instruments and how they are accounted for and reported in an entity's financial statements. The new disclosure requirements for SFAS No. 161 are effective for fiscal years beginning after November 15, 2008, and will be adopted by us in the first quarter of 2009.

Item 7A. ***Quantitative and Qualitative Disclosures about Market Risk***

We are exposed to interest rate changes, primarily as a result of our New Credit Facility which bears interest based on floating rates. In order to manage the volatility relating to the market risk, we entered into interest rate swap agreements described under the heading "Liquidity and Capital Resources". We do not anticipate any material changes in our primary market risk exposures in 2009. We utilize risk management procedures and controls in executing derivative financial instrument transactions. We do not execute transactions or hold derivative financial instruments for trading purposes. Derivative financial instruments related to interest rate sensitivity of debt obligations are used with the goal of mitigating a portion of the exposure when it is cost effective to do so.

A 1% change in interest rates on variable rate debt in excess of that amount covered by interest rate swaps would have resulted in interest expense fluctuating approximately $13 million in 2008, $14 million in 2007 and $4 million in 2006.

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

Index to Financial Statements

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Community Health Systems, Inc.
Franklin, Tennessee

We have audited the accompanying consolidated balance sheets of Community Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 2008 and 2007, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2008. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Community Health Systems, Inc. and subsidiaries as of December 31, 2008 and 2007, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2008, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 8 to the consolidated financial statements, the Company adopted Statement of Financial Accounting Standards No. 157, *Fair Value Measurements* ("SFAS No. 157") effective January 1, 2008, which changed the Company's definitions of fair value, framework for measuring fair value, and disclosures for fair value measurements.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2008, based on the criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 26, 2009 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 26, 2009

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31, 2008	2007	2006
	(In thousands, except share and per share data)		
Net operating revenues	$ 10,840,098	$ 7,063,775	$ 4,180,136
Operating costs and expenses:			
Salaries and benefits	4,326,526	2,875,795	1,661,619
Provision for bad debts	1,208,687	885,653	518,861
Supplies	1,518,987	935,812	487,778
Other operating expenses	2,073,713	1,422,972	855,596
Rent	229,526	153,695	91,943
Depreciation and amortization	499,085	311,122	179,282
Total operating costs and expenses	9,856,524	6,585,049	3,795,079
Income from operations	983,574	478,726	385,057
Interest expense, net of interest income of $7,057, $8,181, and $1,779 in 2008, 2007 and 2006, respectively	651,925	361,773	94,411
(Gain) loss from early extinguishment of debt	(2,525)	27,388	4
Minority interest in earnings	40,101	15,155	2,795
Equity in earnings of unconsolidated affiliates	(42,064)	(25,132)	—
Income from continuing operations before income taxes	336,137	99,542	287,847
Provision for income taxes	129,479	41,828	110,152
Income from continuing operations	206,658	57,714	177,695
Discontinued operations, net of taxes:			
Income (loss) from operations of hospitals sold and held for sale	5,316	(8,884)	(6,873)
Gain (loss) on sale of hospitals and partnership interests	9,580	(2,594)	(2,559)
Impairment of long-lived assets of hospitals held for sale	(3,250)	(15,947)	—
Income (loss) on discontinued operations	11,646	(27,425)	(9,432)
Net income	$ 218,304	$ 30,289	$ 168,263
Earnings per common share — basic:			
Income from continuing operations	$ 2.21	$ 0.62	$ 1.87
Income (loss) on discontinued operations	$ 0.13	$ (0.30)	$ (0.10)
Net income	$ 2.34	$ 0.32	$ 1.77
Earnings per common share — diluted:			
Income from continuing operations	$ 2.19	$ 0.61	$ 1.85
Income (loss) on discontinued operations	$ 0.13	$ (0.29)	$ (0.10)
Net income	$ 2.32	$ 0.32	$ 1.75
Weighted-average number of shares outstanding:			
Basic	93,371,782	93,517,337	94,983,646
Diluted	94,288,829	94,642,294	96,232,910

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

	December 31, 2008	December 31, 2007
	(In thousands, except share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 220,655	$ 132,874
Patient accounts receivable, net of allowance for doubtful accounts of $1,102,900 and $1,033,516 in 2008 and 2007, respectively	1,613,959	1,533,798
Supplies	272,937	262,903
Prepaid income taxes	92,710	99,417
Deferred income taxes	91,875	113,741
Prepaid expenses and taxes	72,900	70,339
Other current assets (including assets of hospitals held for sale of $40,853 and $118,893 at December 31, 2008 and 2007, respectively)	240,014	339,826
Total current assets	2,605,050	2,552,898
Property and equipment:		
Land and improvements	508,690	463,373
Buildings and improvements	4,480,999	4,166,888
Equipment and fixtures	2,093,241	1,679,979
	7,082,930	6,310,240
Less accumulated depreciation and amortization	(1,213,871)	(797,666)
Property and equipment, net	5,869,059	5,512,574
Goodwill	4,166,091	4,247,714
Other assets, net of accumulated amortization of $158,532 and $100,556 in 2008 and 2007, respectively (including assets of hospitals held for sale of $172,870 and $362,546 at December 31, 2008 and 2007, respectively)	1,178,054	1,180,457
Total assets	$ 13,818,254	$ 13,493,643
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Current maturities of long-term debt	$ 29,462	$ 20,710
Accounts payable	529,429	492,693
Deferred income taxes	6,740	—
Accrued liabilities:		
Employee compensation	427,688	403,598
Interest	152,228	153,832
Other (including liabilities of hospitals held for sale of $106,856 and $67,606 at December 31, 2008 and 2007, respectively)	388,423	377,102
Total current liabilities	1,533,970	1,447,935
Long-term debt	8,937,984	9,077,367
Deferred income taxes	460,793	407,947
Other long-term liabilities	887,445	483,459
Minority interests in equity of consolidated subsidiaries	325,197	366,131
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $.01 par value per share, 100,000,000 shares authorized; none issued	—	—
Common stock, $.01 par value per share, 300,000,000 shares authorized; 92,483,166 shares issued and 91,507,617 shares outstanding at December 31, 2008 and 96,611,085 shares issued and 95,635,536 shares outstanding at December 31, 2007	925	966
Additional paid-in capital	1,197,944	1,240,308
Treasury stock, at cost, 975,549 shares at December 31, 2008 and 2007	(6,678)	(6,678)
Unearned stock compensation	—	—
Accumulated other comprehensive income (loss)	(295,575)	(81,737)
Retained earnings	776,249	557,945
Total stockholders' equity	1,672,865	1,710,804
Total liabilities and stockholders' equity	$ 13,818,254	$ 13,493,643

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock Shares	Common Stock Amount	Additional Paid-in Capital	Treasury Stock Shares	Treasury Stock Amount	Unearned Stock Compensation	Accumulated Other Comprehensive Income (Loss)	Retained Earnings (Accumulated Deficit)	Total
			(In thousands, except share data)						
BALANCE, December 31, 2005	94,539,811	$ 945	$ 1,208,930	(975,549)	$ (6,678)	$ (13,204)	$ 15,191	$ 359,391	$ 1,564,572
Comprehensive income (loss)									
Net income	—	—	—	—	—	—	—	168,263	168,263
Net change in fair value of interest rate swaps, net of tax benefit of $931	—	—	—	—	—	—	(1,654)	—	(1,654)
Net change in fair value of available for sale securities	—	—	—	—	—	—	562	—	562
Total comprehensive income (loss)							(1,092)	168,263	167,171
Adjustment to adopt FASB statement No. 158, net of tax benefit of $5,465	—	—	—	—	—	—	(8,301)	—	(8,301)
Repurchases of common stock	(5,000,000)	(50)	(176,265)	—	—	—	—	—	(176,315)
Issuance of common stock in connection with the exercise of options	867,833	9	14,564	—	—	—	—	—	14,573
Issuance of common stock in connection with the conversion of convertible debt	4,074,510	41	137,157	—	—	—	—	—	137,198
Tax benefit from exercise of options	—	—	4,750	—	—	—	—	—	4,750
Share-based compensation	544,314	5	20,068	—	—	—	—	—	20,073
Reclassification of unearned stock compensation	—	—	(13,257)	—	—	13,204	—	—	(53)
BALANCE, December 31, 2006	95,026,494	$ 950	$ 1,195,947	(975,549)	$ (6,678)	$ —	$ 5,798	$ 527,656	$ 1,723,673
Comprehensive income (loss)									
Net income	—	—	—	—	—	—	—	30,289	30,289
Net change in fair value of interest rate swaps, net of tax benefit of $51,223	—	—	—	—	—	—	(91,063)	—	(91,063)
Net change in fair value of available for sale securities	—	—	—	—	—	—	237	—	237
Adjustment to pension liability, net of tax of $496	—	—	—	—	—	—	3,291	—	3,291
Total comprehensive income (loss)							(87,535)	30,289	(57,246)
Issuance of common stock in connection with the exercise of options	321,535	3	8,362	—	—	—	—	—	8,365
Tax benefit from exercise of options	—	—	(2,760)	—	—	—	—	—	(2,760)
Share-based compensation	1,263,056	13	38,759	—	—	—	—	—	38,772
BALANCE, December 31, 2007	96,611,085	$ 966	$ 1,240,308	(975,549)	$ (6,678)	$ —	$ (81,737)	$ 557,945	$ 1,710,804
Comprehensive income (loss):									
Net income	—	—	—	—	—	—	—	218,304	218,304
Net change in fair value of interest rate swaps, net of tax benefit of $112,915	—	—	—	—	—	—	(200,737)	—	(200,737)
Net change in fair value of available for sale securities	—	—	—	—	—	—	(2,613)	—	(2,613)
Adjustment to pension liability, net of tax of $7,262	—	—	—	—	—	—	(10,488)	—	(10,488)
Total comprehensive income (loss)							(213,838)	218,304	4,466
Repurchases of common stock	(4,780,609)	(48)	(90,141)	—	—	—	—	—	(90,189)
Issuance of common stock in connection with the exercise of options	281,831	3	1,803	—	—	—	—	—	1,806
Cancellation of restricted stock for tax withholdings on vested shares	(310,806)	(3)	(5,455)	—	—	—	—	—	(5,455)
Tax benefit from exercise of options	—	—	(672)	—	—	—	—	—	(672)
Share-based compensation	687,663	7	52,101	—	—	—	—	—	52,108
BALANCE, December 31, 2008	92,483,166	$ 925	$ 1,197,944	(975,549)	$ (6,678)	$ —	$ (295,575)	$ 776,249	$ 1,672,865

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2008	2007	2006
		(In thousands)	
Cash flows from operating activities:			
Net income	$ 218,304	$ 30,289	$ 168,263
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	506,694	332,580	188,771
Deferred income taxes	159,870	(39,894)	(25,228)
Stock-based compensation expense	52,105	38,771	20,073
Excess tax benefits relating to stock-based compensation	(1,278)	(1,216)	(6,819)
(Gain) loss on early extinguishment of debt	(2,525)	27,388	—
Minority interest in earnings	40,101	15,996	2,795
Impairment on hospitals held for sale	5,000	19,044	—
(Gain) loss on sale of hospitals and partnership interest, net	(17,687)	3,954	3,937
Other non-cash expenses, net	3,577	19,017	500
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	(57,437)	131,300	(71,141)
Supplies, prepaid expenses and other current assets	(34,711)	(31,977)	(4,544)
Accounts payable, accrued liabilities and income taxes	119,596	125,959	52,151
Other	65,672	16,527	21,497
Net cash provided by operating activities	1,057,281	687,738	350,255
Cash flows from investing activities:			
Acquisitions of facilities and other related equipment	(161,907)	(7,018,048)	(384,618)
Purchases of property and equipment	(692,233)	(522,785)	(224,519)
Proceeds from disposition of hospitals and other ancillary operations	365,636	109,996	750
Proceeds from sale of property and equipment	13,483	4,650	4,480
Increase in other assets	(190,450)	(72,671)	(36,350)
Net cash used in investing activities	(665,471)	(7,498,858)	(640,257)
Cash flows from financing activities:			
Proceeds from exercise of stock options	1,806	8,214	14,573
Stock buy-back	(90,188)	—	(176,316)
Deferred financing costs	(3,136)	(182,954)	(2,153)
Excess tax benefits relating to stock-based compensation	1,278	1,216	6,819
Redemption of convertible notes	—	—	(128)
Proceeds from minority investors in joint ventures	14,329	2,351	6,890
Redemption of minority investments in joint ventures	(77,587)	(1,356)	(915)
Distribution to minority investors in joint ventures	(46,890)	(6,645)	(3,220)
Borrowings under Credit Agreement	131,277	9,221,627	1,031,000
Repayments of long-term indebtedness	(234,918)	(2,139,025)	(650,090)
Net cash (used in) provided by financing activities	(304,029)	6,903,428	226,460
Net change in cash and cash equivalents	87,781	92,308	(63,542)
Cash and cash equivalents at beginning of period	132,874	40,566	104,108
Cash and cash equivalents at end of period	$ 220,655	$ 132,874	$ 40,566

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Business and Summary of Significant Accounting Policies

Business. Community Health Systems, Inc. is a holding company and operates no business in its own name. On a consolidated basis, Community Health Systems, Inc. and its subsidiaries (collectively the "Company"), own, lease and operate acute care hospitals in non-urban and select urban markets. As of December 31, 2008, included in its continuing operations, the Company owned or leased 118 hospitals, licensed for 17,245 beds in 28 states. As of December 31, 2008, Indiana and Texas represent the only areas of geographic concentration. Net operating revenues generated by the Company's hospitals in Indiana, as a percentage of consolidated net operating revenues, were 11.0% in 2008 and 7.7% in 2007. Net operating revenues generated by the Company's hospitals in Texas, as a percentage of consolidated net operating revenues, were 13.4% in 2008, 13.0% in 2007 and 10.4% in 2006. As a result of the Company's growth and expansion of services in other states, Pennsylvania no longer represents an area of geographic concentration, which it did as of December 31, 2007.

Use of Estimates. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates under different assumptions or conditions.

Principles of Consolidation. The consolidated financial statements include the accounts of the Company, its subsidiaries, all of which are controlled by the Company through majority voting control, and variable interest entities for which the Company is the primary beneficiary. All significant intercompany accounts and transactions have been eliminated. Certain of the subsidiaries have minority stockholders. The amount of minority interest in equity is disclosed separately on the consolidated balance sheets and minority interest in earnings is disclosed separately on the consolidated statements of income.

Cost of Revenue. The majority of the Company's operating expenses are "cost of revenue" items. Operating costs that could be classified as general and administrative by the Company would include the Company's corporate office costs at the Company's Franklin, Tennessee offices and former offices in Brentwood, Tennessee and Plano, Texas, which were $149.9 million, $133.4 million and $88.9 million for the years ended December 31, 2008, 2007 and 2006, respectively. Included in these amounts is stock-based compensation of $52.1 million, $38.8 million and $20.1 million for the years ended December 31, 2008, 2007 and 2006, respectively.

Cash Equivalents. The Company considers highly liquid investments with original maturities of three months or less to be cash equivalents.

Supplies. Supplies, principally medical supplies, are stated at the lower of cost (first-in, first-out basis) or market.

Marketable Securities. The Company accounts for marketable securities in accordance with the provisions of Statement of Financial Accounting Standards ("SFAS") No. 115, "Accounting for Certain Investments in Debt and Equity Securities." The Company's marketable securities are classified as trading or available-for-sale. Available-for-sale securities are carried at fair value as determined by quoted market prices, with unrealized gains and losses reported as a separate component of stockholders' equity. Trading securities are reported at fair value with unrealized gains and losses included in earnings. Interest and dividends on securities classified as available-for-sale or trading are included in net operating revenue and were not material in all periods presented. Accumulated other comprehensive income (loss) included an unrealized loss of $2.6 million at December 31, 2008 and an unrealized gain of $0.2 million at December 31, 2007, related to these available-for-sale securities.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Property and Equipment. Property and equipment are recorded at cost. Depreciation is recognized using the straight-line method over the estimated useful lives of the land and improvements (2 to 15 years; weighted average useful life is 14 years), buildings and improvements (5 to 40 years; weighted average useful life is 24 years) and equipment and fixtures (4 to 18 years; weighted average useful life is 8 years). Costs capitalized as construction in progress were $196.4 million and $457.5 million at December 31, 2008 and 2007, respectively. Expenditures for renovations and other significant improvements are capitalized; however, maintenance and repairs which do not improve or extend the useful lives of the respective assets are charged to operations as incurred. Interest capitalized in accordance with SFAS No. 34, "Capitalization of Interest Cost," was $22.1 million, $19.0 million and $3.0 million for the years ended December 31, 2008, 2007 and 2006, respectively. Net property and equipment additions included in accounts payable decreased $7.9 million for the year ended December 31, 2008, and increased $21.4 million and $16.9 million for the years ended December 31, 2007 and 2006, respectively.

The Company also leases certain facilities and equipment under capital leases (see Note 9). Such assets are amortized on a straight-line basis over the lesser of the term of the lease or the remaining useful lives of the applicable assets.

Goodwill. Goodwill represents the excess cost over the fair value of net assets acquired. Goodwill arising from business combinations is accounted for under the provisions of SFAS No. 141, "Business Combinations" ("SFAS No. 141"), and SFAS No. 142, "Goodwill and Other Intangible Assets" ("SFAS No. 142"), and is not amortized. SFAS No. 142 requires goodwill to be evaluated for impairment at the same time every year and when an event occurs or circumstances change such that it is reasonably possible that an impairment may exist. The Company has selected September 30th as its annual testing date.

Other Assets. Other assets consist of costs associated with the issuance of debt, which are included in interest expense over the life of the related debt using the effective interest method, and costs to recruit physicians to the Company's markets, which are deferred and amortized in amortization expense over the term of the respective physician recruitment contract, which is generally three years. Long-term assets held for sale at December 31, 2008 and 2007 are also included in other assets.

Third-Party Reimbursement. Net patient service revenue is reported at the estimated net realizable amount from patients, third party payors and others for services rendered. Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems, provisions of cost-reimbursement and other payment methods. Approximately 36.6% of net operating revenues for the year ended December 31, 2008, 39.3% of net operating revenues for the year ended December 31, 2007 and 41.5% of net operating revenues for the year ended December 31, 2006, are related to services rendered to patients covered by the Medicare and Medicaid programs. Revenues from Medicare outlier payments are included in the amounts received from Medicare and were approximately 0.55% of net operating revenues for 2008, 0.42% of net operating revenues for 2007, and 0.44% for 2006. In addition, the Company is reimbursed by non-governmental payors using a variety of payment methodologies. Amounts received by the Company for treatment of patients covered by such programs are generally less than the standard billing rates. The differences between the estimated program reimbursement rates and the standard billing rates are accounted for as contractual adjustments, which are deducted from gross revenues to arrive at net operating revenues. These net operating revenues are an estimate of the net realizable amount due from these payors. The process of estimating contractual allowances requires the Company to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification and historical paid claims data. Due to the complexities involved in these estimates, actual payments the Company receives could be different from the amounts it estimates and records. Final settlements under certain of these programs are subject to adjustment based on administrative review and audit by third parties. Adjustments to the estimated billings are recorded in the periods that such adjustments become known. Adjustments to previous program

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

reimbursement estimates are accounted for as contractual allowance adjustments and reported in the periods that such adjustments become known. Adjustments related to final settlements were insignificant to both net operating revenue and net income in each of the years ended December 31, 2008, 2007 and 2006.

Amounts due to third-party payors were $87.9 million and $91.4 million as of December 31, 2008 and 2007, respectively, and are included in accrued liabilities-other in the accompanying consolidated balance sheets. Amounts due from third party payors were $73.6 million and $90.8 million as of December 31, 2008 and 2007, respectively, and are included in other current assets in the accompanying consolidated balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 2006.

Net Operating Revenues. Net operating revenues are recorded net of provisions for contractual allowance of approximately $26.433 billion, $16.718 billion and $10.024 billion in 2008, 2007 and 2006, respectively. Net operating revenues are recognized when services are provided and are reported at the estimated net realizable amount from patients, third party payors and others for services rendered. Also included in the provision for contractual allowance shown above is the value of administrative and other discounts provided to self-pay patients eliminated from net operating revenues which was $458.6 million, $266.0 million and $100.3 million for the years ended December 31, 2008, 2007 and 2006, respectively. In the ordinary course of business, the Company renders services to patients who are financially unable to pay for hospital care. Included in the provision for contractual allowance shown above is the value (at the Company's standard charges) of these services to patients who are unable to pay that is eliminated from net operating revenues when it is determined they qualify under the Company's charity care policy. The value of these services was $380.2 million, $322.2 million and $214.2 million for the years ended December 31, 2008, 2007 and 2006, respectively. In the fourth quarter of 2007, in conjunction with an analysis of the net realizable value of accounts receivable, which included updating the Company's analysis of historical cash collections, as well as conforming estimation methodologies with those of the hospitals acquired from Triad Hospitals, Inc. ("Triad"), the Company revised its methodology whereby the Company has revised its estimate of contractual allowances for estimated amounts of self-pay accounts receivable that will ultimately qualify as charity care, or that will ultimately qualify for Medicaid, indigent care or other specific governmental reimbursement. Previous estimates of uncollectible amounts for such receivables were included in the Company's bad debt reserves for each period. The impact of these changes in estimates decreased net operating revenue approximately $96.3 million for the year ended December 31, 2007.

Allowance for Doubtful Accounts. Accounts receivable are reduced by an allowance for amounts that could become uncollectible in the future. Substantially all of the Company's receivables are related to providing healthcare services to its hospitals' patients.

The Company experienced a significant increase in self-pay volume and related revenue, combined with lower cash collections during the quarter ended September 30, 2006. The Company believes this trend reflected an increased collection risk from self-pay accounts, and as a result the Company performed a review and an alternative analysis of the adequacy of its allowance for doubtful accounts. Based on this review, the Company recorded a $65.0 million increase to its allowance for doubtful accounts to maintain an adequate allowance for doubtful accounts as of September 30, 2006. The Company believed that the increase in self-pay accounts was a result of economic trends, including an increase in the number of uninsured patients, reduced enrollment under Medicaid programs such as TennCare, and higher deductibles and co-payments for patients with insurance.

In conjunction with recording the $65.0 million increase to the allowance for doubtful accounts, the Company changed its methodology for estimating its allowance for doubtful accounts effective September 30, 2006, as follows: The Company reserved a percentage of all self-pay accounts receivable without regard to aging category, based on collection history adjusted for expected recoveries and, if present, other changes in trends. For all other payor categories, the Company reserved 100% of all accounts aging over 365 days from the date of discharge. Previously, the Company estimated its allowance for doubtful accounts by reserving all

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

accounts aging over 150 days from the date of discharge without regard to payor class. The Company believes its revised methodology provided a better approach to reflect changes in payor mix and historical collection patterns and to respond to changes in trends.

During the quarter ended December 31, 2007, in conjunction with the Company's ongoing process of monitoring the net realizable value of its accounts receivable, as well as integrating the methodologies, data and assumptions used by the former Triad management, the Company performed various analyses including updating a review of historical cash collections.

The primary key cash collection indicator that experienced deterioration during the fourth quarter of 2007 was "cash receipts as a percentage of net revenue less bad debts." This percentage decreased to the lowest percentage experienced by the Company since the quarter ended September 30, 2006. Further analysis indicated the primary causes of this deterioration were a continuing increase in the volume of indigent non-resident aliens, an increase in the number of patients qualifying for charity care and a greater than expected impact of the removal of participants from TennCare (Tennessee's state provided Medicaid program) which increased the number of uninsured patients with limited financial means receiving care at the Company's eight Tennessee hospitals. During the fourth quarter of 2007, due to the deteriorating cash collections and desire to standardize processes with those of the former Triad hospitals, the Company undertook a detailed programming effort to develop data around the deteriorating classes of accounts receivable needed to update its historical cash collections percentages as well as enable it to estimate how much of certain self-pay categories ultimately convert to Medicaid, charity and indigent programs. Triad's processes for establishing contractual allowances and allowances for bad debts related to accounts classified as Medicaid — pending, charity — pending and indigent non-resident alien included inputs and assumptions based on the historical percentage of these accounts which ultimately qualified for specific government programs or for write-off as charity care.

The Company used these new inputs and assumptions regarding Medicaid — pending, charity — pending, and indigent non-resident alien in conjunction with the new data developed in the fourth quarter of 2007 as described above to evaluate the realizability of accounts receivable and to revise the Company's estimate of contractual allowances for estimated amounts of self-pay accounts receivable that will ultimately qualify as charity care, or that will ultimately qualify for Medicaid, indigent care or other specific governmental reimbursement, resulting in an increase to the Company's contractual reserves of $96.3 million as of December 31, 2007. Previous estimates of uncollectible amounts for such receivables were included in the Company's bad debt reserves for each period.

Furthermore, in updating the historical collection statistics of all its hospitals, the Company also took into account a detailed study of the historical collection information for the hospitals acquired from Triad. The updated collection statistics of the hospitals acquired from Triad also showed subsequent deterioration in cash collections similar to those experienced by the other hospitals that the Company owns. Therefore, the Company also standardized the processes for calculating the allowance for doubtful accounts of the hospitals acquired from Triad to that of its other hospitals which, along with the allowance percentages determined from the new collection data, resulted in the recording of an additional $70.1 million of allowance for bad debts as of December 31, 2007.

The resulting impact of the above, net of taxes, for the year ended December 31, 2007 was a decrease to income from continuing operations of $105.4 million. The Company believes this lower collectability was primarily the result of an increase in the number of patients qualifying for charity care, reduced enrollment in certain state Medicaid programs and an increase in the number of indigent non-resident aliens. Collections are impacted by the economic ability of patients to pay and the effectiveness of the Company's collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect the Company's collection of accounts receivable. The process of estimating the allowance for doubtful accounts requires the Company to estimate the collectability of self-pay accounts receivable, which is primarily based on its collection history, adjusted for expected recoveries

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

and, if available, anticipated changes in collection trends. Significant change in payor mix, business office operations, economic conditions, trends in federal and state governmental healthcare coverage or other third party payors could affect the Company's estimates of accounts receivable collectability.

The Company believes the revised methodology provides a better approach to estimating changes in payor mix, continued increases in charity and indigent care as well as the monitoring of historical collection patterns. The revised accounting methodology and the adequacy of resulting estimates will continue to be reviewed by monitoring accounts receivable write-offs, monitoring cash collections as a percentage of trailing net revenues less provision for bad debts, monitoring historical cash collection trends, as well as analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, and the impact of recent acquisitions and dispositions.

Physician Income Guarantees. The Company enters into physician recruiting agreements under which it supplements physician income to a minimum amount over a period of time, typically one year, while the physician establishes themselves in the community. As part of the agreements, the physicians are committed to practice in the community for a period of time, typically three years, which extends beyond their income guarantee period. The Company accounts for these agreements in accordance with FASB Staff Position No. 45-3, "Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners," ("FIN 45-3"). FIN 45-3 requires that an asset and liability for the estimated fair value of minimum revenue guarantees be recorded on new agreements entered into on or after January 1, 2006. Adjustments to the ultimate value of the guarantee paid to physicians are recognized in the period that the change in estimate is identified. The Company amortizes such costs over the life of the agreement. As of December 31, 2008 and 2007, the unamortized portion of these physician income guarantees was $49.1 million and $45.7 million, respectively.

Concentrations of Credit Risk. The Company grants unsecured credit to its patients, most of whom reside in the service area of the Company's facilities and are insured under third-party payor agreements. Because of the economic diversity of the Company's facilities and non-governmental third-party payors, Medicare represents the only significant concentration of credit risk from payors. Accounts receivable, net of contractual allowances, from Medicare were $256.6 million and $302.1 million as of December 31, 2008 and 2007, respectively, representing 9.4% and 11.8% of consolidated net accounts receivable, before allowance for doubtful accounts, as of December 31, 2008 and 2007, respectively.

Professional Liability Claims. The Company accrues for estimated losses resulting from professional liability. The accrual, which includes an estimate for incurred but not reported claims, is based on historical loss patterns and actuarially-determined projections and is discounted to its net present value. To the extent that subsequent claims information varies from management's estimates, the liability is adjusted when such information becomes available.

Accounting for the Impairment or Disposal of Long-Lived Assets. In accordance with SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets" ("SFAS No. 144"), whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

Income Taxes. The Company accounts for income taxes under the asset and liability method, in which deferred income tax assets and liabilities are recognized for the tax consequences of "temporary differences" by applying enacted statutory tax rates applicable to future years to differences between the financial statement carrying amounts and the tax bases of existing assets and liabilities. The effect on deferred taxes of a change

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

in tax rates is recognized in the consolidated statement of income during the period in which the tax rate change becomes law.

Comprehensive Income (Loss). Comprehensive income (loss) is the change in equity of a business enterprise during a period from transactions and other events and circumstances from non-owner sources.

Accumulated Other Comprehensive Income (Loss) consists of the following (in thousands):

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Adjustment to Pension Liability	Accumulated Other Comprehensive Income (Loss)
Balance as of December 31, 2006	$ 13,315	$ 784	$ (8,301)	$ 5,798
2007 Activity, net of tax	(91,063)	237	3,291	(87,535)
Balance as of December 31, 2007	$ (77,748)	$ 1,021	$ (5,010)	$ (81,737)
2008 Activity, net of tax	(200,737)	(2,613)	(10,488)	(213,838)
Balance as of December 31, 2008	$ (278,485)	$ (1,592)	$ (15,498)	$ (295,575)

Segment Reporting. SFAS No. 131, "Disclosures About Segments of an Enterprise and Related Information" ("SFAS No. 131"), requires that a public company report annual and interim financial and descriptive information about its reportable operating segments. Operating segments, as defined, are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker in deciding how to allocate resources and in assessing performance. SFAS No. 131 allows aggregation of similar operating segments into a single reportable operating segment if the businesses have similar economic characteristics and are considered similar under the criteria established by SFAS No. 131.

Prior to the acquisition of Triad, the Company aggregated its operating segments into one reportable segment as all of its operating segments had similar services, had similar types of patients, operated in a consistent manner and had similar economic and regulatory characteristics. In connection with the Triad acquisition, certain aspects of the Company's organizational structure and the information that is reviewed by the chief operating decision maker have changed. As a result, management has determined that the Company now operates in three distinct operating segments, represented by the hospital operations (which includes the Company's acute care hospitals and related healthcare entities that provide inpatient and outpatient health care services), the home care agencies operations (which provide outpatient care generally in the patient's home), and the hospital management services business (which provides executive management and consulting services to independent acute care hospitals). SFAS No. 131 requires (1) that financial information be disclosed for operating segments that meet a 10% quantitative threshold of the consolidated totals of net revenue, profit or loss, or total assets; and (2) that the individual reportable segments disclosed contribute at least 75% of total consolidated net revenue. Based on these measures, only the hospital operations segment meets the criteria as a separate reportable segment. Financial information for the home care agencies and management services segments do not meet the quantitative thresholds defined in SFAS No. 131 and are therefore combined with corporate into the all other reportable segment.

The financial information from 2006 has been presented in Note 14 to reflect this change in the composition of the Company's reportable operating segments.

Derivative Instruments and Hedging Activities. In accordance with SFAS No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133"), as amended, the Company records derivative instruments (including certain derivative instruments embedded in other contracts) on the consolidated balance sheet as either an asset or liability measured at its fair value. Changes in a derivative's fair value are recorded each period in earnings or other comprehensive income ("OCI"), depending on whether the derivative is designated and is effective as a hedged transaction, and on the type of hedge transaction. Changes in the fair value of derivative instruments recorded

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to OCI are reclassified to earnings in the period affected by the underlying hedged item. Any portion of the fair value of a derivative instrument determined to be ineffective under the standard is recognized in current earnings.

The Company has entered into several interest rate swap agreements subject to the scope of this pronouncement. See Note 6 for further discussion about the swap transactions.

New Accounting Pronouncements. In February 2007, the FASB issued SFAS No. 159, "The Fair Value Option for Financial Assets and Financial Liabilities — Including an Amendment of FASB Statement No. 115" ("SFAS No. 159"). SFAS No. 159 expands the use of fair value accounting but does not affect existing standards that require assets or liabilities to be carried at fair value. SFAS No. 159 permits an entity, on a contract-by-contract basis, to make an irrevocable election to account for certain types of financial instruments and warranty and insurance contracts at fair value, rather than historical cost, with changes in the fair value, whether realized or unrealized, recognized in earnings. SFAS No. 159 is effective for fiscal years beginning after November 15, 2007. The Company adopted SFAS No. 159 as of January 1, 2008 and did not elect to re-measure any assets or liabilities. The adoption of this statement has not had a material effect on the Company's consolidated results of operations or consolidated financial position.

In December 2007, the FASB issued SFAS No. 141(R), "Business Combinations" ("SFAS No. 141(R)"). SFAS No. 141(R) replaces SFAS No. 141 and addresses the recognition and accounting for identifiable assets acquired, liabilities assumed, and noncontrolling interests in business combinations. This standard will require more assets and liabilities to be recorded at fair value and will require expense recognition (rather than capitalization) of certain pre-acquisition costs. This standard also will require any adjustments to acquired deferred tax assets and liabilities occurring after the related allocation period to be made through earnings. Furthermore, this standard requires this treatment of acquired deferred tax assets and liabilities also to be applied to acquisitions occurring prior to the effective date of this standard. SFAS No. 141(R) is effective for fiscal years beginning after December 15, 2008 and is required to be adopted prospectively with no early adoption permitted. SFAS No. 141(R) will be adopted by the Company in the first quarter of 2009. The Company does not currently have on its consolidated balance sheet any material deferred costs related to prospective acquisitions that would be required to be expensed upon the adoption of SFAS No. 141(R). Any outstanding deferred costs will be expensed in 2009 for any acquisitions that are not closed by December 31, 2008. Furthermore, the impact of SFAS No. 141(R) on the Company's consolidated results of operations and consolidated financial position in future periods will be largely dependent on the number of acquisitions pursued by the Company; however, it is not anticipated at this time that such impact will be material.

In December 2007, the FASB issued SFAS No. 160, "Noncontrolling Interests in Consolidated Financial Statements" ("SFAS No. 160"). SFAS No. 160 addresses the accounting and reporting framework for noncontrolling ownership interests in consolidated subsidiaries of the parent. SFAS No. 160 also establishes disclosure requirements that clearly identify and distinguish between the interests of the parent company and the interests of the noncontrolling owners and that require minority ownership interests be presented separately within equity in the consolidated financial statements. SFAS No. 160 is effective for fiscal years beginning after December 15, 2008, and will be adopted by the Company in the first quarter of 2009. The Company is currently assessing the potential impact that SFAS No. 160 will have on its consolidated results of operations or financial position.

In March 2008, the FASB issued SFAS No. 161, "Disclosures about Derivative Instruments and Hedging Activities" ("SFAS No. 161"). SFAS No. 161 expands the disclosure requirements for derivative instruments and for hedging activities in order to provide additional understanding of how an entity uses derivative instruments and how they are accounted for and reported in an entity's financial statements. The new disclosure requirements for SFAS No. 161 are effective for fiscal years beginning after November 15, 2008, and will be adopted by the Company in the first quarter of 2009.

Reclassifications. The Company disposed of one hospital in August 2007, disposed of one hospital in October 2007, disposed of one hospital in November 2007, disposed of eleven hospitals during the first quarter

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of 2008, and has designated two hospitals as being held for sale as of December 31, 2008. The operating results of those hospitals have been classified as discontinued operations on the consolidated statements of income for all periods presented. There is no effect on net income for all periods presented related to the reclassifications made for the discontinued operations.

2. Accounting for Stock-Based Compensation

The Company adopted the provisions of SFAS No. 123(R), "Share-Based Payments" ("SFAS No. 123(R)") on January 1, 2006, electing to use the modified prospective method for transition purposes. The modified prospective method requires that compensation expense be recorded for all unvested stock options and share awards that subsequently vest or are modified, without restatement of prior periods. Prior to January 1, 2006, the Company accounted for stock-based compensation using the recognition and measurement principles of Accounting Principles Board Opinion No. 25, "Accounting for Stock Issued to Employees" and related interpretations ("APB No. 25"), and provided the pro-forma disclosure requirements of SFAS No. 123 "Accounting for Stock-Based Compensation" and SFAS No. 148 "Accounting for Stock-Based Compensation Transition and Disclosures — an Amendment of FASB Statement No. 123" ("SFAS No. 148"). Under APB No. 25, when the exercise price of the Company's stock was equal to the market price of the underlying stock on the date of grant, no compensation expense was recognized.

Stock-based compensation awards are granted under the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan (the "2000 Plan"). The 2000 Plan allows for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code, as well as stock options which do not so qualify, stock appreciation rights, restricted stock, performance units and performance shares, phantom stock awards and share awards. Persons eligible to receive grants under the 2000 Plan include the Company's directors, officers, employees and consultants. To date, all options granted under the 2000 Plan have been "nonqualified" stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date. Options granted prior to 2005 have a 10 year contractual term, options granted in 2005 through 2007 have an 8 year contractual term and options granted in 2008 have a 10 year contractual term. The exercise price of all options granted under the 2000 Plan is equal to the fair value of the Company's common stock on the option grant date. As of December 31, 2008, 4,129,347 shares of unissued common stock remain reserved for future grants under the 2000 Plan.

The following table reflects the impact of total compensation expense related to stock-based equity plans under SFAS No. 123(R), on the reported operating results for the respective periods (in thousands, except per share data):

	Year Ended December 31,		
	2008	2007	2006
Effect on income from continuing operations before income taxes	$ (52,105)	$ (38,771)	$ (20,073)
Effect on net income	$ (31,655)	$ (23,541)	$ (12,762)
Effect on net income per share-diluted	$ (0.34)	$ (0.25)	$ (0.13)

At December 31, 2008, $55.9 million of unrecognized stock-based compensation expense is expected to be recognized over a weighted-average period of 19.0 months. Of that amount, $20.9 million relates to outstanding unvested stock options expected to be recognized over a weighted-average period of 20.6 months and $35.0 million relates to outstanding unvested restricted stock expected to be recognized over a weighted-average period of 18.0 months. There were no modifications to awards during 2008, 2007, or 2006.

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The fair value of stock options was estimated using the Black Scholes option pricing model with the assumptions and weighted-average fair values during the years ended December 31, 2008, 2007 and 2006, as follows:

	Year Ended December 31, 2008	2007	2006
Expected volatility	24.9%	24.4%	24.2%
Expected dividends	0	0	0
Expected term	4 years	4 years	4 years
Risk-free interest rate	2.53%	4.48%	4.67%

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

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

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

Options outstanding and exercisable under the 2000 Plan as of December 31, 2008, and changes during each of the years in the three year period ended December 31, 2008 were as follows (in thousands, except share and per share data):

	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (In Years)	Aggregate Intrinsic Value as of December 31, 2008
Outstanding at December 31, 2005	5,370,274	$ 22.63		
Granted	1,151,000	38.07		
Exercised	(865,833)	16.47		
Forfeited and cancelled	(172,913)	34.02		
Outstanding at December 31, 2006	5,482,528	26.48		
Granted	3,544,000	37.79		
Exercised	(295,854)	26.89		
Forfeited and cancelled	(291,659)	35.70		
Outstanding at December 31, 2007	8,439,015	30.90		
Granted	1,251,000	31.89		
Exercised	(281,831)	22.10		
Forfeited and cancelled	(644,100)	35.71		
Outstanding at December 31, 2008	8,764,084	$ 30.97	5.7 years	$ 436
Exercisable at December 31, 2008	5,306,366	$ 27.73	5.0 years	$ 436

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The weighted-average grant date fair value of stock options granted during the years ended December 31, 2008, 2007 and 2006, was $7.56, $10.24 and $10.38, respectively. The aggregate intrinsic value (the number of in-the-money stock options multiplied by the difference between the Company's closing stock price on the last trading day of the reporting period and the exercise price of the respective stock options) in the table above represents the amount that would have been received by the option holders had all option holders exercised their options on December 31, 2008. This amount changes based on the market value of the Company's common stock. The aggregate intrinsic value of options exercised during the years ended December 31, 2008, 2007 and 2006 was $3.4 million, $3.5 million and $18.2 million, respectively. The aggregate intrinsic value of options vested and expected to vest approximates that of the outstanding options.

The Company has also awarded restricted stock under the 2000 Plan to its directors and employees. The restrictions on these shares generally lapse in one-third increments on each of the first three anniversaries of the award date, except for restricted stock granted on July 25, 2007, which restrictions lapse equally on the first two anniversaries of the award date. Certain of the restricted stock awards granted to the Company's senior executives contain a performance objective that must be met in addition to any vesting requirements. If the performance objective is not attained, the awards will be forfeited in their entirety. Once the performance objective has been attained, restrictions will lapse in one-third increments on each of the first three anniversaries of the award date with the exception of the July 25, 2007 restricted stock awards, which have no additional time vesting restrictions once the performance restrictions are met. Notwithstanding the above mentioned performance objectives and vesting requirements, the restrictions will lapse earlier in the event of death, disability, termination of employment of the holder of the restricted stock by the Company for any reason other than for cause, or change in control of the Company. Restricted stock awards subject to performance standards are not considered outstanding for purposes of determining earnings per share until the performance objectives have been satisfied.

Restricted stock outstanding under the 2000 Plan as of December 31, 2008, and changes during each of the years in the three year period ended December 31, 2008 were as follows:

	Shares	Weighted Average Grant Date Fair Value
Unvested at December 31, 2005	558,000	$ 32.37
Granted	606,000	38.26
Vested	(185,975)	32.43
Forfeited	(8,334)	35.93
Unvested at December 31, 2006	969,691	36.05
Granted	1,392,000	38.70
Vested	(384,646)	35.47
Forfeited	(20,502)	36.73
Unvested at December 31, 2007	1,956,543	38.04
Granted	795,500	31.99
Vested	(960,001)	37.64
Forfeited	(107,835)	35.62
Unvested at December 31, 2008	1,684,207	35.57

Under the Director's Fee Deferral Plan, the Company's outside directors may elect to receive share equivalent units in lieu of cash for their director's fee. These units are held in the plan until the director electing to receive the share equivalent units retires or otherwise terminates his/her directorship with the Company. Share equivalent units are converted to shares of common stock of the Company at the time of distribution. The following table represents the amount of directors' fees which were deferred and the equivalent units into which they converted for each of the respective periods:

	Year Ended December 31,	
	2008	2007
Directors' fees earned and deferred into plan	$ 90,875	$ 129,000
Equivalent units	3,410.470	3,622.531

At December 31, 2008, there are a total of 16,819.002 units deferred in the plan with an aggregate fair value of $0.2 million, based on the closing market price of the Company's common stock at December 31, 2008 of $14.58.

3. Acquisitions and Divestitures of Hospitals

Triad Acquisition

On July 25, 2007, the Company completed its acquisition of Triad. Triad owned and operated 50 hospitals with 49 hospitals located in 17 states in non-urban and middle market communities and one hospital located in the Republic of Ireland. As of December 31, 2008, seven hospitals acquired from Triad have been sold and two hospitals acquired from Triad were classified as held for sale. As a result of its acquisition of Triad, the Company also provides management and consulting services to independent hospitals, through its subsidiary, Quorum Health Resources, LLC, on a contract basis. The Company acquired Triad for approximately $6.857 billion, including the assumption of $1.686 billion of existing indebtedness. Prior to entering the merger agreement, Triad terminated an Agreement and Plan of Merger that it had entered into on February 4, 2007 (the "Prior Merger Agreement") with Panthera Partners, LLC, Panthera Holdco Corp. and Panthera Acquisition Corporation (collectively, "Panthera"). Concurrent with the termination of the Prior Merger Agreement and pursuant to the terms thereof, Triad paid a termination fee of $20 million and out-of-pocket expenses of $18.8 million to Panthera. The Company reimbursed Triad for the termination fee and the advance for expense reimbursement paid to Panthera. These amounts are included in the Triad allocated purchase price.

In connection with the consummation of the acquisition of Triad, the Company obtained $7.215 billion of senior secured financing under a new credit facility (the "New Credit Facility") and its wholly-owned subsidiary CHS/Community Health Systems, Inc. ("CHS") issued $3.021 billion aggregate principal amount of 8.875% senior notes due 2015 (the "Notes"). The Company used the net proceeds of $3.000 billion from the Notes offering and the net proceeds of $6.065 billion of term loans under the New Credit Facility to acquire the outstanding shares of Triad, to refinance certain of Triad's indebtedness and the Company's indebtedness, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. This New Credit Facility also provides an additional $750 million revolving credit facility and a $400 million delayed draw term loan facility for future acquisitions, working capital and general corporate purposes. As of December 31, 2007, the $400 million delayed draw term loan was reduced to $300 million at the request of the Company. As of December 31, 2008, $100 million of the delayed draw term loan had been drawn by the Company, reducing the delayed draw term loan availability to $200 million at that date. In January 2009, the Company drew down the remaining $200 million of the delayed draw term loan.

The total cost of the Triad acquisition has been allocated to the assets acquired and liabilities assumed based upon their respective fair values in accordance with SFAS No. 141. The purchase price represented a premium over the fair value of the net tangible and identifiable intangible assets acquired for reasons such as:

- strategically, Triad had operations in five states in which the Company previously had no operations;

- the combined company has smaller concentrations of credit risk through greater geographic diversification;
- many support functions will be centralized; and
- duplicate corporate functions will be eliminated.

The allocation process required the analysis of acquired fixed assets, contracts, contractual commitments, and legal contingencies to identify and record the fair value of all assets acquired and liabilities assumed. The Company completed the allocation of the total cost of the Triad acquisition in the third quarter of 2008 and has made a final analysis and adjustment as of December 31, 2008 to deferred tax accounts based on the final cost allocation, resulting in approximately $2.781 billion of goodwill being recorded with respect to the Triad acquisition.

Other Acquisitions

Effective November 14, 2008, the Company acquired from Willamette Community Health Solutions all of its joint venture interest in MWMC Holdings, LLC, which indirectly owns and operates McKenzie-Willamette Medical Center of Springfield, Oregon. This acquisition resulted from a put right held by Willamette Community Health Solutions in connection with the 2003 transaction establishing the joint venture. The purchase price for this minority interest was $22.7 million in cash. Physicians affiliated with Oregon Healthcare Resources, Inc. will continue to own a minority interest in the hospital.

Effective October 1, 2008, the Company completed the acquisition of Deaconess Medical Center (388 licensed beds) and Valley Hospital and Medical Center (123 licensed beds) both located in Spokane, Washington, from Empire Health Services. The total consideration for these two hospitals was approximately $182.6 million, of which $149.2 million was paid in cash and $33.4 million was assumed in liabilities. Based upon the Company's preliminary purchase price allocation relating to this acquisition as of December 31, 2008, no goodwill has been recorded. The acquisition transaction was accounted for using the purchase method of accounting. This preliminary allocation of purchase price has been determined by the Company based upon available information and is subject to settling amounts related to purchased working capital and final appraisals of tangible and intangible assets. Adjustments to the purchase price allocation are not expected to be material.

Effective June 30, 2008, the Company acquired the remaining 35% equity interest in Affinity Health Systems, LLC which indirectly owns and operates Trinity Medical Center (560 licensed beds) in Birmingham, Alabama, from Baptist Health Systems, Inc. of Birmingham, Alabama ("Baptist"), giving the Company 100% ownership of that facility. The purchase price for this minority interest was $51.5 million in cash and the cancellation of a promissory note issued by Baptist to Affinity Health Systems, LLC in the original principal amount of $32.8 million.

Effective April 1, 2007, the Company completed its acquisition of Lincoln General Hospital (157 licensed beds), located in Ruston, Louisiana. The total consideration for this hospital was approximately $48.2 million, of which $44.7 million was paid in cash and $3.5 million was assumed in liabilities. On May 1, 2007, the Company completed its acquisition of Porter Health (301 licensed beds), located in Valparaiso, Indiana, with a satellite campus in Portage, Indiana and outpatient medical campuses located in Chesterton, Demotte, and Hebron, Indiana. As part of this acquisition, the Company has agreed to construct a 225-bed replacement facility for the Valparaiso hospital no later than April 2011. The total consideration for Porter Health was approximately $117.1 million, of which $93.9 million was paid in cash and $23.2 million was assumed in liabilities. The Company's purchase price allocation relating to these acquisitions resulted in approximately $6.3 million of goodwill being recorded, which is expected to be fully deductible for tax purposes.

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During 2006, the Company acquired through seven separate purchase transactions and three capital lease transactions, substantially all of the assets and working capital of eight hospitals and three home care agencies. On March 1, 2006, the Company acquired, through a combination of purchasing certain assets and entering into a capital lease for other related assets, Forrest City Hospital, a 118-bed hospital located in Forrest City, Arkansas. On April 1, 2006, the Company completed the acquisition of two hospitals from Baptist Health System, Birmingham, Alabama: Baptist Medical Center — DeKalb (134 beds) and Baptist Medical Center — Cherokee (60 beds). On May 1, 2006, the Company acquired Via Christi Oklahoma Regional Medical Center, a 140-bed hospital located in Ponca City, Oklahoma. On June 1, 2006, the Company acquired Mineral Area Regional Medical Center, a 135-bed hospital located in Farmington, Missouri. On June 30, 2006 the Company acquired Cottage Home Options, a home care agency and related business, located in Galesburg, Illinois. On July 1, 2006, the Company acquired the healthcare assets of Vista Health, which included Victory Memorial Hospital (336 beds) and St. Therese Medical Center (71 non-acute care beds), both located in Waukegan, Illinois. On September 1, 2006, the Company acquired Humble Texas Home Care, a home care agency located in Humble, Texas. On October 1, 2006, the Company acquired Helpsource Home Health, a home care agency located in Wichita Falls, Texas. On November 1, 2006, the Company acquired through two separate capital lease transactions, Campbell Memorial Hospital, a 99-bed hospital located in Weatherford, Texas and Union County Hospital, a 25-bed hospital located in Anna, Illinois. The aggregate consideration for these eight hospitals and three home care agencies totaled approximately $385.7 million, of which $353.8 million was paid in cash and $31.9 million was assumed in liabilities. Goodwill recognized in these transactions totaled $65.6 million, which is expected to be fully deductible for tax purposes.

The 2007 and 2006 acquisition transactions were accounted for using the purchase method of accounting. The final allocation of the purchase price for these acquisitions was determined by the Company within one year of the date of acquisition.

The table below summarizes the allocations of the purchase price (including assumed liabilities) for these acquisitions (in thousands):

	2008	2007	2006
Current assets	$ 35,619	$ 1,394,082	$ 56,896
Property and equipment	146,986	3,824,521	262,335
Goodwill	—	2,787,509	66,490
Intangible assets	—	84,804	—
Other long-term assets	—	516,067	—
Liabilities	33,452	1,611,129	27,247

The operating results of the foregoing hospitals have been included in the consolidated statements of income from their respective dates of acquisition. The following pro forma combined summary of operations of the Company gives effect to using historical information of the operations of the hospitals purchased in 2008 and 2007 as if the acquisitions had occurred as of January 1, 2008 and 2007 (in thousands, except per share data):

	Year Ended December 31, 2008	Year Ended December 31, 2007
	(Unaudited)	
Pro forma net operating revenues	$ 11,071,479	$ 9,772,807
Pro forma net income (loss)	216,520	(102,030)
Pro forma net income per share:		
Basic	$ 2.32	$ (1.09)
Diluted	$ 2.30	$ (1.08)

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Pro forma adjustments to net income (loss) include adjustments to depreciation and amortization expense, net of the related tax effect, based on the estimated fair value assigned to the long-lived assets acquired, and to interest expense, net of the related tax effect, assuming the increase in long-term debt used to fund the acquisitions had occurred as of January 1, 2007. The pro forma net income for the year ended December 31, 2007, includes a charge for the early extinguishment of debt of $27.3 million before taxes and $17.5 million after tax, or $0.19 per share (diluted). The pro forma results do not include transaction costs incurred by Triad prior to the date of acquisition, cost savings or other synergies that are anticipated as a result of this acquisition. These pro forma results are not necessarily indicative of the actual results of operations.

Discontinued Operations

Effective March 1, 2008, the Company sold Woodland Medical Center (100 licensed beds) located in Cullman, Alabama; Parkway Medical Center (108 licensed beds) located in Decatur, Alabama; Hartselle Medical Center (150 licensed beds) located in Hartselle, Alabama; Jacksonville Medical Center (89 licensed beds) located in Jacksonville, Alabama; National Park Medical Center (166 licensed beds) located in Hot Springs, Arkansas; St. Mary's Regional Medical Center (170 licensed beds) located in Russellville, Arkansas; Mineral Area Regional Medical Center (135 licensed beds) located in Farmington, Missouri; Willamette Valley Medical Center (80 licensed beds) located in McMinnville, Oregon; and White County Community Hospital (60 licensed beds) located in Sparta, Tennessee, to Capella Healthcare, Inc., headquartered in Franklin, Tennessee. The proceeds from this sale were $315 million in cash.

Effective February 21, 2008, the Company sold THI Ireland Holdings Limited, a private limited company incorporated in the Republic of Ireland, which leased and managed the operations of Beacon Medical Center (122 licensed beds) located in Dublin, Ireland, to Beacon Medical Group Limited, headquartered in Dublin, Ireland. The proceeds from this sale were $1.5 million in cash.

Effective February 1, 2008, the Company sold Russell County Medical Center (78 licensed beds) located in Lebanon, Virginia to Mountain States Health Alliance, headquartered in Johnson City, Tennessee. The proceeds from this sale were $48.6 million in cash.

Effective November 30, 2007, the Company sold Barberton Citizens Hospital (312 licensed beds) located in Barberton, Ohio to Summa Health System of Akron, Ohio. The proceeds from this sale were $53.8 million in cash.

Effective October 31, 2007, the Company sold its 60% membership interest in Northeast Arkansas Medical Center, a 104 bed facility in Jonesboro, Arkansas to Baptist Memorial Health Care ("Baptist Memorial"), headquartered in Memphis, Tennessee, for $16.8 million. In connection with this transaction, the Company also sold real estate and other assets to a subsidiary of Baptist Memorial for $26.2 million in cash.

Effective September 1, 2007, the Company sold its partnership interest in River West L.P., which owned and operated River West Medical Center (80 licensed beds) located in Plaquemine, Louisiana, to an affiliate of Shiloh Health Services, Inc. of Lubbock, Texas. The proceeds from this sale were $0.3 million in cash.

Effective March 18, 2006, the Company sold Highland Medical Center, a 123-bed facility located in Lubbock, Texas, to Shiloh Health Services, Inc. of Louisville, Kentucky. The proceeds from this sale were $0.5 million in cash.

As of December 31, 2008, the Company had two hospitals classified as held for sale.

In connection with management's decision to sell the previously mentioned facilities and in accordance with SFAS No. 144, the Company has classified the results of operations of the above mentioned hospitals as discontinued operations in the accompanying consolidated statements of income.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Net operating revenues and loss reported for the hospitals in discontinued operations are as follows:

	Year Ended December 31, 2008	2007 (In thousands)	2006
Net operating revenues	$ 316,312	$ 481,396	$ 189,734
Income (loss) from operations of hospitals sold or held for sale before income taxes	9,379	(11,270)	(10,694)
Gain (loss) on sale of hospitals and partnership interests	17,687	(3,954)	(3,938)
Impairment of long-lived assets of hospitals held for sale	(5,000)	(19,044)	—
Income (loss) on discontinued operations, before taxes	22,066	(34,268)	(14,632)
Income tax expense (benefit)	10,420	(6,843)	(5,200)
Income (loss) on discontinued operations, net of tax	$ 11,646	$ (27,425)	$ (9,432)

Interest expense was allocated to discontinued operations based on estimated sales proceeds available for debt repayment and using the weighted-average borrowing rate for the year.

The assets and liabilities of the two hospitals held for sale as of December 31, 2008 are included in the accompanying consolidated balance sheet as follows: current assets of $40.9 million, included in other current assets; net property and equipment of $168.1 million and other long-term assets of $4.8 million, included in other assets; and current liabilities of $106.9 million, included in other accrued liabilities. The assets and liabilities of the hospitals held for sale as of December 31, 2007 are included in the accompanying consolidated balance sheet as follows: current assets of $118.9 million, included in other current assets; net property and equipment of $331.1 million and other long-term assets of $31.4 million, included in other assets; and current liabilities of $67.6 million, included in other accrued liabilities.

4. Goodwill and Other Intangible Assets

The changes in the carrying amount of goodwill are as follows (in thousands):

	Year Ended December 31, 2008	2007
Balance, beginning of year	$ 4,247,714	$ 1,336,525
Goodwill acquired as part of acquisitions during the year	49,368	2,912,392
Consideration adjustments and finalization of purchase price allocations for prior year's acquisitions	(119,650)	22,053
Goodwill related to hospital operations segment written off as part of disposals	(11,161)	(1,913)
Goodwill related to home health agencies segment written off as part of disposals	(180)	—
Goodwill related to hospital operations segment assigned to the disposal group classified as held for sale	—	(21,343)
Balance, end of year	$ 4,166,091	$ 4,247,714

SFAS No. 142 requires that goodwill be allocated to each identified reporting unit, which is defined as an operating segment or one level below the operating segment (referred to as a component of the entity). Management has determined that the Company's operating segments meet the criteria to be classified as reporting units. At December 31, 2008, the hospital operations, home care agencies, and hospital management services reporting units had $4.099 billion, $34.2 million, and $33.3 million, respectively, of goodwill. At

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

December 31, 2007, the hospital operations reporting unit had $1.309 billion and the home care agencies reporting unit had $32.2 million of goodwill. No goodwill was allocated to the hospital management services segment as of December 31, 2007 because that business relates entirely to the Triad acquisition for which the final purchase price allocation had not been completed at that date.

SFAS No. 142 requires goodwill to be evaluated for impairment at the same time every year and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. SFAS No. 142 requires a two-step method for determining goodwill impairment. Step one is to compare the fair value of the reporting unit with the unit's carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit's goodwill with the carrying value of the reporting unit's goodwill. The Company has selected September 30th as its annual testing date. The Company performed its annual goodwill evaluation as required by SFAS No. 142 as of September 30, 2008. No impairment was indicated by this evaluation.

The Company estimates the fair value of the related reporting units using both a discounted cash flow model as well as an EBITDA multiple model. These models are both based on the Company's best estimate of future revenues and operating costs and are reconciled to the Company's consolidated market capitalization. The cash flow forecasts are adjusted by an appropriate discount rate based on the Company's weighted-average cost of capital. Historically the Company's valuation models did not fully capture the fair value of the Company's business as a whole, as they did not consider the increased consideration a potential acquirer would be required to pay, in the form of a control premium, in order to gain sufficient ownership to set policies, direct operations and control management decisions. However, because the Company's models have indicated value significantly in excess of the carrying amount of assets in the Company's reporting units, the additional value from a control premium was not a determining factor in the outcome of step one of the Company's impairment assessment.

As indicated above, in addition to the annual impairment analysis, the Company is required to evaluate goodwill for impairment whenever an event occurs or circumstances change such that it is more likely than not that an impairment may exist. In light of this requirement the Company has considered whether the decline in the Company's market capitalization between September 30, 2008 and December 31, 2008 has, more likely than not, resulted in the existence of an impairment and concluded that the decline in the Company's market capitalization did not, more likely than not, result in the existence of an impairment. In making this conclusion the Company gave consideration to the valuation of hospitals in which it sold equity interests during periods subsequent to September 30, 2008, currently proposed hospital equity sale transactions, the proposed purchase price for a hospital which the Company anticipates closing on the acquisition in the first half of 2009, the increase in stock price since December 31, 2008 and the average stock price over the trailing 3-month, 6-month and 1-year periods. The Company also considered the fact that the decline in its stock price has not been related to a decline in operating performance and that any near term credit tightening within the financial markets could be overcome by the Company through the substantial amount of cash flows being generated by the Company, as well as, the borrowing capacity available through its existing credit facilities. The current turmoil in the financial markets and weakness in macroeconomic conditions globally continue to be challenging and the Company cannot be certain of the duration of these conditions and their potential impact on the Company's stock price performance. If a further decline in the Company's market capitalization and other factors resulted in the decline in the Company's fair value, it is reasonably likely that a goodwill impairment assessment prior to the next annual review, in the fourth quarter of 2009, would be necessary. If such an assessment is required, an impairment of goodwill may be recognized. A non-cash goodwill impairment charge would have the effect of decreasing the Company's earnings or increasing the Company's losses in the period the impairment is recognized. The amount of such effect on earnings and losses is dependent on the size of the impairment charge. Such a charge, however, would be a non-cash charge and therefore would not impact the Company's compliance with covenants contained in the New Credit Facility.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Approximately $3.3 million of intangible assets were acquired during the year ended December 31, 2008. The gross carrying amount of the Company's other intangible assets subject to amortization was $68.6 million and $76.3 million as of December 31, 2008 and 2007, respectively, and the net carrying amount was $54.1 million and $62.7 million as of December 31, 2008 and 2007, respectively. The carrying amount of the Company's other intangible assets not subject to amortization was $35.2 million and $118.3 million at December 31, 2008 and 2007, respectively. Other intangible assets are included in other assets, net on the Company's consolidated balance sheets. Substantially all of the Company's intangible assets are contract-based intangible assets related to operating licenses, management contracts, or non-compete agreements entered into in connection with prior acquisitions.

The weighted average amortization period for the intangible assets subject to amortization is approximately ten years. There are no expected residual values related to these intangible assets. Amortization expense for these intangible assets was $6.2 million, $6.1 million and $1.9 million during the years ended December 31, 2008, 2007 and 2006, respectively. Amortization expense on intangible assets is estimated to be $12.4 million in 2009, $10.6 million in 2010, $5.7 million in 2011, $4.2 million in 2012, $3.8 million in 2013 and $18.4 million thereafter.

5. Income Taxes

The provision for income taxes for income from continuing operations consists of the following (in thousands):

	Year Ended December 31, 2008	2007	2006
Current			
Federal	$ 2,129	$ 27,416	$ 120,209
State	3,515	11,411	13,555
	5,644	38,827	133,764
Deferred			
Federal	110,870	5,769	(21,793)
State	12,965	(2,768)	(1,819)
	123,835	3,001	(23,612)
Total provision for income taxes for income from continuing operations	$ 129,479	$ 41,828	$ 110,152

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The following table reconciles the differences between the statutory federal income tax rate and the effective tax rate (dollars in thousands):

	Year Ended December 31,					
	2008		2007		2006	
	Amount	%	Amount	%	Amount	%
Provision for income taxes at statutory federal rate	$ 117,648	35.0%	$ 34,840	35.0%	$ 100,746	35.0%
State income taxes, net of federal income tax benefit	10,712	3.2	5,618	5.5	7,628	2.7
Change in valuation allowance	(110)	0.0	3,825	3.7	—	—
Federal and state tax credits	(2,270)	(0.7)	(2,625)	(2.6)	—	—
Other	3,499	1.0	170	0.2	1,778	0.6
Provision for income taxes and effective tax rate for income from continuing operations	$ 129,479	38.5%	$ 41,828	41.8%	$ 110,152	38.3%

Deferred income taxes are based on the estimated future tax effects of differences between the financial statement and tax bases of assets and liabilities under the provisions of the enacted tax laws. Deferred income taxes as of December 31, 2008 and 2007 consist of (in thousands):

	2008		2007	
	Assets	Liabilities	Assets	Liabilities
Net operating loss and credit carryforwards	$ 143,873	$ —	$ 75,879	$ —
Property and equipment	—	511,687	—	464,753
Self-insurance liabilities	56,447	—	100,642	—
Intangibles	—	147,669	—	139,757
Investments in unconsolidated affiliates	—	51,557	—	6,940
Other liabilities	—	7,315	—	7,804
Long-term debt and interest	—	30,256	—	42,447
Accounts receivable	23,490	—	104,727	—
Accrued expenses	27,374	—	21,928	—
Other comprehensive income	173,661	—	58,933	—
Stock-based compensation	52,889	—	54,464	—
Other	20,070	—	19,480	—
	497,804	748,484	436,053	661,701
Valuation allowance	(124,978)		(68,558)	
Total deferred income taxes	$ 372,826	$ 748,484	$ 367,495	$ 661,701

The Company believes that the net deferred tax assets will ultimately be realized, except as noted below. Its conclusion is based on its estimate of future taxable income and the expected timing of temporary difference reversals. The Company has state net operating loss carry forwards of approximately $1.8 billion, which expire from 2009 to 2028. With respect to the deferred tax liability pertaining to intangibles, as included above, goodwill purchased in connection with certain of the Company's business acquisitions is amortizable for income tax reporting purposes. However, for financial reporting purposes, there is no corresponding amortization allowed with respect to such purchased goodwill.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The valuation allowance increased by $56.4 million and $47.4 million during the years ended December 31, 2008 and 2007, respectively. In addition to amounts previously discussed, the change in valuation allowance relates to a redetermination of the amount of, and realizability of, net operating losses in certain state income tax jurisdictions.

The Company adopted the provisions of FASB Interpretation No. 48, "Accounting for Uncertainty in Income Taxes" ("FIN 48"), on January 1, 2007. The total amount of unrecognized benefit that would affect the effective tax rate, if recognized, is approximately $10.5 million as of December 31, 2008. It is the Company's policy to recognize interest and penalties accrued related to unrecognized benefits in its statement of operations as income tax expense. During the year ended December 31, 2008, the Company decreased liabilities by approximately $0.8 million and recorded $0.2 million in interest and penalties related to prior state income tax returns through its income tax provision from continuing operations and which are included in its FIN 48 liability at December 31, 2008. A total of approximately $1.2 million of interest and penalties is included in the amount of FIN 48 liability at December 31, 2008. During the year ended December 31, 2008, the Company released $7.5 million for income taxes and $1.8 million for accrued interest of its FIN 48 liability, as a result of the expiration of the statute of limitations pertaining to tax positions taken in prior years relative to state tax positions.

The Company believes that it is reasonably possible that approximately $5.3 million of its current unrecognized tax benefit may be recognized within the next twelve months as a result of a lapse of the statute of limitations and settlements with taxing authorities.

The following is a tabular reconciliation of the total amount of unrecognized tax benefit for the years ended December 31, 2008 and 2007 (in thousands):

	Year Ended December 31, 2008	Year Ended December 31, 2007
Unrecognized Tax Benefit at beginning of year	$ 14,880	$ 10,510
Gross increases — purchase business combination	8,325	10,160
Gross increases — tax positions in current period	—	1,930
Gross increases — tax positions in prior period	223	1,820
Lapse of statute of limitations	(7,460)	(6,700)
Settlements	(338)	(2,840)
Unrecognized Tax Benefit at end of year	$ 15,630	$ 14,880

The Company or one of its subsidiaries files income tax returns in the U.S. federal jurisdiction and various state jurisdictions. The Company has extended the federal statute of limitations for Triad for the tax periods ended December 31, 1999, December 31, 2000, April 30, 2001, June 30, 2001, December 31, 2001, December 31, 2002, and December 31, 2003. With few exceptions, the Company is no longer subject to state income tax examinations for years prior to 2003. During 2007, the Company agreed to a settlement with the Internal Revenue Service (the "IRS") Appeals Office with respect to the 2003 tax year. The Company has since received a closing letter with respect to the examination for that tax year. The settlement was not material to the Company's results of operations or financial position.

The IRS has concluded an examination of the federal income tax returns of Triad for the short taxable years ended April 27, 2001, June 30, 2001 and December 31, 2001, and the taxable years ended December 31, 2002 and 2003. On May 10, 2006, the IRS issued an examination report with proposed adjustments. Triad filed a protest on June 9, 2006 and the matter was referred to the IRS Appeals Office. Representatives of the former Triad hospitals met with the IRS Appeals Office in April 2007 and reached a tentative settlement. Triad has since received a closing letter with respect to the examination for those tax years. The settlement was not

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

material to the Company's results of operations or financial position. In December 2008, the Company was notified by the IRS of its intent to examine the federal tax return of Triad for the tax periods ended December 31, 2005 and July 25, 2007. The Company believes the results of this examination will not be material to the Company's results of operations or consolidated financial position.

Cash paid for income taxes, net of refunds received, resulted in a net cash refund of $65.0 million during 2008. The Company paid income taxes, net of refunds received, of $85.2 million and $128.1 million during 2007 and 2006, respectively.

6. Long-Term Debt

Long-term debt consists of the following (in thousands):

	As of December 31, 2008	As of December 31, 2007
Credit Facilities:		
Term loans	$ 5,965,866	$ 5,965,000
Tax-exempt bonds	8,000	8,000
Senior notes	2,910,831	3,021,331
Capital lease obligations (see Note 9)	41,086	35,136
Other	41,663	68,610
Total debt	8,967,446	9,098,077
Less current maturities	(29,462)	(20,710)
Total long-term debt	$ 8,937,984	$ 9,077,367

Terminated Credit Facility and Notes

On August 19, 2004, CHS entered into a $1.625 billion senior secured credit facility with a consortium of lenders which was subsequently amended on December 16, 2004, July 8, 2005 and December 13, 2006 (the "Terminated Credit Facility"). The purpose of the Terminated Credit Facility was to refinance and replace the Company's previous credit agreement, repay specified other indebtedness, and fund general corporate purposes, including amending the credit facility to permit declaration and payment of cash dividends, to repurchase shares or make other distributions, subject to certain restrictions. The Terminated Credit Facility consisted of a $1.2 billion term loan that was due to mature in 2011 and a $425 million revolving credit facility that was due to mature in 2009. The First Incremental Facility Amendment, dated as of December 13, 2006, increased the Company's term loans by $400 million (the "Incremental Term Loan Facility") and also gave the Company the ability to add up to $400 million of additional term loans. The full amount of the Incremental Term Loan Facility was funded on December 13, 2006, and the proceeds were used to repay the full outstanding amount (approximately $326 million) of the revolving credit facility under the Terminated Credit Agreement and the balance was available to be used for general corporate purposes. The Company was able to elect from time to time an interest rate per annum for the borrowings under the term loan, including the incremental term loan, and revolving credit facility equal to (a) an alternate base rate, which would have been equal to the greatest of (i) the Prime Rate (as defined) in effect and (ii) the Federal Funds Effective Rate (as defined), plus 50 basis points, plus (1) 75 basis points for the term loan and (2) the Applicable Margin (as defined) for revolving credit loans or (b) the Eurodollar Rate (as defined) plus (1) 175 basis points for the term loan and (2) the Applicable Margin for Eurodollar revolving credit loans. The Company also paid a commitment fee for the daily average unused commitments under the revolving credit facility. The commitment fee was based on a pricing grid depending on the Applicable Margin for Eurodollar revolving credit loans and ranged from 0.250% to 0.500%. The commitment fee was payable quarterly in arrears and on the revolving credit

CHS/COMMUNITY HEALTH SYSTEMS, INC.
DEFERRED COMPENSATION PLAN

WITNESSETH:

WHEREAS, Community Health Investment Corporation (formerly CHS Management Corporation) has previously established the CHS/Community Health Systems, Inc. Deferred Compensation Plan (the "Plan") to provide retirement and incidental benefits for certain executive employees of the company, effective June 1, 1991; and

WHEREAS, the Plan was amended in certain respects, effective December 1, 1991; and

WHEREAS, effective January 1, 1992, Community Health Systems, Inc. (the "Company") adopted the Plan and assumed all of the duties and responsibilities of Community Health Investment Corporation; and

WHEREAS, the Plan was further amended in certain respects effective October 1, 1993, January 1, 1994, January 1, 1995, April 1, 1999, July 1, 2000, and January 1, 2001, including the change in the name of the Company to CHS/Community Health Systems, Inc.; and

WHEREAS, the Company wishes to amend the Plan further as provided herein;

NOW, THEREFORE, the Plan shall be and is hereby amended and restated in this form, effective as of June 30, 2002, except as otherwise provided herein

ARTICLE I

Definitions and Construction

1.1 Definitions. Where the following words and phrases appear in the Plan, they shall have the respective meanings set forth below, unless their context clearly indicates to the contrary:

(1) Account: A memorandum bookkeeping account established on the records of the Company for a Member that is credited with amounts determined pursuant to Sections 4.1 and 4.2 of the Plan. As of any Determination Date, a Member's benefit under the Plan shall be equal to the amount credited to his Account as of such date. If a Member has made an election to defer a portion of his Compensation until a specified date pursuant to Section 3.4, the account described herein shall consist of such subaccounts as are necessary to segregate such deferral from the other amounts deferred by the Member.

(2) Affiliate: Any subsidiary of Community Health Systems, Inc., the corporate parent of the Company.

(3) Benefit Exchange Agreement: An agreement entered into between certain Members and the Company in connection with the surrender of the Member's interest in the Split Dollar Agreement and the Member's vested interest in the cash value of the variable life insurance policy that is subject to the terms of the Split Dollar Agreement, as it may be amended.

(4) Bonus: The bonus paid by the Company or an Affiliate to a Member pursuant to an employment agreement between the Company or an Affiliate and the Member or otherwise for services rendered or labor performed while a Member.

(5) Change of Control: A Change of Control occurs in the event of a sale of all or substantially all of the stock or assets of the Company to a purchaser if the debt-to-equity ratio of the purchaser, taking into account the sale of the stock or assets of the Company, is greater than .75 to 1 as determined by the Committee immediately prior to the sale.

(6) Committee: The administrative committee appointed by the Company to administer the Plan, if any, which committee shall consist of the same persons designated by the Company pursuant to the terms of the Retirement Plan to act on behalf of the Company, as the administrator of such Plan.

(7) Company: CHS/Community Health Systems, Inc.

(8) Company Matching Contributions: Contributions made to the Retirement Plan by the Company or an Affiliate on a Member's behalf pursuant to Section 4.1(b) of the Retirement Plan or otherwise as provided for therein.

(9) Compensation: The total base salary paid by the Company or an Affiliate during the Plan Year to or for the benefit of a Member for services rendered or labor performed while a Member.

(10) Contributing Member: A Member who, for a Plan Year, made a deferral election pursuant to Section 3.2, Section 3.3 and/or Section 3.4.

(11) Determination Date. The last business day of each quarter in a calendar year.

(12) Earnings Credit: The earnings applied to a Member's Account as of each Determination Date pursuant to Section 4.2(b).

(13) Effective Date: June 1, 1991.

(14) Investment(s): Any investment fund(s) offered through the Trustee or its affiliates including Nations Fund, Inc., Nations Fund Trust, or Nations Fund Portfolios, Inc. (or their successors).

(15) Investment Gains or Losses: Actual gains or losses realized from investments applied to a Member's Account as of each Determination Date pursuant to Section 4.2(a) of the Plan, after deducting applicable investment-related costs and expenses, if any. For the

Determination Date, such Member's Account shall be reduced or increased for an amount equal to the Federal or state income taxes that the Company is required to pay or expects to realize in relation to such investment(s)' taxable gain or loss realized during such year.

(16) Limitations: Benefit limitations imposed on the Retirement Plan under the Employee Retirement Income Security Act of 1974, as amended, and under sections 401(a)(17), 401(k)(3), 401(m)(2), 402(g) and 415 of the Internal Revenue Code of 1986, as amended.

(17) Member: Any employee of the Company or an Affiliate who has been designated by the Committee as a Member of the Plan until such employee ceases to be a Member in accordance with Section 3.1 of the Plan.

(18) Plan: CHS/Community Health Systems, Inc. Deferred Compensation Plan, as amended from time to time.

(19) Plan Year: The seven-month period commencing June 1, 1991, and ending December 31, 1991 and each twelve-consecutive month period commencing January 1 of each year thereafter.

(20) Post-Termination Benefits Deposit: Certain deposit provided for under the terms of the Split Dollar Agreement.

(21) Retirement Plan: Community Health Systems, Inc. 401(k) Plan.

(22) Split Dollar Agreement: An agreement entered into between the Company and the Member pursuant to the provisions of the Supplemental Survivor Accumulation portion of the Community Health Systems, Inc. Supplemental Benefits Plan.

(23) SSP: CHS 401(k) Supplemental Savings Plan.

(24) Trust Agreement: The agreement entered into between the Company and the Trustee establishing a trust to hold and invest contributions made by the Company under the Plan and from which all or a portion of the amounts payable under the Plan to Members and their beneficiaries will be distributed.

(25) Trust Assets: All assets held by the Trustee under the Trust Agreement.

(26) Trustee: The trustee or trustees qualified and acting under the Trust Agreement at any time.

1.2 Number and Gender. Wherever appropriate herein, words used in the singular shall be considered to include the plural and the plural to include the singular. The masculine gender, where appearing in this Plan, shall be deemed to include the feminine gender and vice versa.

1.3 Headings. The headings of Articles and Sections herein are included solely for convenience and if there is any conflict between such headings and the text of the Plan, the text shall control.

ARTICLE II

Administration

The Plan shall be administered by the Committee that shall be authorized, subject to the provisions of the Plan, to establish rules and regulations and make such interpretations and determinations as it may deem necessary or advisable for the proper administration of the Plan and all such rules, regulations, interpretations, and determinations shall be binding on all Plan Members and their beneficiaries. The Committee shall be composed of not less than three individuals. Each member of the Committee shall serve until he resigns or is removed by the Company. Upon the resignation or removal of a member of the Committee, the Company shall appoint a substitute member. No member of the Committee shall have any right to vote or decide upon any matter relating solely to himself under the Plan or to vote in any case in which his individual right to claim any benefit under the Plan is particularly involved. In any case in which a Committee member is so disqualified to act, and the remaining members cannot agree, the Company shall appoint a temporary substitute member to exercise all the powers of the disqualified member concerning the matter in which he is disqualified. All expenses incurred in connection with the administration of the Plan shall be borne by the Company.

ARTICLE III

Participation

3.1 Eligibility. Any employee of the Company or an Affiliate shall become a Member upon designation by the Committee. Once an employee has been designated as a Member, he shall automatically continue to be a Member until he ceases to be an employee of the Company or an Affiliate or is removed as a Member by the Committee. Notwithstanding the preceding provisions of this Section 3.1, participation in this Plan shall at all times be limited to a selected group of management or highly compensated employees of the Company.

3.2 Compensation Deferral Election. Any Member may elect to defer receipt of an integral percentage of his Compensation for one or more calendar quarters during a Plan Year under the Plan. A Member's election to defer receipt of Compensation for any calendar quarter(s) of a Plan Year shall be made prior to the beginning of such calendar quarter(s) of the Plan Year and shall be irrevocable for such calendar quarter(s) of the Plan Year. The reduction in a Member's Compensation pursuant to his election shall be effected by Compensation reductions as of each payroll period within the election period.

3.3 Bonus Deferral Election. Any Member may elect to defer receipt of an integral percentage of his Bonus for any Plan Year under the Plan. A Member's election to defer receipt of his Bonus for any Plan Year shall be made prior to the earlier of (i) the date on which such bonus becomes payable and ascertainable, or (ii) October 1 of such Plan Year for which such Bonus is payable, and shall be irrevocable for such Plan Year. The election to defer receipt of such percentage of a Member's Bonus pursuant to the deferral election above shall be effected by a reduction in the amount of the Bonus to which such deferral election relates.

3.4 Targeted Deferral Election. In general, all amounts deferred by a Member pursuant to Sections 3.2 and 3.3 shall be held for the Member and distributed following the Member's termination of employment or the occurrence of a hardship event pursuant to Sections 7.1, 7.2 and 8.1. Notwithstanding the preceding sentence, a Member may also defer the receipt of any portion of the Member's Compensation otherwise deferred pursuant to the provisions of Sections 3.2 and 3.3 until a specific future date, by executing a deferral form designed for such purpose as specified by the Committee. Upon the occurrence of any such date specified by a Member in such an election form, the deferred amount, and the Earnings Credit and Investment(s) Gains or Losses attributable thereto, shall be distributed to the Member. Until so distributed, such deferral amounts shall continue to be a part of the Member's Account.

3.5 Investment Request. A Member may request the Committee to invest or change the investment of all or a portion of his Account in any Investments. A Member may make such request at any time, provided that the Committee shall only be obligated to direct the Trustee to make such investment or charge such investment as soon as reasonably practicable and within the guidelines and requirements established by the Trustee for the investment of funds held in the Account. A Member who does not request the Committee to invest any portion of his Account shall have the funds held in such Account in a money market fund offered through the Trustee or its affiliates.

3.6 Post-Termination Benefits Deposit. Notwithstanding any provision of the Plan to the contrary, the Company may make for any Member an annual contribution equal to that portion of Post-Termination Benefit Deposits to be made to the Plan as calculated under the terms of any Benefits Exchange Agreement between the Member and the Company.

ARTICLE IV

Benefits

4.1 Amount of Benefit.

(a) Deferral Contributions. As of the last day of each payroll period of each Plan Year, a Member's Account shall be credited with an amount equal to the Compensation deferred under the Plan pursuant to an election by the Member as described in Article III for such payroll period. Effective as of June 30, 2002, as of the last day of each payroll period of each Plan Year, a Member's Account shall be credited with an amount equal to that portion of Post-Termination Benefit Deposits made to the Plan, if any, as calculated under the terms of the Benefits Exchange Agreement between the Member and the Company.

(b) Matching Contributions. As of the last day of each Plan Year, or, if later, the date on which the Company Matching Contributions are made under the Retirement Plan for any such Plan Year, the Member's Account of each Contributing Member during such Plan Year who remains employed by the Company on such date shall be credited with an amount equal to the following:

(1) the Company Matching Contributions to which such Contributing Member would have been entitled under the Retirement Plan taking into account

both (i) the salary deferrals made by such Contributing Member to the Retirement Plan for the Plan Year, and (ii) the deferrals made by such Contributing Member under this Plan pursuant to Sections 3.1, 3.2, or 3.3 for the same Plan Year (up to a combined maximum of six percent (6.00%) of such Contributing Member's Compensation assuming that none of the Limitations were imposed); minus

(2) the Company Matching Contributions, if any, actually made on behalf of such Contributing Member under the Retirement Plan for such Plan Year; minus

(3) the Company contributions, if any, to accounts actually made on behalf of such Contributing Member under the SSP for such Plan Year.

In addition, if (i) the total of such Contributing Member's salary deferrals under the Retirement Plan (as adjusted after application of the Limitations) and deferrals pursuant to the SSP and Sections 3.1, 3.2 or 3.3 under this Plan is less than 6.00% of such Contributing Member's Compensation for a Plan Year; and (ii) the Contributing Member elects to increase his or her deferrals under this Plan by all or any portion of any salary deferrals to the Retirement Plan that are returned to the Contributing Member as a result of the application of the Limitations within 120 days after receipt of such returned salary deferrals, even if such increased deferrals are made in the next Plan Year; such increased deferrals shall also be taken into account in subparagraph (a) above until the total of the Contributing Member's salary deferrals under the Retirement Plan, SSP, and deferrals under this Plan for the Plan Year equals 6.00% of the Contributing Member's Compensation.

(c) Benefit Exchange Agreement Contributions. Effective for Plan Years beginning on or after January 1, 2002, the Company shall credit to the Account of each Member who has entered into a Benefit Exchange Agreement with the Company the following amounts, as specified under the terms of each such Benefit Exchange Agreement:

(1) all unpaid 2001 and 2002 variable life insurance policy premium payments required under the terms of the Split Dollar Agreement;

(2) an amount equal to 100% of the net cash surrender value of such variable life insurance policy on the date such policy is surrendered by the Company; and

(3) if required by the Member's Benefit Exchange Agreement, annual amounts equal to the premium payments to such variable life insurance policy that would have been required under the Split Dollar Agreement for years after 2002, reduced each year by the actual cost of providing supplemental life insurance coverage to the Member pursuant to the terms of the Benefit Exchange Agreement.

As of any Determination Date, the benefit to which a Member or his beneficiary shall be entitled under the Plan shall be equal to the amount credited to such Member's Account as of such date.

(d) Special Contributions. For the Plan Year beginning January 1, 2003, the Company shall make a special one-time cash contribution to each Participant's Account in an amount equal to the dollar value of the matching contributions that were forfeited by the Participants under the Retirement Plan for the plan years of the Retirement Plan that ended on December 31, 2001, and December 31, 2002. The Plan Administrator shall determine the dollar value of all such forfeited matching contributions, which determination shall be final and binding on all Participants. Such special contributions shall be made no later than September 15, 2003, unless the Plan Administrator has not yet finally determined the amount of the forfeited matching contributions, in which event such contributions shall be made not later than 30 days after such forfeited matching contributions are finally determined by the Plan Administrator. Notwithstanding the foregoing, no such special contribution shall be made for a Member if the Company makes a similar contribution for a Member to the SSP.

4.2 Investment Credit. As of each Determination Date, the Account of each Member shall be credited with Investment Gains or Losses as provided in this Section 4.2.

(a) If a Member has requested in accordance with Section 3.5 of the Plan that all or a portion of his Account be invested in any particular Investment(s), the Account of such Member shall be credited with the Investment Gains or Losses since the preceding Determination Date.

(b) Any portion of a Member's Account, the investment of which has not been requested by the Member, shall be credited with the Earnings Credit for such Determination Date.

(c) A Member's Account shall not be credited with any Investment Credit under this Section 4.2 on the Company Matching Contributions portion credited to his Account as of the last day of each Plan Year pursuant to Section 4.1 of the Plan until the Company actually makes the cash deposit of such Matching Contributions with the Trustee.

ARTICLE V

Vesting

All amounts credited to a Member's Account shall be fully vested and not subject to forfeiture for any reason; provided, however, the amounts credited to a Member's Account pursuant to the second paragraph of Section 4.1, including any Earnings Credit and/or Investment Gains or Losses allocable to such credits, shall be subject to the same vesting schedule as that set forth in the Retirement Plan. Notwithstanding the preceding sentence, the benefits payable to each Member hereunder constitute an unfunded, unsecured obligation of the Company, and the assets held by the Company and the Trustee remain subject to the claims of the Company's creditors.

ARTICLE VI

Trust

The Company may, from time to time and in its sole discretion, pay and deliver money or other property to the Trustee for the payment of benefits under the Plan. Notwithstanding any provision in the Plan to the contrary, distributions due under the Plan to or on behalf of Members shall be made by the Trustee in accordance with the terms of the Trust Agreement and the Plan; provided, however, that the Company shall remain obligated to pay all amounts due to such persons under the Plan. To the extent that Trust Assets are not sufficient to pay any amounts due under the Plan to or on behalf of the Members when such amounts are due, the Company shall pay such amounts directly. Nothing in the Plan or the Trust Agreement shall relieve the Company of its obligation to make the distributions required in Article VII hereof except to the extent that such obligation is satisfied by the application of funds held by the Trustee under the Trust Agreement. Any recipient of benefits hereunder shall have no security or other interest in Trust Assets. Any and all Trust Assets shall remain subject to the claims of the general creditors of the Company, present and future, and no payment shall be made under the Plan unless the Company is then solvent. Should an inconsistency or conflict exist between the specific terms of the Plan and those of the Trust Agreement, then the relevant terms of the Trust Agreement shall govern and control.

ARTICLE VII

Payment of Benefits

7.1 Termination of Employment. Upon a Member's termination of employment with the Company or an Affiliate for any reason, the amount credited to such Member's Account as of the Determination Date immediately preceding such Member's termination of employment, adjusted for any amount deferred and Earnings Credit and Investment(s) Income or Loss realized from such Determination Date to the date of the Member's termination of employment, shall be distributed to such Member or, if the Member's termination of employment is on account of death, to the Member's beneficiary as determined pursuant to Section 7.2 below.

7.2 Death. Upon a Member's death, the amount credited to such Member's Account as of the Determination Date immediately preceding the date of such Member's death, adjusted for any amount deferred and Earnings Credit and Investment Gains or Losses realized from such Determination Date to the date of the Member's death, shall be distributed to such Member's designated beneficiary. The Member, by written instrument filed with the Committee in such manner and form as the Committee may prescribe, may designate one or more beneficiaries to receive such payment. The beneficiary designation may be changed from time to time prior to the death of the Member. In the event that the Committee has no valid beneficiary designation on file, the amount credited to such Member's Account shall be distributed to the Member's surviving spouse, if any, or if the Member has no surviving spouse, to the executor or administrator of the Member's estate.

7.3 Targeted Deferrals. If a Member has made one or more targeted deferrals pursuant to Section 3.4, upon the date specified in any election form used by the Member to make such election, the amount credited in the subaccount of the Member's Account which relates to such deferral as of the Determination Date immediately preceding such specified date shall be distributed to such Member. If some event takes place that would entitle a Member to a distribution under Sections 7.1 or 7.2 prior to such specified date, the amounts in such subaccount shall be distributed along with any other amounts in the Member's Account pursuant to Section 7.1 or 7.2.

7.4 Time of Payment. Payment of a Member's benefit hereunder shall be made (or commence if payment is in the form of an annuity contract) as soon as administratively feasible following the date on which the Member or his beneficiary becomes entitled to such benefit pursuant to Sections 7.1, 7.2, or 7.3, but no earlier than 10 days thereafter and no later than 45 days thereafter, except for the Company Matching Contributions as provided herein. If a Member's termination of employment or death or any other events which caused termination of the Plan, occurs within the first four months of a year, the portion of the Company Matching Contributions for the preceding Plan Year that has been credited to a Member's Account shall be distributed to such Member no later than the earlier of (i) the date of which the calculation of such contributions has been finalized or (ii) May 1 of the year of termination of employment or death, or any other events which shall entitle the Member to a distribution. In all other events, the 10 days and 45 days limitation shall apply to the distribution of the Member's entire Account balance, unless expressly provided otherwise.

7.5 Form of Payment. For purposes of distributing all of a Member's Account other than any portion thereof attributable to targeted deferrals and earnings thereon, the form of any payment to a Member or his designated beneficiary shall be in substantially equal annual installments over a period of ten (10) years, paid in cash or by certified check, with the first such payment to be made on the first business day of the calendar year following the Member's termination of employment (for purposes of payments made pursuant to Section 7.1) or death (for purposes of payments made pursuant to Section 7.2), unless the Member has made an election to receive such distribution in the form of a lump sum payment or in five (5) substantially equal installment payments in such manner and form as prescribed by the Committee. Any election, or subsequent election, made by the Member pursuant to this Section shall not be effective until the passage of twelve (12) consecutive months before the date of the Member's termination of employment with the Company or an Affiliate, if payment is required pursuant to Section 7.1, or the Member's date of death, if the payment is required pursuant to Section 7.2. All distributions of that portion of a Member's Account attributable to any targeted deferral and earnings thereon shall be distributed in a single lump sum payment, in cash or certified check, on the date specified by the Member in the election form used to make the targeted deferral, or as soon thereafter as administratively possible.

ARTICLE VIII

Hardship Distributions

Upon written application by a Member who has experienced an unforeseeable emergency, as determined by the Committee, the Committee may distribute to such Member an amount not to exceed the lesser of the amount credited to such Member's Account or the amount determined by the Committee as being reasonably necessary to satisfy the emergency need. For purposes of this Article VIII, a hardship distribution pursuant to an unforeseeable emergency shall be authorized in the event of severe financial hardship to the Member resulting from a sudden and unexpected illness or accident of the Member or his dependent, loss of the Member's property due to casualty, or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the Member's control. An unforeseeable emergency will not include the need to send a Member's child to college or the desire to purchase a home. Additionally, the Member must demonstrate that the hardship may not be relieved through reimbursement or compensation by insurance or otherwise, by liquidation of the Member's assets, to the extent the liquidation of such assets would not itself cause severe financial hardship, or by cessation of deferrals under this Plan.

ARTICLE IX

Sale of the Company

In the event of a sale of all or substantially all of the stock or assets of the Company, either (a) the purchaser shall assume the liabilities of the Plan and shall continue to operate the Plan in accordance with the provisions set forth herein (including any subsequent amendments hereto) or (b) the Plan shall be terminated and the amount credited to each Member's Account shall be distributed in a lump sum payment in cash or by certified check to each such Member in accordance with Section 7.4. However, should such sale result in a Change of Control, the Plan shall be terminated and the amount credited to each Member's Account shall be distributed in a lump sum payment in cash or by certified check to each such Member in accordance with Section 7.4.

ARTICLE X

Nature of the Plan

The Plan shall constitute an unfunded, unsecured obligation of the Company to make cash payments in accordance with the provisions of the Plan. The Plan is not intended to meet the qualification requirements of section 401 of the Internal Revenue Code of 1986, as amended. The Company in its sole discretion may set aside such amounts for the payment of Accounts as the Company may from time to time determine. Neither the establishment of the Plan, the operation thereof, nor the setting aside of any amounts shall be deemed to create a funding arrangement. No Member shall have any security or other interest in any such amounts set aside or any other assets of the Company.

ARTICLE XI

Employment Relationship

Nothing in the adoption or implementation of the Plan shall confer on any employee the right to continued employment by the Company or an Affiliate or affect in any way the right of the Company or an Affiliate to terminate his employment at any time. Any question as to whether and when there has been a termination of a Member's employment, and the cause of such termination, shall be determined by the Committee, and its determination shall be final.

ARTICLE XII

Amendment and Termination

The Company may amend or terminate the Plan, by resolution duly adopted, without the consent of the Members; provided, however, that no such amendment or termination shall adversely affect any benefits which have been earned prior to any such amendment or termination. Further, upon termination of the Plan, the Committee, in its sole discretion, may elect to distribute the amount credited to each Member's Account in a lump sum cash payment in accordance with Section 7.4; provided, however, in the event of a Change of Control, the amount credited to each Member's Account must be distributed in accordance with Section 7.4.

ARTICLE XIII

Claims Procedure

The Committee shall have full power and authority to interpret, construe and administer the Plan, and the Committee's interpretations and construction hereof, and actions hereunder, including the timing, form, amount or recipient of any payment to be made hereunder, shall be binding and conclusive on all persons for all purposes. In the event that an individual's claim for a benefit is denied or modified, the Committee shall provide such individual with a written statement setting forth the specific reasons for such denial or modification in a manner calculated to be understood by the individual. Any such written statement shall reference the pertinent provisions of the Plan upon which the denial or modification is based and shall explain the Plan's claim review procedure. Such individual may, within forty-five (45) days of receipt of such written statement, make written request to the Committee for review of its initial decision. Within forty-five (45) days following such request for review, the Committee shall, after affording such individual a reasonable opportunity for a full and fair hearing, render its final decision in writing to such individual. Notwithstanding the preceding sentence, should a Member's claim be related to the preceding Plan Year's Company Matching Contributions, the Committee shall render its final decision on the later of (i) forty-five (45) days following such request for review, or (ii) 120 days after the end of the preceding Plan Year. No member of the Committee shall be liable to any person for any action taken or omitted in connection with the interpretation and administration of the Plan unless attributable to his own willful misconduct or lack of good faith. Members of the Committee shall not participate in any action or determination regarding their own benefits hereunder.

ARTICLE XIV

Miscellaneous

14.1 Indemnification. The Company shall indemnify and hold harmless each member of the Committee and any other persons acting on its behalf, against any and all expenses and liabilities arising out of his or her administrative functions or fiduciary responsibilities, excepting only expenses and liabilities arising out of the individual's own willful misconduct or lack of good faith. Expenses against which such person shall be indemnified hereunder include, without limitation, the amounts of any settlement or judgment, costs, counsel fees and related charges reasonably incurred in connection with a claim asserted or a proceeding brought or settlement thereof.

14.2 Effective Date. The Plan shall become operative and effective as of the Effective Date and shall continue until amended or terminated as provided in Article XII.

14.3 Withholding Taxes. The Company shall have the right to deduct from any payments made under this Plan, any federal, state or local taxes required by law to be withheld with respect to such payments.

14.4 Nonalienation of Benefits. Subject to income tax withholding, benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Member, prior to actually being received; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder shall be void. The Company shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

14.5 Severability. If any provision of the Plan shall be held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining provisions hereof; rather, each provision shall be fully severable and the Plan shall be construed and enforced as if said illegal or invalid provision had never been included herein.

14.6 Jurisdiction. The situs of the Plan hereby created is Tennessee. All provisions of the Plan shall be construed in accordance with the laws of Tennessee except to the extent preempted by federal law.

IN WITNESS WHEREOF, the undersigned has caused this restated Plan to be executed effective as of June 30, 2002.

CHS/COMMUNITY HEALTH SYSTEMS, INC.

By: /s/ Linda Parsons

Title: Vice President, Human Resources

Exhibit 10.12

CHS/COMMUNITY HEALTH SYSTEMS, INC.
DEFERRED COMPENSATION PLAN

January 1, 2008

CHS/COMMUNITY HEALTH SYSTEMS, INC.
DEFERRED COMPENSATION PLAN

WITNESSETH:

WHEREAS, CHS/Community Health Systems, Inc. (the "Company") has previously established and currently maintains the CHS/Community Health Systems, Inc. Deferred Compensation Plan (the "Plan"); and

WHEREAS, the Company has previously amended and restated the Plan in order to establish a deferred compensation arrangement under the Plan for deferrals made on or after January 1, 2005, in compliance with Internal Revenue Code Section 409A and the guidance related thereto; and

WHEREAS, the Company wishes to amend and restate the Plan to incorporate required provisions for compliance with Code Section 409A and the final Treasury regulations promulgated thereunder and to make certain other changes;

NOW, THEREFORE, the Plan is hereby amended and restated, effective as of January 1, 2008, except as otherwise provided herein, as follows:

ARTICLE I

Definitions and Construction

1.1 Definitions. Where the following words and phrases appear in the Plan, they shall have the respective meanings set forth below, unless their context clearly indicates to the contrary:

(1) Account: An account shall be established for a Member that is credited with amounts determined pursuant to Sections 4.1 and 4.2 of the Plan. As of any Determination Date, a Member's benefit under the Plan shall be equal to the amount credited to his Account as of such date. If a Member has made an election to defer a portion of his Compensation until a specified date pursuant to Section 3.4, the account described herein shall consist of such subaccounts as are necessary to segregate such deferral from the other amounts deferred by the Member.

(2) Affiliate: Any subsidiary of Community Health Systems, Inc., the corporate parent of the Company.

(3) Bonus: A bonus paid by the Company or an Affiliate to a Member for services rendered or labor performed while a Member during a Plan Year other than an Incentive Compensation Bonus.

(4) Bonuses: A Bonus or an Incentive Compensation Bonus.

(5) Change in Control: The occurrence of any of the following events, but only to the extent such event would constitute a change in the ownership or effective control of CHS, or in the ownership of a substantial portion of the assets of CHS, as set

forth in Code Section 409A(a)(2)(A)(v) and defined in regulations promulgated by the U.S. Department of Treasury thereunder:

(a) An acquisition (other than directly from CHS) of any voting securities of CHS ("Voting Securities") by any Person (as the term person is used for purposes of Section 13(d) or 14(d) of the Securities Exchange Act of 1934, as amended ("Exchange Act")) immediately after which such Person has Beneficial Ownership (within the meaning of Rule 13d-3 promulgated under the Exchange Act) of more than 50% of the then-outstanding shares of Common Stock of CHS ("Shares") or the combined voting power of CHS' then-outstanding Voting Securities; provided, however, in determining whether a Change in Control has occurred pursuant to this Section 2.1(f)(1), Shares or Voting Securities which are acquired in a Non-Control Acquisition (as hereinafter defined) shall not constitute an acquisition that would cause a Change in Control. A "Non-Control Acquisition" shall mean an acquisition by (i) an employee benefit plan (or a trust forming a part thereof) maintained by the Company or any Subsidiary, (ii) CHS or any Subsidiary, or (iii) any Person in connection with a Non-Control Transaction (as hereinafter defined);

(b) The individuals who, as of the date hereof, are members of the Board of CHS ("Incumbent Board"), cease for any reason to constitute at least a majority of the members of the Board of CHS or, following a Merger (as hereinafter defined) that results in CHS having a Parent Corporation (as hereinafter defined), the board of directors of the ultimate Parent Corporation; provided, however, that if the election, or nomination for election, by the CHS common stockholders, of any new director was approved by a vote of at least two-thirds of the Incumbent Board of CHS, such new director shall, for purposes of the Plan, be considered as a member of the Incumbent Board of CHS; provided further, however, that no individual shall be considered a member of the Incumbent Board of CHS if such individual initially assumed office as a result of either an actual or threatened Election Contest (as described in Rule 14a-11 promulgated under the Exchange Act) or other actual or threatened solicitation of proxies or consents by or on behalf of a Person other than the Board of CHS ("Proxy Contest"), including by reason of any agreement intended to avoid or settle any Election Contest or Proxy Contest; or

(c) The consummation of:

(1) A merger, consolidation or reorganization with or into the Company or in which securities of the Company are issued ("Merger"), unless such Merger, is a Non-Control Transaction. A Non-Control Transaction shall mean a Merger where:

(A) the stockholders of CHS immediately before such Merger own, directly or indirectly, immediately following such Merger, at least 50% of the combined voting power of the outstanding voting securities of (x) the corporation resulting from such Merger ("Surviving Corporation"), if 50% or more of the combined voting power of the then outstanding voting securities of the Surviving Corporation is not Beneficially Owned, directly or indirectly, by another Person ("Parent Corporation"), or (y) if there are one or more Parent Corporations, the ultimate Parent Corporation; and

(B) the individuals who were members of the Incumbent Board of CHS immediately prior to the execution of the agreement providing for such Merger, constitute at least a majority of the members of the board of directors of (x) the Surviving Corporation, if there is no Parent Corporation, or (y) if there are one or more Parent Corporations, the ultimate Parent Corporation.

(2) A complete liquidation or dissolution of CHS; or

(3) The sale or other disposition of all, or substantially all, of the assets of CHS to any Person (other than a transfer to a Subsidiary or under conditions that would constitute a Non-Control Transaction with the disposition of assets being regarded as a Merger for this purpose or the distribution to the CHS' stockholders of the stock of a Subsidiary or any other assets).

Notwithstanding the foregoing, a Change in Control shall not be deemed to occur solely because any Person ("Subject Person") acquired Beneficial Ownership of more than the permitted amount of the then-outstanding Shares or Voting Securities as a result of the acquisition of Shares or Voting Securities by CHS which, by reducing the number of Shares or Voting Securities then-outstanding, increases the proportional number of shares Beneficially Owned by the Subject Person, provided that if a Change in Control would occur (but for the operation of this sentence) as a result of the acquisition of Shares or Voting Securities by CHS, and after such share acquisition by CHS the Subject Person becomes the Beneficial Owner of any additional Shares or Voting Securities which increases the percentage of the then-outstanding Shares or Voting Securities Beneficially Owned by the Subject Person, then a Change in Control shall occur.

(6) <u>CHS</u>: Community Health Systems, Inc., a Delaware corporation.

(7) <u>Code</u>: The Internal Revenue Code of 1986, as amended.

(8) <u>Committee</u>: The administrative committee appointed by the Company to administer the Plan, if any, which committee shall consist of the same persons designated by the Company pursuant to the terms of the Retirement Plan to act on behalf of the Company.

(9) <u>Company</u>: CHS/Community Health Systems, Inc.

(10) <u>Company Matching Contributions</u>: Contributions made to the Retirement Plan by the Company or an Affiliate on a Member's behalf pursuant to Section 4.1(b) of the Retirement Plan or otherwise as provided for therein.

(11) <u>Compensation</u>: The total base salary paid by the Company or an Affiliate during the Plan Year to or for the benefit of a Member for services rendered or labor performed while a Member as determined by the Company in its sole discretion.

(12) Contributing Member: A Member who, for a Plan Year, made a deferral election pursuant to Section 3.2, Section 3.3 and/or Section 3.4.

(13) Determination Date. The last day of the Plan Year, or such other dates as established by the plan administrator.

(14) ERISA: Employee Retirement Income Security Act of 1974, as amended.

(15) Incentive Compensation Bonus: Performance-based compensation, as such term is defined under Code Section 409A and the regulations promulgated thereunder, paid by the Company or an Affiliate to a Member for services rendered or labor performed while a Member during the entire Plan Year.

(16) Investment(s): Any investment fund(s) offered through the Trustee or its affiliates.

(17) Investment Gains or Losses: Actual gains or losses realized from investments applied to a Member's Account as of each Determination Date pursuant to Section 4.1 of the Plan, after deducting applicable investment-related costs and expenses, if any. For the Determination Date, such Member's Account may be reduced or increased for an amount equal to the Federal or state income taxes that the Company is required to pay or expects to realize in relation to such investment(s)' taxable gain or loss realized during such year.

(18) Limitations: Benefit limitations imposed on the Retirement Plan under the Employee Retirement Income Security Act of 1974, as amended, and under sections 401(a)(17), 401(k)(3), 401(m)(2), 402(g) and 415 of the Internal Revenue Code of 1986, as amended.

(19) Member: Any employee of the Company or an Affiliate who has been designated by the Committee as a Member of the Plan until such employee ceases to be a Member in accordance with Section 3.1 of the Plan.

(20) Plan: CHS/Community Health Systems, Inc. Deferred Compensation Plan, as amended from time to time.

(21) Plan Year: The twelve-consecutive month period commencing January 1 and ending December 31 of each year.

(22) Retirement Plan: Community Health Systems, Inc. 401(k) Plan.

(23) Separation from Service: The termination of employment with the Company, as set forth in Code Section 409A(a)(2)(A)(i) and defined in regulations promulgated by the U.S. Department of Treasury thereunder, provided that no separation from service shall occur while a Member is on military leave, sick leave, or other bona fide leave of absence not extending beyond six months, or, if longer, so long as the Member's right to reemployment is provided either by statute or by contract. If a period of leave exceeds six months and the Member's right to reemployment is not provided either by statute or contract, for the purposes of the Plan, the employment relationship is

deemed to terminate on the first date immediately following such six-month period; provided, however, that that a Member shall not be deemed to have Separated from Service on account of a leave of absence until the first date immediately following the end of a 29-month period of leave (if the employment relationship is not terminated sooner) where such leave is due to any medically determinable physical or mental impairment that can be expected to result in death or can be expected to last for a continuous period of not less than six months and where such impairment causes the Member to be unable to perform the duties of his or her position of employment or any substantially similar position of employment..

(24) Specified Employee: A key employee, as defined in Code Section 416(i) without regard to Section 416(i)(5), of an employer any stock of which is publicly traded on an established securities market or otherwise. The identification date for determining a key employee shall be December 31. For the purposes of this definition, the term employer shall refer to the entity for whom the services are performed by the Specified Employee and with respect to whom the legally binding right to compensation arises together with and all entities with whom such entity would be considered a single employer under Code Section 414(b) or Code Section 414(c).

(25) SSP: CHS 401(k) Supplemental Savings Plan.

(26) Trust Agreement: The agreement entered into between the Company and the Trustee establishing a trust to hold and invest contributions made by the Company under the Plan and from which all or a portion of the amounts payable under the Plan to Members and their beneficiaries will be distributed.

(27) Trust Assets: All assets held by the Trustee under the Trust Agreement.

(28) Trustee: The trustee or trustees qualified and acting under the Trust Agreement at any time.

1.2 Number and Gender. Wherever appropriate herein, words used in the singular shall be considered to include the plural and the plural to include the singular. Wherever appropriate herein, the masculine gender, where appearing in this Plan, shall be deemed to include the feminine gender and vice versa.

1.3 Headings. The headings of Articles and Sections herein are included solely for convenience, and, if there is any conflict between such headings and the text of the Plan, the text shall control.

ARTICLE II

Administration

The Plan shall be administered by the Committee, which shall be authorized, subject to the provisions of the Plan, to establish rules and regulations and make such interpretations and determinations as it may deem necessary or advisable for the proper administration of the Plan and all such rules, regulations, interpretations, and determinations shall be binding on all Plan Members and their beneficiaries. The Committee shall be composed of not less than three individuals. Each member of the Committee shall serve until he resigns or is removed by the Company. Upon the resignation or removal of a member of the Committee, the Company shall appoint a substitute member. No member of the Committee shall have any right to vote or decide upon any matter relating solely to himself under the Plan or to vote in any case in which his individual right to claim any benefit under the Plan is particularly involved. In any case in which a Committee member is so disqualified to act, and the remaining members cannot agree, the Company shall appoint a temporary substitute member to exercise all the powers of the disqualified member concerning the matter in which he is disqualified. All expenses incurred in connection with the administration of the Plan shall be borne by the Company.

ARTICLE III

Participation

3.1 Eligibility. Any employee of the Company or an Affiliate shall become a Member upon designation by the Committee. Once an employee has been designated as a Member, he shall automatically continue to be a Member until he ceases to be an employee of the Company or an Affiliate or is removed as a Member by the Committee. Notwithstanding the preceding provisions of this Section 3.1, participation in this Plan shall at all times be limited to a selected group of management or highly compensated employees of the Company and its Affiliates.

3.2 Compensation Deferral Election. Any Member may elect to defer receipt of a whole percentage or amount of his Compensation during a Plan Year under the Plan. A Member's election to defer receipt of Compensation shall be made prior to the beginning of such Plan Year and shall be irrevocable for such Plan Year. The reduction in a Member's Compensation pursuant to his election shall be effected by Compensation reductions each payroll period within the Plan Year. For new Members, the election shall be made within thirty (30) days of becoming eligible.

3.3 Bonus Deferral Election. Any Member may elect to defer receipt of a whole percentage or amount of his Bonus or Incentive Compensation Bonus for any Plan Year under the Plan. A Member's election to defer receipt of any Bonus shall be made prior to the beginning of such Plan Year and shall be irrevocable for such Plan Year. A Member's election to defer receipt of any Incentive Compensation Bonus for any Plan Year shall be made at least six months prior to the end of the Plan Year. The election to defer receipt of such whole percentage of a Member's Bonus or Incentive Compensation Bonus pursuant to the deferral election above shall be effected by a reduction in the amount of the Bonus or Incentive Compensation Bonus to which such deferral election relates.

3.4 Targeted Deferral Election. Subject to the rules in Section 3.2, any Member may elect to defer receipt of a whole percentage or amount of any portion of the Member's Compensation until a specific future date by executing a deferral form designed for such purpose as specified by the Committee. Upon the occurrence of any such date specified by a Member in such an election form, the deferred amount, without the Investment(s) Gains or Losses attributable thereto, shall be distributed to the Member. Until so distributed, such deferral amounts shall continue to be a part of the Member's Account.

3.5 Investment Request. A Member may request the Committee to invest or change the investment of all or a portion of his Account in any Investments. A Member may make such request at any time, provided that the Committee shall only be obligated to direct the Trustee to make such Investment or change such Investment as soon as reasonably practicable and within the guidelines and requirements established by the Trustee for the investment of funds held in the Account. A Member who does not request the Committee to invest any portion of his Account shall have the funds held in such Account in a money market or similar fund.

ARTICLE IV

Benefits

4.1 Deferral Contributions. As of the last day of each payroll period of each Plan Year, a Member's Account shall be credited with an amount equal to the Compensation deferred under the Plan pursuant to an election by the Member as described in Article III for such payroll period. As of the last day of the payroll period in which Bonuses are paid, a Member's Account shall be credited with an amount equal to the Bonuses deferred under the Plan pursuant to an election by the Member as described in Article III.

4.2 Matching Contributions. As of the last day of each Plan Year, or, if later, the date on which the Company Matching Contributions are made under the Retirement Plan for any such Plan Year, the Member's Account of each Contributing Member during such Plan Year who remains employed by the Company on such date shall be credited with an amount equal to the following:

(1) the Company Matching Contributions to which such Contributing Member would have been entitled under the Retirement Plan taking into account both (i) the salary deferrals made by such Contributing Member to the Retirement Plan for the Plan Year, and (ii) the deferrals made by such Contributing Member under this Plan pursuant to Sections 3.2, 3.3, or 3.4 for the same Plan Year (up to a combined maximum of six percent (6.00%) of such Contributing Member's Compensation assuming that none of the Limitations were imposed); minus

(2) the Company Matching Contributions, if any, actually made on behalf of such Contributing Member under the Retirement Plan for such Plan Year; minus

(3) the Company contributions, if any, to accounts actually made on behalf of such Contributing Member under the SSP for such Plan Year.

In addition, if (i) the total of such Contributing Member's salary deferrals under the Retirement Plan (as adjusted after application of the Limitations) and deferrals pursuant to the SSP and Sections 3.2, 3.3 or 3.4 under this Plan is less than 6.00% of such Contributing Member's Compensation for a Plan Year; and (ii) the Contributing Member elects to increase his or her deferrals under this Plan by all or any portion of any salary deferrals to the Retirement Plan that are returned to the Contributing Member as a result of the application of the Limitations within 120 days after receipt of such returned salary deferrals, even if such increased deferrals are made in the next Plan Year, such increased deferrals shall also be taken into account in subparagraph (i) above until the total of the Contributing Member's salary deferrals under the Retirement Plan, SSP, and deferrals under this Plan for the Plan Year equals 6.00% of the Contributing Member's Compensation.

Effective as of January 1, 2009, no additional amounts shall be credited to a Contributing Member's Account pursuant to this Section 4.2.

ARTICLE V

Vesting

All amounts credited to a Member's Account shall be fully vested and not subject to forfeiture for any reason; provided, however, the amounts credited to a Member's Account pursuant to Section 4.2, including any Investment Gains or Losses allocable to such credits, shall be subject to the same vesting schedule as that set forth in the Retirement Plan. Notwithstanding the preceding sentence, the benefits payable to each Member hereunder constitute an unfunded, unsecured obligation of the Company, and the assets held by the Company and the Trustee remain subject to the claims of the Company's creditors.

ARTICLE VI

Trust

The Company may, from time to time and in its sole discretion, pay and deliver money or other property to the Trustee for the payment of benefits under the Plan. Notwithstanding any provision in the Plan to the contrary, distributions due under the Plan to or on behalf of Members shall be made by the Trustee in accordance with the terms of the Trust Agreement and the Plan; provided, however, that the Company shall remain obligated to pay all amounts due to such persons under the Plan. To the extent that Trust Assets are not sufficient to pay any amounts due under the Plan to or on behalf of the Members when such amounts are due, the Company shall pay such amounts directly. Nothing in the Plan or the Trust Agreement shall relieve the Company of its obligation to make the distributions required in Article VII hereof except to the extent that such obligation is satisfied by the application of funds held by the Trustee under the Trust Agreement. Any recipient of benefits hereunder shall have no security or other interest in Trust Assets. Any and all Trust Assets shall remain subject to the claims of the general creditors of the Company, present and future, and no payment shall be made under the Plan unless the Company is then solvent. Should an inconsistency or conflict exist between the specific terms of the Plan and those of the Trust Agreement, then the relevant terms of the Trust Agreement shall govern and control.

ARTICLE VII

Payment of Benefits

7.1 Separation from Service. Upon a Member's Separation from Service with the Company or an Affiliate for any reason, the amount credited to such Member's Account as of the Determination Date immediately preceding such Member's Separation from Service, adjusted for any amount deferred and Investment Gains or Losses realized from such Determination Date to the date of the Member's Separation from Service, shall be distributed to such Member or, if the Member's Separation from Service is on account of death, to the Member's beneficiary as determined pursuant to Section 7.2 below.

7.2 Death. Upon a Member's death, the amount credited to such Member's Account as of the Determination Date immediately preceding the date of such Member's death, adjusted for any amount deferred and Investment Gains or Losses realized from such Determination Date to the date of the Member's death, shall be distributed to such Member's designated beneficiary. The Member, by written instrument filed with the Committee in such manner and form as the Committee may prescribe, may designate one or more beneficiaries to receive such payment. The beneficiary designation may be changed from time to time prior to the death of the Member. In the event that the Committee has no valid beneficiary designation on file, the amount credited to such Member's Account shall be distributed to the Member's surviving spouse, if any, or if the Member has no surviving spouse, to the executor or administrator of the Member's estate, as applicable.

7.3 Targeted Deferrals. If a Member has made one or more targeted deferrals pursuant to Section 3.4, upon the date specified in any election form used by the Member to make such election, the amount credited in the subaccount of the Member's Account which relates to such deferral as of the Determination Date immediately preceding such specified date shall be distributed to such Member. If some event takes place that would entitle a Member to a distribution under Sections 7.1 or 7.2 prior to such specified date, the amounts in such subaccount shall be distributed along with any other amounts in the Member's Account pursuant to Section 7.1 or 7.2.

7.4 Time of Payment. Payment of a Member's benefit hereunder shall be made as soon as administratively feasible following the date on which the Member or his beneficiary becomes entitled to such benefit pursuant to Sections 7.1, 7.2, or 7.3, but no earlier than 10 days thereafter and no later than 45 days thereafter, except for the Company Matching Contributions as provided herein. If a Member's Separation from Service or death or any other events that entitle the Member to a distribution occurs within the first four months of a year, the portion of the Company Matching Contributions for the preceding Plan Year that has been credited to a Member's Account shall be distributed to such Member no later than the earlier of (i) the date of which the calculation of such contributions has been finalized or (ii) May 1 of the year of termination of employment or death, or any other events which shall entitle the Member to a distribution. In all other events, the 10 days and 45 days limitation shall apply to the distribution of the Member's entire Account balance, unless expressly provided otherwise. Notwithstanding the foregoing, for a Specified Employee, distributions may not be made before the day immediately following the date that is six (6) months after the date of the Member's Separation from Service (or, if earlier, the date of death of the Member). Also, notwithstanding the foregoing, a Member may elect to delay the time of payment under the following conditions: (i) such election shall not take effect until at least 12 months after the date on which the election is made; (ii) with respect to a payment made upon Separation from Service, a targeted deferral, or as a result of a Change in Control, the first payment with respect to which such election is made be deferred for a period of not less than 5 years from the date such payment would otherwise have been made; and (iii) any election related to a targeted deferral may not be made less than 12 months prior to the date of the first scheduled payment. Notwithstanding anything in this Section 7.4 to the contrary, an election relating to the time of payment may be made as permitted under Code Section 409A and applicable guidance of the Internal Revenue Service.

7.5 Form of Payment. For purposes of distributing all of a Member's Account, the form of any payment to a Member or his designated beneficiary shall be in a lump sum, paid in cash or by check; provided, however, if an election is made to delay the time of payment under Section 7.4, such payments shall be made, at the election of the Member, in a lump sum, in five (5) annual installments, or in ten (10) annual installments. Notwithstanding anything in this Section 7.5 to the contrary, an election relating to the form of payment may be made as permitted under Code Section 409A and applicable guidance of the Internal Revenue Service.

7.6 2008 Transitional Rule Election. By election made no later than December 31, 2008, a Member may elect to change the time or form of payment of a Member's Account and the election shall not be treated as a change in time or form of payment under Code Section 409A(a)(4) or an acceleration of payment under Code Section 409A(a)(3). Such election may apply only to amounts that would not otherwise be payable in 2008 and may not cause an amount to be paid in 2008 that would not otherwise be payable in 2008.

ARTICLE VIII

Hardship Distributions

Upon written application by a Member who has experienced an unforeseeable emergency, the Committee may distribute to such Member an amount not to exceed the lesser of the amount credited to such Member's Account or the amount determined by the Committee as being reasonably necessary to satisfy the emergency need (a "Hardship Distribution"). For purposes of this Article VIII, an unforeseeable emergency shall mean a severe financial hardship to the Member resulting from an illness or accident of the Member, the Member's spouse, or a dependent (as defined in Code Section 152(a)) of the Member, loss of the Member's property due to casualty, or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Member. The requirement for a Hardship Distribution is met only if, as determined under regulations of the Secretary of Treasury, the amounts distributed with respect to an emergency do not exceed the amounts necessary to satisfy such emergency plus amounts necessary to pay taxes reasonably anticipated as a result of the distribution, after taking into account the extent to which such hardship is or may be relieved through reimbursement or compensation by insurance or otherwise or by liquidation of the Member's assets (to the extent the liquidation of such assets would not itself cause severe financial hardship).

ARTICLE IX

Change in Control

Notwithstanding any provision of the Plan to the contrary, in the event of a Change in Control, the amount credited to such Member's Account as of the Determination Date immediately preceding such Change in Control, adjusted for any amount deferred and Investment Gains or Losses realized from such Determination Date to the date of the Change in Control, shall be distributed to such Member in a single lump sum payment as soon as administratively feasible, but no earlier than 10 days thereafter and no later than 45 days after the date of the Change in Control.

ARTICLE X

Nature of the Plan

The Plan shall constitute an unfunded, unsecured obligation of the Company to make cash payments in accordance with the provisions of the Plan. The Plan is not intended to meet the qualification requirements of section 401 of the Internal Revenue Code of 1986, as amended. The Company in its sole discretion may set aside such amounts for the payment of Accounts as the Company may from time to time determine. Neither the establishment of the Plan, the operation thereof, nor the setting aside of any amounts shall be deemed to create a funding arrangement. No Member shall have any security or other interest in any such amounts set aside or any other assets of the Company.

The arrangement provided for in this January 1, 2008, amendment of the Plan shall apply only with respect to amounts deferred after December 31, 2004. For amounts deferred before January 1, 2005, such deferrals shall be governed by the arrangement in place prior to the January 1, 2005, amendment of the Plan, as set forth in Exhibit A. No provision of this document is intended to be and shall not be a material modification of the arrangement in place as of October 3, 2004. To the extent any term of this document constitutes a material modification (that is, a benefit or right existing as of October 3, 2004, is enhanced or a new benefit or right is added) to the prior arrangement, such modification shall be of no force or effect.

ARTICLE XI

Employment Relationship

Nothing in the adoption or implementation of the Plan shall confer on any employee the right to continued employment by the Company or an Affiliate or affect in any way the right of the Company or an Affiliate to terminate his employment at any time. For the purposes of the Plan, any question as to whether and when there has been a termination of a Member's employment, and the cause of such termination, shall be determined by the Committee, and its determination shall be final.

ARTICLE XII

Amendment and Termination

The Company may amend or terminate the Plan, by written action, without the consent of the Members; provided, however, that no such amendment or termination shall adversely affect any benefits that have been earned prior to any such amendment or termination, except as required by law.

ARTICLE XIII

Claims Procedure

The Committee shall have full power and authority to interpret, construe, and administer the Plan, and the Committee's interpretations and construction hereof, and actions hereunder, including the value, amount, timing, form, or recipient of any payment to be made hereunder, shall be binding and conclusive on all persons for all purposes. Notwithstanding the foregoing, the determination of a Change in Control event will be objectively determinable under Article IX and the Committee shall not have discretionary authority to determine whether a Change in Control has occurred.

In the event that a claim for a benefit is wholly or partially denied, the Committee shall, within 90 days after receipt of the claim by the Plan, provide the claimant with a written statement setting forth the specific reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and a description of the Plan's review procedures and time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of the ERISA following an adverse benefit determination on review.

The claimant will have 60 days following receipt of an adverse benefit determination within which to appeal the determination. During such time, the Participant will have the opportunity to submit written comment, documents, records, and other information relating to the claim for benefits. The claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Committee will notify the claimant within 60 days after receipt of the claimant's request for review by the Plan. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the benefit determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA.

No member of the Committee shall be liable to any person for any action taken or omitted in connection with the interpretation and administration of the Plan unless attributable to his own willful misconduct or lack of good faith. Claimants who are members of the Committee shall not participate in any action or determination regarding their own benefits hereunder.

ARTICLE XIV

Miscellaneous

14.1 Indemnification. The Company shall indemnify and hold harmless each member of the Committee and any other persons acting on its behalf, against any and all expenses and liabilities arising out of his or her administrative functions or fiduciary responsibilities, excepting only expenses and liabilities arising out of the individual's own willful misconduct or lack of good faith. Expenses against which such person shall be indemnified hereunder include, without limitation, the amounts of any settlement or judgment, costs, counsel fees and related charges reasonably incurred in connection with a claim asserted or a proceeding brought or settlement thereof.

14.2 Withholding Taxes. The Company shall have the right to deduct from any payments made under this Plan, any federal, state or local taxes required by law to be withheld with respect to such payments.

14.3 Nonalienation of Benefits. Subject to income tax withholding, benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability that is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Member, prior to actually being received; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder shall be void. The Company shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

14.4 Severability. If any provision of the Plan shall be held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining provisions hereof; rather, each provision shall be fully severable and the Plan shall be construed and enforced as if said illegal or invalid provision had never been included herein.

14.5 Jurisdiction. The situs of the Plan hereby created is Tennessee. All provisions of the Plan shall be construed in accordance with the laws of Tennessee except to the extent preempted by federal law.

IN WITNESS WHEREOF, the undersigned has caused this Plan to be executed on the 24th day of December, 2008, to be effective as of January 1, 2008.

CHS/COMMUNITY HEALTH SYSTEMS, INC.

By: /s/ Rachel A. Seifert

Title: Senior Vice President

EXHIBIT A

CHS/COMMUNITY HEALTH SYSTEMS, INC.

DEFERRED COMPENSATION PLAN

As Amended Effective October 1, 1993; January 1, 1994; January 1, 1995; April 1, 1999; July 1, 2000; January 1, 2001; and June 30, 2002

Original Effective Date: June 1, 1991

EXHIBIT A

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CHS/COMMUNITY HEALTH SYSTEMS, INC.
DEFERRED COMPENSATION PLAN

WITNESSETH:

WHEREAS, Community Health Investment Corporation (formerly CHS Management Corporation) has previously established the CHS/Community Health Systems, Inc. Deferred Compensation Plan (the "Plan") to provide retirement and incidental benefits for certain executive employees of the company, effective June 1, 1991; and

WHEREAS, the Plan was amended in certain respects, effective December 1, 1991; and

WHEREAS, effective January 1, 1992, Community Health Systems, Inc. (the "Company") adopted the Plan and assumed all of the duties and responsibilities of Community Health Investment Corporation; and

WHEREAS, the Plan was further amended in certain respects effective October 1, 1993, January 1, 1994, January 1, 1995, April 1, 1999, July 1, 2000, and January 1, 2001, including the change in the name of the Company to CHS/Community Health Systems, Inc.; and

WHEREAS, the Company wishes to amend the Plan further as provided herein;

NOW, THEREFORE, the Plan shall be and is hereby amended and restated in this form, effective as of June 30, 2002, except as otherwise provided herein

ARTICLE I

Definitions and Construction

1.1 Definitions. Where the following words and phrases appear in the Plan, they shall have the respective meanings set forth below, unless their context clearly indicates to the contrary:

(1) Account: A memorandum bookkeeping account established on the records of the Company for a Member that is credited with amounts determined pursuant to Sections 4.1 and 4.2 of the Plan. As of any Determination Date, a Member's benefit under the Plan shall be equal to the amount credited to his Account as of such date. If a Member has made an election to defer a portion of his Compensation until a specified date pursuant to Section 3.4, the account described herein shall consist of such subaccounts as are necessary to segregate such deferral from the other amounts deferred by the Member.

(2) Affiliate: Any subsidiary of Community Health Systems, Inc., the corporate parent of the Company.

(3) Benefit Exchange Agreement: An agreement entered into between certain Members and the Company in connection with the surrender of the Member's interest in the Split Dollar

EXHIBIT A

Agreement and the Member's vested interest in the cash value of the variable life insurance policy that is subject to the terms of the Split Dollar Agreement, as it may be amended.

(4) Bonus: The bonus paid by the Company or an Affiliate to a Member pursuant to an employment agreement between the Company or an Affiliate and the Member or otherwise for services rendered or labor performed while a Member.

(5) Change of Control: A Change of Control occurs in the event of a sale of all or substantially all of the stock or assets of the Company to a purchaser if the debt-to-equity ratio of the purchaser, taking into account the sale of the stock or assets of the Company, is greater than .75 to 1 as determined by the Committee immediately prior to the sale.

(6) Committee: The administrative committee appointed by the Company to administer the Plan, if any, which committee shall consist of the same persons designated by the Company pursuant to the terms of the Retirement Plan to act on behalf of the Company, as the administrator of such Plan.

(7) Company: CHS/Community Health Systems, Inc.

(8) Company Matching Contributions: Contributions made to the Retirement Plan by the Company or an Affiliate on a Member's behalf pursuant to Section 4.1(b) of the Retirement Plan or otherwise as provided for therein.

(9) Compensation: The total base salary paid by the Company or an Affiliate during the Plan Year to or for the benefit of a Member for services rendered or labor performed while a Member.

(10) Contributing Member: A Member who, for a Plan Year, made a deferral election pursuant to Section 3.2, Section 3.3 and/or Section 3.4.

(11) Determination Date. The last business day of each quarter in a calendar year.

(12) Earnings Credit: The earnings applied to a Member's Account as of each Determination Date pursuant to Section 4.2(b).

(13) Effective Date: June 1, 1991.

(14) Investment(s): Any investment fund(s) offered through the Trustee or its affiliates including Nations Fund, Inc., Nations Fund Trust, or Nations Fund Portfolios, Inc. (or their successors).

(15) Investment Gains or Losses: Actual gains or losses realized from investments applied to a Member's Account as of each Determination Date pursuant to Section 4.2(a) of the Plan, after deducting applicable investment-related costs and expenses, if any. For the Determination Date, such Member's Account shall be reduced or increased for an amount equal to the Federal or state income taxes that the Company is required to pay or expects to realize in relation to such investment(s)' taxable gain or loss realized during such year.

EXHIBIT A

(16) Limitations: Benefit limitations imposed on the Retirement Plan under the Employee Retirement Income Security Act of 1974, as amended, and under sections 401(a)(17), 401(k)(3), 401(m)(2), 402(g) and 415 of the Internal Revenue Code of 1986, as amended.

(17) Member: Any employee of the Company or an Affiliate who has been designated by the Committee as a Member of the Plan until such employee ceases to be a Member in accordance with Section 3.1 of the Plan.

(18) Plan: CHS/Community Health Systems, Inc. Deferred Compensation Plan, as amended from time to time.

(19) Plan Year: The seven-month period commencing June 1, 1991, and ending December 31, 1991 and each twelve-consecutive month period commencing January 1 of each year thereafter.

(20) Post-Termination Benefits Deposit: Certain deposit provided for under the terms of the Split Dollar Agreement.

(21) Retirement Plan: Community Health Systems, Inc. 401(k) Plan.

(22) Split Dollar Agreement: An agreement entered into between the Company and the Member pursuant to the provisions of the Supplemental Survivor Accumulation portion of the Community Health Systems, Inc. Supplemental Benefits Plan.

(23) SSP: CHS 401(k) Supplemental Savings Plan.

(24) Trust Agreement: The agreement entered into between the Company and the Trustee establishing a trust to hold and invest contributions made by the Company under the Plan and from which all or a portion of the amounts payable under the Plan to Members and their beneficiaries will be distributed.

(25) Trust Assets: All assets held by the Trustee under the Trust Agreement.

(26) Trustee: The trustee or trustees qualified and acting under the Trust Agreement at any time.

1.2 Number and Gender. Wherever appropriate herein, words used in the singular shall be considered to include the plural and the plural to include the singular. The masculine gender, where appearing in this Plan, shall be deemed to include the feminine gender and vice versa.

1.3 Headings. The headings of Articles and Sections herein are included solely for convenience and if there is any conflict between such headings and the text of the Plan, the text shall control.

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ARTICLE II

Administration

The Plan shall be administered by the Committee that shall be authorized, subject to the provisions of the Plan, to establish rules and regulations and make such interpretations and determinations as it may deem necessary or advisable for the proper administration of the Plan and all such rules, regulations, interpretations, and determinations shall be binding on all Plan Members and their beneficiaries. The Committee shall be composed of not less than three individuals. Each member of the Committee shall serve until he resigns or is removed by the Company. Upon the resignation or removal of a member of the Committee, the Company shall appoint a substitute member. No member of the Committee shall have any right to vote or decide upon any matter relating solely to himself under the Plan or to vote in any case in which his individual right to claim any benefit under the Plan is particularly involved. In any case in which a Committee member is so disqualified to act, and the remaining members cannot agree, the Company shall appoint a temporary substitute member to exercise all the powers of the disqualified member concerning the matter in which he is disqualified. All expenses incurred in connection with the administration of the Plan shall be borne by the Company.

ARTICLE III

Participation

3.1 Eligibility. Any employee of the Company or an Affiliate shall become a Member upon designation by the Committee. Once an employee has been designated as a Member, he shall automatically continue to be a Member until he ceases to be an employee of the Company or an Affiliate or is removed as a Member by the Committee. Notwithstanding the preceding provisions of this Section 3.1, participation in this Plan shall at all times be limited to a selected group of management or highly compensated employees of the Company.

3.2 Compensation Deferral Election. Any Member may elect to defer receipt of a whole percentage of his Compensation for one or more calendar quarters during a Plan Year under the Plan. A Member's election to defer receipt of Compensation for any calendar quarter(s) of a Plan Year shall be made prior to the beginning of such calendar quarter(s) of the Plan Year and shall be irrevocable for such calendar quarter(s) of the Plan Year. The reduction in a Member's Compensation pursuant to his election shall be effected by Compensation reductions as of each payroll period within the election period.

3.3 Bonus Deferral Election. Any Member may elect to defer receipt of a whole percentage of his Bonus for any Plan Year under the Plan. A Member's election to defer receipt of his Bonus for any Plan Year shall be made prior to the earlier of (i) the date on which such bonus becomes payable and ascertainable, or (ii) October 1 of such Plan Year for which such Bonus is payable, and shall be irrevocable for such Plan Year. The election to defer receipt of such whole percentage of a Member's Bonus pursuant to the deferral election above shall be effected by a reduction in the amount of the Bonus to which such deferral election relates.

EXHIBIT A

3.4 Targeted Deferral Election. In general, all amounts deferred by a Member pursuant to Sections 3.2 and 3.3 shall be held for the Member and distributed following the Member's termination of employment or the occurrence of a hardship event pursuant to Sections 7.1, 7.2 and 8.1. Notwithstanding the preceding sentence, a Member may also defer the receipt of any portion of the Member's Compensation otherwise deferred pursuant to the provisions of Sections 3.2 and 3.3 until a specific future date, by executing a deferral form designed for such purpose as specified by the Committee. Upon the occurrence of any such date specified by a Member in such an election form, the deferred amount, and the Earnings Credit and Investment(s) Gains or Losses attributable thereto, shall be distributed to the Member. Until so distributed, such deferral amounts shall continue to be a part of the Member's Account.

3.5 Investment Request. A Member may request the Committee to invest or change the investment of all or a portion of his Account in any Investments. A Member may make such request at any time, provided that the Committee shall only be obligated to direct the Trustee to make such investment or charge such investment as soon as reasonably practicable and within the guidelines and requirements established by the Trustee for the investment of funds held in the Account. A Member who does not request the Committee to invest any portion of his Account shall have the funds held in such Account in a money market fund offered through the Trustee or its affiliates.

3.6 Post-Termination Benefits Deposit. Notwithstanding any provision of the Plan to the contrary, the Company may make for any Member an annual contribution equal to that portion of Post-Termination Benefit Deposits to be made to the Plan as calculated under the terms of any Benefits Exchange Agreement between the Member and the Company.

ARTICLE IV

Benefits

4.1 Amount of Benefit.

(a) Deferral Contributions. As of the last day of each payroll period of each Plan Year, a Member's Account shall be credited with an amount equal to the Compensation deferred under the Plan pursuant to an election by the Member as described in Article III for such payroll period. Effective as of June 30, 2002, as of the last day of each payroll period of each Plan Year, a Member's Account shall be credited with an amount equal to that portion of Post-Termination Benefit Deposits made to the Plan, if any, as calculated under the terms of the Benefits Exchange Agreement between the Member and the Company.

(b) Matching Contributions. As of the last day of each Plan Year, or, if later, the date on which the Company Matching Contributions are made under the Retirement Plan for any such Plan Year, the Member's Account of each Contributing Member during such Plan Year who remains employed by the Company on such date shall be credited with an amount equal to the following:

(1) the Company Matching Contributions to which such Contributing Member would have been entitled under the Retirement Plan taking into account

both (i) the salary deferrals made by such Contributing Member to the Retirement Plan for the Plan Year, and (ii) the deferrals made by such Contributing Member under this Plan pursuant to Sections 3.1, 3.2, or 3.3 for the same Plan Year (up to a combined maximum of six percent (6.00%) of such Contributing Member's Compensation assuming that none of the Limitations were imposed); minus

(2) the Company Matching Contributions, if any, actually made on behalf of such Contributing Member under the Retirement Plan for such Plan Year; minus

(3) the Company contributions, if any, to accounts actually made on behalf of such Contributing Member under the SSP for such Plan Year.

In addition, if (i) the total of such Contributing Member's salary deferrals under the Retirement Plan (as adjusted after application of the Limitations) and deferrals pursuant to the SSP and Sections 3.1, 3.2 or 3.3 under this Plan is less than 6.00% of such Contributing Member's Compensation for a Plan Year; and (ii) the Contributing Member elects to increase his or her deferrals under this Plan by all or any portion of any salary deferrals to the Retirement Plan that are returned to the Contributing Member as a result of the application of the Limitations within 120 days after receipt of such returned salary deferrals, even if such increased deferrals are made in the next Plan Year; such increased deferrals shall also be taken into account in subparagraph (a) above until the total of the Contributing Member's salary deferrals under the Retirement Plan, SSP, and deferrals under this Plan for the Plan Year equals 6.00% of the Contributing Member's Compensation.

(c) Benefit Exchange Agreement Contributions. Effective for Plan Years beginning on or after January 1, 2002, the Company shall credit to the Account of each Member who has entered into a Benefit Exchange Agreement with the Company the following amounts, as specified under the terms of each such Benefit Exchange Agreement:

(1) all unpaid 2001 and 2002 variable life insurance policy premium payments required under the terms of the Split Dollar Agreement;

(2) an amount equal to 100% of the net cash surrender value of such variable life insurance policy on the date such policy is surrendered by the Company; and

(3) if required by the Member's Benefit Exchange Agreement, annual amounts equal to the premium payments to such variable life insurance policy that would have been required under the Split Dollar Agreement for years after 2002, reduced each year by the actual cost of providing supplemental life insurance coverage to the Member pursuant to the terms of the Benefit Exchange Agreement.

As of any Determination Date, the benefit to which a Member or his beneficiary shall be entitled under the Plan shall be equal to the amount credited to such Member's Account as of such date.

EXHIBIT A

(d) Special Contributions. For the Plan Year beginning January 1, 2003, the Company shall make a special one-time cash contribution to each Participant's Account in an amount equal to the dollar value of the matching contributions that were forfeited by the Participants under the Retirement Plan for the plan years of the Retirement Plan that ended on December 31, 2001, and December 31, 2002. The Plan Administrator shall determine the dollar value of all such forfeited matching contributions, which determination shall be final and binding on all Participants. Such special contributions shall be made no later than September 15, 2003, unless the Plan Administrator has not yet finally determined the amount of the forfeited matching contributions, in which event such contributions shall be made not later than 30 days after such forfeited matching contributions are finally determined by the Plan Administrator. Notwithstanding the foregoing, no such special contribution shall be made for a Member if the Company makes a similar contribution for a Member to the SSP.

4.2 Investment Credit. As of each Determination Date, the Account of each Member shall be credited with Investment Gains or Losses as provided in this Section 4.2.

(a) If a Member has requested in accordance with Section 3.5 of the Plan that all or a portion of his Account be invested in any particular Investment(s), the Account of such Member shall be credited with the Investment Gains or Losses since the preceding Determination Date.

(b) Any portion of a Member's Account, the investment of which has not been requested by the Member, shall be credited with the Earnings Credit for such Determination Date.

(c) A Member's Account shall not be credited with any Investment Credit under this Section 4.2 on the Company Matching Contributions portion credited to his Account as of the last day of each Plan Year pursuant to Section 4.1 of the Plan until the Company actually makes the cash deposit of such Matching Contributions with the Trustee.

ARTICLE V

Vesting

All amounts credited to a Member's Account shall be fully vested and not subject to forfeiture for any reason; provided, however, the amounts credited to a Member's Account pursuant to the second paragraph of Section 4.1, including any Earnings Credit and/or Investment Gains or Losses allocable to such credits, shall be subject to the same vesting schedule as that set forth in the Retirement Plan. Notwithstanding the preceding sentence, the benefits payable to each Member hereunder constitute an unfunded, unsecured obligation of the Company, and the assets held by the Company and the Trustee remain subject to the claims of the Company's creditors.

EXHIBIT A

ARTICLE VI

Trust

The Company may, from time to time and in its sole discretion, pay and deliver money or other property to the Trustee for the payment of benefits under the Plan. Notwithstanding any provision in the Plan to the contrary, distributions due under the Plan to or on behalf of Members shall be made by the Trustee in accordance with the terms of the Trust Agreement and the Plan; provided, however, that the Company shall remain obligated to pay all amounts due to such persons under the Plan. To the extent that Trust Assets are not sufficient to pay any amounts due under the Plan to or on behalf of the Members when such amounts are due, the Company shall pay such amounts directly. Nothing in the Plan or the Trust Agreement shall relieve the Company of its obligation to make the distributions required in Article VII hereof except to the extent that such obligation is satisfied by the application of funds held by the Trustee under the Trust Agreement. Any recipient of benefits hereunder shall have no security or other interest in Trust Assets. Any and all Trust Assets shall remain subject to the claims of the general creditors of the Company, present and future, and no payment shall be made under the Plan unless the Company is then solvent. Should an inconsistency or conflict exist between the specific terms of the Plan and those of the Trust Agreement, then the relevant terms of the Trust Agreement shall govern and control.

ARTICLE VII

Payment of Benefits

7.1 Termination of Employment. Upon a Member's termination of employment with the Company or an Affiliate for any reason, the amount credited to such Member's Account as of the Determination Date immediately preceding such Member's termination of employment, adjusted for any amount deferred and Earnings Credit and Investment(s) Income or Loss realized from such Determination Date to the date of the Member's termination of employment, shall be distributed to such Member or, if the Member's termination of employment is on account of death, to the Member's beneficiary as determined pursuant to Section 7.2 below.

7.2 Death. Upon a Member's death, the amount credited to such Member's Account as of the Determination Date immediately preceding the date of such Member's death, adjusted for any amount deferred and Earnings Credit and Investment Gains or Losses realized from such Determination Date to the date of the Member's death, shall be distributed to such Member's designated beneficiary. The Member, by written instrument filed with the Committee in such manner and form as the Committee may prescribe, may designate one or more beneficiaries to receive such payment. The beneficiary designation may be changed from time to time prior to the death of the Member. In the event that the Committee has no valid beneficiary designation on file, the amount credited to such Member's Account shall be distributed to the Member's surviving spouse, if any, or if the Member has no surviving spouse, to the executor or administrator of the Member's estate.

7.3 Targeted Deferrals. If a Member has made one or more targeted deferrals pursuant to Section 3.4, upon the date specified in any election form used by the Member to make such election, the amount credited in the subaccount of the Member's Account which relates to such deferral as of the Determination Date immediately preceding such specified date shall be distributed to such Member. If some event takes place that would entitle a Member to a distribution under Sections 7.1 or 7.2 prior to such specified date, the amounts in such subaccount shall be distributed along with any other amounts in the Member's Account pursuant to Section 7.1 or 7.2.

7.4 Time of Payment. Payment of a Member's benefit hereunder shall be made (or commence if payment is in the form of an annuity contract) as soon as administratively feasible following the date on which the Member or his beneficiary becomes entitled to such benefit pursuant to Sections 7.1, 7.2, or 7.3, but no earlier than 10 days thereafter and no later than 45 days thereafter, except for the Company Matching Contributions as provided herein. If a Member's termination of employment or death or any other events which caused termination of the Plan, occurs within the first four months of a year, the portion of the Company Matching Contributions for the preceding Plan Year that has been credited to a Member's Account shall be distributed to such Member no later than the earlier of (i) the date of which the calculation of such contributions has been finalized or (ii) May 1 of the year of termination of employment or death, or any other events which shall entitle the Member to a distribution. In all other events, the 10 days and 45 days limitation shall apply to the distribution of the Member's entire Account balance, unless expressly provided otherwise.

7.5 Form of Payment. For purposes of distributing all of a Member's Account other than any portion thereof attributable to targeted deferrals and earnings thereon, the form of any payment to a Member or his designated beneficiary shall be in substantially equal annual installments over a period of ten (10) years, paid in cash or by certified check, with the first such payment to be made on the first business day of the calendar year following the Member's termination of employment (for purposes of payments made pursuant to Section 7.1) or death (for purposes of payments made pursuant to Section 7.2), unless the Member has made an election to receive such distribution in the form of a lump sum payment or in five (5) substantially equal installment payments in such manner and form as prescribed by the Committee. Any election, or subsequent election, made by the Member pursuant to this Section shall not be effective until the passage of twelve (12) consecutive months before the date of the Member's termination of employment with the Company or an Affiliate, if payment is required pursuant to Section 7.1, or the Member's date of death, if the payment is required pursuant to Section 7.2. All distributions of that portion of a Member's Account attributable to any targeted deferral and earnings thereon shall be distributed in a single lump sum payment, in cash or certified check, on the date specified by the Member in the election form used to make the targeted deferral, or as soon thereafter as administratively possible.

ARTICLE VIII

Hardship Distributions

Upon written application by a Member who has experienced an unforeseeable emergency, as determined by the Committee, the Committee may distribute to such Member an amount not to exceed the lesser of the amount credited to such Member's Account or the amount determined by the Committee as being reasonably necessary to satisfy the emergency need. For purposes of this Article VIII, a hardship distribution pursuant to an unforeseeable emergency shall be authorized in the event of severe financial hardship to the Member resulting from a sudden and unexpected illness or accident of the Member or his dependent, loss of the Member's property due to casualty, or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the Member's control. An unforeseeable emergency will not include the need to send a Member's child to college or the desire to purchase a home. Additionally, the Member must demonstrate that the hardship may not be relieved through reimbursement or compensation by insurance or otherwise, by liquidation of the Member's assets, to the extent the liquidation of such assets would not itself cause severe financial hardship, or by cessation of deferrals under this Plan.

ARTICLE IX

Sale of the Company

In the event of a sale of all or substantially all of the stock or assets of the Company, either (a) the purchaser shall assume the liabilities of the Plan and shall continue to operate the Plan in accordance with the provisions set forth herein (including any subsequent amendments hereto) or (b) the Plan shall be terminated and the amount credited to each Member's Account shall be distributed in a lump sum payment in cash or by certified check to each such Member in accordance with Section 7.4. However, should such sale result in a Change of Control, the Plan shall be terminated and the amount credited to each Member's Account shall be distributed in a lump sum payment in cash or by certified check to each such Member in accordance with Section 7.4.

ARTICLE X

Nature of the Plan

The Plan shall constitute an unfunded, unsecured obligation of the Company to make cash payments in accordance with the provisions of the Plan. The Plan is not intended to meet the qualification requirements of section 401 of the Internal Revenue Code of 1986, as amended. The Company in its sole discretion may set aside such amounts for the payment of Accounts as the Company may from time to time determine. Neither the establishment of the Plan, the operation thereof, nor the setting aside of any amounts shall be deemed to create a funding arrangement. No Member shall have any security or other interest in any such amounts set aside or any other assets of the Company.

ARTICLE XI

Employment Relationship

Nothing in the adoption or implementation of the Plan shall confer on any employee the right to continued employment by the Company or an Affiliate or affect in any way the right of the Company or an Affiliate to terminate his employment at any time. Any question as to whether and when there has been a termination of a Member's employment, and the cause of such termination, shall be determined by the Committee, and its determination shall be final.

EXHIBIT A

ARTICLE XII

Amendment and Termination

The Company may amend or terminate the Plan, by resolution duly adopted, without the consent of the Members; provided, however, that no such amendment or termination shall adversely affect any benefits which have been earned prior to any such amendment or termination. Further, upon termination of the Plan, the Committee, in its sole discretion, may elect to distribute the amount credited to each Member's Account in a lump sum cash payment in accordance with Section 7.4; provided, however, in the event of a Change of Control, the amount credited to each Member's Account must be distributed in accordance with Section 7.4.

ARTICLE XIII

Claims Procedure

The Committee shall have full power and authority to interpret, construe and administer the Plan, and the Committee's interpretations and construction hereof, and actions hereunder, including the timing, form, amount or recipient of any payment to be made hereunder, shall be binding and conclusive on all persons for all purposes. In the event that an individual's claim for a benefit is denied or modified, the Committee shall provide such individual with a written statement setting forth the specific reasons for such denial or modification in a manner calculated to be understood by the individual. Any such written statement shall reference the pertinent provisions of the Plan upon which the denial or modification is based and shall explain the Plan's claim review procedure. Such individual may, within forty-five (45) days of receipt of such written statement, make written request to the Committee for review of its initial decision. Within forty-five (45) days following such request for review, the Committee shall, after affording such individual a reasonable opportunity for a full and fair hearing, render its final decision in writing to such individual. Notwithstanding the preceding sentence, should a Member's claim be related to the preceding Plan Year's Company Matching Contributions, the Committee shall render its final decision on the later of (i) forty-five (45) days following such request for review, or (ii) 120 days after the end of the preceding Plan Year. No member of the Committee shall be liable to any person for any action taken or omitted in connection with the interpretation and administration of the Plan unless attributable to his own willful misconduct or lack of good faith. Members of the Committee shall not participate in any action or determination regarding their own benefits hereunder.

ARTICLE XIV

Miscellaneous

14.1 Indemnification. The Company shall indemnify and hold harmless each member of the Committee and any other persons acting on its behalf, against any and all expenses and liabilities arising out of his or her administrative functions or fiduciary responsibilities, excepting only expenses and liabilities arising out of the individual's own willful misconduct or lack of good faith. Expenses against which such person shall be indemnified hereunder include, without limitation, the amounts of any settlement or judgment, costs, counsel fees and related charges reasonably incurred in connection with a claim asserted or a proceeding brought or settlement thereof.

14.2 Effective Date. The Plan shall become operative and effective as of the Effective Date and shall continue until amended or terminated as provided in Article XII.

14.3 Withholding Taxes. The Company shall have the right to deduct from any payments made under this Plan, any federal, state or local taxes required by law to be withheld with respect to such payments.

14.4 Nonalienation of Benefits. Subject to income tax withholding, benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Member, prior to actually being received; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder shall be void. The Company shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

14.5 Severability. If any provision of the Plan shall be held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining provisions hereof; rather, each provision shall be fully severable and the Plan shall be construed and enforced as if said illegal or invalid provision had never been included herein.

14.6 Jurisdiction. The situs of the Plan hereby created is Tennessee. All provisions of the Plan shall be construed in accordance with the laws of Tennessee except to the extent preempted by federal law.

Exhibit 10.13

CHS/COMMUNITY HEALTH SYSTEMS, INC.
AMENDED AND RESTATED
SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

January 1, 2009

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(continued)

CHS/COMMUNITY HEALTH SYSTEMS, INC.

AMENDED AND RESTATED

SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

WHEREAS, Community Health Systems, Inc. established the Community Health Systems, Inc. Supplemental Executive Retirement Plan (the "Original Plan") on December 10, 2002; and

WHEREAS, the Original Plan was amended as of April 8, 2004, to change the definition of "Service" thereunder; and

WHEREAS, the Original Plan was next amended as of May 25, 2005, to reflect the assumption of the Plan by CHS/Community Health Systems, Inc. and the change of the name of the Original Plan to the CHS/Community Health Systems, Inc. Supplemental Executive Retirement Plan; and

WHEREAS, the Original Plan was required to be maintained in good faith compliance with Internal Revenue Code Section 409A and guidance of the U.S. Department of Treasury thereunder for the period beginning January 1, 2005, and ending December 31, 2008; and

WHEREAS, the Original Plan is required to be restated to comply with Internal Revenue Code Section 409A; and

WHEREAS, the Original Plan shall be amended and restated as the CHS/Community Health Systems, Inc. Amended and Restated Supplemental Executive Retirement Plan (the "Plan"), effective as of January 1, 2009, except as otherwise stated herein;

NOW, THEREFORE, the Plan shall provide as follows:

1. Purpose. The purpose of this Plan is to advance the interests of CHS by encouraging officers and other key employees of the Company and its subsidiaries who will largely be responsible for the long-term success and development of CHS to continue their employment with the Company and its subsidiaries by providing retirement benefits for them. The Plan is also intended to assist the Company and its subsidiaries in attracting and retaining such employees and stimulating their efforts on behalf of the Company and its subsidiaries.

2. Definitions and Construction.

2.1 ***Definitions.*** As used in the Plan, terms defined parenthetically immediately after their use shall have the respective meanings provided by such definitions, and the following words and phrases shall have the meanings specified below (in either case, such terms shall apply equally to both the singular and plural forms of the terms defined), unless a different meaning is plainly required by the context:

(a) "Actuarial Equivalent" shall mean a benefit of equivalent value calculated based on the Uninsured Pensioners 1994 Mortality Table including Projections to 2003 using 50% of the Male Rates and 50% of the Female Rates as prescribed for qualified retirement plans under the General Agreement on Trades and Tariffs (GATT) and a discount rate equal to the yield on 10-Year Treasury Bonds as of the last day of the previous month, but in no event greater than 4% per annum.

(b) "Annual Retirement Benefit" shall mean an amount equal to a Participant's Final Average Earnings multiplied by the lesser of (i) 60%, or (ii) a percentage equal to 2% multiplied by the Participant's years of Service.

(c) "Beneficiary" shall mean the person or persons designated by a Participant pursuant to Section 7 to receive the benefits to which a Participant is entitled upon the death of a Participant.

(d) "Board" shall mean the Board of Directors of the Company or, as the context requires, CHS.

(e) "Cause" shall mean a felony conviction of a Participant or the failure of a Participant to contest prosecution for a felony, or a Participant's willful misconduct, dishonesty or gross negligence, any of which is determined by the Board to be directly and materially harmful to the business or reputation of the Company or its Subsidiaries.

(f) "Change in Control" shall mean the occurrence of any of the following events, but only to the extent such event would constitute a change in the ownership or effective control of CHS, or in the ownership of a substantial portion of the assets of CHS, as set forth in Code Section 409A(a)(2)(A)(v) and defined in regulations promulgated by the U.S. Department of Treasury thereunder:

(1) An acquisition (other than directly from CHS) of any voting securities of CHS ("Voting Securities") by any Person (as the term person is used for purposes of Section 13(d) or 14(d) of the Securities Exchange Act of 1934, as amended ("Exchange Act")) immediately after which such Person has Beneficial Ownership (within the meaning of Rule 13d-3 promulgated under the Exchange Act) of more than 50% of the then-outstanding shares of Common Stock of CHS ("Shares") or the combined voting power of CHS' then-outstanding Voting Securities; provided, however, in determining whether a Change in Control has occurred pursuant to this Section 2.1(f)(1), Shares or Voting Securities which are acquired in a Non-Control Acquisition (as hereinafter defined) shall not constitute an acquisition that would cause a Change in Control. A "Non-Control Acquisition" shall mean an acquisition by (i) an employee benefit plan (or a trust forming a part thereof) maintained by the Company or any Subsidiary, (ii) CHS or any Subsidiary, or (iii) any Person in connection with a Non-Control Transaction (as hereinafter defined);

(2) The individuals who, as of the date hereof, are members of the Board of CHS ("Incumbent Board"), cease for any reason to constitute at least a majority of the members of the Board of CHS or, following a Merger (as hereinafter defined) that results in CHS having a Parent Corporation (as hereinafter defined), the board of directors of the ultimate Parent Corporation; provided, however, that if the election, or nomination for election, by the CHS common stockholders, of any new director was approved by a vote of at least two-thirds of the Incumbent Board of CHS, such new director shall, for purposes of the Plan, be considered as a member of the Incumbent Board of CHS; provided further, however, that no individual shall be considered a member of the Incumbent Board of CHS if such individual initially assumed office as a result of either an actual or threatened Election Contest (as described in Rule 14a-11 promulgated under the Exchange Act) or other actual or threatened solicitation of proxies or consents by or on behalf of a Person other than the Board of CHS ("Proxy Contest"), including by reason of any agreement intended to avoid or settle any Election Contest or Proxy Contest; or

(3) The consummation of:

(A) A merger, consolidation or reorganization with or into the Company or in which securities of the Company are issued ("Merger"), unless such Merger, is a Non-Control Transaction. A Non-Control Transaction shall mean a Merger where:

(i) the stockholders of CHS immediately before such Merger own, directly or indirectly, immediately following such Merger, at least 50% of the combined voting power of the outstanding voting securities of (x) the corporation resulting from such Merger ("Surviving Corporation"), if 50% or more of the combined voting power of the then outstanding voting securities of the Surviving Corporation is not Beneficially Owned, directly or indirectly, by another Person ("Parent Corporation"), or (y) if there are one or more Parent Corporations, the ultimate Parent Corporation; and

(ii) the individuals who were members of the Incumbent Board of CHS immediately prior to the execution of the agreement providing for such Merger, constitute at least a majority of the members of the board of directors of (x) the Surviving Corporation, if there is no Parent Corporation, or (y) if there are one or more Parent Corporations, the ultimate Parent Corporation.

(B) A complete liquidation or dissolution of CHS; or

(C) The sale or other disposition of all, or substantially all, of the assets of CHS to any Person (other than a transfer to a Subsidiary or under conditions that would constitute a Non-Control Transaction with the disposition of assets being regarded as a Merger for this purpose or the distribution to the CHS' stockholders of the stock of a Subsidiary or any other assets).

Notwithstanding the foregoing, a Change in Control shall not be deemed to occur solely because any Person ("Subject Person") acquired Beneficial Ownership of more than the permitted amount of the then-outstanding Shares or Voting Securities as a result of the acquisition of Shares or Voting Securities by CHS which, by reducing the number of Shares or Voting Securities then-outstanding, increases the proportional number of shares Beneficially Owned by the Subject Person, provided that if a Change in Control would occur (but for the operation of this sentence) as a result of the acquisition of Shares or Voting Securities by CHS, and after such share acquisition by CHS the Subject Person becomes the Beneficial Owner of any additional Shares or Voting Securities which increases the percentage of the then-outstanding Shares or Voting Securities Beneficially Owned by the Subject Person, then a Change in Control shall occur.

(g) "CHS" shall mean Community Health Systems, Inc., a Delaware corporation.

(h) "Code" shall mean the Internal Revenue Code of 1986, as amended from time to time, or any successor thereto.

(i) "Committee" shall mean the Compensation Committee of the Board of CHS.

(j) "Company" shall mean CHS/Community Health Systems, Inc., a Delaware corporation; provided, however, that Company shall mean Community Health Systems, Inc. prior to May 25, 2005, for the purposes of determining the rights, powers, and obligations under the terms of the Plan of the plan sponsor.

(k) "Compensation" shall mean only the salary plus the bonus paid to a Participant.

(l) "Disabled Participant" shall mean any Participant who has been credited with five years of Service and who Separates from Service by reason of being Totally and Permanently Disabled.

(m) "Early Retirement Date" shall mean the date a Participant has been credited with at least five years of Service and is at least 55 years old.

(n) "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

(o) "Final Average Earnings" shall mean an amount equal to (i) the sum of a Participant's Compensation for the highest three years out of the last five full years of Service preceding a Participant's termination of employment with the Company and its Subsidiaries, divided by (ii) three.

(p) "Key Employee" shall mean an employee (other than an Officer) of CHS, the Company, or a Subsidiary who has been selected by the Committee to be a Participant.

(q) "Monthly Retirement Income" shall mean a monthly income computed as provided in the Plan.

(r) "Normal Retirement Date" shall mean the day of a Participant's 65th birthday.

(s) "Officer" shall mean all employees of CHS, the Company, or a Subsidiary who have been duly elected as officers of CHS by the Board of CHS.

(t) "Participant" shall mean any Officer or Key Employee.

(u) "Primary Insurance Amount" as of any date shall mean the monthly amount of Social Security old age and survivor disability insurance benefits received or receivable by a Participant commencing at the Participant's unreduced Social Security retirement age. The amount will be calculated based on the Social Security Act in effect as of the date of calculation, without regard to any dependent benefits.

(v) "Rabbi Trust" shall mean the trust to be established by the Company in accordance with the provisions of Section 8.

(w) "Retired Participant" shall mean any Participant who has ceased to be an employee of the Company or a Subsidiary and who is entitled to receive a benefit under Section 5 of the Plan.

(x) "Separation from Service" or "Separate from Service" means a separation from service as set forth in Code Section 409A(a)(2)(A)(i) and defined in regulations promulgated by the U.S. Department of Treasury thereunder, provided, however, that a Participant shall not be deemed to have Separated from Service on account of a leave of absence until the first date immediately following the end of a 29-month period of leave (if the employment relationship is not terminated sooner) where such leave is due to any medically determinable physical or mental impairment that can be expected to result in death or can be expected to last for a continuous period of not less than six months and where such impairment causes the Participant to be unable to perform the duties of his or her position of employment or any substantially similar position of employment.

(y) "Service" shall mean one of the following: (i) in the case of an Officer, all years and completed months of service with the Company and any Subsidiary, whether before or after the adoption of the Plan, but not beginning earlier than January 1, 1997 (as indicated for some Participants in Exhibit A hereto) or, in the alternative, if the Committee so specifies for a designated Participant, additional years and months of service, provided, however, such additional years and months of service shall not exceed two years for every year of completed service and two months for every one month of completed service with the Company, but not beginning before January 1, 1997, and (ii) in the case of an Officer or Key Employee who becomes a Participant after January 1, 2003, all years and completed months of service following the date the person becomes a Participant. If a Participant's name is not listed on Exhibit A, such Participant's Service shall begin on the date described in clause (ii) above.

(z) "Specified Employee" means "specified employee" as defined in Code Section 409A(a)(2)(B)(i) and the regulations promulgated by the U.S. Department of Treasury thereunder. For purposes of the preceding sentence, "specified employee" means a "key employee" of the Company as defined in Code Section 416(i) without regard to paragraph (5) thereof. A Participant shall be a "key employee" of the Company if the Participant meets the requirements of Code Section 416(i)(1)(A)(i), (ii) or (iii) (applied in accordance with the regulations thereunder and disregarding Code Section 416(i)(5)) at any time during any 12-month period ending on December 31 (the "Identification Date"). If a Participant is a "key employee" of the Company as of the Identification Date, the Participant shall be treated as a Specified Employee for the 12-month period beginning on the first day of the fourth month following the Identification Date.

(aa) "Subsidiary" shall mean, with respect to CHS or the Company, as applicable, any corporation or other entity of which a majority of its voting power, equity securities or equity interests is owned, directly or indirectly, by CHS or the Company, as applicable.

(bb) "Total and Permanent Disability" shall mean a physical or mental condition that renders a Participant eligible for disability benefits under the long-term disability insurance program in effect at the Company on the date of this amendment and restatement of the Plan, even if such Participant no longer participates in such long-term disability program on the date such physical or mental condition occurs.

2.2 ***Captions; Section References.*** Section titles or captions contained in the Plan are inserted only as a matter of convenience and reference, and in no way define, limit, extend or describe the scope of the Plan, or the intent of any provision hereof. All references herein to Sections shall refer to Sections of the Plan unless the context clearly requires otherwise.

2.3 ***Severability.*** If any provision of the Plan, or the application thereof to any person, entity or circumstances, shall be invalid or unenforceable to any extent, the remainder of the Plan, and the application of such provision to other persons, entities or circumstances, shall not be affected thereby and the Plan shall be enforced to the greatest extent permitted by law.

3. Administration.

3.1 ***The Committee.*** The Plan shall be administered by the Committee. The Committee shall meet at such times and places as it determines and may meet through a telephone conference call.

3.2 ***Authority of the Committee.*** Subject to the provisions of the Plan, the Committee shall have full authority to:

(a) Select Key Employees.

(b) Construe and interpret the Plan.

(c) Establish, amend and rescind rules and regulations for the Plan's administration.

(d) Make all other determinations which may be necessary or advisable for the administration of the Plan.

To the extent permitted by law, the Committee may delegate its authority as identified hereunder.

3.3 ***Decisions Binding.*** All determinations and decisions made by the Committee pursuant to the provisions of the Plan, and all related orders or resolutions of the Board, shall be final, conclusive and binding upon all persons, including the Company, its stockholders, employees, Participants and their estates and Beneficiaries.

3.4 ***Plan Administrator.*** For purposes of ERISA, the Committee is the Plan administrator. Any claim for benefits under the Plan shall be made in writing to the Committee. The Committee and the claimant shall follow the claims procedures set forth in Department of Labor Regulation §2560.503-1.

3.5 ***Costs and Expenses.*** In discharging their duties under the Plan, the Committee may employ such counsel, accountants and consults as it deems necessary or appropriate. The Company shall pay all costs of such third parties and any other expenses incurred by the Committee with respect to the Plan.

3.6 ***Indemnification.*** No member of the Committee, nor any officer or employee acting on behalf of the Committee, CHS, the Company, or its Subsidiaries shall be personally liable for any action, determination or interpretation taken or made in good faith with respect to the Plan, and all members of the Committee, and each and every officer or employee of CHS, the Company, or its Subsidiaries acting on their behalf, shall, to the extent permitted by law, be fully indemnified and protected by the Company with respect to any such action, determination or interpretation.

4. Participation in the Plan.

4.1 ***Notification of Participation.*** Each Officer and Key Employee shall be notified that they are a Participant under the Plan.

4.2 ***Termination of Participation.*** A Participant who ceases to be an Officer or a Key Employee of the Company (as determined by the Committee), or who terminates employment with the Company and all Subsidiaries for any reason other than death or Total and Permanent Disability, shall not be entitled to any benefits hereunder unless that change of status occurs after the Participant has reached their Early Retirement Date.

5. Benefits Upon Separation from Service or Death.

5.1 ***Normal Retirement Benefit.*** A Participant (including, without limitation, a Specified Employee) who has been credited with at least five years of Service and Separates from Service by reason of retirement on or after the Participant's Normal Retirement Date shall receive a single lump-sum payment, commencing on the day immediately following the date that is six (6) months after the date of the Participant's Separation from Service, in an amount that is the Actuarial Equivalent of a Monthly Retirement Income equal to:

(i) one-twelfth of the Participant's Annual Retirement Benefit, reduced by

(ii) the Primary Insurance Amount.

If a Participant who has had a Separation from Service and is entitled to a Normal Retirement Benefit under this Section 5.1 dies prior to the date of such payment, such payment shall be made, instead, to the Participant's Beneficiary on the date that it otherwise would have been made to the Participant, or as soon as administratively feasible thereafter within the same taxable year (or, if later, by the 15th day of the third calendar month following the date the payment otherwise would have been made to the Participant, provided that neither the Participant nor Beneficiary shall be permitted, directly or indirectly, to designate the taxable year of payment).

5.2 ***Early Retirement Benefit.*** A Participant (including, without limitation, a Specified Employee) who Separates from Service by reason of retirement after attaining age 55 and who has been credited with at least five years of Service shall receive a single lump-sum payment, commencing on the day immediately following the date that is six (6) months after the date of the Participant's Separation from Service, in an amount that is the Actuarial Equivalent of a Monthly Retirement Income computed in the manner set forth in Section 5.1, except that the amount set forth in Section 5.1 shall be reduced by two/twelfths of one percent (.001667) of that amount for each month that payments commence prior to the Participant's Normal Retirement Date. The reduction referred to in the immediately preceding sentence shall not apply in the event of a Change in Control. If a Participant who has had a Separation from Service and is entitled to an Early Retirement Benefit under this Section 5.2 dies prior to the date of such payment, such payment shall be made, instead, to the Participant's Beneficiary on the date that it otherwise would have been made to the Participant, or as soon as administratively feasible thereafter within the same taxable year (or, if later, by the 15th day of the third calendar month following the date the payment otherwise would have been made to the Participant, provided that neither the Participant nor Beneficiary shall be permitted, directly or indirectly, to designate the taxable year of payment).

5.3 *Disability Benefit.*

(a) A Disabled Participant (including, without limitation, a Specified Employee) shall receive a single lump-sum payment, commencing on the later of (i) the day immediately following the date that is six (6) months after the date of the Participant's Separation from Service by reason of becoming Totally and Permanently Disabled, or (ii) the first day of the month following the Participant's 55th birthday, in an amount that is the Actuarial Equivalent of a Monthly Retirement Income computed in the manner set forth in Section 5.1. This benefit shall be payable at the time prescribed in this Section 5.3(a) regardless of whether the Participant recovers from the disability before payment is due.

(b) If a Disabled Participant dies before the payment of the benefit described in Section 5.3(a), a death benefit shall be payable to the Disabled Participant's Beneficiary. Such death benefit shall be a single lump-sum payment equal to the Actuarial Equivalent present value of a Monthly Retirement Income as of the Participant's date of death, computed in accordance with the provisions of Section 5.3(a). Such death benefit shall be paid to the Participant's Beneficiary no later than ninety (90) days after the date of death (provided that neither the Participant nor Beneficiary shall be permitted, directly or indirectly, to designate the taxable year of payment).

5.4 ***Death Benefit.*** If a Participant who has been credited with five or more years of Service dies prior to incurring a Separation from Service, a single, lump-sum death benefit shall be paid to the deceased Participant's Beneficiary. Such death benefit shall be the Actuarial Equivalent of the Participant's Monthly Retirement Income as of the Participant's date of death, computed in the same manner as provided in Section 5.3(a) in the case of a Disabled Participant. Such death benefit shall be paid to the deceased Participant's Beneficiary no later than ninety (90) days after the date of death (provided that neither the Participant nor Beneficiary shall be permitted, directly or indirectly, to designate the taxable year of payment).

5.5 ***Termination for Cause.*** If a Participant's employment is terminated due to Cause, then notwithstanding anything else set forth herein, such Participant shall not be entitled to receive any benefit under the Plan.

6. Benefits Upon Change in Control.

6.1 ***Change in Control Benefit.*** In the event of a Change in Control, the benefit of any Participant with five years or more of Service but not yet otherwise entitled to a benefit under the other provisions of this Plan shall be fully vested and shall be paid out as soon as administratively feasible but no later than ninety (90) days after the Change in Control (provided that the Participant shall not be permitted, directly or indirectly, to designate the taxable year of payment) in a single lump-sum payment pursuant to the applicable provisions in Section 5. Upon such payment to all Participants, the Plan shall terminate.

6.2 ***Participants Under Age 55.*** Any Participant who has been credited with five years or more years of Service on the date of the Change in Control who is under age 55 will be deemed to be age 55 solely for purposes of determining if the Participant is eligible for benefits under the Plan but, in computing the lump sum payment provided for in Section 6.1 and the applicable provisions of Section 5, the Monthly Retirement Income shall be deemed payable based upon the Participant's actual age on the date of the Change in Control.

6.3 *Additional Years of Service.* All Participants who have been credited with five years or more of Service as of a Change in Control will be credited with an additional three years of Service as a result of a Change in Control.

6.4 *Certain Terminations of Employment.* If a Participant's employment is terminated by the Company without Cause prior to the date of a Change in Control, but the Participant reasonably demonstrates to the satisfaction of the Committee that the termination (i) was at the request of a third party who has indicated an intention to, or has taken steps reasonably calculated to, effect a Change in Control, or (ii) otherwise arose in connection with, or in anticipation of, a Change in Control which has been threatened or proposed, such termination shall be deemed to have occurred after a Change in Control for purposes of the Plan, provided a Change in Control actually occurs. Such a Participant shall be entitled to receive the same benefits under the Plan as if the Participant had been an employee of the Company or a Subsidiary on the date the Change in Control actually occurs. Notwithstanding the foregoing, no payment under this Section 6.4 shall be made before the date that is six (6) months after the date of the Participant's actual Separation from Service.

7. **Beneficiaries.** Each Participant shall have the right, by giving written notice to the Committee on such form as the Committee shall adopt, to designate a Beneficiary or Beneficiaries to receive payments which become available under the Plan should the Participant die. A Participant may change the designated Beneficiary by filing a new beneficiary designation form with the Committee. If a Participant dies and has not designated a Beneficiary, or if the Beneficiary predeceases the Participant, the estate of the deceased Participant shall be deemed to be the Beneficiary.

8. **Rabbi Trust.** The Company intends to establish a Rabbi Trust with a commercial bank or other financial or trust institution of which the Company would be considered the owner for Federal income tax purposes. The Rabbi Trust will be established to provide a source of funds to enable the Company to make payments to the Participants and their Beneficiaries pursuant to the terms of the Plan and will be administered in a manner consistent with the requirements of Code Section 409A. Payments to which Participants are entitled under the terms of the Plan shall be paid out of the Rabbi Trust to the extent of the assets therein. The assets of the Rabbi Trust will be subject to the claims of general creditors of the Company.

9. **Withholding.** The Company shall have the right to withhold from the payments to be made to any Participant or Beneficiary hereunder all amounts required to be so withheld under applicable law.

10. Modification and Termination.

10.1 *Amendment and Termination.* The Company reserves the right at any time, by action of the Board, to modify or amend, in whole or in part, any or all of the provisions of the Plan, or to terminate the Plan. In the event of Plan termination, benefits shall be payable at the time and in the manner provided in Sections 5 and 6; however, the Company may accelerate the time and form of payment pursuant to a termination and liquidation of the Plan in accordance with Code Section 409A and the regulations thereunder.

10.2 *Effect on Participants.* Notwithstanding the provisions of Section 10.1, no amendment, modification or termination of the Plan shall adversely affect:

(a) The Monthly Retirement Income of any Participant, or the Beneficiary of any Participant, who has Separated from Service or died prior thereto.

(b) The right of any Participant then employed by the Company or a Subsidiary who has been credited with at least five years of Service to receive upon death, Separation from Service (including Separation from Service by reason of Total and Permanent Disability) or Change in Control, the benefit to which such person would have been entitled under the Plan prior to the amendment, modification or termination, provided, however, that the Company may accelerate the time and form of payment pursuant to a termination and liquidation of the Plan in accordance with Code Section 409A and the regulations thereunder.

10.3 ***No Obligation to Continue Plan.*** Although it is the intention of the Company that the Plan shall be continued indefinitely, the Plan is entirely voluntary on the part of the Company, and the continuance of the Plan is not a contractual obligation of the Company.

11. Claims and Review Procedures. The Committee shall establish and maintain reasonable procedures governing the filing of claims, notification of benefit determinations, and appeal of adverse benefit determinations in accordance with applicable law. Such procedures shall provide for adequate notice in writing to any Participant or Beneficiary whose claim for benefits under the Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Participant or Beneficiary. Such procedures shall also afford a reasonable opportunity to any Participant or Beneficiary whose claim for benefits has been denied for a full and fair review by the Committee of the decision denying the claim.

12. Miscellaneous Provisions.

12.1 ***Non-Transferability.*** Neither the interest of a Participant or any other person in the Plan, nor the benefits payable hereunder, shall be subject to the claim of creditors of a Participant or their Beneficiaries and will not be subject to attachment, garnishment or any other legal process. Neither a Participant nor a Beneficiary may assign, sell, pledge or otherwise encumber any of their beneficial interest in the Plan, nor shall any such benefits be in any manner liable for, or subject to, the deeds, contracts, liabilities, engagements or torts of any Participant or their Beneficiary. All such payments and rights thereto are expressly declared to be non-assignable and non-transferable, and in the event of any attempted assignment or transfer (whether voluntary or involuntary) by a Participant or a Beneficiary, the Company shall have no further liability hereunder to such Participant or Beneficiary.

12.2 ***Payment of Benefits.*** Although the Company intends to establish the Rabbi Trust to fund its obligations under the Plan, the rights of Participants and Beneficiaries to receive payments under the Plan shall constitute only a general claim against the Company and will not be a lien or claim on any specific assets of the Company.

12.3 ***No Rights of Employment.*** The Plan shall not be deemed to constitute a contract of employment between a Participant and the Company or a Subsidiary. Nothing contained in the Plan shall be deemed to give any Participant the right to be retained in the employment of the Company or a Subsidiary. The Plan shall not interfere in any way with the Company's or a Subsidiary's right to discharge a Participant at any time, regardless of the effect which such discharge would have upon such Participant under the Plan, and such actions by the Company or a Subsidiary in discharging any Participant shall not be deemed a breach of contract, nor give rise to any rights or actions in favor of such Participant.

12.4 ***Applicable Law.*** The Plan shall be governed by, and construed in accordance with, the laws of the State of Tennessee without regard to its conflict of laws rules. It is intended that the Plan be an unfunded plan maintained primarily for the purpose of providing deferred compensation for a select group of highly compensated employees of the Company. As such, the Plan is intended to be exempt from certain otherwise applicable provisions of Title I of ERISA, and any ambiguities in construction shall be resolved in favor of an interpretation which will effectuate such intention. The Plan is intended to comply with Code Section 409A and the Treasury Regulations promulgated thereunder as applicable to nonqualified deferred compensation plans and shall be construed in furtherance of such intent.

12.5 ***Payment to Minors.*** In making any payment to or for the benefit of any minor or incompetent Beneficiary, the Committee, in its sole, absolute and uncontrolled discretion, may, but need not, make such payment to a legal or natural guardian or other relative of such minor or court appointed committee of such incompetent, or to any adult with whom such minor or incompetent temporarily or permanently resides, and the receipt by such guardian, committee, relative or other person shall be a complete discharge of the Company, without any responsibility on its part or on the part of the Committee to see to the application thereof.

IN WITNESS WHEREOF, the Company has caused the Plan to be executed by its duly authorized officer the 10th day of December, 2008, being the date the Board approved the Plan.

CHS/COMMUNITY HEALTH SYSTEMS, INC.

By: /s/ Rachel A. Seifert

Title: Senior Vice President

Exhibit 10.14

SUPPLEMENTAL EXECUTIVE BENEFITS

(Effective as of December 31, 2008)

INTRODUCTION

This document outlines the supplemental benefits for eligible executive employees of affiliates of Community Health Systems, Inc. ("Employer" or the "Company"), including the hospital companies that are consolidated with the Company. Benefits are provided by the entity that employs the particular eligible executive (the "Employer"), provided, however, certain benefits are provided through group plans sponsored by Employer/Community Health Systems, Inc. The benefits described in this document substitute in their entirety the benefit categories below that were previously provided by the Supplemental Survivor and Accumulation Plan.[1]

- Survivor Benefits
- Post-Termination Benefits
- Severance Benefits

Plan benefit categories are based upon your position with an affiliate of the Company. The following benefit categories are referenced throughout this summary:

Executive Corporate Vice Presidents and Above

Group 1 Vice Presidents (non-officer)
Corporate Management Grades 7-9
Facility Chief Executive Officers

Group 2 Corporate Management Grades 4-6
Facility Assistant Chief Executive Officers
Facility Chief Financial Officers
Facility Chief Nursing Officers

Benefit category determination is the exclusive right of the Employer its sole discretion.

As used in this document, "Cause" means gross neglect of duties, which gross neglect continues more than 30 days after receiving written notice from the chief executive officer of the Company, its board of directors, or other officers of the Company or Employer of the actions or inactions constituting gross neglect; insubordination; intentional misconduct or deliberate disruption of the workplace and working environment; conviction of a felony; dishonesty, embezzlement, theft, or fraud committed in connection with employment resulting in substantial financial harm to the Company; the issuance of any final order for your removal as an employee or representative of the Company or Employer by any state or federal regulatory agency; and your material breach of any duty owed to the Company or Employer, including without limitation the duty of loyalty. "Cause" shall not include ordinary negligence or failure to act, whether due to an error in judgment or otherwise, if you have exercised substantial efforts in good faith to perform the duties reasonably assigned or appropriate to your position.

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1 The retirement benefits that were provided under the now terminated Supplemental Survivor and Accumulation Plan were discontinued in 2002 and were provided for separately.

SURVIVOR BENEFITS

Survivor benefits are life insurance proceeds intended to provide cash to your beneficiary(ies) in the event of your death. These Survivor Benefits are provided through group-term life insurance or a combination of group-term life insurance and individually-owned life insurance policies, as determined by the plan sponsor.

Amount of Benefit.

Executive 4X Base Salary

Group 1 3X Base Salary

Group 2 2X Base Salary

Your survivor benefits may be subject to the terms of any Benefit Exchange Agreement entered into between you and the Company.

POST-TERMINATION BENEFITS

Post-termination benefits are generally designed to provide supplemental retirement benefits. They are provided through contributions to a combination of one or more of the following:

- the Employer/Community Health Systems, Inc. Deferred Compensation Plan (Vice President (non-officer) and above);
- the Community Health Systems, Inc. Supplemental Executive Retirement Plan (Corporate Vice Presidents and above);
- matching contributions under the Community Health Systems, Inc. 401(k) Plan; and
- any other non-qualified retirement plan of the Company or any affiliate.

You should refer to the underlying policies and/or plan documents relating to these benefits to learn more about eligibility and your right to post-termination benefits under these policies and plans. Certain post-termination benefits are also subject to the terms of any Benefit Exchange Agreement entered into between you and the Company.

SEVERANCE BENEFITS

Payout upon Termination (Salary and Vacation Time).

In the event you are terminated from your employment by your Employer, without Cause, severance benefits of a multiple of your then base monthly salary will be paid to you based upon your position, as shown in the schedule below:

Benefits Category	*Severance Multiple*
President	24 months
Executive Vice President	24 months
Senior Vice President	12 months
Corporate Vice President	12 months
Vice President (non-officer)	9 months
Group 1	6 months
Group 2	3 months

The vacation time payout for Corporate Vice Presidents and above (for whom no accruals are maintained) shall be based upon a reasonable estimate of the vacation time taken during the twelve month period preceding the date of termination.

Additional Payments (to be made no later than March 15th of the year following termination)

In addition, if your employment is terminated without Cause, you will receive and additional amount of severance pay determined as follows:

All Levels: the Employer shall pay the Executive, at the same time that the Employer makes annual bonus payments under the 2004 Employee Performance Incentive Plan (or any replacement or successor plan providing for similar benefits, collectively the "Incentive Plan") to other senior executives, a pro rata portion of the annual bonus that would have been paid to the Executive under the Incentive Plan in respect of the year in which the termination date occurred had the Executive remained employed through the applicable payment date under the Incentive Plan, calculated by multiplying such amount by a fraction, the numerator of which is the number of days in the year though the termination date and the denominator of which is 365.

Termination within First 12 Months of Employment

If your employment is terminated without Cause before completing 12 full months of employment, you will only receive one-half of the salary benefits provided for above and none of the bonus benefit. Severance payments will be in the form of a lump sum payment or salary continuation, as determined by Employer, and subject to withholdings and other deductions as described below.

COBRA Payment Limitation

In addition to the severance benefits described above, terminated employees who elect continuation health coverage under COBRA will be required to pay only the equivalent of the *active employee premium* for this coverage for a period of time equal the time period applicable to such employee based on the above chart, subject to the eligibility provisions of COBRA coverage.

Release.

As a condition of providing any payments and/or benefits described above. you will be required to execute a comprehensive full and final release agreement satisfactory to the Company and substantially in the form attached as Attachment 2, as amended from time to time.

Stock Options.

The respective Plans and Stock Option Agreements under which they were granted govern any stock options and any capitalized terms used in this section. Generally, all vesting will cease on your date of termination of employment, without regard to the reason, provided, however, if you are terminated for Cause, all options are forfeited. If your employment is terminated without Cause, you will have an additional 90 days from the date of termination of employment to exercise your vested stock options.

Restricted Stock Awards.

The respective Plans and Restricted Stock Award Agreements under which they were granted govern any awards of restricted stock and any capitalized terms used in this section. Upon any termination by you, your restricted stock awards that have not already lapsed will be forfeited. Generally, for awards granted after January 1, 2009, upon a termination by your employer that is without Cause, the award will not be forfeited. Subject to the following sentence, upon termination by your employer without Cause, or upon death or disability the award will accelerate and the restrictions will immediately lapse. Notwithstanding the foregoing, in the event the date of termination is prior to either (a) the first anniversary date of the award or (b) prior to the attainment of any performance objective required under any performance based restricted stock award, then the award will not lapse until both (a) and (b), if applicable, have been attained, and if attained, then all restrictions on the entire award shall lapse.

Attachment 1

RELEASE OF CLAIMS AGREEMENT

In consideration of the severance benefits to be paid by Employer, an affiliate of Employer/Community Health Systems, Inc. ("Employer"), to the undersigned employee ("Employee"), Employer and the Employee agree and enter into this Release of Claims Agreement ("Agreement") as follows:

1. Termination of Employment. The Employee acknowledges that the Employee's employment with Employer is terminated on and as of date of termination specified at the end of this Agreement. The Employee further acknowledges that the Employee has no right of, nor will the Employee seek, recall, rehire, or reinstatement of employment with Employer, its parent company, its subsidiaries, or its affiliates.

2. Severance Pay. Employer will pay the Employee severance pay in the gross amount of $___, based on ___months of salary [and additional amount, if applicable], subject to withholding for income taxes and deductions for employment taxes, in accordance with the CHS/Community Health Systems, Inc. Supplemental Benefit Plan ("Plan"). Employer may offset from the payment of severance pay the cost of any Employer property that Employer has agreed to sell to the Employee.

3. Medical Benefits. Provided the Employee properly elects continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), Employer agrees it will pay for the cost of such continuation coverage for the Employee (and, to the extent such coverage is provided by Employer at the time of termination, the Employee's current eligible spouse and other current eligible dependents, if any), as provided below, under Employer's group health plan in accordance with the provisions of such plan through the later of the date specified at the end of this Agreement or the date the Employee becomes covered under a subsequent employer's group health plan. However, the Employee shall pay the amount of monthly premium payment regularly paid by a then-current regular employee of Employer for such coverage, and Employer will pay only the difference between the COBRA premium payment and the portion of the premium paid by the Employee through the later of the date specified at the end of this Agreement or the date the Employee becomes covered under a subsequent employer's group health plan.

4. Consideration. The Employee hereby acknowledges that the consideration for entering into this Agreement is the above-stated severance pay and benefits contained in Sections 2 and 3. The Employee further acknowledges that the Employee has been paid all monies owed to and/or earned by the Employee based upon the Employee's employment with Employer, its parent company, its subsidiaries, or affiliates, including but not limited to wages, bonuses, and vacation pay.

5. Release. The Employee, on the Employee's own behalf and on behalf of the Employee's heirs, executors, administrators, personal representatives, successors, assigns, agents, servants, and attorneys, whether past, present, or future (collectively, the "Releasing Parties"), releases and forever discharges Community Health Systems, Inc., its subsidiaries, affiliates, successors, assigns, agents, servants, representatives, shareholders, owners, members,

directors, officers, and employees, whether past, present, or future, including without limitation, Employer (collectively, the "Released Parties"), from any and all claims, causes of action, liabilities, covenants, agreements, obligations, damages, and/or demands of every nature, character, and description, without limitation in law, equity, or otherwise, that the Employee had, has, or may now have, whether known or unknown, whether vicarious, derivative, direct, or indirect (collectively, the "Released Claims"), including, but not limited to, (i) any claims under the Age Discrimination in Employment Act, Title VII of the Civil Rights Act of 1964, the Fair Labor Standards Act, the Equal Pay Act, the Employment Retirement Income Security Act, the Family and Medical Leave Act, the Americans with Disabilities Act, the Tennessee Human Rights Act, and any other federal, state or local laws, (ii) any claims for wrongful discharge or wrongful termination, defamation, breach of contract, breach of any implied duty or covenant of good faith and fair dealing, retaliation, infliction of emotional distress, or any other right or claim arising out of or related in any way to the Employee's employment with Employer or any of its subsidiaries or affiliates and/or the termination of the Employee's employment with Employer or any of its subsidiaries or affiliates, (iii) any claims for damages (actual, compensatory, punitive, or otherwise and however characterized), back wages, future wages, commission payments, bonuses, reinstatement, vacation leave or paid time off benefits (whether accrued, credited, and/or earned), past and future employee benefits (except to which there is vested entitlement by law), penalties, equitable relief, and any and all other loss, expense, or detriment of whatever kind arising out of or related in any way to the Employee's employment with Employer or any of its subsidiaries or affiliates and/or the termination of the Employee's employment with Employer or any of its subsidiaries or affiliates; and (iv) any claims for attorneys' fees, costs, or expenses; provided, however, that the foregoing Released Claims shall not include a claim for the payment or provision of the severance benefits as provided in Section 2 or the COBRA premium payments provided for in Section 3.

6. Covenant Not to Sue and Indemnification. The Employee hereby specifically covenants and agrees that the Employee shall not initiate, or cause to be initiated, a lawsuit against Employer or any of the other Released Parties in the future asserting any Released Claims. Except as prohibited by law, the Employee further agrees to indemnify Employer and all other Released Parties for (i) any sum of money that any of them may hereafter be compelled to pay the Employee or any other Releasing Parties, and (ii) any of Employer's or other Released Parties' legal fees, costs, and expenses associated therewith, on account of the Employee bringing or allowing to be brought on the Employee's behalf any legal action based directly or indirectly upon the Released Claims.

7. Consideration and Revocation Period. The Employee has been advised by Employer of the Employee's right to seek legal counsel. The Employee also acknowledges that the Employee has a period of up to 21 days in which to consider entering into this Agreement, and, as evidenced by the Employee's signature here below, acknowledges that the Employee has had the opportunity to read and review this Agreement and seek legal advice and now, freely and voluntarily, without coercion, agrees to and understands the significance and consequences of its terms. The Employee further acknowledges that, following the date of execution of this Agreement, the Employee has a period of 7 days within which to revoke the Employee's acceptance of the Agreement, in which case this Agreement shall be null and void, the Employee will be contractually obligated to repay any payments or other consideration paid to the Employee by Employer under this Agreement, and Employer will have a right of restitution,

recoupment, and setoff to recover such payments. The Employee understands that, should the Employee not exercise the Employee's right to revoke this Agreement within 7 days of the date of execution, this Agreement shall be held in full force and effect and each party shall be obligated to comply with its requirements. The parties agree that any changes made to this Agreement (material or immaterial) will not start the 21-day period referenced above to run again or otherwise require a new 21-day period for consideration by the Employee.

8. Nondisparagement. The Employee agrees that the Employee shall refrain from engaging in any conduct, verbal or otherwise, that would disparage or harm the reputation of Employer or any of the other Released Parties. Such conduct shall include, but not be limited to, any negative statements made orally or in writing by the Employee about Employer or any of the other Released Parties.

9. Confidentiality of the Agreement. The Employee further agrees that all terms of this Agreement are to be kept confidential and that the Employee will not discuss or disclose the details or terms of this Agreement to any other individual, including but not limited to present or former employees of Employer or any of the other Released Parties, with the exception of the Employee's attorney, spouse, accountant, or other tax adviser, provided such persons agree to maintain the confidentiality of this Agreement.

10. Property and Confidential Information. The Employee agrees that the Employee has returned, or promptly hereafter (but in no event later than three (3) days from the date of termination of employment) will return, to Employer any and all property of Employer or any of the other Released Parties including any and all originals and/or copies of business documents in whatever form including electronic form. The Employee represents that the Employee has taken no action to alter or destroy improperly any such property and agrees not to take any such action directly or indirectly in the future. The Employee further agrees that the Employee will not directly or indirectly disclose to anyone, or use for the Employee's own benefit or the benefit of anyone other than Employer, any "confidential information" that the Employee has received through the Employee's employment with Employer. Confidential information shall include, but not be limited to, Employer's business plans and files; hospital management information; and any other related information of Employer or any of the other Released Parties. The Employee further agrees that, in the event it appears that the Employee will be compelled by law or judicial process to disclose any such confidential information to avoid potential liability, the Employee will notify Employer in writing immediately upon the Employee's receipt of a subpoena or other legal process.

11. No Admission of Liability. The Employee agrees and acknowledges that this Agreement does not constitute any admission by Employer or any of the other Released Parties of any liability or of any violation of any federal or state laws or regulations prohibiting employment discrimination, retaliation, breach of contract, wrongful discharge, wrongful termination, or any other statutory or common law rights or provisions.

12. References. The Employee understands that Employer will provide in response to inquiries from prospective employers only the Employee's dates of employment with Employer, job titles while employed by Employer, and final salary (with written authorization) while employed by Employer, and the Employee agrees to advise all prospective employers that any

requests for information concerning employment with Employer should be directed only to the Human Resources Department in Franklin, Tennessee.

13. Compliance Disclosure. In connection with the termination of the Employee's employment, and pursuant to the CHS Compliance Program and the Code of Conduct, the Employee hereby represents and warrants to Employer and the other Released Parties that the Employee has at all times during the Employee's employment complied with the CHS Compliance Program and the Code of Conduct, and that the Employee has disclosed in writing to the CHS Corporate Compliance Officer any and all instances of known or suspected violations of laws, rules, regulations, or corporate policy by any of the Released Parties. Further, the Employee represents and warrants that the Employee has not brought and has no intention to bring any whistleblower or similar lawsuits (which terms shall include, but not be limited to, a qui tam action under the Federal False Claims Act or any similar laws), claims, or disclosures to any governmental agency that would subject any of the Released Parties to any liability as a result of any violations of any laws, rules, or regulations and that the Employee knows of no facts that would give rise to any such whistleblower or similar lawsuits, claims, or disclosures to any governmental agency. In the event the representations and warranties contained herein become inaccurate or untrue after the date hereof, the Employee agrees that the Employee will notify the CHS Corporate Compliance Officer, in writing, of the necessary corrections to make the representations and warranties accurate and true, prior to initiating any whistleblower or similar lawsuits, claims, or disclosures to any governmental agency. The Employee also agrees to indemnify against and hold Employer and the other Released Parties harmless from any loss, cost, damage, or penalty incurred by Employer or any other Released Parties as a result of any inaccuracy in or breach of the representations, warranties, or agreements contained herein.

14. Miscellaneous Provisions.

(a) This Agreement is executed and delivered within the State of Tennessee, and the rights, duties, and obligations of the parties hereunder shall be construed and enforced in accordance with the laws of the State of Tennessee, except to the extent preempted by the Employee Retirement Income Security Act of 1974, and without the benefit of any rule of construction under which a contract may be construed against the drafter. Venue for any lawsuit arising out of or related to this Agreement will lie in Williamson County.

(b) This writing together with the Plan represents the entire agreement and understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements and understandings of the parties in connection therewith; it may not be altered or amended except by mutual agreement evidenced by a writing signed by both parties and specifically identified as an amendment to this Agreement.

(c) Except as specifically provided above, this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, executors, administrators, personal representatives, successors, and assigns.

(d) If any provision or part of any provision of this Agreement is deemed to be unenforceable in whole by any court of competent jurisdiction, except Section 5, then the parties agree that such provision shall be severed from the Agreement and the remainder of the Agreement shall remain in full force and effect. The parties further agree that, to the extent a court of competent jurisdiction deems any provision of this Agreement unenforceable in part, such court shall have the power to modify the terms of the Agreement by adding, deleting, or changing in its discretion any language necessary to make such provision enforceable to the maximum extent permitted by law, and the parties expressly agree to be bound by any such provision as reformed by the court. Furthermore, if the release provided for under Section 5 of this Agreement is deemed to be void or otherwise unenforceable by any court of competent jurisdiction, then the Employee will be contractually obligated to repay immediately any severance payments and benefits paid to the Employee by Employer under this Agreement, and Employer will have a right of restitution, recoupment, and setoff against the Employee for the recovery of such payments and benefits.

Date of
Termination: ______________

EMPLOYER __________________________________ .:

By: ______________________________________
Name: ____________________________________
Title: _____________________________________

Benefit Payments Guaranteed by:
CHS/COMMUNITY HEALTH SYSTEMS, INC.

By: ______________________________________
Name: ____________________________________
Title: _____________________________________

EMPLOYEE:

Employee's
Signature: ____________________________________

Employee's
Full Name: ____________________________________

Date
Signed: ____________________________________

Witness'
Signature: ____________________________________

Exhibit 10.15

COMMUNITY HEALTH SYSTEMS, INC.
DIRECTORS' FEES DEFERRAL PLAN

Adopted as of December 14, 2004
Amended and Restated as of December 10, 2008

COMMUNITY HEALTH SYSTEMS, INC.
DIRECTOR'S FEES DEFERRAL PLAN

Section 1. Purpose, Participation

(a) Purpose: The purpose of this Directors' Fees Deferral Plan (the "Plan") is to enable Community Health Systems, Inc. (the "Corporation") to attract and retain Directors of outstanding ability by providing them with a mechanism to defer and accumulate Director's fees, meaning (1) the retainer, and (2) fees for attendance at meetings of the Board of Directors of the Corporation (the "Board") and Board committees.

(b) Participation: This Plan extends to Directors of the Corporation not employed by the Corporation or any subsidiary.

Section 2. Payment of Deferred Amounts

(a) Deferral Election: At any time prior to the beginning of a calendar year, a Director may elect that all or any specified portion of the Director's fees to be earned during such calendar year be credited to a Director's Cash Account and/or a Director's Stock Unit Account maintained on such Director's behalf in lieu of payment (a "Deferral Election"). A Director may also make a Deferral Election during the 30 days following the date on which a Director first becomes eligible to receive Director's fees, although any Deferral Election made pursuant to this sentence will apply only to all or any specified portion of the Director's fees earned thereafter. Each Deferral Election must be made on a deferral election form to be provided by the Corporation and must specify (i) the portion of the Director's fees to be deferred, (ii) the Payment Commencement Event (as hereinafter defined), and (iii) the Payment Method (as hereinafter defined). Each Deferral Election must be submitted to the Secretary of the Corporation in writing, and will be deemed to authorize deferral to only a Director's Cash Account except to the extent deferral to a Director's Stock Unit Account is expressly specified.

(b) Effect of Deferral Election: Pursuant to such Deferral Election, the Corporation (i) will not pay the Director's fees covered thereby and (ii) will make payments in accordance with the Deferral Election and this Section 2.

(c) Payment Commencement Event. At the time of making the Deferral Election, a Director will designate as a "Payment Commencement Event" either (1) the Director's "separation from service" (as defined in Section 409A ("Section 409A") of the Internal Revenue

Code of 1986, as amended (the "Code") and the regulations issued thereunder) with the Corporation (or any successor), or (2) the Director's attainment of an age specified by the Director, provided that such age cannot be attained prior to the end of the calendar year following the date on which the Deferral Election is made. In addition, (A) a Director who has elected (2) as a Payment Commencement Event may also elect that, in the event that the Director experiences a separation from service as a Director of the Corporation within one year following a "Change of Control" (as defined in Section 5(g)) and which also constitutes a change in control or effective control of the Corporation or a change in the ownership of a substantial portion of its assets, in each case within the meaning of Section 409A of the Code and the regulations and interpretive guidance issued thereunder (a "Section 409A Change in Control"), the Payment Commencement Event for payments from a deferral account will be the Director's separation from service, and (B) a Director may also elect as a Payment Commencement Event the Director becoming Disabled (as hereinafter defined) if that is earlier than any other Payment Commencement Event elected by the Director. For purposes of this Plan, "Disabled" means that a Director is unable to engage in any substantial gainful activity because of a medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than 12 months.

(d) Payment. Payment of amounts credited to a Director's Cash Account and Stock Unit Account will be made in accordance with the Payment Method elected by the Director in his Deferral Election. For purposes of this Plan, "Payment Method" shall mean, with respect to payments of amounts credited to a Director's Cash Account and Stock Unit Account pursuant to a Deferral Election, either (i) a lump sum payment on the last business day of the calendar quarter in which the Payment Commencement Event (either as originally designated or as subsequently designated pursuant to Section 2(e)) occurs, or (ii) a number of annual installments (not exceeding 15) specified by the Director in his Deferral Election commencing on the last business day of the calendar quarter in which the Payment Commencement Event (either as originally designated or as subsequently designated pursuant to Section 2(e)) occurs and, subject to Section 2(g), continuing to be made on the last business day of that same calendar quarter in each subsequent year. The amount of any installment payment made with respect to amounts subject to a Deferral Election shall equal the sum of (i) the amount subject to that Deferral Election and credited to the Director's Cash Account as of the applicable payment date divided by the number of installments remaining to be paid (including the installment with respect to which the determination is being made) (the "Installment Factor") and (ii) a number of shares of the Corporation's Common Stock, par value $.01 per share (the "Common Stock") equal to the number of Stock Units subject to that Deferral Election and credited to the Director's Stock Unit Account as of the applicable payment date divided by the Installment Factor. Notwithstanding the foregoing, the Payment Method in connection with a separation from service within 2 years following a Section 409A Change in Control shall be a lump sum payment on the last business day of the calendar quarter in which the Payment Commencement Event occurs.

(e) Changes in Payment Commencement Event or Payment Method. A Director may also elect to defer the Payment Commencement Event to a later Payment Commencement Date specified by the Director or change the Payment Method with respect to amounts subject to a Deferral Election. Such elections (1) will not be effective for 12 months after the date on which such election is made, (2) must be made not less than 12 months prior to the date of the first scheduled payment of any amount subject to that Deferral Election, (3) must provide for an additional deferral for a period of not less than 5 years from the date the payment would otherwise have been made (except with respect to amounts payable upon a Director becoming Disabled or upon the death of the Director), and (4) must be submitted to and approved by the Plan Committee. A Director may make no more than one election pursuant to this Section 2(e) in any calendar year with respect to amounts subject to any particular Deferral Election.

(f) Renewal of Payment Commencement and Payment Method Elections. Once a Deferral Election, (including designation of the portion of Director's fees to be deferred, the Payment Commencement Event and the Payment Method) has been made, it will be automatically applied to Director's fees earned in all subsequent calendar years unless the Director changes or revokes such election prior to the commencement of such calendar year. Each such change or revocation must be submitted to the Secretary of the Corporation in writing. However, except as provided in Section 2(e), each Deferral Election is irrevocable as to Director's fees earned prior to the calendar year next following any change or revocation.

(g) Death. A Director may designate a beneficiary (and change such beneficiary, from time to time) for payment of any balance of the deferral account at the Director's death. Upon a Director's death, any balance in the deferral account (including amounts credited to such account as specified in Section 3(b) and Section 4(b)) will be paid to the deceased Director's beneficiary in a lump sum at the end of the first calendar quarter which ends at least 30 days after the Director dies. If no beneficiary has been designated, the Director's estate will be deemed the beneficiary, and any payments pursuant to this Section 2(g) will be paid in a lump sum at the end of the first calendar quarter which ends at least 30 days after appointment of the deceased Director's legal representative.

Section 3. Credits and Debits to Director's Cash Account

(a) Principal. The Corporation will create and maintain on its books a Director's Cash Account for each Director who has made a Deferral Election to such an account under Section 2(a). The Corporation will credit to such account the amount of any Director's fee which would have been paid to the Director but for such Deferral Election, as of the date the fee would have otherwise been payable.

(b) Interest. At the end of each calendar quarter, regardless of whether any other credits are then made to the Director's Cash Account or whether the Director is then a Director, the Corporation will also credit to the Director's Cash Account a sum which is equal to the product of (i) the average daily balance in the Director's Cash Account for the quarter (without regard to any debits made at the end of such quarter), times (ii) one-fourth of the annual Base Rate (prime rate) for corporate borrowers quoted by J.P. Morgan Chase (or any successor thereto) of New York as of the first business day of the quarter.

(c) Debits. At the end of each calendar quarter, the Corporation will make a payment if required under the payment schedule for such Director's Cash Account and will debit the Director's Cash Account for the amount thereof. Payment with respect to a Director's Cash Account will be in cash only.

(d) Mid-quarter Payments. If Payment is to be made other than at the end of a calendar quarter, prior to such payment the Corporation will credit to the Director's Cash Account an amount equal to the product of (i) the average daily balance in the Director's Cash Account for the period from the beginning of the calendar quarter to the date of payment (without regard to any debits to be made upon such payment), times (ii) a fraction of the annual Base Rate (prime rate) for corporate borrowers quoted by J. P. Morgan Chase (or any successor thereto) as of the first business day of the quarter, the numerator of which is the number of days in the period described in clause (i), and the denominator of which is 365.

Section 4. Credits and Debits to Director's Stock Unit Account

(a) Stock Units. The Corporation will create and maintain on its books a Director's Stock Unit Account for each Director who has made a Deferral Election under Section 2(a) and expressly specifies deferral to such Stock Unit Account. The Corporation will credit to such account the number of Stock Units equal to the number of shares of Common Stock that could be purchased with the amount of any Director's fee which the Director has specified be deferred to the Stock Account and which would have been paid to the Director but for such Deferral Election, as of the date the fee would have otherwise been payable. The number of Stock Units will be calculated to three decimals by dividing the amount of the Director's fee as to which a Director's Stock Unit Account Deferral Election was made by the closing price of the Corporation's common stock as reported on the New York Stock Exchange on the date the fee would have otherwise been payable.

(b) Dividends. As of the date any dividend is paid to holders of shares of Common Stock, each Director's Stock Unit Account, regardless of whether the Director is then a Director, will be credited with additional Stock Units equal to the number of shares of Common Stock that could have been purchased with the amount which would have been paid as dividends on that number of shares of Common Stock (including fractions of a share to three decimals) equal to the number of Stock Units attributed to such Director's Stock Account as of the record date applicable to such dividend. The number of additional Stock Units to be credited will be calculated to three decimals by dividing the amount which would have been paid as dividends by the closing price of the Corporation's common stock as reported on the New York Stock Exchange as of the date the dividend would have been paid. In the case of dividends paid in property other than cash, the amount of the dividend shall be deemed to be the fair market value of the property at the time of the payment of the dividend, as determined in good faith by the Plan Committee.

(c) Debits and Calculation of Payments. The Corporation will debit the Director's Stock Unit Account for Stock Units as required under the payment schedule for such Director's Stock Unit Account. Payment with respect to whole Stock Units will be in shares of Common Stock only, at the rate of one shares of Common Stock per Stock Unit. Until such time as shares of Common Stock have been listed on The New York Stock Exchange for issuance under this Plan, only Treasury shares shall be used for such payment. With respect to fractional Stock Units, payment will be made in cash only, and calculated by multiplying the fractional number of the Stock Unit to be debited by the closing price of the Corporation's common stock as reported on the New York Stock Exchange as of the last business day of the week preceding the week of the date the Stock Units are payable. Should payment of shares of Common Stock be made with respect to Stock Units after the record date, but before the payment date applicable to a dividend paid to holders of shares of Common Stock, the dividend that would otherwise have been credited as additional Stock Units to a Director's Stock Unit Account in respect of those shares will be paid to the Directors in cash (or other property) at the same time as the dividend is paid to shareholders generally.

(d) Adjustment. If at any time the number of outstanding shares of Common Stock is increased as the result of any stock dividend, stock split, subdivision or reclassification of shares, the number of Stock Units with which each Director's Stock Unit Account is credited will be increased in the same proportion as the outstanding number of shares of Common Stock is increased. If the number of outstanding shares of Common Stock is decreased as the result of any combination, reverse stock split or reclassification of shares, the number of Stock Units with which each Director's Stock Unit Account is credited will be decreased in the same proportion as the outstanding number of shares of Common Stock is decreased. In the event the Corporation is consolidated with or merged into any other corporation and holders of shares of Common Stock receive shares of the capital stock of the resulting or surviving corporation, there shall be credited to each Director's Stock Unit Account, in lieu of the extant Stock Units, new Stock Units in an amount equal to the product of the number of shares of capital stock exchanged for one share of the Corporation's common stock upon such consolidation or merger, and the number of Stock Units with which such account then is credited. If, in such a consolidation or merger, holders of shares of Common Stock receive any consideration other than shares of the capital stock of the resulting or surviving corporation or its parent corporation, the Plan Committee will determine any appropriate change in Directors' Stock Unit Accounts. In the event of a recapitalization or other corporate transaction affecting the Common Stock, the Plan Committee will determine an appropriate change in Directors' Stock Unit Accounts.

(e) Accounting. Amounts credited to a Director's Cash Account and/or Stock Unit Account in respect of amounts subject to a particular Deferral Election shall at all times be accounted for separately under this Plan. A change in a particular Deferral Election shall apply to all amounts separately accounted for with respect to that Deferral Election. Any references herein to "amounts subject to a Deferral Election" shall be deemed to refer to the amounts deferred pursuant to a particular Deferral Election, amounts credited to a Directors Cash Account and/or Stock Unit Account in respect of those deferrals and any amounts distributed or to be distributed from the Director's Cash Account and/or Stock Unit Account in respect of those deferrals.

Section 5. Unfunded Arrangement

Neither this Plan nor any deferral account will be funded; a deferral account and all entries thereto constitute bookkeeping records only and do not relate to any specific funds or shares of the Corporation. Payments due with respect to balances in a deferral account will be made from the general assets of the Corporation, and the right of any participant to receive future payments under this Plan's provisions will be an unsecured claim against such assets.

Section 6. Administration

(a) Plan Committee. The Plan will be administered by a Plan Committee, which will be the Compensation Committee of the Board, or such other committee as may be appointed by the Board, and may include Directors who have elected to participate in the Plan. No member of the Plan Committee will be liable for any act done or determination made in good faith.

(b) Committee Determination Final. The construction and interpretation of any provision of the Plan by the Plan Committee, and a determination by the Plan Committee of the amount of any deferral account, will be final and conclusive.

(c) Amendments. The Corporation, by action of its Board, reserves the right to terminate, modify or amend this Plan, effective prospectively as of the first day of any calendar quarter; provided, however, that (i) the Plan will not be subject to termination, modification or amendment with respect to any balance of a deferral account and rights therein, including the right to future interest pursuant to Section 3(b) and future dividends pursuant to Section 4(b), unless the affected Director consents and (ii) the Board may delegate to any officer of the Corporation the authority to adopt any amendment to the Plan deemed necessary so that the Plan complies or continues to comply with all applicable law, including without limitation, complying with Section 409A of the Code and the regulations issued thereunder, provided that any such amendment does not result in any material cost to the Corporation.

(d) Non-Alienation. No Director (or estate of a Director) will have power to transfer, assign, anticipate, mortgage or otherwise encumber any rights or any amounts payable hereunder; nor will any such rights or payments be subject to seizure for the payment of any debts, judgments, alimony, or separate maintenance, or be transferable by operation of law in the event of bankruptcy, insolvency, or otherwise.

(e) Expenses. The expenses of administering the Plan will be borne by the Corporation and not be charged against any deferral account.

(f) Withholding. The Corporation may deduct from all cash payments any taxes required to be withheld with respect to such payments. In order to enable the Corporation to meet any applicable federal, state or local withholding tax requirements arising as a result of payments made hereunder in the form of stock, a Director shall pay the Corporation the amount of tax to be withheld or may elect to satisfy such obligation by having the Corporation withhold shares of Common Stock that otherwise would be delivered to the Director pursuant to the deferral account payment for which the tax is being withheld, by delivering to the Corporation other shares of Common Stock owned by the Director prior to the payment date, or by making a payment to the Corporation consisting of a combination of cash and such shares of Common Stock. Such an election shall be made prior to the date to be used to determine the tax to be withheld. The value of any share of common stock to be withheld by, or delivered to, the Corporation pursuant to this Section 6(f) shall be the closing price of the Corporation's common stock as reported on the New York Stock Exchange on the date to be used to determine the amount of tax to be withheld.

(g) Change of Control. A "Change of Control" means the occurrence of any of the following events with respect to the Corporation:

1. An acquisition (other than directly from the Corporation) of any voting securities of the Corporation (the "Voting Securities") by any "Person" (as the term person is used for purposes of Section 13(d) or 14(d) of the Securities Exchange Act of 1934, as amended (the "Exchange Act")), immediately after which such Person has "Beneficial Ownership" (within the meaning of Rule 13d-3 promulgated under the Exchange Act) of more than fifty percent (50%) of the then outstanding shares of the Corporation's Common Stock or the combined voting power of the Corporation's then outstanding Voting Securities; *provided, however*, that in determining whether a Change of Control has occurred shares of Common Stock or Voting Securities which are acquired in a "Non-Control Acquisition" ("as hereinafter defined) shall not constitute an acquisition which would cause a Change of Control. A "Non-Control Acquisition" shall mean an acquisition by (i) an employee benefit plan (or a trust forming a part thereof) maintained by (A) the Corporation or (B) any corporation or other Person the majority of the voting power, voting equity securities or equity interest of which is owned, directly or indirectly, by the Corporation (for purposes of this definition, a "Related Entity"), (ii) the Corporation or any Related Entity, or (iii) any Person in connection with a "Non-Control Transaction" (as hereinafter defined);

2. The individuals who, as of December 10, 2008, are members of the Board (the "Incumbent Board"), cease for any reason to constitute at least a majority of the members of the Board or, following a Merger (as hereinafter defined) which results in a Parent Corporation (as hereinafter defined), the board of directors of the ultimate Parent Corporation; *provided, however,* that if the election, or nomination for election by the Corporation's common stockholders, of any new director was approved by a vote of at least two-thirds of the Incumbent Board, such new director shall, for purposes of this Plan, be considered a member of the Incumbent Board; *provided further, however,* that no individual shall be considered a member of the Incumbent Board if such individual initially assumed office as a result of an actual or threatened solicitation of proxies or consents by or on behalf of a Person other than the Board (a "Proxy Contest") including by reason of any agreement intended to avoid or settle any Proxy Contest; or

3. The consummation of:

(i) A merger, consolidation or reorganization with or into the Corporation or in which securities of the Corporation are issued (a "Merger"), unless such Merger is a "Non-Control Transaction." A "Non-Control Transaction" shall mean a Merger where:

(A) the stockholders of the Corporation immediately before such Merger own directly or indirectly immediately following such Merger at least fifty percent (50%) of the combined voting power of the outstanding voting securities of (x) the corporation resulting from such Merger (the "Surviving Corporation"), if fifty percent (50%) or more of the combined voting power of the then outstanding voting securities of the Surviving Corporation is not Beneficially Owned, directly or indirectly, by another Person (a "Parent Corporation"), or (y) if there is one or more than one Parent Corporation, the ultimate Parent Corporation; and

(B) the individuals who were members of the Incumbent Board immediately prior to the execution of the agreement providing for such Merger constitute at least a majority of the members of the board of directors of (x) the Surviving

Corporation, if there is no Parent Corporation or (y) if there is one or more than one Parent Corporation, the ultimate Parent Corporation;

(ii) A complete liquidation or dissolution of the Corporation; or

(iii) The sale or other disposition of all or substantially all of the assets of the Corporation to any Person (other than a transfer to a Related Entity or under conditions that would constitute a Non-Control Transaction with the disposition of assets being regarded as a Merger for this purpose or the distribution to the Corporation's stockholders of the stock of a Related Entity or any other assets).

Notwithstanding the foregoing, a Change of Control shall not be deemed to occur solely because any Person (the "Subject Person") acquired Beneficial Ownership of more than the permitted amount of the then outstanding shares of Common Stock or Voting Securities as a result of the acquisition of shares of Common Stock or Voting Securities by the Corporation which, by reducing the number of shares of Common Stock or Voting Securities then outstanding, increases the proportional number of shares Beneficially Owned by the Subject Persons, provided that if a Change of Control would occur (but for the operation of this sentence) as a result of the acquisition of shares of Common Stock or Voting Securities by the Corporation, and after such share acquisition by the Corporation, the Subject Person becomes the Beneficial Owner of any additional shares of Common Stock or Voting Securities which increases the percentage of the then outstanding shares of Common Stock or Voting Securities Beneficially Owned by the Subject Person, then a Change of Control shall occur.

(h) Stock Unit Status. Stock Units are not, and do not constitute, shares of Common Stock, and no right as a holder of shares of Common Stock devolves upon a Director by reason of participation in this Plan.

(i) Savings Provision. The Corporation intends for the Plan to comply with Section 409A of the Code and the regulations issued thereunder. If there is ambiguity as to the intent or meaning of any provision of the Plan, such provision shall be interpreted in a manner that complies with Section 409A and regulations promulgated thereunder.

Exhibit 10.17

AMENDMENT TO THE

COMMUNITY HEALTH SYSTEMS, INC.

2004 EMPLOYEE PERFORMANCE INCENTIVE PLAN

WHEREAS, Community Health Systems, Inc. (the "Company") has previously established and currently maintains the Community Health Systems, Inc. 2004 Employee Performance Incentive Plan (the "Plan") for the benefit of certain employees of the Company; and

WHEREAS, the Company has retained the right to amend the Plan; and

WHEREAS, the Company wishes to amend the Plan as set forth herein;

NOW, THEREFORE, the Plan is hereby amended in the following respects, effective as of January 1, 2005:

1. Section 4.10 is hereby added to Article IV of the Plan, "Payment of Performance Incentive Awards," to read as follows:

   Notwithstanding any provision of this Plan to the contrary, in no event shall the payment of Awards or partial Awards under the terms of the Plan be made to the Participant later than the 15th day of the third month of the Fiscal Year following the end of the Fiscal Year for which the Awards have been determined.

2. Except as provided in this Amendment, the provisions of the Plan shall remain in full force and effect.

EXECUTED and **EFFECTIVE** as of the 10th day of December, 2008.

COMMUNITY HEALTH SYSTEMS, INC.

By: /s/ Rachel A. Seifert

Title: Senior Vice President

Exhibit 10.18

RESTRICTED STOCK AWARD AGREEMENT

Community Health Systems, Inc.

THIS AGREEMENT between you and Community Health Systems, Inc., a Delaware corporation (the "Company") governs an award of restricted stock in the amount and on the date specified in your award notification (the "Grant Date").

WHEREAS, the Company has adopted the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan (the "Plan") in order to provide additional incentive to certain employees and directors of the Company and its Subsidiaries; and

WHEREAS, the Committee has determined to grant to you an Award of Restricted Stock as provided herein to encourage your efforts toward the continuing success of the Company.

NOW, THEREFORE, the parties hereto agree as follows:

1. Grant of Restricted Stock.

1.1 The Company hereby grants to you an award of Shares of Restricted Stock (the "Award") in the number set out in an electronic notification by the Company's stock option plan administrator, as may be appointed from time to time (the "Plan Administrator"). The Shares of Restricted Stock granted pursuant to the Award shall be issued in the form of book entry Shares in your name as soon as reasonably practicable after the Date of Grant and shall be subject to your acknowledgement and acceptance (or your estate, if applicable) of this agreement by electronic means to the Plan Administrator as provided in Section 9 hereof, or as you have been otherwise instructed.

1.2 This Agreement shall be construed in accordance and consistent with, and subject to, the provisions of the Plan (the provisions of which are hereby incorporated by reference) and, except as otherwise expressly set forth herein, the capitalized terms used in this Agreement shall have the same definitions as set forth in the Plan.

2. Restrictions on Transfer.

The Shares of Restricted Stock issued under this Agreement may not be sold, transferred or otherwise disposed of and may not be pledged or otherwise hypothecated until all restrictions on such Restricted Stock shall have lapsed in the manner provided in Section 3, 4 or 5 hereof.

3. Lapse of Restrictions Generally.

Except as provided in Sections 4, 5 and 6 hereof, one-third (1/3) of the number of Shares of Restricted Stock issued hereunder (rounded up to the next whole Share, if necessary) shall vest, and the restrictions with respect to such Restricted Stock shall lapse, on each of the first three (3) anniversaries of the Date of Grant.

4. Effect of Certain Terminations of Employment.

If your employment terminates as a result of your death or Disability, in each case if such termination occurs on or after the Date of Grant, all Shares of Restricted Stock which have not become vested in accordance with Section 3 or 5 hereof shall vest, and the restrictions on such Restricted Stock shall lapse, as of the date of such termination. If your employment is terminated by your employer for any reason other than for Cause, then the restrictions on the entire Award shall lapse on the later of the first anniversary date of the Date of Grant and the date of your termination of employment.

5. Effect of Change in Control.

In the event of a Change in Control at any time on or after the Date of Grant, all Shares of Restricted Stock which have not become vested in accordance with Section 3 or 4 hereof shall vest, and the restrictions on such Restricted Stock shall lapse, immediately.

6. Forfeiture of Restricted Stock.

In addition to the circumstance described in Section 9(a) hereof, any and all Shares of Restricted Stock which have not become vested in accordance with Section 3, 4 or 5 hereof shall be forfeited and shall revert to the Company upon the termination by you, the Company or its Subsidiaries of your employment for any reason other than those set forth in Section 4 hereof prior to such vesting.

7. Delivery of Restricted Stock.

7.1 Except as otherwise provided in Section 7.2 hereof, evidence of book entry Shares or, if requested by you prior to such lapse of restrictions, a stock certificate with respect to shares of Restricted Stock for which the restrictions have lapsed pursuant to Section 3, 4 or 5 hereof, shall be delivered to you as soon as practicable following the date on which the restrictions on such Restricted Stock have lapsed, free of all restrictions hereunder.

7.2 Evidence of book entry Shares with respect to shares of Restricted Stock whose restrictions have lapsed upon your death pursuant to Section 4 hereof or, if requested by the executors or administrators of your estate upon such lapse of restrictions, a stock certificate with respect to such shares of Restricted Stock, shall be delivered to the executors or administrators of your estate as soon as practicable following the Company's receipt of notification of your death, free of all restrictions hereunder. All references herein to "you" shall also include your executors, administrators, heirs or assigns in the event of your death.

8. Dividends and Voting Rights.

Subject to Section 9(a) hereof, upon issuance of the Restricted Stock, you shall have all of the rights of a stockholder with respect to such Stock, including the right to vote the Stock and to receive all dividends or other distributions paid or made with respect thereto; provided, however, that dividends or distributions declared or paid on the Restricted Stock by the Company shall be deferred and reinvested in Shares of Restricted Stock based on the Fair Market Value of a Share on the date such dividend or distribution is paid or made (provided that no fractional Shares will be issued), and the additional Shares of Restricted Stock thus acquired shall be subject to the same restrictions on transfer, forfeiture and vesting schedule as the Restricted Stock in respect of which such dividends or distributions were made.

9. Acknowledgement and Acceptance of Award Agreement.

(a) The Shares of Restricted Stock granted to you pursuant to this Award shall be subject to your acknowledgement and acceptance of this Agreement to the Company or its Plan Administrator (including by electronic means, if so provided) no later than the earlier of (i) 180 days from the Date of Grant and (ii) the date that is immediately prior to the date that the Restricted Stock lapses pursuant to Section 4 or 5 hereof (the "Return Date"); provided that if you dies before your Return Date, this requirement shall be deemed to be satisfied if the executor or administrator of your estate acknowledges and accepts this Agreement through the Company or its Plan Administrator designee no later than ninety (90) days following your death (the "Executor Return Date"). If this Agreement is not so acknowledged and accepted executed and returned on or prior to your Return Date or the Executor Return Date, as applicable, the Shares of Restricted Stock evidenced by this Agreement shall be forfeited, and neither you nor your heirs, executors, administrators and successors shall have any rights with respect thereto.

(b) If this Agreement is so acknowledged and accepted and returned on or prior to your Return Date or the Executor Return Date, as applicable, all dividends and other distributions paid or made with respect to the Shares of Restricted Stock granted hereunder prior to such Return Date or Executor Return Date shall be treated in the manner provided in Section 8 hereof.

10. No Right to Continued Employment.

Nothing in this Agreement or the Plan shall interfere with or limit in any way the right of the Company or its Subsidiaries to terminate your employment, nor confer upon you any right to continuance of employment by the Company or any of its Subsidiaries or continuance of service as a Board member.

11. Withholding of Taxes.

Prior to the delivery to you of a stock certificate or evidence of book entry Shares with respect to shares of Restricted Stock whose restrictions have lapsed, you shall pay to the Company or the Company's Plan Administrator, the federal, state and local income taxes and other amounts as may be required by law to be withheld (the "Withholding Taxes") with respect to such Restricted Stock. By acknowledging and accepting this Agreement in the manner provided in Section 9 hereof, you shall be deemed to elect to have the Company or the Plan Administrator withhold a portion of such Restricted Stock having an aggregate Fair Market Value equal to the Withholding Taxes in satisfaction thereof, such election to continue in effect until you notify the Company or its Plan Administrator before such delivery that you shall satisfy such obligation in cash, in which event the Company or the Plan Administrator shall not withhold a portion of such Restricted Stock as otherwise provided in this Section 11.

12. You Are Bound by the Plan.

By acknowledging and accepting this award you hereby confirm the availability, your review of a copy of the Plan and the Prospectus, and other documents provided to you in connection with this award by the Company or its Plan Administrator, and you agree to be bound by all the terms and provisions thereof.

13. Modification of Agreement.

This Agreement may be modified, amended, suspended or terminated, and any terms or conditions may be waived, but only by a written instrument executed by both parties hereto.

14. Severability.

Should any provision of this Agreement be held by a court of competent jurisdiction to be unenforceable or invalid for any reason, the remaining provisions of this Agreement shall not be affected by such holding and shall continue in full force in accordance with their terms.

15. Governing Law.

The validity, interpretation, construction and performance of this Agreement shall be governed by the laws of the State of Tennessee without giving effect to the conflicts of laws principles thereof.

16. Successors in Interest.

This Agreement shall inure to the benefit of and be binding upon any successor to the Company. This Agreement shall inure to the benefit of your legal representatives. All obligations imposed upon you and all rights granted to the Company under this Agreement shall be binding upon your heirs, executors, administrators and successors.

17. Resolution of Disputes.

Any dispute or disagreement which may arise under, or as a result of, or in any way relate to, the interpretation, construction or application of this Agreement shall first be referred to the Chief Executive Officer for informal resolution, and if necessary, referred to the Committee for its determination. Any determination made hereunder shall be final, binding and conclusive on you, your heirs, executors, administrators and successors, and the Company and its Subsidiaries for all purposes.

18. Entire Agreement.

This Agreement and the terms and conditions of the Plan constitute the entire understanding between you and the Company and its Subsidiaries, and supersede all other agreements, whether written or oral, with respect to the Award.

19. Headings.

The headings of this Agreement are inserted for convenience only and do not constitute a part of this Agreement.

20. Deemed Execution. On the date of your electronic acceptance of the terms of the Award and this Agreement, this Agreement shall be deemed to have been executed and delivered by you and the Company.

COMMUNITY HEALTH SYSTEMS, INC.

Exhibit 10.19

DIRECTOR PHANTOM STOCK AWARD AGREEMENT

Community Health Systems, Inc.

THIS AGREEMENT between the Grantee and Community Health Systems, Inc., a Delaware corporation (the "Company"), governs an Award of Phantom Stock in the amount and on the date specified in the Grantee's award notification (the "Grant Date");

WHEREAS, the Company has adopted the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan (the "Plan") in order to provide additional incentive to certain employees and directors of the Company and its Subsidiaries;

WHEREAS, Section 10.2 of the Plan provides for grants of shares of Phantom Stock to Eligible Individuals; and

WHEREAS, the Compensation Committee of the Board of Directors has approved this form of Agreement.

NOW, THEREFORE, the parties hereto agree as follows:

1. Grant of Phantom Stock.

The Company hereby grants to the Grantee an award of Phantom Stock (the "Award") in respect of the number of Shares set out in an electronic notification by the Company's stock option plan administrator (the "Plan Administrator").

This Agreement shall be construed in accordance and consistent with, and subject to, the provisions of the Plan (the provisions of which are hereby incorporated by reference) and, except as otherwise expressly set forth herein, the capitalized terms used in this Agreement shall have the same definitions as set forth in the Plan.

2. Vesting Generally.

Except as provided in Sections 3 and 4 hereof, the Award shall vest in respect of one-third (1/3) of the Shares subject to the Award (rounded up to the next whole Share, if necessary), on each of the first three (3) anniversaries of the Date of Grant.

3. Effect of Certain Terminations of Service.

If the Grantee's service as a member of the Board of Directors terminates as a result of his or her death, Disability, or for any reason other than for Cause, in each case if such termination occurs on or after the Date of Grant, the Award shall become vested in respect of all Shares as to which it had not previously become vested pursuant to Section 2 or 4 hereof as of the date of such termination.

4. Effect of Change in Control.

In the event that a Change in Control which also constitutes a change in control or effective control of the Company or a change in the ownership of a substantial portion of its assets, in each case within the meaning of Section 409A of the Code and the regulations and interpretive guidance issued thereunder (a "Section 409A Change in Control") occurs at any time on or after the Date of Grant and prior to the Grantee's termination of service as a member of the Board of Directors, the Award shall become vested in respect of all Shares as to which it had not previously become vested pursuant to Section 2 hereof as of the date of such Section 409A Change in Control.

5. Delivery of Shares.

Except as otherwise provided in this Section 5, a stock certificate (or other electronic indicia of ownership) with respect to Shares as to which the Award has become vested pursuant to Section 2, 3 or 4 hereof shall be delivered to the Grantee as soon as practicable following the date on which the Award or portion thereof has become vested.

Upon the Grantee's death, a stock certificate (or other electronic indicia of ownership) for the Shares with respect to which the Award or portion thereof has become vested by reason of the Grantee's death pursuant to Section 3 hereof, shall be delivered to the executors or administrators of the Grantee's estate as soon as practicable following the Company's or the Company's Plan Administrator's receipt of notification of the Grantee's death. All references herein to "the Grantee" shall also include the Grantee's executors, administrators, heirs or assigns in the event of the Grantee's death.

6. Forfeiture of Phantom Stock.

In addition to the circumstance described in Section 7(a) hereof, the Award (and any and all Shares in respect thereof), to the extent it has not become vested in accordance with Section 2, 3 or 4 hereof, shall be forfeited upon the termination of the Grantee's service as a member of the Board of Directors for any reason other than those set forth in Section 3 hereof prior to such vesting.

7. Acknowledgement and Acceptance of Award Agreement.

The Award shall be subject to the Grantee's acknowledgement and acceptance of this Agreement to the Company or its Plan Administrator (including by electronic means, if so provided) no later than the earlier of (i) 180 days from the Date of Grant and (ii) the date that is immediately prior to the date that the Award vests pursuant to Section 3 or 4 hereof (the "Return Date"); provided that if the Grantee dies before the Return Date, this requirement shall be deemed to be satisfied if the executor or administrator of the Grantee's estate acknowledges and accepts this Agreement through the Company or its Plan Administrator no later than ninety (90) days following the Grantee's death (the "Executor Return Date"). If this Agreement is not so acknowledged and accepted on or prior to the Return Date or the Executor Return Date, as applicable, the Award (and any and all Shares in respect thereof) shall be forfeited, and neither the Grantee nor the Grantee's heirs, executors, administrators and successors shall have any rights with respect thereto.

8. No Right to Continued Service.

Nothing in this Agreement or the Plan shall interfere with or limit in any way the right of the Company to terminate the Grantee's service on its Board of Directors, nor confer upon the Grantee any right to continuance of such service as a Board member.

9. Withholding of Taxes.

Prior to the delivery of a stock certificate or evidence of book entry Shares with respect to the Award, the Grantee shall pay to the Company or the Company's Plan Administrator, the federal, state and local income taxes and other amounts as may be required by law to be withheld (the "Withholding Taxes") with respect to such Shares, if any. By acknowledging and accepting this Agreement in the manner provided in Section 7 hereof, the Grantee shall be deemed to elect to have the Company or the Company's Plan Administrator, withhold a portion of such Shares having an aggregate Fair Market Value equal to the Withholding Taxes in satisfaction thereof, such election to continue in effect until the Grantee notifies the Company or its Plan Administrator before such delivery that the Grantee shall satisfy such obligation in cash, in which event the Company shall not withhold a portion of such Shares as otherwise provided in this Section 9.

10. The Grantee is Bound by the Plan.

By acknowledging and accepting the Award, the Grantee hereby confirms the availability and his or her review of a copy of the Plan, the Prospectus, and other documents provided to the Grantee in connection with the Award, by the Company or its Plan Administrator, and the Grantee agrees to be bound by all the terms and provisions thereof.

11. Modification of Agreement.

This Agreement may be modified, amended, suspended or terminated, and any terms or conditions may be waived, but only by a written instrument executed by both parties hereto.

12. Severability.

Should any provision of this Agreement be held by a court of competent jurisdiction to be unenforceable or invalid for any reason, the remaining provisions of this Agreement shall not be affected by such holding and shall continue in full force in accordance with their terms.

13. Governing Law.

The validity, interpretation, construction and performance of this Agreement shall be governed by the laws of the State of Tennessee without giving effect to the conflicts of laws principles thereof.

14. Successors in Interest.

This Agreement shall inure to the benefit of and be binding upon any successor to the Company. This Agreement shall inure to the benefit of the Grantee's legal representatives. All obligations imposed upon the Grantee and all rights granted to the Company under this Agreement shall be binding upon the Grantee's heirs, executors, administrators and successors.

15. Resolution of Disputes.

Any dispute or disagreement which may arise under, or as a result of, or in any way relate to, the interpretation, construction or application of this Agreement shall first be referred to the Chief Executive Officer for informal resolution, and if necessary, referred to the Committee for its determination. Any determination made hereunder shall be final, binding and conclusive on the Grantee, his or her heirs, executors, administrators and successors, and the Company and its Subsidiaries for all purposes.

16. Entire Agreement.

This Agreement and the terms and conditions of the Plan constitute the entire understanding between the Grantee and the Company and its Subsidiaries, and supersede all other agreements, whether written or oral, with respect to the Award.

17. Headings.

The headings of this Agreement are inserted for convenience only and do not constitute a part of this Agreement.

18. Deemed Execution.

On the date of the Grantee's electronic acceptance of the terms of the Award, and this Agreement, this Agreement shall be deemed to have been executed and delivered by the Grantee and the Company.

COMMUNITY HEALTH SYSTEMS, INC.

Exhibit 10.20

PERFORMANCE BASED RESTRICTED STOCK AWARD AGREEMENT
(Most Highly Compensated Executive Officers)

Community Health Systems, Inc.

THIS AGREEMENT governs your award of restricted stock made by Community Health Systems, Inc., a Delaware corporation (the "Company").

WHEREAS, the Company has adopted the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan (the "Plan") in order to provide additional incentive to certain employees and directors of the Company and its Subsidiaries;

WHEREAS, the Compensation Committee (the "Committee") of the Board of Directors (as described in Section 3.1 of the Plan) has determined to grant to you an Award of Restricted Stock as provided herein to encourage your efforts toward the continuing success of the Company;

WHEREAS, the Committee has determined to place a performance-based restriction on the Award of Restricted Stock to better align your economic interests with those of the other stockholders of the Company and to ensure that the compensation attributable to this Award of Restricted Stock constitutes "qualified performance-based compensation" pursuant to IRC §162(m) and the regulations promulgated thereunder; and

WHEREAS, the Committee has established the Performance Objective (as defined in Section 3.1 below) (a) utilizing objectively determinable criteria, (b) on a date which is prior to the ninetieth (90th) day of the Company's fiscal year, and (c) at a time when the attainment of the Performance Objective is substantially uncertain..

NOW, THEREFORE, the parties hereto agree as follows:

1. Grant of Restricted Stock.

1.1 The Company hereby grants to you an award of Shares of Performance Based Restricted Stock (the "Award"). The Shares of Performance Based Restricted Stock granted pursuant to this Award shall be issued in the form of book entry Shares in your name as soon as reasonably practicable after the Date of Grant and shall be subject to your acceptance of this grant (or your estate, if applicable) by online communication with the Company's option plan administrator, as may be determined from time to time, and in accordance with Section 9 hereof.

1.2 This Agreement shall be construed in accordance and consistent with, and subject to, the provisions of the Plan (the provisions of which are hereby incorporated by reference) and, except as otherwise expressly set forth herein, the capitalized terms used in this Agreement shall have the same definitions as set forth in the Plan.

2. Restrictions on Transfer.

The Shares of Performance Based Restricted Stock issued under this Agreement may not be sold, transferred or otherwise disposed of and may not be pledged or otherwise hypothecated until all restrictions on such Performance Based Restricted Stock shall have lapsed in the manner provided in Section 3, 4 or 5 hereof.

3. Performance Objective; Lapse of Restrictions.

3.1 The Award is subject to the Company attaining the following "Performance Objective" (herein so called): The Company's "income per share from continuing operations for the fiscal year" in which granted, as reported by the Company in its earnings release for such fiscal year, shall be not less than the amount which is seventy-five percent (75%) of the low end of the projected "income per share from continuing operations for the fiscal year," in which granted as stated in the Company's Form 8-K filed with the SEC for the current fiscal year. The Performance Objective shall be adjusted upward or downward in the event the Company enters into one or more material acquisition or divestiture transactions and as a result thereof or in connection therewith files one or more Forms 8-K issuing revised guidance to investors projecting a higher or lower "income per share from continuing operations for the fiscal year" in which granted, (but only to the extent such change in guidance is attributable to the material acquisition and/or divestiture transactions). The adjusted Performance Objective shall be seventy-five percent (75%) of the low end of the range of revised projected "income per share from continuing operations for fiscal year" in which granted. For purposes of this Agreement, "material acquisition" or "material divestiture" transaction shall mean any single transaction or series of related transactions in which the consideration exceeds fifteen percent (15%) of the Company's assets on a consolidated basis. The computation of "income per share from continuing operations" shall be adjusted for Changes in Capitalization (as defined in the Plan).

3.2 Except as provided in Sections 4, 5 and 6 hereof, if the Performance Objective is not attained, the Award shall lapse in its entirety.

3.3 Except as provided in Sections 4, 5 and 6 hereof, if the Performance Objective is attained, one-third (1/3) of the number of Shares of Performance Based Restricted Stock issued hereunder (rounded up to the next whole Share, if necessary) shall vest, and the restrictions with respect to such Performance Based Restricted Stock shall lapse, on each of the first three (3) anniversaries of the Date of Grant.

4. Effect of Certain Terminations of Employment.

If your employment terminates as a result of your death or Disability, in each case if such termination occurs on or after the Date of Grant, all Shares of Performance Based Restricted Stock which have not become vested in accordance with Section 3 or 5 hereof shall vest, and the restrictions on such Performance Based Restricted Stock shall lapse, as of the date of such termination. If your employment is terminated by your employer for any reason other than for Cause, then your Award shall continue until such time as it is determined that the Performance Objective set forth in Section 3.1 above has been attained, and if attained, then the restrictions on the entire Award shall lapse on the first anniversary of the Date of Grant (or if the termination occurs after the Performance Objective has been attained, the restrictions on the entire Award shall lapse immediately upon such termination); if the Performance Objective is not attained, the Award shall lapse in its entirety.

5. Effect of Change in Control.

In the event of a Change in Control at any time on or after the Date of Grant, all Shares of Performance Based Restricted Stock which have not become vested in accordance with Section 3 or 4 hereof shall vest, and the restrictions on such Performance Based Restricted Stock shall lapse, immediately.

6. Forfeiture of Performance Based Restricted Stock.

In addition to the circumstance described in Section 9(a) hereof, any and all Shares of Performance Based Restricted Stock which have not become vested in accordance with Section 3, 4 or 5 hereof shall be forfeited and shall revert to the Company upon the termination of your employment by the Company or its Subsidiaries for any reason other than those set forth in Section 4 hereof prior to such vesting.

7. Delivery of Restricted Stock.

7.1 Except as otherwise provided in Section 7.2 hereof, evidence of book entry Shares or, if requested by you prior to such lapse of restrictions, a stock certificate with respect to shares of Restricted Stock for which the restrictions have lapsed pursuant to Section 3, 4 or 5 hereof with respect to such shares of Restricted Stock, shall be delivered to you as soon as practicable following the date on which the restrictions on such Restricted Stock have lapsed, free of all restrictions hereunder.

7.2 Evidence of book entry Shares with respect to shares of Restricted Stock in respect of which the restrictions have lapsed upon your death pursuant to Section 4 hereof or, if requested by the executors or administrators of your estate upon such lapse of restrictions, a stock certificate with respect to such shares of Restricted Stock, shall be delivered to the executors or administrators of your estate as soon as practicable following the Company's receipt of notification of your death, free of all restrictions hereunder.

8. Dividends and Voting Rights.

Subject to Section 9(a) hereof, upon issuance of the Performance Based Restricted Stock, you shall have all of the rights of a stockholder with respect to such Stock, including the right to vote the Stock and to receive all dividends or other distributions paid or made with respect thereto; provided, however, that dividends or distributions declared or paid on the Performance Based Restricted Stock by the Company shall be deferred and reinvested in Shares of Performance Based Restricted Stock based on the Fair Market Value of a Share on the date such dividend or distribution is paid or made (provided that no fractional Shares will be issued), and the additional Shares of Performance Based Restricted Stock thus acquired shall be subject to the same restrictions on transfer, forfeiture and vesting schedule as the Performance Based Restricted Stock in respect of which such dividends or distributions were made.

9. Execution of Award Agreement.

(a) The Shares of Performance Based Restricted Stock granted to you pursuant to this Award shall be subject to (i) your acknowledgment and acceptance of this Award and Agreement by electronic notification to the Company's designee (currently UBS Financial Services, Inc.) within 180 days from the date of grant, and (ii) the date that is immediately prior to the date that the Performance Based Restricted Stock vest pursuant to Section 4 or 5 hereof "Your Return Date"); provided that if you die before Your Return Date, this requirement shall be deemed to be satisfied if the executor or administrator of your estate executes and returns this Agreement to the Company or its designee no later than ninety (90) days following the your death (the "Executor Return Date"). If this Agreement is not so executed and returned on or prior to Your Return Date or the Executor Return Date, as applicable, the Shares of Performance Based Restricted Stock evidenced by this Agreement shall be forfeited, and neither you nor your Grantee's heirs, executors, administrators or successors shall have any rights with respect thereto.

(b) If this Agreement is so executed and returned, or electronically acknowledged and accepted on or prior to Your Return Date or the Executor Return Date, as applicable, all dividends and other distributions paid or made with respect to the Shares of Performance Based Restricted Stock granted hereunder prior to Your Return Date or the Executor Return Date shall be treated in the manner provided in Section 8 hereof.

10. No Right to Continued Employment.

Nothing in this Agreement or the Plan shall interfere with or limit in any way the right of the Company or its Subsidiaries to terminate your employment, nor confer upon you any right to continuance of employment by the Company or any of its Subsidiaries or continuance of service as a Board member.

11. Withholding of Taxes.

Prior to the delivery to you (or your estate, if applicable) of a stock certificate or evidence of book entry Shares with respect to shares of Performance Based Restricted Stock in respect of which all restrictions have lapsed, you (or your estate) shall pay to the Company the federal, state and local income taxes and other amounts as may be required by law to be withheld by the Company (the "Withholding Taxes") with respect to such Performance Based Restricted Stock. By executing and returning this Agreement in the manner provided in Section 9 hereof, you (or your estate) shall be deemed to elect to have the Company withhold a portion of such Restricted Stock having an aggregate Fair Market Value equal to the Withholding Taxes in satisfaction of the Withholding Taxes, such election to continue in effect until you (or your estate) notifies the Company or the Company's designee before such delivery that you (or your estate) shall satisfy such obligation in cash, in which event the Company shall not withhold a portion of such Restricted Stock as otherwise provided in this Section 11.

12. You are Bound by the Plan.

You acknowledge receipt of a copy of the Plan and agree to be bound by all the terms and provisions thereof by electronic notification to the Company's designee (currently UBS Financial Services, Inc.) within 180 days from the date of grant.

13. Modification of Agreement.

This Agreement may be modified, amended, suspended or terminated, and any terms or conditions may be waived, but only by a written instrument executed by both parties hereto.

14. Severability.

Should any provision of this Agreement be held by a court of competent jurisdiction to be unenforceable or invalid for any reason, the remaining provisions of this Agreement shall not be affected by such holding and shall continue in full force in accordance with their terms.

15. Governing Law.

The validity, interpretation, construction and performance of this Agreement shall be governed by the laws of the State of Tennessee without giving effect to the conflicts of laws principles thereof.

16. Successors in Interest.

This Agreement shall inure to the benefit of and be binding upon any successor to the Company. This Agreement shall inure to the benefit of your legal representatives. All obligations imposed upon you and all rights granted to the Company under this Agreement shall be binding upon your heirs, executors, administrators and successors.

17. Resolution of Disputes.

Any dispute or disagreement which may arise under, or as a result of, or in any way relate to, the interpretation, construction or application of this Agreement shall first be referred to the Chief Executive Officer for informal resolution, and if necessary, referred to the Committee for its determination. Any determination made hereunder shall be final, binding and conclusive on you, your heirs, executors, administrators and successors, and the Company and its Subsidiaries for all purposes.

18. Entire Agreement.

This Agreement and the terms and conditions of the Plan constitute the entire understanding between you and the Company and its Subsidiaries, and supersede all other agreements, whether written or oral, with respect to the Award.

19. Headings.

The headings of this Agreement are inserted for convenience only and do not constitute a part of this Agreement.

COMMUNITY HEALTH SYSTEMS, INC.

Exhibit 10.22

AMENDED AND RESTATED
CHANGE IN CONTROL SEVERANCE AGREEMENT

THIS AMENDED AND RESTATED CHANGE IN CONTROL SEVERANCE AGREEMENT made as of the ___ day of _________, 2008, by and among Community Health Systems, Inc. (the "Corporation"), Community Health Systems Professional Services Corporation (the "Employer"), and _________ (the "Executive").

WHEREAS, the Board of Directors of the Corporation and the Board of Directors of the Employer (the "Boards") recognize that the possibility of a Change in Control (as hereinafter defined) exists and that the threat or the occurrence of a Change in Control can result in significant distraction of the Employer's key management personnel because of the uncertainties inherent in such a situation;

WHEREAS, the Boards have determined that it is essential and in the best interest of the Employer, and the Corporation and its stockholders, for the Employer to retain the services of the Executive in the event of a threat or occurrence of a Change in Control and to ensure the Executive's continued dedication and efforts in such event without undue concern for the Executive's personal financial and employment security;

WHEREAS, in order to induce the Executive to remain in the employ of the Employer, particularly in the event of a threat or the occurrence of a Change in Control, the Employer desires to enter into this Agreement with the Executive to provide the Executive with certain benefits in the event the Executive's employment is terminated as a result of, or in connection with, a Change in Control;

WHEREAS, the Corporation and the Executive previously entered into a change in control severance agreement (the "Prior Agreement"); and

WHEREAS, the Corporation and the Executive desire to amend and restate the Prior Agreement to comply with Section 409A ("Section 409A") of the Internal Revenue Code of 1986, as amended ("Code"), and the regulations issued thereunder.

NOW, THEREFORE, in consideration of the respective agreements of the parties contained herein, it is agreed as follows:

1. Term of Agreement. This Agreement shall commence as of December 31, 2008, and shall continue in effect until December 31, 2010 (the "Term"); provided, however, that on December 31, 2009, and on each December 31st thereafter, the Term shall automatically be extended for one (1) year unless either the Executive or the Employer shall have given written notice to the other at least ninety (90) days prior thereto (i.e., on or before October 1st immediately preceding) that the Term shall not be so extended; *provided, further, however,* that following the occurrence of a Change in Control, the Term shall not expire prior to the expiration of thirty-six months (36) months[1] after such occurrence.

1 36 months applies to CEO, CFO, and SVPs; change to 24 months for VPs.

2. Termination of Employment. If the Executive's employment with the Employer and with all other Affiliates of the Corporation shall be terminated, the Executive shall be entitled to the following compensation and benefits:

(a) If the Executive experiences a "separation from service" (within the meaning of Section 409A(a)(2)(A)(i) of the Code) with the Employer and all other Affiliates of the Corporation as a result of (i) termination of Executive's employment by the Employer without Cause (other than by reason of the Executive's Disability) within thirty-six (36) months[2] following a Change in Control, or (ii) by the Executive's termination of his or her employment for Good Reason within twenty-four (24) months[3] following a Change of Control, the Executive shall be entitled to the following:

(i) the Employer shall pay the Executive the Executive's Accrued Compensation;

(ii) the Employer shall pay the Executive, at the same time that the Employer makes annual bonus payments under the Incentive Plan to other senior Executives, a pro rata portion of the annual bonus that would have been paid to the Executive under the Incentive Plan in respect of the year in which the Termination Date occurred had the Executive remained employed through the applicable payment date under the Incentive Plan, calculated by multiplying such amount by a fraction, the numerator of which is the number of days in the year through the Termination Date and the denominator of which is 365 .

(iii) the Employer shall pay the Executive as severance pay and in lieu of any further compensation for periods subsequent to the Termination Date, an amount determined by multiplying (A) three (3)[4] times the sum of (i) the Executive's Base Amount and (ii) the Executive's Bonus Amount;

(iv) (A) for thirty-six (36)[5] months following the Termination Date (the "Continuation Period"), the Employer shall arrange, at its sole expense, to provide the Executive with health and welfare benefits (other than long-term disability insurance benefits) that are substantially similar to the better of (when considered in the aggregate) (X) those health and welfare benefits (other than long-term disability insurance benefits) that the Executive was receiving or entitled to receive immediately prior to the Change in Control, and (Y) those health and welfare benefits (other than long-term disability insurance benefits) that the Executive was receiving or entitled to receive immediately prior to the Termination Date, and (B) such Continuation Period will be considered service with the Employer for the purpose of determining service credits under or in respect of any health and welfare benefits applicable to the Executive or the Executive's dependents or beneficiaries; and

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2 Change to 24 months for VPs.

3 Change to 12 months for VPs.

4 Severance for CEO, EVP and SVPs. For VPs, severance shall be 24 months (or 2 times base and bonus).

5 Change to 24 months for VPs.

(v) the Employer shall reimburse the Executive for the costs, fees and expenses of outplacement assistance services (not to exceed twenty-five thousand dollars ($25,000)) provided by any bona fide outplacement agency selected by the Executive.

(b) If the Executive's employment with the Employer and with all Affiliates of the Corporation shall be terminated by the Employer without Cause (other than by reason of the Executive's Disability) at any time prior to the date of a Change in Control and such termination (A) occurred after the Corporation or the Employer entered into a definitive agreement, the consummation of which would constitute a Change in Control or (B) the Executive reasonably demonstrates that such termination was at the request of a third party who has indicated an intention or has taken steps reasonably calculated to effect a Change in Control (a "Third Party"), such termination shall be deemed to have occurred after a Change in Control.

(c) If the Executive's employment with the Employer and with all Affiliates of the Corporation shall be terminated for Cause, the Employer shall pay to the Executive any unpaid portion of the Executive's base salary through the Termination Date at the rate in effect at the time Notice of Termination is given and shall pay any amounts required to be paid to the Executive pursuant to any other compensation plans, programs or arrangements then in effect, or which are required to be paid under applicable law, and the Employer shall have no further obligations to the Executive under this Agreement.

(d) The amounts provided for in Sections 2(a) and 2(b)shall be subject to the Executive's execution, delivery and non-revocation of a Waiver and Release of Claims substantially the form attached hereto as Exhibit A (the "Release") within forty five (45) days after the Executive's Termination Date and the amounts provided for in Sections 2(a)(ii), 2(b)(i), 2(b)(ii) and 2(b)(iii) shall be paid in a single lump sum cash payment on the forty fifth (45th) after the Executive's Termination Date; provided, however, that, notwithstanding the foregoing, if the Executive is a "specified employee" for purposes of Section 409A of Code and the regulations issued thereunder (a "Specified Employee"), any payments required to be made pursuant to Section 2(a)(ii), 2(b)(ii) and 2(b)(iii) shall not commence until one (1) day after the day which is six (6) months after the Executives separation from service (the "Delay Period"). In addition, if the Executive is a Specified Employee, to the extent that benefits to be provided to the Executive pursuant to Sections 2(b)(iv) and 2(b)(v) of this Agreement are not "disability pay," "death benefit" plans or non-taxable medical benefits within the meaning of Treasury Regulation Section 1.409A-1(a)(5) or other benefits not considered nonqualified deferred compensation within the meaning of that regulation, such provision of benefits shall be delayed until the end of the Delay Period, unless the Executive's termination occurs by reason of his death. Notwithstanding the foregoing, to the extent that the previous sentence applies to the provision of any ongoing benefits that would not be required to be delayed if the premiums were paid by the Executive, the Executive shall pay the full cost of the premiums for such benefits during the Delay Period and the Corporation shall pay the Executive an amount equal to the amount of such premiums paid by the Executive during the Delay Period within ten (10) days after the end of the Delay Period. To the extent that any benefits to be provided to the Executive pursuant to this Agreement are considered nonqualified deferred compensation and are reimbursements subject to Treasury Regulation Section 1.409A-3(i)(1)(iv), then (i) the reimbursement of eligible expenses related to such benefits shall be made on or before the last day of the Executive taxable year following the Executive taxable year in which the expense was incurred and (ii) notwithstanding anything to the contrary in this Agreement or any plan providing for such benefits, the amount of expenses eligible for reimbursements during any taxable year of the Executive shall not affect the expenses eligible for reimbursements in any other taxable year.

(e) The Executive shall not be required to mitigate the amount of any payment or benefit provided for in this Agreement by seeking other employment or otherwise and no such payment or benefit shall be offset or reduced by the amount of any compensation or benefits provided to the Executive in any subsequent employment.

(f) The severance pay and benefits provided for in this Section 2 shall be in lieu of any other severance pay to which the Executive may be entitled under the Employer's severance policy or any other plan, agreement or arrangement of the Employer or any other Affiliate of the Corporation.

(g) The Executive's entitlement to other compensation or benefits pursuant to the Employer's employee benefit plans and other applicable programs and practices shall be determined in accordance with the terms of those plans, programs and practices as in effect from time to time.

(h) The Employer's and the Corporation's obligations pursuant to this Section 2 shall be conditioned upon the Executive's execution, delivery and non-revocation of the Release.

3. Gross-Up Payment.

(a) In the event that it shall be determined that any payment or distribution of any type to or for the benefit of the Executive, by the Employer, the Corporation, any Affiliate, any Person (as defined in Section 17.6(a) hereof) who acquires ownership or effective control of the Corporation or ownership of a substantial portion of the Corporation's assets (within the meaning of Section 280G of the Code and the regulations thereunder) or any affiliate of such Person, whether paid or payable or distributed or distributable pursuant to the terms of this Agreement or under any other plan, program, policy or arrangement of the Corporation, the Employer or any of their Affiliates (the "Total Payments"), is or will be subject to the excise tax imposed by Section 4999 of the Code or any interest or penalties with respect to such excise tax (such excise tax, together with any such interest and penalties, are collectively referred to as the "Excise Tax"), then the Executive shall be entitled to receive an additional payment (a "Gross-Up Payment") in an amount such that after payment by the Executive of all taxes (including any interest or penalties imposed with respect to such taxes), including any Excise Tax, imposed upon the Gross-Up Payment, the Executive retains an amount of the Gross-Up Payment equal to the Excise Tax imposed upon the Total Payments. Payments and reimbursements to which the Executive is entitled under this Section 3(a) shall be made not later than April 15 of the taxable year of the Executive next following the taxable year of the Executive in which the Executive receives amounts subject to Section 4999.

Notwithstanding the immediately preceding paragraph, in the event that a reduction to the Total Payments in respect of the Executive of 10% or less would cause no

Excise Tax to be payable, the Executive will not be entitled to a Gross-Up Payment and the Total Payments shall be reduced to the extent necessary so that the Total Payments shall not be subject to the Excise Tax. Unless the Executive shall have given prior written notice to the Employer specifying a different order by which to effectuate the foregoing, the Employer shall reduce or eliminate the Total Payments (x) by first reducing or eliminating the portion of the Total Payments which are not payable in cash (other than that portion of the Total Payments subject to clause (z) hereof), (y) then by reducing or eliminating cash payments (other than that portion of the Total Payments subject to clause (z) hereof) and (z) then by reducing or eliminating the portion of the Total Payments (whether payable in cash or not payable in cash) to which Treasury Regulation Section 1.280G-1 Q/A 24(c) (or successor thereto) applies, in each case in reverse order beginning with payments or benefits which are to be paid the farthest in time from the date of the Change in Control. Any notice given by the Executive pursuant to the preceding sentence shall take precedence over the provisions of any other plan, arrangement or agreement governing the Executive's rights and entitlements to any benefits or compensation.

(b) Determination by Accountant. All mathematical determinations, and all determinations as to whether any of the Total Payments are "parachute payments" (within the meaning of Section 280G of the Code), that are required to be made under this Section 3, including determinations as to whether a Gross-Up Payment is required, the amount of such Gross-Up Payment and amounts relevant to the last sentence of this Section 3(b), shall be made by an independent accounting firm selected by the Executive from among the nationally recognized accounting firms in the United States (the "Accounting Firm"), which shall provide its determination (the "Determination"), together with detailed supporting calculations regarding the amount of any Gross-Up Payment and any other relevant matter, both to the Employer and the Executive by no later than ten (10) days following the Termination Date, if applicable, or such earlier time as is requested by the Employer or the Executive (if the Executive reasonably believes that any of the Total Payments may be subject to the Excise Tax). If the Accounting Firm determines that no Excise Tax is payable by the Executive, it shall furnish the Executive and the Employer with a written statement that such Accounting Firm has concluded that no Excise Tax is payable (including the reasons therefor) and that the Executive has substantial authority not to report any Excise Tax on the Executive's federal income tax return. If a Gross-Up Payment is determined to be payable, it shall be paid to the Executive within twenty (20) days after the Determination (and all accompanying calculations and other material supporting the Determination) is delivered to the Employer by the Accounting Firm. Any determination by the Accounting Firm shall be binding upon the Employer and the Executive, absent manifest error. As a result of uncertainty in the application of Section 4999 of the Code at the time of the initial determination by the Accounting Firm hereunder, it may be the case that Gross-Up Payments not made by the Employer should have been made ("Underpayment") or that Gross-Up Payments will have been made by the Employer which should not have been made ("Overpayments"). In either such event, the Accounting Firm shall determine the amount of the Underpayment or Overpayment that has occurred. In the case of an Underpayment, the amount of such Underpayment shall be promptly paid by the Employer to or for the benefit of the Executive. In the case of an Overpayment, the Executive shall, at the direction and expense of the Employer, take such steps as are reasonably necessary (including the filing of returns and claims for refund), follow reasonable instructions from, and procedures established by, the Employer, and otherwise reasonably cooperate with the Employer to correct such Overpayment, *provided, however,* that (i) the Executive shall not in any event be obligated to return to the Employer an amount greater than the net after-tax portion of the Overpayment that the Executive has retained or has recovered as a refund from the applicable taxing authorities and (ii) this provision shall be interpreted in a manner consistent with the intent of Section 3(a), which is to make the Executive whole, on an after-tax basis, from the application of the Excise Tax, it being understood that the correction of an Overpayment may result in the Executive repaying to the Employer an amount which is less than the Overpayment.

(c) Access; Binding Effect. The Corporation, the Employer and the Executive shall each provide the Accounting Firm access to and copies of any books, records and documents in the possession of the Employer or the Executive, as the case may be, reasonably requested by the Accounting Firm, and otherwise cooperate with the Accounting Firm in connection with the preparation and issuance of the determinations and calculations contemplated by this Section 3. Any determination by the Accounting Firm as to the amount of any Gross-Up Payment or Underpayment shall be binding upon the Employer, its Affiliates and the Executive; *provided* that if the Executive is ultimately required to pay an Excise Tax by the Internal Revenue Service despite the opinion of such Accounting Firm, then the Employer shall make the appropriate Gross-Up Payment contemplated herein.

(d) Income Tax Returns. The federal income returns filed by the Executive shall be prepared and filed on a basis consistent with the determination of the Accounting Firm with respect to the Excise Tax payable by the Executive. The Executive shall make proper payment of the amount of any Excise Tax that has not been withheld by the Employer, and at the request of the Employer, provide to the Employer true and correct copies (with any amendments) of the Executive's federal income tax return as filed with the Internal Revenue Service and corresponding state and local tax returns, if relevant, as filed with the applicable taxing authority, and such other documents reasonably requested by the Employer, evidencing the proper reporting of the Gross-Up Payment and any Excise Tax due. If prior to the filing of the Executive's federal income tax return, or corresponding state or local tax return, if relevant, the Accounting Firm determines that the amount of the Gross-Up Payment should be reduced, the Executive shall within five (5) business days of such determination pay to the Employer the amount of such reduction.

(e) Fees and Expenses. The fees and expenses of the Accounting Firm for its services in connection with the determinations and calculations contemplated by this Section 3 shall be borne by the Employer. If such fees and expenses are initially paid by the Executive, the Employer shall reimburse the Executive the full amount of such fees and expenses within five (5) business days after receipt from the Executive of a statement therefor and reasonable evidence of the Executive's payment thereof.

(f) Indemnification. The Executive shall notify the Employer in writing of any claim by the Internal Revenue Service that, if successful, would require the payment by the Employer of a Gross-Up Payment. Such notification shall be given as promptly as practicable but no later than ten (10) business days after the Executive actually receives notice of such claim and the Executive shall further apprise the Employer of the nature of such claim and the date on which such claim is requested to be paid (in each case, to the extent known by the Executive). The Executive shall not pay such claim prior to the earlier of (i) the expiration of the thirty (30)-day period following the date on which the Executive gives such notice to the Employer and (ii) the date that any payment of the amount with respect to such claim is due. If the Employer notifies the Executive in writing prior to the expiration of such period that it desires to contest such claim, the Executive shall:

(i) provide the Employer with any written records or documents in the Executive's possession relating to such claim reasonably requested by the Employer;

(ii) take such action in connection with contesting such claim as the Employer shall reasonably request in writing from time to time, including without limitation accepting legal representation with respect to such claim by an attorney competent in respect of the subject matter and reasonably selected by the Employer;

(iii) cooperate with the Employer in good faith in order effectively to contest such claim; and

(iv) permit the Employer to participate in any proceedings relating to such claim; *provided, however*, that the Employer shall bear and pay directly all costs in a court of initial jurisdiction and in one or more appellate courts, as the Employer shall determine; and *provided, further, however*, that if the Employer directs the Executive to pay the tax claimed and sue for a refund, the Employer shall make such payment to the Executive on an interest-free basis and shall indemnify and hold the Executive harmless, on an after-tax basis, from any Excise Tax or income or other tax, including interest or penalties with respect thereto, imposed with respect to such payment; and provided, further, however, that any extension of the statute of limitations relating to payment of taxes for the taxable year of the Executive with respect to which the contested amount is claimed to be due is limited solely to such contested amount. Furthermore, the Employer's control of any such contested claim shall be limited to issues with respect to which a Gross-Up Payment would be payable hereunder and the Executive shall be entitled to settle or contest, as the case may be, any other issue raised by the Internal Revenue Service.

(g) Refunds. If, after the receipt by the Executive of an amount paid by the Employer pursuant to Section 3(f), the Executive receives any refund with respect to such claim, the Executive shall (subject to the Employer's complying with the requirements of Section 3(f) promptly pay to the Employer the amount of such refund (together with any interest paid or credited thereon after any taxes applicable thereto). If, after the receipt by the Executive of an amount paid by the Employer pursuant to Section 3(f) a determination is made that the Executive shall not be entitled to any refund with respect to such claim and the Employer does not notify the Executive in writing of its intent to contest such denial or refund prior to the expiration of thirty (30) days after such determination, then such amount shall not be required to be repaid and shall offset, to the extent thereof, the amount of Gross-Up Payment required to be paid by the Employer to the Executive pursuant to this Section 3.

(h) Confidentiality. Any information provided by the Executive to the Employer under this Section 3 shall be treated confidentially by the Employer and, except as required by law, will not be provided by the Employer to any other person, other than the Employer's professional advisors, without Executive's prior written consent.

4. Notice of Termination. Following a Change in Control, (i) any intended termination of the Executive's employment by the Employer shall be communicated by a Notice of Termination from the Employer to the Executive, and (ii) any intended termination of the Executive's employment by the Executive for Good Reason shall be communicated by a Notice of Termination from the Executive to the Employer within six (6) months of the Executive becoming aware of the event or action constituting Good Reason or, if later, within six (6) months after the date of the Change in Control.

5. Fees and Expenses. The Employer shall pay all legal fees and related expenses (including the costs of experts, evidence and counsel) incurred in good faith by the Executive as they become due over the lifetime of the Executive as a result of (a) the termination of the Executive's employment by the Employer or by the Executive for Good Reason (including all such fees and expenses, if any, incurred in contesting, defending or disputing the basis for any such termination of employment), (b) the Executive's hearing before the Board of Directors of the Corporation as contemplated in Section 17.5 of this Agreement or (c) the Executive seeking to obtain or enforce any right or benefit provided by this Agreement or by any other plan or arrangement maintained by the Employer under which the Executive is or may be entitled to receive benefits. Payments and reimbursements to which the Executive is entitled under this Section 5 shall be made not later than April 15 of the taxable year of the Employee next following the taxable year in which the expense was incurred.

6. Transfer of Employment. Notwithstanding any other provision herein to the contrary, the Employer shall cease to have any further obligation or liability to the Executive under this Agreement if (a) the Executive's employment with the Employer terminates as a result of the transfer of the Executive's employment to any other Affiliate of the Corporation, (b) this Agreement is assigned to such other Affiliate, and (c) such other Affiliate expressly assumes and agrees to perform this Agreement in the same manner and to the same extent that the Employer would be required to perform it if no assignment had taken place. Any Affiliate to which this Agreement is so assigned shall be treated as the "Employer" for all purposes of this Agreement on or after the date as of which such assignment to the Affiliate, and the Affiliate's assumption and agreement to so perform this Agreement, becomes effective.

7. Corporation's Obligation. The Corporation agrees that it will take such steps as may be necessary to cause the Employer (or any Affiliate that has become the "Employer" pursuant to Section 6 hereof) to meet each of its obligations to the Executive under this Agreement.

8. Notice. For the purposes of this Agreement, notices and all other communications provided for in this Agreement (including any Notice of Termination) shall be in writing, shall be signed by the Executive if to the Employer or by a duly authorized officer of the Employer if to the Executive, and shall be deemed to have been duly given when personally delivered or sent by certified mail, return receipt requested, postage prepaid. Notices to the Employer or the Corporation shall be delivered to the attention of the General Counsel at the corporate

headquarters of the Corporation. Notices to the Executive shall be delivered to the address reflected in the payroll records of the Employer. All notices and communications shall be deemed to have been received on the date of delivery thereof or on the third business day after the mailing thereof, except that notice of change of address shall be effective only upon receipt.

9. Nature of Rights. The Executive shall have the status of a mere unsecured creditor of the Employer and the Corporation with respect to the Executive's right to receive any payment under this Agreement. This Agreement shall constitute a mere promise by the Employer and the Corporation to make payments in the future of the benefits provided for herein. It is the intention of the parties hereto that the arrangements reflected in this Agreement shall be treated as unfunded for tax purposes and, if it should be determined that Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), is applicable to this Agreement, for purposes of Title I of ERISA. Except as provided in Section 2(g), nothing in this Agreement shall prevent or limit the Executive's continuing or future participation in any benefit, bonus, incentive or other plan or program provided by the Employer, the Corporation or any other Affiliate of the Corporation and for which the Executive may qualify, nor shall anything herein limit or reduce such rights as the Executive may have under any other agreements with the Employer, the Corporation or any other Affiliate of the Corporation. Amounts which are vested benefits or which the Executive is otherwise entitled to receive under any plan or program of the Employer, the Corporation or any other Affiliate of the Corporation shall be payable in accordance with such plan or program, except as explicitly modified by this Agreement.

10. Settlement of Claims. The Employer's obligation to make the payments provided for in this Agreement and otherwise to perform its obligations hereunder shall not be affected by any circumstances, including, without limitation, any set-off, counterclaim, defense, recoupment, or other right which the Employer may have against the Executive or others.

11. Alternative Dispute Resolution. The parties hereto agree that any controversy or claim arising out of or relating to this Agreement or the breach thereof, shall be settled by binding arbitration by an arbitration panel selected in accordance with the then-current arbitrator selection procedures of the American Arbitration Association. Such arbitration shall be conducted in the Middle District of Tennessee (absent mutual agreement by the parties to do otherwise) pursuant to the national rules for the resolution of employment disputes of the American Arbitration Association then in effect. The decision or award in any such arbitration will be final and binding upon the parties and judgment upon such decision or award may be entered in any court of competent jurisdiction or application may be made to any such court for judicial acceptance of such decision or award and an order of enforcement. In the event that any procedural matter is not covered by the aforesaid rules, the procedural law of Delaware will govern. The Employer shall bear all costs and expenses incurred by the Executive in the arbitration, as well as its own costs and expenses and the costs and expenses of any of its Affiliates.

12. Miscellaneous. No provision of this Agreement may be modified, waived or discharged unless such waiver, modification or discharge is agreed to in writing and signed by the Executive, the Corporation and the Employer. No waiver by any party hereto at any time of any breach by any other party hereto of, or compliance with, any condition or provision of this Agreement to be performed by such other party shall be deemed a waiver of similar or dissimilar

provisions or conditions at the same or at any prior or subsequent time. No agreement or representation, oral or otherwise, express or implied, with respect to the subject matter hereof has been made by any party which is not expressly set forth in this Agreement.

13. Successors; Binding Agreement.

(a) This Agreement shall be binding upon and shall inure to the benefit of the Employer, the Corporation and their respective Successors and Assigns. The Employer and the Corporation shall require their respective Successors and Assigns to expressly assume and agree to perform this Agreement in the same manner and to the same extent that the Employer and/or the Corporation would be required to perform it if no such succession or assignment had taken place.

(b) Neither this Agreement nor any right or interest hereunder shall be assignable or transferable by the Executive or the Executive's beneficiaries or legal representatives, except by will or by the laws of descent and distribution. This Agreement shall inure to the benefit of and be enforceable by the Executive's legal personal representative.

14. Governing Law. This Agreement shall be governed by and construed and enforced in accordance with the substantive laws of the State of Delaware without giving effect to the conflict of laws principles thereof.

15. Severability. The provisions of this Agreement shall be deemed severable and the invalidity or unenforceability of any provision shall not affect the validity or enforceability of the other provisions hereof.

16. Entire Agreement. This Agreement constitutes the entire agreement between the parties hereto, and supersedes all prior agreements, if any, understandings and arrangements, oral or written, between the parties hereto.

17. Definitions.

17.1 Accrued Compensation. For purposes of this Agreement, "Accrued Compensation" shall mean all amounts of compensation for services rendered to the Employer or any other Affiliate that have been earned or accrued through the Termination Date but that have not been paid as of the Termination Date including (a) base salary, (b) reimbursement for reasonable and necessary business expenses incurred by the Executive on behalf of the Employer during the period ending on the Termination Date and (c) vacation pay; *provided, however*, that Accrued Compensation shall not include any amounts described in clause (a) or clause (d) that have been deferred pursuant to any salary reduction or deferred compensation elections made by the Executive.

17.2 Affiliate. For purposes of this Agreement, "Affiliate" means any entity directly or indirectly controlled by, controlling or under common control with the Corporation or any corporation or other entity acquiring, directly or indirectly, all or substantially all the assets and business of the Corporation, whether by operation of law or otherwise.

17.3 Base Amount. For purposes of this Agreement, "Base Amount" shall mean the Executive's annual base salary at the rate in effect as of the date of a Change in Control or, if greater, at any time thereafter, determined without regard to any salary reduction or deferred compensation elections made by the Executive.

17.4 Bonus Amount. For purposes of this Agreement, "Bonus Amount" shall mean the greater of (a) the target annual bonus that would be payable to the Executive under the Incentive Plan in respect of the fiscal year during which the Termination Date occurs assuming that both the Corporation and the Executive satisfy 100% (but not in excess of 100%) of the performance objective(s) specified in or pursuant to the applicable agreement, policy, plan, program or arrangement and communicated to the Executive, and (b) the highest annual bonus paid or payable under the Incentive Plan in respect of any of the three full fiscal years ended prior to the Termination Date or, if greater, the three (3) full fiscal years ended prior to the Change in Control.

17.5 Cause. For purposes of this Agreement, a termination of employment is for "Cause" if the Executive has been convicted of a felony or the termination is evidenced by a resolution adopted in good faith by two-thirds of the Board of Directors of the Corporation that the Executive:

(a) intentionally and continually failed substantially to perform the Executive's reasonably assigned duties with the Employer or the Corporation (other than a failure resulting from the Executive's incapacity due to physical or mental illness or from the assignment to the Executive of duties that would constitute Good Reason) which failure continued for a period of at least thirty (30) days after a written notice of demand for substantial performance, signed by a duly authorized officer of the Employer or the Corporation, has been delivered to the Executive specifying the manner in which the Executive has failed substantially to perform, or

(b) intentionally engaged in conduct which is demonstrably and materially injurious to the Corporation or the Employer; *provided, however*, that no termination of the Executive's employment shall be for Cause as set forth in this Section 17.5(b) until (1) there shall have been delivered to the Executive a copy of a written notice, signed by a duly authorized officer of the Employer or the Corporation, setting forth that the Executive was guilty of the conduct set forth in this Section 17.5(b) and specifying the particulars thereof in detail, and (2) the Executive shall have been provided an opportunity to be heard in person by the Board of Directors of the Corporation (with the assistance of the Executive's counsel if the Executive so desires).

No act, nor failure to act, on the Executive's part, shall be considered "intentional" unless the Executive has acted, or failed to act, with a lack of good faith and with a lack of reasonable belief that the Executive's action or failure to act was in the best interest of the Corporation and the Employer. Notwithstanding anything contained in this Agreement to the contrary, no failure to perform by the Executive after a Notice of Termination is given to the Employer by the Executive shall constitute Cause for purposes of this Agreement.

17.6 Change in Control. A "Change in Control" shall mean the occurrence of any of the following:

(a) An acquisition (other than directly from the Corporation) of any voting securities of the Corporation (the "Voting Securities") by any "Person" (as the term "person" is used for purposes of Section 13(d) or 14(d) of the Securities Exchange Act of 1934, as amended (the "Exchange Act")), immediately after which such Person has "Beneficial Ownership" (within the meaning of Rule 13d-3 promulgated under the Exchange Act) of more than twenty-five percent (25%) of (1) the then-outstanding shares of common stock of the Corporation (or any other securities into which such shares of common stock are changed or for which such shares of common stock are exchanged) (the "Shares") or (2) the combined voting power of the Corporation's then-outstanding Voting Securities; *provided, however*, that in determining whether a Change in Control has occurred pursuant to this paragraph (a), the acquisition of Shares or Voting Securities in a "Non-Control Acquisition" (as hereinafter defined) shall not constitute a Change in Control. A "Non-Control Acquisition" shall mean an acquisition by (i) an employee benefit plan (or a trust forming a part thereof) maintained by (A) the Corporation or (B) any corporation or other Person the majority of the voting power, voting equity securities or equity interest of which is owned, directly or indirectly, by the Corporation (for purposes of this definition, a "Related Entity"), (ii) the Corporation or any Related Entity, or (iii) any Person in connection with a "Non-Control Transaction" (as hereinafter defined); or

(b) The individuals who, as of the date hereof, are members of the board of directors of the Corporation (the "Incumbent Board"), cease for any reason to constitute at least a majority of the members of the board of directors of the Corporation or, following a Merger (as hereinafter defined), the board of directors of (x) the corporation resulting from such Merger (the "Surviving Corporation"), if fifty percent (50%) or more of the combined voting power of the then-outstanding voting securities of the Surviving Corporation is not Beneficially Owned, directly or indirectly, by another Person (a "Parent Corporation") or (y) if there is one or more than one Parent Corporation, the ultimate Parent Corporation; *provided, however*, that, if the election, or nomination for election by the Corporation's common stockholders, of any new director was approved by a vote of at least two-thirds of the Incumbent Board, such new director shall, for purposes of the Plan, be considered a member of the Incumbent Board; and *provided, further, however*, that no individual shall be considered a member of the Incumbent Board if such individual initially assumed office as a result of an actual or threatened solicitation of proxies or consents by or on behalf of a Person other than the board of directors of the Corporation (a "Proxy Contest"), including by reason of any agreement intended to avoid or settle any Proxy Contest; or

(c) The consummation of:

(i) A merger, consolidation or reorganization (1) with or into the Corporation or (2) in which securities of the Corporation are issued (a "Merger"), unless such Merger is a "Non-Control Transaction." A "Non-Control Transaction" shall mean a Merger in which:

(A) the stockholders of the Corporation immediately before such Merger own directly or indirectly immediately following such Merger at least fifty percent (50%) of the combined voting power of the outstanding voting securities of (x) the Surviving Corporation, if there is no Parent Corporation or (y) if there is one or more than one Parent Corporation, the ultimate Parent Corporation;

(B) the individuals who were members of the Incumbent Board immediately prior to the execution of the agreement providing for such Merger constitute at least a majority of the members of the board of directors of (x) the Surviving Corporation, if there is no Parent Corporation, or (y) if there is one or more than one Parent Corporation, the ultimate Parent Corporation; and

(C) no Person other than (1) the Corporation, (2) any Related Entity, or (3) any employee benefit plan (or any trust forming a part thereof) that, immediately prior to the Merger, was maintained by the Corporation or any Related Entity, or (4) any Person who, immediately prior to the Merger had Beneficial Ownership of twenty-five percent (25%) or more of the then outstanding Shares or Voting Securities, has Beneficial Ownership, directly or indirectly, of twenty-five percent (25%) or more of the combined voting power of the outstanding voting securities or common stock of (x) the Surviving Corporation, if fifty percent (50%) or more of the combined voting power of the then outstanding voting securities of the Surviving Corporation is not Beneficially Owned, directly or indirectly by a Parent Corporation, or (y) if there is one or more than one Parent Corporation, the ultimate Parent Corporation; *provided, however*, that any Person described in clause (4) of this subsection (C) may not, immediately following the Merger, Beneficially Own more than forty percent (40%) of the combined voting power of the outstanding voting securities of the Surviving Corporation or the Parent Corporation, as applicable, for the Merger to constitute a Non-Control Transaction; or

(ii) A complete liquidation or dissolution of the Corporation; or

(iii) A Major Asset Disposition.

For purposes of the foregoing definition, the term "Major Asset Disposition" means the sale or other disposition in one transaction or a series of related transactions (other than a transfer to a Related Entity or a transfer under conditions that would constitute a Non-Control Transaction, with the disposition of assets being regarded as a Merger) of 50% or more of the assets of the Corporation and its subsidiaries on a consolidated basis; and any specified percentage or portion of the assets of the Corporation shall be based on the total gross fair market value, as determined by a majority of the members of the Incumbent Board without regard to any associated liabilities. For the avoidance of doubt, the distribution to the Corporation's stockholders of the stock of a Related Entity or any other assets that constitute 50% or more of the assets of the Corporation and its subsidiaries on a consolidated basis (determined as aforesaid) shall constitute a Major Asset Disposition (whether or not such distribution constitutes a Non-Control Transaction).

Notwithstanding the foregoing, a Change in Control shall not be deemed to occur solely because any Person (the "Subject Person") acquired Beneficial Ownership of more than the permitted amount of the then outstanding Shares or Voting Securities as a result of the acquisition of Shares or Voting

Securities by the Corporation which, by reducing the number of Shares or Voting Securities then outstanding, increases the proportional number of shares Beneficially Owned by the Subject Persons; *provided* that if a Change in Control would occur (but for the operation of this sentence) as a result of the acquisition of Shares or Voting Securities by the Corporation and, after such share acquisition by the Corporation, the Subject Person becomes the Beneficial Owner of any additional Shares or Voting Securities and such Beneficial Ownership increases the percentage of the then outstanding Shares or Voting Securities Beneficially Owned by the Subject Person, then a Change in Control shall occur.

17.7. Employer and Corporation. For purposes of this Agreement, all references to the Employer and the Corporation shall include their respective Successors and Assigns.

17.8. Disability. For purposes of this Agreement, "Disability" shall mean a physical or mental infirmity which impairs the Executive's ability to substantially perform the Executive's duties with the Employer for six (6) consecutive months, and within the time period set forth in a Notice of Termination given to the Executive (which time period shall not be less than thirty (30) days), the Executive shall not have returned to full-time performance of the Executive's duties; *provided, however,* that if the Employer's Long Term Disability Plan, or any successor plan (the "Disability Plan"), is then in effect, the Executive shall not be deemed disabled for purposes of this Agreement unless the Executive is also eligible for "Total Disability" (as defined in the Disability Plan) benefits (or similar benefits in the event of a successor plan) under the Disability Plan.

17.9. Good Reason.

(a) For purposes of this Agreement, "Good Reason" shall mean the occurrence after a Change in Control of any of the following events or conditions:

(1) a change in the Executive's status, title, position or responsibilities (including reporting responsibilities) which, in the Executive's reasonable judgment, represents an adverse change from the Executive's status, title, position or responsibilities as in effect immediately prior thereto; the assignment to the Executive of any duties or responsibilities which, in the Executive's reasonable judgment, are inconsistent with the Executive's status, title, position or responsibilities; or any removal of the Executive from or failure to reappoint or reelect the Executive to any of such offices or positions, except in connection with the termination of the Executive's employment for Disability, Cause, as a result of the Executive's death or by the Executive other than for Good Reason;

(2) a reduction in the Executive's annual base salary below the Base Amount;

(3) the relocation of the offices of the Employer to a location more than twenty-five (25) miles from the location of such offices immediately prior to such Change in Control, or the Employer's or the Corporation's requiring the Executive to be based anywhere other than such offices, except to the extent the Executive was not previously assigned to a principal location and except for required travel on the Employer's or the Corporation's business to an extent substantially consistent with the Executive's business travel obligations at the time of the Change in Control;

(4) the failure by the Employer or the Corporation to pay to the Executive any portion of the Executive's current compensation or to pay to the Executive any portion of an installment of deferred compensation under any deferred compensation program of the Employer or the Corporation in which the Executive participated, within seven (7) days of the date such compensation is due;

(5) the failure by the Employer or the Corporation to (A) continue in effect (without reduction in benefit level, and/or reward opportunities) any material compensation or employee benefit plan in which the Executive was participating immediately prior to the Change in Control, unless a substitute or replacement plan has been implemented which provides substantially identical compensation or benefits to the Executive or (B) provide the Executive with compensation and benefits, in the aggregate, at least equal (in terms of benefit levels and/or reward opportunities) to those provided for under each other compensation or employee benefit plan, program and practice in which the Executive was participating immediately prior to the Change in Control;

(6) the failure of the Employer or the Corporation to obtain from its Successors or Assigns the express assumption and agreements required under Section 13 hereof; or

(7) any purported termination of the Executive's employment by the Employer which is not effected pursuant to a Notice of Termination satisfying the terms set forth in the definition of Notice of Termination (and, if applicable, the terms set forth in the definition of Cause).

(b) Any event or condition (1) described in Section 17.9(a)(1), (2), (3), (4), (6) or (7) which occurs at any time prior to the date of a Change in Control and (A) which occurred after the Employer entered into a definitive agreement, the consummation of which would constitute a Change in Control or (B) which the Executive reasonably demonstrates was at the request of a Third Party who has indicated an intention or has taken steps reasonably calculated to effect a Change in Control, shall constitute Good Reason for purposes of this Agreement, notwithstanding that it occurred prior to a Change in Control.

17.10. Incentive Plan. For purposes of this Agreement, "Incentive Plan" shall mean the 2004 Cash Incentive Plan, or any successor annual incentive plan, maintained by the Employer or any other Affiliate.

17.11. Notice of Termination. For purposes of this Agreement, following a Change in Control, "Notice of Termination" shall mean a written notice of termination of the Executive's employment, signed by the Executive if to the Employer or by a duly authorized officer of the Employer if to the Executive, which indicates the specific termination provision in this Agreement, if any, relied upon and which sets forth in reasonable detail the facts and circumstances claimed to provide a basis for termination of the Executive's employment under the provision so indicated.

17.12. Interest Rate. Without limiting the rights of the Executive at law or in equity, if the Employer fails to make any payment or provide any benefit required to be made or provided hereunder on a timely basis, the Employer will pay interest on the amount or value thereof at an annualized rate of interest equal to the so-called composite "prime rate" as quoted from time to time during the relevant period in the Southwest Edition of The Wall Street Journal. Such interest will be payable as it accrues on demand. Any change in such prime rate will be effective on and as of the date of such change.

17.13. Successors and Assigns. For purposes of this Agreement, "Successors and Assigns" shall mean, with respect to the Employer or the Corporation, a corporation or other entity acquiring all or substantially all the assets and business of the Employer or the Corporation, as the case may be (including this Agreement) whether by operation of law or otherwise.

17.14. Termination Date.

(a) For purposes of this Agreement, "Termination Date" shall mean (i) in the case of the Executive's death, the date of death, (ii) if the Executive's employment is terminated for Disability, thirty (30) days after Notice of Termination is given (provided that the Executive shall not have returned to the performance of the Executive's duties on a full-time basis during such thirty (30) day period) and (iii) if the Executive's employment is terminated for any other reason, the date specified in the Notice of Termination (which, in the case of a termination for Cause, shall not be less than thirty (30) days and, in the case of a termination for Good Reason, shall not be more than sixty (60) days, from the date such Notice of Termination is given); *provided, however,* that if within thirty (30) days after a Notice of Termination by the Employer for Cause or a Notice of Termination by the Executive for Good Reason is given, the party receiving such Notice of Termination in good faith notifies the other party that a dispute exists concerning the basis for the termination, the provisions of paragraph (b) shall apply.

(b) (i) If the Executive gives the Employer Notice of Termination for Good Reason and the Employer disputes the basis for the termination, the Termination Date shall be the date on which the dispute is finally determined, either by mutual written agreement of the parties, or by arbitration as provided in Section 11, and the Employer shall continue to pay the Executive the Executive's Base Amount and continue the Executive as a participant in all compensation, incentive, bonus, pension, profit sharing, medical, hospitalization, dental, life insurance and disability benefit plans in which the Executive was participating when the notice giving rise to the dispute was given, until such Termination Date, *provided* that if the Executive continues to perform the Executive's duties with the Employer during the pendency of such dispute, the Executive shall not be obligated to repay to the Employer any amounts paid or benefits provided pursuant to this Section 17.14(b), and *provided, further,* that if the Executive ceased performing the Executive's duties with the Employer during the pendency of such dispute, and the dispute is resolved in favor of the Executive, any amount owed to the Executive pursuant to Sections 2 and 3 of this Agreement shall be reduced to the extent of any amount the Executive received pursuant to this Section 17.14(b) during the pendency of such dispute; and (ii) if the Employer gives the Executive Notice of Termination for Cause and the Executive disputes the basis for the termination, the Termination Date shall be as determined pursuant to

Section 17.14(a) and during the pendency of such dispute the Executive shall not be entitled to payment of the Executive's Base Amount from the Employer and, except as required by law, the Executive's participation in the Employer's benefit plans and programs shall be discontinued.

[signature page follows]

IN WITNESS WHEREOF, the Corporation and the Employer have caused this Agreement to be executed by their duly authorized officers and the Executive has executed this Agreement as of the day and year first above written.

Corporation:

COMMUNITY HEALTH SYSTEMS, INC.

By: ______________________________

Wayne T. Smith, Chairman, President and Chief Executive Officer

Employer:

COMMUNITY HEALTH SYSTEMS PROFESSIONAL SERVICES CORPORATION

By: ______________________________

Rachel A. Seifert, Senior Vice President, Secretary and General Counsel

Executive:

By: ______________________________

Exhibit A

WAIVER AND RELEASE OF CLAIMS

1. General Release. In consideration of the payments and benefits to be made under the Change in Control Severance Agreement, dated as of ________, 2008, to which Community Health Systems, Inc. (the "Corporation"), Community Health Systems Professional Services Corporation (the "Employer"), and ________ (the "Executive") are parties (the "Agreement"), the Executive, with the intention of binding the Executive and the Executive's heirs, executors, administrators and assigns, does hereby release, remise, acquit and forever discharge the Corporation, the Employer and the parents, subsidiaries and affiliates of each of them (collectively, the "Corporation Affiliated Group"), their present and former officers, directors, executives, agents, shareholders, attorneys, employees and employee benefits plans (and the fiduciaries thereof), and the successors, predecessors and assigns of each of the foregoing (collectively, the "Corporation Released Parties"), of and from any and all claims, actions, causes of action, complaints, charges, demands, rights, damages, debts, sums of money, accounts, financial obligations, suits, expenses, attorneys' fees and liabilities of whatever kind or nature in law, equity or otherwise, whether accrued, absolute, contingent, unliquidated or otherwise and whether now known, unknown, suspected or unsuspected which the Executive, individually or as a member of a class, now has, owns or holds, or has at any time heretofore had, owned or held, against any Corporation Released Party (an "Action") arising out of or in connection with the Executive's service as an employee, officer and/or director to any member of the Corporation Affiliated Group (or the predecessors thereof), including (i) the termination of such service in any such capacity, (ii) for severance or vacation benefits, unpaid wages, salary or incentive payments, (iii) for breach of contract, wrongful discharge, impairment of economic opportunity, defamation, intentional infliction of emotional harm or other tort and (iv) for any violation of applicable state and local labor and employment laws (including, without limitation, all laws concerning harassment, discrimination, retaliation and other unlawful or unfair labor and employment practices), any and all Actions based on the Employee Retirement Income Security Act of 1974 ("ERISA"), and any and all Actions arising under the civil rights laws of any federal, state or local jurisdiction, including, without limitation, Title VII of the Civil Rights Act of 1964 ("Title VII"), the Americans with Disabilities Act ("ADA"), Sections 503 and 504 of the Rehabilitation Act, the Family and Medical Leave Act and the Age Discrimination in Employment Act ("ADEA"), excepting only:

(a) rights of the Executive under this Waiver and Release of Claims and under the Agreement;

(b) rights of the Executive relating to equity awards held by the Executive as of the Executive's date of termination;

(c) the right of the Executive to receive benefits required to be paid in accordance with applicable law;

(d) rights to indemnification the Executive may have (i) under applicable corporate law, (ii) under the by-laws or certificate of incorporation of any Corporation Released Party or (iii) as an insured under any director's and officer's liability insurance policy now or previously in force;

(e) claims (i) for benefits under any health, disability, retirement, supplemental retirement, deferred compensation, life insurance or other, similar employee benefit plan or arrangement of the Corporation Affiliated Group and (ii) for earned but unused vacation pay through the date of termination in accordance with applicable policy of the Corporation Affiliated Group; and

(f) claims for the reimbursement of unreimbursed business expenses incurred prior to the date of termination pursuant to applicable policy of the Corporation Affiliated Group.

2. No Admissions, Complaints or Other Claims. The Executive acknowledges and agrees that this Waiver and Release of Claims is not to be construed in any way as an admission of any liability whatsoever by any Corporation Released Party, any such liability being expressly denied. The Executive also acknowledges and agrees that the Executive has not, with respect to any transaction or state of facts existing prior to the date hereof, filed any Actions against any Corporation Released Party with any governmental agency, court or tribunal.

3. Application to all Forms of Relief. This Waiver and Release of Claims applies to any relief no matter how called, including, without limitation, wages, back pay, front pay, compensatory damages, liquidated damages, punitive damages for pain or suffering, costs and attorney's fees and expenses.

4. Specific Waiver. The Executive specifically acknowledges that the Executive's acceptance of the terms of this Waiver and Release of Claims is, among other things, a specific waiver of any and all Actions under Title VII, ADEA, ADA and any state or local law or regulation in respect of discrimination of any kind; provided, however, that nothing herein shall be deemed, nor does anything herein purport, to be a waiver of any right or Action which by law the Executive is not permitted to waive.

5. Voluntariness. The Executive acknowledges and agrees that the Executive is relying solely upon the Executive's own judgment; that the Executive is over eighteen years of age and is legally competent to sign this Waiver and Release of Claims; that the Executive is signing this Waiver and Release of Claims of the Executive's own free will; that the Executive has read and understood the Waiver and Release of Claims before signing it; and that the Executive is signing this Waiver and Release of Claims in exchange for consideration that the Executive believes is satisfactory and adequate. The Executive also acknowledges and agrees that the Executive has been informed of the right to consult with legal counsel and has been encouraged to do so.

6. Complete Agreement/Severability. This Waiver and Release of Claims constitutes the complete and final agreement between the parties and supersedes and replaces all prior or contemporaneous agreements, negotiations, or discussions relating to the subject matter of this Waiver and Release of Claims. All provisions and portions of this Waiver and Release of Claims are severable. If any provision or portion of this Waiver and Release of Claims or the application of any provision or portion of the Waiver and Release of Claims shall be determined to be invalid or unenforceable to any extent or for any reason, all other provisions and portions of this Waiver

and Release of Claims shall remain in full force and shall continue to be enforceable to the fullest and greatest extent permitted by law.

7. Acceptance and Revocability. The Executive acknowledges that the Executive has been given a period of 21 days within which to consider this Waiver and Release of Claims, unless applicable law requires a longer period, in which case the Executive shall be advised of such longer period and such longer period shall apply. The Executive may accept this Waiver and Release of Claims at any time within this period of time by signing the Waiver and Release of Claims and returning it to the Employer. This Waiver and Release of Claims shall not become effective or enforceable until seven calendar days after the Executive signs it. The Executive may revoke the Executive's acceptance of this Waiver and Release of Claims at any time within that seven calendar day period by sending written notice to the Employer. Such notice must be received by the Employer within the seven calendar day period in order to be effective and, if so received, would void this Waiver and Release of Claims for all purposes.

8. Governing Law. Except for issues or matters as to which federal law is applicable, this Waiver and Release of Claims shall be governed by and construed and enforced in accordance with the laws of the State of Delaware without giving effect to the conflicts of law principles thereof.

Executive:

____

Exhibit 12

STATEMENT RE: COMPUTATION OF RATIO OF EARNINGS TO FIXED CHARGES
(DOLLARS IN THOUSANDS)

	Year Ended December 31,				
	2004	2005	2006	2007	2008
Earnings					
Income from continuing operations before provision for income taxes and extraordinary item	$ 259,749	$ 308,174	$ 287,847	$ 99,542	$ 336,137
Minority interest in the income of subsidiaries with fixed charges (1)	—	—	—	15,155	40,101
Income from equity investees (2)	—	—	—	(25,132)	(42,064)
Distributed income from equity investees	—	—	—	19,902	32,897
Interest and amortization of deferred finance costs	69,736	87,185	94,411	361,773	651,925
Amortization of capitalized interest	433	494	567	881	1,469
Implicit rental interest expense	18,041	20,564	22,986	38,424	57,382
Total Earnings	$ 347,959	$ 416,417	$ 405,811	$ 510,545	$ 1,077,847
Fixed Charges					
Interest and amortization of deferred finance costs	$ 69,736	$ 87,185	$ 94,411	$ 361,773	$ 651,925
Capitalized interest	2,131	2,144	2,955	19,009	22,147
Implicit rental interest expense	18,041	20,564	22,986	38,424	57,382
Total fixed charges	$ 89,908	$ 109,893	$ 120,352	$ 419,206	$ 731,454
Ratio of earnings to fixed charges	3.87x	3.79x	3.37x	1.22x	1.47x

(1) The Company recognized an immaterial amount of minority interest in income from consolidated subsidiaries prior to 2007.

(2) The Company recognized an immaterial amount of income from equity investees prior to 2007.

Community Health Systems, Inc.
SUBSIDIARY LISTING

(*) Majority position held in an entity with physicians, non-profit entities or both
(#) Minority position held in a non-consolidating entity

5300 Grand Limited Partnership	
A Woman's Place, LLC	
Abilene Hospital, LLC	
Abilene Merger, LLC	
Affinity Health Systems, LLC*	
Affinity Hospital, LLC*	d/b/a Trinity Medical Center
Affinity Physician Services, LLC	
Alaska Physician Services, LLC	
Alice Hospital, LLC	
Alice Surgeons, LLC	
Ambulance Services of Dyersburg, Inc.	
Ambulance Services of Forrest City, LLC	
Ambulance Services of Lexington, Inc.	
Ambulance Services of McKenzie, Inc.	
Ambulance Services of McNairy, Inc.	
Ambulance Services of Tooele, LLC	
American Health Facilities Development, LLC	
Anesthesiology Group of Hattiesburg, LLC	
Angelo Community Healthcare Services, Inc.	
Anna Clinic Corp.	
Anna Home Care Services, LLC	
Anna Hospital Corporation	d/b/a Union County Hospital
APS Medical, LLC	
Arizona ASC Management, Inc.	
Arizona DH, LLC	
Arizona Medco, LLC	
Arkansas Healthcare System Limited Partnership#	
ARMC, LP	d/b/a Abilene Regional Medical Center
Arusha LLC*	
Augusta Health System, LLC*	
Augusta Home Care Services, LLC	
Augusta Hospital, LLC*	d/b/a Trinity Hospital of Augusta

Augusta Physician Services, LLC	
Barberton Health System, LLC	
Barberton Physician Services, LLC	
Barstow Healthcare Management, Inc.	
Beauco, LLC	
Beaumont Medical Center, L.P.	
Beaumont Regional, LLC	
Berwick Clinic Company, LLC	
Berwick Clinic Corp.	
Berwick Home Care Services, LLC	
Berwick Home Health Private Care, Inc.	
Berwick Hospital Company, LLC	d/b/a Berwick Hospital Center
Berwick Medical Professionals, P.C.	
BH Trans Company, LLC	
Big Bend Home Care Services, LLC	
Big Bend Hospital Corporation	d/b/a Big Bend Regional Medical Center
Big Spring Hospital Corporation	d/b/a Scenic Mountain Medical Center
Birmingham Holdings, LLC	
Birmingham Holdings II, LLC	
Bluffton Health System, LLC	d/b/a Bluffton Regional Medical Center
Bluffton Physician Services, LLC	
Brandywine Hospital Malpractice Assistance Fund, Inc.	
Brazos Medco, LLC	
Brazos Valley of Texas, L.P.	
Brazos Valley Surgical Center, LLC	
Broken Arrow Medical Group, LLC	
Brownsville Clinic Corp.	
Brownsville Hospital Corporation	d/b/a Haywood Park Community Hospital
Brownwood Hospital, L.P.	d/b/a Brownwood Regional Medical Center
Brownwood Medical Center, LLC	
Bullhead City Clinic Corp.	
Bullhead City Hospital Corporation*	d/b/a Western Arizona Regional Medical Center.
Bullhead City Hospital Investment Corporation*	
Bullhead City Imaging Corporation	
BVSC, LLC	
Byrd Medical Clinic, Inc.	

Carlsbad Medical Center, LLC	d/b/a Carlsbad Medical Center
Carolina Surgery Center, LLC*	
Carolinas Medical Alliance, Inc.	
Carolinas OB/GYN Medical Group, LLC	
Cedar Park Health System, L.P.*	d/b/a Cedar Park Regional Medical Center
Center for Adult Healthcare, LLC	
Central Alabama Physician Services, Inc.	
Central Arkansas Anesthesia Services, LLC	
Central Arkansas Pharmacy, LLC	
Central Arkansas Physician Services, LLC	
Central Arkansas Real Property, LLC	
Centre Clinic Corp.	
Centre Home Care Corporation	
Centre Hospital Corporation	d/b/a Cherokee Medical Center
Centre RHC Corp.	
Chesterfield Clinic Corp.	
Chesterfield/Marlboro, L.P.	d/b/a Marlboro Park Hospital; Chesterfield General Hospital
Chestnut Hill Clinic Company, LLC*	
Chestnut Hill Health System, LLC*	
CHHS ALF Company, LLC*	
CHHS Development Company, LLC*	
CHHS Holdings, LLC	
CHHS Hospital Company, LLC*	d/b/a Chestnut Hill Hospital
CHHS Rehab Company, LLC*	
CHS Kentucky Holdings, LLC	
CHS Pennsylvania Holdings, LLC	
CHS Realty Holdings I, Inc.	
CHS Realty Holdings II, Inc.	
CHS Realty Holdings Joint Venture	
CHS Utah Holdings, LLC	
CHS Virginia Holdings, LLC	
CHS Washington Holdings, LLC	
CHS/Community Health Systems, Inc.	
Claremore Anesthesia, LLC	
Claremore Diagnostic Center, LLC	
Claremore Internal Medicine, LLC	

Claremore Physicians, LLC	
Claremore Regional Hospital, LLC	d/b/a Claremore Regional Hospital
Clarksville Health System, G.P.*	d/b/a Gateway Health System
Clarksville Holdings, LLC	
Clarksville Home Care Services, LLC	
Clarksville Imaging Center, LLC#	
Clarksville Physician Services, G.P.*	
Cleveland Clinic Corp.	
Cleveland Home Care Services, LLC	
Cleveland Hospital Corporation	
Cleveland Medical Clinic, Inc.	
Cleveland PHO, Inc.	
Cleveland Regional Medical Center, L.P.	d/b/a Cleveland Regional Medical Center
Cleveland Tennessee Hospital Company, LLC	d/b/a SkyRidge Medical Center
Clinico, LLC	
Clinton County Health System, LLC	
Clinton Hospital Corporation	d/b/a Lock Haven Hospital
Coatesville Clinic Company, LLC	
Coatesville Hospital Corporation	d/b/a Brandywine Hospital
C-OK, LLC	
College Station Hospital, L.P.	d/b/a College Station Medical Center
College Station Medical Center, LLC	
College Station Merger, LLC	
Colonial Heights Imaging, LLC	
Community GP Corp.	
Community Health Care Partners, Inc.	
Community Health Investment Company, LLC	
Community Health Network, Inc.	
Community Health Systems Foundation	
Community Health Systems Professional Services Corporation	
Community Health Systems, Inc.	
Community Health United Home Care, LLC	
Community Information Network, Inc.#	
Community Insurance Group SPC, LTD.	
Community LP Corp.	
Consolidated Hospital Laundry Services, Inc.#	

Coronado Hospital, LLC	
Coronado Medical, LLC	
Cottage Home Options, L.L.C.	
Cottage Rehabilitation and Sports Medicine, L.L.C.#	
Coventry Clinic Company, LLC	
CP Hospital GP, LLC	
CPLP, LLC	
Crestview Hospital Corporation*	d/b/a North Okaloosa Medical Center
Crestview Professional Condominiums Association, Inc.*	
Crestview Surgery Center, L.P.	
Crestwood Healthcare, L.P.*	d/b/a Crestwood Medical Center
Crestwood Hospital LP, LLC	
Crestwood Hospital, LLC	
Crestwood Surgery Center, LLC*	
Crossroads Community Hospital Malpractice Assistance Fund, Inc.	
Crossroads Healthcare Management, LLC#	
Crossroads Home Care Services, LLC	
Crossroads Physician Corp.	
CSDS, LLC	
CSMC, LLC	
CSRA Holdings, LLC	
Dallas Phy Service, LLC	
Dallas Physician Practice, L.P.	
Day Surgery, Inc.	
Deaconess Clinical Associates, Inc.	
Deaconess Health System, LLC*	d/b/a Deaconess Hospital
Deaconess Holdings, LLC	
Deaconess Hospital Holdings, LLC	
Deaconess Metropolitan Physicians, LLC	
Deaconess Physician Services, LLC	
Deaconess Portland MOB Limited Partnership#	
Deming Clinic Corporation	
Deming Home Care Services, LLC	
Deming Hospital Corporation	d/b/a Mimbres Memorial Hospital
Denton ASC-GP, LLC	

Denton Surgery Center, L.P.*	
DeQueen Regional I, LLC	
Desert Hospital Holdings, LLC	
Detar Hospital, LLC	
DFW Physerv, LLC	
DHFW Holdings, LLC	
DHSC, LLC*	d/b/a Affinity Medical Center -- Massillon
Diagnostic Imaging Management of Brandywine Valley, LLC	
Diagnostic Imaging of Brandywine Valley, LP	
Doctors Hospital Physician Services, LLC*	
Doctors Medical Center, LLC	
Doctors of Laredo, LLC	
Douglas Medical Center, LLC	
Dukes Health System, LLC	d/b/a Dukes Memorial Hospital
Dukes Physician Services, LLC	
Dupont Hospital, LLC*	d/b/a Dupont Hospital
Dyersburg Clinic Corp.	
Dyersburg Home Care Services, LLC	
Dyersburg Hospital Corporation	d/b/a Dyersburg Regional Medical Center
E.D. Clinics, LLC	
East Tennessee Clinic Corp.	
East Tennessee Health Systems, Inc.	
Easton Hospital Malpractice Assistance Fund, Inc.	
Edge Medical Clinic, Inc.	
Edwardsville Ambulatory Surgery Center, LLC	
El Dorado Surgery Center, L.P.*	
EL Med, LLC	
Empire Health Services	
Emporia Clinic Corp.	
Emporia Home Care Services, LLC	
Emporia Hospital Corporation	d/b/a Southern Virginia Regional Medical Center
Eufaula Clinic Corp.	
Eufaula Hospital Corporation	
Evanston Clinic Corp.	
Evanston Hospital Corporation	d/b/a Evanston Regional Hospital
Eye Institute of Southern Arizona, LLC	

Fairmont Health System, LLC	
Fallbrook Home Care Services, LLC	
Fallbrook Hospital Corporation	d/b/a Fallbrook Hospital
Family Home Care, Inc.	
Fannin Regional Hospital, Inc.	d/b/a Fannin Regional Hospital
Fannin Regional Orthopaedic Center, Inc.	
Firstcare, Inc.#	
First Choice Health Network, Inc.#	
Florence ASC Management, LLC	
Florence Home Care Services, LLC	
Foley Clinic Corp.	
Foley Home Care Services, LLC	
Foley Home Health Corporation	
Foley Hospital Corporation	d/b/a South Baldwin Regional Medical Center
Forrest City Arkansas Hospital Company, LLC	d/b/a Forrest City Medical Center
Forrest City Clinic Company, LLC	
Forrest City Home Care Services, LLC	
Forrest City Hospital Corporation	
Fort Payne Clinic Corp.	
Fort Payne Home Care Corporation	
Fort Payne Hospital Corporation	d/b/a DeKalb Regional Medical Center
Fort Payne RHC Corp.	
Fort Wayne Cardiac Center, LLC#	
Fort Wayne Surgery Center, LLC*	
Frankfort Health Partner, Inc.	
Franklin Clinic Corp.	
Franklin Home Care Services, LLC	
Franklin Hospital Corporation	d/b/a Southampton Memorial Hospital
Fulton Home Care Services, LLC	
Gadsden Home Care Services, LLC	
Gadsden Regional Medical Center, LLC	d/b/a Gadsden Regional Medical Center
Gadsden Regional Physician Group Practice, LLC	
Gadsden Regional Primary Care, LLC	
Galesburg Home Care Corporation	
Galesburg Hospital Corporation	d/b/a Galesburg Cottage Hospital
Galesburg In-Home Assistance, Inc.	
Gateway Malpractice Assistance Fund, Inc.	

Gateway Medical Services, Inc.	
GCMC, LLC	
GH Texas, LLC	
GHC Hospital, LLC	
Good Hope Health System, LLC	
Granbury Hospital Corporation	d/b/a Lake Granbury Medical Center
Granbury Texas Hospital Investment Corporation	
Granite City ASC Investment Company, LLC	
Granite City Clinic Corp.	
Granite City Home Care Services, LLC	
Granite City Hospital Corporation	
Granite City Illinois Hospital Company, LLC	d/b/a Gateway Regional Medical Center
Granite City Orthopedic Physicians Company, LLC	
Granite City Physicians Corp.	
GRB Real Estate, LLC	
Great Plains Medical Foundation	
Greenbrier Valley Anesthesia, LLC	
Greenbrier Valley Emergency Physicians, LLC	
Greenbrier VMC, LLC	d/b/a Greenbrier Valley Medical Center
Greenville Clinic Corp.	
Greenville Home Care Services, LLC	
Greenville Hospital Corporation	d/b/a L. V. Stabler Memorial Hospital
GRMC Holdings, LLC	
Gulf Coast Hospital, L.P.	
Gulf Coast Medical Center, LLC	
Hallmark Healthcare Company, LLC	
Harris Managed Services, Inc.	
Harris Medical Clinics, Inc.	
Hattiesburg ASC-GP, LLC	
Hattiesburg Home Care Services, LLC	
Haven Clinton Medical Associates, LLC	
HDP DeQueen, LLC	
HDP Woodland Heights, L.P.	
HDP Woodland Property, LLC	
HDPWH, LLC	
Healdsburg of California, LLC	
Healthcare Group, LLC#	

Healthcare of Forsyth County, Inc.	
HealthTrust Purchasing Group, L.P.#	
Healthwest Holdings, Inc.	
Heartland Malpractice Assistance Fund, Inc.	
Heartland Regional Health System, LLC	
Heartland Rural Healthcare, LLC	
Heck, Mourning, Smith & Barnes Partnership#	
Hefner Pointe Medical Associates, LLC#	
HEH Corporation	
Helena Home Care Services, LLC	
Hidden Valley Medical Center, Inc.	
Highland Health Systems, Inc.	
HIH, LLC	
Hill Regional Clinic Corp.	
Hill Regional Medical Group	
Hobbs Medco, LLC	
Hobbs Physician Practice, LLC	
Hood Medical Group	
Hood Medical Services, Inc.	
Hospital of Barstow, Inc.	d/b/a Barstow Community Hospital
Hospital of Beaumont, LLC	
Hospital of Fulton, Inc.	d/b/a Parkway Regional Hospital
Hospital of Louisa, Inc.	d/b/a Three Rivers Medical Center
Hospital of Morristown, Inc.	d/b/a Lakeway Regional Hospital
Hot Springs Outpatient Surgery Center, G.P.	
HTI Tucson Rehabilitation, Inc.	
Humble Texas Home Care Corporation	
Huntington Associates	
Huntington Beach Amdeco, LLC	
Imaging Diagnostic Center Partnership#	
INACTCO, Inc.	
In-Home Assistance, L.L.C.	
In-Home Medical Equipment Supplies and Services, Inc.	
Inland Empire Hospital Services Association#	
Inland Northwest Genetics Clinic#	
Inland Northwest Health Services#	

Innovative Recoveries, LLC	
IOM Health System, L.P.	d/b/a Lutheran Hospital of Indiana
IRHC, LLC	
Jackson Home Care Services, LLC	
Jackson Hospital Corporation	d/b/a Kentucky River Medical Center
Jackson Hospital Corporation	
Jackson Physician Corp.	
Jackson, Tennessee Hospital Company, LLC	d/b/a Regional Hospital of Jackson
Jennersville Family Medicine, LLC	
Jennersville Regional Hospital Malpractice Assistance Fund, Inc.	
Jonesboro Real Property, LLC	
Jourdanton Home Care Services, LLC	
Jourdanton Hospital Corporation	d/b/a South Texas Regional Medical Center
Kay County Clinic Company, LLC	
Kay County Hospital Corporation	
Kay County Oklahoma Hospital Company, LLC	d/b/a Ponca City Medical Center
Kensingcare, LLC	
Kentucky River Physician Corporation	
King's Daughters Malpractice Assistance Fund, Inc.	
Kirksville Academic Medicine, LLC	
Kirksville Clinic Corp.	
Kirksville Home Care Services, LLC	
Kirksville Hospital Company, LLC	
Kirksville Missouri Hospital Company, LLC*	d/b/a Northeast Regional Medical Center
Kirksville Physical Therapy Services, LLC	
Knox Clinic Corp.	
Knox Home Care Services, LLC	
Knox Indiana Hospital Company, LLC	
Knox Physician Services, LLC	
Lake Area Physician Services, LLC	
Lake Area Surgicare, A Partnership in Commendam*	
Lake Wales Clinic Corp.	
Lake Wales Hospital Corporation*	d/b/a Lake Wales Medical Center
Lake Wales Hospital Investment Corporation*	
Lakeway Hospital Corporation	
Lancaster Clinic Corp.	

Lancaster Home Care Services, LLC	
Lancaster Hospital Corporation	d/b/a Springs Memorial Hospital
Lancaster Imaging Center, LLC*	
Laredo Hospital, L.P.	
Laredo Texas Home Care Services Company, L.P.	
Laredo Texas Hospital Company, L.P.*	d/b/a Laredo Medical Center
Las Cruces ASC-GP, LLC	
Las Cruces Medical Center, LLC	d/b/a Mountain View Regional Medical Center
Las Cruces Physician Services, LLC	
Las Cruces Surgery Center, L.P.*	
Lea Regional Hospital, LLC	d/b/a Lea Regional Medical Center
Leesville Diagnostic Center, L.P.*	
Leesville Surgery Center, LLC*	
Lexington Clinic Corp.	
Lexington Home Care Services, LLC	
Lexington Hospital Corporation	d/b/a Henderson County Community Hospital
Lindenhurst Illinois Hospital Company, LLC	
Lithotripsy Providers of Alabama, LLC#	
Lock Haven Clinic Company, LLC	
Lock Haven Home Care Services, LLC	
Lock Haven Medical Professionals, P.C.	
Logan Hospital Corporation	
Logan, West Virginia Hospital Company, LLC	
Longview Medical Center, L.P.*	d/b/a Longview Regional Medical Center
Longview Merger, LLC	
Louisa Home Care Services, LLC	
LRH, LLC	
LS Psychiatric, LLC	
Lutheran Health Network CBO, LLC	
Lutheran Health Network Investors, LLC	
Lutheran Health Network of Indiana, LLC	
Lutheran Heart Alliance, LLC#	
Lutheran Medical Office Park Phase I#	
Lutheran Medical Office Park Phase II#	
Lutheran Musculoskeletal Center, LLC*	
Lutheran/TRMA Network, LLC#	
Macon Healthcare, LLC#	

Madison Clinic Corp.	
Madison Hospital, LLC	
Malulani Health and Medical Center, LLC	
Marion Hospital Corporation	d/b/a Heartland Regional Medical Center
Marlboro Clinic Corp.	
Martin Clinic Corp.	
Martin Hospital Corporation	d/b/a Volunteer Community Hospital
Mary Black Health System LLC*	d/b/a Mary Black Memorial Hospital
Mary Black Medical Office Building Limited Partnership	
Mary Black MOB II, L.P.	
Mary Black Physician Services, LLC	
Mary Black Physicians Group, LLC	
Massillon Community Health System, LLC*	
Massillon Health System, LLC	
Mat-Su Regional ASC GP, LLC	
Mat-Su Regional Surgery Center, L.P.	
Mat-Su Valley II, LLC*	
Mat-Su Valley III, LLC*	
Mat-Su Valley Medical Center, LLC*	d/b/a Mat-Su Regional Medical Center
MCI Panhandle Surgical, L.P.	
McKenzie Clinic Corp.	
McKenzie Physician Services, LLC	
McKenzie Tennessee Hospital Company, LLC	d/b/a McKenzie Regional Hospital
McKenzie-Willamette Regional Medical Center Associates, LLC*	d/b/a McKenzie-Willamette Medical Center
McNairy Clinic Corp.	
McNairy Hospital Corporation	d/b/a McNairy Regional Hospital
MCSA, LLC#	
Medical Center at Terrell, LLC	
Medical Center of Brownwood, LLC	
Medical Center of Sherman, LLC	
Medical Diagnostic Center Associates, LP#	
Medical Holdings, Inc.	
Medical Park Hospital, LLC	
Medical Park MSO, LLC	
MEDSTAT, LLC	

Memorial Hospital of Salem Malpractice Assistance Fund, Inc.	
Memorial Hospital, LLC	
Memorial Management, Inc.	
Mesa View Physical Rehabilitation, LLC#	
Mesa View PT, LLC	
MHS Ambulatory Surgery Center, Inc.	
Mid-America Health Partners, Inc.#	
Mid-Plains, LLC	
Minot Health Services, Inc.	
Mission Bay Memorial Hospital, LLC	
Missouri Healthserv, LLC	
MMC of Nevada, LLC	d/b/a Mesa View Regional Hospital
Moberly Hospital Company, LLC	d/b/a Moberly Regional Medical Center
Moberly Medical Clinics, Inc.	
Moberly Physicians Corp.	
Mohave Imaging Center, LLC	
Morristown Clinic Corp.	
Morristown Professional Centers, Inc.	
Morristown Surgery Center, LLC	
MWMC Holdings, LLC	
National Healthcare of England Arkansas, Inc.	
National Healthcare of Holmes County, Inc.	
National Healthcare of Leesville, Inc.	d/b/a Byrd Regional Hospital
National Healthcare of Mt. Vernon, Inc.	d/b/a Crossroads Community Hospital
National Healthcare of Newport, Inc.	d/b/a Harris Hospital
Navarro Hospital, L.P.	d/b/a Navarro Regional Hospital
Navarro Regional, LLC	
NC-CSH, Inc.	
NC-DSH, Inc.	
NeuroSpine-Pain Surgery Center, LLC#	
Newport Home Care Services, LLC	
NHCI of Hillsboro, Inc.	d/b/a Hill Regional Hospital
North Anaheim Surgicare, LLC	
North Okaloosa Clinic Corp.	
North Okaloosa Home Health Corp.	
North Okaloosa Medical Corp.*	

North Okaloosa Surgery Venture Corp.	
Northampton Clinic Company, LLC	
Northampton Home Care, LLC	
Northampton Hospital Company, LLC	d/b/a Easton Hospital
Northampton Physician Services Corp.	
Northeast Medical Center, L.P.	
Northern Indiana Oncology Center, LLC*	
Northwest Allied Physicians, LLC	
Northwest Arkansas Employees, LLC	
Northwest Arkansas Hospitals, LLC*	d/b/a Northwest Medical Center -- Bentonville; Northwest Medical Center -- Springdale; Willow Creek Women's Hospital
Northwest Benton County Physician Services, LLC	
Northwest Hospital, LLC	d/b/a Northwest Medical Center
Northwest Indiana Health System, LLC*	
Northwest Marana Hospital, LLC	
Northwest Medical Center CT/MRI at Marana, LLC#	
Northwest Physicians, LLC	
Northwest Rancho Vistoso Imaging Services, LLC	
Northwest Tucson ASC-GP, LLC	
Northwest Tucson Surgery Center, L.P.*	
NOV Holdings, LLC	
Novasys Health Network, L.L.C.#	
NRH, LLC	
Oak Hill Clinic Corp.	
Oak Hill Hospital Corporation	d/b/a Plateau Medical Center
Odessa, LLC	
Ohio Sleep Disorders Centers, LLC#	
Oklahoma City ASC-GP, LLC	
Oklahoma City Home Care Services, LLC	
Oklahoma City Surgery Center, L.P.	
Olive Branch Clinic Corp.	
Olive Branch Hospital, Inc.	
OPRMC, LLC	
Oro Valley Hospital, LLC	d/b/a Northwest Medical Center
Pacific East Division Office, L.P.	
Pacific Group ASC Division, Inc.	

Pacific Physicians Services, LLC	
Pacific West Division Office, LLC	
Pain Management Join Venture, L.L.P.#	
Palm Drive Hospital, L.P.	
Palm Drive Medical Center, LLC	
Palmer-Wasilla Health System, LLC	
Palmetto Women's Care, LLC	
Pampa Hospital, L.P.	
Pampa Medical Center, LLC	
Panhandle Medical Center, LLC	
Panhandle Property, LLC	
Panhandle Surgical Hospital, L.P.	
Panhandle, LLC	
Parkway Regional Medical Clinic, Inc.	
Payson Healthcare Management, Inc.	
Payson Home Care Services, LLC	
Payson Hospital Corporation	d/b/a Payson Regional Medical Center
PDMC, LLC	
Pecos Valley of New Mexico, LLC	
Peerless Healthcare, LLC	
Pennsylvania Hospital Company, LLC	
Pennsylvania Medical Professionals, P.C.	
Petersburg Clinic Company, LLC	
Petersburg Home Care Services, LLC	
Petersburg Hospital Company, LLC	d/b/a Southside Regional Medical Center
PH Denton Physicians, Inc.	
Phillips & Coker OB-GYN, LLC	
Phillips Clinic Corp.	
Phillips Hospital Corporation	d/b/a Helena Regional Medical Center
Phoenix Amdeco, LLC	
Phoenix Surgical, LLC	
Phoenixville Clinic Company, LLC	
Phoenixville Hospital Company, LLC	d/b/a Phoenixville Hospital
Phoenixville Hospital Malpractice Assistance Fund, Inc.	
Physician Practice Support, Inc.	
Physicians and Surgeons Hospital of Alice, L.P.	

Physicians' Surgery Center of Florence, LLC	
Phys-Med, LLC	
Piney Woods Healthcare System, L.P.*	d/b/a Woodland Heights Medical Center
Plymouth Hospital Corporation	
Polk Medical Services, Inc.	
Ponca City Home Care Services, Inc.	
Porter County Endoscopy Center, LLC#	
Porter Health Services, LLC	
Porter Hospital, LLC*	d/b/a Porter Hospital
Porter Physician Services, LLC	
Pottstown Clinic Company, LLC	
Pottstown Home Care Services, LLC	
Pottstown Hospital Company, LLC	d/b/a Pottstown Memorial Medical Center
Pottstown Hospital Corporation	
Pottstown Imaging Company, LLC	
Pottstown Memorial Malpractice Assistance Fund, Inc.	
Premier Care Hospital, LLC	
PremierCare of Arkansas, LLC#	
PremierCare of Northwest Arkansas, LLC*	
Premier Care Super PHO, LLC	
Primary Medical, LLC	
Procure Solutions, LLC	
Professional Account Services Inc.	
Psychiatric Services of Paradise Valley, LLC	
QHG Georgia Holdings, Inc.	
QHG Georgia, L.P.	
QHG of Barberton, Inc.	
QHG of Bluffton Company, LLC	
QHG of Clinton County, Inc.	
QHG of Enterprise, Inc.	d/b/a Medical Center Enterprise
QHG of Forrest County, Inc.	
QHG of Fort Wayne Company, LLC	
QHG of Hattiesburg, Inc.	
QHG of Kenmare, Inc.	
QHG of Lake City, Inc.	
QHG of Massillon, Inc.	

QHG of Minot, Inc.	
QHG of Ohio, Inc.	
QHG of South Carolina, Inc.	d/b/a Carolinas Hospital System
QHG of Spartanburg, Inc.	
QHG of Springdale, Inc.	
QHG of Texas, Inc.	
QHG of Warsaw Company, LLC	
QHR International, LLC	
Quorum ELF, Inc.	
Quorum Health Resources, LLC	
Quorum Health Services, Inc.	
Red Bud Clinic Corp.	
Red Bud Home Care Services, LLC	
Red Bud Hospital Corporation	
Red Bud Illinois Hospital Company, LLC	d/b/a Red Bud Regional Hospital
Redimed DeKalb, LLC#	
Regional Cancer Treatment Center, Ltd.#	
Regional Employee Assistance Program	
Regional Hospital of Longview, LLC	
Rehab Hospital of Fort Wayne General Partnership	
River Region Medical Corporation	
River to River Heart Group, LLC	
Riverside MSO, LLC#	
Roswell Clinic Corp.	
Roswell Community Hospital Investment Corporation	
Roswell Hospital Corporation	d/b/a Eastern New Mexico Medical Center
Russell County Clinic Corp.	
Russell County Medical Center, Inc.	
Ruston Clinic Company, LLC	
Ruston Hospital Corporation	
Ruston Louisiana Hospital Company, LLC	d/b/a Northern Louisiana Medical Center
SACMC, LLC	
Salem Clinic Corp.	
Salem Home Care Services, LLC	
Salem Hospital Corporation	d/b/a The Memorial Hospital of Salem County
Salem Medical Professionals, P.C.	
Samaritan Surgicenters of Arizona II, LLC	

San Angelo Ambulatory Surgery Center, Ltd.#	
San Angelo Community Medical Center, LLC	
San Angelo Hospital, L.P.	d/b/a San Angelo Community Medical Center
San Angelo Medical, LLC	
San Diego Hospital, L.P.	
San Leandro, LLC	
San Leandro Hospital, L.P.	
San Leandro Medical Center, LLC	
San Leandro Surgery Center, Ltd.#	
San Miguel Clinic Corp.	
San Miguel Hospital Corporation	d/b/a Alta Vista Regional Hospital
Scenic Managed Services, Inc.	
Schuylkill Internal Medicine Associates, LLC	
SDH, LLC	
Searcy Holdings, LLC	
Sebastopol, LLC	
Senior Circle Association (not-for-profit)	
Shelbyville Clinic Corp.	
Shelbyville Home Care Services, LLC	
Shelbyville Hospital Corporation	d/b/a Heritage Medical Center
Sherman Hospital, L.P.	
Sherman Medical Center, LLC	
Siloam Springs Arkansas Hospital Company, LLC	d/b/a Siloam Springs Memorial Hospital
Siloam Springs Clinic Company, LLC	
Siloam Springs Holdings, LLC	
Silsbee Doctors Hospital, L.P.	
Silsbee Medical Center, LLC	
Silsbee Texas, LLC	
Silver Creek MRI, LLC*	
SJ Home Care, LLC	
SkyRidge Clinical Associates, LLC	
SLH, LLC	
SMMC Medical Group	
Software Sales Corp.	
South Alabama Managed Care Contracting, Inc.	
South Alabama Medical Management Services, Inc.	
South Alabama Physician Services, Inc.	

South Arkansas Clinic, LLC	
South Arkansas Physician Services, LLC#	
South Tulsa Medical Group, LLC	
SouthCrest Anesthesia Group, LLC	
SouthCrest Medical Group, LLC	
SouthCrest Surgery Center, L.P.*	
SouthCrest, L.L.C.	d/b/a SouthCrest Hospital
Southeast Alabama Maternity Center, LLC#	
Southern Chester County Medical Building I#	
Southern Chester County Medical Building II#	
Southern Illinois Medical Care Associates, LLC	
Southern Texas Medical Center, LLC	
Southside Physician Network, LLC	
Spokane Valley Washington Hospital Company, LLC	d/b/a Valley Hospital and Medical Center
Spokane Washington Hospital Company, LLC	d/b/a Deaconess Medical Center
Springdale/Bentonville ASC-GP, LLC	
Springdale/Bentonville Surgery Center, L.P.*	
Springdale Home Care Services, LLC	
Springfield Oregon Holdings, LLC	
Sprocket Medical Management, LLC	
St. Joseph Health System, LLC	d/b/a St. Joseph Health System
St. Joseph Medical Group, Inc.	
StrokeCareNow, LLC#	
Summerlin Hospital Medical Center, LLC#	
Summit Surgical Suites, LLC#	
Sunbury Clinic Company, LLC	
Sunbury Hospital Company, LLC*	d/b/a Sunbury Community Hospital
Surgical Center of Amarillo, LLC	
Surgical Center of Carlsbad, LLC	
Surgicare of Independence, Inc.	
Surgicare of San Leandro, Inc.	
Surgicare of Sherman, Inc.	
Surgicare of Southeast Texas I, LLC	
Surgicare of Victoria, Inc.	
Surgicare of Victoria, Ltd.	
Surgicare Outpatient Center of Lake Charles, Inc.	
Surgicenter of Johnson County, Inc.	

Surgicenters of America, Inc.	
Tennyson Holdings, LLC	
Terrell Hospital, L.P.	
Terrell Medical Center, LLC	
The Intensive Resource Group, LLC	
The Surgery Center of Salem County, L.L.C.*	
The Vicksburg Clinic, LLC	
Three Rivers Medical Clinics, Inc.	
Timberland Medical Group	
Tooele Clinic Corp.	
Tooele Home Care Services, LLC	
Tooele Hospital Corporation	d/b/a Mountain West Medical Center
Triad Corporate Services, Limited Partnership	
Triad CSGP, LLC	
Triad CSLP, LLC	
Triad DeQueen Regional Medical Center, LLC	
Triad Healthcare Corporation	
Triad Healthcare System of Phoenix, L.P.	
Triad Holdings III, LLC	
Triad Holdings IV, LLC	
Triad Holdings V, LLC	
Triad Holdings VI, Inc.	
Triad Indiana Holdings, LLC	
Triad Nevada Holdings, LLC	
Triad of Alabama, LLC	d/b/a Flowers Hospital
Triad of Arizona (L.P.), Inc.	
Triad of Oregon, LLC	
Triad of Phoenix, Inc.	
Triad RC, Inc.	
Triad Texas, LLC	
Triad-Arizona I, Inc.	
Triad-ARMC, LLC	
Triad-Denton Hospital GP, LLC	
Triad-Denton Hospital, L.P.	
Triad-El Dorado, Inc.	
Triad-Medical Center at Terrell Subsidiary, LLC	

Triad-Medical Center of Sherman Subsidiary, LLC	
Triad-Navarro Regional Hospital Subsidiary, LLC	
Triad-South Tulsa Hospital Company, Inc.	
Triad-Willow Creek, LLC	
Tri-Irish, Inc.	
Tri-Shell 37 LLC	
Tri-World, LLC	
TROSCO, LLC	
Troy Hospital Corporation	
Trufor Pharmacy, LLC	
TTHR Limited Partnership*	d/b/a Presbyterian Hospital of Denton
Tucson Rehabilitation, LLC	
Tulsa Home Care Services, LLC	
Tuscora Park Medical Specialists, LLC	
Valley Advanced Imaging, LLC#	
Valley Advanced MRI, LLC#	
Valley Health System, LLC#	
Vanderbilt-Gateway Cancer Center, G.P.#	
VFARC, LLC	
VHC Holdings, LLC	
VHC Medical, LLC	
Vicksburg Healthcare, LLC	d/b/a River Region Medical Center
Vicksburg Surgical Center, LLC	
Victoria Functional Assessment & Restoration Ltd.	
Victoria Hospital, LLC	
Victoria of Texas, L.P.	d/b/a DeTar Hospital Navarro; DeTar Hospital North
Victoria Texas Home Care Services, LLC	
Village Medical Center Associates, LLC	
Virginia Hospital Company, LLC	
VMF Medical, LLC	
WA-SPOK DH CRNA, LLC	
WA-SPOK DH Urgent Care, LLC	
WA-SPOK Kidney Care, LLC	
WA-SPOK Medical Care, LLC	
WA-SPOK Primary Care, LLC	
WA-SPOK Pulmonary & Critical Care, LLC	

WA-SPOK VH CRNA, LLC	
WA-SPOK VH Urgent Care, LLC	
Wagoner Community Hospital, LLC	
WAMC, LLC	
Warsaw Health System, LLC*	d/b/a Kosciusko Community Hospital
Washington Clinic Corp.	
Washington Hospital Corporation	
Washington Physician Corp.	
Watsonville Hospital Corporation	d/b/a Watsonville Community Hospital
Waukegan Clinic Corp.	
Waukegan Hospice Corp.	
Waukegan Hospital Corporation	
Waukegan Illinois Hospital Company, LLC	d/b/a Vista Medical Center East; Vista Medical Center West
Weatherford Home Care Services, LLC	
Weatherford Hospital Corporation	
Weatherford Texas Hospital Company, LLC	d/b/a Weatherford Regional Medical Center
Webb County Texas Home Care Services, LLC	
Webb Hospital Corporation	
Webb Hospital Holdings, LLC	
Wesley Health System, LLC	d/b/a Wesley Medical Center
Wesley HealthTrust, Inc.	
Wesley Physician Services, LLC	
West Anaheim Hospital, L.P.	
West Anaheim Medical Center, LLC	
West Anaheim, LLC	
West Grove Clinic Company, LLC	
West Grove Family Practice, LLC	
West Grove Home Care, LLC	
West Grove Hospital Company, LLC	d/b/a Jennersville Regional Hospital
West Virginia MS, LLC	
Western Arizona Regional Home Health and Hospice, Inc.	
Western Illinois Kidney Center, L.L.C.#	
Wharton Medco, LLC	
WHMC, LLC	
Wichita Falls Texas Home Care Corporation	

Wichita Falls Texas Private Duty Corporation	
Wilkes-Barre Academic Medicine, LLC	
Wilkes-Barre Behavioral Hospital Company, LLC	
Wilkes-Barre Community Counseling Services, LLC	
Wilkes-Barre Holdings, LLC	
Wilkes-Barre Home Care Services, LLC	
Wilkes-Barre Hospital Company, LLC	
Wilkes-Barre Personal Care Services, LLC	
Wilkes-Barre Skilled Nursing Services, LLC	
Willamette Community Medical Group, LLC	
Williamston Clinic Corp.	
Williamston Hospital Corporation	d/b/a Martin General Hospital
WM Medical, LLC	
Women & Children's Hospital, LLC	d/b/a Women & Children's Hospital
Women's Health Care Associates of Phoenixville, LLC	
Woodland Heights Medical Center, LLC	
Woodward Clinic Company, LLC	
Woodward Health System, LLC	d/b/a Woodward Hospital
Woodward Home Care Services, LLC	

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement Nos. 333-117697 and 333-156405 on Form S-3 and in Registration Statement Nos. 333-100349, 333-61614, 333-44870, 333-107810, 333-121282, 333-121283, and 333-144525 on Form S-8 of our reports dated February 26, 2009 (which reports express an unqualified opinion and include an explanatory paragraph referring to the Company adopting Statement of Financial Accounting Standards No. 157, *Fair Value Measurements* effective January 1, 2008), relating to the consolidated financial statements and financial statement schedule of Community Health Systems, Inc., and the effectiveness of Community Health Systems, Inc.'s internal control over financial reporting, appearing in this Annual Report on Form 10-K of Community Health Systems, Inc. for the year ended December 31, 2008.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 26, 2009

I, Wayne T. Smith, certify that:

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

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

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

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

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

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

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

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

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

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

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

/s/ Wayne T. Smith
Wayne T. Smith
Chairman of the Board, President
and Chief Executive Officer

Date: February 27, 2009

Exhibit 31.2

I, W. Larry Cash, certify that:

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

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

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

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

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

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

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

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

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

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

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

/s/ W. Larry Cash

W. Larry Cash
Executive Vice President,
Chief Financial Officer and Director

Date: February 27, 2009

Exhibit Number 32.1

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

In connection with the Annual Report of Community Health Systems, Inc. (the "Company") on Form 10-K for the period ending December 31, 2008, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Wayne T. Smith, Chairman of the Board, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ WAYNE T. SMITH
Wayne T. Smith
Chairman of the Board, President and
Chief Executive Officer

February 27, 2009

Exhibit Number 32.2

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

In connection with the Annual Report of Community Health Systems, Inc. (the "Company") on Form 10-K for the period ending December 31, 2008, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, W. Larry Cash, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ W. LARRY CASH
W. Larry Cash
Executive Vice President, Chief Financial Officer and Director

February 27, 2009

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FORM 10-K

COMMUNITY HEALTH SYSTEMS INC - CYH

Filed: February 26, 2010 (period: December 31, 2009)

Annual report which provides a comprehensive overview of the company for the past year

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, 2009

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 *(State of incorporation)*	**13-3893191** *(IRS Employer Identification No.)*
4000 Meridian Boulevard **Franklin, Tennessee** *(Address of principal executive offices)*	**37067** *(Zip Code)*

Registrant's telephone number, including area code:
(615) 465-7000

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

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, $.01 par value	New York Stock Exchange

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

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

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

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

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

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

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

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

The aggregate market value of the voting stock held by non-affiliates of the Registrant was $2,341,348,569. Market value is determined by reference to the closing price on June 30, 2009 of the Registrant's Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2009) have any non-voting common stock outstanding. As of February 17, 2010, there were 93,110,682 shares of common stock, par value $.01 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required for Part III of this annual report is incorporated by reference from portions of the Registrant's definitive proxy statement for its 2010 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, 2009.

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FORM 10-K ANNUAL REPORT

COMMUNITY HEALTH SYSTEMS, INC.
Year ended December 31, 2009

PART I

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

Overview of Our Company

We are the largest publicly traded operator of hospitals in the United States in terms of number of facilities and net operating revenues. We were incorporated in 1996 as a Delaware corporation. We provide healthcare services through these hospitals that we own and operate in non-urban and selected urban markets throughout the United States. As of December 31, 2009, we owned or leased 122 hospitals. These hospitals are geographically diversified across 29 states, with an aggregate of 18,140 licensed beds. We generate revenues by providing a broad range of general and specialized hospital healthcare services to patients in the communities in which we are located. Services provided by our hospitals include general acute care services, emergency room services, general and specialty surgery, critical care, internal medicine, obstetrics and diagnostic services. As part of providing these services, we also own physician practices, imaging centers, and ambulatory surgery centers. 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 quality of care improvement programs; and assistance in the recruitment of additional physicians to the markets in which our hospitals are located. In a number of our markets, we have partnered with local physicians or not-for-profit providers, or both, in the ownership of our facilities. In addition to our hospitals and related businesses, we also own and operate home care agencies, including four home care agencies located in markets where we do not operate a hospital. Through our wholly-owned subsidiary, Quorum Health Resources, LLC, or QHR, we also provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. The home care agencies and the management services businesses constitute operating segments but are not considered reportable segments since they do not meet the quantitative thresholds for a separate identifiable reportable segment. The financial information for our reportable operating segments is presented in Note 14 of the Notes to our Consolidated Financial Statements included under Item 8 of this Report.

Our strategy has also included growth by acquisition. We target hospitals in growing, non-urban and select urban healthcare markets for acquisition because of their favorable demographic and economic trends and competitive conditions. Because these service areas have smaller populations, there are generally fewer hospitals and other healthcare service providers in these communities and generally a lower level of managed care presence in these markets. We believe that smaller populations support less direct competition for hospital-based services. Also, we believe that these communities generally view the local hospital as an integral part of the community.

Over the past three years, we have acquired 57 hospitals, including our July 25, 2007 acquisition of Triad Hospitals, Inc., or Triad, which owned and operated 50 hospitals with 49 hospitals located in 17 states in non-urban and middle market communities and one hospital located in the Republic of Ireland. As of December 31, 2009, we still own 42 of the 50 hospitals acquired from Triad. These acquisitions have expanded our operations into six states where we previously did not own facilities.

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

Available Information

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

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

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

Our Business Strategy

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

- increase revenue at our facilities;
- improve profitability;
- improve quality; and
- grow through selective acquisitions.

Increase Revenue at Our Facilities

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

- recruiting additional primary care physicians and specialists;
- expanding the breadth of services offered at our hospitals through targeted capital expenditures to support the addition of more complex services, including orthopedics, cardiovascular services, and urology; and
- providing the capital to invest in technology and the physical plant at the facilities, particularly in our emergency rooms, surgery departments, critical care departments, and diagnostic services.

Physician Recruiting. The primary method of adding or expanding medical services is the recruitment of new physicians into the community. A core group of primary care physicians is necessary as an initial contact point for all local healthcare. The addition of specialists who offer services, including general surgery, OB/GYN, 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 by analyzing demographic data and patient referral trends. As a result of this analysis, we are able to determine what we believe to be the optimum mix of primary care physicians and specialists. We employ recruiters at the corporate level to support the local hospital managers in their recruitment efforts. We have increased the number of physicians affiliated with us through our recruiting efforts, net of turnover, by approximately 772 in 2009, 686 in 2008, and 440 in 2007. The percentage of recruited or other physicians commencing practice with us that were specialists was over 50% in 2009. Although in recent years we have begun employing more physicians, most of the physicians in our communities are in private practice and are not our employees. We have been successful in recruiting physicians because of the practice opportunities afforded physicians in our markets, as well as lower managed care penetration as compared to larger urban areas.

Emergency Room Initiatives. Approximately 55% of our hospital admissions originate in the emergency room. Therefore, we systematically take steps to increase patient flow in our emergency rooms as a means of optimizing utilization rates for our hospitals. Furthermore, the impression of our overall operations by our customers is substantially influenced by our emergency rooms since generally that is their first experience with our hospitals. The steps we take to increase patient flow in our emergency rooms include renovating and expanding our emergency room facilities, improving service and reducing waiting times, as well as publicizing our emergency room capabilities in the local community. We have expanded or renovated 12 of our emergency rooms during the past three years, including five in 2009. We have also implemented marketing campaigns that emphasize the speed, convenience, and quality of our emergency rooms to enhance each community's awareness of our emergency room services.

One component of upgrading our emergency rooms is the implementation of specialized computer software programs designed to assist physicians in making diagnoses and determining treatments. The software also benefits patients and hospital personnel by assisting in proper documentation of patient records and tracking patient flow. It enables our nurses to provide more consistent patient care and provides clear instructions to patients at time of discharge to help them better understand their treatments.

Expansion of Services. In an effort to better meet the healthcare needs of the communities we serve and to capture a greater portion of the healthcare spending in our markets, we have added a broad range of services to our facilities. These services range from various types of diagnostic equipment capabilities to additional and renovated emergency rooms, surgical and critical care suites and specialty services. For example, in 2009, we spent $260.4 million as a part of 34 major construction projects. The 2009 projects included new emergency rooms, cardiac cathertization labs, intensive care units, hospital additions, and surgical suites. These projects improved various diagnostic and other inpatient and outpatient service capabilities. We continue to believe that appropriate capital investments in our facilities combined with the development of our service capabilities will reduce the migration of patients to competing providers while providing an attractive return on investment. We also employ a small group of clinical consultants at our corporate headquarters to assist the hospitals in their development of surgery, emergency, critical care, cardiovascular, and hospitalist services. In addition to spending capital on expanding services at our existing hospitals, we also build replacement facilities to better meet the healthcare needs of our communities. In 2009, we spent $4.8 million on planning costs for future construction projects related to three replacement hospitals, which we are required to build pursuant to either a hospital purchase agreement or an amendment to a lease agreement. The total cost of these three replacement hospitals is estimated to be $310.0 million.

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

Improve Profitability

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

- standardizing and centralizing our operations;
- optimizing resource allocation by utilizing our company-devised case and resource management program, which assists in improving clinical care and containing expenses;

- capitalizing on purchasing efficiencies through the use of company-wide standardized purchasing contracts and terminating or renegotiating specified vendor contracts;
- installing a standardized management information system, resulting in more efficient billing and collection procedures; and
- monitoring and enhancing productivity of our human resources.

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, which has an average of over 25 years of experience in the healthcare industry.

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

- *Billing and Collections.* We have adopted standard policies and procedures with respect to billing and collections. We have also automated and standardized various components of the collection cycle, including statement and collection letters and the movement of accounts through the collection cycle. Upon completion of an acquisition, our management information system 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.
- *Physician Support.* We support our newly recruited physicians to enhance their transition into our communities. We have implemented physician practice management seminars and training. We host these seminars bi-monthly. All newly recruited physicians who enter into contracts with us are required to attend a three-day introductory seminar that covers issues involved in starting up a practice.
- *Procurement and Materials Management.* We have standardized and centralized our operations with respect to medical supplies, equipment and pharmaceuticals used in our hospitals. We have a participation agreement with HealthTrust Purchasing Group, L.P., or HealthTrust, a group purchasing organization, or GPO. HealthTrust contracts with certain vendors who supply a substantial portion of our medical supplies, equipment and pharmaceuticals. Our agreement with HealthTrust extends to January 2011, 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 while maintaining the same level of quality and have shortened the time it takes us to complete these projects.
- *Other Initiatives.* We have also improved margins by implementing standard programs with respect to ancillary services in areas, including emergency rooms, pharmacy, laboratory, imaging, home care, skilled nursing, centralized outpatient scheduling and health information management. We have reduced costs associated with these services by improving contract terms and standardizing information systems. We work to identify and communicate best practices and monitor these improvements throughout the Company.
- *Internal Controls Over Financial Reporting.* We have centralized many of our significant internal controls over financial reporting and standardized those other controls that are performed at our hospital locations. We continuously monitor compliance with and evaluate the effectiveness of our internal controls over financial reporting.

Case and Resource Management. Our case and resource management program is a company-devised program developed with the goal of improving clinical care and cost containment. The program focuses on:

- appropriately treating patients along the care continuum;
- reducing inefficiently applied processes, procedures and resources;
- developing and implementing standards for operational best practices; and
- using on-site clinical facilitators to train and educate care practitioners on identified best practices.

Our case and resource management program integrates the functions of utilization review, discharge planning, overall clinical management, and resource management into a single effort to improve the quality and efficiency of care. Issues evaluated in this process include patient treatment, patient length of stay and utilization of resources.

Under our case and resource management program, patient care begins with a clinical assessment of the appropriate level of care, discharge planning, and medical necessity for planned services. Beginning when a patient presents to the hospital, we conduct ongoing reviews for medical necessity using appropriateness criteria. We reassess and adjust discharge plan options as the needs of the patient change. We closely monitor cases to prevent delayed service or inappropriate utilization of resources. Once the patient attains clinical improvement, we work with the attending physician to evaluate further needs for acute care treatment through discussions with the facility's physician advisor. Finally, we refer the patient to the appropriate post-hospitalization resources.

Improve Quality

We have implemented various programs to ensure continuous improvement in the quality of care provided. We have developed training programs for all senior hospital management, chief nursing officers, quality directors, physicians and other clinical staff. We share information among our hospital management to implement best practices and assist in complying with regulatory requirements. We have standardized accreditation documentation and requirements. All hospitals conduct patient, physician, and staff satisfaction surveys to help identify methods of improving the quality of care.

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

Grow Through Selective Acquisitions

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

- have a service area population between 20,000 and 400,000 with a stable or growing population base;
- are the sole or primary provider of acute care services in the community;
- are located in an area with the potential for service expansion;
- are not located in an area that is dependent upon a single employer or industry; and
- have financial performance that we believe will benefit from our management's operating skills.

In each year since 1997, we have met or exceeded our acquisition goals. Occasionally, we have pursued acquisition opportunities outside of our specified criteria when such opportunities have had uniquely favorable characteristics. In addition to two hospitals acquired from local governmental entities in 2007, we also acquired Triad, which owned and operated 50 hospitals, of which 49 hospitals were located in 17 states across the U.S. and one hospital was located in the Republic of Ireland. Since our acquisition of Triad's 50 hospital portfolio in July, 2007, we have focused most of our efforts on integrating those hospitals, as opposed to pursuing further acquisition opportunities. In the fourth quarter of 2008, we completed the acquisition of a two hospital system located in Spokane, Washington. In 2009, we acquired two hospitals located in Wilkes-Barre, Pennsylvania and Siloam Springs, Arkansas and purchased the remaining equity in a hospital located in El Dorado, Arkansas in which we previously had a noncontrolling interest.

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

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

At the time we acquire a hospital, we may commit to an amount of capital expenditures, such as a replacement facility, renovations, or equipment over a specified period of time. As obligations under two hospital purchase agreements in effect as of December 31, 2009, we are required to build a replacement facility in Valparaiso, Indiana by April 2011 and in Siloam Springs, Arkansas by February 2013. Also, as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location. Estimated construction costs, including equipment costs, are approximately $310.0 million for these three replacement hospitals, of which approximately $12.6 million has been incurred to date. In addition, under other purchase agreements in effect as of December 31, 2009, we have committed to spend $468.5 million, generally over a five to seven year period after acquisition, for costs such as capital improvements, equipment, selected leases and physician recruiting. Through December 31, 2009, we have incurred approximately $171.4 million related to these commitments. In October 2008, after the purchase of the noncontrolling owner's interest in our Birmingham, Alabama facility, we initiated the purchase of a site for a potential replacement to our existing Birmingham facility. The new site includes a partially constructed hospital structure. This project is subject to the approval of a certificate of need, or CON, expected to be granted by mid to late 2010. Upon receiving the CON, and after resolution of any legal issues, we will complete our assessment of the costs to complete construction of the unfinished facility and relocate our existing Birmingham facility to the new site.

Industry Overview

The Centers for Medicare and Medicaid Services, or CMS, reported that in 2008 total U.S. healthcare expenditures grew by 4.4% to approximately $2.3 trillion. CMS also projected total U.S. healthcare spending to grow by 5.5% in 2009 and by an average of 6.3% annually from 2010 through 2018. By these estimates, healthcare expenditures will account for approximately $4.4 trillion, or 20.3% of the total U.S. gross domestic product, by 2018.

Hospital services, the market in which we operate, is the largest single category of healthcare at 30% of total healthcare spending in 2008, or approximately $718.4 billion, as reported by CMS. CMS projects the hospital services category to grow by at least 5.1% per year through 2018. It expects growth in hospital healthcare spending to continue due to the aging of the U.S. population and consumer demand for expanded medical services. As hospitals remain the

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primary setting for healthcare delivery, CMS expects hospital services to remain the largest category of healthcare spending.

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

Urban vs. Non-Urban Hospitals

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

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

- facility size and location;
- facility ownership structure (i.e., tax-exempt or investor owned);
- a facility's ability to participate in group purchasing organizations; and
- facility payor mix.

We believe that non-urban hospitals are generally able to obtain higher operating margins than urban hospitals. Factors contributing to a non-urban hospital's margin advantage include fewer patients with complex medical problems, a lower cost structure, limited competition, and favorable Medicare payment provisions. Patients needing the most complex care are more often served by the larger and/or more specialized urban hospitals. A non-urban hospital's lower cost structure results from its geographic location, as well as the lower number of patients treated who need the most highly advanced services. Additionally, because non-urban hospitals are generally sole providers or one of a small group of providers in their markets, there is limited competition. This generally results in more favorable pricing with commercial payors. Medicare has special payment provisions for "sole community hospitals." Under present law, hospitals that qualify for this designation can receive higher reimbursement rates. As of December 31, 2009, 26 of our hospitals were "sole community hospitals." In addition, we believe that non-urban communities are generally characterized by a high level of patient and physician loyalty that fosters cooperative relationships among the local hospitals, physicians, employees and patients.

The type of third party responsible for the payment of services performed by healthcare service providers is also an important factor which affects hospital operating margins. These payors have increasingly exerted pressure on healthcare service providers to reduce the cost of care. The most active payors in this regard have been HMOs, PPOs, and other managed care organizations. The characteristics of non-urban markets make them less attractive to these managed care organizations. This is partly because the limited size of non-urban markets and their diverse, non-national employer bases minimize the ability of managed care organizations to achieve economies of scale as compared to economies of scale that can be achieved in many urban markets.

Hospital Industry Trends

Demographic Trends. According to the U.S. Census Bureau, there are presently approximately 38.9 million Americans aged 65 or older in the U.S. who comprise approximately 12.8% of the total U.S. population. By the year

2030, the number of elderly is expected to climb to 72.1 million, or 19.3% of the total population. Due to the increasing life expectancy of Americans, the number of people aged 85 years and older is also expected to increase from 5.5 million to 8.7 million by the year 2030. This increase in life expectancy will increase demand for healthcare services and, as importantly, the demand for innovative, more sophisticated means of delivering those services. Hospitals, as the largest category of care in the healthcare market, will be among the main beneficiaries of this increase in demand. Based on data compiled for us, the populations of the service areas where our hospitals are located grew by 24.8% from 1990 to 2008 and are expected to grow by 6.1% from 2008 to 2013. The number of people aged 65 or older in these service areas grew by 25.1% from 1990 to 2008 and is expected to grow by 11.3% from 2008 to 2013.

Consolidation. During recent years a significant amount of private equity capital has been invested into the hospital industry. Also, in addition to our own acquisition of Triad in 2007, consolidation activity, primarily through mergers and acquisitions involving both for-profit and not-for-profit hospital systems is continuing. Reasons for this activity included:

- excess capacity of available capital;
- valuation levels;
- financial performance issues, including challenges associated with changes in reimbursement and collectability of self-pay revenue;
- the desire to enhance the local availability of healthcare in the community;
- the need and ability to recruit primary care physicians and specialists;
- the need to achieve general economies of scale and to gain access to standardized and centralized functions, including favorable supply agreements and access to malpractice coverage; and
- regulatory changes.

As a result of the global economic conditions over this past year, we have seen a decline in the trend of consolidation activity, including mergers and acquisitions. We anticipate that future consolidation activity will be highly dependent on the availability of capital from the financial markets, hospital valuation levels, as well as the impact from any healthcare reform.

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 2009 include a full year of operations for 119 hospitals and partial periods for two hospitals acquired during the year and one hospital in which we previously had a noncontrolling interest and purchased the remaining interest during the year. Statistics for 2008 include a full year of operations for 117 hospitals and partial periods for two hospitals acquired during the year. Statistics for 2007 include a full year of operations for 70 hospitals and partial periods for 46 hospitals acquired during the year. Statistics for hospitals which have been sold are excluded from all periods presented.

	Year Ended December 31, 2009	2008 (Dollars in thousands)	2007
Consolidated Data			
Number of hospitals (at end of period)	122	119	116
Licensed beds (at end of period)(1)	18,140	17,411	17,148
Beds in service (at end of period)(2)	15,897	15,194	14,600
Admissions(3)	692,569	668,526	461,058
Adjusted admissions(4)	1,275,888	1,207,756	846,835
Patient days(5)	2,937,194	2,835,795	1,934,120
Average length of stay (days)(6)	4.2	4.2	4.2
Occupancy rate (beds in service)(7)	51.3%	52.3%	52.1%
Net operating revenues	$ 12,107,613	$ 10,919,095	$ 7,095,861
Net inpatient revenues as a % of total net operating revenues	50.1%	50.2%	49.2%
Net outpatient revenues as a % of total net operating revenues	47.6%	47.5%	48.8%
Net Income attributable to Community Health Systems, Inc.	$ 243,150	$ 218,304	$ 30,289
Net Income attributable to Community Health Systems, Inc. as a % of total net operating revenues	2.0%	2.0%	0.4%
Liquidity Data			
Adjusted EBITDA(8)	$ 1,671,397	$ 1,513,329	$ 810,066
Adjusted EBITDA as a % of total net operating revenues(8)	13.8%	13.9%	11.4%
Net cash flows provided by operating activities	$ 1,076,429	$ 1,056,581	$ 688,438
Net cash flows provided by operating activities as a % of total net operating revenues	8.9%	9.7%	9.7%
Net cash flows used in investing activities	$ (867,182)	$ (665,471)	$ (7,498,858)
Net cash flows provided by (used in) financing activities	$ (85,361)	$ (304,029)	$ 6,903,428

See pages 10 and 11 for footnotes.

	Year Ended December 31, 2009	2008	(Decrease) Increase
	(Dollars in thousands)		
Same-Store Data(9)			
Admissions(3)	658,215	668,526	(1.5)%
Adjusted admissions(4)	1,215,606	1,207,750	0.7%
Patient days(5)	2,768,470	2,835,795	
Average length of stay (days)(6)	4.2	4.2	
Occupancy rate (beds in service)(7)	51.1%	52.3%	
Net operating revenues	$ 11,556,401	$ 10,917,362	5.9%
Income from operations	$ 1,078,969	$ 969,737	11.3%
Income from operations as a % of net operating revenues	9.3%	8.9%	
Depreciation and amortization	$ 545,408	$ 499,386	
Equity in earnings of unconsolidated affiliates	$ 36,145	$ 43,777	

(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 of beds in service.

(8) EBITDA consists of net income attributable to Community Health Systems, Inc. before interest, income taxes, depreciation and amortization. Adjusted EBITDA is EBITDA adjusted to exclude discontinued operations, gain/loss from early extinguishment of debt and net income attributable to noncontrolling interests. We have from time to time sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. We believe that it is useful to present adjusted EBITDA because it excludes the portion of EBITDA attributable to these third party interests and clarifies for investors our portion of EBITDA generated by continuing operations. We use adjusted EBITDA as a measure of liquidity. We have included this measure because we believe it provides investors with additional information about our ability to incur and service debt and make capital expenditures. Adjusted EBITDA is the basis for a key component in the determination of our compliance with some of the covenants under our senior secured credit facility, as well as 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).

Adjusted EBITDA is not a measurement of financial performance or liquidity under generally accepted accounting principles. It should not be considered in isolation or as a substitute for net income, operating income, cash flows from operating, investing or financing activities, or any other measure calculated in accordance with generally accepted accounting principles. The items excluded from adjusted EBITDA are significant components in understanding and evaluating financial performance and liquidity. Our calculation of adjusted EBITDA may not be comparable to similarly titled measures reported by other companies.

The following table reconciles adjusted EBITDA, as defined, to our net cash provided by operating activities as derived directly from our consolidated financial statements for the years ended December 31, 2009, 2008 and 2007 (in thousands):

	Year Ended December 31,		
	2009	2008	2007
Adjusted EBITDA	$ 1,671,397	$ 1,513,329	$ 810,066
Interest expense, net	(648,964)	(652,468)	(362,065)
Provision for income taxes	(141,325)	(125,273)	(39,860)
Deferred income taxes	34,268	159,870	(39,894)
Income (loss) from operations of hospitals sold or held for sale	1,977	9,427	(4,199)
Income tax (expense) benefit on the non-cash impairment and (gain) loss on sale of hospitals	—	(8,107)	4,457
Depreciation and amortization of discontinued operations	332	7,308	19,258
Stock compensation expense	44,501	52,105	38,771
Income tax payable increase (excess tax benefits) relating to stock-based compensation	3,472	(1,278)	(1,216)
Other non-cash (income) expenses, net	22,870	3,577	19,018
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	58,390	(49,578)	128,743
Supplies, prepaid expenses and other current assets	(34,535)	(34,397)	(31,734)
Accounts payable, accrued liabilities and income taxes	86,098	119,869	122,282
Other	(22,052)	62,197	24,811
Net cash provided by operating activities	$ 1,076,429	$ 1,056,581	$ 688,438

(9) Includes former Triad hospital's data, as if we owned them as of January 1, 2007 (acquisition date was July 25, 2007) and other acquired hospitals to the extent we operated them during comparable periods in both years. We have restated our 2008 and 2007 financial statements and statistical results to include a hospital and related businesses, which were previously reported as discontinued operations and is now included in continuing operations.

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 net operating revenue received from Medicare, Medicaid, managed care, self-pay and other sources for the periods indicated. The data for the years presented are not strictly comparable due to the significant effect that hospital acquisitions have had on these statistics.

Net Operating Revenues by Payor Source	2009	2008	2007
Medicare	27.1%	27.5%	29.0%
Medicaid	9.8%	9.1%	10.3%
Managed Care and other third party payors	51.9%	52.7%	50.7%
Self-pay	11.2%	10.7%	10.0%
Total	100.0%	100.0%	100.0%

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

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, which provides medical benefits to individuals who are 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. 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.

In addition to government programs, we are paid by private payors, which include insurance companies, HMOs, PPOs, other managed care companies, employers, and by patients directly. Blue Cross payors are included in "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 are negotiating discounted fee structures or fixed amounts for hospital services performed, rather than paying healthcare providers the amounts billed. We negotiate discounts with managed care companies, which are typically smaller than discounts under governmental programs. If an increased number of insurance companies, HMOs, PPOs, and other managed care companies succeed in negotiating discounted fee structures or fixed amounts, our results of operations may be negatively affected. For more information on the payment programs on which our revenues depend, see "Payment" on page 17.

As of December 31, 2009, Indiana and Texas represented our only areas of geographic concentration. Net operating revenues as a percentage of consolidated net operating revenues generated in Indiana were 10.9% in 2009, 10.9% in 2008 and 7.8% in 2007. Net operating revenues as a percentage of consolidated net operating revenues generated in Texas were 13.2% in 2009, 13.3% in 2008 and 12.5% in 2007. As a result of our growth and expansion of services in other states, Pennsylvania no longer represents an area of geographic concentration, as it did at December 31, 2007.

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

- advances in technology, which have permitted us to provide more services on an outpatient basis; and

- pressure from Medicare or Medicaid programs, insurance companies, and managed care plans to reduce hospital stays and to reduce costs by having services provided on an outpatient rather than on an inpatient basis.

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 relate to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, hospital use, rate-setting, compliance with building codes, and environmental protection laws. There are also extensive regulations governing a hospital's participation in these government programs. If we fail to comply with applicable laws and regulations, we can be subject to criminal penalties and civil sanctions, our hospitals can lose their licenses and we could lose our ability to participate in these government programs. In addition, 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 in substantial compliance with current federal, state, and local regulations and standards.

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 on Accreditation of Healthcare Organizations. This accreditation indicates that a hospital satisfies the applicable health and administrative standards to participate in Medicare and Medicaid programs.

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

The "American Recovery and Reinvestment Act of 2009" has been signed into law providing for a temporary increase in the federal matching assistance percentage (FMAP), a temporary increase in federal Medicaid Disproportionate Share Hospital, or DSH, allotments, subsidization of health insurance premiums (COBRA) for up to nine months, and grants and loans for infrastructure and incentive payments for providers who adopt and use health information technology. The 2010 Department of Defense Appropriations Bill signed into law expands the subsidization of health insurance premiums (COBRA) to 15 months and extends the eligibility period for individuals losing their jobs through February 28, 2010. Additionally, the Obama administration has stated as a top priority its desire to reform the U.S. healthcare system with the goal of reducing the costs of healthcare and reducing the current number of uninsured and underinsured Americans. Several proposals have been considered, including cost controls on hospitals and insurance industry reforms. Currently, separate bills have been passed in both the U.S. House of Representatives and the U.S. Senate and debate in Congress is continuing in an attempt to draft a final piece of legislation. The costs of implementing the "American Recovery and Reinvestment Act of 2009" and these other proposals being considered could be financed, in part, by reductions in payments to healthcare providers under Medicare, Medicaid, and other government programs. In addition, federal funding for existing programs may not be approved in the future.

The current administration and Congress have now debated healthcare reform for over one year and, at this time, we cannot predict the outcome of this debate. A reduction in uninsured patients may reduce our expense from uncollectible accounts receivable; however, legislative proposals to achieve this reduction in uninsured patients may result in lower reimbursement from other payor sources and/or a migration of patients from private payor sources to lower paying government payor sources. Furthermore, we cannot predict the course of any other future legislation, changes the current administration may seek to implement regarding healthcare or interpretations by the current administration of existing governmental healthcare programs and the related effect that any legislative or interpretive change may have on us.

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

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of the fraud and abuse laws. Under HIPAA, 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.

Another law regulating the healthcare industry is a section of the Social Security Act, known as the "anti-kickback" statute. This law 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 program. Violations of the anti-kickback statute may be punished by criminal and civil fines, exclusion from federal healthcare programs, and damages up to three times the total dollar amount involved.

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. However, the failure of a particular activity to comply with the safe harbor regulations does not necessarily mean that the activity violates the anti-kickback statute.

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

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 believe that we have structured our arrangements with physicians in light of the "safe harbor" rules, 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.

The Social Security Act also includes a provision commonly known as the "Stark law." This law prohibits physicians from referring Medicare patients to healthcare entities in which they or any of their immediate family members have ownership interests or other financial arrangements. These types of referrals are commonly known as "self referrals." Sanctions for violating the Stark law include denial of payment, civil money penalties, assessments equal to twice the dollar value of each service, and exclusion from government payor programs. There are ownership and compensation arrangement exceptions to the self-referral prohibition. One 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. We strive to comply with the Stark law and regulations; however, the government may interpret the law and regulations differently. If we are found to have violated the Stark law or regulations, we could be subject to significant sanctions, including damages, penalties, and exclusion from federal healthcare programs.

Many states in which we operate also have adopted similar laws relating to financial relationships with physicians. Some of these state laws apply even if the payment for care does not come from the government. These statutes typically provide criminal and civil penalties as well as loss of licensure. While there is little precedent for the interpretation or enforcement of these state laws, we have attempted to structure our financial relationships with physicians and others in light of these laws. However, if we are found to have violated these state laws, it could result in the imposition of criminal and civil penalties as well as possible licensure revocation.

False Claims Act. Another trend in healthcare litigation is the increased use of the False Claims Act, or FCA. This law makes providers liable for, among other things, the knowing submission of a false claim for reimbursement by the federal government. The FCA has been used not only by the U.S. government, but also by individuals who bring an action on behalf of the government under the law's "qui tam" or "whistleblower" provisions and share in any recovery. When a private party brings a qui tam action under the FCA, it files the complaint with the court under seal, and the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation.

Civil liability under the FCA can be up to three times the actual damages sustained by the government plus civil penalties of up to $11,000 for each separate false claim submitted to the government. There are many potential bases for liability under the FCA. Although liability under the FCA arises when an entity knowingly submits a false claim for reimbursement, the FCA defines the term "knowingly" to include reckless disregard of the truth or falsity of the claim being submitted.

A number of states in which we operate have enacted state false claims legislation. These state false claims laws are generally modeled on the federal FCA, with similar damages, penalties, and qui tam enforcement provisions. An increasing number of healthcare false claims cases seek recoveries under both federal and state law.

Provisions in the Deficit Reduction Act of 2005, or DRA, that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal FCA. Additionally, the DRA requires every entity that receives annual payments of at least $5 million from a state Medicaid plan to establish written policies for its employees that provide detailed information about federal and state false claims statutes and the whistleblower protections that exist under those laws. Both provisions of the DRA are expected to result in increased false claims litigation against health care providers. We have substantially complied with the written policy requirements.

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 or fee-splitting arrangements between physicians and unlicensed persons or business entities. Possible sanctions for violations of these restrictions include loss of a physician's license, civil and criminal penalties and rescission of business arrangements. These laws vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. We structure our arrangements with healthcare providers to comply with the relevant state law. However, we cannot assure you 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. In addition, the law creates private civil remedies which 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 or others will not assert we are in violation of these laws.

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 additional 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, 2009, we operated 54 hospitals in 16 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.

Privacy and Security Requirements of HIPAA. The Administrative Simplification Provisions of HIPAA require 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. We believe we are in compliance with these regulations.

The Administrative Simplification Provisions also require CMS to adopt standards to protect the security and privacy of health-related information. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. If we violate these regulations, we could be subject to monetary fines and penalties, criminal sanctions and civil causes of action. We have implemented and operate continuing employee education programs to reinforce operational compliance with policy and procedures which adhere to privacy regulations. The HIPAA security standards and privacy regulations serve similar purposes and overlap to a certain extent, but the security regulations relate more specifically to protecting the integrity, confidentiality and availability of electronic protected health information while it is in our custody or being transmitted to others. We believe we have established proper controls to safeguard access to protected health information.

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. For the federal fiscal year 2008 (i.e., the federal fiscal year beginning October 1, 2007), each DRG was assigned a payment rate using 67% of the national average cost per case and 33% of the national average charge per case and 50% of the change to severity adjusted DRG weights. Severity adjusted DRG's more accurately reflect the costs a hospital incurs for caring for a patient and accounts more fully for the severity of each patient's condition. Commencing with the federal fiscal year 2009 (i.e., the federal fiscal year beginning October 1, 2008), 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. 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 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 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 2007, 2008, 2009 and 2010 or 3.4%, 3.3%, 3.6% and 2.1%, respectively. The Deficit Reduction Act of 2005 imposes a two percentage point reduction to the market basket index beginning October 1, 2007, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement. Future legislation may decrease the rate of increase for DRG payments, but we are not able to predict the amount of any reduction or the effect that any reduction will have on us.

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. For the majority of our hospitals that qualify to receive Medicare disproportionate share payments, these payments were increased by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 effective April 1, 2004. These Medicare disproportionate share payments as a percentage of net operating revenues were 1.6%, 1.8% and 1.8% for the years ended December 31, 2009, 2008 and 2007, respectively.

Beginning August 1, 2000, we began receiving Medicare reimbursement for outpatient services through a PPS. Under the Balanced Budget Refinement Act of 1999, non-urban hospitals with 100 beds or less were held harmless through December 31, 2004 under this Medicare outpatient PPS. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 extended the hold harmless provision for non-urban hospitals with 100 beds or less and for non-urban sole community hospitals with more than 100 beds through December 31, 2005. The Deficit Reduction Act of 2005 extended the hold harmless provision for non-urban hospitals with 100 beds or less that are not sole community hospitals through December 31, 2008; however, that Act reduced the amount these hospitals would receive in hold harmless payment by 10% in 2007 and 15% in 2008. Of our 119 hospitals in continuing operations at December 31, 2008, 31 qualified for this relief. The Medicare Improvements for Patients and Providers Act extends the hold harmless provision for non-urban hospitals with 100 beds or less, including non-urban sole community hospitals, through December 31, 2009, at 85% of the hold harmless amount. Of our 122 hospitals at December 31, 2009, 44 qualified for this relief. The outpatient conversion factor was increased 3.4% effective January 1, 2007; however, coupled with adjustments to other variables with the outpatient PPS, an approximate 2.5% to 2.9% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.3% effective January 1, 2008; however, coupled with adjustments to other variables with the outpatient PPS, an approximate 3.0% to 3.4% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.6% effective January 1, 2009; however, coupled with adjustments to other variables with outpatient PPS, an approximate 3.5% to 3.9% net increase in outpatient payments is expected to occur. The outpatient conversion factor was increased 2.1% effective January 1, 2010; however, coupled with adjustments to other variables with outpatient PPS, an approximate 1.8% to 2.2% net increase in outpatient payments is expected to occur. The Medicare Improvements and Extension Act of the Tax Relief and Health Care Act of 2006 imposes a two percentage point reduction to the market basket index beginning January 1, 2009, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement.

Skilled nursing facilities and swing bed facilities were historically paid by Medicare on the basis of actual costs, subject to limitations. The Balanced Budget Act of 1997 established a PPS for Medicare skilled nursing facilities and mandated that swing bed facilities must be incorporated into the skilled nursing facility PPS. Skilled nursing facility PPS rates were increased by the full SNF market basket index of 3.1%, 3.3% and 3.4% for the federal fiscal years 2007, 2008 and 2009, respectively. For the federal fiscal year 2010 (i.e., the federal fiscal year beginning October 1, 2009), the skilled nursing PPS rates were increased by 2.2%; however, coupled with adjustments to other variables, within the skilled nursing PPS, an approximate 1.1% net decrease in skilled nursing payments is expected to occur.

The Department of Health and Human Services established a PPS for home health services (i.e. home care) effective October 1, 2000. The home health agency PPS per episodic payment rate increased by 3.3% on January 1, 2007. The home health agency PPS per episodic payment rate increased by 3% on January 1, 2008; however, coupled with adjustments to other variables with home health agency PPS, an approximate 1.5% to 1.9% net increase in home health agency payments occurred. The home health agency PPS per episodic payment rate increased by 2.9% on January 1, 2009; however, coupled with adjustments to other variables with home health agency PPS, an approximate 0.2% net increase in home health agency payments is expected to occur. The home health agency PPS per episodic payment rate increased by 2.0% on January 1, 2010; however, coupled with adjustments to other variables with home health agency PPS, an approximate 2.3% net increase in home health agency payments is expected to occur. The Deficit Reduction Act of 2005 imposes a two percentage point reduction to the market basket index beginning January 1, 2007, and each year thereafter, if patient quality data is not submitted. We are complying with this data submission requirement.

Medicaid. Most state Medicaid payments are made under a PPS or under programs which negotiate payment levels with individual hospitals. Medicaid is currently 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. We can provide no assurance that reductions to Medicaid fundings will not have a material adverse effect on our consolidated results of operations.

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

Commercial Insurance. Our hospitals provide services to individuals covered by private healthcare insurance. Private insurance carriers 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. Commercial insurers are trying to limit the costs of hospital services by negotiating discounts, including PPS, which would reduce payments by commercial insurers to our hospitals. Reductions in payments for services provided by our hospitals to individuals covered by commercial insurers could adversely affect us.

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. Triad was also a noncontrolling partner in HealthTrust and we acquired their ownership interest and contractual rights in the acquisition. As of December 31, 2009, we have an 18% 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 we expect to achieve.

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 select 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 has intensified in recent years. Our hospitals are located in non-urban and selected urban service areas. 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 do 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.

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

The number and quality of the physicians on a hospital's staff is an important factor in a hospital's competitive advantage. 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.

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. 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.

Since its initial adoption, the compliance program continues to be expanded and developed to meet the industry's expectations and our needs. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring activities have been prepared and implemented to address the functional and operational aspects of our business. Included within these functional areas are materials and activities for business sub-units, including laboratory, radiology, pharmacy, emergency, surgery, observation, home care, skilled nursing, and clinics. Specific areas identified through regulatory interpretation and enforcement activities have also been addressed in our program. Claims preparation and submission, including coding, billing, and cost reports, comprise the bulk of these areas. Financial arrangements with physicians and other referral sources, including compliance with anti-kickback and Stark laws, 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_conduct.html.

Employees

At December 31, 2009, we employed approximately 58,555 full-time employees and 20,659 part-time employees. In addition, we employed approximately 3,465 union members. We currently believe that our labor relations are good.

Professional Liability Claims

As part of our business of owning and operating hospitals, we are subject to legal actions alleging liability on our part. To cover claims arising out of the operations of hospitals, we maintain professional malpractice liability insurance and general liability insurance on a claims made basis in excess of those amounts for which we are self-insured, in amounts we believe to be sufficient for our operations. We also maintain umbrella liability coverage for claims which, due to their nature or amount, are not covered by our other insurance policies. However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. For a further discussion of our insurance coverage, see our discussion of professional liability claims in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Item 7 of this Report.

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 waste products. Compliance with these laws and regulations is not expected 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*

The following risk factors could materially and adversely affect our future operating results and could cause actual results to differ materially from those predicted in the forward-looking statements we make about our business.

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

We are significantly leveraged. The chart below shows our level of indebtedness and other information as of December 31, 2009. In connection with the consummation of our acquisition of Triad in July 2007, approximately $7.2 billion of senior secured financing under a new credit facility, or "Credit Facility," was obtained by our wholly-owned subsidiary, CHS/Community Health Systems, Inc., or CHS. CHS also issued 8.875% senior notes, or the "Notes," having an aggregate principal amount of approximately $3.0 billion. Both the indebtedness under the Credit Facility and the Notes are senior obligations of CHS and are guaranteed on a senior basis by us and by certain of our domestic subsidiaries. We used the net proceeds from the Notes offering and the net proceeds of the approximately $6.1 billion term loans under the Credit Facility to pay the consideration under the merger agreement with Triad, to refinance certain of our existing indebtedness and the indebtedness of Triad, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. As of December 31, 2009, a $750 million revolving credit facility was available to us for working capital and general corporate purposes under the Credit Facility, with $90.0 million of the revolving credit facility being set aside for outstanding letters of credit. With the exception of some small principal payments of our term loans under our Credit Facility, representing less than 1% of the outstanding balance each year through 2013, the term loans under our Credit Facility mature in 2014 and our Notes are not due until 2015.

	As of December 31, 2009 ($ in millions)
Senior secured credit facility	
Term loans	$ 6,043.8
Notes	2,784.3
Other	83.0
Total debt	$ 8,911.1
Community Health Systems, Inc. stockholders' equity	$ 1,950.6

The following table shows the ratio of earnings to fixed charges for the periods indicated:

	Year Ended December 31,				
	2005	2006	2007	2008	2009
Ratio of earnings to fixed charges(1)	3.79 x	3.37 x	1.22 x	1.47 x	1.59 x

(1) There are no shares of preferred stock outstanding.

As of December 31, 2009, our approximately $5.4 billion notional amount of interest rate swap agreements represented approximately 89% of our variable rate debt. On a prospective basis, a 1% change in interest rates on the remaining unhedged variable rate debt existing as of December 31, 2009, would result in interest expense fluctuating approximately $6.9 million per year..

The Credit Facility and/or the Notes contain various covenants that limit our ability to take certain actions, including our ability to:

- incur, assume or guarantee additional indebtedness;
- issue redeemable stock and preferred stock;
- repurchase capital stock;
- make restricted payments, including paying dividends and making investments;
- redeem debt that is junior in right of payment to the notes;
- create liens;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- enter into agreements that restrict dividends from subsidiaries;
- merge, consolidate, sell or otherwise dispose of substantial portions of 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 restricted covenants and financial ratios and tests can be affected by events beyond our control, and we cannot assure you that we will meet those tests.

The counterparty to the interest rate swap agreements exposes us to credit risk in the event of non-performance. However, at December 31, 2009, we do not anticipate non-performance by the counterparty due to the net settlement feature of the agreements and our liability position with respect to the majority of our counterparties.

A breach of any of these covenants could result in a default under our Credit Facility and/or the Notes. Upon the occurrence of an event of default under our Credit Facility or the Notes, all amounts outstanding under our Credit Facility and the Notes may become due and payable and all commitments under the Credit Facility to extend further credit may be terminated.

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

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

- we may be vulnerable in a downturn in general economic conditions or in our business, or we may be unable to carry out capital spending that is important to our growth.

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

We may be able to incur substantial additional indebtedness in the future. The terms of the indenture governing the Notes do not fully prohibit us from doing so. For example, under the indenture for the Notes, we may incur up to approximately $7.8 billion pursuant to a credit facility or a qualified receivables transaction, less certain amounts repaid with the proceeds of asset dispositions. Our Credit Facility provides for commitments of up to approximately $7.1 billion in the aggregate. Our Credit Facility also gives us the ability to provide for one or more additional tranches of term loans in aggregate principal amount of up to $600 million without the consent of the existing lenders if specified criteria are satisfied. If new debt is added to our current debt levels, the related risks that we now face could intensify.

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

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

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

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

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

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

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

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

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

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

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

The hospital industry is highly competitive. In addition to the competition we face for acquisitions and physicians, we must also compete with other hospitals and healthcare providers for patients. The competition among hospitals and other healthcare providers for patients has intensified in recent years. Our hospitals are located in non-urban service areas. In approximately 65% of our markets, we are the sole provider of general healthcare services. In most of our other markets, the primary competitor is a not-for-profit hospital. These not-for-profit hospitals generally differ in each jurisdiction. However, our hospitals face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in our primary service areas may travel to these other hospitals for a variety of reasons. These reasons include physician referrals or the need for services we do not offer. Patients who seek services from these other hospitals may subsequently shift their preferences to those hospitals for the services we provide.

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

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

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

We have a five-year participation agreement with a GPO. This agreement extends to January 2011, with automatic renewal terms of one year, unless either party terminates by giving notice of non-renewal. GPOs attempt to obtain favorable pricing on medical supplies with manufacturers and vendors who sometimes negotiate exclusive supply arrangements in exchange for the discounts they give. To the extent these exclusive supply arrangements are challenged or deemed unenforceable, we could incur higher costs for our medical supplies obtained through HealthTrust. These higher costs could cause our operating results to decline.

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

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

At December 31, 2009, we had approximately $4.2 billion of goodwill recorded on our books. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. If the carrying value of our goodwill is impaired, we may incur a material non-cash charge to earnings.

Risks related to our industry

We are subject to uncertainties regarding healthcare reform.

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

The "American Recovery and Reinvestment Act of 2009" has been signed into law providing for a temporary increase in the federal matching assistance percentage (FMAP), a temporary increase in federal Medicaid DSH allotments, subsidization of health insurance premiums (COBRA) for up to nine months, and grants and loans for infrastructure and incentive payments for providers who adopt and use health information technology. The 2010 Department of Defense Appropriations Bill signed into law expands the subsidization of health insurance premiums (COBRA) to 15 months and extends the eligibility period for individuals losing their jobs through February 28, 2010. Additionally, the Obama administration has stated as a top priority its desire to reform the U.S. healthcare system with the goal of reducing the costs of healthcare and reducing the current number of uninsured and underinsured Americans. Several proposals have been considered, including cost controls on hospitals and insurance industry reforms. Currently, separate bills have been passed in both the U.S. House of Representatives and the U.S. Senate and debate in Congress is continuing in an attempt to draft a final piece of legislation. The costs of implementing the "American Recovery and Reinvestment Act of 2009" and these other proposals being considered could be financed, in part, by reductions in payments to healthcare providers under Medicare, Medicaid, and other government programs. In addition, federal funding for existing programs may not be approved in the future.

The current administration and Congress have now debated healthcare reform for over one year and, at this time, we cannot predict the outcome of this debate. A reduction in uninsured patients may reduce our expense from uncollectible accounts receivable; however, legislative proposals to achieve this reduction in uninsured patients may result in lower reimbursement from other payor sources and/or a migration of patients from private payor sources to lower paying government payor sources. Furthermore, we cannot predict the course of any other future legislation, changes the current administration may seek to implement regarding healthcare or interpretations by the current administration of existing governmental healthcare programs and the related effect that any legislative or interpretive change may have on us.

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

In 2009, 36.9% of our net operating revenues came from the Medicare and Medicaid programs. Federal healthcare expenditures continue to increase and state governments continue to face budget shortfalls as a result of the current economic downturn and accelerating Medicaid enrollment. As a result, federal and state governments have made, and continue to make, significant changes in the Medicare and Medicaid programs. Some of these changes have decreased, or could decrease, the amount of money we receive for our services relating to these programs.

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

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

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

In addition, there are heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment. The ongoing investigations of certain healthcare providers relate to various referral, inpatient status cost reporting and billing practices, laboratory and home care services, and physician ownership and joint ventures involving hospitals. For example, the Department of Justice has alleged that we and three of our New Mexico hospitals have caused the state of New Mexico to submit improper claims for federal funds in violation of the Civil False Claims Act. For a further discussion of this matter, see "Legal Proceedings" in Item 3 of this Report.

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

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

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

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

In recent years, physicians, hospitals, and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability, or related legal theories. Even in states that have imposed caps on damages, litigants are seeking recoveries under new theories of liability that might not be subject to the caps on damages. Many of these actions involve large claims and significant defense costs. To protect us from the cost of these claims, we maintain professional malpractice liability insurance and general liability insurance coverage in excess of those amounts for which we are self-insured. This insurance coverage is in amounts that we believe to be sufficient for our operations. However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. Our expense related to malpractice and other professional liability claims, including the cost of excess insurance, decreased in 2007 by 0.1%. decreased in 2008 by 0.2% and increased in 2009 by 0.2% as a percentage of net operating revenues. If these costs rise rapidly, our profitability could decline. For a further discussion of our insurance coverage, see our discussion of professional liability claims in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Item 7 of this Report.

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

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

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

This Report includes forward-looking statements which could differ from actual future results.

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

- general economic and business conditions, both nationally and in the regions in which we operate;
- legislative proposals for healthcare reform and universal access to healthcare coverage;
- risks associated with our substantial indebtedness, leverage and debt service obligations;
- demographic changes;
- changes in, or the failure to comply with, governmental regulations;
- potential adverse impact of known and unknown government investigations, audits and Federal and State False Claims Act litigation;
- our ability, where appropriate, to enter into and maintain managed care provider arrangements and the terms of these arrangements;
- changes in, or the failure to comply with, managed care provider contracts could result in disputes and changes in reimbursement that could be applied retroactively;
- changes in inpatient or outpatient Medicare and Medicaid payment levels;
- increases in the amount and risk of collectability of patient accounts receivable;
- increases in wages as a result of inflation or competition for highly technical positions and rising supply costs due to market pressure from pharmaceutical companies and new product releases;
- liabilities and other claims asserted against us, including self-insured malpractice claims;
- competition;
- our ability to attract and retain, without significant employment costs, qualified personnel, key management, physicians, nurses and other healthcare workers;
- trends toward treatment of patients in less acute or specialty healthcare settings, including ambulatory surgery centers or specialty hospitals;
- changes in medical or other technology;
- changes in U.S. GAAP;
- the availability and terms of capital to fund additional acquisitions or replacement facilities;

- our ability to successfully acquire additional hospitals and complete the sale of hospitals held for sale;
- our ability to successfully integrate any acquired hospitals or to recognize expected synergies from such acquisitions;
- our ability to obtain adequate levels of general and professional liability insurance; and
- timeliness of reimbursement payments received under government programs.

Although we believe that these statements are based upon reasonable assumptions, we can give no assurance that our goals will be achieved. Given these uncertainties, prospective investors are cautioned not to place undue reliance on these forward-looking statements. These forward-looking statements are made as of the date of this filing. We assume no obligation to update or revise them or provide reasons why actual results may differ.

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 internal medicine, surgery, cardiology, oncology, orthopedics, OB/GYN, diagnostic and emergency room, laboratory, radiology, respiratory therapy, physical therapy, 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, 2009, 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				
LV Stabler Memorial Hospital	Greenville	72	October, 1994	Owned
South Baldwin Regional Medical Center	Foley	112	June, 2000	Leased
Cherokee Medical Center	Centre	60	April, 2006	Owned
Dekalb Regional Medical Center	Fort Payne	134	April, 2006	Owned
Trinity Medical Center	Birmingham	560	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	150	July, 2007	Owned
Alaska				
Mat-Su Regional Medical Center	Palmer	74	July, 2007	Owned
Arizona				
Payson Regional Medical Center	Payson	44	August, 1997	Leased
Western Arizona Regional Medical Center	Bullhead City	139	July, 2000	Owned
Northwest Medical Center	Tucson	300	July, 2007	Owned

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Northwest Medical Center Oro Valley	Oro Valley	144	July, 2007	Owned
Arkansas				
Harris Hospital	Newport	133	October, 1994	Owned
Helena Regional Medical Center	Helena	155	March, 2002	Leased
Forrest City Medical Center	Forrest City	118	March, 2006	Leased
Northwest Medical Center — Bentonville	Bentonville	128	July, 2007	Owned
Northwest Medical Center — Springdale	Springdale	222	July, 2007	Owned
Willow Creek Women's Hospital (2)	Johnson	64	July, 2007	Owned
Siloam Springs Memorial Hospital	Siloam Springs	73	February, 2009	Owned
Medical Center of South Arkansas	El Dorado	166	April, 2009	Leased
California				
Barstow Community Hospital	Barstow	56	January, 1993	Leased
Fallbrook Hospital	Fallbrook	47	November, 1998	Operated (3)
Watsonville Community Hospital	Watsonville	106	September, 1998	Owned
Florida				
Lake Wales Medical Center	Lake Wales	160	December, 2002	Owned
North Okaloosa Medical Center	Crestview	110	March, 1996	Owned
Georgia				
Fannin Regional Hospital	Blue Ridge	50	January, 1986	Owned
Trinity Hospital of Augusta	Augusta	231	July, 2007	Owned
Illinois				
Crossroads Community Hospital	Mt. Vernon	57	October, 1994	Owned
Gateway Regional Medical Center	Granite City	382	January, 2002	Owned
Heartland Regional Medical Center	Marion	92	October, 1996	Owned
Red Bud Regional Hospital	Red Bud	31	September, 2001	Owned
Galesburg Cottage Hospital	Galesburg	173	July, 2004	Owned
Vista Medical Center East/West	Waukegan	407	July, 2006	Owned
Union County Hospital	Anna	25	November, 2006	Leased
Indiana				
Porter Hospital	Valparaiso	301	May, 2007	Owned
Bluffton Regional Medical Center	Bluffton	79	July, 2007	Owned
Dupont Hospital	Fort Wayne	131	July, 2007	Owned
Lutheran Hospital	Fort Wayne	432	July, 2007	Owned
St. Joseph's Hospital	Fort Wayne	191	July, 2007	Owned
Dukes Memorial Hospital	Peru	25	July, 2007	Owned
Kosciusko Community Hospital	Warsaw	72	July, 2007	Owned
Lutheran Musculoskeletal Center(4)	Fort Wayne	39	July, 2007	Owned
Kentucky				
Parkway Regional Hospital	Fulton	70	May, 1992	Owned
Three Rivers Medical Center	Louisa	90	May, 1993	Owned
Kentucky River Medical Center	Jackson	55	August, 1995	Leased

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Louisiana				
Byrd Regional Hospital	Leesville	60	October, 1994	Owned
Northern Louisiana Medical Center	Ruston	159	April, 2007	Owned
Women & Children's Hospital	Lake Charles	88	July, 2007	Owned
Mississippi				
Wesley Medical Center	Hattiesburg	211	July, 2007	Owned
River Region Health System	Vicksburg	341	July, 2007	Owned
Missouri				
Moberly Regional Medical Center	Moberly	103	November, 1993	Owned
Northeast Regional Medical Center	Kirksville	115	December, 2000	Leased
Nevada				
Mesa View Regional Hospital	Mesquite	25	July, 2007	Owned
New Jersey				
Memorial Hospital of Salem County	Salem	140	September, 2002	Owned
New Mexico				
Mimbres Memorial Hospital	Deming	49	March, 1996	Owned
Eastern New Mexico Medical Center	Roswell	162	April, 1998	Owned
Alta Vista Regional Hospital	Las Vegas	54	April, 2000	Owned
Carlsbad Medical Center	Carlsbad	112	July, 2007	Owned
Lea Regional Medical Center	Hobbs	201	July, 2007	Owned
Mountain View Regional Medical Center	Las Cruces	168	July, 2007	Owned
North Carolina				
Martin General Hospital	Williamston	49	November, 1998	Leased
Ohio				
Affinity Medical Center	Massillon	166	July, 2007	Owned
Oklahoma				
Ponca City Medical Center	Ponca City	140	May, 2006	Owned
Claremore Regional Hospital	Claremore	81	July, 2007	Owned
Deaconess Hospital	Oklahoma City	313	July, 2007	Owned
SouthCrest Hospital	Tulsa	180	July, 2007	Owned
Woodward Regional Hospital	Woodward	87	July, 2007	Leased
Oregon				
McKenzie-Willamette Medical Center	Springfield	114	July, 2007	Owned
Pennsylvania				
Berwick Hospital	Berwick	101	March, 1999	Owned
Brandywine Hospital	Coatesville	179	June, 2001	Owned
Jennersville Regional Hospital	West Grove	59	October, 2001	Owned
Easton Hospital	Easton	254	October, 2001	Owned
Lock Haven Hospital	Lock Haven	49	August, 2002	Owned
Pottstown Memorial Medical Center	Pottstown	215	July, 2003	Owned
Phoenixville Hospital	Phoenixville	138	August, 2004	Owned
Chestnut Hill Hospital	Philadelphia	164	February, 2005	Owned

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Sunbury Community Hospital	Sunbury	92	October, 2005	Owned
Wilkes-Barre General Hospital	Wilkes-Barre	553	April, 2009	Owned
South Carolina				
Marlboro Park Hospital	Bennettsville	102	August, 1996	Leased
Chesterfield General Hospital	Cheraw	59	August, 1996	Leased
Springs Memorial Hospital	Lancaster	231	November, 1994	Owned
Carolinas Hospital System — Florence	Florence	420	July, 2007	Owned
Mary Black Memorial Hospital	Spartanburg	209	July, 2007	Owned
Tennessee				
Lakeway Regional Hospital	Morristown	135	May, 1993	Owned
Regional Hospital of Jackson	Jackson	154	January, 2003	Owned
Dyersburg Regional Medical Center	Dyersburg	225	January, 2003	Owned
Haywood Park Community Hospital	Brownsville	62	January, 2003	Owned
Henderson County Community Hospital	Lexington	45	January, 2003	Owned
McKenzie Regional Hospital	McKenzie	45	January, 2003	Owned
McNairy Regional Hospital	Selmer	45	January, 2003	Owned
Volunteer Community Hospital	Martin	100	January, 2003	Owned
Heritage Medical Center	Shelbyville	60	July, 2005	Owned
Sky Ridge Medical Center	Cleveland	351	October, 2005	Owned
Gateway Medical Center	Clarksville	270	July, 2007	Owned
Texas				
Big Bend Regional Medical Center	Alpine	25	October, 1999	Owned
Cleveland Regional Medical Center	Cleveland	107	August, 1996	Leased
Scenic Mountain Medical Center	Big Spring	150	October, 1994	Owned
Hill Regional Hospital	Hillsboro	92	October, 1994	Owned
Lake Granbury Medical Center	Granbury	83	January, 1997	Leased
South Texas Regional Medical Center	Jourdanton	67	November, 2001	Owned
Laredo Medical Center	Laredo	326	October, 2003	Owned
Weatherford Regional Medical Center	Weatherford	99	November, 2006	Leased
Abilene Regional Medical Center	Abilene	231	July, 2007	Owned
Brownwood Regional Medical Center	Brownwood	194	July, 2007	Owned
College Station Medical Center	College Station	141	July, 2007	Owned
Navarro Regional Hospital	Corsicana	162	July, 2007	Owned
Longview Regional Medical Center	Longview	131	July, 2007	Owned
Woodland Heights Medical Center	Lufkin	149	July, 2007	Owned
San Angelo Community Medical Center	San Angelo	171	July, 2007	Owned
DeTar Healthcare System	Victoria	308	July, 2007	Owned
Cedar Park Regional Medical Center	Cedar Park	77	December, 2007	Owned
Utah				
Mountain West Medical Center	Tooele	35	October, 2000	Owned
Virginia				
Southern Virginia Regional Medical Center	Emporia	80	March, 1999	Owned

Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Southampton Memorial Hospital	Franklin	105	March, 2000	Owned
Southside Regional Medical Center	Petersburg	300	August, 2003	Owned
Washington				
Deaconess Medical Center	Spokane	388	October, 2008	Owned
Valley Hospital and Medical Center	Spokane Valley	123	October, 2008	Owned
West Virginia				
Plateau Medical Center	Oak Hill	25	July, 2002	Owned
Greenbrier Valley Medical Center	Ronceverte	122	July, 2007	Owned
Wyoming				
Evanston Regional Hospital	Evanston	42	November, 1999	Owned
Total Licensed Beds at December 31, 2009		18,140		

(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) In 2008, we segregated this entity from Northwest Medical Center — Bentonville for reporting purposes.

(3) We operate this hospital under a lease-leaseback and operating agreement. We recognize all operating statistics, revenues and expenses associated with this hospital in our consolidated financial statements.

(4) In 2008, we segregated this entity from Lutheran Hospital for reporting purposes.

The real property of substantially all of our wholly-owned hospitals is encumbered by mortgages under the Credit Facility.

The following table lists the hospitals owned by joint venture entities in which we do not have a consolidating ownership interest, along with our percentage ownership interest in the joint venture entity as of December 31, 2009. Information on licensed beds was provided by the majority owner and manager of each joint venture. A subsidiary of HCA is the majority owner of Macon Healthcare LLC and a subsidiary of Universal Health Systems Inc. is the majority owner of Summerlin Hospital Medical Center LLC and Valley Health System LLC.

Joint Venture	Facility Name	City	State	Licensed Beds
Macon Healthcare LLC	Coliseum Medical Center (38%)	Macon	GA	250
Macon Healthcare LLC	Coliseum Psychiatric Center (38%)	Macon	GA	60
Macon Healthcare LLC	Coliseum Northside Hospital (38%)	Macon	GA	103
Summerlin Hospital Medical Center LLC	Summerlin Hospital Medical Center (26.1%)	Las Vegas	NV	454
Valley Health System LLC	Desert Springs Hospital (27.5%)	Las Vegas	NV	286
Valley Health System LLC	Valley Hospital Medical Center (27.5%)	Las Vegas	NV	404
Valley Health System LLC	Spring Valley Hospital Medical Center (27.5%)	Las Vegas	NV	231
Valley Health System LLC	Centennial Hills Medical Center (27.5%)	Las Vegas	NV	165

Item 3. ***Legal Proceedings***

From time to time, we receive various inquiries or subpoenas from state regulators, fiscal intermediaries, the Centers for Medicare and Medicaid Services and the Department of Justice regarding various Medicare and Medicaid issues. In addition, we are subject to other claims and lawsuits arising in the ordinary course of our business. We are not aware of any pending or threatened litigation that is not covered by insurance policies or reserved for in our financial statements or which we believe would have a material adverse impact on us; however, some pending or threatened proceedings against us may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Additionally, qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits.

Community Health Systems, Inc. Legal Proceedings

In May 1999, we were served with a complaint in U.S. ex rel. Bledsoe v. Community Health Systems, Inc., subsequently moved to the Middle District of Tennessee, Case No. 2-00-0083. This qui tam action sought treble damages and penalties under the False Claims Act against us. The relator has now dismissed this case.

In August 2004, we were served a complaint in Arleana Lawrence and Robert Hollins v. Lakeview Community Hospital and Community Health Systems, Inc. (now styled Arleana Lawrence and Lisa Nichols vs. Eufaula Community Hospital, Community Health Systems, Inc., South Baldwin Regional Medical Center and Community Health Systems Professional Services Corporation) in the Circuit Court of Barbour County, Alabama (Eufaula Division). This alleged class action was brought by the plaintiffs on behalf of themselves and as the representatives of similarly situated uninsured individuals who were treated at our Lakeview Hospital or any of our other Alabama hospitals. This case has now been dismissed.

On March 3, 2005, we were served with a complaint in Sheri Rix v. Heartland Regional Medical Center and Health Care Systems, Inc. in the Circuit Court of Williamson County, Illinois. This alleged class action was brought by the plaintiff on behalf of herself and as the representative of similarly situated uninsured individuals who were treated at our Heartland Regional Medical Center. This case has now been dismissed.

On February 10, 2006, we received a letter from the Civil Division of the Department of Justice requesting documents in an investigation it was conducting involving the Company. The inquiry related to the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients. These programs are referred to by different names, including "intergovernmental payments," "upper payment limit programs," and "Medicaid disproportionate share hospital payments." The February 2006 letter focused on our hospitals in three states: Arkansas, New Mexico, and South Carolina. On August 31, 2006, we received a follow up letter from the Department of Justice requesting additional documents relating to the programs in New Mexico and the payments to the Company's three hospitals in that state. Through the beginning of 2009, we provided the Department of Justice with requested documents, met with them on numerous occasions, and otherwise cooperated in its investigation. During the course of the investigation, the Civil Division notified us that it believed that we and these three New Mexico hospitals caused the State of New Mexico to submit improper claims for federal funds, in violation of the Federal False Claims Act. At one point, the Civil Division calculated that the three hospitals received ineligible federal participation payments from August 2000 to June 2006 of approximately $27.5 million and said that if it proceeded to trial, it would seek treble damages plus an appropriate penalty for each of the violations of the Federal False Claims Act. This investigation has culminated in the federal government's intervention in a qui tam lawsuit styled U.S. ex rel. Baker vs. Community Health Systems, Inc., pending in the United States District Court for the District of New Mexico. The federal government filed its complaint in intervention on June 30, 2009. The relator filed a second amended complaint on July 1, 2009. Both of these complaints expand the time period during which alleged improper payments were made. We filed motions to dismiss all of the federal government's and the relator's claims on August 28, 2009. The federal government and the relator responded on October 16, 2009. We filed a reply to each response and are waiting on the court's rulings. We are vigorously defending this action.

On June 12, 2008, two of our hospitals received letters from the U.S. Attorney's Office for the Western District of New York requesting documents in an investigation it was conducting into billing practices with respect to kyphoplasty procedures performed during the period January 1, 2002, through June 9, 2008. On September 16, 2008, one of our hospitals in South Carolina also received an inquiry. Kyphoplasty is a surgical spine procedure that returns a compromised vertebrae (either from trauma or osteoporotic disease process) to its previous height, reducing or eliminating severe pain. We have been informed that similar investigations have been initiated at unaffiliated facilities in Alabama, South Carolina, Indiana and other states. We believe that this investigation is related to a recent qui tam settlement between the same U.S. Attorney's office and the manufacturer and distributor of the Kyphon product, which is used in performing the kyphoplasty procedure. We are cooperating with the investigation by collecting and producing material responsive to the requests. At this stage, we do not have sufficient information to determine whether our hospitals have engaged in inappropriate billing for kyphoplasty procedures. We are continuing to evaluate and discuss this matter with the federal government.

On April 19, 2009, we were served in Roswell, New Mexico with an answer and counterclaim in the case of Roswell Hospital Corporation d/b/a Eastern New Mexico Medical Center vs. Patrick Sisneros and Tammie McClain (sued as Jane Doe Sineros). The case was originally filed as a collection matter. The counterclaim was filed as a putative class action and alleged theories of breach of contract, unjust enrichment, misrepresentation, prima facie tort, Fair Trade Practices Act and violation of the New Mexico RICO statute. On May 7, 2009, the hospital filed a notice of removal to federal court. On July 27, 2009, the case was remanded to state court for lack of a federal question. A motion to dismiss and a motion to dismiss misjoined counterclaim plaintiffs were filed on October 20, 2009. These motions were denied. Extensive discovery is under way. A motion for class certification has been filed and is set to be heard on March 3, 2010. We are vigorously defending this action.

On December 7, 2009, we received a document subpoena from the U.S. Department of Health and Human Services, Office of the Inspector General, or OIG, requesting documents related to our hospital in Laredo, Texas. The categories of documents requested included case management, resource management, admission criteria, patient medical records, coding, billing, compliance, the Joint Commission accreditation, physician documentation, payments to referral sources, transactions involving physicians, disproportionate share hospital status, and audits by the hospital's Quality Improvement organization. On January 22, 2010, we received a "request for information or assistance" from the OIG's Office of Investigation requesting patient medical records from Laredo Medical Center in Laredo, Texas for certain Medicaid patients with an extended length of stay. We are cooperating fully with these investigations.

Triad Hospitals, Inc. Legal Proceedings

Triad, and its subsidiary, Quorum Health Resources, Inc. are defendants in a qui tam case styled U.S. ex rel. Whitten vs. Quorum Health Resources, Inc. et al., which is pending in the Southern District of Georgia, Brunswick Division. Whitten, a long-term employee of a two hospital system in Brunswick and Camden, Georgia sued both his employer and Quorum Health Resources, Inc. and its predecessors, which had managed the facility from 1989 through September 2000; upon his termination of employment, Whitten signed a release and was paid $124,000. Whitten's original qui tam complaint was filed under seal in November 2002 and the case was unsealed in 2004. Whitten alleges various charging and billing infractions, including charging for routine equipment supplies and services not separately billable, billing for observation services that were not medically necessary or for which there was no physician order, billing labor and delivery patients for durable medical equipment that was not separately billable, inappropriate preparation of patients' histories and physicals, billing for cardiac rehabilitation services without physician supervision, performing outpatient dialysis without Medicare certification, and performing mental health services without the proper staff assignments. This case has been settled for $0.3 million and final settlement documents are being prepared.

In a case styled U.S. ex rel. Bartlett vs. Quorum Health Resources, Inc., et al., pending in the Western District of Pennsylvania, Johnstown Division, the relator alleges in his second amended complaint, filed in January 2006 (the first amended complaint having been dismissed), that Quorum conspired with an unaffiliated hospital to pay an illegal remuneration in violation of the anti-kickback statute and the Stark laws, thus causing false claims to be filed. A renewed motion to dismiss that was filed in March 2006 asserting that the second amended complaint did not cure the defects contained in the first amended complaint. In September 2006, the hospital and one of the other

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defendants affiliated with the hospital filed for protection under Chapter 11 of the federal bankruptcy code, which imposed an automatic stay on proceedings in the case. Relators entered into a settlement agreement with the hospital, subject to confirmation of the hospital's reorganization plan. The District Court conducted a status conference on January 30, 2009 and later convened another conference on March 30, 2009 and heard arguments on whether to proceed with a motion to dismiss, but did not make a ruling. We believe that this case is without merit and should the stay be lifted, will continue to vigorously defend it.

Item 4. ***Submission of Matters to a Vote of Security Holders***

No matters were submitted to a vote of security holders during the fourth quarter of the year ended December 31, 2009.

PART II

Item 5. *Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities*

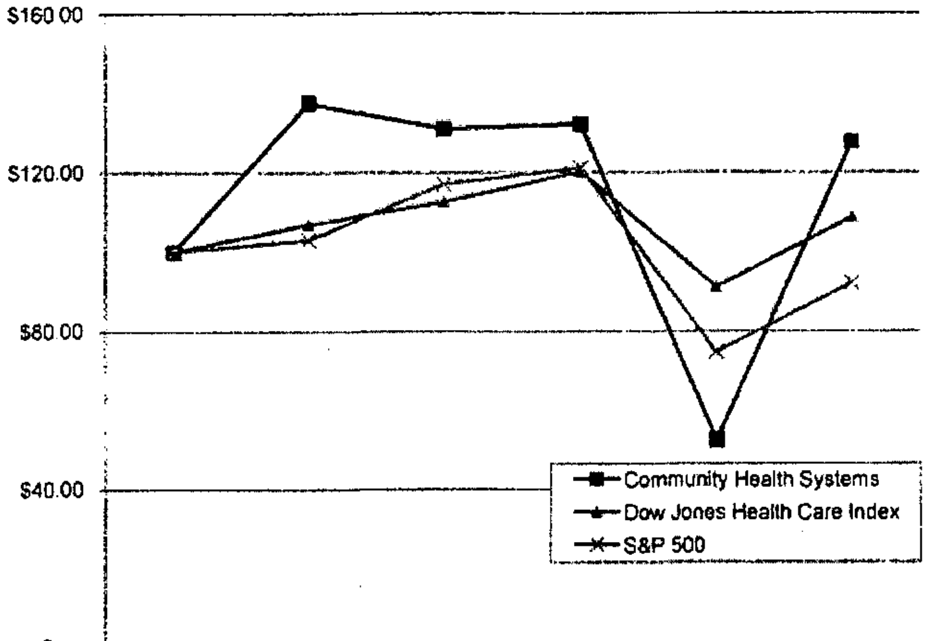
We completed an initial public offering of our common stock on June 14, 2000. Our common stock began trading on June 9, 2000 and is listed on the New York Stock Exchange under the symbol CYH. At February 17, 2010, there were approximately 40 record holders of our common stock. The following table sets forth, for the periods indicated, the high and low sale prices per share of our common stock as reported by the New York Stock Exchange.

	High	Low
Year Ended December 31, 2008		
First Quarter	$ 36.85	$ 29.79
Second Quarter	40.05	32.40
Third Quarter	36.81	28.24
Fourth Quarter	28.38	10.47
Year Ended December 31, 2009		
First Quarter	$ 21.60	$ 12.96
Second Quarter	28.79	13.95
Third Quarter	35.50	24.42
Fourth Quarter	38.00	29.35

In 2009, we discovered that we had inadvertently not fully complied with the registration requirements of the Securities Act of 1933 with respect to our common stock purchased in the open market on behalf of participants in certain of our employee 401(K) plans. As a result, certain plan participants who purchased these shares were offered rescission rights with respect to their interests in our common stock held under these plans. Based upon a final review of the rescission offer that ended on February 11, 2010, 793 shares of common stock were repurchased by us and other payments were made for a total of approximately $40,000. We have fulfilled the registration requirements as of December 31, 2009 in order to become fully compliant on an ongoing basis.

Corporate Performance Graph

The following graph sets forth the cumulative return of our common stock during the five year period ended December 31, 2009, as compared to the cumulative return of the Standard & Poor's 500 Stock Index (S&P 500) and the cumulative return of the Dow Jones Healthcare Index. The graph assumes an initial investment of $100 in our common stock and in each of the foregoing indices and the reinvestment of dividends where applicable.



	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008	12/31/2009
Community Health Systems	$100.00	$137.52	$130.99	$132.21	$52.30	$127.69
Dow Jones Health Care Index	$100.00	$106.87	$112.59	$120.21	$91.03	$108.57
S&P 500	$100.00	$103.00	$117.03	$121.16	$74.53	$92.01

We have not paid any cash dividends since our inception, and do not anticipate the payment of cash dividends in the foreseeable future. Our Credit Facility limits our ability to pay dividends and/or repurchase stock and the Notes to an amount not to exceed $400 million in the aggregate (but not in excess of $200 million unless we receive confirmation from Moody's and S&P that dividends or repurchases would not result in a downgrade, qualification or withdrawal of the then corporate credit rating). The indenture governing our Notes also limits our ability to pay dividends and/or repurchase stock. As of December 31, 2009, under the most restrictive test under these agreements, we have approximately $100 million remaining available with which to pay permitted dividends and/or make stock and Note repurchases.

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Item 6. ***Selected Financial Data***

The following table summarizes specified selected financial data and should be read in conjunction with our related Consolidated Financial Statements and accompanying Notes to Consolidated Financial Statements. The amounts shown below have been adjusted for discontinued operations. We have restated our 2008 and 2007 financial statements and statistical results to include a hospital and related businesses, which were previously reported as discontinued operations and are now included in continuing operations.

Community Health Systems, Inc.
Five Year Summary of Selected Financial Data

	Year Ended December 31,				
	2009	2008	2007(1)	2006	2005
	(in thousands, except share and per share data)				
Consolidated Statement of Operations Data					
Net operating revenues	$ 12,107,613	$ 10,919,095	$ 7,095,861	$ 4,180,136	$ 3,576,117
Income from operations	1,068,665	971,880	471,612	385,057	398,463
Income from continuing operations	304,805	233,727	67,431	177,695	188,370
Net income attributable to Community Health Systems, Inc.	243,150	218,304	30,289	168,263	167,544
Income from continuing operations attributable to Community Health Systems, Inc. common stockholders per share (2):					
Basic	$ 2.67	$ 2.13	$ 0.58	$ 1.87	$ 2.13
Diluted	$ 2.64	$ 2.11	$ 0.57	$ 1.85	$ 2.00
Discontinued operations attributable to Community Health Systems, Inc. common stockholders per share (2):					
Basic	$ 0.01	$ 0.21	$ (0.25)	$ (0.10)	$ (0.24)
Diluted	$ 0.01	$ 0.21	$ (0.25)	$ (0.10)	$ (0.21)
Net income attributable to Community Health Systems, Inc. common stockholders per share (2):					
Basic	$ 2.68	$ 2.34	$ 0.32	$ 1.77	$ 1.89
Diluted	$ 2.66	$ 2.32	$ 0.32	$ 1.75	$ 1.79
Weighted-average number of shares outstanding					
Basic	90,614,886	93,371,782	93,517,337	94,983,646	88,601,168
Diluted (3)	91,517,274	94,288,829	94,642,294	96,232,910	98,579,977(4)
Cash and cash equivalents	$ 344,541	$ 220,655	$ 133,574	$ 40,566	$ 104,108
Total assets	14,021,472	13,818,254	13,493,644	4,506,579	3,934,218
Long-term obligations	10,179,402	10,287,535	9,974,516	2,207,623	1,932,238
Community Health Systems, Inc. stockholders' equity	1,950,635	1,611,029	1,687,293	1,718,697	1,564,577

(1) Includes the results of operations of the former Triad hospitals from July 25, 2007, the date of acquisition.

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

(3) See Note 12 to the Consolidated Financial Statements, included in Item 8 of this Form 10-K.

(4) Included 8,385,031 shares related to the convertible notes under the if-converted method of determining weighted average shares outstanding.

Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*

You should read this discussion together with our consolidated financial statements and the accompanying notes to consolidated financial statements and "Selected Financial Data" included elsewhere in this Form 10-K.

Executive Overview

We are the largest publicly traded operator of hospitals in the United States in terms of number of facilities and net operating revenues. We provide healthcare services through these hospitals that we own and operate in non-urban and selected urban markets. We generate revenue primarily by providing a broad range of general hospital healthcare services to patients in the communities in which we are located. We currently have 122 general acute care hospitals. In addition, we own four home care agencies, located in markets where we do not operate a hospital and through our wholly-owned subsidiary, Quorum Health Resources, LLC ("QHR"), we provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States. We are paid for our services by governmental agencies, private insurers and directly by the patients we serve.

Over the past three years, we have acquired 57 hospitals, including the 50 hospitals owned by Triad, which we acquired on July 25, 2007. Since our acquisition of Triad, we have focused most of our efforts toward integrating the former Triad hospitals and realigning our hospital portfolio and have taken a cautious approach in acquiring additional hospitals. Our realignment has resulted in the selling of eight hospitals acquired from Triad and seven hospitals which we owned prior to the acquisition of Triad. During 2008, we acquired a two hospital system located in Spokane, Washington and in 2009 we acquired hospitals located in Siloam Springs, Arkansas, El Dorado, Arkansas and Wilkes-Barre, Pennsylvania. In addition, on December 31, 2009, we entered into an agreement with a multi-specialty physician clinic that has 32 locations across the Inland Northwest region of the state of Washington. This agreement will allow our affiliated hospitals in Spokane, Washington to work with this clinic to offer a fully integrated healthcare delivery system in that market.

During 2009, we were challenged to navigate the uncertainties of the global and domestic economies. Unemployment continued to increase, credit markets remained tightened and there remained a low level of liquidity in the financial markets. Consequently, as previously disclosed, we are continuing to take a cautious approach to our acquisition strategy during this uncertain economic environment while focusing our efforts on increasing revenue and improving profitability and quality.

Despite the uncertainties in the economy, our net operating revenues for the year ended December 31, 2009 increased to approximately $12.1 billion, as compared to approximately $10.9 billion for the year ended December 31, 2008. Income from continuing operations, before noncontrolling interests, for the year ended December 31, 2009 increased 24.3% over the year ended December 31, 2008. This increase in income from continuing operations during the year ended December 31, 2009, as compared to the year ended December 31, 2008, is due primarily to an increase in surgeries performed at our hospitals, strong outpatient growth, the realization of synergies from our acquisition of Triad and the recognition of cost savings from our ability to effectively control costs. Our successful physician recruiting efforts have also been a key driver in the execution of our operating strategies. Total inpatient admissions for the year ended December 31, 2009 increased 3.6% compared to the year ended December 31, 2008 and adjusted admissions for the year ended December 31, 2009 increased 5.6% compared to the year ended December 31, 2008. This increase in inpatient and adjusted admissions was due primarily to our recent acquisitions.

Self-pay revenues represented approximately 11.2% of our net operating revenues in 2009 compared to 10.7% in 2008. The value of charity care services relative to total net operating revenues increased to 3.9% in 2009 from 3.5% in 2008. Uninsured and underinsured patients continue to be an industry-wide issue, and we anticipate this trend will continue into the foreseeable future. Legislative reform impacting the healthcare industry remains a priority of the current presidential administration and various proposals continue to be strongly debated in Congress. Given the current level of uncertainty of what may result from these reform proposals, it is not possible, at this time, to accurately predict what impact any final legislation would have on us.

During the three months ended June 30, 2009, we decided to retain a hospital and related businesses previously classified as held for sale. Results of operations for all periods presented have been restated to include this retained hospital and related businesses, which previously were reported as discontinued operations. The consolidated balance sheets for each of the periods presented have been restated to present the assets and liabilities previously reported as held for sale in the applicable financial statement line items.

As a result of our current levels of cash, available borrowing capacity, long-term outlook on our debt repayments and our continued projection of our ability to generate cash flows, we do not anticipate a significant impact on our ability to invest the necessary capital in our business over the next twelve months and into the foreseeable future. We believe there continues to be ample opportunity for growth in substantially all of our markets by decreasing the need for patients to travel outside their communities for healthcare services. Furthermore, we continue to benefit from synergies from the acquisition of Triad as well as our more recent acquisitions and will continue to strive to improve operating efficiencies and procedures in order to improve our profitability at all of our hospitals.

Acquisitions and Dispositions

On December 31, 2009, we completed a transaction providing $54.2 million of financing to Rockwood Clinic, P.S., a multi-specialty clinic with 32 locations across the Inland Northwest region of Eastern Washington State and Western Idaho. This transaction was accounted for as a purchase business combination as required by U.S. GAAP.

Effective June 1, 2009, we acquired from Akron General Medical Center the remaining 20% noncontrolling interest in Massillon Community Health System, LLC not then owned by us. This entity indirectly owns and operates Affinity Medical Center of Massillon, Ohio. The purchase price for this noncontrolling interest was $1.1 million in cash. Affinity Medical Center is now wholly-owned by us.

Effective April 30, 2009, we acquired Wyoming Valley Health Care System in Wilkes-Barre, Pennsylvania. This health care system includes Wilkes-Barre General Hospital, a 392-bed, full-service acute care hospital located in Wilkes-Barre, Pennsylvania, and First Hospital Wyoming Valley, a behavioral health facility located in Kingston, Pennsylvania, as well as other outpatient and ancillary services. The total consideration for fixed assets and working capital of Wyoming Valley Health Care System was approximately $179.1 million, of which $153.7 million was paid in cash, net of $14.2 million of cash in acquired bank accounts, and approximately $25.4 million was assumed in liabilities. This acquisition transaction was accounted for using the purchase method of accounting. This preliminary allocation of the purchase price has been determined by us based upon available information and the allocation is subject to the settlement of the amounts related to purchased working capital. Adjustments to the purchase price allocation are not expected to be material.

Effective April 1, 2009, we acquired from Share Foundation the remaining 50% equity interest in MCSA L.L.C., an entity in which we previously had a 50% unconsolidated noncontrolling interest. We provided MCSA L.L.C. certain management services. This acquisition resulted in us owning a 100% equity interest in that entity. MCSA L.L.C. owns and operates Medical Center of South Arkansas (166 licensed beds) in El Dorado, Arkansas. The purchase price was $26.0 million in cash. As of the acquisition date, we had a liability to MCSA L.L.C. of $14.1 million, as a result of a cash management agreement previously entered into with the hospital. Upon completion of the acquisition, this liability was eliminated in consolidation.

Effective February 1, 2009, we completed the acquisition of Siloam Springs Memorial Hospital (74 licensed beds), located in Siloam Springs, Arkansas, from the City of Siloam Springs. The total consideration for this hospital consisted of approximately $0.1 million paid in cash for working capital and approximately $1.0 million of assumed liabilities. In connection with this acquisition, we entered into a lease agreement for the existing hospital and agreed to build a replacement facility at this location, with construction required to commence by February 2011 and be completed by February 2013. As security for this obligation, we deposited $1.6 million into an escrow account at closing and agreed to deposit an additional $1.6 million by February 1, 2010, which we deposited in January 2010. If the construction of the replacement facility is not completed within the agreed time frame, the escrow balance will be remitted to the City of Siloam Springs. If the construction of the replacement facility is completed within the agreed time frame, the escrow balance will be returned to us.

Effective March 31, 2009, through our subsidiaries Triad-Denton Hospital LLC and Triad-Denton Hospital LP, we completed the settlement of pending litigation, which resulted in the sale of our ownership interest in a partnership, which owned and operated Presbyterian Hospital of Denton (255 licensed beds) in Denton, Texas, to

Texas Health Resources for $103.0 million in cash. Also as part of the settlement, our subsidiaries transferred certain hospital related assets to Texas Health Resources.

Sources of Revenue

The following table presents the approximate percentages of net operating revenues derived from Medicare, Medicaid, managed care and other third party payors, and self-pay for the periods indicated. The data for the years presented are not strictly comparable due to the significant effect that hospital acquisitions have had on these statistics.

	Year Ended December 31,		
	2009	2008	2007
Medicare	27.1%	27.5%	29.0%
Medicaid	9.8%	9.1%	10.3%
Managed care and other third party payors	51.9%	52.7%	50.7%
Self pay	11.2%	10.7%	10.0%
Total	100.0%	100.0%	100.0%

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-based reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net income by an insignificant amount in each of the years ended December 31, 2009, 2008 and 2007. In the future, we expect the percentage of revenues received from the Medicare program to increase due to the general aging of the population.

The payment rates under the Medicare program for inpatient acute services are based on a prospective payment system, depending upon the diagnosis of a patient's condition. These rates are indexed for inflation annually, although the increases have historically been less than actual inflation. Reductions in the rate of increase in Medicare reimbursement may cause our net operating revenue growth to decline.

In addition, specified managed care programs, insurance companies, and employers are actively negotiating the amounts paid to hospitals. The trend toward increased enrollment in managed care may adversely effect our net operating revenue growth.

Results of Operations

Our hospitals offer a variety of services involving a broad range of inpatient and outpatient medical and surgical services. These include orthopedics, cardiology, occupational medicine, diagnostic services, emergency services, rehabilitation treatment, home care and skilled nursing. The strongest demand for hospital services generally occurs during January through April and the weakest demand for these services occurs during the summer months. Accordingly, eliminating the effect of new acquisitions, our net operating revenues and earnings are historically highest during the first quarter and lowest during the third quarter.

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

	Year Ended December 31, 2009	2008	2007
	(Expressed as a percentage of net operating revenues)		
Consolidated (a)			
Net operating revenues	100.0%	100.0%	100.0%
Operating expenses (b)	(86.5)	(86.5)	(89.0)
Depreciation and amortization	(4.7)	(4.6)	(4.4)
Income from operations	8.8	8.9	6.6
Interest expense, net	(5.4)	(6.0)	(5.1)
Gain (loss) from early extinguishment of debt (c)	—	—	(0.4)
Equity in earnings of unconsolidated affiliates	0.3	0.4	0.4
Income from continuing operations before income taxes	3.7	3.3	1.5
Provision for income taxes	(1.2)	(1.2)	(0.6)
Income from continuing operations	2.5	2.1	0.9
Income (loss) from discontinued operations, net of tax	—	0.2	(0.3)
Net income	2.5	2.3	0.6
Less: Net income attributable to noncontrolling interests	(0.5)	(0.3)	(0.2)
Net income attributable to Community Health Systems, Inc.	2.0%	2.0%	0.4%

	Year Ended December 31, 2009	2008
	(Expressed in percentages)	
Percentage increase from same period prior year(a):		
Net operating revenues	10.9%	53.9%
Admissions	3.6	45.0
Adjusted admissions(d)	5.6	42.8
Average length of stay	—	—
Net income attributable to Community Health Systems, Inc. (e)	11.4	620.7
Same-store percentage increase (decrease) from same period prior year(a)(f):		
Net operating revenues	5.9%	6.4%
Admissions	(1.5)	1.8
Adjusted admissions(d)	0.7	2.1

(a) We have restated our 2008 and 2007 financial statements and statistical results to include a hospital and related businesses, which were previously reported as discontinued operations and are now included in continuing operations.

(b) Operating expenses include salaries and benefits, provision for bad debts, supplies, rent, and other operating expenses.

(c) Gain (loss) from early extinguishment of debt was less than 0.1% for the years ended December 31, 2009 and 2008.

(d) 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.

(e) Includes income or loss from discontinued operations.

(f) Includes acquired hospitals to the extent we operated them in both years.

Year Ended December 31, 2009 Compared to Year Ended December 31, 2008

Net operating revenues increased by 10.9% to approximately $12.1 billion in 2009, from approximately $10.9 billion in 2008. Growth from hospitals owned throughout both periods contributed $639 million of that increase and $550 million was contributed by hospitals acquired in 2009 and 2008. On a same-store basis, net operating revenues increased 5.9%. The increase from hospitals that we owned throughout both periods was primarily attributable to higher acuity level of services provided and outpatient growth, along with rate increases and favorable payor mix. These improvements were partially offset by the stronger flu and respiratory season during the year ended December 31, 2008, as compared to the year ended December 31, 2009, and the extra day from the leap year in 2008.

On a consolidated basis, inpatient admissions increased by 3.6% and adjusted admissions increased by 5.6%. On a same-store basis, inpatient admissions decreased by 1.5% during the year ended December 31, 2009. This decrease in inpatient admissions was due primarily to the strong flu and respiratory season during the year ended December 31, 2008, which did not recur during 2009, the 2008 period having one additional day because it was a leap year, and the impact of closing certain less profitable services.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, remained consistent at 86.5% for 2008 and 2009. Salaries and benefits, as a percentage of net operating revenues, remained consistent at 40.0% for 2008 and 2009. Provision for bad debts, as a percentage of net revenues, increased from 11.2% in 2008 to 12.1% in 2009. This increase in the provision for bad debts primarily represents an increase in self-pay revenues over the comparable period of 2008 due to increased charges and the impact of current economic conditions on individuals' ability to pay. Supplies, as a percentage of net operating revenues, decreased from 14.0% in 2008 to 13.9% in 2009. Rent and other operating expenses, as a percentage of net operating revenues, decreased from 21.3% in 2008 to 20.5% in 2009. This decrease in rent and other operating expenses is due primarily to reductions in contract labor. As part of our acquisition of Triad, we acquired noncontrolling ownership interests in several hospitals. Our percentage of ownership interests in these joint ventures provided earnings of 0.3% in 2009 compared to 0.4% in 2008 of net operating revenues. Prior to the Triad acquisition, we did not have any material noncontrolling investments in joint ventures.

Depreciation and amortization increased from 4.6% of net operating revenues in 2008 to 4.7% of net operating revenues in 2009. The increase in depreciation and amortization as a percentage of net operating revenues is primarily due to the opening of three replacement hospitals in the second and third quarters of 2008.

Interest expense, net, decreased by $3.5 million from $652.5 million in 2008, to $649.0 million in 2009. A decrease in interest rates during the year ended December 31, 2009, compared to the year ended December 31, 2008, accounted for $9.9 million of this decrease. In addition, we incurred an additional $1.8 million of interest expense in 2008, which was not incurred in 2009, since 2008 was a leap year. These decreases were offset by an increase in our average outstanding debt during the year ended December 31, 2009, compared to December 31, 2008, which resulted in a $2.8 million increase in interest expense. Additionally, interest expense increased by $5.4 million as a result of more of the interest during the year ended December 31, 2008 being capitalized interest due to more major construction projects during that period, compared to the year ended December 31, 2009.

Impairment of long-lived and other assets of $12.5 million in 2009 and $5.0 million in 2008 resulted from our assessment of the recoverability of these assets.

The net results of the above mentioned changes resulted in income from continuing operations before income taxes increasing $87.1 million from $359.0 million in 2008 to $446.1 million for 2009.

Provision for income taxes from continuing operations increased from $125.3 million in 2008 to $141.3 million in 2009 due to the increase in income from continuing operations before income taxes. Our effective tax rates were 31.7% and 34.9% for the years ended December 31, 2009 and 2008, respectively. The decrease in our effective tax rate is primarily a result of the recognition of a tax benefit of $3.0 million from adjustments and revaluation of deferred income tax accounts and a decrease in our effective state tax rate.

Income from continuing operations as a percentage of net operating revenues increased from 2.1% in 2008 to 2.5% in 2009. Net income as a percentage of net operating revenues increased from 2.3% in 2008 to 2.5% in 2009. The increase in income from continuing operations as a percentage of net operating revenues is primarily due to the decrease in interest expense as a percentage of net operating revenues, discussed above.

Net income attributable to noncontrolling interests as a percentage of net operating revenues increased from 0.3% for the year ended December 31, 2008 to 0.5% for the year ended December 31, 2009. The increase in net income attributable to noncontrolling interests is due primarily to additional syndications entered into throughout 2008 and 2009.

Net income attributable to Community Health Systems, Inc. was $243.2 million in 2009 compared to $218.3 million for 2008, an increase of 11.4%. The increase in net income attributable to Community Health Systems, Inc. is reflective of the increase in net operating revenues while maintaining substantially the same profit margin levels as discussed above.

Year Ended December 31, 2008 Compared to Year Ended December 31, 2007

Net operating revenues increased by 53.9% to approximately $10.9 billion in 2008, from approximately $7.1 billion in 2007. Growth from hospitals owned throughout both periods, including the former Triad Hospitals, contributed approximately $3.6 billion of that increase and $219 million was contributed by hospitals acquired in 2008 and 2007. On a same-store basis, net operating revenues increased 6.4%. The increase from hospitals that we owned throughout both periods was attributable to volume increases, rate increases, payor mix and the acuity level of services provided.

On a consolidated basis inpatient admissions increased by 45.0% and adjusted admissions increased by 42.8%. On a same-store basis, inpatient admissions increased by 1.8% during the year ended December 31, 2008. This increase in inpatient admissions was due primarily to the strong flu and respiratory season during the year ended December 31, 2008 and the 2008 period having one additional day because it was a leap year.

Operating expenses, excluding depreciation and amortization, as a percentage of net operating revenues, decreased from 89.0% in 2007 to 86.5% in 2008. Salaries and benefits, as a percentage of net operating revenues, decreased from 40.8% in 2007 to 40.0% in 2008, primarily as a result of efficiency improvements realized at hospitals owned throughout both periods. These improvements were partially offset by an increase in the number of employed physicians as well as an increase in salaries for certain IT employees who were previously treated as leased employees with related expense previously being included in other operating expense. Provision for bad debts, as a percentage of net revenues, decreased from 12.5% in 2007 to 11.2% in 2008, due primarily to $70.1 million of additional bad debt expense recorded as a change in estimate to increase the allowance for doubtful accounts in 2007. Supplies, as a percentage of net operating revenues, increased from 13.3% in 2007 to 14.0% in 2008, primarily the result of the acquisition of the former Triad hospitals whose higher acuity of services resulted in higher supply costs than our other hospitals taken collectively, offsetting improvements from greater utilization of and improved pricing under our purchasing program. Rent and other operating expenses, as a percentage of net operating revenues, decreased from 22.4% in 2007 to 21.3% in 2008, primarily as a result of the hospitals acquired from Triad having lower rent expense as a percentage of net operating revenues. As part of our acquisition of Triad, we acquired noncontrolling ownership interests in several hospitals. Our percentage of ownership interests in these joint ventures provided earnings of 0.4% of net operating revenues during both of the years ended December 31, 2008 and 2007. Prior to the Triad acquisition, we did not have any material noncontrolling investments in joint ventures.

Depreciation and amortization increased from 4.4% of net operating revenues in 2007 to 4.6% of net operating revenues in 2008.

Interest expense, net, increased by $290.4 million from $362.1 million in 2007, to $652.5 million in 2008. The primary reason for the increase in interest expense is the increase in our average outstanding debt during the year ended December 31, 2008, as compared to the year ended December 31, 2007, resulting in an additional $309.7 million of interest expense. Interest expense for the year ended December 31, 2008 includes a full year of interest expense from borrowings under our Credit Facility and the issuance of Notes in connection with the acquisition of Triad in 2007. Since 2008 was a leap year, one additional day in the year resulted in $1.8 million of the increase in interest expense. These increases were offset by a decrease in interest expense of $3.1 million as a result of more of the interest during the year ended December 31, 2008 being capitalized interest due to more major construction projects during that period, compared to the year ended December 31, 2007. In addition, a decrease in our effective interest rate during the year ended December 31, 2008, as compared to the year ended December 31, 2007, resulted in a decrease in interest expense of $18.0 million.

The net results of the above mentioned changes resulted in income from continuing operations before income taxes increasing $251.7 million from $107.3 million in 2007 to $359.0 million for 2008.

Provision for income taxes from continuing operations increased from $39.9 million in 2007 to $125.3 million in 2008 due to the increase in income from continuing operations before income taxes. Our effective tax rates were 34.9% and 37.2% for the years ended December 31, 2008 and 2007, respectively. The decrease in our effective tax rate is primarily a result of a decrease in our effective state tax rate.

Income from continuing operations as a percentage of net operating revenues increased from 0.9% in 2007 to 2.1% in 2008. Net income as a percentage of net operating revenues increased from 0.6% in 2007 to 2.3% in 2008. The increase in income from continuing operations as a percentage of net operating revenues is primarily due to the impact of the net decrease in expenses, as a percentage of net revenues, discussed above.

Net income attributable to noncontrolling interests as a percentage of net operating revenues was 0.3% for the year ended December 31, 2008, compared to 0.2% for the year ended December 31, 2007.

Net income attributable to Community Health Systems, Inc. was $218.3 million in 2008 compared to $30.3 million for 2007, an increase of 620.7%. The increase in net income attributable to Community Health Systems, Inc. is reflective of the impact of the net decrease in expenses discussed above, including the effect of the change in estimate that increased bad debt expense in 2007.

Liquidity and Capital Resources

2009 Compared to 2008

Net cash provided by operating activities increased $19.8 million, from approximately $1.1 billion for the year ended December 31, 2008 to approximately $1.1 billion for the year ended December 31, 2009. The increase is due to an increase in cash flows from net income of $53.6 million and an increase in non-cash depreciation and amortization expense of $59.8 million and an increase in cash generated from accounts receivable of $108.0 million, a result of the reduction in days revenue outstanding. These increases in cash flows outstanding were offset by decreases in cash flows from accounts payable, accrued liabilities and income taxes of $33.8 million, primarily as a result of the timing of payments and an increase in cash paid for income taxes during 2009. Also, other non-cash expenses decreased $83.5 million, primarily attributable to a reduction in deferred income tax expense resulting in a reduction to cash flows, and cash flows generated from the change in all other assets and liabilities decreased $84.3 million.

The cash used in investing activities was $867.2 million for the year ended December 31, 2009, compared to $665.5 million for the year ended December 31, 2008. The increase in cash used in investing activities, in comparison to the prior year, is primarily attributable to an increase in acquisitions of facilities and other related equipment of $101.9 million, a reduction in the amount of proceeds from the.disposition of hospitals and other ancillary operations of $276.1 million due to the sale of one hospital in 2009 versus the sale of 11 hospitals in 2008, a reduction in the amount of the proceeds from sale of property and equipment of $9.4 million. This increase in cash used in investing activities was offset by a reduction in the amount of purchases of property and equipment of $115.3 million and a net decrease in other non-operating assets of $70.4 million, primarily attributable to a decrease in cash invested in our captive insurance subsidiary, a decrease in cash used for physician recruiting and a decrease in cash used for software related expenditures. We anticipate being able to fund future routine capital expenditures with cash flows generated from operations.

In 2009, our net cash used in financing activities decreased $218.6 million from $304.0 million in 2008 to $85.4 million in 2009, primarily due to an increase in borrowing under our Credit Facility. In January 2009, we drew down the remaining $200 million of the delayed draw term loan.

In 2008, we used $90.0 million for the repurchase of 4,786,609 shares of our outstanding common stock on the open market. We believed this to be a prudent use of cash as a result of the severely depressed stock price. Our Credit Facility limits our ability to pay dividends and/or repurchase stock and the Notes to an amount not to exceed $400 million in the aggregate (but not in excess of $200 million unless we receive confirmation from Moody's and S&P that dividends or repurchases would not result in a downgrade, qualification or withdrawal of the then corporate credit rating). The indenture governing our Notes also limits our ability to pay dividends and/or repurchase stock in an amount higher than permitted by our Credit Facility. As of December 31, 2009, under the most restrictive test under these agreements, we have approximately $100 million remaining available with which to pay permitted dividends and/or make stock and Note repurchases.

With the exception of some small principal payments of our term loans under our Credit Facility, representing less than 1% of the outstanding balance each year through 2013, the term loans under our Credit Facility mature in 2014 and our Notes are not due until 2015. We believe this four to five year period before final maturity allows sufficient time for the current financial environment to improve and permits us to make favorable changes, including refinancing, to our debt structure. Furthermore, we do not anticipate the need to use funds currently available under our Credit Facility for purposes of funding our operations, although these funds could be used for the purpose of making further acquisitions or for restructuring our existing debt. Furthermore, we anticipate we will remain in compliance with our debt covenants through the next 12 months and beyond into the foreseeable future.

As described in Notes 6, 9 and 15 of the Notes to Consolidated Financial Statements, at December 31, 2009, we had certain cash obligations, which are due as follows *(in thousands)*:

	Total	2010	2011-2013	2014-2015	2016 and thereafter
Long Term Debt	$ 6,089,862	$ 59,994	$ 145,222	$ 5,862,736	$ 21,910
Senior Notes	2,784,331	—	—	2,784,331	—
Interest on Bank Facility and Notes(1)	2,057,292	400,140	1,194,089	463,063	—
Capital Leases, including interest	49,777	8,399	12,436	5,653	23,289
Total Long-Term Debt	10,981,262	468,533	1,351,747	9,115,783	45,199
Operating Leases	927,106	176,755	375,135	155,362	219,854
Replacement Facilities and Other Capital Commitments (2)	594,440	127,936	379,326	50,000	37,178
Open Purchase Orders (3)	201,078	201,078	—	—	—
Liability for uncertain tax positions, including interest and penalties	8,869	7,194	1,675	—	—
Total	$ 12,712,755	$ 981,496	$ 2,107,883	$ 9,321,145	$ 302,231

(1) Estimate of interest payments assumes the interest rates at December 31, 2009 remain constant during the period presented for the Credit Facility, which is variable rate debt. The interest rate used to calculate interest payments for the Credit Facility was LIBOR as of December 31, 2009 plus the spread. The Notes are fixed at an interest rate of 8.875% per annum.

(2) Pursuant to purchase agreements in effect as of December 31, 2009 and where CON approval has been obtained, we have commitments to build the following replacement facilities and the following capital commitments. As required by an amendment to our lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location by November 2012. As part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana by April 2011. As part of an acquisition in 2009, we agreed to build a replacement hospital in Siloam Springs, Arkansas by February 2013. Construction costs, including equipment costs, for these three replacement facilities are currently estimated to be approximately $310.0 million of which approximately $12.6 million has been incurred to date. In addition, under other purchase agreements, we have committed to spend approximately $468.5 million for costs such as capital improvements, equipment, selected leases and physician recruiting. These commitments are required to be fulfilled generally over a five to seven year period after acquisition. Through December 31, 2009, we have incurred approximately $171.4 million related to these commitments.

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

At December 31, 2009, we had issued letters of credit primarily in support of potential insurance related claims and specified outstanding bonds of approximately $90.0 million.

Our debt as a percentage of total capitalization decreased from 85% at December 31, 2008 to 82% for December 31, 2009.

2008 Compared to 2007

Net cash provided by operating activities increased $368.1 million from $688.4 million for the year ended December 31, 2007 to approximately $1.1 billion for the year ended December 31, 2008. This increase is due to an increase in cash flow from net income of $208.0 million, increases in cash flows from other assets of $37.4 million and a net increase in non-cash expenses of $306.1 million, of which $174.1 million was related to depreciation and $199.8 million related to deferred income taxes. These cash flow increases were offset by decreases in cash flows from supplies, prepaid expenses and other current assets of $2.7 million, accounts receivable of $178.3 million and accounts payable, accrued liabilities and income taxes of $2.4 million. The decrease in income taxes was primarily a result of a prior year prepaid tax position which was used to offset taxes owed during the current year.

The use of cash in investing activities decreased approximately $6.8 billion from approximately $7.5 billion in 2007 to $665.5 million in 2008, primarily as a result of the Triad acquisition occurring in 2007. The purchase of property and equipment in 2008 increased $169.4 million from $522.8 million in 2007 to $692.2 million in 2008. This increase reflects the increased number of hospitals owned by us after the acquisition of Triad.

In 2008, our net cash provided by financing activities decreased approximately $7.2 billion from approximately $6.9 billion in 2007 to a net cash used in financing activities of $304.0 million in 2008, primarily due to borrowings under our Credit Facility and issuance of Notes in connection with the acquisition of Triad in 2007. During the fourth quarter of 2008, $100 million of delayed draw term loans had been drawn by us.

Capital Expenditures

Cash expenditures for purchases of facilities were $263.8 million in 2009, $161.9 million in 2008 and approximately $7.0 billion in 2007. Our expenditures in 2009 included $182.2 million for the purchase of two hospitals and the remaining equity in a hospital in which we previously had a noncontrolling interest, $72.3 million for the purchase of clinics, surgery centers and physician practices, and $9.3 million for the settlement of acquired working capital. Our expenditures in 2008 included $149.1 million for the purchase of two hospitals and $12.8 million for the purchase of physician practices and a home care agency. Our expenditures in 2007 included approximately $6.9 billion for the purchase of Triad, $133.7 million for the purchase of two additional hospitals, $3.4 million for the purchase of physician practices, $7.7 million for equipment to integrate acquired hospitals and $8.5 million for the settlement of acquired working capital.

Excluding the cost to construct replacement hospitals, our cash expenditures for routine capital for 2009 totaled $572.1 million compared to $569.4 million in 2008, and $344.1 million in 2007. These capital expenditures related primarily to the purchase of additional equipment, minor renovations and information systems infrastructure. Costs to construct replacement hospitals totaled $4.8 million in 2009, $122.8 million in 2008 and $178.7 million in 2007. The costs to construct replacement hospitals for year ended December 31, 2009 represent planning costs for future construction projects since there were no replacement hospitals under construction at year ended December 31, 2009. In 2008, we completed construction of and opened three replacement hospitals, accounting for the higher costs incurred during the year ended December 31, 2008.

Pursuant to hospital purchase agreements in effect as of December 31, 2009, as part of an acquisition in 2007, we agreed to build a replacement hospital in Valparaiso, Indiana by April 2011 and as part of an acquisition in 2009, we agreed to build a replacement hospital in Siloam Springs, Arkansas by February 2013. Also as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement facility at Barstow Community Hospital in Barstow, California. Estimated construction costs, including equipment costs, are approximately $310.0 million for these three replacement facilities. We expect total capital expenditures of approximately $650 to $750 million in 2010 (which includes amounts which are required to be expended pursuant to the terms of hospital purchase agreements), including approximately $595 to $690 million for renovation and equipment cost and approximately $55 to $60 million for construction and equipment cost of the replacement hospitals.

Capital Resources

Net working capital was approximately $1.2 billion at December 31, 2009 compared to approximately $1.1 billion at December 31, 2008, an increase of $121 million. This increase was primarily attributable to an increase in working capital attributable to the acquisition of Siloam Springs Memorial Hospital, Wyoming Valley Health Care System and a controlling equity interest in MCSA L.L.C., the entity that owns and operates the Medical Center of South Arkansas in El Dorado, Arkansas, and an increase in cash as a result of cash flows from operations.

In connection with the consummation of the Triad acquisition in July 2007, we obtained approximately $7.2 billion of senior secured financing under a Credit Facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The Credit Facility consists of an approximately $6.1 billion funded term loan facility with a maturity of seven years, a $300 million delayed draw term loan facility (reduced by us from $400 million) with a maturity of seven years and a $750 million revolving credit facility with a maturity of six years. During the fourth quarter of 2008, $100 million of the delayed draw term loan had been drawn down by us reducing the delayed draw term loan availability to $200 million at December 31, 2008. In January 2009, we drew down the remaining $200 million of the delayed draw term loan. The revolving credit facility also includes a subfacility for letters of credit and a swingline subfacility. The Credit Facility requires quarterly amortization payments of each term loan facility equal to 0.25% of the outstanding amount of the term loans, if any, with the outstanding principal balance payable on July 25, 2014.

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

The obligor under the Credit Facility is CHS/Community Health Systems, Inc., or CHS, a wholly-owned subsidiary of Community Health Systems, Inc. All of our obligations under the Credit Facility are unconditionally guaranteed by Community Health Systems, Inc. and certain existing and subsequently acquired or organized domestic subsidiaries. All obligations under the Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of Community Health Systems, Inc., CHS and each subsidiary guarantor, including equity interests held by us or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries.

The loans under the Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at our option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus one-half of 1.0%, or (b) a reserve adjusted London interbank offered rate for dollars (Eurodollar rate) (as defined). The applicable percentage for term loans is 1.25% for Alternate Base Rate loans and 2.25% for Eurodollar rate loans. The applicable percentage for revolving loans was initially 1.25% for Alternate Base Rate revolving loans and 2.25% for Eurodollar revolving loans, in each case subject to reduction based on our leverage ratio. Loans under the swingline subfacility bear interest at the rate applicable to Alternate Base Rate loans under the revolving credit facility.

We have agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to Eurodollar rate loans under the revolving credit facility times the maximum aggregate amount available to be drawn under all letters of credit outstanding under the subfacility for letters of credit. The issuer of any letter of credit issued under the subfacility for letters of credit will also receive a customary fronting fee and other customary processing charges. We were initially obligated to pay commitment fees of 0.50% per annum (subject to reduction based upon on our leverage ratio), on the unused portion of the revolving credit facility. For purposes of this calculation, swingline loans are not treated as usage of the revolving credit facility. With respect to the delayed draw term loan facility, we were also obligated to pay commitment fees of 0.50% per annum for the first nine months after the close of the Credit Facility and 0.75% per annum for the next three months after such nine-month period and thereafter 1.0% per annum. In each case, the commitment fee was based on the unused amount of the delayed draw term loan facility. After the draw down of the remaining $200 million of the delayed draw term loan in January 2009, we no longer pay any commitment fees for the delayed draw term loan facility. We also paid arrangement fees on the closing of the Credit Facility and pay an annual administrative agent fee.

The Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting our and our subsidiaries' ability to, among other things and subject to various exceptions, (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of our businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change our fiscal year. We and our subsidiaries are also required to comply with specified financial covenants (consisting of a leverage ratio and an interest coverage ratio) and various affirmative covenants.

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

As of December 31, 2009, the availability for additional borrowings under our Credit Facility was approximately $750 million pursuant to the revolving credit facility, of which $90.0 million was set aside for outstanding letters of credit. We believe that these funds, along with internally generated cash and continued access to the bank credit and capital markets, will be sufficient to finance future acquisitions, capital expenditures and working capital requirements through the next 12 months and into the foreseeable future.

During the year ended December 31, 2008, we repurchased on the open market and cancelled $110.5 million of principal amount of the Notes. This resulted in a net gain from early extinguishment of debt of $2.5 million with an after-tax impact of $1.6 million.

During the year ended December 31, 2009, we repurchased on the open market and cancelled $126.5 million of principal amount of the Notes. This resulted in a net gain from early extinguishment of debt of $2.7 million with an after-tax impact of $1.7 million.

On April 2, 2009, we paid down $110.4 million of our term loans under the Credit Facility. Of this amount, $85.0 million was paid down as required under the terms of the Credit Facility with the net proceeds received from the sale of the ownership interest in the partnership that owned and operated Presbyterian Hospital of Denton. This resulted in a loss from early extinguishment of debt of $1.1 million with an after-tax impact of $0.7 million recorded in discontinued operations for the year ended December 31, 2009. The remaining $25.4 million was paid on the term loans as required under the terms of the Credit Facility with the net proceeds received from the sale of various other assets. This resulted in a loss from early extinguishment of debt of $0.3 million with an after-tax impact of $0.2 million recorded in continuing operations for the year ended December 31, 2009.

As of December 31, 2009, we are currently a party to the following interest rate swap agreements to limit the effect of changes in interest rates on approximately 89% of our variable rate debt. On each of these swaps, we received a variable rate of interest based on the three-month London Inter-Bank Offer Rate ("LIBOR"), in exchange for the payment by us of a fixed rate of interest. We currently pay, on a quarterly basis, a margin above LIBOR of 225 basis points for revolving credit and term loans under the Credit Facility.

Swap #	Notional Amount (in 000's)	Fixed Interest Rate	Termination Date	Fair Value (in 000's)
1	$ 200,000	2.8800%	September 17, 2010	$ (3,655)
2	100,000	4.9360%	October 4, 2010	(3,630)
3	100,000	4.7090%	January 24, 2011	(4,343)
4	300,000	5.1140%	August 8, 2011	(19,843)
5	100,000	4.7185%	August 19, 2011	(6,033)
6	100,000	4.7040%	August 19, 2011	(6,009)
7	100,000	4.6250%	August 19, 2011	(5,874)
8	200,000	4.9300%	August 30, 2011	(12,961)
9	200,000	3.0920%	September 18, 2011	(6,709)
10	100,000	3.0230%	October 23, 2011	(3,323)
11	200,000	4.4815%	October 26, 2011	(12,151)
12	200,000	4.0840%	December 3, 2011	(11,135)
13	100,000	3.8470%	January 4, 2012	(5,193)
14	100,000	3.8510%	January 4, 2012	(5,201)
15	100,000	3.8560%	January 4, 2012	(5,211)
16	200,000	3.7260%	January 8, 2012	(9,914)
17	200,000	3.5065%	January 16, 2012	(9,034)
18	250,000	5.0185%	May 30, 2012	(20,877)
19	150,000	5.0250%	May 30, 2012	(12,638)
20	200,000	4.6845%	September 11, 2012	(15,831)
21	100,000	3.3520%	October 23, 2012	(4,299)
22	125,000	4.3745%	November 23, 2012	(8,981)
23	75,000	4.3800%	November 23, 2012	(5,439)
24	150,000	5.0200%	November 30, 2012	(13,694)
25	200,000	2.2420%	February 28, 2013	1,219(1)
26	100,000	5.0230%	May 30, 2013	(9,575)
27	300,000	5.2420%	August 6, 2013	(31,724)
28	100,000	5.0380%	August 30, 2013	(9,887)
29	50,000	3.5860%	October 23, 2013	(2,282)
30	50,000	3.5240%	October 23, 2013	(2,165)
31	100,000	5.0500%	November 30, 2013	(10,077)
32	200,000	2.0700%	December 19, 2013	3,000
33	100,000	5.2310%	July 25, 2014	(11,157)
34	100,000	5.2310%	July 25, 2014	(11,157)
35	200,000	5.1600%	July 25, 2014	(21,694)
36	75,000	5.0405%	July 25, 2014	(7,744)
37	125,000	5.0215%	July 25, 2014	(12,803)
38	100,000	2.6210%	July 25, 2014	259
39	100,000	3.1100%	July 25, 2014	89(2)
40	100,000	3.2580%	July 25, 2014	153(3)
41	100,000	3.0050%	November 30, 2016	2,458

(1) This interest rate swap becomes effective September 17, 2010, concurrent with the termination of swap #1.

(2) This interest rate swap becomes effective October 4, 2010, concurrent with the termination of swap #2.

(3) This interest rate swap becomes effective January 24, 2011, concurrent with the termination of swap #3.

The Credit Facility and/or the Notes contain various covenants that limit our ability to take certain actions including; among other things, our ability to:

- incur, assume or guarantee additional indebtedness;
- issue redeemable stock and preferred stock;
- repurchase capital stock;
- make restricted payments, including paying dividends and making investments;
- redeem debt that is junior in right of payment to the notes;
- create liens without securing the notes;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- enter into agreements that restrict dividends from subsidiaries;
- merge, consolidate, sell or otherwise dispose of substantial portions of 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 restricted covenants and financial ratios and tests can be affected by events beyond our control, and we cannot assure you that we will meet those tests. A breach of any of these covenants could result in a default under our Credit Facility and/or the Notes. Upon the occurrence of an event of default under our Credit Facility or the Notes, all amounts outstanding under our Credit Facility and the Notes may become due and payable and all commitments under the Credit Facility to extend further credit may be terminated.

We believe that internally generated cash flows, availability for additional borrowings under our Credit Facility of $750 million (consisting of a $750 million revolving credit facility) and our ability to add up to $300 million of borrowing capacity from receivable transactions (including securitizations) and continued access to the bank credit and capital markets will be sufficient to finance acquisitions, capital expenditures and working capital requirements through the next 12 months. We believe these same sources of cash flows, borrowings under our Credit Facility as well as access to bank credit and capital markets will be available to us beyond the next 12 months and into the foreseeable future. On December 22, 2008, we filed a universal automatic shelf registration statement on Form S-3ASR that will permit us, from time to time, in one or more public offerings, to offer debt securities, common stock, preferred stock, warrants, depositary shares, or any combination of such securities. The shelf registration statement will also permit our subsidiary, CHS, to offer debt securities that would be guaranteed by us, from time to time in one or more public offerings. The terms of any such future offerings would be established at the time of the offering.

Off-balance sheet arrangements

Our consolidated operating results for the years ended December 31, 2009 and 2008, included $286.6 million and $282.0 million, respectively, of net operating revenues and $18.1 million and $18.4 million, respectively, of income from continuing operations, generated from seven hospitals operated by us under operating lease arrangements. In accordance with accounting principles generally accepted in the United States of America, or U.S. GAAP, the respective assets and the future lease obligations under these arrangements are not recorded in our consolidated balance sheet. Lease payments under these arrangements are included in rent expense and totaled approximately $16.5 million and $16.7 million for the years ended December 31, 2009 and 2008, respectively. The current terms of these operating leases expire between June 2012 and December 2020, not including lease extension options. If we allow these leases to expire, we would no longer generate revenues nor incur expenses from these hospitals.

In the past, we have utilized operating leases as a financing tool for obtaining the operations of specified hospitals without acquiring, through ownership, the related assets of the hospital and without a significant outlay of cash at the front end of the lease. We utilize the same operating strategies to improve operations at those hospitals held under operating leases as we do at those hospitals that we own. We have not entered into any operating leases for hospital operations since December 2000.

As described more fully in Note 15 of the Notes to Consolidated Financial Statements, at December 31, 2009, we have certain cash obligations for replacement facilities and other construction commitments of $594.4 million and open purchase orders for $201.1 million.

Noncontrolling Interests

We have sold noncontrolling interests in certain of our subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. As of December 31, 2009, we have hospitals in 23 of the markets we serve, with noncontrolling physician ownership interests ranging from less than 1% to 40%, including one hospital that also had a non-profit entity as a partner. In addition, we own three other hospitals with noncontrolling interests owned by non-profit entities. During 2009, we sold noncontrolling interests in six of our hospitals, including additional noncontrolling interests in hospitals with existing physician ownership, for total consideration of $19.3 million. During 2008, we sold noncontrolling interests in seven of our hospitals, including additional noncontrolling interests in hospitals with existing physician ownership, for total consideration of $82.1 million. Effective June 1, 2009, we acquired from Akron General Medical Center the remaining 20% noncontrolling interest in Massillon Community Health System, LLC not then owned by us. This entity indirectly owns and operates Affinity Medical Center of Massillon, Ohio. The purchase price for this noncontrolling interest was $1.1 million in cash. Affinity Medical Center is now wholly-owned by us. Effective June 30, 2008, we acquired the remaining 35% noncontrolling interest in Affinity Health Systems, LLC which indirectly owns and operates Trinity Medical Center (560 licensed beds) in Birmingham, Alabama, from Baptist Health Systems, Inc. of Birmingham, Alabama ("Baptist"), giving us 100% ownership of that facility. The purchase price to acquire this interest was $51.5 million in cash and the cancellation of a promissory note issued by Baptist to Affinity Health Systems, LLC in the original principal amount of $32.8 million. Effective November 14, 2008, we acquired from Willamette Community Health Solutions all of its noncontrolling interest in MWMC Holdings, LLC, which indirectly owns a controlling interest in and operates McKenzie-Willamette Medical Center of Springfield, Oregon. This acquisition resulted from a put right held by Willamette Community Health Solutions in connection with the 2003 transaction establishing the joint venture. The purchase price for this noncontrolling interest was $22.7 million in cash. Physicians affiliated with Oregon Health Resources, Inc. continue to own a noncontrolling interest in the hospital. Redeemable noncontrolling interests in equity of consolidated subsidiaries was $368.9 million and $348.8 million as of December 31, 2009 and 2008, respectively, and noncontrolling interests in equity of consolidated subsidiaries was $64.8 million and $61.5 million as of December 31, 2009 and 2008, respectively, and the amount of net income attributable to noncontrolling interests was $63.2 million, $34.4 million and $14.4 million for the years ended December 31, 2009, 2008 and 2007, respectively.

Reimbursement, Legislative and Regulatory Changes

Legislative and regulatory action has resulted in continuing change in the Medicare and Medicaid reimbursement programs which will continue to limit payment increases under these programs and in some cases implement payment decreases. Within the statutory framework of the Medicare and Medicaid programs, there are substantial areas subject to administrative rulings, interpretations, and discretion which may further affect payments made under those programs, and the federal and state governments might, in the future, reduce the funds available under those programs or require more stringent utilization and quality reviews of hospital facilities. Additionally, there may be a continued rise in managed care programs and future restructuring of the financing and delivery of healthcare in the United States. These events could cause our future financial results to decline.

Inflation

The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. In addition, our suppliers pass along rising costs to us in the form of higher prices. We have implemented cost control measures, including our case and resource management program, to curb increases in operating costs and expenses. We have generally offset increases in operating costs by increasing reimbursement for services, expanding services and reducing costs in other areas. However, we cannot predict our ability to cover or offset future cost increases.

Critical Accounting Policies

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

Critical accounting policies are defined as those that are reflective of significant judgments and uncertainties, and potentially result in materially different results under different assumptions and conditions. We believe that our critical accounting policies are limited to those described below. For a detailed discussion on the application of these and other accounting policies, see Note 1 in the Notes to the Consolidated Financial Statements included under Item 8 of this Report.

Third Party Reimbursement

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. Contractual allowances are automatically calculated and recorded through our internally developed "automated contractual allowance system." Within the automated system, actual Medicare DRG data and payors' historical paid claims data are utilized to calculate the contractual allowances. This data is automatically updated on a monthly basis. All hospital contractual allowance calculations are subjected to monthly review by management to ensure reasonableness and accuracy. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual allowance adjustments, which we deduct from gross revenues to arrive at net operating revenues. The process of estimating contractual allowances requires us to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification and historical paid claims data. Due to the complexities involved in these estimates, actual payments we receive could be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs and managed care contracts differed by 1% from our estimated reimbursement percentage, net income for the year ended December 31, 2009 would have changed by approximately $24.6 million, and net accounts receivable would have changed by $40.0 million. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net income by an insignificant amount in each of the years ended December 31, 2009, 2008 and 2007.

Allowance for Doubtful Accounts

Substantially all of our accounts receivable are related to providing healthcare services to our hospitals' patients. Collection of these accounts receivable is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and outstanding patient balances for which the primary insurance payor has paid some but not all of the outstanding balance, with the remaining outstanding balance (generally deductibles and co-payments) owed by the patient. At the point of service, for patients required to make a co-payment, we generally collect less than 15% of the related revenue. For all procedures scheduled in advance, our policy is to verify insurance coverage prior to the date of the procedure. Insurance coverage is not verified in advance of procedures for walk-in and emergency room patients.

We estimate the allowance for doubtful accounts by reserving a percentage of all self-pay accounts receivable without regard to aging category, based on collection history, adjusted for expected recoveries and, if present, anticipated changes in trends. For all other non self-pay payor categories we reserve 100% of all accounts aging over 365 days from the date of discharge. The percentage used to reserve for all self-pay accounts is based on our collection history. We believe that we collect substantially all of our third-party insured receivables which include receivables from governmental agencies. During the quarter ended December 31, 2007, in conjunction with our ongoing process of monitoring the net realizable value of our accounts receivable, as well as integrating the methodologies, data and assumptions used by the former Triad management, we performed various analyses, including updating a review of historical cash collections. As a result of these analyses, we noted deterioration in certain key cash collection indicators.

The primary key cash collection indicator that experienced deterioration during the fourth quarter of 2007 was "cash receipts as a percentage of net revenue less bad debts." This percentage decreased to the lowest percentage experienced by us since the quarter ended September 30, 2006. Further analysis indicated the primary causes of this deterioration were a continuing increase in the volume of indigent non-resident aliens, an increase in the number of patients qualifying for charity care and a greater than expected impact of the removal of participants from TennCare (Tennessee's state provided Medicaid program) which increased the number of uninsured patients with limited financial means receiving care at our eight Tennessee hospitals. During the fourth quarter of 2007, due to the deteriorating cash collections and the desire to standardize processes with those of the former Triad hospitals, we undertook a detailed programming effort to develop data around the deteriorating classes of accounts receivable needed to update our historical cash collections percentages as well as enable us to estimate how much of certain self-pay categories ultimately convert to Medicaid, charity and indigent programs. Triad's processes for establishing contractual allowances and allowances for bad debts related to accounts classified as Medicaid — pending, charity — pending and indigent non-resident alien included inputs and assumptions based on the historical percentage of these accounts which ultimately qualified for specific government programs or for write-off as charity care.

We used these new inputs and assumptions regarding Medicaid — pending, charity — pending, and indigent non-resident alien in conjunction with the new data developed in the fourth quarter of 2007 as described above to evaluate the realizability of accounts receivable and to revise our estimate of contractual allowances for estimated amounts of self-pay accounts receivable that will ultimately qualify as charity care, or that will ultimately qualify for Medicaid, indigent care or other specific governmental reimbursement, resulting in an increase to our contractual reserves of $96.3 million as of December 31, 2007. Previous estimates of uncollectible amounts for such receivables were included in our bad debt reserves for each period.

Furthermore, in updating the historical collection statistics of all our hospitals, we also took into account a detailed study of the historical collection information for the hospitals acquired from Triad. The updated collection statistics of the hospitals acquired from Triad also showed subsequent deterioration in cash collections similar to those experienced by the other hospitals that we own. Therefore, we also standardized the processes for calculating the allowance for doubtful accounts of the hospitals acquired from Triad to that of our other hospitals which, along with the allowance percentages determined from the new collection data, resulted in the recording of an additional $70.1 million of allowance for bad debts as of December 31, 2007.

The resulting impact of the above, net of taxes, for the year ended December 31, 2007 was a decrease to income from continuing operations of $105.4 million. We believe this lower collectability was primarily the result of an increase in the number of patients qualifying for charity care, reduced enrollment in certain state Medicaid programs and an increase in the number of indigent non-resident aliens. 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 could affect our collection of accounts receivable. The process of estimating the allowance for doubtful accounts requires us to estimate the collectability of self-pay accounts receivable, which is primarily based on our collection history, adjusted for expected recoveries and, if available, anticipated changes in collection trends. Significant change in payor mix, business office operations, economic conditions, trends in federal and state governmental healthcare coverage or other third party payors could affect our estimates of accounts receivable collectability. If the actual collection percentage differed by 1% from our estimated collection percentage as a result of a change in expected recoveries, net income for the year ended December 31, 2009 would have changed by $14.4 million, and net accounts receivable would have changed by $23.5 million. We also continually review our overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net revenue less provision for bad debts, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, and the impact of recent acquisitions and dispositions.

Our policy is to write-off gross accounts receivable if the balance is under $10.00 or when such amounts are placed with outside collection agencies. We believe this policy accurately reflects our ongoing collection efforts and is consistent with industry practices. We had approximately $1.5 billion at December 31, 2009 and 2008, being pursued by various outside collection agencies. We expect to collect less than 3%, net of estimated collection fees, of the amounts being pursued by outside collection agencies. As these amounts have been written-off, they are not included in our gross accounts receivable or our allowance for doubtful accounts. Collections on amounts previously written-off are recognized as a reduction to bad debt expense when received. However, we take into consideration estimated collections of these future amounts written-off in evaluating the reasonableness of our allowance for doubtful accounts.

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

Patient accounts receivable from our hospitals represent approximately 95% of our total consolidated accounts receivable.

Days revenue outstanding was 48 days at December 31, 2009 and 53 days at December 31, 2008. Our target range for days revenue outstanding is from 46 to 56 days.

Total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) was approximately $6.1 billion as of December 31, 2009 and approximately $5.5 billion as of December 31, 2008.

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

	As of December 31,	
	2009	2008
Insured receivables	62.4%	67.0%
Self-pay receivables (a)	37.6%	33.0%
Total	100.0%	100.0%

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(a) The increase in self-pay accounts receivable as a percentage of total gross accounts receivable is primarily the result of the former Triad hospitals utilizing our internal collection agency. This began for some hospitals in 2008 and others in 2009. Prior to utilizing our internal collection agency, such accounts were written off and sent to outside collection agencies.

For the hospital segment, the combined total of the allowance for doubtful accounts and related allowances for other self-pay discounts and contractuals, as a percentage of gross self-pay receivables, was approximately 82% at December 31, 2009 and 80% at December 31, 2008. If the receivables that have been written-off, but where collections are still being pursued by outside collection agencies, were included in both the allowances and gross self-pay receivables specified above, the percentage of combined allowances to total self-pay receivables would have been approximately 89% at December 31, 2009 and 2008.

Goodwill and Other Intangibles

Goodwill represents the excess of cost over the fair value of net assets acquired. Goodwill is evaluated for impairment at the same time every year and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. There is a two-step method for determining goodwill impairment. Step one is to compare the fair value of the reporting unit with the unit's carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit's goodwill with the carrying value of the reporting unit's goodwill. We have selected September 30th as our annual testing date. Based on the results of our most recent annual impairment test, we have concluded that we do not have any reporting units that are at risk of failing step one of the goodwill impairment test.

Impairment or Disposal of Long-Lived Assets

Whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, we project the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

Professional Liability Claims

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

The net present value of the projected payments was discounted using a weighted-average risk-free rate of 1.3%, 2.6% and 4.1% in 2009, 2008 and 2007, respectively. This liability is adjusted for new claims information in the period such information becomes known to us. Professional malpractice expense includes the losses resulting from professional liability claims and loss adjustment expense, as well as paid excess insurance premiums, and is presented within other operating expenses in the accompanying consolidated statements of income.

Our processes for obtaining and analyzing claims and incident data are standardized across all of our hospitals and have been consistent for many years. We monitor the outcomes of the medical care services that we provide and

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for each reported claim, we obtain various information concerning the facts and circumstances related to that claim. In addition, we routinely monitor current key statistics and volume indicators in our assessment of utilizing historical trends. The average lag period between claim occurrence and payment of a final settlement is between 4 and 5 years, although the facts and circumstances of individual claims could result in the timing of such payments being different from this average. Since claims are paid promptly after settlement with the claimant is reached, settled claims represent less than 1.0% of the total liability at the end of any period.

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

Based on these analyses we determine our estimate of the professional liability claims. The determination of management's estimate, including the preparation of the reserve analysis that supports such estimate, involves subjective judgment of the management. Changes in reserving data or the trends and factors that influence reserving data may signal fundamental shifts in our future claim development patterns or may simply reflect single-period anomalies. Even if a change reflects a fundamental shift, the full extent of the change may not become evident until years later. Moreover, since our methods and models use different types of data and we select our liability from the results of all of these methods, we typically cannot quantify the precise impact of such factors on our estimates of the liability. Due to our standardized and consistent processes for handling claims and the long history and depth of our company-specific data, our methodologies have produced reliably determinable estimates of ultimate paid losses.

The following table presents the amounts of our accrual for professional liability claims and approximate amounts of our activity for each of the respective years listed (excludes premiums for excess insurance coverage) (in thousands):

	Year Ended December 31, 2009	2008	2007
Accrual for professional liability claims, January 1	$ 350,579	$ 300,184	$ 104,161
Liability acquired through acquisition:			
Gross liability acquired	—	—	197,453
Discount of liability acquired	—	—	(26,309)
Discounted liability acquired	—	—	171,144
Expense (income) related to(1):			
Current accident year	136,424	110,010	73,039
Prior accident years	(6,702)	(15,826)	7,158
Expense (income) from discounting	11,515	11,499	(1,040)
Total incurred loss and loss expense	141,237	105,683	79,157
Paid claims and expenses related to:			
Current accident year	(1,387)	(688)	(701)
Prior accident years	(59,204)	(54,600)	(53,577)
Total paid claims and expenses	(60,591)	(55,288)	(54,278)
Accrual for professional liability claims, December 31	$ 431,225	$ 350,579	$ 300,184

(1) Total expense, including premiums for insured coverage, was $176.4 million in 2009, $136.6 million in 2008 and $99.7 million in 2007.

The increase in current accident year claims expense in each year from 2007 to 2009 is consistent with the increase in net operating revenues during these periods. Income/expense related to prior accident years reflects changes in estimates resulting from the filing of claims for prior year incidents, claim settlements, updates from litigation, and our ongoing investigation of open claims. Expense/income from discounting reflects the changes in the weighted-average risk-free interest rate used and timing of estimated payments for discounting in each year.

We are primarily self-insured for these claims; however, we obtain excess insurance that transfers the risk of loss to a third-party insurer for claims in excess of our self-insured retentions. Our excess insurance is underwritten on a claims-made basis. For claims reported prior to June 1, 2002, substantially all of our professional and general liability risks were subject to a $0.5 million per occurrence self-insured retention and for claims reported from June 1, 2002 through June 1, 2003, these self-insured retentions were $2.0 million per occurrence. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 are self-insured up to $5 million per claim. Management on occasion has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals has been purchased through commercial insurance companies and generally covers us for liabilities in excess of the self-insured retentions. The excess coverage consists of multiple layers of insurance, the sum of which totals up to $95 million per occurrence and in the aggregate for claims reported on or after June 1, 2003 and up to $145 million per occurrence and in the aggregate for claims incurred and reported after January 1, 2008. For certain policy years, if the first aggregate layer of excess coverage becomes fully utilized, then the self-insured retention could increase to $10 million per claim for any subsequent claims in that policy year until our total aggregate coverage is met.

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

Income Taxes

We must make estimates in recording provision for income taxes, including determination of deferred tax assets and deferred tax liabilities and any valuation allowances that might be required against the deferred tax assets. We believe that future income will enable us to realize these deferred tax assets, subject to the valuation allowance we have established. In 2009, we made adjustments to our deferred tax assets and liabilities resulting from a revaluation of these items and a decrease in our effective state tax rate that resulted in a net tax benefit of $3.0 million.

The total amount of unrecognized benefit that would impact the effective tax rate, if recognized, is approximately $9.4 million as of December 31, 2009. It is our policy to recognize interest and penalties accrued related to unrecognized benefits in our consolidated statements of income as income tax expense. Adjustments for purchase business combinations generally impact goodwill and do not affect net income. During the year ended December 31, 2009, we decreased liabilities by approximately $0.4 million and recorded $0.6 million in interest and penalties related to prior state income tax returns through our income tax provision from continuing operations, which are included in our liability for uncertain tax positions at December 31, 2009. A total of approximately $2.0 million of interest and penalties is included in the amount of liability for uncertain tax positions at December 31, 2009. During the year ended December 31, 2009, we released $0.6 million for income taxes and $0.2 million for accrued interest of our liability for uncertain tax positions, as a result of the expiration of the statute of limitations pertaining to tax positions taken in prior years relative to state tax positions.

We believe it is reasonably possible that approximately $6.4 million of our current unrecognized tax benefit may be recognized within the next twelve months as a result of a lapse of the statute of limitations and settlements with taxing authorities.

We, or one of our subsidiaries, file income tax returns in the U.S. federal jurisdiction and various state jurisdictions. We have extended the federal statute of limitations for Triad for the tax periods ended December 31, 1999, December 31, 2000, April 30, 2001, June 30, 2001, December 31, 2001, December 31, 2002 and December 31, 2003. We are currently under examination by the IRS regarding the federal tax return of Triad for the tax periods ended December 31, 2004, December 31, 2005, December 31, 2006 and July 25, 2007. We believe the results of this examination will not be material to our consolidated results of operations or consolidated financial position. With few exceptions, we are no longer subject to state income tax examinations for years prior to 2006 and federal income tax examinations with respect to Community Health Systems, Inc. federal returns for years prior to 2006.

Prior to January 1, 2009, income attributable to noncontrolling interests was deducted from earnings before arriving at income from continuing operations. With the adoption of certain updates to the U.S. GAAP related to consolidations effective January 1, 2009, the income attributable to noncontrolling interests has been reclassified below net income and therefore is no longer deducted in arriving at income from continuing operations. However, the provision for income taxes does not change because those less than wholly-owned consolidated subsidiaries attribute their taxable income to their respective investors. Accordingly, we will not pay tax on the income attributable to the noncontrolling interests. As a result of separately reporting income that is taxed to others, our effective tax rate on continuing operations before income taxes, as reported on the face of the financial statements is 31.7%, 34.9% and 37.2% for the years ended December 31, 2009, 2008 and 2007, respectively. However, the actual effective tax rate that is attributable to our share of income from continuing operations before income taxes (income from continuing operations before income taxes, as presented on the face of the statement of income, less income from continuing operations attributable to noncontrolling interests of $62.9 million, $34.9 million and $13.4 million for the years ended December 31, 2009, 2008 and 2007, respectively) is 36.9%, 38.7% and 42.4% for the years ended December 31, 2009, 2008 and 2007, respectively.

Recent Accounting Pronouncements

On January 1, 2010, we adopted the revisions to U.S. GAAP related to the accounting and consolidation requirements for variable interest entities. These revisions significantly change the criteria in determining the primary beneficiary of a variable interest entity, or VIE, from a more quantitative model to both a quantitative and qualitative evaluation of the enterprise that has (1) the power to direct the activities that most significantly affect the VIE's economic performance and (2) the obligation to absorb losses or the right to receive returns that could be potentially significant to the VIE. Additionally, this guidance requires ongoing reassessments of whether an enterprise is the primary beneficiary of a VIE and requires enhanced disclosures that will provide users of financial statements with more transparent information about an enterprise's involvement in a VIE. Given our limited amount of activity with entities for which these provisions would apply, the adoption of this standard is not expected to have a material effect on our consolidated results of operations or financial position, either upon adoption or into the foreseeable future.

Item 7A. *Quantitative and Qualitative Disclosures about Market Risk*

We are exposed to interest rate changes, primarily as a result of our Credit Facility which bears interest based on floating rates. In order to manage the volatility relating to the market risk, we entered into interest rate swap agreements described under the heading "Liquidity and Capital Resources." We do not anticipate any material changes in our primary market risk exposures in 2010. We utilize risk management procedures and controls in executing derivative financial instrument transactions. We do not execute transactions or hold derivative financial instruments for trading purposes. Derivative financial instruments related to interest rate sensitivity of debt obligations are used with the goal of mitigating a portion of the exposure when it is cost effective to do so.

A 1% change in interest rates on variable rate debt in excess of that amount covered by interest rate swaps would have resulted in interest expense fluctuating approximately $2.5 million in 2009, $13 million in 2008 and $14 million in 2007.

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

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Community Health Systems, Inc.
Franklin, Tennessee

We have audited the accompanying consolidated balance sheets of Community Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 2009 and 2008, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2009. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Community Health Systems, Inc. and subsidiaries as of December 31, 2009 and 2008, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2009, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 3 to the consolidated financial statements, the Company adopted revisions to accounting principles generally accepted in the United States of America related to business combinations effective January 1, 2009.

As discussed in Note 1 to the consolidated financial statements, the Company adopted revisions to accounting principles generally accepted in the United States of America and changed its method of accounting and financial statement presentation for noncontrolling interests in equity of consolidated subsidiaries in 2009, 2008, and 2007.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2009, based on the criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 25, 2010 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 25, 2010

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31, 2009	2008	2007
	(In thousands, except share and per share data)		
Net operating revenues	$ 12,107,613	$ 10,919,095	$ 7,095,861
Operating costs and expenses:			
Salaries and benefits	4,842,330	4,367,664	2,895,105
Provision for bad debts	1,460,307	1,218,612	886,985
Supplies	1,685,493	1,531,376	940,525
Other operating expenses	2,237,475	2,099,010	1,434,617
Rent	247,132	231,167	153,695
Depreciation and amortization	566,211	499,386	313,322
Total operating costs and expenses	11,038,948	9,947,215	6,624,249
Income from operations	1,068,665	971,880	471,612
Interest expense, net of interest income of $3,561, $7,057, and $8,181 in 2009, 2008, and 2007, respectively	648,964	652,468	362,065
(Gain) loss from early extinguishment of debt	(2,385)	(2,525)	27,388
Equity in earnings of unconsolidated affiliates	(36,521)	(42,063)	(25,132)
Impairment of long-lived and other assets	12,477	5,000	—
Income from continuing operations before income taxes	446,130	359,000	107,291
Provision for income taxes	141,325	125,273	39,860
Income from continuing operations	304,805	233,727	67,431
Discontinued operations, net of taxes:			
Income (loss) from operations of hospitals sold and hospitals held for sale	1,977	9,427	(4,199)
(Loss) gain on sale of hospitals, net	(405)	9,580	(2,594)
Impairment of long-lived assets of hospitals held for sale	—	—	(15,947)
Income (loss) from discontinued operations	1,572	19,007	(22,740)
Net income	306,377	252,734	44,691
Less: Net income attributable to noncontrolling interests	63,227	34,430	14,402
Net income attributable to Community Health Systems, Inc.	$ 243,150	$ 218,304	$ 30,289
Income from continuing operations attributable to Community Health Systems, Inc. common stockholders per share (1):			
Basic	$ 2.67	$ 2.13	$ 0.58
Diluted	$ 2.64	$ 2.11	$ 0.57
Discontinued operations attributable to Community Health Systems, Inc. common stockholders per share (1):			
Basic	$ 0.01	$ 0.21	$ (0.25)
Diluted	$ 0.01	$ 0.21	$ (0.25)
Net income attributable to Community Health Systems, Inc. common stockholders per share (1):			
Basic	$ 2.68	$ 2.34	$ 0.32
Diluted	$ 2.66	$ 2.32	$ 0.32
Weighted-average number of shares outstanding:			
Basic	90,614,886	93,371,782	93,517,337
Diluted	91,517,274	94,288,829	94,642,294

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

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS

	December 31, 2009	December 31, 2008
	(In thousands, except share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 344,541	$ 220,655
Patient accounts receivable, net of allowance for doubtful accounts of $1,417,188 and $1,111,131 at December 31, 2009 and December 31, 2008, respectively	1,617,903	1,625,470
Supplies	302,609	275,696
Prepaid income taxes	45,414	92,710
Deferred income taxes	80,714	91,875
Prepaid expenses and taxes	89,475	73,792
Other current assets (including assets of hospitals held for sale of $0 and $25,505 at December 31, 2009 and 2008, respectively)	194,339	224,852
Total current assets	2,674,995	2,605,050
Property and equipment:		
Land and improvements	537,307	510,292
Buildings and improvements	4,806,542	4,495,568
Equipment and fixtures	2,443,407	2,104,497
	7,787,256	7,110,357
Less accumulated depreciation and amortization	(1,655,010)	(1,215,952)
Property and equipment, net	6,132,246	5,894,405
Goodwill	4,157,927	4,166,091
Other assets, net of accumulated amortization of $197,880 and $158,532 in 2009 and 2008, respectively (including assets of hospitals held for sale of $0 and $145,799 at December 31, 2009 and 2008, respectively)	1,056,304	1,152,708
Total assets	$ 14,021,472	$ 13,818,254
LIABILITIES AND EQUITY		
Current liabilities:		
Current maturities of long-term debt	$ 66,470	$ 33,904
Accounts payable	428,565	532,595
Deferred income taxes	28,397	6,740
Accrued liabilities:		
Employee compensation	500,101	432,385
Interest	145,201	153,234
Other (including liabilities of hospitals held for sale of $0 and $67,190 at December 31, 2009 and 2008, respectively)	289,062	350,559
Total current liabilities	1,457,796	1,509,417
Long-term debt	8,844,638	8,938,185
Deferred income taxes	475,812	460,793
Other long-term liabilities	858,952	888,557
Total liabilities	11,637,198	11,796,952
Redeemable noncontrolling interests in equity of consolidated subsidiaries	368,857	348,816
Commitments and contingencies (Note 15)		
EQUITY		
Community Health Systems, Inc. stockholders' equity		
Preferred stock, $.01 par value per share, 100,000,000 shares authorized; none issued	—	—
Common stock, $.01 par value per share, 300,000,000 shares authorized; 94,013,537 shares issued and 93,037,988 shares outstanding at December 31, 2009 and 92,483,166 shares issued and 91,507,617 shares outstanding at	940	925

December 31, 2008		
Additional paid-in capital	1,158,359	1,136,108
Treasury stock, at cost, 975,549 shares at December 31, 2009 and December 31, 2008	(6,678)	(6,678)
Accumulated other comprehensive income (loss)	(221,385)	(295,575)
Retained earnings	1,019,399	776,249
Total Community Health Systems, Inc. stockholders' equity	1,950,635	1,611,029
Noncontrolling interests in equity of consolidated subsidiaries	64,782	61,457
Total equity	2,015,417	1,672,486
Total liabilities and equity	$ 14,021,472	$ 13,818,254

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Redeemable Noncontrolling Interests	Community Health Systems, Inc. Stockholders: Common Stock Shares	Common Stock Amount	Additional Paid-in Capital	Treasury Stock Shares	Treasury Stock Amount	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Noncontrolling Interests	Total
						(In thousands, except share data)				
BALANCE, December 31, 2006 (as previously reported)	$ —	95,026,494	$ 950	$ 1,195,947	(975,549)	$ (6,678)	$ 5,798	$ 527,656	$ —	$ 1,723,673
January 1, 2007 adjustment to non- controlling interests from adoption of updates to U.S. GAAP	23,478	—	—	(4,976)	—	—	—	—	5,057	81
Balance, December 31, 2006 (as adjusted)	23,478	95,026,494	950	1,190,971	(975,549)	(6,678)	5,798	527,656	5,057	1,723,754
Comprehensive income (loss):										
Net income	16,243	—	—	—	—	—	—	30,289	(1,841)	28,448
Net change in fair value of interest rate swaps, net of tax benefit of $51,223	—	—	—	—	—	—	(91,063)	—	—	(91,063)
Net change in fair value of available for sale securities	—	—	—	—	—	—	237	—	—	237
Adjustment to pension liability, net of tax of $496	—	—	—	—	—	—	3,291	—	—	3,291
Total comprehensive income (loss)	—	—	—	—	—	—	(87,535)	30,289	(1,841)	(59,087)
Noncontrolling interests from acquisition of Triad	284,737	—	—	—	—	—	—	—	59,201	59,201
Net contributions (distributions) to noncontrolling interests	5,345	—	—	—	—	—	—	—	(1,308)	(1,308)
Purchase of subsidiary shares from noncontrolling interests	(1,339)	—	—	—	—	—	—	—	(18)	(18)
Sale of less than wholly-owned subsidiaries	—	—	—	—	—	—	—	—	(9,672)	(9,672)
Adjustment to redemption value of redeemable noncontrolling interests	18,535	—	—	(18,535)	—	—	—	—	—	(18,535)
Issuance of common stock in connection with the exercise of options	—	321,535	3	8,362	—	—	—	—	—	8,365
Tax benefit from exercise of options	—	—	—	(2,760)	—	—	—	—	—	(2,760)
Share-based compensation	—	1,263,056	13	38,759	—	—	—	—	—	38,772

BALANCE, December 31, 2007	346,999	96,611,085	966	1,216,797	(975,549)	(6,678)	(81,737)	557,945	51,419	1,738,712
Comprehensive income (loss):										
Net income	30,017	—	—	—	—	—	—	218,304	4,410	222,714
Net change in fair value of interest rate swaps, net of tax benefit of $112,915	—	—	—	—	—	—	(200,737)	—	—	(200,737)
Net change in fair value of available for sale securities	—	—	—	—	—	—	(2,613)	—	—	(2,613)
Adjustment to pension liability, net of tax of $7,262	—	—	—	—	—	—	(10,488)	—	—	(10,488)
Total comprehensive income (loss)							(213,838)	218,304	4,410	8,876
Contributions from noncontrolling interests, net of distributions	7,056	—	—	—	—	—	—	—	29,931	29,931
Purchase of subsidiary shares from noncontrolling interests	(73,581)	—	—	—	—	—	—	—	(22,497)	(22,497)
Sale of less than wholly-owned subsidiaries	—	—	—	—	—	—	—	—	(1,806)	(1,806)
Adjustment to redemption value of redeemable noncontrolling interests	38,325	—	—	(38,325)	—	—	—	—	—	(38,325)
Repurchases of common stock	—	(4,786,609)	(48)	(90,141)	—	—	—	—	—	(90,189)
Issuance of common stock in connection with the exercise of options	—	281,831	3	1,803	—	—	—	—	—	1,806
Cancellation of restricted stock for tax withholdings on vested shares	—	(310,806)	(3)	(5,455)	—	—	—	—	—	(5,458)
Tax benefit from exercise of options	—	—	—	(672)	—	—	—	—	—	(672)
Share-based compensation	—	687,665	7	52,101	—	—	—	—	—	52,108
BALANCE, December 31, 2008	348,816	92,483,166	925	1,136,108	(975,549)	(6,678)	(295,575)	776,249	61,457	1,672,486
Comprehensive income (loss):										
Net income	46,716	—	—	—	—	—	—	243,150	16,511	259,661
Net change in fair value of interest rate swaps, net of tax benefit of $42,876	—	—	—	—	—	—	76,225	—	—	76,225
Net change in fair value of available for sale securities	—	—	—	—	—	—	412	—	—	412
Adjustment to pension liability, net of tax of $3,262	—	—	—	—	—	—	(2,447)	—	—	(2,447)
Total comprehensive income (loss)	—	—	—	—	—	—	74,190	243,150	16,511	333,851
Distributions to noncontrolling interests, net of	(27,072)	—	—	—	—	—	—	—	(13,582)	(13,582)

contributions										
Purchase of subsidiary shares from noncontrolling interests	(5,439)	—	—	3,106	—	—	—	—	396	3,502
Sale of less than wholly-owned subsidiaries	(21,691)	—	—	—	—	—	—	—	—	—
Adjustment to redemption value of redeemable noncontrolling interests	27,527	—	—	(27,527)	—	—	—	—	—	(27,527)
Issuance of common stock in connection with the exercise of options	—	680,898	7	12,760	—	—	—	—	—	12,767
Cancellation of restricted stock for tax withholdings on vested shares	—	(328,470)	(3)	(7,117)	—	—	—	—	—	(7,120)
Tax benefit from exercise of options	—	—	—	(3,472)	—	—	—	—	—	(3,472)
Share-based compensation	—	1,177,943	11	44,501	—	—	—	—	—	44,512
BALANCE, December 31, 2009	$ 368,857	94,013,537	$ 940	$ 1,158,359	(975,549)	$ (6,678)	$ (221,385)	$ 1,019,399	$ 64,782	$ 2,015,417

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
Cash flows from operating activities:			
Net income	$ 306,377	$ 252,734	$ 44,691
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	566,543	506,694	332,580
Deferred income taxes	34,268	159,870	(39,894)
Stock-based compensation expense	44,501	52,105	38,771
Loss (gain) on sale of hospitals and partnership interest, net	405	(17,687)	3,954
Income tax payable increase (excess tax benefit) relating to stock-based compensation	3,472	(1,278)	(1,216)
(Gain) loss on early extinguishment of debt	(2,385)	(2,525)	27,388
Impairment of long-lived and other assets	12,477	5,000	19,044
Other non-cash expenses, net	22,870	3,577	19,018
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	58,390	(49,578)	128,743
Supplies, prepaid expenses and other current assets	(34,535)	(34,397)	(31,734)
Accounts payable, accrued liabilities and income taxes	86,098	119,869	122,282
Other	(22,052)	62,197	24,811
Net cash provided by operating activities	1,076,429	1,056,581	688,438
Cash flows from investing activities:			
Acquisitions of facilities and other related equipment	(263,773)	(161,907)	(7,018,048)
Purchases of property and equipment	(576,888)	(692,233)	(522,785)
Proceeds from disposition of hospitals and other ancillary operations	89,514	365,636	109,996
Proceeds from sale of property and equipment	4,019	13,483	4,650
Increase in other non-operating assets	(120,054)	(190,450)	(72,671)
Net cash used in investing activities	(867,182)	(665,471)	(7,498,858)
Cash flows from financing activities:			
Proceeds from exercise of stock options	12,759	1,806	8,214
(Income tax payable increase) excess tax benefit relating to stock-based compensation	(3,472)	1,278	1,216
Deferred financing costs	(82)	(3,136)	(182,954)
Stock buy-back	—	(90,188)	—
Proceeds from noncontrolling investors in joint ventures	29,838	14,329	2,351
Redemption of noncontrolling investments in joint ventures	(7,268)	(77,587)	(1,356)
Distributions to noncontrolling investors in joint ventures	(58,963)	(46,890)	(6,645)
Borrowings under credit agreement	200,000	131,277	9,221,627
Repayments of long-term indebtedness	(258,173)	(234,918)	(2,139,025)
Net cash (used in) provided by financing activities	(85,361)	(304,029)	6,903,428
Net change in cash and cash equivalents	123,886	87,081	93,008
Cash and cash equivalents at beginning of period	220,655	133,574	40,566
Cash and cash equivalents at end of period	$ 344,541	$ 220,655	$ 133,574

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Business and Summary of Significant Accounting Policies

Business. Community Health Systems, Inc. is a holding company and operates no business in its own name. On a consolidated basis, Community Health Systems, Inc. and its subsidiaries (collectively the "Company") own, lease and operate acute care hospitals in non-urban and select urban markets. As of December 31, 2009, the Company owned or leased 122 hospitals, licensed for 18,140 beds in 29 states. Throughout these notes to the consolidated financial statements, Community Health Systems, Inc., (the "Parent"), and its consolidated subsidiaries are referred to on a collective basis as the "Company." This drafting style is not meant to indicate that the publicly-traded Parent or any subsidiary of the Parent owns or operates any asset, business, or property. The hospitals, operations and businesses described in this filing are owned and operated, and management services provided, by distinct and indirect subsidiaries of Community Health Systems, Inc. References to the Company may include one or more of its subsidiaries.

As of December 31, 2009, Indiana and Texas represent the only areas of geographic concentration. Net operating revenues generated by the Company's hospitals in Indiana, as a percentage of consolidated net operating revenues, were 10.9% in 2009, 10.9% in 2008 and 7.8% in 2007. Net operating revenues generated by the Company's hospitals in Texas, as a percentage of consolidated net operating revenues, were 13.2% in 2009, 13.3% in 2008 and 12.5% in 2007. As a result of the Company's growth and expansion of services in other states, Pennsylvania no longer represents an area of geographic concentration, as it did at December 31, 2007.

Use of Estimates. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America ("U.S. GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates under different assumptions or conditions.

Principles of Consolidation. The consolidated financial statements include the accounts of the Parent, its subsidiaries, all of which are controlled by the Parent through majority voting control, and variable interest entities for which the Company is the primary beneficiary. All significant intercompany accounts and transactions have been eliminated. Noncontrolling interests in less-than-wholly-owned consolidated subsidiaries of the Parent are presented as a component of total equity to distinguish between the interests of the Parent and the interests of the noncontrolling owners. Revenues, expenses and income from continuing operations from these subsidiaries are included in the consolidated amounts as presented on the consolidated statements of income, along with a net income measure that separately presents the amounts attributable to the controlling interests and the amounts attributable to the noncontrolling interests for each of the periods presented. Noncontrolling interests that are redeemable or may become redeemable at a fixed or determinable price at the option of the holder or upon the occurrence of an event outside of the control of the Company are presented in mezzanine equity on the consolidated balance sheets.

Cost of Revenue. The majority of the Company's operating expenses are "cost of revenue" items. Operating costs that could be classified as general and administrative by the Company would include the Company's corporate office costs at its Franklin, Tennessee offices and former offices in Brentwood, Tennessee and Plano, Texas, which were $157.9 million, $167.2 million and $133.4 million for the years ended December 31, 2009, 2008 and 2007, respectively. Included in these amounts is stock-based compensation of $44.5 million, $52.1 million and $38.8 million for the years ended December 31, 2009, 2008 and 2007, respectively.

Cash Equivalents. The Company considers highly liquid investments with original maturities of three months or less to be cash equivalents.

Supplies. Supplies, principally medical supplies, are stated at the lower of cost (first-in, first-out basis) or market.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Marketable Securities. The Company's marketable securities are classified as trading or available-for-sale. Available-for-sale securities are carried at fair value as determined by quoted market prices, with unrealized gains and losses reported as a separate component of stockholders' equity. Trading securities are reported at fair value with unrealized gains and losses included in earnings. Interest and dividends on securities classified as available-for-sale or trading are included in net operating revenue and were not material in all periods presented. Accumulated other comprehensive income (loss) included an unrealized gain of $0.4 million at December 31, 2009 and an unrealized loss of $2.6 million at December 31, 2008, related to these available-for-sale securities.

Property and Equipment. Property and equipment are recorded at cost. Depreciation is recognized using the straight-line method over the estimated useful lives of the land and improvements (2 to 15 years; weighted average useful life is 14 years), buildings and improvements (5 to 40 years; weighted average useful life is 24 years) and equipment and fixtures (4 to 18 years; weighted average useful life is 8 years). Costs capitalized as construction in progress were $130.5 million and $196.4 million at December 31, 2009 and 2008, respectively. Expenditures for renovations and other significant improvements are capitalized; however, maintenance and repairs which do not improve or extend the useful lives of the respective assets are charged to operations as incurred. Interest capitalized related to construction in progress was $16.7 million, $22.1 million and $19.0 million for the years ended December 31, 2009, 2008 and 2007, respectively. Purchases of property and equipment accrued in accounts payable and not yet paid were $39.6 million and $31.6 million at December 31, 2009 and 2008, respectively.

The Company also leases certain facilities and equipment under capital leases (see Note 9). Such assets are amortized on a straight-line basis over the lesser of the term of the lease or the remaining useful lives of the applicable assets.

Goodwill. Goodwill represents the excess cost over the fair value of net assets acquired. Goodwill arising from business combinations is not amortized. Goodwill is required to be evaluated for impairment at the same time every year and when an event occurs or circumstances change such that it is reasonably possible that an impairment may exist. The Company has selected September 30th as its annual testing date.

Other Assets. Other assets primarily consist of costs associated with the issuance of debt, which are included in interest expense over the life of the related debt using the effective interest method, and costs to recruit physicians to the Company's markets, which are deferred and amortized in amortization expense over the term of the respective physician recruitment contract, which is generally three years. Long-term assets held for sale at December 31, 2008 are also included in other assets.

Third-Party Reimbursement. Net patient service revenue is reported at the estimated net realizable amount from patients, third party-payors and others for services rendered. Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems, provisions of cost-reimbursement and other payment methods. Approximately 36.9% of net operating revenues for the year ended December 31, 2009, 36.6% of net operating revenues for the year ended December 31, 2008 and 39.3% of net operating revenues for the year ended December 31, 2007, are related to services rendered to patients covered by the Medicare and Medicaid programs. Revenues from Medicare outlier payments are included in the amounts received from Medicare and were approximately 0.43% of net operating revenues for 2009, 0.55% of net operating revenues for 2008, and 0.42% of net operating revenues for 2007. In addition, the Company is reimbursed by non-governmental payors using a variety of payment methodologies. Amounts received by the Company for treatment of patients covered by such programs are generally less than the standard billing rates. The differences between the estimated program reimbursement rates and the standard billing rates are accounted for as contractual adjustments, which are deducted from gross revenues to arrive at net operating revenues. These net operating revenues are an estimate of the net realizable amount due from these payors. The process of estimating contractual allowances requires the Company to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification and historical paid claims data. Due to the complexities involved in these estimates, actual payments the Company receives could be different from the amounts it estimates and records. Final settlements under certain of these programs are subject to adjustment based on administrative review and audit by third parties. Adjustments to the estimated billings are recorded in the periods that such adjustments become known. Adjustments to previous program reimbursement estimates are accounted for as contractual allowance adjustments and reported in the

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenue and net income by an insignificant amount in each of the years ended December 31, 2009, 2008 and 2007.

Amounts due to third-party payors were $78.1 million and $87.9 million as of December 31, 2009 and 2008, respectively, and are included in accrued liabilities-other in the accompanying consolidated balance sheets. Amounts due from third party payors were $96.0 million and $73.6 million as of December 31, 2009 and 2008, respectively, and are included in other current assets in the accompanying consolidated balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 2006.

Net Operating Revenues. Net operating revenues are recorded net of provisions for contractual allowance of approximately $31.5 billion, $26.6 billion and $16.7 billion in 2009, 2008 and 2007, respectively. Net operating revenues are recognized when services are provided and are reported at the estimated net realizable amount from patients, third-party payors and others for services rendered. Also included in the provision for contractual allowance shown above is the value of administrative and other discounts provided to self-pay patients eliminated from net operating revenues which was $544.2 million, $456.0 million and $266.0 million for the years ended December 31, 2009, 2008 and 2007, respectively. In the ordinary course of business, the Company renders services to patients who are financially unable to pay for hospital care. Included in the provision for contractual allowance shown above is the value (at the Company's standard charges) of these services to patients who are unable to pay that is eliminated from net operating revenues when it is determined they qualify under the Company's charity care policy. The value of these services was $472.4 million, $384.1 million and $322.2 million for the years ended December 31, 2009, 2008 and 2007, respectively. In the fourth quarter of 2007, in conjunction with an analysis of the net realizable value of accounts receivable, which included updating the Company's analysis of historical cash collections, as well as conforming estimation methodologies with those of the hospitals acquired from Triad Hospitals, Inc. ("Triad"), the Company revised its methodology with respect to its estimate of contractual allowances for estimated amounts of self-pay accounts receivable that will ultimately qualify as charity care, or that will ultimately qualify for Medicaid, indigent care or other specific governmental reimbursement. Previous estimates of uncollectible amounts for such receivables were included in the Company's bad debt reserves for each period. The impact of these changes in estimates decreased net operating revenues approximately $96.3 million for the year ended December 31, 2007.

Allowance for Doubtful Accounts. Accounts receivable are reduced by an allowance for amounts that could become uncollectible in the future. Substantially all of the Company's receivables are related to providing healthcare services to its hospitals' patients.

During the quarter ended December 31, 2007, in conjunction with the Company's ongoing process of monitoring the net realizable value of its accounts receivable, as well as integrating the methodologies, data and assumptions used by the former Triad management, the Company performed various analyses including updating a review of historical cash collections.

The primary key cash collection indicator that experienced deterioration during the fourth quarter of 2007 was "cash receipts as a percentage of net revenue less bad debts." This percentage decreased to the lowest percentage experienced by the Company since the quarter ended September 30, 2006. Further analysis indicated the primary causes of this deterioration were a continuing increase in the volume of indigent non-resident aliens, an increase in the number of patients qualifying for charity care and a greater than expected impact of the removal of participants from TennCare (Tennessee's state provided Medicaid program) which increased the number of uninsured patients with limited financial means receiving care at the Company's eight Tennessee hospitals. During the fourth quarter of 2007, due to the deteriorating cash collections and desire to standardize processes with those of the former Triad hospitals, the Company undertook a detailed programming effort to develop data around the deteriorating classes of accounts receivable needed to update its historical cash collections percentages as well as enable it to estimate how much of certain self-pay categories ultimately convert to Medicaid, charity and indigent programs. Triad's processes for establishing contractual allowances and allowances for bad debts related to accounts classified as Medicaid — pending, charity — pending and indigent non-resident alien included inputs and assumptions based on the historical percentage of these accounts which ultimately qualified for specific government programs or for write-off as charity care.

The Company used these new inputs and assumptions regarding Medicaid — pending, charity — pending, and indigent non-resident alien in conjunction with the new data developed in the fourth quarter of 2007, as described above to evaluate the realizability of accounts receivable and to revise the Company's estimate of contractual allowances for estimated amounts of self-pay accounts receivable that will ultimately qualify as charity care, or that

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will ultimately qualify for Medicaid, indigent care or other specific governmental reimbursement, resulting in an increase to the Company's contractual reserves of $96.3 million as of December 31, 2007. Previous estimates of uncollectible amounts for such receivables were included in the Company's bad debt reserves for each period.

Furthermore, in updating the historical collection statistics of all its hospitals, the Company also took into account a detailed study of the historical collection information for the hospitals acquired from Triad. The updated collection statistics of the hospitals acquired from Triad also showed subsequent deterioration in cash collections similar to those experienced by the other hospitals that the Company owns. Therefore, the Company also standardized the processes for calculating the allowance for doubtful accounts of the hospitals acquired from Triad to that of its other hospitals which, along with the allowance percentages determined from the new collection data, resulted in the recording of an additional $70.1 million of allowance for bad debts as of December 31, 2007.

The resulting impact of the above, net of taxes, for the year ended December 31, 2007 was a decrease to income from continuing operations of $105.4 million. The Company believes this lower collectability was primarily the result of an increase in the number of patients qualifying for charity care, reduced enrollment in certain state Medicaid programs and an increase in the number of indigent non-resident aliens. Collections are impacted by the economic ability of patients to pay and the effectiveness of the Company's collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect the Company's collection of accounts receivable. The process of estimating the allowance for doubtful accounts requires the Company to estimate the collectability of self-pay accounts receivable, which is primarily based on its collection history, adjusted for expected recoveries and, if available, anticipated changes in collection trends. Significant change in payor mix, business office operations, economic conditions, trends in federal and state governmental healthcare coverage or other third-party payors could affect the Company's estimates of accounts receivable collectability.

The Company believes the revised methodology provides a better approach to estimating changes in payor mix, continued increases in charity and indigent care as well as the monitoring of historical collection patterns. The revised accounting methodology and the adequacy of resulting estimates will continue to be reviewed by monitoring accounts receivable write-offs, monitoring cash collections as a percentage of trailing net revenues less provision for bad debts, monitoring historical cash collection trends, as well as analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, and the impact of recent acquisitions and dispositions.

Physician Income Guarantees. The Company enters into physician recruiting agreements under which it supplements physician income to a minimum amount over a period of time, typically one year, while the physicians establish themselves in the community. As part of the agreements, the physicians are committed to practice in the community for a period of time, typically three years, which extends beyond their income guarantee period. The Company records an asset and liability for the estimated fair value of minimum revenue guarantees on new agreements. Adjustments to the ultimate value of the guarantee paid to physicians are recognized in the period that the change in estimate is identified. The Company amortizes an asset over the life of the agreement. As of December 31, 2009 and 2008, the unamortized portion of these physician income guarantees was $41.2 million and $49.1 million, respectively.

Concentrations of Credit Risk. The Company grants unsecured credit to its patients, most of whom reside in the service area of the Company's facilities and are insured under third-party payor agreements. Because of the economic diversity of the Company's facilities and non-governmental third-party payors, Medicare represents the only significant concentration of credit risk from payors. Accounts receivable, net of contractual allowances, from Medicare were $241.3 million and $256.6 million as of December 31, 2009 and 2008, respectively, representing 7.9% and 9.4% of consolidated net accounts receivable, before allowance for doubtful accounts, as of December 31, 2009 and 2008, respectively.

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Professional Liability Claims. The Company accrues for estimated losses resulting from professional liability. The accrual, which includes an estimate for incurred but not reported claims, is based on historical loss patterns and actuarially-determined projections and is discounted to its net present value. To the extent that subsequent claims information varies from management's estimates, the liability is adjusted when such information becomes available.

Accounting for the Impairment or Disposal of Long-Lived Assets. Whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

Income Taxes. The Company accounts for income taxes under the asset and liability method, in which deferred income tax assets and liabilities are recognized for the tax consequences of "temporary differences" by applying enacted statutory tax rates applicable to future years to differences between the financial statement carrying amounts and the tax bases of existing assets and liabilities. The effect on deferred taxes of a change in tax rates is recognized in the consolidated statement of income during the period in which the tax rate change becomes law.

Comprehensive Income (Loss). Comprehensive income (loss) is the change in equity of a business enterprise during a period from transactions and other events and circumstances from non-owner sources.

Accumulated Other Comprehensive Income (Loss) consists of the following (in thousands):

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Adjustment to Pension Liability	Accumulated Other Comprehensive Income (Loss)
Balance as of December 31, 2007	$ (77,748)	$ 1,021	$ (5,010)	$ (81,737)
2008 Activity, net of tax	(200,737)	(2,613)	(10,488)	(213,838)
Balance as of December 31, 2008	(278,485)	(1,592)	(15,498)	(295,575)
2009 Activity, net of tax	76,225	412	(2,447)	74,190
Balance as of December 31, 2009	$ (202,260)	$ (1,180)	$ (17,945)	$ (221,385)

Segment Reporting. A public company is required to report annual and interim financial and descriptive information about its reportable operating segments. Operating segments, as defined, are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker in deciding how to allocate resources and in assessing performance. Aggregation of similar operating segments into a single reportable operating segment is permitted if the businesses have similar economic characteristics and meet the criteria established by U.S. GAAP.

The Company operates in three distinct operating segments, represented by the hospital operations (which includes the Company's acute care hospitals and related healthcare entities that provide inpatient and outpatient healthcare services), the home care agencies operations (which provide outpatient care generally in the patient's home), and the hospital management services business (which provides executive management and consulting services to independent acute care hospitals). U.S. GAAP requires (1) that financial information be disclosed for operating segments that meet a 10% quantitative threshold of the consolidated totals of net revenue, profit or loss, or total assets; and (2) that the individual reportable segments disclosed contribute at least 75% of total consolidated net revenue. Based on these measures, only the hospital operations segment meets the criteria as a separate reportable segment. Financial information for the home care agencies and management services segments do not meet the quantitative thresholds and are therefore combined with corporate into the all other reportable segment.

Derivative Instruments and Hedging Activities. The Company records derivative instruments (including certain derivative instruments embedded in other contracts) on the consolidated balance sheet as either an asset or liability measured at its fair value. Changes in a derivative's fair value are recorded each period in earnings or other comprehensive income ("OCI"), depending on whether the derivative is designated and is effective as a hedged transaction, and on the type of hedge transaction. Changes in the fair value of derivative instruments recorded to OCI are reclassified to earnings in the period affected by the underlying hedged item. Any portion of the fair value of a derivative instrument determined to be ineffective under the standard is recognized in current earnings.

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The Company has entered into several interest rate swap agreements. See Note 7 for further discussion about the swap transactions.

New Accounting Pronouncement. On January 1, 2010, the Company adopted the revisions to U.S. GAAP related to the accounting and consolidation requirements for variable interest entities. These revisions significantly change the criteria in determining the primary beneficiary of a variable interest entity ("VIE") from a more quantitative model to both a quantitative and qualitative evaluation of the enterprise that has (1) the power to direct the activities that most significantly affect the VIE's economic performance and (2) the obligation to absorb losses or the right to receive returns that could be potentially significant to the VIE. Additionally, this guidance requires ongoing reassessments of whether an enterprise is the primary beneficiary of a VIE and requires enhanced disclosures that will provide users of financial statements with more transparent information about an enterprise's involvement in a VIE. Given the Company's limited amount of activity with entities for which these provisions would apply, the adoption of this standard is not expected to have a material effect on the Company's consolidated results of operations or financial position, either upon adoption or into the foreseeable future.

Reclassifications. Certain amounts in the consolidated balance sheets and consolidated statements of income for all periods presented have been reclassified to reflect the adoption of changes to U.S. GAAP related to the presentation of noncontrolling interests, the provisions of which, among other things, require that minority interests be renamed noncontrolling interests and presented as a component of total equity on the consolidated balance sheets. Additionally, these changes require the presentation of a consolidated net income measure that includes the amounts attributable to both the controlling and noncontrolling interests for all periods presented. There was no impact to net income attributable to the Company for all periods presented as a result of these changes.

During the three months ended June 30, 2009, the Company decided to retain a hospital and related businesses previously classified as held for sale. Results of operations for all periods presented have been restated to include this retained hospital and related businesses, which were previously reported as discontinued operations. The consolidated balance sheets for each of the periods presented have been restated to present the assets and liabilities previously reported as held for sale in the applicable financial statement line items.

2. Accounting for Stock-Based Compensation

Stock-based compensation awards are granted under the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan (the "2000 Plan") and the Community Health Systems, Inc. 2009 Stock Option and Award Plan (the "2009 Plan").

The 2000 Plan allows for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code ("IRC"), as well as stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units, phantom stock and other share awards. Persons eligible to receive grants under the 2000 Plan include the Company's directors, officers, employees and consultants. To date, all options granted under the 2000 Plan have been "nonqualified" stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date. Options granted prior to 2005 have a 10 year contractual term, options granted in 2005 through 2007 have an eight year contractual term and options granted in 2008 and 2009 have a 10 year contractual term. The exercise price of all options granted under the 2000 Plan is equal to the fair value of the Company's common stock on the option grant date. As of December 31, 2009, 4,064,612 shares of unissued common stock remain available for future grants under the 2000 Plan.

The 2009 Plan, which was adopted by the Board of Directors of the Parent as of March 24, 2009 and approved by stockholders on May 19, 2009, provides for the grant of incentive stock options intended to qualify under Section 422 of the IRC and for the grant of stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Persons eligible to receive grants under the 2009 Plan include the Company's directors, officers, employees and consultants. The duration of any option granted under the 2009 Plan will be determined by the Company's compensation committee. Generally, however, no option may be exercised more than 10 years from the date of grant, provided that the

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compensation committee may provide that a stock option may, upon the death of the grantee, be exercised for up to one year following the date of death even if such period extends beyond 10 years. As of December 31, 2009, no grants had been made under the 2009 Plan, with 3,500,000 shares of unissued common stock remaining reserved for future grants.

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

	Year Ended December 31,		
	2009	2008	2007
Effect on income from continuing operations before income taxes	$ (44,501)	$ (52,105)	$ (38,771)
Effect on net income	$ (26,986)	$ (31,655)	$ (23,541)

At December 31, 2009, $40.3 million of unrecognized stock-based compensation expense was expected to be recognized over a weighted-average period of 20 months. Of that amount, $13.5 million related to outstanding unvested stock options expected to be recognized over a weighted-average period of 17 months and $26.9 million relates to outstanding unvested restricted stock, restricted stock units and phantom shares expected to be recognized over a weighted-average period of 21 months. There were no modifications to awards during 2009, 2008, or 2007.

The fair value of stock options was estimated using the Black Scholes option pricing model with the assumptions and weighted-average fair values during the years ended December 31, 2009, 2008 and 2007, as follows:

	Year Ended December 31,		
	2009	2008	2007
Expected volatility	40.7%	24.9%	24.4%
Expected dividends	0	0	0
Expected term	4 years	4 years	4 years
Risk-free interest rate	1.64%	2.53%	4.48%

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

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

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

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Options outstanding and exercisable under the 2000 Plan as of December 31, 2009, and changes during each of the years in the three-year period ended December 31, 2009 were as follows (in thousands, except share and per share data):

	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (In Years)	Aggregate Intrinsic Value as of December 31, 2009
Outstanding at December 31, 2006	5,482,528	$ 26.48		
Granted	3,544,000	37.79		
Exercised	(295,854)	26.89		
Forfeited and cancelled	(291,659)	35.70		
Outstanding at December 31, 2007	8,439,015	30.90		
Granted	1,251,000	31.89		
Exercised	(281,831)	22.10		
Forfeited and cancelled	(644,100)	35.71		
Outstanding at December 31, 2008	8,764,084	30.97		
Granted	1,313,000	19.43		
Exercised	(680,898)	18.74		
Forfeited and cancelled	(442,105)	31.27		
Outstanding at December 31, 2009	8,954,081	$ 30.19	5.7 years	$ 59,304
Exercisable at December 31, 2009	6,089,995	$ 30.94	4.7 years	$ 36,509

The weighted-average grant date fair value of stock options granted during the years ended December 31, 2009, 2008 and 2007, was $6.61, $7.56 and $10.24, respectively. The aggregate intrinsic value represents the number of in-the-money stock options multiplied by the difference between the Company's closing stock price on the last trading day of the reporting period and the exercise price of the respective stock options based on the closing market price of the Company's common stock at December 31, 2009 of $35.60. This amount changes based on the market value of the Company's common stock. The aggregate intrinsic value of options exercised during the years ended December 31, 2009, 2008 and 2007 was $7.6 million, $3.4 million and $3.5 million, respectively. The aggregate intrinsic value of options vested and expected to vest approximates that of the outstanding options.

The Company has also awarded restricted stock under the 2000 Plan to its directors and employees of certain subsidiaries. The restrictions on these shares generally lapse in one-third increments on each of the first three anniversaries of the award date. Certain of the restricted stock awards granted to the Company's senior executives contain a performance objective that must be met in addition to any vesting requirements. If the performance objective is not attained, the awards will be forfeited in their entirety. Once the performance objective has been attained, restrictions will lapse in one-third increments on each of the first three anniversaries of the award date. Notwithstanding the above-mentioned performance objectives and vesting requirements, the restrictions will lapse earlier in the event of death, disability or termination of employment by the Company for any reason other than for cause of the holder of the restricted stock, or change in control of the Company. Restricted stock awards subject to performance standards are not considered outstanding for purposes of determining earnings per share until the performance objectives have been satisfied.

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Restricted stock outstanding under the 2000 Plan as of December 31, 2009, and changes during each of the years in the three-year period ended December 31, 2009 were as follows:

	Shares	Weighted Average Grant Date Fair Value
Unvested at December 31, 2006	969,691	$ 36.05
Granted	1,392,000	38.70
Vested	(384,646)	35.47
Forfeited	(20,502)	36.73
Unvested at December 31, 2007	1,956,543	38.04
Granted	795,500	31.99
Vested	(960,001)	37.64
Forfeited	(107,835)	35.62
Unvested at December 31, 2008	1,684,207	35.57
Granted	1,188,814	18.45
Vested	(965,478)	37.08
Forfeited	(10,002)	32.52
Unvested at December 31, 2009	1,897,541	$ 24.09

On February 25, 2009, under the 2000 Plan, each of the Company's outside directors received a grant of shares of phantom stock equal in value to $130,000 divided by the closing price of the Company's common stock on that date ($18.18), or 7,151 shares per director (a total of 42,906 shares of phantom stock). Pursuant to a March 24, 2009 amendment to the 2000 Plan, future grants of this type will be denominated as "restricted stock unit" awards. On May 19, 2009, the newly elected outside director received a grant of 7,151 restricted stock units under the 2000 Plan, having a value at the time of grant of $180,706 based upon the closing price of the Company's common stock on that date of $25.27. Vesting of these shares of phantom stock and restricted stock units occurs in one-third increments on each of the first three anniversaries of the award date. As of December 31, 2009, there were 50,057 shares of phantom stock and restricted stock units unvested at a weighted-average grant date fair value of $19.19. None of these grants were vested or canceled during the year ended December 31, 2009.

Under the Directors' Fees Deferral Plan, the Company's outside directors may elect to receive share equivalent units in lieu of cash for their directors' fees. These units are held in the plan until the director electing to receive the share equivalent units retires or otherwise terminates his/her directorship with the Company. Share equivalent units are converted to shares of common stock of the Company at the time of distribution. The following table represents the amount of directors' fees which were deferred and the equivalent units into which they converted for each of the respective periods (in thousands, except units):

	Year Ended December 31, 2009	2008
Directors' fees earned and deferred into plan	$ 80	$ 91
Equivalent units	3,284.028	3,410.470

At December 31, 2009, a total of 20,103.030 units were deferred in the plan with an aggregate fair value of $0.7 million, based on the closing market price of the Company's common stock at December 31, 2009 of $35.60.

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3. Acquisitions and Divestitures of Hospitals

Triad Acquisition

On July 25, 2007, the Company completed its acquisition of Triad. Triad owned and operated 50 hospitals with 49 hospitals located in 17 states in non-urban and middle market communities and one hospital located in the Republic of Ireland.

As of December 31, 2009, eight of the hospitals acquired from Triad have been sold. As a result of its acquisition of Triad, the Company also provides management and consulting services on a contract basis to independent hospitals, through its subsidiary, Quorum Health Resources, LLC. The Company acquired Triad for approximately $6.9 billion, including the assumption of approximately $1.7 billion of existing indebtedness.

In connection with the consummation of the acquisition of Triad, the Company's wholly-owned subsidiary CHS/Community Health Systems, Inc. ("CHS") obtained approximately $7.2 billion of senior secured financing under a new credit facility (the "Credit Facility") and issued approximately $3.0 billion aggregate principal amount of 8.875% senior notes due 2015 (the "Notes"). The Company used the net proceeds of $3.0 billion from the Notes offering and the net proceeds of approximately $6.1 billion of term loans under the Credit Facility to acquire the outstanding shares of Triad, to refinance certain of Triad's indebtedness and the Company's indebtedness, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. This Credit Facility also provides an additional $750 million revolving credit facility and had provided a $400 million delayed draw term loan facility for future acquisitions, working capital and general corporate purposes. As of December 31, 2007, the $400 million delayed draw term loan was reduced to $300 million at the request of the Company. As of December 31, 2008, $100 million of the delayed draw term loan had been drawn by the Company, reducing the delayed draw term loan availability to $200 million at that date. In January 2009, the Company drew down the remaining $200 million of the delayed draw term loan.

The total cost of the Triad acquisition has been allocated to the assets acquired and liabilities assumed based upon their respective fair values. The purchase price represented a premium over the fair value of the net tangible and identifiable intangible assets acquired for reasons such as:

- strategically, Triad had operations in five states in which the Company previously had no operations;
- the combined company has smaller concentrations of credit risk through greater geographic diversification;
- many support functions were centralized; and
- duplicate corporate functions were eliminated.

The allocation process required the analysis of acquired fixed assets, contracts, contractual commitments, and legal contingencies to identify and record the fair value of all assets acquired and liabilities assumed. The Company completed the allocation of the total cost of the Triad acquisition in the third quarter of 2008 and made a final analysis and adjustment as of December 31, 2008 to deferred tax accounts based on the final cost allocation, resulting in approximately $2.8 billion of goodwill being recorded with respect to the Triad acquisition.

Other Acquisitions

On December 31, 2009, one or more subsidiaries of the Company completed a transaction providing $54.2 million of financing to Rockwood Clinic, P.S., a multi-specialty clinic with 32 locations across the Inland Northwest region of Eastern Washington State and Western Idaho. This transaction was accounted for as a purchase business combination as required by U.S. GAAP.

Effective June 1, 2009, one or more subsidiaries of the Company acquired from Akron General Medical Center the remaining 20% noncontrolling interest in Massillon Community Health System, LLC not then owned by one or more subsidiaries of the Company. This entity indirectly owns and operates Affinity Medical Center of Massillon, Ohio. The purchase price for this noncontrolling interest was $1.1 million in cash. Affinity Medical Center is now wholly-owned by these subsidiaries of the Company.

Effective April 30, 2009, one or more subsidiaries of the Company acquired Wyoming Valley Health Care System in Wilkes-Barre, Pennsylvania. This health care system includes Wilkes-Barre General Hospital, a 392-bed,

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full-service acute care hospital located in Wilkes-Barre, Pennsylvania, and First Hospital Wyoming Valley, a behavioral health facility located in Kingston, Pennsylvania, as well as other outpatient and ancillary services. The total consideration for fixed assets and working capital of Wyoming Valley Health Care System was approximately $179.1 million, of which $153.7 million was paid in cash, net of $14.2 million of cash in acquired bank accounts, and approximately $25.4 million was assumed in liabilities. This acquisition transaction was accounted for using the purchase method of accounting. This preliminary allocation of the purchase price has been determined by the Company based upon available information and the allocation is subject to the settlement of the amounts related to purchased working capital. Adjustments to the purchase price allocation are not expected to be material.

Effective April 1, 2009, one or more subsidiaries of the Company acquired from Share Foundation the remaining 50% equity interest in MCSA L.L.C., an entity in which one or more subsidiaries of the Company previously had a 50% unconsolidated noncontrolling interest. One or more subsidiaries of the Company provided MCSA L.L.C. certain management services. This acquisition resulted in these subsidiaries of the Company owning a 100% equity interest in that entity. MCSA L.L.C. owns and operates Medical Center of South Arkansas (166 licensed beds) in El Dorado, Arkansas. The purchase price was $26.0 million in cash. As of the acquisition date, one or more subsidiaries of the Company had a liability to MCSA L.L.C. of $14.1 million, as a result of a cash management agreement previously entered into with the hospital. Upon completion of the acquisition, this liability was eliminated in consolidation.

Effective February 1, 2009, one or more subsidiaries of the Company completed the acquisition of Siloam Springs Memorial Hospital (73 licensed beds), located in Siloam Springs, Arkansas, from the City of Siloam Springs. The total consideration for this hospital consisted of approximately $0.1 million paid in cash for working capital and approximately $1.0 million of assumed liabilities. In connection with this acquisition, a subsidiary of the Company entered into a lease agreement for the existing hospital and agreed to build a replacement facility at this location, with construction required to commence by February 2011 and be completed by February 2013. As security for this obligation, a subsidiary of the Company deposited $1.6 million into an escrow account at closing and agreed to deposit an additional $1.6 million by February 1, 2010, which the Company's subsidiary deposited in January 2010. If the construction of the replacement facility is not completed within the agreed time frame, the escrow balance will be remitted to the City of Siloam Springs. If the construction of the replacement facility is completed within the agreed time frame, the escrow balance will be returned to one of these subsidiaries of the Company.

Effective November 14, 2008, one or more subsidiaries of the Company acquired from Willamette Community Health Solutions all of its noncontrolling interest in MWMC Holdings, LLC, which indirectly owns a controlling interest in and operates McKenzie-Willamette Medical Center of Springfield, Oregon. This acquisition resulted from a put right held by Willamette Community Health Solutions in connection with the 2003 transaction establishing the joint venture. The purchase price for this noncontrolling interest was $22.7 million in cash. Physicians affiliated with Oregon Healthcare Resources, Inc. continue to own a noncontrolling interest in the hospital, with the balance owned by these subsidiaries of the Company.

Effective October 1, 2008, one or more subsidiaries of the Company completed the acquisition of Deaconess Medical Center (388 licensed beds) and Valley Hospital and Medical Center (123 licensed beds) both located in Spokane, Washington, from Empire Health Services. The total consideration for these two hospitals was approximately $193.1 million, of which $158.1 million was paid in cash and approximately $35.0 million was assumed in liabilities. Based upon the Company's purchase price allocation relating to this acquisition as of September 30, 2009, no goodwill has been recorded. The acquisition transaction was accounted for using the purchase method of accounting.

Effective June 30, 2008, one or more subsidiaries of the Company acquired the remaining 35% noncontrolling interest in Affinity Health Systems, LLC, which indirectly owns and operates Trinity Medical Center (560 licensed beds) in Birmingham, Alabama, from Baptist Health Systems, Inc. of Birmingham, Alabama ("Baptist"), giving these subsidiaries 100% ownership of that facility. The purchase price for this noncontrolling interest was $51.5 million in cash and the cancellation of a promissory note issued by Baptist to Affinity Health Systems, LLC in the original principal amount of $32.8 million. Noncontrolling interests in Affinity Health Systems, LLC were subsequently sold to physicians on the hospital's medical staff.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Prior to January 1, 2009, U.S. GAAP for business combinations required certain acquisition-related costs be recognized as part of the consideration paid for a business, resulting in adjustments to the value of the acquired assets when recorded. As a result of revisions to U.S. GAAP adopted as of January 1, 2009, such acquisition-related costs must be expensed for business combinations that close subsequent to December 31, 2008. Approximately $6.7 million of acquisition costs related to prospective and completed acquisitions were expensed during the year ended December 31, 2009. The impact of this change in U.S. GAAP on the Company's consolidated results of operations or consolidated financial position in future periods will be largely dependent on the number of acquisitions pursued by the Company; however, it is not anticipated that such impact will be material.

The table below summarizes the allocations of the purchase price (including assumed liabilities) for these transactions (in thousands):

	2009	2008
Current assets	$ 83,975	$ 45,867
Property and equipment	192,668	146,021
Goodwill	12,233	—
Intangible assets	11,244	—
Other long-term assets	841	1,200
Liabilities	53,756	34,966

The operating results of the foregoing transactions have been included in the consolidated statements of income from their respective dates of acquisition, including net operating revenues of $308.1 million for the year ended December 31, 2009 from acquisitions that closed during 2009 and net operating revenues of $77.8 million for the year ended December 31, 2008 from acquisitions that closed during 2008. The following pro forma combined summary of operations of the Company gives effect to using historical information of the operations of these entities in 2009 and 2008 as if the transactions had occurred as of January 1, 2009 and 2008 (in thousands, except per share data):

	Year Ended December 31,	
	2009	2008
	(Unaudited)	
Pro forma net operating revenues	$ 12,372,299	$ 11,697,865
Pro forma net income	$ 235,910	$ 202,688
Pro forma net income per share:		
Basic	$ 2.60	$ 2.17
Diluted	$ 2.58	$ 2.15

Pro forma adjustments to net income include adjustments to depreciation and amortization expense, net of the related tax effect, based on the estimated fair value assigned to the long-lived assets acquired, and to interest expense, net of the related tax effect, assuming the increase in long-term debt used to fund the acquisitions had occurred as of January 1, 2008. These pro forma results are not necessarily indicative of the actual results of operations.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Discontinued Operations

Effective March 31, 2009, the Company, through its subsidiaries Triad-Denton Hospital LLC and Triad-Denton Hospital LP, completed the settlement of pending litigation, which resulted in the sale of its ownership interest in a partnership, which owned and operated Presbyterian Hospital of Denton (255 licensed beds) in Denton, Texas, to Texas Health Resources for $103.0 million in cash. Also as part of the settlement, these subsidiaries transferred certain hospital related assets to Texas Health Resources.

Effective March 1, 2008, one or more subsidiaries of the Company sold Woodland Medical Center (100 licensed beds) located in Cullman, Alabama; Parkway Medical Center (108 licensed beds) located in Decatur, Alabama; Hartselle Medical Center (150 licensed beds) located in Hartselle, Alabama; Jacksonville Medical Center (89 licensed beds) located in Jacksonville, Alabama; National Park Medical Center (166 licensed beds) located in Hot Springs, Arkansas; St. Mary's Regional Medical Center (170 licensed beds) located in Russellville, Arkansas; Mineral Area Regional Medical Center (135 licensed beds) located in Farmington, Missouri; Willamette Valley Medical Center (80 licensed beds) located in McMinnville, Oregon; and White County Community Hospital (60 licensed beds) located in Sparta, Tennessee, to Capella Healthcare, Inc., headquartered in Franklin, Tennessee. The proceeds from this sale were $315.0 million in cash.

Effective February 21, 2008, one or more subsidiaries of the Company sold THI Ireland Holdings Limited, a private limited company incorporated in the Republic of Ireland, which leased and managed the operations of Beacon Medical Center (122 licensed beds) located in Dublin, Ireland, to Beacon Medical Group Limited, headquartered in Dublin, Ireland. The proceeds from this sale were $1.5 million in cash.

Effective February 1, 2008, one or more subsidiaries of the Company sold Russell County Medical Center (78 licensed beds) located in Lebanon, Virginia to Mountain States Health Alliance, headquartered in Johnson City, Tennessee. The proceeds from this sale were $48.6 million in cash.

Effective November 30, 2007, the Company sold Barberton Citizens Hospital (312 licensed beds) located in Barberton, Ohio to Summa Health System of Akron, Ohio. The proceeds from this sale were $53.8 million in cash.

Effective October 31, 2007, the Company sold its 60% membership interest in Northeast Arkansas Medical Center, a 104 bed facility in Jonesboro, Arkansas to Baptist Memorial Health Care ("Baptist Memorial"), headquartered in Memphis, Tennessee, for $16.8 million. In connection with this transaction, the Company also sold real estate and other assets to a subsidiary of Baptist Memorial for $26.2 million in cash.

Effective September 1, 2007, the Company sold its partnership interest in River West L.P., which owned and operated River West Medical Center (80 licensed beds) located in Plaquemine, Louisiana, to an affiliate of Shiloh Health Services, Inc. of Lubbock, Texas. The proceeds from this sale were $0.3 million in cash.

In connection with management's decision to sell the previously mentioned facilities, the Company has classified the results of operations of the above mentioned hospitals as discontinued operations in the accompanying consolidated statements of income. As of December 31, 2009, no hospitals are held for sale.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Net operating revenues and loss reported for the hospitals in discontinued operations are as follows (in thousands):

	Year Ended December 31, 2009	2008	2007
Net operating revenues	$ 42,113	$ 237,315	$ 449,310
Income (loss) from operations of hospitals sold or held for sale before income taxes	3,024	15,956	(4,725)
(Loss) gain on sale of hospitals, net	(644)	17,687	(3,954)
Impairment of long-lived assets of hospitals held for sale	—	—	(19,044)
Income (loss) from discontinued operations, before taxes	2,380	33,643	(27,723)
Income tax expense (benefit)	808	14,636	(4,983)
Income (loss) from discontinued operations, net of tax	$ 1,572	$ 19,007	$ (22,740)

Interest expense and loss from early extinguishment of debt was allocated to discontinued operations based on estimated sales proceeds available for debt repayment and using the weighted-average borrowing rate for the year.

The assets and liabilities of the hospital held for sale as of December 31, 2008 are included in the accompanying consolidated balance sheet as follows: current assets of $25.5 million, included in other current assets; net property and equipment of $142.8 million and other long-term assets of $3.0 million, included in other assets; and current liabilities of $67.2 million, included in other accrued liabilities.

During the three months ended June 30, 2009, the Company decided to retain a hospital and related businesses previously classified as held for sale. Results of operations for all periods presented have been restated to include this retained hospital and related businesses, which were previously reported as discontinued operations. The consolidated balance sheets for each of the periods presented have been restated to present the assets and liabilities previously reported as held for sale in the applicable financial statement line items.

4. Goodwill and Other Intangible Assets

The changes in the carrying amount of goodwill are as follows (in thousands):

	Year Ended December 31, 2009	2008
Balance, beginning of year	$ 4,166,091	$ 4,247,714
Goodwill acquired as part of acquisitions during the year	25,813	49,368
Consideration adjustments and purchase price allocation adjustments for prior year's acquisitions	(144)	(119,650)
Adjustments for acquisition-related deferred taxes	(33,833)	—
Goodwill related to hospital operations segment written off as part of disposals	—	(11,161)
Goodwill related to home health agencies segment written off as part of disposals	—	(180)
Balance, end of year	$ 4,157,927	$ 4,166,091

The Company's goodwill was adjusted in 2009 for the effects of its deferred tax analysis that reduced goodwill and acquisition-related deferred taxes by $33.8 million.

Goodwill is allocated to each identified reporting unit, which is defined as an operating segment or one level below the operating segment (referred to as a component of the entity). Management has determined that the Company's operating segments meet the criteria to be classified as reporting units. At December 31, 2009, the hospital operations reporting unit, the home care agency operations reporting unit, and the hospital management services reporting unit had approximately $4.1 billion, $34.3 million and $33.3 million, respectively, of goodwill. At December 31,

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

2008, the hospital operations reporting unit, the home care agency operations reporting unit, and the hospital management services reporting unit had approximately $4.1 billion, $34.2 million, and $33.3 million, respectively, of goodwill.

Goodwill is evaluated for impairment at the same time every year and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. There is a two-step method for determining goodwill impairment. Step one is to compare the fair value of the reporting unit with the unit's carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit's goodwill with the carrying value of the reporting unit's goodwill. The Company has selected September 30th as its annual testing date. The Company performed its last annual goodwill evaluation as of September 30, 2009, which evaluation took place during the fourth quarter of 2009. No impairment was indicated by this evaluation.

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

Approximately $21.5 million of intangible assets were acquired during the year ended December 31, 2009. The gross carrying amount of the Company's other intangible assets subject to amortization was $76.2 million at December 31, 2009 and $68.6 million at December 31, 2008, and the net carrying amount was $47.0 million at December 31, 2009 and $54.1 million at December 31, 2008. The carrying amount of the Company's other intangible assets not subject to amortization was $44.4 million and $35.2 million at December 31, 2009 and 2008, respectively. Other intangible assets are included in other assets, net on the Company's consolidated balance sheets. Substantially all of the Company's intangible assets are contract-based intangible assets related to operating licenses, management contracts, or non-compete agreements entered into in connection with acquisitions.

The weighted average amortization period for the intangible assets subject to amortization is approximately nine years. There are no expected residual values related to these intangible assets. Amortization expense for these intangible assets was $13.0 million, $6.2 million and $6.1 million during the years ended December 31, 2009, 2008 and 2007, respectively. Amortization expense on intangible assets is estimated to be $12.2 million in 2010, $6.4 million in 2011, $5.6 million in 2012, $4.3 million in 2013, $2.8 million in 2014 and $15.7 million thereafter.

5. Income Taxes

The provision for income taxes for income from continuing operations consists of the following (in thousands):

	Year Ended December 31,		
	2009	2008	2007
Current:			
Federal	$ 93,496	$ 2,129	$ 26,014
State	13,561	3,515	11,411
	107,057	5,644	37,425
Deferred:			
Federal	15,667	106,664	5,203
State	18,601	12,965	(2,768)
	34,268	119,629	2,435
Total provision for income taxes for income from continuing operations	$ 141,325	$ 125,273	$ 39,860

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

The following table reconciles the differences between the statutory federal income tax rate and the effective tax rate (dollars in thousands):

	Year Ended December 31,					
	2009		2008		2007	
	Amount	%	Amount	%	Amount	%
Provision for income taxes at statutory federal rate	$ 156,146	35.0%	$ 125,650	35.0%	$ 37,552	35.0%
State income taxes, net of federal income tax benefit	9,090	2.0	10,720	2.9	5,618	5.2
Net income attributable to noncontrolling interests	(22,006)	(4.9)	(12,216)	(3.4)	(4,680)	(4.4)
Change in valuation allowance	1,113	0.3	(110)	0.0	3,825	3.6
Federal and state tax credits	(4,241)	(1.0)	(2,270)	(0.6)	(2,625)	(2.4)
Deferred tax revaluation	(2,996)	(0.7)	—	0.0	—	0.0
Other	4,219	1.0	3,499	1.0	170	0.2
Provision for income taxes and effective tax rate for income from continuing operations	$ 141,325	31.7%	$ 125,273	34.9%	$ 39,860	37.2%

Deferred income taxes are based on the estimated future tax effects of differences between the financial statement and tax bases of assets and liabilities under the provisions of the enacted tax laws. Deferred income taxes as of December 31, 2009 and 2008 consist of (in thousands):

	As of December 31, 2009		As of December 31, 2008	
	Assets	Liabilities	Assets	Liabilities
Net operating loss and credit carryforwards	$ 121,568	$ —	$ 143,873	$ —
Property and equipment	—	585,001	—	511,687
Self-insurance liabilities	109,152	—	56,447	—
Intangibles	—	171,070	—	147,669
Investments in unconsolidated affiliates	—	45,570	—	51,557
Other liabilities	—	15,395	—	7,315
Long-term debt and interest	—	21,499	—	30,256
Accounts receivable	44,691	—	23,490	—
Accrued expenses	67,092	—	27,374	—
Other comprehensive income	129,264	—	173,661	—
Stock-based compensation	23,242	—	52,889	—
Other	35,159	—	20,070	—
	530,168	838,535	497,804	748,484
Valuation allowance	(115,128)	—	(124,978)	—
Total deferred income taxes	$ 415,040	$ 838,535	$ 372,826	$ 748,484

The Company's deferred tax liabilities have been revalued and adjusted in 2009 for the effects of its deferred tax analysis, reducing acquisition-related deferred taxes by $33.8 million, goodwill by $33.8 million, other deferred tax liabilities by $3.0 million and the provision by $3.0 million. The effects of this adjustment on previously issued consolidated financial statements were not material.

The Company believes that the net deferred tax assets will ultimately be realized, except as noted below. Its conclusion is based on its estimate of future taxable income and the expected timing of temporary difference reversals. The Company has state net operating loss carry forwards of approximately $1.7 billion, which expire from 2010 to 2029. With respect to the deferred tax liability pertaining to intangibles, as included above, goodwill purchased in connection with certain of the Company's business acquisitions is amortizable for income tax reporting purposes. However, for financial reporting purposes, there is no corresponding amortization allowed with respect to such purchased goodwill.

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The valuation allowance decreased by $9.9 million during the year ended December 31, 2009 and increased $56.4 million during the year ended December 31, 2008. In addition to amounts previously discussed, the change in valuation allowance relates to a redetermination of the amount of, and realizability of, net operating losses in certain state income tax jurisdictions.

The total amount of unrecognized benefit that would impact the effective tax rate, if recognized, is approximately $9.4 million as of December 31, 2009. It is the Company's policy to recognize interest and penalties accrued related to unrecognized benefits in its consolidated statements of income as income tax expense. Adjustments for purchase business combinations generally impact goodwill and do not affect net income. During the year ended December 31, 2009, the Company decreased liabilities by approximately $0.4 million and recorded $0.6 million in interest and penalties related to prior state income tax returns through its income tax provision from continuing operations, which are included in its liability for uncertain tax positions at December 31, 2009. A total of approximately $2.0 million of interest and penalties is included in the amount of liability for uncertain tax positions at December 31, 2009. During the year ended December 31, 2009, the Company released $0.6 million for income taxes and $0.2 million for accrued interest of its liability for uncertain tax positions, as a result of the expiration of the statute of limitations pertaining to tax positions taken in prior years relative to state tax positions.

The Company believes that it is reasonably possible that approximately $6.4 million of its current unrecognized tax benefit may be recognized within the next twelve months as a result of a lapse of the statute of limitations and settlements with taxing authorities.

The following is a tabular reconciliation of the total amount of unrecognized tax benefit for the years ended December 31, 2009, 2008 and 2007 (in thousands):

	Year Ended December 31,		
	2009	2008	2007
Unrecognized Tax Benefit at beginning of year	$ 15,630	$ 14,880	$ 10,510
Gross (decreases) increases — purchase business combination	(4,173)	8,325	10,160
Gross increases — tax positions in current period	—	—	1,930
Gross increases — tax positions in prior period	—	223	1,820
Lapse of statute of limitations	(663)	(7,460)	(6,700)
Settlements	(1,560)	(338)	(2,840)
Unrecognized Tax Benefit at end of year	$ 9,234	$ 15,630	$ 14,880

The Company or one of its subsidiaries files income tax returns in the U.S. federal jurisdiction and various state jurisdictions. The Company has extended the federal statute of limitations for Triad for the tax periods ended December 31, 1999, December 31, 2000, April 30, 2001, June 30, 2001, December 31, 2001, December 31, 2002, and December 31, 2003. The Company is currently under examination by the IRS regarding the federal tax return of Triad for the tax periods ended December 31, 2004, December 31, 2005, December 31, 2006 and July 25, 2007. The Company believes the results of this examination will not be material to its consolidated results of operations or consolidated financial position. With few exceptions, the Company is no longer subject to state income tax examinations for years prior to 2006 and federal income tax examinations with respect to Community Health Systems, Inc. federal returns for years prior to 2006.

Prior to January 1, 2009, income attributable to noncontrolling interests was deducted from earnings before arriving at income from continuing operations. With the adoption of certain updates to the U.S. GAAP related to consolidations effective January 1, 2009, the income attributable to noncontrolling interests has been reclassified below net income and therefore is no longer deducted in arriving at income from continuing operations. However, the provision for income taxes does not change because those less than wholly-owned consolidated subsidiaries attribute their taxable income to their respective investors. Accordingly, the Company will not pay tax on the income attributable to the noncontrolling interests. As a result of separately reporting income that is taxed to others, the Company's effective tax rate on continuing operations before income taxes, as reported on the face of the financial statements is 31.7%, 34.9% and 37.2% for the years ended December 31, 2009, 2008 and 2007, respectively. However, the actual effective tax rate that is attributable to the Company's share of income from continuing operations before income taxes (income from continuing operations before income taxes, as presented on the face of

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the statement of income, less income from continuing operations attributable to noncontrolling interests of $62.9 million, $34.9 million and $13.4 million for the years ended December 31, 2009, 2008 and 2007, respectively) is 36.9%, 38.7% and 42.4% for the years ended December 31, 2009, 2008 and 2007, respectively.

The Company paid income taxes, net of refunds received, of $57.3 million during 2009. Cash paid for income taxes, net of refunds received, resulted in a net cash refund of $65.0 million during 2008.

6. Long-Term Debt

Long-term debt consists of the following (in thousands):

	As of December 31, 2009	As of December 31, 2008
Credit Facilities:		
Term loans	$ 6,043,847	$ 5,965,866
Tax-exempt bonds	8,000	8,000
Senior notes	2,784,331	2,910,831
Capital lease obligations (see Note 9)	36,915	41,086
Other	38,015	46,306
Total debt	8,911,108	8,972,089
Less current maturities	(66,470)	(33,904)
Total long-term debt	$ 8,844,638	$ 8,938,185

Terminated Credit Facility and Notes

On August 19, 2004, CHS entered into an approximately $1.6 billion senior secured credit facility with a consortium of lenders which was subsequently amended on December 16, 2004, July 8, 2005 and December 13, 2006 (the "Terminated Credit Facility"). The purpose of the Terminated Credit Facility was to refinance and replace the Company's previous credit agreement, repay specified other indebtedness, and fund general corporate purposes, including amending the credit facility to permit declaration and payment of cash dividends, to repurchase shares or make other distributions, subject to certain restrictions. The Terminated Credit Facility consisted of an approximately $1.2 billion term loan that was due to mature in 2011 and a $425 million revolving credit facility that was due to mature in 2009. The First Incremental Facility Amendment, dated as of December 13, 2006, increased the Company's term loans by $400 million (the "Incremental Term Loan Facility") and also gave the Company the ability to add up to $400 million of additional term loans. The full amount of the Incremental Term Loan Facility was funded on December 13, 2006, and the proceeds were used to repay the full outstanding amount (approximately $326 million) of the revolving credit facility under the Terminated Credit Agreement and the balance was available to be used for general corporate purposes. The Company was able to elect from time to time an interest rate per annum for the borrowings under the term loan, including the incremental term loan, and revolving credit facility equal to (a) an alternate base rate, which would have been equal to the greatest of (i) the Prime Rate (as defined) in effect and (ii) the Federal Funds Effective Rate (as defined), plus 50 basis points, plus (1) 75 basis points for the term loan and (2) the Applicable Margin (as defined) for revolving credit loans or (b) the Eurodollar Rate (as defined) plus (1) 175 basis points for the term loan and (2) the Applicable Margin for Eurodollar revolving credit loans. The Company also paid a commitment fee for the daily average unused commitments under the revolving credit facility. The commitment fee was based on a pricing grid depending on the Applicable Margin for Eurodollar revolving credit loans and ranged from 0.250% to 0.500%. The commitment fee was payable quarterly in arrears and on the revolving credit termination date with respect to the available revolving credit commitments. In addition, the Company paid fees for each letter of credit issued under the credit facility.

On December 16, 2004, the Company issued $300 million 6.50% senior subordinated notes due 2012. On April 8, 2005, the Company exchanged these notes for notes having substantially the same terms as the outstanding notes, except the exchanged notes were registered under the Securities Act of 1933, as amended (the "1933 Act"). These exchanged notes were repaid in 2007.

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Credit Facility and Notes

On July 25, 2007, the Company entered into the Credit Facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The Credit Facility consists of an approximately $6.1 billion funded term loan facility with a maturity of seven years, a $400 million delayed draw term loan facility with a maturity of seven years and a $750 million revolving credit facility with a maturity of six years. As of December 31, 2007, the $400 million delayed draw term loan facility had been reduced to $300 million at the request of CHS. During the fourth quarter of 2008, $100 million of the delayed draw term loan was drawn by CHS, reducing the delayed draw term loan availability to $200 million at December 31, 2008. In January 2009, CHS drew down the remaining $200 million of the delayed draw term loan. The revolving credit facility also includes a subfacility for letters of credit and a swingline subfacility. In connection with the consummation of the acquisition of Triad, CHS used a portion of the net proceeds from its Credit Facility and the Notes offering to repay its outstanding debt under the previously outstanding credit facility, the 6.50% senior subordinated notes due 2012 and certain of Triad's existing indebtedness. During the third quarter of 2007, the Company recorded a pre-tax write-off of approximately $13.9 million in deferred loan costs relative to the early extinguishment of the debt under the previously outstanding credit facility and incurred tender and solicitation fees of approximately $13.4 million on the early repayment of the Company's $300 million aggregate principal amount of 6.50% senior subordinated notes due 2012 through a cash tender offer and consent solicitation.

The Credit Facility requires quarterly amortization payments of each term loan facility equal to 0.25% of the outstanding amount of the term loans, if any, with the outstanding principal balance payable on July 25, 2014.

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

The obligor under the Credit Facility is CHS. All of the obligations under the Credit Facility are unconditionally guaranteed by the Company and certain existing and subsequently acquired or organized domestic subsidiaries. All obligations under the Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of the Company, CHS and each subsidiary guarantor, including equity interests held by the Company, CHS or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries.

The loans under the Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at CHS's option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus one-half of 1.0%, or (b) a reserve adjusted London interbank offered rate for dollars (Eurodollar Rate) (as defined). The applicable percentage for term loans is 1.25% for Alternate Base Rate loans and 2.25% for Eurodollar rate loans. The applicable percentage for revolving loans is 1.25% for Alternate Base Rate revolving loans and 2.25% for Eurodollar revolving loans, in each case subject to reduction based on the Company's leverage ratio. Loans under the swingline subfacility bear interest at the rate applicable to Alternate Base Rate loans under the revolving credit facility.

CHS has agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to Eurodollar rate loans under the revolving credit facility times the maximum aggregate amount available to be drawn under all letters of credit outstanding under the subfacility for letters of credit. The issuer of any letter of credit issued under the subfacility for letters of credit will also receive a customary fronting fee and other customary processing charges. CHS was initially obligated to pay commitment fees of 0.50% per annum (subject to reduction based upon the Company's leverage ratio) on the unused portion of the revolving credit facility. For purposes of this

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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calculation, swingline loans are not treated as usage of the revolving credit facility. With respect to the delayed draw term loan facility, CHS was also obligated to pay commitment fees of 0.50% per annum for the first nine months after the closing of the Credit Facility, 0.75% per annum for the next three months after such nine-month period and thereafter, 1.0% per annum. In each case, the commitment fee was paid on the unused amount of the delayed draw term loan facility. After the draw down of the remaining $200 million of the delayed draw term loan in January 2009, CHS no longer pays any commitment fees for the delayed draw term loan facility. CHS paid arrangement fees on the closing of the Credit Facility and pays an annual administrative agent fee.

The Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting the Company's and its subsidiaries' ability to, among other things and subject to certain exceptions, (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of the Company's businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change the Company's fiscal year. The Company is also required to comply with specified financial covenants (consisting of a leverage ratio and an interest coverage ratio) and various affirmative covenants.

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

The Notes were issued by CHS in connection with the Triad acquisition in the principal amount of approximately $3.0 billion. The Notes will mature on July 15, 2015. The Notes bear interest at the rate of 8.875% per annum, payable semiannually in arrears on January 15 and July 15, commencing January 15, 2008. Interest on the Notes accrues from the date of original issuance. Interest is calculated on the basis of 360-day year comprised of twelve 30-day months.

Except as set forth below, CHS is not entitled to redeem the Notes prior to July 15, 2011.

On and after July 15, 2011, CHS is entitled, at its option, to redeem all or a portion of the Notes upon not less than 30 nor more than 60 days notice, at the redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the 12-month period commencing on July 15 of the years set forth below:

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

In addition, any time prior to July 15, 2010, CHS is entitled, at its option, on one or more occasions to redeem the Notes (which include additional Notes (the "Additional Notes"), if any, which may be issued from time to time under the indenture under which the Notes were issued) in an aggregate principal amount not to exceed 35% of the aggregate principal amount of the Notes (which includes Additional Notes, if any) originally issued at a redemption price (expressed as a percentage of principal amount) of 108.875%, plus accrued and unpaid interest to the redemption date, with the Net Cash Proceeds (as defined) from one or more Public Equity Offerings (as defined) (provided that if the Public Equity Offering is an offering by the Company, a portion of the Net Cash Proceeds thereof equal to the amount required to redeem any such Notes is contributed to the equity capital of CHS); provided, however, that:

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1) at least 65% of such aggregate principal amount of Notes originally issued remains outstanding immediately after the occurrence of each such redemption (other than the Notes held, directly or indirectly, by the Company or its subsidiaries); and

2) each such redemption occurs within 90 days after the date of the related Public Equity Offering.

CHS is entitled, at its option, to redeem the Notes, in whole or in part, at any time prior to July 15, 2011, upon not less than 30 or more than 60 days notice, at a redemption price equal to 100% of the principal amount of Notes redeemed plus the Applicable Premium (as defined), and accrued and unpaid interest, if any, as of the applicable redemption date.

Pursuant to a registration rights agreement entered into at the time of the issuance of the Notes, as a result of an exchange offer made by CHS, substantially all of the Notes issued in July 2007 were exchanged in November 2007 for new notes (the "Exchange Notes") having terms substantially identical in all material respects to the Notes (except that the Exchange Notes were issued under a registration statement pursuant to the 1933 Act). References to the Notes shall also be deemed to include the Exchange Notes unless the context provides otherwise.

During the year ended December 31, 2008, the Company repurchased on the open market and cancelled $110.5 million of principal amount of the Notes. This resulted in a net gain from early extinguishment of debt of $2.5 million with an after-tax impact of $1.6 million.

During the year ended December 31, 2009, the Company repurchased on the open market and cancelled $126.5 million of principal amount of the Notes. This resulted in a net gain from early extinguishment of debt of $2.7 million with an after-tax impact of $1.7 million.

On April 2, 2009, the Company paid down $110.4 million of its term loans under the Credit Facility. Of this amount, $85.0 million was paid down as required under the terms of the Credit Facility with the net proceeds received from the sale of the ownership interest in the partnership that owned and operated Presbyterian Hospital of Denton. This resulted in a loss from early extinguishment of debt of $1.1 million with an after-tax impact of $0.7 million recorded in discontinued operations for the year ended December 31, 2009. The remaining $25.4 million was paid on the term loans as required under the terms of the Credit Facility with the net proceeds received from the sale of various other assets. This resulted in a loss from early extinguishment of debt of $0.3 million with an after-tax impact of $0.2 million recorded in continuing operations for the year ended December 31, 2009.

As of December 31, 2009, the availability for additional borrowings under the Credit Facility was $750 million pursuant to the revolving credit facility, of which $90.0 million was set aside for outstanding letters of credit. CHS also has the ability to add up to $300 million of borrowing capacity from receivable transactions (including securitizations) under the Credit Facility, which has not yet been accessed. CHS also has the ability to amend the Credit Facility to provide for one or more tranches of term loans in an aggregate principal amount of $600 million, which CHS has not yet accessed. As of December 31, 2009, the weighted-average interest rate under the Credit Facility, excluding swaps, was 2.85%.

The Term Loans are scheduled to be paid with principal payments for future years as follows (in thousands):

Year		Term Loans
2010	$	43,471
2011		46,254
2012		46,471
2013		46,471
2014		5,861,180
Thereafter		—
Total	$	6,043,847

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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As of December 31, 2009 and 2008, the Company had letters of credit issued, primarily in support of potential insurance related claims and certain bonds, of approximately $90.0 million and $93.6 million, respectively.

Tax-Exempt Bonds. Tax-Exempt Bonds bore interest at floating rates, which averaged 0.95% and 2.37% during 2009 and 2008, respectively.

As previously described, in connection with the Triad acquisition, the Company issued approximately $3.0 billion principal amount of Notes. These Notes bear interest at 8.875% interest and mature on July 15, 2015.

Other Debt. As of December 31, 2009, other debt consisted primarily of an industrial revenue bond, the mortgage obligation on the Company's corporate headquarters and other obligations maturing in various installments through 2019.

To limit the effect of changes in interest rates on a portion of the Company's long-term borrowings, the Company is a party to 38 separate interest swap agreements in effect at December 31, 2009, with an aggregate notional amount of approximately $5.4 billion, and to three forward-starting interest swap agreements with an aggregate notional amount of $400 million that will become effective upon the termination of three current agreements. On each of these swaps, the Company receives a variable rate of interest based on the three-month London Inter-Bank Offer Rate ("LIBOR") in exchange for the payment of a fixed rate of interest. The Company currently pays, on a quarterly basis, a margin above LIBOR of 225 basis points for revolver loans and term loans under the Credit Facility. See Note 7 for additional information regarding these swaps.

As of December 31, 2009, the scheduled maturities of long-term debt outstanding, including capital leases for each of the next five years and thereafter are as follows (in thousands):

Year	Amount
2010	$ 66,470
2011	53,960
2012	49,705
2013	49,913
2014	5,863,700
Thereafter	2,827,360
Total	$ 8,911,108

The Company paid interest of $657 million, $654 million and $218 million on borrowings during the years ended December 31, 2009, 2008 and 2007, respectively.

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7. Fair Values of Financial Instruments

The fair value of financial instruments has been estimated by the Company using available market information as of December 31, 2009 and 2008, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Company could realize in a current market exchange (in thousands):

	As of December 31,			
	2009		2008	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Assets:				
Cash and cash equivalents	$ 344,541	$ 344,541	$ 220,655	$ 220,655
Available-for-sale securities	28,025	28,025	6,325	6,325
Trading securities	22,777	22,777	24,325	24,325
Liabilities:				
Credit facilities	6,043,847	5,681,216	5,965,866	4,653,375
Tax-exempt bonds	8,000	8,000	8,000	8,000
Senior notes	2,784,331	2,881,783	2,910,831	2,677,965
Other debt	38,015	38,015	46,306	46,306

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

Available-for-sale securities. Estimated fair value is based on closing price as quoted in public markets.

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

Credit facilities. Estimated fair value is based on information from the Company's bankers regarding relevant pricing for trading activity among the Company's lending institutions.

Tax-exempt bonds. The carrying amount approximates fair value as a result of the weekly interest rate reset feature of these publicly-traded instruments.

Senior notes. Estimated fair value is based on the average bid and ask price as quoted by the bank who served as underwriters in the sale of these notes.

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

Interest Rate Swaps. The fair value of interest rate swap agreements is the amount at which they could be settled, based on estimates calculated by the Company using a discounted cash flow analysis based on observable market inputs and validated by comparison to estimates obtained from the counterparty.

The Company assesses the effectiveness of its hedge instruments on a quarterly basis. For the years ended December 31, 2009 and 2008, the Company completed an assessment of the cash flow hedge instruments and determined the hedges to be highly effective. The Company has also determined that the ineffective portion of the hedges do not have a material effect on the Company's consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements exposes the Company to credit risk in the event of non-performance. However, at December 31, 2009, since the majority of the swap agreements entered into by the Company were in net liability position so that the Company would be required to make the net settlement payments to the counterparties, the Company does not anticipate non-performance by those counterparties. The Company does not hold or issue derivative financial instruments for trading purposes.

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Interest rate swaps consisted of the following at December 31, 2009:

Swap #	Notional Amount (in 000's)	Fixed Interest Rate	Termination Date	Fair Value (in 000's)
1	$ 200,000	2.8800%	September 17, 2010	$ (3,655)
2	100,000	4.9360%	October 4, 2010	(3,630)
3	100,000	4.7090%	January 24, 2011	(4,343)
4	300,000	5.1140%	August 8, 2011	(19,843)
5	100,000	4.7185%	August 19, 2011	(6,033)
6	100,000	4.7040%	August 19, 2011	(6,009)
7	100,000	4.6250%	August 19, 2011	(5,874)
8	200,000	4.9300%	August 30, 2011	(12,961)
9	200,000	3.0920%	September 18, 2011	(6,709)
10	100,000	3.0230%	October 23, 2011	(3,323)
11	200,000	4.4815%	October 26, 2011	(12,151)
12	200,000	4.0840%	December 3, 2011	(11,135)
13	100,000	3.8470%	January 4, 2012	(5,193)
14	100,000	3.8510%	January 4, 2012	(5,201)
15	100,000	3.8560%	January 4, 2012	(5,211)
16	200,000	3.7260%	January 8, 2012	(9,914)
17	200,000	3.5065%	January 16, 2012	(9,034)
18	250,000	5.0185%	May 30, 2012	(20,877)
19	150,000	5.0250%	May 30, 2012	(12,638)
20	200,000	4.6845%	September 11, 2012	(15,831)
21	100,000	3.3520%	October 23, 2012	(4,299)
22	125,000	4.3745%	November 23, 2012	(8,981)
23	75,000	4.3800%	November 23, 2012	(5,439)
24	150,000	5.0200%	November 30, 2012	(13,694)
25	200,000	2.2420%	February 28, 2013	1,219(1)
26	100,000	5.0230%	May 30, 2013	(9,575)
27	300,000	5.2420%	August 6, 2013	(31,724)
28	100,000	5.0380%	August 30, 2013	(9,887)
29	50,000	3.5860%	October 23, 2013	(2,282)
30	50,000	3.5240%	October 23, 2013	(2,165)
31	100,000	5.0500%	November 30, 2013	(10,077)
32	200,000	2.0700%	December 19, 2013	3,000
33	100,000	5.2310%	July 25, 2014	(11,157)
34	100,000	5.2310%	July 25, 2014	(11,157)
35	200,000	5.1600%	July 25, 2014	(21,694)
36	75,000	5.0405%	July 25, 2014	(7,744)
37	125,000	5.0215%	July 25, 2014	(12,803)
38	100,000	2.6210%	July 25, 2014	259
39	100,000	3.1100%	July 25, 2014	89(2)
40	100,000	3.2580%	July 25, 2014	153(3)
41	100,000	3.0050%	November 30, 2016	2,458

(1) This interest rate swap becomes effective September 17, 2010, concurrent with the termination of swap #1.

(2) This interest rate swap becomes effective October 4, 2010, concurrent with the termination of swap #2.

(3) This interest rate swap becomes effective January 24, 2011, concurrent with the termination of swap #3.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The Company is exposed to certain risks relating to its ongoing business operations. The primary risk managed by using derivative instruments is interest rate risk. Interest rate swaps are entered into to manage interest rate risk associated with the term loans in the Credit Facility. Companies are required to recognize all derivative instruments as either assets or liabilities at fair value in the consolidated statement of financial position. The Company designates interest rate swaps as cash flow hedges. For derivative instruments that are designated and qualify as cash flow hedges, the effective portion of the gain or loss on the derivative is reported as a component of other comprehensive income and reclassified into earnings in the same period or periods during which the hedged transactions affects earnings. Gains and losses on the derivative representing either hedge ineffectiveness or hedge components excluded from the assessment of effectiveness are recognized in current earnings.

Assuming no change in December 31, 2009 interest rates, approximately $216.7 million of interest expense resulting from the spread between the fixed and floating rates defined in each interest rate swap agreement will be recognized during the next twelve months. If interest rate swaps do not remain highly effective as a cash flow hedge, the derivatives' gains or losses resulting from the change in fair value reported through other comprehensive income will be reclassified into earnings.

The following tabular disclosure provides the location of pre-tax loss recognized in the consolidated balance sheet through other comprehensive income and reclassified into interest expense on the consolidated statement of income during the year ended December 31, 2009 (in thousands):

Derivatives in Cash Flow Hedging Relationships	Amount of Pre-Tax Loss Recognized in OCI on Derivative (Effective Portion) For the year ended December 31, 2009	Location of Loss Reclassified from Accumulated OCI into Income (Effective Portion)	Amount of Pre-Tax Loss Reclassified from Accumulated OCI into Income (Effective Portion) For the year ended December 31, 2009
Interest rate swaps	($57,576)	Interest expense, net	($176,677)

The fair values of derivative instruments in the consolidated balance sheets as of December 31, 2009 and 2008 were as follows (in thousands):

	Asset Derivatives				Liability Derivatives			
	As of December 31, 2009		As of December 31, 2008		As of December 31, 2009		As of December 31, 2008	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives designated as hedging instruments	Other assets, net	$ —	Other assets net,	$ —	Other long-term liabilities	$316,033	Other long-term liabilities	$435,134

8. Fair Value

Fair Value Hierarchy

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

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

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

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

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

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The following table sets forth, by level within the fair value hierarchy, the financial assets and liabilities recorded at fair value on a recurring basis as of December 31, 2009 and 2008 (in thousands):

	As of December 31, 2009	Level 1	Level 2	Level 3
Available-for-sale securities	$ 28,025	$ 28,025	—	—
Trading securities	22,777	22,777	—	—
Total assets	$ 50,802	$ 50,802	$ —	$ —
Fair value of interest rate swap agreements	$ 316,033	$ —	$ 316,033	$ —
Total liabilities	$ 316,033	$ —	$ 316,033	$ —

	As of December 31, 2008	Level 1	Level 2	Level 3
Available-for-sale securities	$ 6,325	$ 6,325	$ —	$ —
Trading securities	24,325	24,325	—	—
Total assets	$ 30,650	$ 30,650	$ —	$ —
Fair value of interest rate swap agreements	$ 435,134	$ —	$ 435,134	$ —
Contractual obligation	48,985	—	—	48,985
Total liabilities	$ 484,119	$ —	$ 435,134	$ 48,985

Available-for-sale securities and trading securities classified as Level 1 are measured using quoted market prices. The valuation of the Company's interest rate swap agreements is determined using market valuation techniques, including discounted cash flow analysis on the expected cash flows of each agreement. This analysis reflects the contractual terms of the agreement, including the period to maturity, and uses observable market-based inputs, including forward interest rate curves. The fair values of interest rate swap agreements are determined by netting the discounted future fixed cash payments (or receipts) and the discounted expected variable cash receipts (or payments). The variable cash receipts (or payments) are based on the expectation of future interest rates based on observable market forward interest rate curves and the notional amount being hedged.

The Company incorporates credit valuation adjustments ("CVAs") to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. In adjusting the fair value of its interest rate swap agreements for the effect of nonperformance risk, the Company has considered the impact of any netting features included in the agreements. The CVA on the Company's interest rate swap agreements at December 31, 2009 resulted in a decrease in the fair value of the related liability of $5.9 million and an after-tax adjustment of $3.8 million to other comprehensive income.

The majority of the inputs used to value its interest rate swap agreements, including the forward interest rate curves and market perceptions of the Company's credit risk used in the CVAs, are observable inputs available to a market participant. As a result, the Company has determined that the interest rate swap valuations are classified in Level 2 of the fair value hierarchy.

The contractual obligation liability recorded during the year ended December 31, 2008, represented the fair value of a put option assumed in connection with a business combination using unobservable inputs and assumptions available to the Company. The contractual obligation represented by this liability was settled during the three months ended March 31, 2009, as a result of the sale of ownership interest in the partnership that owned Presbyterian Hospital of Denton. The following table presents a rollforward of the contractual obligation liability (in thousands):

	Contractual Obligation
Balance at January 1, 2008	$ —
Initial recognition of obligation	61,000
Unrealized gain, included in discontinued operations	(12,015)
Balance at December 31, 2008	48,985
Settlement of contractual obligation liabililty	(48,985)
Balance at December 31, 2009	$ —

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

9. Leases

The Company leases hospitals, medical office buildings, and certain equipment under capital and operating lease agreements. During 2009, the Company entered into $3.3 million of capital lease obligations. All lease agreements generally require the Company to pay maintenance, repairs, property taxes and insurance costs. Commitments relating to noncancellable operating and capital leases for each of the next five years and thereafter are as follows (in thousands):

Year ended December 31,	Operating (1)	Capital
2010	$ 176,755	$ 8,399
2011	150,328	5,415
2012	123,842	3,717
2013	100,965	3,304
2014	83,656	2,976
Thereafter	291,560	25,966
Total minimum future payments	$ 927,106	$ 49,777
Less imputed interest		(12,862)
		36,915
Less current portion		(6,476)
Long-term capital lease obligations		$ 30,439

(1) Minimum lease payments have not been reduced by minimum sublease rentals due in the future of $36.0 million.

Assets capitalized under capital leases as reflected in the accompanying consolidated balance sheets were $23.6 million of land and improvements, $149.3 million of buildings and improvements, and $65.7 million of equipment and fixtures as of December 31, 2009 and $23.6 million of land and improvements, $141.5 million of buildings and improvements, and $72.9 million of equipment and fixtures as of December 31, 2008. The accumulated depreciation related to assets under capital leases was $96.1 million and $86.5 million as of December 31, 2009 and 2008, respectively. Depreciation of assets under capital leases is included in depreciation and amortization expense and amortization of debt discounts on capital lease obligations is included in interest expense in the consolidated statements of income.

10. Employee Benefit Plans

The Company maintains various benefit plans, including defined contribution plans, defined benefit plans and deferred compensation plans, for which the Company's subsidiary, CHS/Community Health Systems, Inc. is the plan sponsor. On January 1, 2009, the sponsor merged the Triad Hospitals, Inc. Retirement Savings Plan, the Abilene Physicians Group 401(k) Plan and Trust and the Regional Employee Assistance Program 401(k) Plan with and into the Community Health Systems, Inc. 401(k) Plan. Contemporaneously, the sponsor also established the CHS Retirement Savings Plan, and the accounts of substantially all participants in the Community Health Systems, Inc. 401(k) Plan were transferred subsequently to the CHS Retirement Savings Plan. Employees of certain subsidiaries whose employment is covered by collective bargaining agreements have remained participants in the Community Health Systems, Inc. 401(k) Plan. The sponsor also established the CHS Spokane 401(k) Plan on January 1, 2009 for the exclusive benefit of certain employees of the Deaconess Medical Center and Valley Hospital and Medical Center and their beneficiaries. Total expense to the Company under the 401(k) plans was $69.5 million, $72.3 million and $39.8 million for the years ended December 31, 2009, 2008 and 2007, respectively.

The Company maintains unfunded deferred compensation plans that allow participants to defer receipt of a portion of their compensation. The liability under the deferred compensation plans was $57.6 million as of December 31, 2009 and $44.7 million as of December 31, 2008. The Company had assets of $57.5 million and $44.6 million as of December 31, 2009 and 2008, respectively, in a non-qualified plan trust generally designated to pay benefits of the deferred compensation plans, consisting of trading securities of $22.8 million and $24.3 million as of December 31, 2009 and 2008, respectively, and company-owned life insurance contracts of $34.7 million and $20.3 million as of December 31, 2009 and 2008, respectively.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The Company maintains the Community Health Systems Retirement Income Plan, which is a defined benefit, non-contributory pension plan that covers certain employees at three of its hospitals ("Pension Plan"). The Pension Plan provides benefits to covered individuals satisfying certain age and service requirements. Employer contributions to the Pension Plan are in accordance with the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as amended. The Company expects to contribute $3.1 million to the Pension Plan in 2010. The Company also provides an unfunded Supplemental Executive Retirement Plan ("SERP") for certain members of its executive management. The Company uses a December 31 measurement date for the benefit obligations and a January 1 measurement date for its net periodic costs for both the Pension Plan and SERP. Variances from actuarially assumed rates will result in increases or decreases in benefit obligations, net periodic cost and funding requirements in future periods. The Company had available-for-sale securities in a rabbi trust generally designated to pay benefits of the SERP in the amounts of $28.0 million and $6.3 million as of December 31, 2009 and 2008, respectively. These amounts are included in other assets, net on the consolidated balance sheets.

A summary of the benefit obligations and funded status for the Company's pension and SERP plans follows (in thousands):

	Pension Plan		SERP	
	2009	2008	2009	2008
Change in benefit obligation:				
Benefit obligation, beginning of year	$ 37,625	$ 28,655	$ 41,145	$ 28,598
Service cost	3,886	3,457	4,437	3,232
Interest cost	2,200	1,834	2,469	1,716
Plan amendment	—	—	—	7,387
Actuarial (gain)/loss	(1,232)	3,808	13,028	212
Benefits paid	(234)	(129)	—	—
Benefit obligation, end of year	42,245	37,625	61,079	41,145
Change in plan assets:				
Fair value of assets, beginning of year	13,826	15,479	—	—
Actual return on plan assets	5,046	(5,615)	—	—
Employer contributions	9,945	4,091	—	—
Benefits paid	(234)	(129)	—	—
Fair value of assets, end of year	28,583	13,826	—	—
Unfunded status	$ (13,662)	$ (23,799)	$ (61,079)	$ (41,145)

A summary of the amounts recognized in the accompanying consolidated balance sheets follows (in thousands):

	Pension Plan		SERP	
	2009	2008	2009	2008
Noncurrent asset	$ —	$ —	$ —	$ —
Current liability	—	—	—	—
Noncurrent liability	(13,662)	(23,799)	(61,079)	(41,145)
Net amount recognized in the consolidated balance sheets	$ (13,662)	$ (23,799)	$ (61,079)	$ (41,145)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

A summary of the amounts recognized in Accumulated Other Comprehensive Income ("AOCI") (in thousands):

	Pension Plan 2009	Pension Plan 2008	SERP 2009	SERP 2008
Prior service cost	$ 1,515	$ 2,204	$ 10,501	$ 12,206
Net actuarial (gain) loss	3,518	8,538	17,150	4,123
Total amount recognized in AOCI	$ 5,033	$ 10,742	$ 27,651	$ 16,329

A summary of the plans' benefit obligation in excess of the fair value of plan assets as of the end of the year follows (in thousands):

	Pension Plan 2009	Pension Plan 2008	SERP 2009	SERP 2008
Projected benefit obligation	$ 42,245	$ 37,625	$ 61,079	$ 41,145
Accumulated benefit obligation	33,485	28,301	39,334	28,261
Fair value of plan assets	28,583	13,826	—	—

A summary of the weighted-average assumptions used by the Company to determine benefit obligations as of December 31 follows:

	Pension Plan 2009	Pension Plan 2008	SERP 2009	SERP 2008
Discount rate	6.02%	5.96%	6.00%	6.00%
Annual salary increases	4.00%	4.00%	5.00%	5.00%

A summary of net periodic cost and other amounts recognized in Other Comprehensive Income follows (in thousands):

	Pension Plan 2009	Pension Plan 2008	Pension Plan 2007	SERP 2009	SERP 2008	SERP 2007
Service cost	$ 3,886	$ 3,457	$ 3,772	$ 4,437	$ 3,232	$ 2,810
Interest cost	2,200	1,834	1,586	2,469	1,716	1,339
Expected return on plan assets	(1,683)	(1,426)	(1,179)	—	—	—
Amortization of unrecognized prior service cost	689	689	689	1,704	884	884
Amortization of net (gain)/loss	426	—	(13)	1	122	60
Net periodic cost	5,518	4,554	4,855	8,611	5,954	5,093
Prior service cost arising during period	—	—	—	—	7,387	—
Net loss (gain) arising during period	(4,595)	10,849	(2,466)	13,028	212	1,155
Amortization of:						
Prior service cost (credit)	(689)	(689)	(689)	(1,704)	(884)	(883)
Net actuarial (gain) loss	(426)	—	13	(1)	(122)	(60)
Total amount recognized in OCI	(5,710)	10,160	(3,142)	11,323	6,593	212
Total recognized in Net periodic cost and OCI	$ (192)	$ 14,714	$ 1,713	$ 19,934	$ 12,547	$ 5,305

A summary of the expected amortization amounts to be included in net periodic cost for 2010 are as follows (in thousands):

	Pension Plan	SERP
Prior service cost	$ 689	$ 1,704
Actuarial (gain)/loss	—	1,340

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

A summary of the weighted-average assumptions used by the Company to determine net periodic cost follows:

	Pension Plan			SERP		
	2009	2008	2007	2009	2008	2007
Discount rate	5.96%	6.55%	5.94%	6.00%	6.00%	5.75%
Rate of compensation increase	4.00%	4.00%	4.00%	5.00%	5.00%	5.00%
Expected long term rate of return on assets	8.50%	8.50%	8.50%	N/A	N/A	N/A

The Company's weighted-average asset allocations by asset category for its pension plans as of the end of the year follows:

	Pension Plan		SERP	
	2009	2008	2009	2008
Equity securities	100%	100%	N/A	N/A
Debt securities	0%	0%	N/A	N/A
Total	100%	100%	N/A	N/A

The Pension Plan assets are invested in mutual funds with an underlying investment allocation of 60% equity securities and 40% debt securities. All assets are measured at fair value using quoted prices in active markets and therefore are classified as Level 1 measurements in the fair value hierarchy. The expected long-term rate of return for the Pension Plan assets is based on current expected long-term inflation and historical rates of return on equities and fixed income securities, taking into account the investment policy under the plan. The expected long-term rate of return is weighted based on the target allocation for each asset category. Equity securities are expected to return between 7% and 11% and debt securities are expected to return between 4% and 7%. The Company expects the Pension Plan asset managers will provide a premium of approximately 0% to 1.5% per annum to the respective market benchmark indices.

The Company's investment policy related to the Pension Plan is to provide for growth of capital with a moderate level of volatility by investing in accordance with the target asset allocations stated above. The Company reviews its investment policy, including its target asset allocations, on a semi-annual basis to determine whether any changes in market conditions or amendments to its pension plans requires a revision to its investment policy.

The estimated future benefit payments reflecting future service as of the end of 2009 for the Pension Plan and SERP plan follows (in thousands):

Year ending	Pension Plan	SERP
2010	$ 739	$ —
2011	874	31,220
2012	1,206	904
2013	1,507	—
2014	1,824	29,040
2015-2019	14,857	24,026

11. Stockholders' Equity

Authorized capital shares of the Company include 400,000,000 shares of capital stock consisting of 300,000,000 shares of common stock and 100,000,000 shares of preferred stock. Each of the aforementioned classes of capital stock has a par value of $.01 per share. Shares of preferred stock, none of which are outstanding as of December 31, 2009, may be issued in one or more series having such rights, preferences and other provisions as determined by the Board of Directors without approval by the holders of common stock.

On December 13, 2006, the Company commenced an open market repurchase program for up to 5,000,000 shares of the Company's common stock, not to exceed $200 million in repurchases. This program had an expiration date of the earlier of three years or when the maximum number of shares has been repurchased. This repurchase program expired on December 13, 2009. During the year ended December 31, 2008, the Company repurchased 4,786,609 shares, which is the cumulative number of shares that have been repurchased under this program, at a weighted-average price of $18.80 per share. During the year ended December 31, 2009, the Company did not repurchase any shares under this program.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

On December 9, 2009, the Company commenced a new open market repurchase program for up to 3,000,000 shares of the Company's common stock, not to exceed $100 million in repurchases. This program will conclude at the earlier of three years or when the maximum number of shares has been repurchased. During the year ended December 31, 2009, the Company did not repurchase any shares under this program.

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

	Year Ended December 31,		
	2009	2008	2007
Net income attributable to Community Health Systems, Inc.	$ 243,150	$ 218,304	$ 30,289
Transfers from the noncontrolling interests:			
Net increase in Community Health Systems, Inc. paid-in capital for purchase of subsidiary partnership interests	3,106	—	—
Net transfers from the noncontrolling interests	3,106	—	—
Change from net income attributable to Community Health Systems, Inc. and transfers from noncontrolling interests	$ 246,256	$ 218,304	$ 30,289

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

12. Earnings Per Share

The following table sets forth the components of the numerator and denominator for the computation of basic and diluted income from continuing operations per share (in thousands, except share data):

	Year Ended December 31, 2009	2008	2007
Numerator:			
Income from continuing operations, net of tax	$ 304,805	$ 233,727	$ 67,431
Less: Income from continuing operations attributable to noncontrolling interests, net of taxes	62,872	34,902	13,371
Income from continuing operations attributable to Community Health Systems, Inc. common stockholders — basic and diluted	$ 241,933	$ 198,825	$ 54,060
Income (loss) from discontinued operations, net of tax	$ 1,572	$ 19,007	$ (22,740)
Less: Income (loss) from discontinued operations attributable to noncontrolling interests, net of taxes	355	(472)	1,031
Income (loss) from discontinued operations attributable to Community Health Systems, Inc. common stockholders — basic and diluted	$ 1,217	$ 19,479	$ (23,771)
Denominator:			
Weighted-average number of shares outstanding —basic	90,614,886	93,371,782	93,517,337
Effect of dilutive securities:			
Non-employee director options	—	—	2,957
Restricted Stock awards	469,134	269,165	227,200
Employee options	422,637	647,882	894,800
Other equity based awards	10,617	—	—
Weighted-average number of shares outstanding — diluted	91,517,274	94,288,829	94,642,294
Dilutive securities outstanding not included in the computation of earning per share because their effect is antidilutive:			
Employee options	6,820,393	5,001,223	4,398,307

13. Equity Investments

As of December 31, 2009, the Company owned equity interests of 27.5% in four hospitals in Las Vegas, Nevada, and 26.1% in one hospital in Las Vegas, Nevada, in which Universal Health Systems, Inc. owns the majority interest, and an equity interest of 38.0% in three hospitals in Macon, Georgia, in which HCA Inc. ("HCA"), owns the majority interest. Effective April 1, 2009, one or more subsidiaries of the Company acquired from Share Foundation the remaining 50% equity interest in MCSA L.L.C., an entity in which one or more subsidiaries of the Company previously had a 50% unconsolidated noncontrolling interest. One or more subsidiaries of the Company provided MCSA L.L.C. certain management services. This acquisition resulted in these subsidiaries of the Company owning 100% equity interest in that entity. MCSA L.L.C. owns and operates Medical Center of South Arkansas in El Dorado, Arkansas. The results of operations for MCSA L.L.C. were included in the consolidated financial statements effective April 1, 2009.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Summarized combined financial information for the unconsolidated entities in which the Company owned an equity interest is as follows (in thousands):

	As of December 31,	
	2009	2008
Current assets	$ 207,005	$ 222,802
Noncurrent assets	744,360	774,320
	$ 951,365	$ 997,122
Current liabilities	$ 83,484	$ 100,443
Noncurrent liabilities	2,899	9,808
Members' equity	864,982	886,871
	$ 951,365	$ 997,122

	For the year ended December 31,		
	2009	2008	2007
Revenues	$ 1,398,784	$ 1,426,463	$ 1,276,555
Operating costs and expenses	$ 1,253,533	$ 1,284,645	$ 1,125,477
Income from continuing operations before taxes	$ 145,211	$ 148,012	$ 153,435

The summarized financial information as of and for the year ended December 31, 2009 was derived from the unaudited financial information provided to the Company by those unconsolidated entities. The summarized financial information as of and for the year ended December 31, 2008 has been revised from the prior year disclosure to reflect the final audited financial information of the equity investee for that period.

The Company's investment in all of its unconsolidated affiliates was $399.4 million and $421.6 million at December 31, 2009 and 2008, respectively, and is included in other assets, net in the accompanying consolidated balance sheets. Included in the Company's results of operations is the Company's equity in pre-tax earnings from all of its investments in unconsolidated affiliates, which was $36.5 million, $42.1 million and $25.1 million for the years ended December 31, 2009, 2008 and 2007, respectively.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

14. Segment Information

The Company operates in three distinct operating segments, represented by hospital operations (which includes its general acute care hospitals and related healthcare entities that provide inpatient and outpatient healthcare services), home care agency operations (which provides in-home outpatient care), and hospital management services (which provides executive management and consulting services to non-affiliated acute care hospitals). Only the hospital operations segment meets the criteria as a separate reportable segment. The financial information for the home care agencies and management services segments do not meet the quantitative thresholds for a separate identifiable reportable segment and are combined into the corporate and all other reportable segment.

The accounting policies of the segments are the same as those described in the summary of significant accounting policies in Note 1. Expenditures for segment assets are reported on an accrual basis, which includes amounts that are reflected in accounts payable. Substantially all depreciation and amortization as reflected in the consolidated statements of income relates to the hospital operations segment.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The distribution between reportable segments of the Company's revenues, income from continuing operations before income taxes, expenditures for segment assets and total assets is summarized in the following tables (in thousands):

	For the Year Ended December 31, 2009	2008	2007
Revenues:			
Hospital operations	$ 11,839,515	$ 10,680,497	$ 6,917,521
Corporate and all other	268,098	238,598	178,340
	$ 12,107,613	$ 10,919,095	$ 7,095,861
Income from continuing operations before income taxes:			
Hospital operations	$ 588,857	$ 494,922	$ 265,410
Corporate and all other	(142,727)	(135,922)	(158,119)
	$ 446,130	$ 359,000	$ 107,291
Expenditures for segment assets:			
Hospital operations	$ 543,969	$ 643,180	$ 499,044
Corporate and all other	15,105	41,443	35,091
	$ 559,074	$ 684,623	$ 534,135

	As of December 31, 2009	2008
Total assets:		
Hospital operations	$ 12,715,228	$ 12,646,590
Corporate and all other	1,306,244	1,171,664
	$ 14,021,472	$ 13,818,254

15. Commitments and Contingencies

Construction and Other Capital Commitments. Pursuant to hospital purchase agreements in effect as of December 31, 2009, and where required certificate of need approval has been obtained, the Company is required to build replacement facilities. As required by an amendment to a lease agreement entered into in 2005, the Company agreed to build a replacement facility at its Barstow, California location. Construction costs for this replacement facility are estimated to be approximately $65.0 million. Of this amount, approximately $8.0 million has been expended through December 31, 2009. The Company expects to spend approximately $3.0 million in replacement hospital construction and equipment costs related to this project in 2010. This project is required to be completed in 2012. The Company has agreed, as part of an acquisition in 2007, to build a replacement hospital in Valparaiso, Indiana with an aggregate estimated construction cost, including equipment costs, of approximately $210.0 million. Of this amount, approximately $4.6 million has been expended through December 31, 2009. The Company expects to spend approximately $50.0 million in replacement hospital construction and equipment costs related to this project in 2010. This project is required to be completed in 2011. The Company has agreed, as part of an acquisition in 2009, to build a replacement hospital in Siloam Springs, Arkansas with an aggregate estimated construction cost, including equipment costs, of approximately $35.0 million. Of this amount, approximately $0.1 million has been expended through December 31, 2009. The Company expects to spend approximately $2.0 million in replacement hospital construction and equipment costs related to this project in 2010. This project is required to be completed in 2013. In addition, in October 2008, after the purchase of the noncontrolling owner's interest in the Company's Birmingham, Alabama facility, the Company initiated the purchase of a site for a potential replacement to its existing Birmingham facility. The new site includes a partially constructed hospital structure. This project is subject to the approval of a certificate of need expected to be granted by mid to late 2010. Upon receiving the certificate of need, and after resolution of any legal issues, the Company will complete its assessment of the costs to complete construction of the unfinished facility and relocate the existing Birmingham facility to the new site. In addition, under other purchase agreements, the Company had committed to spend approximately $468.5 million for costs such as capital improvements, equipment, selected leases and physician recruiting. These commitments are required to be fulfilled generally over a five to seven year period after acquisition. Through December 31, 2009, the Company has spent approximately $171.4 million related to these commitments. The Company expects to spend approximately $72.9 million related to these commitments in 2010.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Physician Recruiting Commitments. As part of its physician recruitment strategy, the Company provides income guarantee agreements to certain physicians who agree to relocate to its communities and commit to remain in practice there. Under such agreements, the Company is required to make payments to the physicians in excess of the amounts they earned in their practice up to the amount of the income guarantee. These income guarantee periods are typically for 12 months. Such payments are recoverable by the Company from physicians who do not fulfill their commitment period, which is typically three years, to the respective community. At December 31, 2009, the maximum potential amount of future payments under these guarantees in excess of the liability recorded is $37.9 million.

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

The net present value of the projected payments was discounted using a weighted-average risk-free rate of 1.3%, 2.6% and 4.1% in 2009, 2008 and 2007, respectively. This liability is adjusted for new claims information in the period such information becomes known. The Company's estimated liability for the self-insured portion of professional and general liability claims was $431.2 million and $350.6 million as of December 31, 2009 and 2008, respectively. The estimated undiscounted claims liability was $452.7 million and $383.5 million as of December 31, 2009 and 2008, respectively. The current portion of the liability for the self-insured portion of professional and general liability claims was $77.1 million and $64.0 million as of December 31, 2009 and 2008, respectively, and is included in other accrued liabilities in the accompanying consolidated balance sheets. Professional malpractice expense includes the losses resulting from professional liability claims and loss adjustment expense, as well as paid excess insurance premiums, and is presented within other operating expenses in the accompanying consolidated statements of income.

The Company's processes for obtaining and analyzing claims and incident data are standardized across all of its hospitals and have been consistent for many years. The Company monitors the outcomes of the medical care services that it provides and for each reported claim, the Company obtains various information concerning the facts and circumstances related to that claim. In addition, the Company routinely monitors current key statistics and volume indicators in its assessment of utilizing historical trends. The average lag period between claim occurrence and payment of a final settlement is between 4 and 5 years, although the facts and circumstances of individual claims could result in the timing of such payments being different from this average. Since claims are paid promptly after settlement with the claimant is reached, settled claims represent less than 1.0% of the total liability at the end of any period.

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

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Based on these analyses the Company determines its estimate of the professional liability claims. The determination of management's estimate, including the preparation of the reserve analysis that supports such estimate, involves subjective judgment of the management. Changes in reserving data or the trends and factors that influence reserving data may signal fundamental shifts in the Company's future claim development patterns or may simply reflect single-period anomalies. Even if a change reflects a fundamental shift, the full extent of the change may not become evident until years later. Moreover, since the Company's methods and models use different types of data and the Company selects its liability from the results of all of these methods, it typically cannot quantify the precise impact of such factors on its estimates of the liability. Due to the Company's standardized and consistent processes for handling claims and the long history and depth of company-specific data, the Company's methodologies have produced reliably determinable estimates of ultimate paid losses.

The Company is primarily self-insured for these claims; however, the Company obtains excess insurance that transfers the risk of loss to a third-party insurer for claims in excess of self-insured retentions. The Company's excess insurance is underwritten on a claims-made basis. For claims reported prior to June 1, 2002, substantially all of the Company's professional and general liability risks were subject to a $0.5 million per occurrence self-insured retention and for claims reported from June 1, 2002 through June 1, 2003, these self-insured retentions were $2.0 million per occurrence. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 are self-insured up to $5 million per claim. Management on occasion has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals has been purchased through commercial insurance companies and generally covers the Company for liabilities in excess of the self-insured retentions. The excess coverage consists of multiple layers of insurance, the sum of which totals up to $95 million per occurrence and in the aggregate for claims reported on or after June 1, 2003 and up to $145 million per occurrence and in the aggregate for claims incurred and reported after January 1, 2008. For certain policy years, if the first aggregate layer of excess coverage becomes fully utilized, then the Company's self-insured retention could increase to $10 million per claim for any subsequent claims in that policy year until the Company's total aggregate coverage is met.

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

Legal Matters. The Company is a party to other legal proceedings incidental to its business. In the opinion of management, any ultimate liability with respect to these actions will not have a material adverse effect on the Company's consolidated financial position, cash flows or results of operations.

In a letter dated October 4, 2007, the Civil Division of the Department of Justice notified the Company that, as a result of an investigation into the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients, it believes the Company and three of its New Mexico hospitals have caused the State of New Mexico to submit improper claims for federal funds in violation of the Federal False Claims Act. In a letter dated January 22, 2008, the Civil Division notified the Company that based on its investigation, it has calculated that these three hospitals received ineligible federal participation payments from August 2000 to June 2006 of approximately $27.5 million. The Civil Division also advised the Company that were it to proceed to trial, it would seek treble damages plus an appropriate penalty for each of the violations of the False Claims Act. This investigation has culminated in the federal government's intervention in a qui tam lawsuit styled U.S. ex rel. Baker vs. Community Health Systems, Inc. The federal government filed its complaint in intervention on June 30, 2009. The relator filed a second amended complaint on July 1, 2009. Both of these complaints expand the time period during which alleged improper payments were made. The Company filed motions to dismiss all of the federal government's and the relator's claims on August 28, 2009. The federal government and the relator responded on October 16, 2009. The Company has filed a reply to each response and is waiting on the court's rulings. The Company is vigorously defending this action.

16. Subsequent Events

The Company adopted certain updates to U.S. GAAP related to subsequent events in the second quarter of 2009. These updates to U.S. GAAP establish general standards of accounting for and disclosure of events that occur after the balance sheet date but before financial statements are issued or are available to be issued. In particular, these updates to U.S. GAAP set forth: (1) the period after the balance sheet date during which management of a reporting entity should evaluate events or transactions that may occur for potential recognition or disclosure in the financial statements, (2) the circumstances under which an entity should recognize events or transactions occurring after the balance sheet date in its financial statements and (3) the disclosures that an entity should make about events or transactions that occurred after the balance sheet date. The Company evaluated all material events occurring subsequent to the balance sheet date for events requiring disclosure or recognition in the consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

17. Quarterly Financial Data (Unaudited)

	Quarter 1st	2nd	3rd	4th	Total
	(in thousands, except share and per share data)				
Year ended December 31, 2009:					
Net operating revenues	2,912,749	3,016,961	3,086,757	3,091,146	12,107,613
Income from continuing operations before taxes	106,454	111,707	112,425	115,544	446,130
Income from continuing operations	70,820	74,498	75,361	84,126	304,805
Income (loss) from discontinued operations	2,080	(508)	—	—	1,572
Net income attributable to Community Health Systems, Inc.	58,915	59,435	59,712	65,088	243,150
Income from continuing operations attributable to Community Health Systems, Inc per share (1):					
Basic	0.63	0.66	0.66	0.71	2.67
Diluted	0.63	0.66	0.65	0.70	2.64
Net income attributable to Community Health Systems, Inc per share (1):					
Basic	0.65	0.66	0.66	0.71	2.68
Diluted	0.65	0.65	0.65	0.70	2.66
Weighted-average number of shares:					
Basic	90,604,767	90,358,583	90,923,052	91,178,060	90,614,886
Diluted	90,885,140	91,071,147	92,010,742	92,698,828	91,517,274
Year ended December 31, 2008:					
Net operating revenues	2,710,355	2,673,153	2,754,509	2,781,078	10,919,095
Income from continuing operations before taxes	88,119	85,583	90,315	94,983	359,000
Income from continuing operations	57,256	55,393	59,105	61,973	233,727
Income (loss) from discontinued operations	11,481	(249)	(608)	8,383	19,007
Net income attributable to Community Health Systems, Inc.	60,127	47,893	50,384	59,900	218,304
Income from continuing operations attributable to Community Health Systems, Inc per share (1):					
Basic	0.52	0.51	0.53	0.57	2.13
Diluted	0.52	0.50	0.52	0.57	2.11
Net income attributable to Community Health Systems, Inc per share (1):					
Basic	0.64	0.51	0.54	0.65	2.34
Diluted	0.63	0.50	0.53	0.65	2.32
Weighted-average number of shares:					
Basic	94,107,532	94,192,295	94,044,564	91,514,652	93,371,782
Diluted	95,006,721	95,513,127	95,159,619	91,833,485	94,288,829

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

During the three months ended June 30, 2009, the Company decided to retain a hospital and related businesses previously classified as held for sale. The quarterly financial data has been restated to include this retained hospital and related businesses, which were previously reported as discontinued operations, for the previously reported first quarter during the year ended December 31, 2009 and the previously reported quarters during the year ended December 31, 2008.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

18. Supplemental Condensed Consolidating Financial Information

In connection with the consummation of the Triad acquisition, CHS obtained approximately $7.2 billion of senior secured financing under the Credit Facility and issued the Notes in the aggregate principal amount of approximately $3.0 billion. The Notes are senior unsecured obligations of CHS and are guaranteed on a senior basis by the Company and by certain of its existing and subsequently acquired or organized 100% owned domestic subsidiaries.

The Notes are fully and unconditionally guaranteed on a joint and several basis. The following condensed consolidating financial statements present Community Health Systems, Inc. (as parent guarantor), CHS (as the issuer), the subsidiary guarantors, the subsidiary non-guarantors and eliminations. These condensed consolidating financial statements have been prepared and presented in accordance with SEC Regulation S-X Rule 3-10 "Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered".

The accounting policies used in the preparation of this financial information are consistent with those elsewhere in the consolidated financial statements of the Company, except as noted below:

- Intercompany receivables and payables are presented gross in the supplemental consolidating balance sheets.
- Cash flows from intercompany transactions are presented in cash flows from financing activities, as changes in intercompany balances with affiliates, net.
- Income tax expense is allocated from the parent guarantor to the income producing operations (other guarantors and non-guarantors) and the issuer through stockholders' equity. As this approach represents an allocation, the income tax expense allocation is considered non-cash for statement of cash flow purposes.
- Interest expense, net has been presented to reflect net interest expense and interest income from outstanding long-term debt and intercompany balances.

The Company's intercompany activity consists primarily of daily cash transfers for purposes of cash management, the allocation of certain expenses and expenditures paid for by the parent on behalf of its subsidiaries, and the push down of investment in its subsidiaries. The Company's subsidiaries generally do not purchase services from one another and therefore the intercompany transactions do not represent revenue generating transactions. All intercompany transactions eliminate in consolidation.

From time to time, the Company sells and/or repurchases noncontrolling interests in consolidated subsidiaries, which changes subsidiaries from guarantors to non-guarantors. Amounts for prior periods are restated to reflect the status of guarantors or non-guarantors as of December 31, 2009.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2009
Statements of Income

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net operating revenues	$ —	$ —	$ 7,075,378	$ 5,032,235	$ —	$ 12,107,613
Operating costs and expenses:						
Salaries and benefits	—	—	2,739,112	2,103,218	—	4,842,330
Provision for bad debts	—	—	908,702	551,605	—	1,460,307
Supplies	—	—	969,337	716,156	—	1,685,493
Other operating expenses	—	—	1,242,809	994,666	—	2,237,475
Rent	—	—	125,486	121,646	—	247,132
Depreciation and amortization	—	—	338,314	227,897	—	566,211
Total operating costs and expenses	—	—	6,323,760	4,715,188	—	11,038,948
Income from operations	—	—	751,618	317,047	—	1,068,665
Interest expense, net	—	(110,507)	720,532	38,939	—	648,964
(Gain) loss from early extinguishment of debt	—	(2,385)	—	—	—	(2,385)
Equity in earnings of unconsolidated affiliates	(243,150)	(118,324)	(165,623)	—	490,576	(36,521)
Impairment of long-lived and other assets	—	—	12,477	—	—	12,477
Income from continuing operations before income taxes	243,150	231,216	184,232	278,108	(490,576)	446,130
Provision for (benefit from) income taxes	—	(11,934)	72,131	81,128	—	141,325
Income from continuing operations	243,150	243,150	112,101	196,980	(490,576)	304,805
Discontinued operations, net of taxes:						
Income (loss) from operations of hospitals sold and hospitals held for sale	—	—	(169)	2,146	—	1,977
(Loss) gain on sale of hospitals, net	—	—	—	(405)	—	(405)
Impairment of long-lived assets of hospitals held for sale	—	—	—	—	—	—
Income (loss) from discontinued operations	—	—	(169)	1,741	—	1,572
Net income	243,150	243,150	111,932	198,721	(490,576)	306,377
Less: Net income attributable to	—	—	(3,611)	66,838	—	63,227

noncontrolling interests						
Net income attributable to Community Health Systems, Inc.	$ 243,150	$ 243,150	$ 115,543	$ 131,883	$ (490,576)	$ 243,150

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2008
Statements of Income

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net operating revenues	$ —	$ —	$ 6,285,338	$ 4,633,757	$ —	$ 10,919,095
Operating costs and expenses:						
Salaries and benefits	—	—	2,389,448	1,978,216	—	4,367,664
Provision for bad debts	—	—	751,887	466,725	—	1,218,612
Supplies	—	—	845,781	685,595	—	1,531,376
Other operating expenses	—	—	1,121,174	977,836	—	2,099,010
Rent	—	—	119,621	111,546	—	231,167
Depreciation and amortization	—	—	295,268	204,118	—	499,386
Total operating costs and expenses	—	—	5,523,179	4,424,036	—	9,947,215
Income from operations	—	—	762,159	209,721	—	971,880
Interest expense, net	—	65,135	539,696	47,637	—	652,468
(Gain) loss from early extinguishment of debt	—	(2,525)	—	—	—	(2,525)
Equity in earnings of unconsolidated affiliates	(218,304)	(218,498)	(132,835)	—	527,574	(42,063)
Impairment of long-lived and other assets	—	—	—	5,000	—	5,000
Income from continuing operations before income taxes	218,304	155,888	355,298	157,084	(527,574)	359,000
Provision for (benefit from) income taxes	—	(62,416)	139,265	48,424	—	125,273
Income from continuing operations	218,304	218,304	216,033	108,660	(527,574)	233,727
Discontinued operations, net of taxes:						
Income (loss) from operations of hospitals sold and hospitals held for sale	—	—	1,105	8,322	—	9,427
(Loss) gain on sale of hospitals, net	—	—	—	9,580	—	9,580
Impairment of long-lived assets of hospitals held for sale	—	—	—	—	—	—
Income (loss) from discontinued operations	—	—	1,105	17,902	—	19,007
Net income	218,304	218,304	217,138	126,562	(527,574)	252,734
Less: Net income attributable to	—	—	(6,429)	40,859	—	34,430

noncontrolling interests						
Net income attributable to Community Health Systems, Inc.	$ 218,304	$ 218,304	$ 223,567	$ 85,703	$ (527,574)	$ 218,304

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2007
Statements of Income

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
Net operating revenues	$ —	$ —	$ 4,567,186	$ 2,528,675	$ —	$ 7,095,861
Operating costs and expenses:						
Salaries and benefits	—	—	1,763,700	1,131,405	—	2,895,105
Provision for bad debts	—	—	635,393	251,592	—	886,985
Supplies	—	—	576,658	363,867	—	940,525
Other operating expenses	—	—	942,488	492,129	—	1,434,617
Rent	—	—	93,442	60,253	—	153,695
Depreciation and amortization	—	—	212,997	100,325	—	313,322
Total operating costs and expenses	—	—	4,224,678	2,399,571	—	6,624,249
Income from operations	—	—	342,508	129,104	—	471,612
Interest expense, net	—	67,495	211,388	83,182	—	362,065
(Gain) loss from early extinguishment of debt	—	27,388	—	—	—	27,388
Equity in earnings of unconsolidated affiliates	(30,289)	(88,501)	(20,450)	—	114,108	(25,132)
Impairment of long-lived and other assets	—	—	—	—	—	—
Income from continuing operations before income taxes	30,289	(6,382)	151,570	45,922	(114,108)	107,291
Provision for (benefit from) income taxes	—	(36,671)	63,837	12,694	—	39,860
Income from continuing operations	30,289	30,289	87,733	33,228	(114,108)	67,431
Discontinued operations, net of taxes:						
Income (loss) from operations of hospitals sold and hospitals held for sale	—	—	(2,706)	(1,493)	—	(4,199)
(Loss) gain on sale of hospitals, net	—	—	—	(2,594)	—	(2,594)
Impairment of long-lived assets of hospitals held for sale	—	—	—	(15,947)	—	(15,947)
Income (loss) from discontinued operations	—	—	(2,706)	(20,034)	—	(22,740)
Net income	30,289	30,289	85,027	13,194	(114,108)	44,691
Less: Net income attributable to noncontrolling interests	—	—	(1,151)	15,553	—	14,402

Net income attributable to Community Health Systems, Inc.	$ 30,289	$ 30,289	$ 86,178	$ (2,359)	$ (114,108)	$ 30,289

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

December 31, 2009
Balance Sheets

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
ASSETS						
Current assets:						
Cash and cash equivalents	$ —	$ —	$ 238,194	$ 106,347	$ —	$ 344,541
Patient accounts receivable, net of allowance for doubtful accounts	—	—	898,734	719,169	—	1,617,903
Supplies	—	—	182,972	119,637	—	302,609
Deferred income taxes	80,714	—	—	—	—	80,714
Prepaid expenses and taxes	45,414	114	74,140	15,221	—	134,889
Other current assets	—	26	120,403	73,910	—	194,339
Total current assets	126,128	140	1,514,443	1,034,284	—	2,674,995
Intercompany receivable	1,119,696	9,222,998	1,718,144	2,340,088	(14,400,926)	—
Property and equipment, net	—	—	3,700,703	2,431,543	—	6,132,246
Goodwill	—	—	2,373,326	1,784,601	—	4,157,927
Other assets, net of accumulated amortization	—	143,292	386,952	526,060	—	1,056,304
Net investment in subsidiaries	1,239,622	5,536,128	3,321,274	—	(10,097,024)	—
Total assets	$ 2,485,446	$ 14,902,558	$ 13,014,842	$ 8,116,576	$ (24,497,950)	$ 14,021,472
LIABILITIES AND EQUITY						
Current liabilities:						
Current maturities of long-term debt	$ —	$ 43,471	$ 17,681	$ 5,318	$ —	$ 66,470
Accounts payable	—	—	229,506	199,059	—	428,565
Deferred income taxes	28,397	—	—	—	—	28,397
Interest payable (receivable)	—	145,033	168	—	—	145,201
Accrued liabilities	8,283	567	514,168	266,145	—	789,163
Total current liabilities	36,680	189,071	761,523	470,522	—	1,457,796
Long-term debt	—	8,785,466	39,882	19,290	—	8,844,638
Intercompany payable	10,000	4,372,369	10,481,885	6,834,264	(21,698,518)	—
Deferred income taxes	475,812	—	—	—	—	475,812
Other long-term liabilities	12,319	316,033	337,350	193,250	—	858,952
Total liabilities	534,811	13,662,939	11,620,640	7,517,326	(21,698,518)	11,637,198
Redeemable noncontrolling interests in equity of consolidated subsidiaries	—	—	278	368,579	—	368,857
Equity:						
Community Health Systems, Inc. stockholders' equity:						

Preferred stock	—	—	—	—	—	—
Common stock	940	—	1	2	(3)	940
Additional paid-in capital	1,158,359	562,557	539,484	71,662	(1,173,703)	1,158,359
Treasury stock, at cost	(6,678)	—	—	—	—	(6,678)
Accumulated other comprehensive income (loss)	(221,385)	(221,385)	(19,124)	—	240,509	(221,385)
Retained earnings	1,019,399	898,447	873,820	93,968	(1,866,235)	1,019,399
Total Community Health Systems, Inc. stockholders' equity	1,950,635	1,239,619	1,394,181	165,632	(2,799,432)	1,950,635
Noncontrolling interests in equity of consolidated subsidiaries	—	—	(257)	65,039	—	64,782
Total equity	1,950,635	1,239,619	1,393,924	230,671	(2,799,432)	2,015,417
Total liabilities and equity	$ 2,485,446	$ 14,902,558	$ 13,014,842	$ 8,116,576	$ (24,497,950)	$ 14,021,472

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

December 31, 2008
Balance Sheets

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In thousands)			
ASSETS						
Current assets:						
Cash and cash equivalents	$ —	$ —	$ 156,621	$ 64,034	$ —	$ 220,655
Patient accounts receivable, net of allowance for doubtful accounts	—	—	967,515	657,955	—	1,625,470
Supplies	—	—	163,892	111,804	—	275,696
Deferred income taxes	91,875	—	—	—	—	91,875
Prepaid expenses and taxes	92,710	111	65,811	7,870	—	166,502
Other current assets	—	85	128,864	95,903	—	224,852
Total current assets	184,585	196	1,482,703	937,566	—	2,605,050
Intercompany receivable	1,011,894	9,036,169	2,425,410	3,382,780	(15,856,253)	—
Property and equipment, net	—	—	3,462,671	2,431,734	—	5,894,405
Goodwill	—	—	2,404,082	1,762,009	—	4,166,091
Other assets, net of accumulated amortization	—	171,396	301,589	679,723	—	1,152,708
Net investment in subsidiaries	1,109,833	4,632,848	2,727,035	—	(8,469,716)	—
Total assets	$ 2,306,312	$ 13,840,609	$ 12,803,490	$ 9,193,812	$ (24,325,969)	$ 13,818,254
LIABILITIES AND EQUITY						
Current liabilities:						
Current maturities of long-term debt	$ —	$ 12,066	$ 7,209	$ 14,629	$ —	$ 33,904
Accounts payable	70	—	368,565	163,960	—	532,595
Deferred income taxes	6,740	—	—	—	—	6,740
Interest payable (receivable)	—	152,070	1,153	11	—	153,234
Accrued liabilities	8,869	567	458,510	314,998	—	782,944
Total current liabilities	15,679	164,703	835,437	493,598	—	1,509,417
Long-term debt	—	8,865,390	29,331	43,464	—	8,938,185
Intercompany payable	200,600	3,453,103	10,419,619	8,015,946	(22,089,268)	—
Deferred income taxes	460,793	—	—	—	—	460,793
Other long-term liabilities	18,211	435,134	218,002	217,210	—	888,557
Total liabilities	695,283	12,918,330	11,502,389	8,770,218	(22,089,268)	11,796,952
Redeemable noncontrolling interests in equity of consolidated	—	—	17,956	330,860	—	348,816

subsidiaries						
Equity:						
Community Health Systems, Inc. stockholders' equity:						
Preferred stock	—	—	—	—	—	—
Common stock	925	—	1	2	(3)	925
Additional paid-in capital	1,136,108	468,874	499,638	12,993	(981,505)	1,136,108
Treasury stock, at cost	(6,678)	—	—	—	—	(6,678)
Accumulated other comprehensive income (loss)	(295,575)	(295,575)	(17,090)	—	312,665	(295,575)
Retained earnings	776,249	748,980	798,123	20,755	(1,567,858)	776,249
Total Community Health Systems, Inc. stockholders' equity	1,611,029	922,279	1,280,672	33,750	(2,236,701)	1,611,029
Noncontrolling interests in equity of consolidated subsidiaries	—	—	2,473	58,984	—	61,457
Total equity	1,611,029	922,279	1,283,145	92,734	(2,236,701)	1,672,486
Total liabilities and equity	$ 2,306,312	$ 13,840,609	$ 12,803,490	$ 9,193,812	$ (24,325,969)	$ 13,818,254

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Year Ended December 31, 2009
Statements of Cash Flows

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
Net cash provided by (used in) operating activities	$ (62,357)	$ 132,528	$ 511,539	$ 494,719	$ —	$ 1,076,429
Cash flows from investing activities:						
Acquisitions of facilities and other related equipment	—	—	(198,825)	(64,948)	—	(263,773)
Purchases of property and equipment	—	—	(375,722)	(201,166)	—	(576,888)
Proceeds from disposition of hospitals and other ancillary operations	—	—	—	89,514	—	89,514
Proceeds from sale of property and equipment	—	—	826	3,193	—	4,019
Increase in other non-operating assets	—	—	(116,929)	(3,125)	—	(120,054)
Net cash (used in) provided by investing activities	—	—	(690,650)	(176,532)	—	(867,182)
Cash flows from financing activities:						
Proceeds from exercise of stock options	12,759	—	—	—	—	12,759
Stock buy-back	—	—	—	—	—	—
Deferred financing costs	—	(82)	—	—	—	(82)
Income tax payable increase relating to stock-based compensation	(3,472)	—	—	—	—	(3,472)
Proceeds from noncontrolling investors in joint ventures	—	—	—	29,838	—	29,838
Redemption of noncontrolling investments in joint ventures	—	—	—	(7,268)	—	(7,268)
Distributions to noncontrolling investors in joint ventures	—	—	—	(58,963)	—	(58,963)
Changes in intercompany balances with affiliates, net	53,070	(85,496)	270,190	(237,764)	—	—
Borrowings under credit agreement	—	200,000	4,045	2,570	(6,615)	200,000
Repayments of long-term indebtedness	—	(246,950)	(13,551)	(4,287)	6,615	(258,173)

Net cash (used in) provided by financing activities	62,357	(132,528)	260,684	(275,874)	—	(85,361)
Net change in cash and cash equivalents	—	—	81,573	42,313	—	123,886
Cash and cash equivalents at beginning of period	—	—	156,621	64,034	—	220,655
Cash and cash equivalents at end of period	$ —	$ —	$ 238,194	$ 106,347	$ —	$ 344,541

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Year Ended December 31, 2008
Statements of Cash Flows

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
Net cash provided by (used in) operating activities	$ (36,792)	$ 67,594	$ 789,652	$ 236,127	$ —	$ 1,056,581
Cash flows from investing activities:						
Acquisitions of facilities and other related equipment	—	—	(156,555)	(5,352)	—	(161,907)
Purchases of property and equipment	—	—	(424,674)	(267,559)	—	(692,233)
Proceeds from disposition of hospitals and other ancillary operations	—	—	—	365,636	—	365,636
Proceeds from sale of property and equipment	—	—	11,971	1,512	—	13,483
Increase in other non-operating assets	—	(15,700)	(115,682)	(59,068)	—	(190,450)
Net cash (used in) provided by investing activities	—	(15,700)	(684,940)	35,169	—	(665,471)
Cash flows from financing activities:						
Proceeds from exercise of stock options	1,806	—	—	—	—	1,806
Stock buy-back	(90,188)	—	—	—	—	(90,188)
Deferred financing costs	—	(3,136)	—	—	—	(3,136)
Excess tax benefits relating to stock-based compensation	1,278	—	—	—	—	1,278
Proceeds from noncontrolling investors in joint ventures	—	—	1,020	13,309	—	14,329
Redemption of noncontrolling investments in joint ventures	—	—	—	(77,587)	—	(77,587)
Distributions to noncontrolling investors in joint ventures	—	—	—	(46,890)	—	(46,890)
Changes in intercompany balances with affiliates, net	123,900	55,247	(61,513)	(117,634)	—	—
Borrowings under credit agreement	—	125,000	—	32,468	(26,191)	131,277
Repayments of long-term indebtedness	(4)	(229,005)	(5,313)	(26,787)	26,191	(234,918)

Net cash (used in) provided by financing activities	36,792	(51,894)	(65,806)	(223,121)	—	(304,029)
Net change in cash and cash equivalents	—	—	38,906	48,175	—	87,081
Cash and cash equivalents at beginning of period	—	—	117,715	15,859	—	133,574
Cash and cash equivalents at end of period	$ —	$ —	$ 156,621	$ 64,034	$ —	$ 220,655

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Year Ended December 31, 2007
Statements of Cash Flows

	Parent Guarantor	Issuer	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
Net cash provided by (used in) operating activities	$ (85,881)	$ 141,137	$ 412,433	$ 220,749	$ —	$ 688,438
Cash flows from investing activities:						
Acquisitions of facilities and other related equipment	—	(6,864,035)	(59,203)	(94,810)	—	(7,018,048)
Purchases of property and equipment	—	—	(423,193)	(99,592)	—	(522,785)
Proceeds from disposition of hospitals and other ancillary operations	—	—	—	109,996	—	109,996
Proceeds from sale of property and equipment	—	—	591	4,059	—	4,650
Increase in other non-operating assets	—	(5,502)	(59,772)	(7,397)	—	(72,671)
Net cash (used in) provided by investing activities	—	(6,869,537)	(541,577)	(87,744)	—	(7,498,858)
Cash flows from financing activities:						
Proceeds from exercise of stock options	8,214	—	—	—	—	8,214
Stock buy-back	—	—	—	—	—	—
Deferred financing costs	—	(182,954)	—	—	—	(182,954)
Excess tax benefits relating to stock-based compensation	1,216	—	—	—	—	1,216
Proceeds from noncontrolling investors in joint ventures	128	—	—	2,223	—	2,351
Redemption of noncontrolling investments in joint ventures	—	—	—	(1,356)	—	(1,356)
Distributions to noncontrolling investors in joint ventures	—	—	—	(6,645)	—	(6,645)
Changes in intercompany balances with affiliates, net	376,319	(468,160)	432,306	(340,465)	—	—
Borrowings under credit agreement	—	9,212,000	(66,068)	75,695	—	9,221,627
Repayments of long-term	(299,996)	(1,832,486)	(147,939)	141,396	—	(2,139,025)

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indebtedness						
Net cash (used in) provided by financing activities	85,881	6,728,400	218,299	(129,152)	—	6,903,428
Net change in cash and cash equivalents	—	—	89,155	3,853	—	93,008
Cash and cash equivalents at beginning of period	—	—	28,560	12,006	—	40,566
Cash and cash equivalents at end of period	$ —	$ —	$ 117,715	$ 15,859	$ —	$ 133,574

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosure***

None

Item 9A. ***Controls and Procedures***

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

There have been no changes in internal control over financial reporting that occurred during the period that have materially affected or are reasonably likely to materially affect our internal controls over financial reporting.

Management's report on internal control over financial reporting is included herein at page 117.

The attestation report from Deloitte & Touche LLP, our independent registered public accounting firm, on our internal control over financial reporting is included herein at page 118.

Item 9B. ***Other Information***

None

Management's Report on Internal Control over Financial Reporting

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States of America and include amounts based on management's estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the consolidated financial statements.

We are also responsible for establishing and maintaining adequate internal controls over financial reporting (as defined in Rule 13a — 15(f) under the Securities and Exchange Act of 1934, as amended). We maintain a system of internal controls that is designed to provide reasonable assurance as to the fair and reliable preparation and presentation of the consolidated financial statements, as well as to safeguard assets from unauthorized use or disposition.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Conduct. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit and Compliance Committee of the Board of Directors, which is composed solely of outside directors, meets periodically with members of management, the internal auditors and the independent registered public accounting firm to review and discuss internal control over financial reporting and accounting and financial reporting matters. The independent registered public accounting firm and internal auditors report to the Audit and Compliance Committee and accordingly have full and free access to the Audit and Compliance Committee at any time.

We conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. This evaluation included review of the documentation of controls, evaluation of the design effectiveness of controls, testing of the operating effectiveness of controls and a conclusion on this evaluation. We have concluded that our internal control over financial reporting was effective as of December 31, 2009, based on these criteria.

Deloitte & Touche LLP, an independent registered public accounting firm, has issued an attestation report on our internal control over financial reporting, which is included herein.

We do not expect that our disclosure controls and procedures or our internal controls will prevent all errors and all fraud. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact there are resource constraints and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, within the Company have been detected.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Community Health Systems, Inc.
Franklin, Tennessee

We have audited the internal control over financial reporting of Community Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 2009, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying *Management's Report on Internal Control over Financial Reporting*. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2009, based on the criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2009 of the Company and our report dated February 25, 2010 expressed an unqualified opinion and included explanatory paragraphs related to the adoption of accounting standards on those consolidated financial statements.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 25, 2010

PART III

Item 10. ***Directors and Executive Officers of the Company***

The information required by this Item is incorporated herein by reference from the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 18, 2010, under "Members of the Board of Directors," "Information About our Executive Officers," "Compliance with Exchange Act Section 16(A) Beneficial Ownership Reporting" and "Corporate Governance Principles and Board Matters."

Item 11. ***Executive Compensation***

The information required by this Item is incorporated herein by reference from the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 18, 2010 under "Executive Compensation."

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

The information required by this Item is incorporated herein by reference from the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 18, 2010 under "Security Ownership of Certain Beneficial Owners and Management."

Item 13. ***Certain Relationships and Related Transactions***

The information required by this Item is incorporated herein by reference from the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 18, 2010 under "Certain Transactions."

Item 14. ***Principal Accountant Fees and Services***

The information required by this Item is incorporated herein by reference from the Company's definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 18, 2010 under "Ratification of the Appointment of Independent Registered Public Accounting Firm."

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

Item 15(a) 1. *Financial Statements*

Reference is made to the index of financial statements and supplementary data under Item 8 in Part II.

Item 15(a) 2. *Financial Statement Schedules*

The following financial statement schedule is filed as part of this Report at page 125 hereof:

Schedule II — *Valuation and Qualifying Accounts*

All other schedules are omitted since the required information is not present or is not present in amounts sufficient to require submission of the schedule, or because the information required is included in the consolidated financial statements and notes thereto.

Item 15(a)(3) and 15(c):

The following exhibits are either filed with this Report or incorporated herein by reference.

Description

2.1 Agreement and Plan of Merger, dated as of March 19, 2007, by and among Triad Hospitals, Inc., Community Health Systems, Inc. and FWCT-1 Acquisition Corporation (incorporated by reference to Exhibit 2.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed March 19, 2007 (No. 001-15925))

3.1 Form of Restated Certificate of Incorporation of Community Health Systems, Inc. (incorporated by reference to Exhibit 3.1 to Amendment No. 2 to Community Health Systems, Inc.'s Registration Statement on Form S-1/A filed May 2, 2000 (No. 333-31790))

3.2 Amended and Restated By-Laws of Community Health Systems, Inc. (as of February 27, 2008) (incorporated by reference to Exhibit 3(ii).1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed February 29, 2008 (No. 001-15925))

4.1 Form of Common Stock Certificate (incorporated by reference to Exhibit 4.1 to Amendment No. 2 to Community Health Systems, Inc.'s Registration Statement on Form S-1/A filed May 2, 2000 (No. 333-31790))

4.2 Senior Notes Indenture, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., the Guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.3 to Community Health System Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))

4.3 Form of 8 7/8% Senior Note due 2015 (included in Exhibit 4.2)

4.4 Registration Rights Agreement, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., the Guarantors party thereto and the Initial Purchasers (incorporated by reference to Exhibit 4.1 to Community Health System Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))

4.5 Joinder to the Registration Rights Agreement dated as of July 25, 2007 (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))

4.6 First Supplemental Indenture relating to the Triad's 7% Senior Subordinated Notes due 2013, dated as of July 24, 2007, by and among Triad Hospitals Inc. and The Bank of New York Trust Company, N.A (incorporated by reference to Exhibit 4.7 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))

4.7 Second Supplemental Indenture relating to Triad's 7% Senior Notes due 2012, dated as of July 24, 2007, by and among Triad Hospitals Inc. and The Bank of New York Trust Company, N.A. (incorporated by reference to Exhibit 4.6 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))

4.8 First Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.4 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))

4.9 Second Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of December 31, 2007, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.7 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))

4.10 Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of January 30, 2008, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.8 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))

4.11 Third Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of October 10, 2008, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.9 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))

4.12 Fourth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of December 1, 2008, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.10 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))

4.13 Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of December 31, 2008, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.11 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))

	Description
4.14	Fifth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of February 5, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.12 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
4.15	Sixth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of March 30, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2009 filed April 29, 2009 (No. 001-15925))
4.16	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of March 30, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2009 filed April 29, 2009 (No. 001-15925))
4.17	Seventh Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of June 30, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
4.18	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of June 30, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
4.19	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of December 31, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association*
10.1	Credit Agreement, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the lender parties thereto and Credit Suisse, as Administrative Agent and Collateral Agent, Credit Suisse Securities (USA) LLC and Wachovia Capital Markets, LLC as Joint Bookrunner and Co-Lead Arrangers, Wachovia Bank, N.A. as Syndication Agent, JPMorgan Chase Bank and Merrill Lynch Capital Corporation as Co-Documentation Agents (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
10.2	Guarantee and Collateral Agreement, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the Subsidiaries from time to time party thereto and Credit Suisse, as Collateral Agent (incorporated by reference to Exhibit 10.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
10.3 †	Form of Indemnification Agreement between Community Health Systems, Inc. and its directors and executive officers (incorporated by reference to Exhibit 10.8 to Amendment No. 2 to Community Health Systems, Inc.'s Registration Statement on Form S-1/A filed May 2, 2000 (No. 333-31790))
10.4 †	CHS/Community Health Systems, Inc. Amended and Restated Supplemental Executive Retirement Plan (incorporated by reference to Exhibit 10.13 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.5 †	Community Health Systems Supplemental Executive Benefits (incorporated by reference to Exhibit 10.14 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.6 †	Supplemental Executive Retirement Plan Trust, dated June 1, 2005, by and between CHS/Community Health Systems, Inc., as grantor, and Wachovia Bank, N.A., as trustee (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Current Report on Form 8-K filed June 1, 2005 (No. 001-15925))
10.7 †	Community Health Systems Deferred Compensation Plan Trust, amended and restated effective February 26, 1999 (incorporated by reference to Exhibit 10.18 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2002 filed March 27, 2003 (No. 001-15925))
10.8 †	CHS/Community Health Systems, Inc. Deferred Compensation Plan, amended and restated effective January 1, 2008 (incorporated by reference to Exhibit 10.12 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year

ended December 31, 2008 filed February 27, 2009 (No. 001-15925))

10.9 CHS NQDCP, effective as of September 1, 2009 (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Registration Statement on Form S-8 filed December 11, 2009 (No. 333-163691))

10.10 CHS NQDCP Adoption Agreement, executed as of August 11, 2009 (incorporated by reference to Exhibit 4.3 to Community Health Systems, Inc.'s Registration Statement on Form S-8 filed December 11, 2009 (No. 333-163691))

	Description
10.11	Guarantee, dated December 9, 2009, made by Community Health Systems, Inc. in favor of CHS/Community Health Systems, Inc. with respect to CHS/Community Health Systems, Inc.'s payment obligations under the CHS/Community Health Systems, Inc. Deferred Compensation Plan and the NQDCP (incorporated by reference to Exhibit 4.4 to Community Health Systems, Inc.'s Registration Statement on Form S-8 filed December 11, 2009 (No. 333-163691))
10.12 †	Community Health Systems, Inc. 2004 Employee Performance Incentive Plan, as amended and restated on March 24, 2009 (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
10.13	Form of Amended and Restated Change in Control Severance Agreement (incorporated by reference to Exhibit 10.22 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.14 †	Community Health Systems, Inc. 2000 Stock Option and Award Plan, as amended and restated on March 24, 2009 (incorporated by reference to Exhibit 10.4 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
10.15 †	Form of Nonqualified Stock Option Agreement (Employee)*
10.16 †	Form of Restricted Stock Award Agreement (incorporated by reference to Exhibit 10.18 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.17 †	Form of Performance Based Restricted Stock Award Agreement (Most Highly Compensated Executive Officers) (incorporated by reference to Exhibit 10.20 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.18 †	Form of Director Phantom Stock Award Agreement (incorporated by reference to Exhibit 10.19 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.19 †	Form of Director Restricted Stock Unit Award Agreement*
10.20 †	Community Health Systems, Inc. Directors' Fees Deferral Plan, as amended and restated on December 10, 2008 (incorporated by reference to Exhibit 10.15 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.21 †	Community Health Systems, Inc. 2009 Stock Option and Award Plan, effective as of March 24, 2009 (incorporated by reference to Exhibit 10.5 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
10.22	Participation Agreement entered into as of January 1, 2005, by and between Community Health Systems Professional Services Corporation and HealthTrust Purchasing Group, L.P. (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed January 7, 2005 (No. 001-15925))
12	Computation of Ratio of Earnings to Fixed Charges*
21	List of Subsidiaries*
23.1	Consent of Deloitte & Touche LLP*
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*

* Filed herewith.

† Indicates a management contract or compensatory plan or arrangement.

SIGNATURES

Pursuant to the requirements of section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

COMMUNITY HEALTH SYSTEMS, INC.

By: /s/ Wayne T. Smith
Wayne T. Smith
Chairman of the Board, President and Chief Executive Officer

Date: February 25, 2010

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Name	Title	Date
/s/ WAYNE T. SMITH Wayne T. Smith	President and Chief Executive Officer and Director (principal executive officer)	02/25/2010
/s/ W. LARRY CASH W. Larry Cash	Executive Vice President, Chief Financial Officer and Director (principal financial officer)	02/25/2010
/s/ T. MARK BUFORD T. Mark Buford	Vice President and Chief Accounting Officer (principal accounting officer)	02/25/2010
/s/ JOHN A. CLERICO John A. Clerico	Director	02/25/2010
/s/ JAMES S. ELY III James S. Ely III	Director	02/25/2010
/s/ JOHN A. FRY John A. Fry	Director	02/25/2010
/s/ WILLIAM NORRIS JENNINGS, M.D. William Norris Jennings, M.D.	Director	02/25/2010
/s/ HARVEY KLEIN, M.D. Harvey Klein, M.D.	Director	02/25/2010
/s/ JULIA B. NORTH Julia B. North	Director	02/25/2010
/s/ H. MITCHELL WATSON, JR. H. Mitchell Watson, Jr.	Director	02/25/2010

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Community Health Systems, Inc.
Franklin, Tennessee

We have audited the consolidated financial statements of Community Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 2009 and 2008, and for each of the three years in the period ended December 31, 2009, and have issued our report thereon dated February 25, 2010 (which report expresses an unqualified opinion and includes explanatory paragraphs related to the adoption of accounting standards); such report is included elsewhere in this Annual Report on Form 10-K. Our audits also included the financial statement schedule of the Company listed in Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 25, 2010

Community Health Systems, Inc. and Subsidiaries

Schedule II — Valuation and Qualifying Accounts

Description	Balance at Beginning of Year	Acquisitions and Dispositions	Charged to Costs and Expenses	Write-offs	Balance at End of Year
			(In thousands)		
Year ended December 31, 2009 allowance for doubtful accounts	$ 1,111,131	$ —	$ 1,460,307	$ (1,154,250)	$ 1,417,188
Year ended December 31, 2008 allowance for doubtful accounts	$ 1,037,334	$ (12,352)	$ 1,218,612	$ (1,132,463)	$ 1,111,131
Year ended December 31, 2007 allowance for doubtful accounts	$ 478,565	$ 421,157	$ 886,985	$ (749,373)	$ 1,037,334

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Exhibit Index

	Description
2.1	Agreement and Plan of Merger, dated as of March 19, 2007, by and among Triad Hospitals, Inc., Community Health Systems, Inc. and FWCT-1 Acquisition Corporation (incorporated by reference to Exhibit 2.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed March 19, 2007 (No. 001-15925))
3.1	Form of Restated Certificate of Incorporation of Community Health Systems, Inc. (incorporated by reference to Exhibit 3.1 to Amendment No. 2 to Community Health Systems, Inc.'s Registration Statement on Form S-1/A filed May 2, 2000 (No. 333-31790))
3.2	Amended and Restated By-Laws of Community Health Systems, Inc. (as of February 27, 2008) (incorporated by reference to Exhibit 3(ii).1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed February 29, 2008 (No. 001-15925))
4.1	Form of Common Stock Certificate (incorporated by reference to Exhibit 4.1 to Amendment No. 2 to Community Health Systems, Inc.'s Registration Statement on Form S-1/A filed May 2, 2000 (No. 333-31790))
4.2	Senior Notes Indenture, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., the Guarantors party thereto and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 4.3 to Community Health System Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.3	Form of 8 7/8% Senior Note due 2015 (included in Exhibit 4.2)
4.4	Registration Rights Agreement, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., the Guarantors party thereto and the Initial Purchasers (incorporated by reference to Exhibit 4.1 to Community Health System Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.5	Joinder to the Registration Rights Agreement dated as of July 25, 2007 (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.6	First Supplemental Indenture relating to the Triad's 7% Senior Subordinated Notes due 2013, dated as of July 24, 2007, by and among Triad Hospitals Inc. and The Bank of New York Trust Company, N.A (incorporated by reference to Exhibit 4.7 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.7	Second Supplemental Indenture relating to Triad's 7% Senior Notes due 2012, dated as of July 24, 2007, by and among Triad Hospitals Inc. and The Bank of New York Trust Company, N.A. (incorporated by reference to Exhibit 4.6 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.8	First Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.4 to Community Health Systems, Inc.'s Current Report on Form 8-K filed July 30, 2007 (No. 001-15925))
4.9	Second Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of December 31, 2007, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.7 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
4.10	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of January 30, 2008, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.8 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
4.11	Third Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of October 10, 2008, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.9 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
4.12	Fourth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of December 1, 2008, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.10 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))

4.13 Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of December 31, 2008, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.11 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))

4.14 Fifth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015,

	Description
	dated as of February 5, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.12 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
4.15	Sixth Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of March 30, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2009 filed April 29, 2009 (No. 001-15925))
4.16	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of March 30, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2009 filed April 29, 2009 (No. 001-15925))
4.17	Seventh Supplemental Indenture relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of June 30, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
4.18	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of June 30, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
4.19	Release of Certain Guarantors relating to CHS/Community Health Systems, Inc.'s 8 7/8% Senior Notes due 2015, dated as of December 31, 2009, by and among CHS/Community Health Systems, Inc., the guarantors party thereto and U.S. Bank National Association*
10.1	Credit Agreement, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the lender parties thereto and Credit Suisse, as Administrative Agent and Collateral Agent, Credit Suisse Securities (USA) LLC and Wachovia Capital Markets, LLC as Joint Bookrunner and Co-Lead Arrangers, Wachovia Bank, N.A. as Syndication Agent, JPMorgan Chase Bank and Merrill Lynch Capital Corporation as Co-Documentation Agents (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
10.2	Guarantee and Collateral Agreement, dated as of July 25, 2007, by and among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the Subsidiaries from time to time party thereto and Credit Suisse, as Collateral Agent (incorporated by reference to Exhibit 10.2 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
10.3 †	Form of Indemnification Agreement between Community Health Systems, Inc. and its directors and executive officers (incorporated by reference to Exhibit 10.8 to Amendment No. 2 to Community Health Systems, Inc.'s Registration Statement on Form S-1/A filed May 2, 2000 (No. 333-31790))
10.4 †	CHS/Community Health Systems, Inc. Amended and Restated Supplemental Executive Retirement Plan (incorporated by reference to Exhibit 10.13 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.5 †	Community Health Systems Supplemental Executive Benefits (incorporated by reference to Exhibit 10.14 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.6 †	Supplemental Executive Retirement Plan Trust, dated June 1, 2005, by and between CHS/Community Health Systems, Inc., as grantor, and Wachovia Bank, N.A., as trustee (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Current Report on Form 8-K filed June 1, 2005 (No. 001-15925))
10.7 †	Community Health Systems Deferred Compensation Plan Trust, amended and restated effective February 26, 1999 (incorporated by reference to Exhibit 10.18 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2002 filed March 27, 2003 (No. 001-15925))
10.8 †	CHS/Community Health Systems, Inc. Deferred Compensation Plan, amended and restated effective January 1, 2008 (incorporated by reference to Exhibit 10.12 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))

10.9 CHS NQDCP, effective as of September 1, 2009 (incorporated by reference to Exhibit 4.2 to Community Health Systems, Inc.'s Registration Statement on Form S-8 filed December 11, 2009 (No. 333-163691))

10.10 CHS NQDCP Adoption Agreement, executed as of August 11, 2009 (incorporated by reference to Exhibit 4.3 to Community Health Systems, Inc.'s Registration Statement on Form S-8 filed December 11, 2009 (No. 333-163691))

10.11 Guarantee, dated December 9, 2009, made by Community Health Systems, Inc. in favor of CHS/Community Health

	Description
	Systems, Inc. with respect to CHS/Community Health Systems, Inc.'s payment obligations under the CHS/Community Health Systems, Inc. Deferred Compensation Plan and the NQDCP (incorporated by reference to Exhibit 4.4 to Community Health Systems, Inc.'s Registration Statement on Form S-8 filed December 11, 2009 (No. 333-163691))
10.12 †	Community Health Systems, Inc. 2004 Employee Performance Incentive Plan, as amended and restated on March 24, 2009 (incorporated by reference to Exhibit 10.3 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
10.13	Form of Amended and Restated Change in Control Severance Agreement (incorporated by reference to Exhibit 10.22 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.14 †	Community Health Systems, Inc. 2000 Stock Option and Award Plan, as amended and restated on March 24, 2009 (incorporated by reference to Exhibit 10.4 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
10.15 †	Form of Nonqualified Stock Option Agreement (Employee)*
10.16 †	Form of Restricted Stock Award Agreement (incorporated by reference to Exhibit 10.18 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.17 †	Form of Performance Based Restricted Stock Award Agreement (Most Highly Compensated Executive Officers) (incorporated by reference to Exhibit 10.20 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.18 †	Form of Director Phantom Stock Award Agreement (incorporated by reference to Exhibit 10.19 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.19 †	Form of Director Restricted Stock Unit Award Agreement*
10.20 †	Community Health Systems, Inc. Directors' Fees Deferral Plan, as amended and restated on December 10, 2008 (incorporated by reference to Exhibit 10.15 to Community Health Systems, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2008 filed February 27, 2009 (No. 001-15925))
10.21 †	Community Health Systems, Inc. 2009 Stock Option and Award Plan, effective as of March 24, 2009 (incorporated by reference to Exhibit 10.5 to Community Health Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 filed July 31, 2009 (No. 001-15925))
10.22	Participation Agreement entered into as of January 1, 2005, by and between Community Health Systems Professional Services Corporation and HealthTrust Purchasing Group, L.P. (incorporated by reference to Exhibit 10.1 to Community Health Systems, Inc.'s Current Report on Form 8-K filed January 7, 2005 (No. 001-15925))
12	Computation of Ratio of Earnings to Fixed Charges*
21	List of Subsidiaries*
23.1	Consent of Deloitte & Touche LLP*
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*

* Filed herewith.

† Indicates a management contract or compensatory plan or arrangement.

Exhibit 4.19

RELEASE OF CERTAIN GUARANTORS (this "**Release**"), dated as of December 31, 2009, by and among CHS/COMMUNITY HEALTH SYSTEMS, INC., a Delaware corporation (the "**Issuer**"), those Subsidiary Guarantors parties hereto, and U.S. BANK NATIONAL ASSOCIATION, as Trustee under the Indenture (the "**Trustee**").

WITNESSETH:

WHEREAS, the Issuer has heretofore executed and delivered to the Trustee an Indenture, dated as of July 25, 2007, as supplemented by the First Supplemental Indenture, dated as of July 25, 2007, the Second Supplemental Indenture, dated as of December 31, 2007, the Third Supplemental Indenture, dated as of October 10, 2008, the Fourth Supplemental Indenture, dated December 1, 2008, the Fifth Supplemental Indenture, dated February 5, 2009, the Sixth Supplemental Indenture, dated March 30, 2009 and the Seventh Supplemental Indenture dated June 30, 2009 (the "**Indenture**"), providing for the issuance of the 8 7/8% Senior Notes due 2015 (the "**Securities**");

WHEREAS, pursuant to that certain Private Placement Memorandum, dated June 1, 2009 (as amended, supplemented or otherwise modified from time to time, the "**PPM**"), Petersburg Hospital Company, LLC, a Delaware limited liability company ("**PHC**"), has offered and sold membership interests in PHC to certain physician investors effective as of November 1, 2009 (such transaction, the "**Petersburg Syndication**").

WHEREAS, pursuant to that certain Private Placement Memorandum, dated August 21, 2009 (as amended, supplemented or otherwise modified from time to time, the "**PPM**"), Greenbrier VMC, LLC, a Delaware limited liability company ("**GVMC**"), has offered and sold membership interests in GVMC to certain physician investors effective as of December 1, 2009 (such transaction, the "**Greenbrier Syndication**" and, collectively with the Petersburg Syndication, the "**Syndications**").

WHEREAS, (i) upon the consummation of the Syndications, each of the Subsidiary Guarantors listed on the signature pages hereto (the "**Syndicated Subsidiary Guarantors**") has been released as a Subsidiary Guarantor under the Credit Agreement, dated as of July 25, 2007, by and among the Issuer, Community Health Systems, Inc., the lenders that from time to time become parties to the Credit Agreement and Credit Suisse, as Collateral Agent, and (ii) the Issuer has delivered an Officer's Certificate to the Trustee certifying that the Syndicated Subsidiary Guarantors no longer have any Indebtedness outstanding that would require such Syndicated Subsidiary Guarantors to enter into a Guaranty Agreement pursuant to Section 4.12 of the Indenture.

WHEREAS pursuant to Section 10.06(4) of the Indenture, a Guarantor will be released from its obligations under the Indenture under the circumstances described in the immediately preceding recital.

WHEREAS pursuant to the last sentence of Section 10.06 of the Indenture, the Issuer requests and the Trustee is authorized to execute and deliver this Release evidencing such release pursuant to Section 10.06(4) of the Indenture.

NOW THEREFORE, in consideration of the foregoing and for good and valuable consideration, the receipt of which is hereby acknowledged, the Issuer, those Subsidiary Guarantors parties hereto and the Trustee mutually covenant and agree as follows:

SECTION 1. Capitalized Terms. Capitalized terms used herein but not defined shall have the meanings assigned to them in the Indenture.

SECTION 2. Subsidiary Guarantors. Effective from and after the consummation of the Syndication, each of the Syndicated Subsidiary Guarantors is hereby irrevocably released and discharged from its obligations under Article 10 of the Indenture, any Guaranty Agreement to which it may be party or any obligations with respect to the Securities.

SECTION 3. Ratification of Indenture; Release Part of Indenture. Except as expressly modified hereby, the Indenture is in all respects ratified and confirmed and all the terms, conditions and provisions thereof shall remain in full force and effect. This Release shall form a part of the Indenture for all purposes, shall inure to the benefit of the Issuer, each of the Syndicated Subsidiary Guarantors, the Trustee and every Holder of Securities heretofore or hereafter authenticated and the Issuer, each of the Syndicated Subsidiary Guarantors, the Trustee and every Holder of Securities heretofore or hereafter authenticated and delivered shall be bound hereby.

SECTION 4. Governing Law. **THIS RELEASE SHALL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK.**

SECTION 5. Trustee Makes No Representation. The Trustee makes no representation as to the accuracy or correctness of the recitals of this Release.

SECTION 6. Counterparts. The parties may sign any number of copies of this Release. Each signed copy shall be an original, but all of them together represent the same agreement.

SECTION 7. Effect of Headings. The Section headings herein are for convenience only and shall not effect the construction of this Release.

IN WITNESS WHEREOF, the parties have caused this Release to be duly executed as of this 31st day of December 2009.

CHS/Community Health Systems, Inc.,
a Delaware corporation

By: /s/ Rachel A. Seifert
Rachel A. Seifert
Senior Vice President, Secretary & General Counsel

Syndicated Subsidiary Guarantors:
Greenbrier VMC, LLC
Petersburg Hospital Company, LLC

By: /s/ James W. Doucette
James W. Doucette
Vice President, Finance and Treasurer

U.S. Bank National Association,
as Trustee

By: /s/ Wally Jones
Wally Jones
Vice President

Exhibit 10.15

COMMUNITY HEALTH SYSTEMS, INC.

AMENDED AND RESTATED 2000 STOCK OPTION AND AWARD PLAN NONQUALIFIED STOCK OPTION AGREEMENT (EMPLOYEE)

THIS AGREEMENT between you and Community Health Systems, Inc. (the "Corporation") governs an award of a nonqualified stock option on a date specified in your award notification (the "Grant Date"), and

WHEREAS, the Corporation has adopted the Community Health Systems, Inc. 2000 Stock Option and Award Plan, as amended (the "Plan") in order to provide additional incentive to certain employees, officers and directors of the Corporation and its Subsidiaries; and

WHEREAS, the Committee responsible for administration of the Plan has determined to grant an option to you as provided herein;

NOW, THEREFORE, the parties hereto agree as follows:

1. Grant of Option.

1.1 The Corporation hereby grants to you the right and option (the "Option") to purchase all or any part of an aggregate of the number of whole Shares (such number being subject to adjustment as provided in Section 10 hereof) set out in your award notification, on the terms and conditions set forth in this Agreement and in the Plan, a copy of which is available to you from the Corporation by request. The Corporation may delegate any of the duties associated with the administration of the Plan or this agreement to one or more affiliates or third-party vendors (the "Plan Administrator").

1.2 This Option is not intended to qualify as an Incentive Stock Option within the meaning of Section 422 of the Code.

1.3 Except as otherwise defined herein, capitalized terms used in this Agreement shall have the same definitions as set forth in the Plan.

2. Purchase Price.

The price at which you shall be entitled to purchase Shares upon the exercise of this Option shall be the close price of the Corporation's stock on the Grant Date, as reported in The Wall Street Journal, and as set out in your award notification (such price being subject to adjustment as provided in Section 10 hereof).

3. Duration of Option.

The Option shall be exercisable to the extent and in the manner provided herein for a period of ten (10) years from the date hereof (the "Exercise Term"); provided, however, that the Option may be earlier terminated as provided in Section 6 or Section 8 hereof; provided, further, that the Option may, upon your death, be later exercised for up to one (1) year following the date of your death if such death occurs prior to the tenth anniversary of the Grant Date.

4. Exercisability of Option.

Unless otherwise provided in this Agreement or the Plan, the Option shall entitle you to purchase, in whole at any time or in part from time to time, thirty-three and one-third percent (33 1/3%) of the total number of Shares covered by the Option after the expiration of one (1) year from the Grant Date and an additional thirty-three and one-third percent (33 1/3%) of the total number of Shares covered by the Option after the expiration of each of the second and third anniversaries of the Grant Date, and each such right of purchase shall be cumulative and shall continue, unless sooner exercised or terminated as herein provided, during the remaining period of the Exercise Term. Any fractional number of Shares resulting from the application of the foregoing percentages shall be rounded down to the next whole number of Shares.

5. Manner of Exercise and Payment.

5.1 Election to Exercise. Subject to the terms and conditions of this Agreement and the Plan, the Option may be exercised by electronic notification to the Corporation's Plan Administrator, or by telephonic request (each as subject to the Corporation's Insider Trading Policy). Such notification shall state that you are electing to exercise the Option and the number of Shares in respect of which the Option is being exercised. In the event of your death, such notification shall be in the form prescribed by the Corporation or its Plan Administrator and shall be signed by your legal guardian, executor, administrator or other legal representative. The Corporation or its Administrator may require proof satisfactory to it as to the right of such person to exercise the Option.

5.2 Deliveries. The notification of exercise described in Section 5.1 hereof shall be accompanied by the full purchase price for the Shares in respect of which the Option is being exercised, in cash or by check or, if acceptable to the Plan Administrator, such payment shall follow by check from a registered broker acting as agent on your behalf. However, at the discretion of the Committee, you may pay the exercise price in part or in full by transferring to the Corporation Shares owned by you for a period of six (6) months (or such lesser period as may be permitted by the Committee) prior to the exercise of the Option. In addition, an Option may be exercised through the Corporation's Plan Administrator pursuant to such cashless exercise procedures which are, from time to time, deemed acceptable by the Committee. Any Shares transferred to the Corporation as payment of the exercise price under an Option shall be valued at their Fair Market Value on the date of exercise of such Option.

5.3 Issuance of Shares. Upon your election to exercise your options, full payment for the Shares in respect of which the Option is being exercised, and subject to Section 11, the Corporation or its Plan Administrator shall take such action as may be necessary under applicable law to affect the issuance to you of the number of Shares as to which such exercise was effected.

5.4 Stockholder Rights. You shall not be deemed to be the holder of, or to have any of the rights of a holder with respect to any Shares subject to the Option until (a) the Option shall have been exercised in accordance with the terms of this Agreement and you shall have paid the full purchase price for the number of Shares in respect of which the Option was exercised and any withholding taxes due in connection with such exercise, (b) the Corporation or its Plan Administrator shall have issued the

Shares to you, and (c) your name shall have been entered as a shareholder of record on the books of the Corporation. Upon the occurrence of all of the foregoing events, you shall have full voting and other ownership rights with respect to such Shares.

6. Termination of Option. Subject to Sections 7 and 8 hereof, each Option shall terminate on the date which is the eighth anniversary of the Grant Date (or if later, the first anniversary of the date of your death if such death occurs prior to such eighth anniversary), unless terminated earlier as follows:

6.1 If your employment is terminated for any reason other than disability, death or for Cause, you may for a period of three (3) months after such termination exercise your Option to the extent, and only to the extent, that the Option or portion thereof was vested and exercisable as of the date of such termination, after which time the Option shall automatically terminate in full.

6.2 If your employment is terminated by reason of Disability, all of the Option shall immediately become vested and exercisable and you may, for a period of twelve (12) months after such termination, exercise your Option, after which time the Option shall automatically terminate in full.

6.3 If your employment is terminated by reason of your death, or if you die within three (3) months after termination as described in Section 6.1 hereof the Option shall immediately become vested and exercisable and the person or persons to whom such rights under the Option shall pass by will, or by the laws of descent or distribution may, for a period of twelve (12) months following your death, exercise the Option, after which time the Option shall terminate in full.

6.4 If your the employment is terminated for Cause, the option granted to you hereunder shall immediately terminate in full and no rights thereunder may be exercised.

6.5 Except as expressly provided herein to the contrary, the Option, to the extent not yet vested and exercisable, shall terminate immediately upon the Employee's termination of employment with the Corporation for any reason.

7. Effect of Change of Control.

In the event of a Change in Control, the Option shall become immediately and fully vested and exercisable and shall, notwithstanding any shorter period set forth in this Agreement, remain exercisable for a period ending not before the earlier of (x) the six (6) month anniversary of the termination of your employment or (y) the expiration of the Exercise Term.

8. Prohibited Activities

8.1 Prohibition Against Certain Activities. You agree that (a) you will not at any time during your employment (other than in the course of your employment) with the Corporation or any Affiliate thereof, or after any termination of employment, directly or indirectly disclose or furnish to any other person or use for your own or any other person's account any confidential or proprietary knowledge or any other information which is not a matter of public knowledge obtained during the course of your employment with, or other performance of services for (including service as a director of), the Corporation or any Affiliate thereof or any predecessor of any of the foregoing, no matter from where or in what manner you may have acquired such knowledge or information, and you shall retain all such knowledge and information in trust for the benefit of the Corporation, its Affiliates and the successors and assigns of any of them, (b) you will not at any time during your employment with the Corporation or any Affiliate thereof, or for three (3) years following any termination of employment, directly or indirectly solicit for employment, including, without limitation, recommending to any subsequent employer the solicitation for employment of, any person who at the time of the solicitation is employed by the Corporation or any Affiliate thereof, (c) you will not at any time during your employment with, or performance of services for (including service as a director of), the Corporation or any Affiliate thereof or after any termination of employment, publish any statement or make any statement (under circumstances reasonably likely to become public or that might reasonably be expected to become public) critical of the Corporation or any Affiliate of the Corporation, or in any way adversely affecting or otherwise maligning the business reputation of any of the foregoing entities, and (d) you will not breach the provisions of Section 9 hereof (any activity described in clause (a), (b), (c) or (d) of this Section 8.1 being herein referred to as a "Prohibited Activity").

8.2 Right to Terminate Option. You understand that the Corporation is granting to you an option to purchase Shares hereunder to reward you for your future efforts and loyalty to the Corporation and its Affiliates by giving you the opportunity to participate in the potential future appreciation of the Corporation. Accordingly, if, at any time during which any portion of the Option, including any exercisable portion, is outstanding (a) if you engage in any Prohibited Activity, or (b) you engage in any Competitive Activity (as hereinafter defined), or (c) you are convicted of a crime against the Corporation or any of its Affiliates, then, in addition to any other rights and remedies available to the Corporation, the Corporation shall be entitled, at its option, to terminate the Option, including any exercisable portion thereof, which shall then be of no further force and effect.

The term "Competitor" shall mean any person that competes either directly or indirectly through one or more Affiliates with any of the businesses in which, at the time your employment is terminated, the Corporation or any of its subsidiaries is engaged.

The term "Competitive Activity" shall mean engaging in any of the following activities: (i) serving as a director of any Competitor; (ii) directly or indirectly (x) controlling any Competitor or (y) owning any equity or debt interests in any Competitor (other than equity or debt interests which are publicly traded and do not exceed 2% of the particular class of interests outstanding) (it being understood that, if any such interests in any Competitor are owned by an investment vehicle or other entity in which you own an equity interest, a portion of the interests in such Competitor owned by such entity shall be attributed to you, such portion determined by applying the percentage of the equity interest in such entity owned by you to the interests in such Competitor owned by such entity); (iii) directly or indirectly soliciting, diverting, taking away, appropriating or otherwise interfering with any of the customers or suppliers of the Corporation or any Affiliate of the Corporation; (iv) employment by (including serving as an officer or director of) or providing consulting services to any Competitor; provided, however, that if the Competitor has more than one discrete and readily distinguishable part of its business, employment by or providing consulting services to any Competitor shall be Competitive

Activity only if (1) your employment duties are at or involving the part of the Competitor's business that competes with any of the businesses conducted by the Corporation or any of its subsidiaries (the "Competing Operations"), including serving in a capacity where any person at the Competing Operations reports to you, or (2) the consulting services are provided to or involve the Competing Operations. For purposes of this definition, the term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of any Competitor, whether through the ownership of equity or debt interests, by contract or otherwise.

9. Non-Transferability.

The Option shall not be transferable other than by will or by the laws of descent and distribution or pursuant to a domestic relations order; provided, however, that the Option may be transferred to members of your immediate family, to trusts solely for the benefit of such immediate family members and to partnerships in which such family members and/or trusts are the only partners. For this purpose, immediate family means your spouse, parents, children, stepchildren and grandchildren and the spouses of such parents, children, stepchildren and grandchildren.

10. Adjustments.

In the event of a Change in Capitalization, the Committee may make appropriate adjustments to the number and class of Shares or other stock or securities subject to this Option and the purchase price for such Shares or other stock or securities (an "Adjustment"). In the event of (i) the liquidation or dissolution of the Corporation or (ii) a merger or consolidation of the Corporation (a "Transaction"), any such Adjustment may be as provided for in the plan or agreement of liquidation, dissolution, merger or consolidation. If such plan or agreement does not expressly provide for the treatment of the Option in connection with the Transaction, the Option shall continue in effect in accordance with its terms and you shall be entitled to receive in respect of all Shares subject to the Option, upon exercise of the Option, the same number and kind of stock, securities, cash, property or other consideration that each holder of Shares was entitled to receive in the Transaction. The Committee's Adjustment shall be final and binding for all purposes of the Plan and the Agreement. No Adjustment provided for in this Section 10 shall require the Corporation to issue a fractional share, and the total adjustment with respect to this Agreement shall be limited accordingly.

11. Withholding.

The Corporation or its Plan Administrator shall have the right to deduct from any amounts payable under this Agreement an amount equal to the federal, state and local income taxes and other amounts as may be required by applicable law to be withheld (the "Withholding Taxes"). If you are entitled to receive Shares upon exercise of the Option, you shall pay the Withholding Taxes to the Corporation or its Plan Administrator in cash prior to the issuance of such Shares. In satisfaction of the Withholding Taxes, you may, unless the Committee determines otherwise, elect to have withheld a portion of the Shares issuable to you upon exercise of the Option having an aggregate Fair Market Value equal to the Withholding Taxes.

12. No Right to Continued Employment.

This Agreement and the Option shall not confer upon you any right with respect to continuance of employment by the Corporation or any Affiliate thereof, nor shall it interfere in any way with the right of the Corporation or any Affiliate thereof to terminate your employment at any time.

13. Entire Agreement.

This Agreement and the Plan constitute the entire agreement, and supersede all prior agreements and understandings, oral and written, between the parties hereto with respect to the subject matter hereof.

14. Acceptance of the Terms of this Agreement; Deemed Execution; Modification of Agreement.

The terms of this Agreement must be acknowledged and accepted by you by electronic means via the Plan Administrator's website, and upon such acceptance shall be deemed to have been executed and delivered by you and the Corporation. This Agreement may be modified, amended, supplemented or terminated by written agreement of the parties hereto; provided that the Corporation may modify, amend, supplement or terminate this Agreement in a writing signed by the Corporation without any further action by you if such modification, amendment, supplement or termination does not adversely affect your rights hereunder.

15. Invalidity of Provisions.

The invalidity or unenforceability of any provision of this Agreement in any jurisdiction shall not affect the validity or enforceability of the remainder of this Agreement in that jurisdiction or the validity or enforceability of this Agreement, including that provision, in any other jurisdiction. If any provision of this Agreement is held unlawful or unenforceable in any respect, such provision shall be revised or applied in a manner that renders it lawful and enforceable to the fullest extent possible.

16. Acknowledgment.

You hereby acknowledge the availability of a copy of the Prospectus, the Plan and this Agreement via the Plan Administrator's website, and agree to be bound by all the terms and provisions of each, and by the Corporation's Insider Trading Policy, as each may be amended from time to time. You hereby acknowledge that you have reviewed these documents and understand your rights and obligations thereunder and hereunder. You also acknowledge that you have been provided with such information concerning the Corporation, the Plan, the Prospectus, the Plan Administrator and this Agreement as you and your advisors have requested. You also acknowledge your right to request a copy of any of the foregoing from the Corporation.

17. Binding Effect.

This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, legal representatives, successors and assigns.

18. Headings.

The headings and captions contained herein are for convenience only and shall not control or affect the meaning or construction of any provision hereof.

19. Resolution of Disputes.

Any dispute or disagreement which may arise under, or as a result of, or in any way relate to, the interpretation, construction or application of this Agreement shall be determined by the Committee in good faith, whose determination shall be final, binding and conclusive for all purposes.

20. Governing Law.

This Agreement and the rights and obligations of the parties hereto shall be governed by, and construed in accordance with, the laws of the State of Delaware without giving effect to the principles of conflicts of laws thereof.

21. Specific Performance.

The parties hereto acknowledge that there will be no adequate remedy at law for a violation of any of the provisions of this Agreement and that, in addition to any other remedies which may be available; all of the provisions of this Agreement shall be specifically enforceable in accordance with their respective terms.

22. Notice.

All notifications and other communications hereunder shall be in writing and, unless otherwise provided herein, shall be deemed to have been given when received by the party to whom such notice is to be given at its address set forth below, or such other address for the party as shall be specified by notice given pursuant hereto:

(a) If to the Corporation, by regular mail to:

Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067
Attention: General Counsel

(b) If to you or your legal representative, to such person at the address as reflected in the records of the Corporation.

23. Consent to Jurisdiction.

Each party hereby irrevocably and unconditionally consents to submit to the exclusive jurisdiction of the courts of the State of Tennessee and of the United States of America, in each case located in the County of Williamson, for any actions, suits or proceedings arising out of or relating to this Agreement, the Option or the Plan and the transactions contemplated hereby and thereby ("Litigation") (and agrees not to commence any Litigation except in any such court), and further agrees that service of process, summons, notice or document by U.S. registered mail to such party's respective address set forth in Section 22 hereof shall be effective service of process for any Litigation brought against such party in any such court. Each party hereby irrevocably and unconditionally waives any objection to the laying of venue of any litigation in the courts of the State of Tennessee or of the United States of America, in each case located in the County of Williamson, and hereby further irrevocably and unconditionally waives and agrees not to plead or claim in any such court that any Litigation brought in any such court has been brought in an inconvenient forum.

COMMUNITY HEALTH SYSTEMS, INC.

Exhibit 10.19

DIRECTOR RESTRICTED STOCK UNIT AWARD AGREEMENT

Community Health Systems, Inc.

THIS AGREEMENT between the Grantee and Community Health Systems, Inc., a Delaware corporation (the "Company"), governs an Award of Restricted Stock Units in the amount and on the date specified in the Grantee's award notification (the "Grant Date");

WHEREAS, the Company has adopted the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan (the "Plan") to provide additional incentives to certain employees and directors of the Company and its Subsidiaries;

WHEREAS, Section 8.2 of the Plan provides for grants of Restricted Stock Units ("Units") to Eligible Individuals; and

WHEREAS, the Compensation Committee of the Board of Directors has approved this form of Agreement and desires to make the Award as specified herein.

NOW, THEREFORE, the parties hereto agree as follows:

1. Grant of Restricted Stock Units; Purchase Price.

The Company hereby grants to the Grantee an award of Restricted Stock Units (the "Award") in respect of the number of Units set out in an electronic notification by the Company's stock option plan administrator (the "Plan Administrator").

The price to be paid by the Grantee in respect of each Unit shall be Zero Dollars ($).

This Agreement shall be construed in accordance and consistent with, and subject to, the provisions of the Plan (the provisions of which are hereby incorporated by reference) and, except as otherwise expressly set forth herein, the capitalized terms used in this Agreement shall have the same definitions as set forth in the Plan.

2. Vesting Generally.

Except as provided in Sections 3 and 4 hereof, the Award shall vest in respect of one-third (1/3) of the Units subject to the Award (rounded down to the next whole Unit, if necessary), on each of the first three (3) anniversaries of the Date of Grant.

Upon the vesting of Units pursuant to this Section 2 or pursuant to Section 3 or 4 hereof, the Company or its Plan Administrator shall, without the requirement of any notice or action on the part of Grantee, take such action as may be necessary under applicable law to effect the issuance to the Grantee (or following the Grantee's death, the executors or administrators of the Grantee's estate) of the number of Shares to which such vested Units relate.

The Grantee shall not be deemed to be the holder of, or to have any of the rights of a holder with respect to any Shares until the Company or the Plan Administrator shall have issued the Shares to the Grantee and his name shall have been entered as a shareholder of record (or the Grantee's ownership recorded via his nominee) on the books of the Company. Upon the occurrence of the foregoing events, the Grantee shall have full voting and other ownership rights with respect to such Shares.

3. Effect of Certain Terminations of Service.

If the Grantee's service as a member of the Board of Directors terminates as a result of his or her death, Disability, or for any reason other than for Cause, in each case if such termination occurs on or after the Date of Grant, the Award shall immediately vest in respect of all Units as to which had not previously become vested pursuant to Section 2 or 4 hereof as of the date of such termination.

4. Effect of Change in Control.

In the event that a Change in Control which also constitutes a change in control or effective control of the Company or a change in the ownership of a substantial portion of its assets, in each case within the meaning of Section 409A of the Code and the regulations and interpretive guidance issued thereunder (a "Section 409A Change in Control") occurs at any time on or after the Date of Grant and prior to the Grantee's termination of service as a member of the Board of Directors, the Award shall become vested in respect of all Units as to which it had not previously become vested pursuant to Section 2 hereof as of the date of such Section 409A Change in Control.

5. Forfeiture of Restricted Stock Units.

In addition to the circumstance described in Section 6 hereof, the Award (and any and all Units in respect thereof), to the extent it has not become vested in accordance with Section 2, 3 or 4 hereof, shall be forfeited upon the termination of the Grantee's service as a member of the Board of Directors for any reason other than those set forth in Section 3 hereof prior to such vesting.

6. Acknowledgement and Acceptance of Award Agreement.

The Award shall be subject to the Grantee's acknowledgement and acceptance of this Agreement to the Company or its Plan Administrator (including by electronic means, if so provided) no later than the earlier of (i) 180 days from the Date of Grant and (ii) the date that is immediately prior to the date that the Award vests pursuant to Section 3 or 4 hereof (the "Return Date"); provided that if the Grantee dies before the Return Date, this requirement shall be deemed to be satisfied if the executor or administrator of the Grantee's estate acknowledges and accepts this Agreement through the Company or its Plan Administrator no later than ninety (90) days following the Grantee's death (the "Executor Return Date"). If this Agreement is not so acknowledged and accepted on or prior to the Return Date or the Executor Return Date, as applicable, the Award (and any and all Units in respect thereof) shall be forfeited, and neither the Grantee nor the Grantee's heirs, executors, administrators and successors shall have any rights with respect thereto.

7. No Right to Continued Service.

Nothing in this Agreement or the Plan shall interfere with or limit in any way the right of the Company to terminate the Grantee's service on its Board of Directors, nor confer upon the Grantee any right to continuance of such service as a Board member.

8. Withholding of Taxes.

Prior to the delivery of a stock certificate with respect to the issuance of Shares upon the vesting of any portion of the Award, the Grantee shall pay to the Company or the Company's Plan Administrator, the federal, state and local income taxes and other amounts as may be required by law to be withheld (the "Withholding Taxes") with respect to such Shares, if any. By acknowledging and accepting this Agreement in the manner provided in Section 6 hereof, the Grantee shall be deemed to elect to have the Company or the Company's Plan Administrator, withhold a portion of such Shares having an aggregate Fair Market Value equal to the Withholding Taxes in satisfaction thereof, such election to continue in effect until the Grantee notifies the Company or its Plan Administrator before such delivery that the

Grantee shall satisfy such obligation in cash, in which event the Company shall not withhold a portion of such Shares as otherwise provided in this Section 8.

9. Non-Transferability.

The Award shall not be transferable other than by will or by the laws of descent and distribution or pursuant to a domestic relations order; provided, however, that the Award may be transferred to members of the Grantee's immediate family, to trusts solely for the benefit of such immediate family members and to partnerships in which such family members and/or trusts are the only partners. For this purpose, immediate family means the Grantee's spouse, parents, children, stepchildren and grandchildren and the spouses of such parents, children, stepchildren and grandchildren.

10. The Grantee is Bound by the Plan.

By acknowledging and accepting the Award, the Grantee hereby confirms the availability and his or her review of a copy of the Plan, the Prospectus, and other documents provided to the Grantee in connection with the Award, by the Company or its Plan Administrator, and the Grantee agrees to be bound by all the terms and provisions thereof.

11. Modification of Agreement.

This Agreement may be modified, amended, suspended or terminated, and any terms or conditions may be waived, but only by a written instrument executed by both parties hereto.

12. Severability.

Should any provision of this Agreement be held by a court of competent jurisdiction to be unenforceable or invalid for any reason, the remaining provisions of this Agreement shall not be affected by such holding and shall continue in full force in accordance with their terms.

13. Governing Law.

The validity, interpretation, construction and performance of this Agreement shall be governed by the laws of the State of Tennessee without giving effect to the conflicts of laws principles thereof.

14. Successors in Interest.

This Agreement shall inure to the benefit of and be binding upon any successor to the Company. This Agreement shall inure to the benefit of the Grantee's legal representatives. All obligations imposed upon the Grantee and all rights granted to the Company under this Agreement shall be binding upon the Grantee's heirs, executors, administrators and successors.

15. Resolution of Disputes.

Any dispute or disagreement which may arise under, or as a result of, or in any way relate to, the interpretation, construction or application of this Agreement shall first be referred to the Chief Executive Officer for informal resolution, and if necessary, referred to the Committee for its determination. Any determination made hereunder shall be final, binding and conclusive on the Grantee, his or her heirs, executors, administrators and successors, and the Company and its Subsidiaries for all purposes.

16. Entire Agreement.

This Agreement and the terms and conditions of the Plan constitute the entire understanding between the Grantee and the Company and its Subsidiaries, and supersede all other agreements, whether written or oral, with respect to the Award.

17. Headings.

The headings of this Agreement are inserted for convenience only and do not constitute a part of this Agreement.

18. Deemed Execution.

On the date of the Grantee's electronic acceptance of the terms of the Award, and this Agreement, this Agreement shall be deemed to have been executed and delivered by the Grantee and the Company.

COMMUNITY HEALTH SYSTEMS, INC.

Exhibit 12

STATEMENT RE: COMPUTATION OF RATIO OF EARNINGS TO FIXED CHARGES (DOLLARS IN THOUSANDS)

	Year Ended December 31,				
	2005	2006	2007	2008	2009
Earnings					
Income from continuing operations before provision for income taxes and extraordinary item	$ 308,174	$ 287,847	$ 107,291	$ 359,000	$ 446,130
Income from equity investees (1)	—	—	(25,132)	(42,063)	(36,521)
Distributed income from equity investees	—	—	19,902	32,897	33,705
Interest and amortization of deferred finance costs	87,185	94,411	362,065	652,468	648,964
Amortization of capitalized interest	494	567	881	1,469	2,024
Implicit rental interest expense	20,564	22,986	38,424	57,792	61,783
Total Earnings	$ 416,417	$ 405,811	$ 503,431	$ 1,061,563	$ 1,156,085
Fixed Charges					
Interest and amortization of deferred finance costs	$ 87,185	$ 94,411	$ 362,065	$ 652,468	$ 648,964
Capitalized interest	2,144	2,955	19,009	22,147	16,695
Implicit rental interest expense	20,564	22,986	38,424	57,792	61,783
Total fixed charges	$ 109,893	$ 120,352	$ 419,498	$ 732,407	$ 727,442
Ratio of earnings to fixed charges	3.79x	3.37x	1.20x	1.45x	1.59x

(1) The Company recognized an immaterial amount of income from equity investees prior to 2007.

Community Health Systems, Inc.
SUBSIDIARY LISTING

(*) Majority position held in an entity with physicians, non-profit entities or both

(#) Minority position held in a non-consolidating entity

5300 Grand Limited Partnership	
A Woman's Place, LLC	
Abilene Hospital, LLC	
Abilene Merger, LLC	
Affinity Health Systems, LLC*	
Affinity Hospital, LLC*	d/b/a Trinity Medical Center
Affinity Orthopedic Services, LLC	
Affinity Physician Services, LLC	
Aiken Home Care Services, LLC	
Alaska Physician Services, LLC	
Alice Hospital, LLC	
Alice Surgeons, LLC	
Ambulance Services of Dyersburg, Inc.	
Ambulance Services of Forrest City, LLC	
Ambulance Services of Lexington, Inc.	
Ambulance Services of McKenzie, Inc.	
Ambulance Services of McNairy, Inc.	
Ambulance Services of Tooele, LLC	
American Health Facilities Development, LLC	
Anesthesiology Group of Hattiesburg, LLC	
Angelo Community Healthcare Services, Inc.	
Anna Clinic Corp.	
Anna Home Care Services, LLC	
Anna Hospital Corporation	d/b/a Union County Hospital
APS Medical, LLC	
Arizona ASC Management, Inc.	
Arizona DH, LLC	
Arizona Medco, LLC	
Arkansas Healthcare System Limited Partnership#	
ARMC, LP	d/b/a Abilene Regional Medical Center
Arusha LLC*	
Augusta Health System, LLC*	
Augusta Home Care Services, LLC	
Augusta Hospital, LLC*	d/b/a Trinity Hospital of Augusta
Augusta Physician Services, LLC	
Barberton Health System, LLC	
Barberton Physician Services, LLC	
Barstow Healthcare Management, Inc.	
Beauco, LLC	

Beaumont Medical Center, L.P.	
Beaumont Regional, LLC	
Berwick Clinic Company, LLC	
Berwick Clinic Corp.	
Berwick Home Care Services, LLC	
Berwick Home Health Private Care, Inc.	
Berwick Hospital Company, LLC	d/b/a Berwick Hospital Center
Berwick Medical Professionals, P.C.	
BH Trans Company, LLC	
Big Bend Home Care Services, LLC	
Big Bend Hospital Corporation	d/b/a Big Bend Regional Medical Center
Big Spring Hospital Corporation	d/b/a Scenic Mountain Medical Center
Birmingham Holdings, LLC	
Birmingham Holdings II, LLC	
Blue Ridge Georgia Hospital Company, LLC*	d/b/a Fannin Regional Hospital
Bluffton Health System, LLC	d/b/a Bluffton Regional Medical Center
Bluffton Physician Services, LLC	
Brandywine Hospital Malpractice Assistance Fund, Inc.	
Brazos Valley of Texas, L.P.	
Brazos Valley Surgical Center, LLC	
Broken Arrow Medical Group, LLC	
Brownsville Clinic Corp.	
Brownsville Hospital Corporation	d/b/a Haywood Park Community Hospital
Brownwood Hospital, L.P.	d/b/a Brownwood Regional Medical Center
Brownwood Medical Center, LLC	
Bullhead City Clinic Corp.	
Bullhead City Hospital Corporation*	d/b/a Western Arizona Regional Medical Center
Bullhead City Hospital Investment Corporation*	
Bullhead City Imaging Corporation	
Byrd Medical Clinic, Inc.	
Carlsbad Medical Center, LLC	d/b/a Carlsbad Medical Center
Carolina Surgery Center, LLC*	
Carolinas Medical Alliance, Inc.	
Carolinas OB/GYN Medical Group, LLC	
Cedar Park Health System, L.P.*	d/b/a Cedar Park Regional Medical Center
Center for Adult Healthcare, LLC	
Central Alabama Physician Services, Inc.	
Centre Clinic Corp.	
Centre Home Care Corporation	
Centre Hospital Corporation	d/b/a Cherokee Medical Center
Centre RHC Corp.	
Chesterfield Clinic Corp.	
Chesterfield/Marlboro, L.P.	d/b/a Marlboro Park Hospital; Chesterfield General Hospital
Chestnut Hill Clinic Company, LLC*	

Chestnut Hill Health System, LLC*	
CHHS ALF Company, LLC*	
CHHS Development Company, LLC*	
CHHS Holdings, LLC	
CHHS Hospital Company, LLC*	d/b/a Chestnut Hill Hospital
CHHS Rehab Company, LLC*	
Children's Mobile Team#	
CHS Kentucky Holdings, LLC	
CHS Pennsylvania Holdings, LLC	
CHS Realty Holdings I, Inc.	
CHS Realty Holdings II, Inc.	
CHS Realty Holdings Joint Venture	
CHS Utah Holdings, LLC	
CHS Virginia Holdings, LLC	
CHS Washington Holdings, LLC	
CHS/Community Health Systems, Inc.	
CHSPSC Leasing, Inc.	
Claremore Anesthesia, LLC	
Claremore Diagnostic Center, LLC	
Claremore Internal Medicine, LLC	
Claremore Physicians, LLC	
Claremore Regional Hospital, LLC	d/b/a Claremore Regional Hospital
Clarksville Health System, G.P.*	d/b/a Gateway Health System
Clarksville Holdings, LLC	
Clarksville Home Care Services, LLC*	
Clarksville Imaging Center, LLC#	
Clarksville Physician Services, G.P.*	
Cleveland Clinic Corp.	
Cleveland Home Care Services, LLC	
Cleveland Hospital Corporation	
Cleveland Medical Clinic, Inc.	
Cleveland PHO, Inc.	
Cleveland Regional Medical Center, L.P.	d/b/a Cleveland Regional Medical Center
Cleveland Tennessee Hospital Company, LLC	d/b/a SkyRidge Medical Center
Clinton County Health System, LLC	
Clinton Hospital Corporation	d/b/a Lock Haven Hospital
Coatesville Clinic Company, LLC	
Coatesville Hospital Corporation	d/b/a Brandywine Hospital
C-OK, LLC	
College Station Hospital, L.P.	d/b/a College Station Medical Center
College Station Medical Center, LLC	
College Station Merger, LLC	
College Station RHC Company, LLC	
Colonial Heights Imaging, LLC	
Community GP Corp.	

Community Health Care Partners, Inc.
Community Health Investment Company, LLC
Community Health Network, Inc.
Community Health Physicians Operations Holding Company, LLC
Community Health Systems Foundation
Community Health Systems Professional Services Corporation
Community Health Systems, Inc.
Community Health United Home Care, LLC
Community Information Network, Inc.#
Community Insurance Group SPC, LTD.
Community LP Corp.
Community Residential Unit#
Consolidated Hospital Laundry Services, Inc.#
Conygham Care Center#
Coronado Hospital, LLC
Coronado Medical, LLC
Cottage Home Options, L.L.C.
Cottage Rehabilitation and Sports Medicine, L.L.C.#
Coventry Clinic Company, LLC
CP Hospital GP, LLC
CPLP, LLC
Crestview Hospital Corporation* d/b/a North Okaloosa Medical Center
Crestview Professional Condominiums Association, Inc.*
Crestview Surgery Center, L.P.
Crestwood Healthcare, L.P.* d/b/a Crestwood Medical Center
Crestwood Hospital LP, LLC
Crestwood Hospital, LLC
Crestwood Surgery Center, LLC*
Crossroads Community Hospital Malpractice Assistance Fund, Inc.
Crossroads Healthcare Management, LLC#
Crossroads Home Care Services, LLC
Crossroads Physician Corp.
CSMC, LLC
CSRA Holdings, LLC
Dallas Phy Service, LLC
Dallas Physician Practice, L.P.
Day Surgery, Inc.
Deaconess Clinical Associates, Inc.
Deaconess Health System, LLC* d/b/a Deaconess Hospital (OK)
Deaconess Holdings, LLC
Deaconess Hospital Holdings, LLC
Deaconess Metropolitan Physicians, LLC
Deaconess Physician Services, LLC
Deaconess Portland MOB Limited Partnership#
Deming Clinic Corporation

Deming Home Care Services, LLC	
Deming Hospital Corporation	d/b/a Mimbres Memorial Hospital
Desert Hospital Holdings, LLC	
Detar Hospital, LLC	
DFW Physerv, LLC	
DH Cardiology, LLC	
DHFW Holdings, LLC	
DHSC, LLC	d/b/a Affinity Medical Center — Massillon
Diagnostic Imaging Management of Brandywine Valley, LLC	
Doctors Hospital Physician Services, LLC	
Doctors of Laredo, LLC	
Douglas Medical Center, LLC	
Dukes Health System, LLC	d/b/a Dukes Memorial Hospital
Dukes Physician Services, LLC	
Dupont Hospital, LLC*	d/b/a Dupont Hospital
Dyersburg Clinic Corp.	
Dyersburg Home Care Services, LLC	
Dyersburg Hospital Corporation	d/b/a Dyersburg Regional Medical Center
E.D. Clinics, LLC	
East Tennessee Clinic Corp.	
East Tennessee Health Systems, Inc.	
Easton Hospital Malpractice Assistance Fund, Inc.	
Edge Medical Clinic, Inc.	
Edwardsville Ambulatory Surgery Center, L.L.C.	
El Dorado Home Care Services, LLC	
El Dorado Surgery Center, L.P.*	
EL MED, LLC	
Eligibility Screening Services, LLC	
Empire Health Services	
Emporia Clinic Corp.	
Emporia Home Care Services, LLC	
Emporia Hospital Corporation	d/b/a Southern Virginia Regional Medical Center
Enterprise Clinic, LLC	
Eufaula Clinic Corp.	
Eufaula Hospital Corporation	
Evanston Clinic Corp.	
Evanston Hospital Corporation	d/b/a Evanston Regional Hospital
Fallbrook Home Care Services, LLC	
Fallbrook Hospital Corporation	d/b/a Fallbrook Hospital
Family Home Care, Inc.	
Fannin Regional Orthopaedic Center, Inc.	
Firstcare, Inc.#	
First Choice Health Network, Inc.#	
Florence ASC Management, LLC	
Florence Home Care Services, LLC	

Flowers Real Estate Holdings, LLC	
Foley Clinic Corp.	
Foley Home Health Corporation	
Foley Hospital Corporation	d/b/a South Baldwin Regional Medical Center
Forrest City Arkansas Hospital Company, LLC	d/b/a Forrest City Medical Center
Forrest City Clinic Company, LLC	
Forrest City Hospital Corporation	
Fort Payne Clinic Corp.	
Fort Payne Home Care Corporation	
Fort Payne Hospital Corporation	d/b/a DeKalb Regional Medical Center
Fort Payne RHC Corp.	
Frankfort Health Partner, Inc.	
Franklin Clinic Corp.	
Franklin Home Care Services, LLC	
Franklin Hospital Corporation	d/b/a Southampton Memorial Hospital
Fulton Home Care Services, LLC	
Gadsden Home Care Services, LLC	
Gadsden Regional Medical Center, LLC	d/b/a Gadsden Regional Medical Center
Gadsden Regional Physician Group Practice, LLC	
Gadsden Regional Primary Care, LLC	
Galesburg Home Care Corporation	
Galesburg Hospital Corporation	d/b/a Galesburg Cottage Hospital
Galesburg In-Home Assistance, Inc.	
Galesburg Professional Services, LLC	
Gateway Malpractice Assistance Fund, Inc.	
Gateway Medical Services, Inc.	
GCMC, LLC	
GH Texas, LLC	
Granbury Hospital Corporation	d/b/a Lake Granbury Medical Center
Granbury Texas Hospital Investment Corporation	
Granite City ASC Investment Company, LLC	
Granite City Clinic Corp.	
Granite City Home Care Services, LLC	
Granite City Hospital Corporation	
Granite City Illinois Hospital Company, LLC	d/b/a Gateway Regional Medical Center
Granite City Orthopedic Physicians Company, LLC	
Granite City Physicians Corp.	
GRB Real Estate, LLC	
Great Plains Medical Foundation	
Greenbrier Valley Anesthesia, LLC	
Greenbrier Valley Emergency Physicians, LLC	
Greenbrier VMC, LLC*	d/b/a Greenbrier Valley Medical Center
Greenville Clinic Corp.	
Greenville Hospital Corporation	d/b/a L. V. Stabler Memorial Hospital
GRMC Holdings, LLC	

Gulf Coast Hospital, L.P.
Gulf Coast Medical Center, LLC
Hallmark Healthcare Company, LLC
Harris Managed Services, Inc.
Harris Medical Clinics, Inc.
Hattiesburg ASC-GP, LLC
Hattiesburg Home Care Services, LLC
Haven Clinton Medical Associates, LLC
HDP Woodland Heights, L.P.
HDP Woodland Property, LLC
HDPWH, LLC
Healthcare Group, LLC#
Healthcare of Forsyth County, Inc.
HealthTrust Purchasing Group, L.P.#
Healthwest Holdings, Inc.
Heartland Malpractice Assistance Fund, Inc.
Heartland Regional Health System, LLC
Heartland Rural Healthcare, LLC
Heck, Mourning, Smith & Barnes Partnership#
Hefner Pointe Medical Associates, LLC#
HEH Corporation
Helena Home Care Services, LLC
Hidden Valley Medical Center, Inc.
Highland Health Systems, Inc.
Hill Regional Clinic Corp.
Hill Regional Medical Group
Hobbs Medco, LLC
Hobbs Physician Practice, LLC
Hood Medical Group
Hood Medical Services, Inc.
Hospital of Barstow, Inc. d/b/a Barstow Community Hospital
Hospital of Fulton, Inc. d/b/a Parkway Regional Hospital
Hospital of Louisa, Inc. d/b/a Three Rivers Medical Center
Hospital of Morristown, Inc. d/b/a Lakeway Regional Hospital
Hot Springs Outpatient Surgery Center, G.P.
HTI Tucson Rehabilitation, Inc.
Humble Texas Home Care Corporation
Huntington Associates
INACTCO, Inc.
In-Home Assistance, L.L.C.
In-Home Medical Equipment Supplies and Services, Inc.
Inland Empire Hospital Services Association#
Inland Northwest Genetics Clinic#
Inland Northwest Health Services#
Innovative Recoveries, LLC

IOM Health System, L.P.	d/b/a Lutheran Hospital of Indiana
Jackson Home Care Services, LLC	
Jackson Hospital Corporation	d/b/a Kentucky River Medical Center
Jackson Hospital Corporation	
Jackson Physician Corp.	
Jackson, Tennessee Hospital Company, LLC	d/b/a Regional Hospital of Jackson
Jennersville Family Medicine, LLC	
Jennersville Regional Hospital Malpractice Assistance Fund, Inc.	
Jonesboro Real Property, LLC	
Jourdanton Home Care Services, LLC	
Jourdanton Hospital Corporation	d/b/a South Texas Regional Medical Center
Kay County Clinic Company, LLC	
Kay County Hospital Corporation	
Kay County Oklahoma Hospital Company, LLC	d/b/a Ponca City Medical Center
Kentucky River HBP, LLC	
Kentucky River Physician Corporation	
King's Daughters Malpractice Assistance Fund, Inc.	
Kirksville Academic Medicine, LLC	
Kirksville Clinic Corp.	
Kirksville Home Care Services, LLC	
Kirksville Hospital Company, LLC	
Kirksville Missouri Hospital Company, LLC*	d/b/a Northeast Regional Medical Center
Kirksville Physical Therapy Services, LLC	
Knox Clinic Corp.	
Kosciusko Medical Group, LLC	
Lake Area Physician Services, LLC	
Lake Area Surgicare, A Partnership in Commendam*	
Lake Wales Clinic Corp.	
Lake Wales Hospital Corporation*	d/b/a Lake Wales Medical Center
Lake Wales Hospital Investment Corporation*	
Lakeway Hospital Corporation	
Lancaster Clinic Corp.	
Lancaster Home Care Services, LLC	
Lancaster Hospital Corporation	d/b/a Springs Memorial Hospital
Lancaster Imaging Center, LLC*	
Laredo Hospital, L.P.	
Laredo Texas Hospital Company, L.P.*	d/b/a Laredo Medical Center
Las Cruces ASC-GP, LLC	
Las Cruces Medical Center, LLC	d/b/a Mountain View Regional Medical Center
Las Cruces Physician Services, LLC	
Las Cruces Surgery Center, L.P.*	
Lea Regional Hospital, LLC	d/b/a Lea Regional Medical Center
Leesville Surgery Center, LLC*	
Lexington Clinic Corp.	
Lexington Family Physicians, LLC	

Lexington Home Care Services, LLC	
Lexington Hospital Corporation	d/b/a Henderson County Community Hospital
Lindenhurst Illinois Hospital Company, LLC	
Lithotripsy Providers of Alabama, LLC#	
Lock Haven Clinic Company, LLC	
Lock Haven Home Care Services, LLC	
Lock Haven Medical Professionals, P.C.	
Logan Hospital Corporation	
Logan, West Virginia Hospital Company, LLC	
Longview Medical Center, L.P.*	d/b/a Longview Regional Medical Center
Longview Merger, LLC	
Louisa Home Care Services, LLC	
LRH, LLC	
LS Psychiatric, LLC	
Lutheran Health Network CBO, LLC	
Lutheran Health Network Investors, LLC*	
Lutheran Health Network of Indiana, LLC	
Lutheran Heart Alliance, LLC#	
Lutheran Medical Group, LLC	
Lutheran Medical Office Park Property Owners Association, Inc.#	
Lutheran Medical Office Park Phase II Property Owners Association, Inc. #	
Lutheran Musculoskeletal Center, LLC*	
Lutheran/TRMA Network, LLC#	
Macon Healthcare, LLC#	
Madison Clinic Corp.	
Madison Hospital, LLC	
Marion Hospital Corporation	d/b/a Heartland Regional Medical Center
Marlboro Clinic Corp.	
Martin Clinic Corp.	
Martin Hospital Corporation	d/b/a Volunteer Community Hospital
Mary Black Health System LLC*	d/b/a Mary Black Memorial Hospital
Mary Black Medical Office Building Limited Partnership	
Mary Black MOB II, L.P.	
Mary Black Physician Services, LLC	
Mary Black Physicians Group, LLC	
Massillon Community Health System, LLC	
Massillon Health System, LLC	
Massillon Holdings, LLC	
Mat-Su Regional ASC GP, LLC	
Mat-Su Regional Surgery Center, L.P.	
Mat-Su Valley II, LLC*	
Mat-Su Valley III, LLC*	
Mat-Su Valley Medical Center, LLC*	d/b/a Mat-Su Regional Medical Center
MCI Panhandle Surgical, L.P.	

McKenzie Clinic Corp.	
McKenzie Physician Services, LLC	
McKenzie Tennessee Hospital Company, LLC	d/b/a McKenzie Regional Hospital
McKenzie-Willamette Regional Medical Center Associates, LLC*	d/b/a McKenzie-Willamette Medical Center
McNairy Clinic Corp.	
McNairy Hospital Corporation	d/b/a McNairy Regional Hospital
MCSA, L.L.C.	
Med-100 Transitional Limited Partnership#	
Medical Center at Terrell, LLC	
Medical Center of Brownwood, LLC	
Medical Center of Sherman, LLC	
Medical Diagnostic Center Associates, LP#	
Medical Holdings, Inc.	
MEDSTAT, LLC	
Memorial Hospital of Salem Malpractice Assistance Fund, Inc.	
Memorial Hospital, LLC	
Memorial Management, Inc.	
Merger Legacy Holdings, LLC	
Mesa View Physical Rehabilitation, LLC#	
Mesa View PT, LLC	
Mesquite Clinic Management Company, LLC	
MHS Ambulatory Surgery Center, Inc.	
Mid-America Health Partners, Inc.#	
Mid-Plains, LLC	
Minot Health Services, Inc.	
Mission Bay Memorial Hospital, LLC	
MMC of Nevada, LLC	d/b/a Mesa View Regional Hospital
Moberly HBP Medical Group, LLC	
Moberly Hospital Company, LLC	d/b/a Moberly Regional Medical Center
Moberly Medical Clinics, Inc.	
Moberly Physicians Corp.	
Mohave Imaging Center, LLC	
Morristown Clinic Corp.	
Morristown Professional Centers, Inc.	
Morristown Surgery Center, LLC	
MWMC Holdings, LLC	
National Healthcare of England Arkansas, Inc.	
National Healthcare of Holmes County, Inc.	
National Healthcare of Leesville, Inc.	d/b/a Byrd Regional Hospital
National Healthcare of Mt. Vernon, Inc.	d/b/a Crossroads Community Hospital
National Healthcare of Newport, Inc.	d/b/a Harris Hospital
Navarro Hospital, L.P.	d/b/a Navarro Regional Hospital
Navarro Regional, LLC	
NC-CSH, Inc.	
NC-DSH, LLC	

NeuroSpine-Pain Surgery Center, LLC#	
Newport Home Care Services, LLC	
NHCI of Hillsboro, Inc.	d/b/a Hill Regional Hospital
North Okaloosa Clinic Corp.	
North Okaloosa Home Health Corp.	
North Okaloosa Medical Corp.*	
North Okaloosa Surgery Venture Corp.	
Northampton Clinic Company, LLC	
Northampton Home Care, LLC	
Northampton Hospital Company, LLC	d/b/a Easton Hospital
Northampton Physician Services Corp.	
Northampton Urgent Care, LLC	
Northeast Medical Center, L.P.	
Northern Indiana Oncology Center of Porter Memorial Hospital, LLC*	
Northwest Allied Physicians, LLC	
Northwest Arkansas Employees, LLC	
Northwest Arkansas Hospitals, LLC*	d/b/a Northwest Medical Center — Bentonville; Northwest Medical Center — Springdale; Willow Creek Women's Hospital
Northwest Benton County Physician Services, LLC	
Northwest Hospital, LLC	d/b/a Northwest Medical Center
Northwest Indiana Health System, LLC*	
Northwest Marana Hospital, LLC	
Northwest Medical Center CT/MRI at Marana, LLC#	
Northwest Physicians, LLC	
Northwest Rancho Vistoso Imaging Services, LLC	
Northwest Tucson ASC-GP, LLC	
Northwest Tucson Surgery Center, L.P.*	
NOV Holdings, LLC	
NRH, LLC	
Oak Hill Clinic Corp.	
Oak Hill Hospital Corporation	d/b/a Plateau Medical Center
Ohio Sleep Disorders Centers, LLC#	
Oklahoma City ASC-GP, LLC	
Oklahoma City Home Care Services, LLC	
Oklahoma City Surgery Center, L.P.	
Olive Branch Clinic Corp.	
Olive Branch Hospital, Inc.	
Palm Drive Medical Center, LLC	
Palmer-Wasilla Health System, LLC	
Palmetto Women's Care, LLC	
Pampa Hospital, L.P.	
Pampa Medical Center, LLC	
Palm Drive Medical Center, LLC	

Palmer-Wasilla Health System, LLC	
Palmetto Women's Care, LLC	
Pampa Hospital, L.P.	
Pampa Medical Center, LLC	
Panhandle Medical Center, LLC	
Panhandle Property, LLC	
Panhandle Surgical Hospital, L.P.	
Panhandle, LLC	
Parkway Regional Medical Clinic, Inc.	
Payson Healthcare Management, Inc.	
Payson Home Care Services, LLC	
Payson Hospital Corporation	d/b/a Payson Regional Medical Center
PDMC, LLC	
Pecos Valley of New Mexico, LLC	
Peerless Healthcare, LLC	
Pennsylvania Hospital Company, LLC	
Pennsylvania Medical Professionals, P.C.	
Petersburg Clinic Company, LLC	
Petersburg Home Care Services, LLC	
Petersburg Hospital Company, LLC*	d/b/a Southside Regional Medical Center
Phillips & Coker OB-GYN, LLC	
Phillips Clinic Corp.	
Phillips Hospital Corporation	d/b/a Helena Regional Medical Center
Phoenix Surgical, LLC	
Phoenixville Clinic Company, LLC	
Phoenixville Hospital Company, LLC	d/b/a Phoenixville Hospital
Phoenixville Hospital Malpractice Assistance Fund, Inc.	
Physician Practice Support, Inc.	
Physicians and Surgeons Hospital of Alice, L.P.	
Physicians' Surgery Center of Florence, LLC	
Piney Woods Healthcare System, L.P.*	d/b/a Woodland Heights Medical Center
Plymouth Hospital Corporation	
Polk Medical Services, Inc.	
Ponca City Home Care Services, Inc.	
Porter County Endoscopy Center, LLC#	
Porter Health Services, LLC	
Porter Hospital, LLC*	d/b/a Porter Hospital
Porter Physician Services, LLC	
Pottstown Clinic Company, LLC	
Pottstown Home Care Services, LLC	
Pottstown Hospital Company, LLC	d/b/a Pottstown Memorial Medical Center
Pottstown Hospital Corporation	
Pottstown Imaging Company, LLC	
Pottstown Memorial Malpractice Assistance Fund, Inc.	
PremierCare of Arkansas, LLC#	

PremierCare of Northwest Arkansas, LLC*	
Premier Care Super PHO, LLC	
Procure Solutions, LLC	
Professional Account Services Inc.	
QHG Georgia Holdings, Inc.	
QHG Georgia Holdings II, LLC	
QHG Georgia, L.P.	
QHG of Barberton, Inc.	
QHG of Bluffton Company, LLC	
QHG of Clinton County, Inc.	
QHG of Enterprise, Inc.	d/b/a Medical Center Enterprise
QHG of Forrest County, Inc.	
QHG of Fort Wayne Company, LLC	
QHG of Hattiesburg, Inc.	
QHG of Kenmare, Inc.	
QHG of Lake City, Inc.	
QHG of Massillon, Inc.	
QHG of Minot, Inc.	
QHG of Ohio, Inc.	
QHG of South Carolina, Inc.	d/b/a Carolinas Hospital System
QHG of Spartanburg, Inc.	
QHG of Springdale, Inc.	
QHG of Texas, Inc.	
QHG of Warsaw Company, LLC	
QHR Intensive Resources, LLC	
QHR International, LLC	
Quorum ELF, Inc.	
Quorum Health Resources, LLC	
Quorum Health Resources Equity Management Solutions, LLC	
Quorum Health Services, Inc.	
Red Bud Clinic Corp.	
Red Bud Home Care Services, LLC	
Red Bud Hospital Corporation	
Red Bud Illinois Hospital Company, LLC	d/b/a Red Bud Regional Hospital
Red Bud Physician Group, LLC	
Regional Cancer Treatment Center, Ltd.#	
Regional Employee Assistance Program	
Regional Hospital of Longview, LLC	
Rehab Hospital of Fort Wayne General Partnership	
River Region Medical Corporation	
River to River Heart Group, LLC	
Riverside MSO, LLC#	
Rockwood Clinic, P.S.*	
Rockwood Clinic Real Estate Holdings, LLC	
Ronceverte Physician Group, LLC	

Roswell Clinic Corp.	
Roswell Community Hospital Investment Corporation	
Roswell Hospital Corporation	d/b/a Eastern New Mexico Medical Center
Russell County Clinic Corp.	
Russell County Medical Center, Inc.	
Ruston Clinic Company, LLC	
Ruston Hospital Corporation	
Ruston Louisiana Hospital Company, LLC	d/b/a Northern Louisiana Medical Center
SACMC, LLC	
Salem Clinic Corp.	
Salem Home Care Services, LLC	
Salem Hospital Corporation	d/b/a The Memorial Hospital of Salem County
Salem Medical Professionals, P.C.	
Samaritan Surgicenters of Arizona II, LLC	
San Angelo Ambulatory Surgery Center, Ltd.#	
San Angelo Community Medical Center, LLC	
San Angelo Hospital, L.P.#	d/b/a San Angelo Community Medical Center
San Angelo Medical, LLC	
San Diego Hospital, L.P.	
San Leandro, LLC	
San Leandro Hospital, L.P.	
San Leandro Medical Center, LLC	
San Leandro Surgery Center, Ltd.#	
San Miguel Clinic Corp.	
San Miguel Hospital Corporation	d/b/a Alta Vista Regional Hospital
Scenic Managed Services, Inc.	
Schuylkill Internal Medicine Associates, LLC	
SDH, LLC	
Sebastopol, LLC	
Senior Circle Association	
Shelby Alabama Real Estate, LLC	
Shelbyville Clinic Corp.	
Shelbyville Home Care Services, LLC	
Shelbyville Hospital Corporation	d/b/a Heritage Medical Center
Sherman Hospital, L.P.	
Sherman Medical Center, LLC	
Siloam Springs Arkansas Hospital Company, LLC	d/b/a Siloam Springs Memorial Hospital
Siloam Springs Clinic Company, LLC	
Siloam Springs Holdings, LLC	
Silsbee Doctors Hospital, L.P.	
Silsbee Medical Center, LLC	
Silsbee Texas, LLC	
Silver Creek MRI, LLC*	
SJ Home Care, LLC	
SkyRidge Clinical Associates, LLC	

SLH, LLC	
SMMC Medical Group	
Software Sales Corp.	
South Alabama Managed Care Contracting, Inc.	
South Alabama Medical Management Services, Inc.	
South Alabama Physician Services, Inc.	
South Arkansas Clinic, LLC	
South Arkansas Physician Services, LLC	
South Tulsa Medical Group, LLC	
SouthCrest Anesthesia Group, LLC	
SouthCrest Medical Group, LLC	
SouthCrest Surgery Center, L.P.*	
SouthCrest, L.L.C.	d/b/a SouthCrest Hospital
Southeast Alabama Maternity Center, LLC#	
Southern Chester County Medical Building I#	
Southern Chester County Medical Building II#	
Southern Illinois Medical Care Associates, LLC	
Southern Texas Medical Center, LLC	
Southside Physician Network, LLC	
Spheris Holding III, Inc.#	
Spokane Valley Washington Hospital Company, LLC	d/b/a Valley Hospital and Medical Center
Spokane Washington Hospital Company, LLC	d/b/a Deaconess Medical Center
Springdale Home Care Services, LLC	
Springfield Oregon Holdings, LLC	
Sprocket Medical Management, LLC	
St. Joseph Health System, LLC	d/b/a St. Joseph Health System
St. Joseph Medical Group, Inc.	
StrokeCareNow, LLC#	
Summerlin Hospital Medical Center, LLC#	
Summit Surgical Suites, LLC#	
Sunbury Clinic Company, LLC	
Sunbury Hospital Company, LLC*	d/b/a Sunbury Community Hospital
Surgical Center of Amarillo, LLC	
Surgical Center of Carlsbad, LLC	
Surgicare of Independence, Inc.	
Surgicare of San Leandro, Inc.	
Surgicare of Sherman, Inc.	
Surgicare of Victoria, Inc.	
Surgicare of Victoria, Ltd.	
Surgicare Outpatient Center of Lake Charles, Inc.	
Surgicenter of Johnson County, Inc.	
Surgicenters of America, Inc.	
Tennyson Holdings, LLC	
Terrell Hospital, L.P.	
Terrell Medical Center, LLC	

The Surgery Center of Salem County, L.L.C.*	
The Vicksburg Clinic, LLC	
Three Rivers Medical Clinics, Inc.	
Timberland Medical Group	
Tooele Clinic Corp.	
Tooele Home Care Services, LLC	
Tooele Hospital Corporation	d/b/a Mountain West Medical Center
Triad Corporate Services, Limited Partnership	
Triad CSGP, LLC	
Triad CSLP, LLC	
Triad Healthcare Corporation	
Triad Healthcare System of Phoenix, L.P.	
Triad Holdings III, LLC	
Triad Holdings IV, LLC	
Triad Holdings V, LLC	
Triad Holdings VI, Inc.	
Triad Indiana Holdings, LLC	
Triad Nevada Holdings, LLC	
Triad of Alabama, LLC	d/b/a Flowers Hospital
Triad of Arizona (L.P.), Inc.	
Triad of Oregon, LLC	
Triad of Phoenix, Inc.	
Triad RC, Inc.	
Triad Texas, LLC	
Triad-Arizona I, Inc.	
Triad-ARMC, LLC	
Triad-Denton Hospital GP, LLC	
Triad-Denton Hospital, L.P.	
Triad-El Dorado, Inc.	
Triad-Medical Center at Terrell Subsidiary, LLC	
Triad-Navarro Regional Hospital Subsidiary, LLC	
Triad-South Tulsa Hospital Company, Inc.	
Triad-Willow Creek, LLC	
Tri-Irish, Inc.	
Tri-World, LLC	
TROSCO, LLC	
Troy Hospital Corporation	
Tuscora Park Medical Specialists, LLC	
Valley Advanced Imaging, LLC#	
Valley Advanced MRI, LLC#	
Valley Health System, LLC#	
Vanderbilt-Gateway Cancer Center, G.P.#	
VHC Holdings, LLC	
VHC Medical, LLC	
Vicksburg Healthcare, LLC	d/b/a River Region Medical Center

Vicksburg Surgical Center, LLC	
Victoria Hospital, LLC	
Victoria of Texas, L.P.	d/b/a DeTar Hospital Navarro; DeTar Hospital North
Victoria Texas Home Care Services, LLC	
Village Medical Center Associates, LLC	
Virginia Hospital Company, LLC	
WA-SPOK DH CRNA, LLC	
WA-SPOK DH Urgent Care, LLC	
WA-SPOK Kidney Care, LLC	
WA-SPOK Medical Care, LLC	
WA-SPOK Primary Care, LLC	
WA-SPOK Pulmonary & Critical Care, LLC	
WA-SPOK VH CRNA, LLC	
WA-SPOK VH Urgent Care, LLC	
WAMC, LLC	
Warsaw Health System, LLC*	d/b/a Kosciusko Community Hospital
Washington Clinic Corp.	
Washington Hospital Corporation	
Washington Physician Corp.	
Watsonville Hospital Corporation	d/b/a Watsonville Community Hospital
Waukegan Clinic Corp.	
Waukegan Hospice Corp.	
Waukegan Hospital Corporation	
Waukegan Illinois Hospital Company, LLC	d/b/a Vista Medical Center East; Vista Medical Center West
Weatherford Home Care Services, LLC	
Weatherford Hospital Corporation	
Weatherford Texas Hospital Company, LLC	d/b/a Weatherford Regional Medical Center
Webb County Texas Home Care Services, LLC	
Webb Hospital Corporation	
Webb Hospital Holdings, LLC	
Wesley Health System, LLC	d/b/a Wesley Medical Center
Wesley HealthTrust, Inc.	
Wesley Physician Services, LLC	
West Anaheim Hospital, L.P.	
West Anaheim Medical Center, LLC	
West Anaheim, LLC	
West Grove Clinic Company, LLC	
West Grove Family Practice, LLC	
West Grove Home Care, LLC	
West Grove Hospital Company, LLC	d/b/a Jennersville Regional Hospital
West Virginia MS, LLC	
Western Arizona Regional Home Health and Hospice, Inc.	
Western Illinois Kidney Center, L.L.C.#	
Wharton Medco, LLC	

WHMC, LLC	
Wichita Falls Texas Home Care Corporation	
Wichita Falls Texas Private Duty Corporation	
Wilkes-Barre Academic Medicine, LLC	
Wilkes-Barre ASC, L.P.*	
Wilkes-Barre ACC Management, L.L.C.*	
Wilkes-Barre Behavioral Hospital Company, LLC	
Wilkes-Barre Behavioral Ventures, LLC	
Wilkes-Barre Holdings, LLC	
Wilkes-Barre Home Care Services, LLC	
Wilkes-Barre Hospital Company, LLC	d/b/a Wilkes-Barre General Hospital
Wilkes-Barre Personal Care Services, LLC	
Wilkes-Barre Skilled Nursing Services, LLC	
Willamette Community Medical Group, LLC	
Williamston Clinic Corp.	
Williamston Hospital Corporation	d/b/a Martin General Hospital
Women & Children's Hospital, LLC	d/b/a Women & Children's Hospital
Women's Health Care Associates of Phoenixville, LLC	
Woodland Heights Medical Center, LLC	
Woodward Clinic Company, LLC	
Woodward Health System, LLC	d/b/a Woodward Hospital
Woodward Home Care Services, LLC	

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement No. 333-156405 on Form S-3 and Registration Statement Nos. 333-100349, 333-61614, 333-44870, 333-107810, 333-121282, 333-121283, 333-144525, 333-163688, 333-163689, 333-163690 and 333-163691 on Form S-8 of our reports dated February 25, 2010 (which reports express an unqualified opinion and include explanatory paragraphs related to the adoption of accounting standards), relating to the consolidated financial statements and financial statement schedule of Community Health Systems, Inc. and subsidiaries, and the effectiveness of Community Health Systems, Inc. and subsidiaries' internal control over financial reporting, appearing in this Annual Report on Form 10-K of Community Health Systems, Inc. and subsidiaries for the year ended December 31, 2009.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 25, 2010

Exhibit 31.1

I, Wayne T. Smith, certify that:

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

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

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

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

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

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

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

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

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

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

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

/s/ Wayne T. Smith
Wayne T. Smith
Chairman of the Board, President
and Chief Executive Officer

Date: February 25, 2010

Exhibit 31.2

I, W. Larry Cash, certify that:

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

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

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

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

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

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

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

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

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

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

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

/s/ W. Larry Cash
W. Larry Cash
Executive Vice President,
Chief Financial Officer and Director

Date: February 25, 2010

Exhibit 32.1

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

In connection with the Annual Report of Community Health Systems, Inc. (the "Company") on Form 10-K for the period ending December 31, 2009, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Wayne T. Smith, Chairman of the Board, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ WAYNE T. SMITH
Wayne T. Smith
Chairman of the Board, President
and Chief Executive Officer

February 25, 2010

Exhibit 32.2

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

In connection with the Annual Report of Community Health Systems, Inc. (the "Company") on Form 10-K for the period ending December 31, 2009, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, W. Larry Cash, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ W. LARRY CASH
W. Larry Cash
Executive Vice President,
Chief Financial Officer and Director

February 25, 2010

VISTA - WAUKEGAN, IL 0286
INCOME STATEMENT D-57
FOR 12TH MONTH ENDED
DECEMBER 31, 2009

DATE: 3/17/10
TIME: 10:46:31

	THIS YEAR 2009				LAST YEAR 2008			
	CURRENT	% BASE	YEAR-TO-DATE	% BASE	CURRENT	% BASE	YEAR-TO-DATE	% BASE
TOTAL PATIENT DAYS BY PAYOR	5,165	**	61,799	**	4,907	**	63,238	**
AVERAGE DAILY CENSUS	166.6	**	169.3	**	158.3	**	172.8	**
Patient Revenue:	$		$		$		$	
Inpatient Routine	9,381,822	**	108,470,213	**	8,215,325	**	99,833,200	**
Inpatient Ancillary	35,696,180	**	377,172,031	**	28,392,735	**	327,963,258	**
Outpatient	28,816,880	**	335,652,008	**	26,750,265	**	297,117,132	**
Total Patient Revenue	73,894,882	**	821,294,252	**	63,358,325	**	724,913,590	**
Deductions From Revenue:								
I/P - M/M Contractual	24,361,553	**	244,852,878	**	16,910,993	**	208,442,287	**
O/P - M/M Contractual	12,405,769	**	141,030,839	**	11,969,584	**	108,405,020	**
Other Contractual Adj.	20,277,275	**	242,800,605	**	20,156,673	**	221,011,236	**
Courtesy Discounts	2,279	**	20,206	**	86	**	28,258	**
Total Deductions From Revenue	57,046,876	**	628,704,528	**	49,037,336	**	537,886,801	**
Net Patient Revenue	16,848,006	**	192,589,724	**	14,320,989	**	187,026,789	**
Other Revenue	71,626	**	2,512,828	**	132,619	**	2,091,207	**
Net Revenue	16,919,632	**	195,102,552	**	14,453,608	**	189,117,996	**
Operating Expenses:								
Salaries & Wages	4,603,823	**	59,597,735	**	4,409,790	**	58,328,838	**
Benefits	901,500	**	11,947,289	**	795,284	**	10,703,496	**
Contract Labor	18,099	**	1,124,935	**	79,781	**	1,636,700	**
Provision for Bad Dbt	4,222,032	**	26,350,840	**	1,905,640	**	17,335,366	**
Supplies	2,070,079	**	23,987,764	**	1,896,622	**	23,552,510	**
Medical Spec Fees	469,500	**	2,867,202	**	317,232	**	5,335,523	**
Purchased Services	1,556,775	**	18,094,070	**	1,673,327	**	17,858,461	**
Physician Recruiting	8,696	**	10,539	**	00	**	257	**
Repairs & Maintenance	353,142	**	4,143,544	**	328,833	**	3,325,917	**
Marketing	19,821	**	1,039,670	**	189,871	**	1,413,230	**
Utilities	288,577	**	2,641,049	**	305,402	**	3,413,427	**
Other Operating Exp	280,866	**	2,682,740	**	237,099	**	2,489,605	**
Prop Taxes & Ins	1,094,663	**	14,982,109	**	1,045,797	**	14,427,954	**
Total Operating Expenses	15,887,773	**	169,469,486	**	13,184,678	**	159,821,284	**
Operating Margin	1,031,859	**	25,633,066	**	1,268,930	**	29,296,712	**
Rent	239,898	**	2,545,174	**	173,023	**	1,778,851	**
E.B.I.T.D.A.	791,961	**	23,087,892	**	1,095,907	**	27,517,861	**
Depreciation and Amortization	679,547	**	7,874,640	**	627,483	**	7,309,340	**
E.B.I.T.	112,414	**	15,213,252	**	468,424	**	20,208,521	**
Interest	215,803	**	2,521,891	**	422,480	**	5,286,000	**
Pre-Tax Profit	$ (103,389)	**	$ 12,691,361	**	$ 45,944	**	$ 14,922,521	**
Corp Mgmt Fees	649,916	**	4,906,377	**	386,951	**	4,643,413	**
TOTAL SURGERIES	1,095	**	13,369	**	1,195	**	14,128	**
TOTAL ADMISSIONS	1,111	**	13,828	**	1,089	**	13,729	**
TOTAL DELIVERIES	132	**	1,831	**	160	**	1,958	**
TOTAL O/P REGS INCL ALL VISITS	15,929	**	171,977	**	11,756	**	150,875	**
TOTAL E.R. VISITS	3,985	**	52,795	**	4,020	**	48,487	**
TOTAL CLINIC AND RHC VISITS	6,075	**	49,352	**	2,556	**	36,028	**
Total Paid Hours	170,605	**	1,987,547	**	189,291	**	2,027,615	**
Total Contract Hours	246	**	12,111	**	1,832	**	25,751	**
Total Paid & Contract Hours	170,851	**	1,999,658	**	191,122	**	2,053,366	**
TOTAL PAID & CONTRACT FTE's	965.26	**	959.99	**	1,079.79	**	983.41	**

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VISTA - WAUKEGAN, IL 0286

BALANCE SHEET : B-77

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DECEMBER 31, 2009

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ASSETS	THIS YEAR 2009	LAST YEAR 2008
Current Assets:		
Cash and cash equivalents	$ (1,283,771)	$ (1,795,259)
Patient accounts receivable	44,431,617	42,530,820
Less: Allowance for bad debts	(12,426,015)	(5,863,078)
Prior yr cst rpt settlemt a/r	(11,485,632)	(16,983,888)
Supplies	3,352,050	3,569,284
Prepaid expenses	1,881,173	1,096,209
Other current assets	189,124	145,463
Total Current Assets	24,658,546	22,699,551
Property & Equipment, at cost:		
Land and improvements	22,260,196	22,172,432
Buildings and improvements	68,367,924	62,527,664
Equipment and fixtures	32,430,801	27,450,462
Construction in progress	00	10,910
	123,058,921	112,161,468
Less accumulated depreciation and amortization	(19,526,310)	(13,169,892)
Net Property and Equipment	103,532,611	98,991,576
Other Assets:		
Goodwill	1,356,506	480,509
Physician recruitment costs	214,119	198,406
Defered MIS charges	994,074	1,676,467
Other deferred charges	121,884	875,439
Total Other Assets	2,686,583	3,230,821
	$ 130,877,740	$ 124,921,948

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VISTA - WAUKEGAN, IL 0286

BALANCE SHEET : B-77

AT

DECEMBER 31, 2009

DATE: 3/17/10
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	THIS YEAR	LAST YEAR
LIABILITIES		
Current Liabilities:		
Current maturities of		
Accounts payable	13,705,491	5.960,278
Accrued liabilities:		
Employee compensation	6,615,876	5,244,962
Other accrued liabilities	2,191,707	2,363,640
Total Current Liabilities	22,513,074	13,568,880
Deferred Credits and		
Intercompany Accounts	76,515,820	87,289,204
Stockholders' Equity:		
Acc. earnings-prior year	24,063,863	13,784,756
Acc. earnings-current year	7,784,983	10,279,108
Total Stockholders' Equity	31,848,846	24,063,864
	$ 130,877,740	$ 124,921,948

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Confidential Information Not To Be Distributed Publicly

Community Health Systems, Inc.
Lindenhurst ER CON
Financial Viability Ratios Under Proposed Amended Section 1120.130

	Projected 2012	Actual 2009	Actual 2008	Actual 2007
Current Ratio	Over 1.5	1.83	1.73	1.76
Net Margin Percentage	> 2.50%	2.01%	2.00%	0.43%
Percent Debt to Capitalization	Under 75%	81%	84%	84%
Debt Service Coverage	> 2.0	2.04	2.00	1.84
Days Cash on Hand	15	35	34	49
Cushion Ratio	0 - 2	0.53	0.34	0.37
Current Assets	Confidential	2,674,995	2,605,050	2,552,898
Current Liabilities	Confidential	1,457,796	1,509,417	1,447,935
Net Income Attributable to Community Health Systems, Inc.		243,150	218,304	30,289
Net Revenue	Confidential	12,107,613	10,919,095	7,095,861
Long-Term Debt	Confidential	8,844,638	8,938,185	9,077,367
Scheduled Principal Payments	Confidential	66,470	33,904	20,710
Stockholders' Equity	Confidential	2,015,417	1,672,486	1,710,804
Net Income	Confidential	243,150	218,304	30,289
Depreciation and Amortization	Confidential	566,211	499,386	313,322
Interest	Confidential	648,964	652,468	362,065
Cash	Confidential	344,541	220,655	133,574
Board Designated Funds		-	-	-
"Line of Credit" Revolver Available	Confidential	659,995	656,418	714,461
LOCs as of 12/31	Confidential	90,005	93,582	35,539
Operating Expense	Confidential	11,038,948	9,947,215	6,624,249
Depreciation and Amortization	Confidential	566,211	499,386	313,322
Cash	Confidential	344,541	220,655	133,574

Note 1: Historical financial data from 2009 form 10-K

Note 2: CHS acquired Triad Hospitals, Inc. on July 25, 2007 for approximately $7.0 billion (including the assumption of $1.7 billion of existing indebtedness)

Note 3: CHS is projected to have ample bank covenant cushions in future years and has committed borrowing capacity in the form of a $750 million revolving credit facility

VIABILITY RATIO CALCULATIONS
WAUKEGAN ILLINOIS HOSPITAL COMPANY

	2007	2008	2009	2012
Current Ratio	**3.71**	**1.67**	**1.10**	**3.31**
Current Assets	46,483,631	22,699,551	24,658,546	33,068,400
Current Liabilities	12,525,412	13,568,880	22,513,074	9,976,404
Net Margin Percentage	**15.3%**	**14.7%**	**11.8%**	**19.2%**
Net Income	27,731,995	27,517,861	23,087,892	46,469,539
Net Operating Revenue	181,302,035	187,117,996	195,102,552	241,745,175
Percent Debt to Total Capitalization	**at corporate**	**at corporate**	**at corporate**	**at corporate**
Long Term Debt	X	X	X	X
Unrestricted Fund Balance	X	X	X	X
Projected Debt Service Coverage	**at corporate**	**at corporate**	**at corporate**	**at corporate**
Net Income	27,731,995	27,517,861	23,087,892	46,469,539
Depreciation	6,505,011	7,309,340	7,874,640	7,870,427
Interest	5,989,771	5,286,000	2,521,891	6,991,680
Long Term Debt	X	X	X	X
Interest	5,989,771	5,286,000	2,521,891	6,991,680
Days of Cash on Hand*	**0**	**0**	**0**	**0**
Cash & Investments				
Bd. Designated Funds				
Operating Expense				
Depreciation				
Cushion Ratio	**at corporate**	**at corporate**	**at corporate**	**at corporate**
Cash & Investments				
Bd. Designated Funds				
Maximum Debt Service				

*swept to corporate

COST AND GROSS S.F. BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	TOTAL
	Cost/ Sq. Foot		Gross Sq. Feet		Gross Sq. Feet		Const. $	Mod. $	
	New	Modern	New	Circ.	Mod.	Circ.	(AxC)	(BxE)	(G+H)
Reviewable									
Emergency	$352.00		4,235				$1,490,720.00		$1,490,720.00
Non-Reviewable									
EMS Office	$352.00		112				$39,424.00		$39,424.00
Public/General Circ.	$352.00	$240.00	824		384		$290,048.00	$92,160.00	$382,208.00
Ambulance Garage	$352.00		1510				$531,520.00		$531,520.00
							$860,992.00	$92,160.00	$953,152.00
Total	$352.00		2446				$2,351,712.00	$92,160.00	$2,443,872.00
Contingency	$23.00	$20.00					$153,663.00	$7,680.00	$161,343.00
PROJECT TOTAL	**$375.00**	**$260.00**	**6,681**		**384**		$2,505,375.00	$99,840.00	$2,605,215.00

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OPERATING AND CAPITAL COSTS PER TREATMENT
YEAR 2 OF OPERATION

OPERATING COSTS					
					FEC
	salaries				$1,601,523
	benefits				$320,305
	supplies				$303,797
	TOTAL				$2,225,625
	Treatments (visits)		12,731		
	Operating cost/treatment				**$174.82**
CAPITAL COSTS					
	interest				$244,275
	depreciation & amortization				$244,005
	TOTAL				$488,280
	Treatments (visits)		12,731		
	Capital cost per treatment				**$38.35**

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