COMMUNITY HEALTH SYSTEMS INC
Form 10-K
February 29, 2008

Table of Contents

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

Form 10-K

(Mark One)

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the year ended December 31, 2007

OR

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission file number 001-15925

COMMUNITY HEALTH SYSTEMS, INC.
(Exact name of registrant as specified in its charter)

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

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

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 þ NO o

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. þ

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

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

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.

TABLE OF CONTENTS

FORM 10-K ANNUAL REPORT

COMMUNITY HEALTH SYSTEMS, INC.
Year ended December 31, 2007

Table of Contents

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

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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

Table of Contents

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

Table of Contents

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

Table of Contents

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.

Table of Contents

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	

Table of Contents

(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.

Table of Contents

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%

Table of Contents

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

Table of Contents

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,

Table of Contents

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.

Table of Contents

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.

Table of Contents

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

Table of Contents

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

Table of Contents

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

Table of Contents

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

Table of Contents

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.

Table of Contents

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;

Table of Contents

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

Table of Contents

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.

Table of Contents

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

Table of Contents

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.

Table of Contents

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 statem involve known and unknown risks, uncertainties, and other

Table of Contents

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

Table of Contents

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

Table of Contents

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				

Table of Contents

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

Table of Contents

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

Table of Contents

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

Table of Contents

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.

Table of Contents

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

Table of Contents

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.

Table of Contents

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

Table of Contents

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

Table of Contents

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

Table of Contents

(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

Table of Contents

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.

Table of Contents

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.

Table of Contents

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

Table of Contents

(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.

Table of Contents

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

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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

Table of Contents

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.

Table of Contents

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

Table of Contents

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.

Table of Contents

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

Table of Contents

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.

Table of Contents

Item 8. ***Financial Statements and Supplementary Data.***

Index to Financial Statements

Table of Contents

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

Table of Contents

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.

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

	December 31, 2007	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.

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS EQUITY

	Common Stock		Additional Paid-in	Treasury Stock		Unearned	Accumulated Other Comprehensive	Retained Earnings (Accumulated	
	Shares	Amount	Capital	Shares	Amount	Compensation	Income (Loss)	Deficit)	Tot
	(In thousands, except share data)								
December 31,	88,591,733	$ 886	$ 1,047,888	(975,549)	$ (6,678)	$	$ 6,046	$ 191,849	$ 1,23
ive Income:									
								167,544	16
n fair value of swaps, net of of $5,019							8,923		
n fair value of sale securities							222		
ehensive							9,145	167,544	17
of common	(2,239,700)	(22)	(79,830)						(7
ommon stock n with the ptions	3,134,721	31	49,543						4
ommon stock n with the f convertible	4,495,083	44	148,576						14
ock grant rom exercise	558,000	6	18,160			(18,160)			
			24,453						2
compensation us			140			4,956			
December 31,	94,539,837	$ 945	$ 1,208,930	(975,549)	$ (6,678)	$ (13,204)	$ 15,191	$ 359,393	$ 1,56
ive Income:									
								168,263	16
n fair value of swaps, net of f $931							(1,654)		(
n fair value of sale securities							562		

ehensive									
							(1,092)	168,263	16
o adopt FASB . 158, net of f $5,465							(8,301)		(
of common	(5,000,000)	(50)	(176,265)						(17
ommon stock n with the ptions	867,833	9	14,564						1
ommon stock n with the f convertible	4,074,510	41	137,157						13
rom exercise			4,750						
compensation ion of ck n	544,314	5	20,068 (13,257)			13,204			2
December 31,	95,026,494	$ 950	$ 1,195,947	(975,549)	$ (6,678)	$	$ 5,798	$ 527,656	$ 1,72
ive Income:									
								30,289	3
n fair value of swaps, net of f $51,223							(91,063)		(9
n fair value of sale securities							237		
o pension of tax benefit							3,291		
ehensive							(87,535)	30,289	(5
ommon stock n with the ptions	321,535	3	8,362						
rom exercise			(2,760)						(
compensation	1,263,056	13	38,759						3
December 31,	96,611,085	$ 966	$ 1,240,308	(975,549)	$ (6,678)	$	$ (81,737)	$ 557,945	$ 1,71

See notes to consolidated financial statements.

Table of Contents

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.

Table of Contents

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,

Table of Contents

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

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

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

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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.

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

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.

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

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

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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.

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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.

Table of Contents

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,

Table of Contents

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.

Table of Contents

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

Table of Contents

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.

Table of Contents

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.

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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

Table of Contents

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%

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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

Table of Contents

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.

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

6. Long-Term Debt

Long-term debt consists of the following (in thousands):

	As of December 31, 2007	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).

Table of Contents

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

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 61/2% 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

Table of Contents

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:

Redemption

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

Table of Contents

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

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.