COMMUNITY HEALTH SYSTEMS INC
Form 10-K
February 20, 2007

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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, 2006

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, or a non-accelerated filer. See definition of accelerated filer and large accelerated filer in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer þ Accelerated filer o Non-accelerated filer 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 $3,486,004,305. Market value is determined by reference to the closing price on June 30, 2006 of the Registrant s Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2006) have any non-voting common stock outstanding. As of February 1, 2007, there were 94,067,133 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 2006 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, 2006.

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FORM 10-K ANNUAL REPORT

COMMUNITY HEALTH SYSTEMS, INC.
Year ended December 31, 2006

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PART I

Item 1. *BUSINESS OF COMMUNITY HEALTH SYSTEMS*

Overview of Our Company

We are the largest non-urban provider of general hospital healthcare services in the United States in terms of number of facilities and net operating revenues. As of December 31, 2006, we owned, leased or operated 77 hospitals, geographically diversified across 22 states, with an aggregate of 9,117 licensed beds. We generate revenues by providing a broad range of general hospital healthcare services to patients in the communities in which we are located. Services provided by our hospitals include emergency room services, general 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, home health agencies and ambulatory surgery centers. Through our corporate ownership and operation of these businesses we provide: standardization and centralization of operations across key business areas; a strategic direction to expand and improve services and facilities at our hospitals; implementation of a disciplined acquisition program; implementation of quality of care improvement programs and assistance in the recruitment of additional physicians to the markets in which our hospitals are located.

Our strategy also includes growth by acquisition. We target hospitals in growing, non-urban healthcare markets for acquisition because of their favorable demographic and economic trends and competitive conditions. Because non-urban service areas have smaller populations, there are generally fewer hospitals and other healthcare service providers in these communities and generally a lower level of managed care presence in these markets. We believe that smaller populations support less direct competition for hospital-based services. Also, we believe that non-urban communities generally view the local hospital as an integral part of the community.

Available Information

Our Internet address is www.chs.net and the investor relations section of our website is located at www.chs.net/investor.relations. We make available free of charge, through the investor relations section of our website, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K as well as amendments to those reports, as soon as reasonably practical after they are filed with 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 2006 Annual CEO certification regarding our compliance with the NYSE s corporate governance listing standards as required by NYSE Rule 303A.

Our Business Strategy

With the objective of increasing shareholder value, the key elements of our business strategy are to:

increase revenue at our facilities;

grow through selective acquisitions;

improve profitability; and

improve quality.

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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/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. When we acquire a hospital, 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 300 in 2006, 290 in 2005 and 270 in 2004. The percentage of recruited or other physicians commencing practice with us that were specialists was over 60% in 2006. Although in recent years we have begun employing more physicians, most of our physicians are in private practice in their communities and thus 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 urban areas. These physicians are generally able to earn incomes comparable to incomes earned by physicians in urban centers.

Emergency Room Initiatives. Given that over 60% 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 six in 2006. We have also implemented marketing campaigns that emphasize the speed, convenience, and quality of our emergency rooms to enhance each community s awareness of our emergency room services.

One component of upgrading our emergency rooms is the implementation of specialized computer software programs designed to assist physicians in making diagnoses and determining treatments. The software also benefits patients and hospital personnel by assisting in proper documentation of patient records and tracking patient flow. It enables our nurses to provide more consistent patient care and provides clear instructions to patients at time of discharge to help them better understand their treatments.

Expansion of Services. In an effort to better meet the healthcare needs of the communities we serve and to capture a greater portion of the healthcare spending in our markets, we have added a broad range of services to our facilities. These services range from various types of diagnostic equipment capabilities to additional and renovated emergency rooms, surgical and critical care suites and specialty services. For example, in 2006, capital investments in 26 major construction projects, totaling approximately $100 million, were made. Those projects included new emergency rooms, cardiac cathertization labs, intensive care units, an

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ambulatory surgery center and hospital additions. 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.

Managed Care Strategy. Managed care has seen growth across the U.S. as health plans expand service areas and membership. As we service primarily non-urban markets, we do not have significant relationships with managed care organizations, including those with 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 business development department reviews and approves all managed care contracts, which are managed by our corporate managed care department using a central database. The primary mission of this department is to select and evaluate appropriate managed care opportunities, manage existing reimbursement arrangements, negotiate increases and educate our physicians. 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.

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. We currently estimate that there are approximately 400 hospitals that meet our acquisition criteria. These hospitals are primarily owned by governmental, not-for-profit, or faith based agencies.

Disciplined Acquisition Approach. We have been disciplined in our approach to acquisitions. We have a dedicated team of internal and external professionals who complete a thorough review of the hospital s financial and operating performance, the demographics and service needs of the market and the physical condition of the facilities. Based on our historical experience, we then build a pro forma financial model that reflects what we believe can be accomplished under our ownership. Whether we buy or lease the existing facility or agree to construct a replacement hospital, we believe we have been disciplined in our approach to pricing. We typically begin the acquisition process by entering into a non-binding letter of intent with an acquisition candidate. After we complete business and financial due diligence and financial modeling, we decide whether or not to enter into a definitive agreement. Once an acquisition is completed, we have an organized and systematic approach to transitioning and integrating the new hospital into our system of hospitals.

Acquisition Efforts. We have focused on identifying possible acquisition opportunities through expanding our internal acquisition group and working with a broad range of financial advisors who are active in the sale of hospitals, especially in the not-for-profit sector.

Most of our acquisition targets are municipal or other not-for-profit hospitals. We believe that our access to capital, ability to recruit physicians and reputation for providing quality care make us an attractive partner

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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, 2006, we are required to construct one replacement facility by August 2008 to be located in Petersburg, Virginia and one replacement facility by June 30, 2009 to be located in Shelbyville, Tennessee. 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. Construction costs for these replacement hospitals are currently estimated to be approximately $230 million. 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, 2006, obligate us to spend approximately $270 million through 2011.

Improve Profitability

Overview. To improve efficiencies and increase operating margins, we implement cost containment programs and adhere to operating philosophies which 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
- managing staffing levels according to patient volumes and the appropriate level of care.

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. Effective March 2005, we entered into a five-year participating agreement with automatic renewal terms of one year with HealthTrust Purchasing Group, L.P. (Health Trust), a group purchasing organization (GPO).

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HealthTrust is the source for a substantial portion of our medical supplies, equipment and pharmaceuticals.

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.

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

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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.

Industry Overview

The Centers for Medicare and Medicaid Services, or CMS, reported that in 2005, total U.S. healthcare expenditures grew by 6.9% to $2.0 trillion. It projected total U.S. healthcare spending to grow by 7.6% in 2006, by an average of 7.5% annually from 2007 through 2009 and by 7.0% annually from 2010 through 2015. By these estimates, healthcare expenditures will account for approximately $4.0 trillion, or 20.0% of the total U.S. gross domestic product, by 2015.

Hospital services, the market in which we operate, is the largest single category of healthcare at 31% of total healthcare spending in 2005, or $611.6 billion, as reported by CMS. CMS projects the hospital services category to grow by at least 6.7% per year through 2015. It expects growth in hospital healthcare spending to continue due to the aging of the U.S. population and consumer demand for expanded medical services. As hospitals remain the primary setting for healthcare delivery, it expects hospital services to remain the largest category of healthcare spending.

U.S. Hospital Industry. The U.S. hospital industry is broadly defined to include acute care, rehabilitation, and psychiatric facilities that are either public (government owned and operated), not-for-profit private (religious or secular), or for-profit institutions (investor owned). According to the American Hospital Association, there are approximately 4,900 inpatient hospitals in the U.S. which are not-for-profit owned, investor owned, or state or local government owned. Of these hospitals, approximately 40% are located in non-urban communities. 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. According to the American Hospital Association, in 2006, there were approximately 2,000 non-urban hospitals in the U.S. We believe that a majority of these hospitals are owned by not-for-profit or governmental entities.

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, 2006, 19 of our hospitals were sole community hospitals. In addition, we believe that non-urban communities are generally characterized by a

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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. In 2006, approximately 23.9% of our net operating revenues were paid by managed care organizations as compared to 23.7% in 2005 and 22.2% in 2004.

Hospital Industry Trends

Demographic Trends. According to the U.S. Census Bureau, there are presently approximately 36.9 million Americans aged 65 or older in the U.S. who comprise approximately 13% of the total U.S. population. By the year 2030 the number of elderly is expected to climb to 71.5 million, or 20% of the total population. Due to the increasing life expectancy of Americans, the number of people aged 85 years and older is also expected to increase from 4.3 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 19.6% from 1990 to 2005 and are expected to grow by 4.9% from 2005 to 2010. The number of people aged 55 or older in these service areas grew by 25.8% from 1990 to 2005 and is expected to grow by 12.7% from 2005 to 2010.

Consolidation. During recent years a significant amount of private equity capital has been invested into the hospital industry. In addition, 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 collectibility 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.

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Selected Operating Data

The following table sets forth operating statistics for our hospitals for each of the years presented. Statistics for 2006 include a full year of operations for 69 hospitals and partial periods for 8 hospitals acquired during the year. Statistics for 2005 include a full year of operations for 66 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. Statistics for 2004 include a full year of operations for 64 hospitals and partial periods for 2 hospitals. Hospitals which have been sold are excluded from all periods presented.

	Years Ended December 31,		
	2006	2005	2004
	(Dollars in thousands)		
Consolidated Data			
Number of hospitals (at end of period)	77	69	66
Licensed beds(1)	9,117	7,974	7,358
Beds in service(2)	7,341	6,476	5,960
Admissions(3)	326,235	291,633	267,390
Adjusted admissions(4)	605,511	538,445	493,776
Patient days(5)	1,334,728	1,204,001	1,091,889
Average length of stay (days)(6)	4.1	4.1	4.1
Occupancy rate (beds in service)(7)	53.0%	52.9%	51.2%
Net operating revenues	$ 4,365,576	$ 3,738,320	$ 3,203,507
Net inpatient revenues as a % of total net operating revenues	50.0%	50.9%	50.5%
Net outpatient revenues as a % of total net operating revenues	48.7%	47.8%	48.1%
Net Income	$ 168,263	$ 167,544	$ 151,433
Net Income as a % of total net operating revenues	3.9%	4.5%	4.7%
Liquidity Data			
Adjusted EBITDA(8)	$ 572,026	$ 573,200	$ 494,121
Adjusted EBITDA as a % of total net operating revenues(8)	13.1%	15.3%	15.4%
Net cash flows provided by operating activities	$ 350,255	$ 411,049	$ 325,750
Net cash flows provided by operating activities as a % of total net operating revenues	8.0%	11.0%	10.2%
Net cash flows used in investing activities	$ (640,257)	$ (327,272)	$ (318,479)
Net cash flows provided by (used in) financing activities	$ 226,460	$ (62,167)	$ 58,896

	Year Ended December 31,	
	2006	2005
	(Dollars in thousands)	
Same-Store Data(9)		
Admissions(3)	294,820	291,633
Adjusted admissions(4)	543,074	538,445
Patient days(5)	1,213,429	1,204,001
Average length of stay (days)(6)	4.1	4.1
Occupancy rate (beds in service)(7)	53.3%	52.9%

Net operating revenues	$ 4,000,828	$ 3,737,607
Income from operations	$ 365,173	$ 406,774
Income from operations as a % of net operating revenues	9.1%	10.9%
Depreciation and amortization	$ 173,443	$ 163,455
Minority interest in earnings	$ 3,140	$ 3,104

(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.

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(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 income 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.

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.

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The following table reconciles adjusted EBITDA, as defined, to our net cash provided by operating activities as derived directly from our consolidated financial statements for the years ended December 31, 2006, 2005, and 2004 (in thousands):

	Year Ended December 31,		
	2006	2005	2004
Adjusted EBITDA	$ 572,026	$ 573,200	$ 494,121
Interest expense, net	(102,299)	(94,613)	(75,256)
Provision for income taxes	(106,682)	(120,782)	(104,071)
Deferred income taxes	(25,228)	9,889	41,902
Loss from operations of hospitals sold or held for sale	(657)	(10,505)	(7,279)
Income tax benefit on the non-cash impairment and loss on sale of hospitals	1,378	924	1,080
Depreciation and amortization of discontinued operations		1,599	9,225
Stock compensation expense	20,073	4,957	2
Excess tax benefits relating to stock based compensation	(6,819)		
Other non-cash (income) expenses, net	500	740	669
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	(71,141)	(47,455)	(31,814)
Supplies, prepaid expenses and other current assets	(4,544)	(16,838)	(13,549)
Accounts payable, accrued liabilities and income taxes	52,151	84,956	(24,371)
Other	21,497	24,977	35,091
Net cash provided by operating activities	$ 350,255	$ 411,049	$ 325,750

(9) Includes 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.

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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	2006	2005	2004
Medicare	30.7%	32.0%	31.9%
Medicaid	11.0%	11.2%	10.3%
Managed Care	23.9%	23.7%	22.2%
Self-pay	11.9%	11.5%	12.9%
Other third party payors	22.5%	21.6%	22.7%
Total	100.0%	100.0%	100.0%

As shown above, we receive a substantial portion of our revenue from the Medicare and Medicaid programs. Other third party payors includes insurance companies for which we do not have insurance provider contracts, worker s compensation carriers, and non-patient service revenue, such as rental income and cafeteria sales.

Medicare is a federal program that provides medical insurance benefits to persons age 65 and over, some disabled persons, and persons with end-stage renal disease. Medicaid is a federal-state funded program, administered by the states, which provides medical benefits to individuals who are unable to afford healthcare. All of our hospitals are certified as providers of Medicare and Medicaid services. Amounts received under the Medicare and Medicaid programs are generally significantly less than a hospital s customary charges for the services provided. Since a substantial portion of our revenue comes from patients under Medicare and Medicaid programs, our ability to operate our business successfully in the future will depend in large measure on our ability to adapt to changes in these programs.

In addition to government programs, we are paid by private payors, which include insurance companies, HMOs, PPOs, other managed care companies, employers, and by patients directly. The Blue Cross HMO payors are included in the above captioned Managed Care line item. All other Blue Cross payors are included in the above captioned Other third party payors line item. 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 15.

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

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pressure from Medicare or Medicaid programs, insurance companies, and managed care plans to reduce hospital stays and to reduce costs by having services provided on an outpatient rather than on an inpatient basis.

Government Regulation

Overview. The healthcare industry is required to comply with extensive government regulation at the federal, state, and local levels. Under these regulations, hospitals must meet requirements to be certified as hospitals and qualified to participate in government programs, including the Medicare and Medicaid programs. These requirements relate to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, hospital use, rate-setting, compliance with building codes, and environmental protection laws. There are also extensive regulations governing a hospital s participation in these government programs. If we fail to comply with applicable laws and regulations, we can be subject to criminal penalties and civil sanctions, our hospitals can lose their licenses and we could lose our ability to participate in these government programs. In addition, government regulations may change. If that happens, we may have to make changes in our facilities, equipment, personnel, and services so that our hospitals remain certified as hospitals and qualified to participate in these programs. We believe that our hospitals are in substantial compliance with current federal, state, and local regulations and standards.

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

Recent Changes. In recent years, numerous changes have been made in the oversight of health care providers to provide an increased emphasis on the linkage between quality of care criteria and payment levels. For example, hospital Medicare payments are now impacted by the hospital s accurate reporting of the basic elements of care provided to patients with certain diagnoses. 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 at 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.

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Another law regulating the healthcare industry is a section of the Social Security Act, known as the anti-kickback statute. This law prohibits some business practices and relationships under Medicare, Medicaid, and other federal healthcare programs. These practices include the payment, receipt, offer, or solicitation of remuneration of any kind in exchange for items or services that are reimbursed under most federal or state healthcare program. Violations of the anti-kickback statute may be punished by criminal and civil fines, exclusion from federal healthcare programs, and damages up to three times the total dollar amount involved.

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

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

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

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

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

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

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

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

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

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

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

We have a variety of financial relationships with physicians who refer patients to our hospitals. Physicians own interests in a limited 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

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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. In January 2002 and March 2004, the federal government issued regulations which interpret some of the provisions included in the Stark law. We strive to comply with the Stark law and regulations; however, the government may interpret the law and regulations differently. If we are found to have violated the Stark law or regulations, we could be subject to significant sanctions, including damages, penalties, and exclusion from federal health care programs.

Many states in which we operate also have adopted, or are considering adopting, 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 or are considering enacting 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 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.

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

Healthcare Reform. The healthcare industry continues to attract much legislative interest and public attention. In recent years, an increasing number of legislative proposals have been introduced or proposed in Congress and in some state legislatures that would affect major changes in the healthcare system. Proposals that have been considered include cost controls on hospitals, insurance market reforms to increase the availability of group health insurance to small businesses, and mandatory health insurance coverage for employees. The costs of implementing some of these proposals could be financed, in part, by reductions in payments to healthcare providers under Medicare, Medicaid, and other government programs. We cannot predict the course of future healthcare legislation or other changes in the administration or interpretation of governmental healthcare programs and the effect that any legislation, interpretation, or change may have on us.

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

Certificates of Need. The construction of new facilities, the acquisition of existing facilities and the addition of new services at our facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. We operate 44 hospitals in 12 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. These privacy regulations became effective April 14, 2001 but compliance with these regulations was not required until April 2003. 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. Regulations relating to the security of electronic protected health information went into effect on April 21, 2003, and compliance was required as of April 21, 2005. The HIPAA security standards and privacy regulations serve similar purposes and overlap to a

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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, each DRG is 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 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. For the federal fiscal year 2009, each DRG is assigned a payment rate using 100% of the national average cost per case. 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 (i.e., the federal fiscal year beginning October 1, 2006 is referred to as the 2007 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 2004, 2005, 2006 and 2007 or 3.4%, 3.3%, 3.7% and 3.4%, respectively. The Deficit Reduction Act of 2005 imposes a 2% reduction to the market basket index beginning in the federal fiscal year 2007 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 2.1% for each of the three years ended December 31, 2006, 2005 and 2004, respectively.

Beginning August 1, 2000, we began receiving Medicare reimbursement for outpatient services through a PPS. Under the Balanced Budget Refinement Act of 1999, non-urban hospitals with 100 beds or less were held harmless through December 31, 2004 under this Medicare outpatient PPS. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 extended the hold harmless provision for non-urban hospitals with 100 beds or less and for non-urban sole community hospitals with more than 100 beds through December 31, 2005. The Deficit Reduction Act of 2005 extended the hold harmless provision for non-urban hospitals with 100 beds or less that are not sole community hospitals through December 31, 2008; however reduces the amount these hospitals would receive in hold harmless payment by 5% in 2006, 10% in 2007 and 15% in 2008. Of our 77 hospitals at December 31, 2006, 31 qualified for this relief. The outpatient conversion factor rate was increased by 3.4% effective January 1, 2004; however, adjustments to other variables within the outpatient PPS resulted in an approximate 4.3% to 4.7% net increase in outpatient PPS payments. 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

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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 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 2004 skilled nursing facility PPS payment rates are increased by the full market basket of 3.0% coupled with a 3.26% increase to reflect the difference between the market basket forecast and the actual market basket increase from the start of the skilled nursing facility PPS in July 1998. For federal fiscal year 2005, skilled nursing facility PPS payment rates were increased by the full market basket of 2.8%. For federal fiscal year 2006, skilled nursing facility PPS payment rates were increased 3.1%; however coupled with adjustments to other variables within the skilled nursing facility PPS, an approximate 3.9% to 4.3% net increase in skilled nursing facility PPS payments occurred. For federal fiscal year 2007, skilled nursing facility PPS rates were increased by the full SNF market basket index of 3.1%.

The Department of Health and Human Services established a PPS for home health services effective October 1, 2000. The home health agency PPS per episodic payment rate increased by 3.3% on October 11, 2003. 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.

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.

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Supply Contracts

In March 2005, we began purchasing items, primarily medical supplies, medical equipment and pharmaceuticals, under an agreement with HealthTrust Purchasing Group L.P., a GPO in which we are a minority partner. 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 provide the discounts we expect to achieve. Prior to March 2005, we had an agreement with and purchased supplies using Broadlane Inc., another GPO.

Competition

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

In addition to the competition we face for acquisitions, we must also compete with other hospitals and healthcare providers for patients. The competition among hospitals and other healthcare providers for patients has intensified in recent years. Our hospitals are primarily located in non-urban service areas. Most of our hospitals 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 our primary 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.

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

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

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

Employees

At December 31, 2006, we employed approximately 27,000 full time employees and 12,000 part-time employees. Of these employees, approximately 2,000 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.

We are insured for damages of personal property or environmental injury arising out of environmental impairment of both underground and above ground storage tanks. 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.

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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, 2006. This chart does not include $425 million that would be available for future borrowings under the revolving tranche of our senior secured credit facility, of which $21 million is reserved for outstanding letters of credit.

	As of December 31, 2006 ($ in millions)
Senior secured credit facility	
Term loans	$ 1,572
Notes	300
Other	69
Total debt	1,941
Stockholder equity	1,724

	Year Ended December 31,2006
Ratio of earnings to fixed charges(a)	3.14 x

(a) In calculating the ratio of earnings to fixed charges, earnings consist of income from continuing operations before income taxes plus fixed charges. Fixed charges consist of interest expense (which includes amortization of deferred financing costs and debt issuance costs) and one-quarter of rent expense deemed representative of that portion of rent expense to be attributable to interest.

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 other indebtedness could make it more difficult for us to satisfy our financial obligations, including those related to the notes;

some of our borrowings, including borrowings under our senior secured 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.

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

An important part of our business strategy is to acquire two to four hospitals each year. However, not-for-profit hospital systems and other for-profit hospital companies generally attempt to acquire the same type of hospitals as we do. Some of these other purchasers have greater financial resources than we do. Our principal competitors for acquisitions have included Health Management Associates, Inc., and LifePoint Hospitals, Inc. On some occasions, we also compete with Universal Health Services, Inc. and Triad Hospitals 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 future acquired hospitals, we may be unable to achieve our growth strategy.

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

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

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

State efforts to regulate the 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.

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.

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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 85% 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. These facilities generally are located in excess of 25 miles from our facilities. 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.

In March 2005, we entered into a five-year participation agreement with automatic renewal terms of one year each with HealthTrust Purchasing Group, L.P., a GPO which replaced a similar arrangement with another GPO. GPOs attempt to obtain favorable pricing on medical supplies with manufacturers and vendors who sometimes negotiate exclusive supply arrangements in exchange for the discounts they give. Recently some vendors who are not GPO members have challenged these exclusive supply arrangements. In addition, the U.S. Senate has held hearings with respect to GPOs and these exclusive supply arrangements. To the extent these exclusive supply arrangements are challenged or deemed unenforceable, we could incur higher costs for our medical supplies obtained through HealthTrust. These higher costs could cause our operating results to decline.

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

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

Affiliates of Forstmann Little & Co. acquired our predecessor company in 1996 principally for cash. We recorded a significant portion of the purchase price as goodwill. Since September 21, 2004, Forstmann Little and Co. has not owned any shares of our common stock. We have also recorded as goodwill a portion of the purchase price for many of our subsequent hospital acquisitions. At December 31, 2006, we had approximately $1.4 billion of goodwill recorded on our books. We expect to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. If the carrying value of our goodwill is impaired, we may incur a material non-cash charge to earnings.

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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 2006, 41.7% 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. Future federal and state legislation may further reduce the payments we receive for our services. For example, the Governor of the State of Tennessee implemented cuts in the second half of 2005 in TennCare by restricting eligibility and capping specified services.

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

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

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

In addition, there are heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment. The ongoing investigations relate to various referral, cost reporting, and billing practices, laboratory and home healthcare services, and physician ownership and joint ventures involving hospitals.

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

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

Hospitals are currently experiencing a shortage of nursing professionals, a trend which we expect to continue for some time. If the supply of qualified nurses declines in the markets in which our hospitals operate, it may result in increased

labor expenses and lower operating margins at those hospitals. In addition, in some markets like California, there are requirements to maintain specified nurse-staffing levels. To the extent we cannot meet those levels, the healthcare services that we provide in these markets may be reduced.

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

In recent years, physicians, hospitals, and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability, or related legal theories. 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 liability insurance decreased in 2004 by 0.2%, decreased in 2005 by 0.2% and increased in 2006 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 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;
- 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;
- 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 collectibility of patient accounts receivable;

uncertainty regarding the application of the Health Insurance Portability and Accountability Act of 1996 regulations;

increases in wages as a result of inflation or competition for highly technical positions and rising supply cost due to market pressure from pharmaceutical companies and new product releases;

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liability 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 and integrate additional hospitals;

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

potential adverse impact of known and unknown government investigations; and

timeliness of reimbursement payments received under government programs.

Although we believe that these statements are based upon reasonable assumptions, we can give no assurance that our goals will be achieved. Given these uncertainties, prospective investors are cautioned not to place undue reliance on these forward-looking statements. These forward-looking statements are made as of the date of this filing. We assume no obligation to update or revise them or provide reasons why actual results may differ.

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

None

Item 2. ***Properties***

Corporate Headquarters

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, general surgery, cardiology, oncology, orthopedics, OB/GYN, diagnostic and emergency room services, outpatient surgery, laboratory, radiology, respiratory therapy, physical therapy, and rehabilitation services. Some of our hospitals include subsidiaries which have minority interest ownership positions. In addition, some of our hospitals provide skilled nursing and home health services based on individual community

needs.

For each of our hospitals, the following table shows its location, the date of its acquisition or lease inception and the number of licensed beds as of December 31, 2006:

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
L.V. Stabler Memorial Hospital	Greenville	72	October, 1994	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
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
Arizona				
Payson Regional Medical Center	Payson	44	August, 1997	Leased
Western Arizona Regional Medical Center	Bullhead City	123	July, 2000	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
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
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
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
River West Medical Center	Plaquemine	80	August, 1996	Leased
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
New Jersey				
Memorial Hospital of Salem County	Salem	140	September, 2002	Owned
New Mexico				
Mimbres Memorial Hospital	Deming	49	March, 1996	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
Eastern New Mexico Medical Center	Roswell	162	April, 1998	Owned
Northeastern Regional Hospital	Las Vegas	54	April, 2000	Owned
North Carolina				
Martin General Hospital	Williamston	49	November, 1998	Leased
Oklahoma				
Ponca City Medical Center	Ponca City	140	May, 2006	Owned
Pennsylvania				
Berwick Hospital	Berwick	101	March, 1999	Owned
Brandywine Hospital	Coatesville	168	June, 2001	Owned
Jennersville Regional Hospital	West Grove	59	October, 2001	Owned
Easton Hospital	Easton	330	October, 2001	Owned
Lock Haven Hospital	Lock Haven	59	August, 2002	Owned
Pottstown Memorial Medical Center	Pottstown	227	July, 2003	Owned
Phoenixville Hospital	Phoenixville	136	August, 2004	Owned
Chestnut Hill Hospital	Philadelphia	222	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
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
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
Texas				
Big Bend Regional Medical Center	Alpine	40	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
Utah				
Mountain West Medical Center	Tooele	35	October, 2000	Owned

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Hospital	City	Licensed Beds(1)	Date of Acquisition/Lease Inception	Ownership Type
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
Wyoming				
Evanston Regional Hospital	Evanston	42	November, 1999	Owned
Total Licensed Beds at December 31, 2006		9,117		

(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.

Item 3. ***Legal Proceedings***

From time to time, we receive various inquiries or subpoenas from state regulators, fiscal intermediaries, CMS 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.

In May 1999, we were served with a complaint in U.S. ex rel. *Bledsoe v. Community Health Systems, Inc.*, subsequently moved to the Middle District of Tennessee, Case No. 2-00-0083. This qui tam action sought treble damages and penalties under the False Claims Act against us. The Department of Justice did not intervene in this action. The allegations in the amended complaint were extremely general, but involved Medicare billing at our White County Community Hospital in Sparta, Tennessee. By order entered on September 19, 2001, the U.S. District Court granted our motion for judgment on the pleadings and dismissed the case, with prejudice.

The qui tam whistleblower (also referred to as a relator) appealed the district court s ruling to the U.S. Court of Appeals for the Sixth Circuit. On September 10, 2003, the Sixth Circuit Court of Appeals rendered its decision in this case, affirming in part and reversing in part the District Court s decision to dismiss the case with prejudice. The court affirmed the lower court s dismissal of certain of plaintiff s claims on the grounds that his allegations had been previously publicly disclosed. In addition, the appeals court agreed that, as to all other allegations, the relator had failed to include enough information to meet the special pleading requirements for fraud under the False Claims Act and the Federal Rules of Civil Procedure. However, the case was returned to the district court to allow the relator another opportunity to amend his complaint in an attempt to plead his fraud allegations with particularity.

In May 2004, the relator in *U.S. ex rel. Bledsoe* filed an amended complaint alleging fraud involving Medicare billing at White County Community Hospital. We then filed a renewed motion to dismiss the amended complaint. On January 6, 2005, the District Court dismissed with prejudice the bulk of the relator s allegations. The only remaining allegations involve a handful 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. The appeal has been fully briefed and oral argument will be heard by the U.S. Court of Appeals on April 10, 2007.

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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. Discovery has been concluded on the class determination issues and briefing will proceed. We are vigorously defending this case.

In September 2004, we were served with a complaint in *James Monroe v. Pottstown Memorial Hospital and Community Health Systems, Inc.* in the Court of Common Pleas, Montgomery County, Pennsylvania. This alleged class action was brought by the plaintiff on behalf of himself and as the representative of similarly situated uninsured individuals who were treated at our Pottstown Memorial Hospital or any of our other Pennsylvania hospitals. 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 under the Pennsylvania Unfair Trade Practices and Consumer Protection Law, restitution of overpayment, compensatory and other allowable damages and injunctive relief. This case was recently dismissed and refiled, adding our management company subsidiary as a defendant. Discovery has commenced in this case. 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 this 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. The parties are briefing their positions. We are vigorously defending this case.

On April 8, 2005, we were served with a first amended complaint, styled *Chronister, et al. v. Granite City Illinois Hospital Company, LLC d/b/a Gateway Regional Medical Center*, in the Circuit Court of Madison County, Illinois. The complaint seeks class action status on behalf of the uninsured patients treated at Gateway Regional Medical Center and alleges statutory, common law, and consumer fraud in the manner in which the hospital bills and collects for the services rendered to uninsured patients. The plaintiff seeks compensatory and punitive damages and declaratory and injunctive relief. We are awaiting a ruling on our motion to dismiss. We are vigorously defending this case.

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

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documents relating to the programs in New Mexico and the payments to the Company s three hospitals there. For hospitals in New Mexico, the payments for this program approximate 0.3% of annual net operating revenue for 2006. We have provided the Department of Justice with the requested documents and continue to cooperate with the government s inquiry. We are unable at this time to evaluate the existence or extent of any potential financial exposure.

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 filed.

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, 2006.

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, 2007, there were approximately 49 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, 2005		
First Quarter	$ 36.33	$ 26.96
Second Quarter	38.60	33.14
Third Quarter	39.52	32.65
Fourth Quarter	40.72	35.62
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

We have not paid any cash dividends since our inception, and do not anticipate the payment of cash dividends in the foreseeable future. Our senior secured credit facility limits our ability to pay dividends and/or repurchase stock to an amount not to exceed $300 million in the aggregate.

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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, 2006 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 program. The following table contains information about our purchases of our common stock during the three months ended December 31, 2006.

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet be Purchased Under the Plans or Programs
October 1, 2006 October 31, 2006		$		1,175,200
November 1, 2006 November 30, 2006	1,175,200	32.86		
December 1, 2006 December 31, 2006				5,000,000

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 Notes) on December 14, 2005. At the conclusion of this call for redemption, $0.3 million in principal amount of the Notes were redeemed. Prior to the redemption date, $149.7 million of the Notes called for redemption, plus an additional $0.9 million of the 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 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 Notes, $0.1 million in principal amount of the Notes were redeemed and $136.5 million of the Notes were converted by the holders into 4,074,510 shares of our common stock prior to the redemption date.

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Item 6. ***SELECTED FINANCIAL DATA***

The following table summarizes specified selected financial data and should be read in conjunction with our related Consolidated Financial Statements and accompanying Notes to Consolidated Financial Statements.

Community Health Systems, Inc.
Five Year Summary of Selected Financial Data

	Year Ended December 31,				
	2006	**2005**	**2004**	**2003**	**2002**
	(In thousands, except share and per share data)				
Consolidated Statement of Operations Data					
Net operating revenues	$ 4,365,576	$ 3,738,320	$ 3,203,507	$ 2,676,520	$ 2,039,250
Income from operations	380,460(4)	405,533	342,472	293,808	240,094
Income from continuing operations	171,479	190,138	162,357	135,419	101,055
Net income	168,263	167,544	151,433	131,472	99,984
Earnings per common share Basic:					
Income from continuing operations	$ 1.81	$ 2.15	$ 1.70	$ 1.38	$ 1.03
(Loss) Income on discontinued operations	(0.04)	(0.26)	(0.12)	(0.04)	(0.01)
Net Income	$ 1.77	$ 1.89	$ 1.58	$ 1.34	$ 1.02
Earnings per common share Diluted:					
Income from continuing operations	$ 1.78	$ 2.02	$ 1.62	$ 1.33	$ 1.01
(Loss) Income on discontinued operations	(0.03)	(0.23)	(0.11)	(0.03)	(0.01)
Net Income	$ 1.75	$ 1.79	$ 1.51	$ 1.30	$ 1.00
Weighted-average number of shares outstanding					
Basic	94,983,646	88,601,168	95,643,733	98,391,849	98,421,052
Diluted(1)	96,232,910	98,579,977(3)	105,863,790(2)	108,094,956(2)	108,378,131

Cash and cash equivalents	$ 40,566	$ 104,108	$ 82,498	$ 16,331	$ 132,844
Total assets	4,506,579	3,934,218	3,632,608	3,350,211	2,809,496
Long-term obligations	2,207,623	1,932,238	2,030,258	1,601,558	1,276,761
Stockholders equity	1,723,673	1,564,577	1,239,991	1,350,589	1,214,305

(1) See Note 10 to the Consolidated Financial Statements, included later in this Form 10-K.

(2) Includes 8,582,076 shares related to the convertible notes under the if-converted method of determining weighted average shares outstanding.

(3) Includes 8,385,031 shares related to the convertible notes under the if-converted method of determining weighted average shares outstanding.

(4) See Note 1 to the Consolidated Financial Statements, included later in this Form 10-K, regarding the Allowance for doubtful accounts.

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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 non-urban provider of general hospital healthcare services in the United States in terms of number of facilities and net operating revenues. We generate revenue by providing a broad range of general hospital healthcare services to patients in the communities in which we are located. We are paid for our services by governmental agencies, private insurers and directly by the patients we serve.

During 2006 we accomplished the following items, each of which demonstrates the continued execution of our operating strategy and our efforts to maximize shareholder value. Each of these accomplishments should be considered in conjunction with our discussion of operating results, liquidity and capital resources.

- acquired eight hospitals;
- acquired three stand-alone home health agencies;
- entered into two joint ventures relating to surgery centers;
- sold one under-performing hospital;
- increased the number of physicians practicing in our markets by approximately 300, net of turnover, primarily through our recruiting efforts;
- completed the redemption of all remaining outstanding 4.25% convertible notes;
- repurchased 5,000,000 shares of our common stock at an average price of $35.23; and
- invested $224.5 million in property and equipment, including $35.1 million in emergency room renovations and $74.3 million in cardiology, radiology, surgery and other facility renovations.

For the year ended December 31, 2006, we generated $4.4 billion in net operating revenues, a growth of 16.8% over the year ended December 31, 2005, and $168.3 million of net income, an increase of 0.4% over the year ended December 31, 2005. For the year ended December 31, 2006, admissions at hospitals owned throughout both periods increased 1.1% and adjusted admissions increased 0.9%.

This growth represents the continued achievement of our strategic objectives of both growing through acquisitions and expanding and improving our services. On a pro-forma annual basis, had all acquisitions been completed on the first day of our fiscal year, the eight hospitals acquired represent approximately $441 million in net operating revenue.

During our third quarter ended September 30, 2006, we experienced a significant increase in self-pay volume and related revenue combined with lower cash collections. We believe this trend reflects an increased collection risk from self-pay accounts, and as a result, we performed a review and an alternative analysis of the adequacy of our allowance

for doubtful accounts. We believe this was caused by 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. Based on this analysis, we recorded a change in estimate to increase our allowance for doubtful accounts by $65 million on our September 30, 2006 balance sheet and a corresponding $65 million pre-tax increase to our provision for bad debts, resulting in a $40 million after-tax reduction in income from continuing operations. We also changed our methodology of estimating our allowance for doubtful accounts, effective September 30, 2006, to reserve as an allowance for doubtful accounts a percentage of all self-pay accounts without regard to aging category and fully reserve all other payor categories of accounts aging over 365 days from the date of discharge. We believe this methodology is preferable to our previous methodology of reserving for all accounts receivable aging greater than 150 days, as the revised methodology will provide a better approach to reflect changes in

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payor mix and historical collection patterns and to respond to changes in trends. As of December 31, 2006, our allowance for doubtful accounts was 64% of our self-pay receivables.

Self-pay revenues represented approximately 11.9% of our net operating revenue. Although uninsured and underinsured patients continue to be an industry-wide issue in certain markets, we do not anticipate a significant amount of continuing deterioration in our self-pay business as the economy in the Gulf Coast region continues to recover and the disenrollment of participants in the TennCare program have passed their one year anniversary.

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 continually to strive to improve operating efficiencies and procedures in order to improve our profitability at all of our hospitals. Approximately 42% of our net operating revenues in 2006 were generated from hospitals we acquired from January 2002 through December 2006. Since we estimate that it may take up to five years for a newly acquired hospital to fully benefit from our ownership, we believe there continues to be greater opportunity for the more recently acquired hospitals to contribute improvements in both revenue growth and profitability to our consolidated results.

Acquisitions and Dispositions

Effective March 1, 2006, we completed the acquisition of Forrest City Hospital, a 118 bed hospital and related assets located in Forrest City, Arkansas, through a combination of purchasing certain of the assets and entering into a capital lease for other related assets. The aggregate consideration for this transaction totaled approximately $10.7 million, of which $10.2 million was paid in cash and $0.5 million was assumed in liabilities.

Effective March 18, 2006, we 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 by us.

Effective April 1, 2006, we completed the acquisition of two hospitals from the Baptist Health System, Birmingham, Alabama: Baptist Medical Center DeKalb (134 beds) and Baptist Medical Center Cherokee (60 beds). The total consideration for these two hospitals was approximately $66.7 million of which $65.1 million was paid in cash and $1.6 million was assumed in liabilities.

Effective May 1, 2006, we completed its acquisition of Via Christi Oklahoma Regional Medical Center, a 140 bed hospital located in Ponca City, Oklahoma. The aggregate consideration for this hospital totaled approximately $66.2 million, of which $63.3 million was paid in cash and $2.9 million was assumed in liabilities.

Effective June 1, 2006, we completed its acquisition of Mineral Area Regional Medical Center, a 135 bed hospital located in Farmington, Missouri. The aggregate consideration for this hospital totaled approximately $23.8 million, of which $19.3 million was paid in cash and $4.5 million was assumed in liabilities.

Effective June 30, 2006, we completed the acquisition of Cottage Home Options, a home health agency and related businesses, located in Galesburg, Illinois, in which we previously held a 40% ownership interest. The aggregate consideration for the additional 60% ownership interest in this agency totaled approximately $7.7 million, of which $6.1 million was paid in cash and $1.6 million was assumed in liabilities.

Effective July 1, 2006, we completed the acquisition of 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. The total consideration for this transaction including working capital was approximately $134.6 million of which $123.6 million was paid in cash and $11.0 million was assumed in liabilities. This transaction is treated as the

acquisition of a single hospital and we refer to this hospital as Vista Medical Center East/West.

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Effective September 1, 2006, we completed the acquisition of Humble Texas Home Care, a home health agency located in Humble, Texas. The aggregate consideration for this agency totaled approximately $5.1 million, of which $4.5 million was paid in cash and $0.6 million was assumed in liabilities.

Effective October 1, 2006, we completed the acquisition of HelpSource Home Health, a home health agency located in Wichita Falls, Texas. The aggregate consideration for this agency totaled approximately $9.1 million of which $8.5 million was paid in cash and $0.6 million was assumed in liabilities.

Effective November 1, 2006, we acquired Campbell County Hospital, a 99-bed facility located in Weatherford, Texas. The aggregate consideration for this hospital totaled approximately $51.9 million of which $49.7 million was paid in cash and $2.2 was assumed in liabilities.

In addition, effective November 1, 2006, we acquired Union County Hospital, a 25-bed facility located in Anna, Illinois, a hospital we previously operated under a management agreement. The aggregate consideration for this hospital totaled approximately $9.0 million of which $3.5 million was paid in cash and $5.5 was assumed in liabilities.

Sources of Revenue

The following table presents the approximate percentages of net operating revenue derived 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.

	Year Ended December 31,		
	2006	**2005**	**2004**
Medicare	30.7%	32.0%	31.9%
Medicaid	11.0%	11.2%	10.3%
Managed care	23.9%	23.7%	22.2%
Self pay	11.9%	11.5%	12.9%
Other third party payors	22.5%	21.6%	22.7%
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, 2006, 2005 and 2004. 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. Beginning April 1, 2003, and extending through March 31, 2004, the Consolidated Appropriations Resolution of 2003 and the Temporary Assistance for Needy Families Block Grant Extension equalized the rural and urban standardized payment amounts under the Medicare inpatient prospective payment system. Along with other changes, this benefit was made permanent when Congress passed the Medicare Prescription Drug, Improvement and Modernization Act of 2003. While the Medicare Prescription Drug, Improvement and Modernization Act of

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2003 provides a broad range of provider payment benefits, 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.

In addition, specified managed care programs, insurance companies, and employers are actively negotiating the amounts paid to hospitals. The trend toward increased enrollment in managed care may adversely effect our net operating revenue growth.

Results of Operations

Our hospitals offer a variety of services involving a broad range of inpatient and outpatient medical and surgical services. These include orthopedics, cardiology, occupational medicine, diagnostic services, emergency services, rehabilitation treatment, home health, 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.

	Years Ended December 31,		
	2006	2005	2004
	(Expressed as a percentage of net operating revenues)		
Consolidated			
Net operating revenues	100.0	100.0	100.0
Operating expenses(a)	(86.9)	(84.7)	(84.6)
Depreciation and amortization	(4.3)	(4.4)	(4.6)
Minority interest in earnings	(0.1)	(0.1)	(0.1)
Income from operations	8.7	10.8	10.7
Interest expense, net	(2.3)	(2.5)	(2.4)
Income from continuing operations before income taxes	6.4	8.3	8.3
Provision for income taxes	(2.4)	(3.2)	(3.2)
Income from continuing operations	4.0	5.1	5.1
Loss on discontinued operations	(0.1)	(0.6)	(0.4)
Net income	3.9	4.5	4.7

	Years Ended December 31,	
	2006	2005

	(Expressed in percentages)	
Percentage increase from prior year:		
Net operating revenues	16.8%	16.7%
Admissions	11.9	9.1
Adjusted admissions(b)	12.5	9.0
Average length of stay		
Net Income	0.4	10.6
Same-store percentage increase from prior year(c):		
Net operating revenues	7.0%	9.0%
Admissions	1.1	2.1
Adjusted admissions(b)	0.9	1.8

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(a) Operating expenses include salaries and benefits, provision for bad debts, supplies, rent, and other operating expenses.

(b) 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.

(c) Includes acquired hospitals to the extent we operated them during comparable periods in both years.

Year Ended December 31, 2006 Compared to Year Ended December 31, 2005

Net operating revenues increased by 16.8% to $4,365.6 million in 2006, from $3,738.3 million in 2005. Of the $627.3 million increase in net operating revenues, the hospitals we acquired in 2005 and 2006, which were not yet included in same-store revenues, contributed approximately $364.1 million, and hospitals we owned throughout both periods contributed approximately $263.2 million, an increase of 7.0%. Of the increase from hospitals owned throughout both periods, approximately 6.1 percentage points were attributable to rate increases, payor mix and the acuity level of services provided and approximately 0.9 percentage points were attributable to volume increases.

Inpatient admissions increased by 11.9%. Adjusted admissions increased by 12.5%. On a same-store basis, inpatient admissions increased by 1.1% and same-store adjusted admissions increased by 0.9%. 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 5.5% and net outpatient revenues increased by 8.8%. Consolidated and same-store average length of stay remained unchanged at 4.1 days.

Operating expenses, as a percentage of net operating revenues, increased from 84.7% in 2005 to 86.9% in 2006. Salaries and benefits, as a percentage of net operating revenues, increased from 39.8% in 2005 to 39.9% 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 10.1% in 2005, to 12.5% 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, remained unchanged at 22.8% in 2006 and 2005. Income from continuing operations margin decreased from 5.1% in 2005 to 3.9% in 2006. On a same-store basis, income from operations as a percentage of net operating revenues decreased from 10.9% in 2005 to 9.1% in 2006. The decrease in income from continuing operations, and income from operations on a same-store basis is primarily due to the increase in the provision for bad debts, offset by the improvements realized and efficiencies gained since the prior year at hospitals owned throughout both periods in the areas of salaries and benefits and supplies. Net income margins decreased from 4.5% in 2005 to 3.9% 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 on assets associated with those discontinued operations.

Depreciation and amortization increased by $24.2 million from $164.6 million in 2005, to $188.8 in 2006. The acquisitions in 2006 not yet included in same-store results accounted for $9.5 million of the increase, and capital expenditures at our other facilities account for the remaining $14.7 million.

Interest expense, net, increased by $7.7 million from $94.6 million in 2005, to $102.3 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.

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Income from continuing operations before income taxes decreased $32.8 million from $310.9 million in 2005 to $278.1 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 $120.8 million in 2005 to $106.7 million in 2006 due to the decrease in income from continuing operations, before income taxes. Our effective tax rates were 38.4% 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.

Year Ended December 31, 2005 Compared to Year Ended December 31, 2004

Net operating revenues increased by 16.7% to $3.7 billion in 2005 from $3.2 billion in 2004. Of the $534.8 million increase in net operating revenues, the hospitals we acquired in 2004 and 2005, which were not yet included in same-store net operating revenues, contributed approximately $247.6 million, and hospitals we owned throughout both periods contributed $287.2 million, an increase of 9.0%. Of the increase in net operating revenues from hospitals owned throughout both years, we estimate approximately 7.2 percentage points was attributable to increases in rates, acuity level of services provided, and government reimbursement, and 1.8 percentage points was attributable to volume increases in both inpatient and outpatient services.

Net operating revenues from volume increases were primarily the result of newly acquired facilities. Net operating revenues attributable to rates and acuity level of services were primarily the result of the recruitment of physician specialists and the addition of new services. As a result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the additional disproportionate share payment began April 1, 2004. The additional disproportionate share payments did not have a measurable impact on us in 2005 as compared to 2004, but did increase reimbursement to us by approximately $3.3 million in 2005 as compared to 2004. The reimbursement improvement from the change in the labor-related share of the hospital diagnosis related group, DRG, inpatient payment to which a wage index is applied provided for in this law was effective October 1, 2004 and increased reimbursement by approximately $3.9 million in 2005. Also, under this law DRG payment rates were increased by the full Market Basket Index of 3.3% on October 31, 2004 and 3.7% on October 1, 2005, and the reimbursement improvement from this increased rate, as compared to the prior period was approximately $17.0 million for 2005 including the reduction in payments attributable to the CMS expansion of the post-acute-transfer policy. Effective October 1, 2005, CMS expanded the post-acute-transfer policy from 30 DRGs to 182 DRGs. Under this regulatory change, DRG payments were reduced by approximately $3.0 million for 2005 as compared to 2004.

Inpatient admissions increased by 9.1% and adjusted admissions increased by 9.0% due to newly acquired hospitals along with same-store growth. On a same-store basis, inpatient admissions increased by 2.1%. Same-store admissions increased in 2005 primarily as a result of additional service offerings, along with a first quarter of 2005 increase in flu and respiratory admissions, offset by services closures and a one-day-stay reclassification change from inpatient admission to outpatient procedure at various hospitals. Same-store adjusted admissions increased by 1.8% and patient days increased 2.4%. On a same-store basis, net inpatient revenues increased 10.2% and net outpatient revenues increased 8.1% reflecting a total same-store net revenue increase of 9.0% resulting from the increases in volume and a higher acuity of service provided.

Operating expenses, as a percentage of net operating revenues, increased from 84.6% in 2004 to 84.7% in 2005. Salaries and benefits, as a percentage of net operating revenues, decreased from 39.9% in 2004 to 39.8% in 2005. Provision for bad debts, as a percentage of net revenues, remained unchanged at 10.1% in 2004 and 2005. Supplies, as a percentage of net operating revenues, decreased from 12.2% in 2004 to 12.0% in 2005, due mainly to entering into and compliance with our new group purchasing arrangement in 2005. Rent and other operating expenses, as a percentage of net operating revenues, increased from 22.4% in 2004 to 22.8% in 2005. This increase was caused primarily by an increase in business taxes. Net income margins

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decreased from 4.7% in 2004 to 4.5% in 2005 due to the lower margins at the hospitals acquired in 2004 and 2005, and the loss on discontinued hospitals.

On a same-store basis, we achieved a decrease in salary and benefits expense of 0.6% of net operating revenue resulting primarily from operating efficiency gains and supplies expense decreased 0.3% of net operating revenue as a result of entering into and compliance with our new group purchasing agreement. On a same-store basis, income from operations as a percentage of net operating revenues increased from 10.7% in 2004 to 11.3% in 2005, due mainly to those decreases in salaries and benefits and supplies expenses as a percent of net operating revenue.

Depreciation and amortization increased by $15.4 million to $164.6 million, or 4.4% of net operating revenues, in 2005, from $149.2 million, or 4.6% of net operating revenues, in 2004. The hospitals acquired in 2004 and 2005, prior to being included in same-store results, accounted for $8.7 million of the increase, while facility renovations and purchases of equipment, information systems upgrades, investments in physician recruiting and other deferred items accounted for the remaining $6.7 million.

Interest expense, net, increased by $19.3 million from $75.3 million in 2004 to $94.6 million in 2005. An increase in the average debt balance in 2005 as compared to 2004, due primarily to a full year outstanding of borrowings to make acquisitions in 2004 and the repurchase of 12,000,000 shares of common stock during the third quarter of 2004, together accounted for a $12.6 million increase in interest expense. An increase in interest rates during 2005 as compared to 2004 increased interest expense, net, by $6.7 million. The increase in average interest rates during 2005 is the result of the increase in LIBOR.

Provision for income taxes increased $16.7 million to $120.8 million in 2005 from $104.1 million in 2004, as a result of the increase in pre-tax income. Our effective tax rates were 38.8% and 39.1% for the years ended December 31, 2005 and 2004, respectively. The decrease in the effective rate in 2005 is primarily a result of a decrease in our state effective tax rate.

Net income was $167.5 million in 2005 compared to net income of $151.4 million in 2004, an increase of $16.1 million.

Liquidity and Capital Resources

2006 Compared to 2005

Net cash provided by operating activities decreased by $60.8 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 $13.1 million, both of which are non-cash expenses, along with an increase of $5.5 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 the current year where we received proceeds of $0.8 million from the sale of one hospital and a nursing home in 2006.

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In 2006, our net cash provided by financing activities increased $288.6 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.

As described more previously in our discussion of Liquidity and Capital Resources and in Notes 6, 8 and 12 of the Notes to Consolidated Financial Statements, at December 31, 2006, the Company had certain cash obligations, which are due as follows *(in thousands)*:

	Total	2007	2008-2010	2011-2012	2013 and thereafter
Long Term Debt	$ 1,596,507	$ 30,213	$ 336,172	$ 1,229,640	$ 482
Senior Subordinated Notes	300,000			300,000	
Capital Leases	44,670	5,183	8,354	2,809	28,324
Total Long-Term Debt	1,941,177	35,396	344,526	1,532,449	28,806
Operating Leases	298,393	62,415	112,879	45,691	77,408
Replacement Facilities and Other Capital Committments(1)	504,535	144,368	328,467	31,700	
Open Purchase Orders(2)	82,758	82,758			
Total	$ 2,826,863	$ 324,937	$ 785,872	$ 1,609,840	$ 106,214

(1) As part of an acquisition in 2003, we agreed to build a replacement hospital in Petersburg, Virginia within five years. The state of Virginia has approved the plans for this replacement hospital. 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. Construction costs for these replacement facilities are currently estimated to be approximately $230 million. 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. Included in the capital lease commitment above is the lease for our corporate headquarters on which construction was completed in December 2006. In January 2007, we exercised a purchase option under that lease agreement and acquired the headquarters by purchasing the equity interests of the previous owner for a purchase price of $34.9 million.

(2) Open purchase orders represent our commitment for items ordered but not yet received.

As more fully described in Note 5 of the Notes to Consolidated Financial Statements at December 31, 2006, we had issued letters of credit primarily in support of potential insurance related claims and specified outstanding bonds of approximately $21 million.

Additional borrowings, 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 51.6% at December 31, 2005 to 53.0% at December 31, 2006.

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2005 Compared to 2004

Net cash provided by operating activities increased by $85.2 million, from $325.8 million during 2004 to $411.0 million during 2005. This increase is the result of increases in net income of $16.1 million, depreciation expense of $7.8 million and other non-cash expenses of $15.1 million in 2005 as compared to 2004. In addition, changes in the timing of payments resulted in positive cash flows of $42.3 million from compensation related liabilities and $30.8 million from accounts payable and other liabilities. These improved cash flows were offset by an increase in accounts receivable of $15.6 million and a one-time advance payment made in connection with our new group purchasing agreement of approximately $11.0 million. Changes in all other operating assets and liabilities decreased net cash flows by $0.3 million during the year ended December 31, 2005. Cash flows provided by operating activities of discontinued operations were not material and are included in the consolidated net cash provided by operating activities.

The use of cash in investing activities increased $8.8 million from $318.5 million in 2004 to $327.3 million in 2005. The cash provided by operating activities, along with cash available at the beginning of the year, and cash from the disposition of hospitals, was sufficient to fund all investing activities during 2005.

In 2005, we generated $49.6 million of cash flows as a result of employees exercise of stock options. This cash along with cash, approximately equivalent to the tax benefit received upon the exercise of these options, was used toward the repurchase of 2.2 million shares under our stock repurchase program, thereby offsetting the impact of stock option exercises on our weighted shares outstanding.

Primarily as a result of our redemption of $150.9 million of principal amount of convertible notes in 2005 along with current year net income for 2005, our debt as a percentage of total capitalization decreased from 59.6% at December 31, 2004 to 51.6% at December 31, 2005.

Capital Expenditures

Cash expenditures for purchases of facilities were $384.6 million in 2006, $158.4 million in 2005 and $133.0 million in 2004. 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. Our capital expenditures in 2004 included $125.5 million for the acquisition of two hospitals and a surgery center in one of our markets, $7.5 million for information systems and other equipment to integrate the hospitals acquired in 2004.

Excluding the cost to construct replacement hospitals, our cash expenditures for routine capital for 2006 totaled $207.7 million compared to $185.6 million in 2005, and $149.8 million in 2004. Costs to construct replacement hospitals totaled $16.8 million in 2006, $2.8 million in 2005, and $14.5 million in 2004. Total additions to capital in 2006, including $44.0 million related to the construction of the new corporate headquarters and other amounts for which cash has not yet been expended, were $269.4 million. The reduction of capital lease liabilities is included in financing activities in our Statements of Cash Flows.

Pursuant to hospital purchase agreements in effect as of December 31, 2006, 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, the Company agreed to build a replacement facility at its Barstow Community Hospital in Barstow, California. Estimated construction costs, including equipment are approximately $230 million for these three replacement facilities. In addition, we entered into an agreement with a developer to build a new corporate headquarters which was completed in 2006. The Company accounts for this project as if it owns the assets. Construction costs of the new corporate headquarters are approximately $45 million of which approximately $43 million has been incurred through

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December 31, 2006. We expect total capital expenditures of approximately $320 to $330 million in 2007, including approximately $252 to $258 million for renovation and equipment purchases (which includes amounts which are required to be expended pursuant to the terms of the hospital purchase agreements) and approximately $68 to $72 million for construction and equipment cost of the replacement hospitals and corporate headquarters.

Capital Resources

Net working capital was $446.1 million at December 31, 2006 compared to $476.8 million at December 31, 2005. The $30.7 million decrease was attributable primarily to increases in accounts payable and employee compensation liabilities and a decrease in our cash on hand offset by increases in accounts receivable and other current assets.

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 Notes) on December 14, 2005. At the conclusion of this call for redemption, $0.3 million in principal amount of the Notes were redeemed for cash and $149.7 million of the Notes called for redemption, plus an additional $0.9 million of the 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 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 Notes, $0.1 million in principal amount of the Notes were redeemed for cash and $136.5 million of the Notes were converted by the holders into 4,074,510 shares of our common stock prior to the second redemption date.

On August 19, 2004 and subsequently amended on December 16, 2004, July 8, 2005 and December 13, 2006, we entered into a $1.625 billion senior secured credit facility with a consortium of lenders. This facility replaced our previous credit facility and consists of a $1.2 billion term loan with a final maturity in 2011 and a $425 million revolving tranche that matures in 2009. The First Incremental Facility Amendment, dated as of December 13, 2006, increased our term loans by $400 million. The proceeds of the borrowing were used to repay the full outstanding amount (approximately $326 million) of the revolving credit facility under the Credit Agreement and the balance is available to be used for general corporate purposes. We may elect from time to time an interest rate per annum for the borrowings under the term loans, and revolving credit facility equal to (a) an alternate base rate, which will be equal to the greatest of (i) the Prime Rate; (ii) the Federal Funds Effective Rate plus 50 basis points (the ABR), plus (1) 75 basis points for the term loan and (2) the Applicable Margin for revolving credit loans or (b) the Eurodollar Rate plus (1) 175 basis points for the term loan and (2) the Eurodollar Applicable Margin for revolving credit loans. The applicable margin varies depending on the ratio of our total indebtedness to annual consolidated EBITDA, ranging from 0.25% to 1.25% for alternate base rate loans and from 1.25% to 2.25% for Eurodollar loans. We also pay a commitment fee for the daily average unused commitments under the revolving tranche. The commitment fee is based on a pricing grid depending on the Applicable Margin for Eurodollar revolving credit loans and ranges from 0.250% to 0.500%. The commitment fee is payable quarterly in arrears and on the revolving credit termination date with respect to the available revolving credit commitments. In addition, we will pay fees for each letter of credit issued under the credit facility. As of December 31, 2006, our availability for additional borrowings under our revolving tranche was $425 million of which $21 million is set aside for outstanding letters of credit. We also have the ability to add up to $200 million of securitized debt and up to $400 million of additional term loans, as approved in the Amendment dated December 13, 2006. As of December 31, 2006, our weighted average interest rate under our credit agreement was 7.3%.

The terms of the credit agreement include various restrictive covenants. These covenants include restrictions on additional indebtedness, liens, investments, asset sales, capital expenditures, sale and leasebacks, contingent obligations, transactions with affiliates, dividends and stock repurchases and fundamental changes. We would be

required to amend the existing credit agreement in order to pay dividends to our shareholders in excess of $300 million subsequent to December 13, 2006. The covenants also require maintenance of various ratios regarding consolidated total indebtedness, consolidated interest, and fixed charges.

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As of December 31, 2006, 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 175 basis points for revolver loans and term loans under the senior secured credit facility.

Swap #	Notional Amount (In 000 s)	Fixed Interest Rate	Termination Date
1	100,000	2.0400%	June 13, 2007
2	150,000	3.3000%	November 4, 2007
3	100,000	2.4000%	June 13, 2008
4	100,000	3.5860%	August 29, 2008
5	100,000	4.0600%	May 30, 2008
6	100,000	3.9350%	June 6, 2009
7	100,000	4.3375%	November 30, 2009
8	100,000	4.9360%	October 4, 2010
9	100,000	4.7090%	January 24, 2011
10	100,000	4.7185%	August 19, 2011
11	100,000	4.7040%	August 19, 2011
12(1)	100,000	4.6250%	August 19, 2011

(1) This swap agreement becomes effective June 13, 2007, concurrent with the termination of agreement #1 listed above.

We believe that internally generated cash flows, availability for additional borrowings under our revolving tranche of $425 million, our ability to add up to $400 million in term loans and $200 million of accounts receivable securitized debt, under our senior secured credit facility 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

Included in our consolidated operating results for the years ended December 31, 2006 and 2005, was $280.1 million and $279.8 million, respectively, of net operating revenue and $6.1 million and $26.0 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 $15.8 million and $15.2 million for the years ended December 31, 2006 and 2005 respectively. The current terms of these operating leases expire between June 2007 and December 2019, not including lease extensions that we have options to exercise. Two of these leases are scheduled to expire in 2007. We intend to renew our lease scheduled to expire in June 2007. However, we have notified the lessor of our lease scheduled to expire in October 2007, of our intent not to renew. This hospital for which we are not renewing our lease generated $24.2 million in net operating revenue and a $4.4 million loss from continuing operations for the year ended December 31, 2006. If we allow the remainder of these leases to expire, we

would no longer generate revenue nor incur expenses from these hospitals.

In the past, we have utilized operating leases as a financing tool for obtaining the operations of specified hospitals without acquiring, through ownership, the related assets of the hospital and without a significant outlay of cash at the front end of the lease. We utilize the same operating strategies to improve operations at

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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 12 of the Notes to Consolidated Financial Statements, at December 31, 2006, the Company has certain cash obligations for replacement facilities and other construction commitments of $504.5 million and open purchase orders for $82.8 million.

Joint Ventures

We have from time to time sold minority interests in certain of our subsidiaries or acquired subsidiaries with existing minority interest ownership positions. This was the case with our acquisition of Chestnut Hill Hospital in March 2005, pursuant to which we acquired an 85% interest with the remaining 15% interest owned by the University of Pennsylvania. In our other joint ventures, physicians are the minority interest holders. The amount of minority interest in equity is included in other long-term liabilities and the minority interest in earnings is recorded as an operating expense. We do not believe these minority ownerships are material to our financial position or operating results. As of and for the years ended December 31, 2006 and 2005, the balance of minority interests included in long-term liabilities was $23.6 million and $17.2 million, respectively, and the amount of minority interest in earnings was $2.8 million and $3.1 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.

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Third Party Reimbursement

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. Contractual allowances are automatically calculated and recorded through our internally developed automated contractual allowance system . Within the automated system, actual Medicare DRG data, coupled with all payors historical paid claims data, is utilized to calculate the contractual allowances. This data is automatically updated on a monthly basis and subjected to 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, 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 10% 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 the Company 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. Previously, we estimated the allowance for doubtful accounts by reserving all accounts aging over 150 days from the date of discharge, without regard to payor class. We believe the revised methodology provides a better approach to reflect changes in payor mix and historical collection patterns and to respond to changes in trends. Collections are impacted by the economic ability of patients to pay and the effectiveness of our collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect our collection of accounts receivable. We also review our overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net revenue less provision for bad debts, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, and the impact of recent acquisitions and dispositions.

Our policy is to write-off gross accounts receivable if the balance is under $10.00 or when such amounts are placed with outside collection agencies. We believe this policy accurately reflects the ongoing collection efforts within the Company and is consistent with industry practices. We had approximately $834 million and $880 million at December 31, 2006 and December 31, 2005, respectively, being pursued by various outside collection agencies. We expect to collect less than 4%, net of estimated collection fees, of the amounts being pursued by outside collection agencies. As these amounts have been written-off, they are not included in our

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gross accounts receivable or our allowance for doubtful accounts. However, we take into consideration estimated collections of these amounts written-off in evaluating the reasonableness of our allowance for doubtful accounts.

Days revenue outstanding was 62 days at December 31, 2006 and 61 days at December 31, 2005. The change in our methodology of estimating our allowance for doubtful accounts reduced our days revenue outstanding by approximately 5 days. This decrease was offset by a similar increase in days revenue outstanding as a result of the build-up of accounts receivable at hospitals acquired in 2006. After giving effect to the change in our methodology of estimating our allowance for doubtful accounts, our target range for days revenue outstanding is 57 62 days.

The following table is an aging of our gross (prior to allowances for contractual adjustments and doubtful accounts) accounts receivable (in thousands):

	As of December 31,	
	2006	2005
0 60 days	63.3%	63.7%
60 150 days	17.7%	17.1%
151 360 days	7.1%	6.5%
Over 360 days	11.9%	12.7%
Total	100.0%	100.0%

The approximate percentage of total gross accounts receivable (prior to allowance for contractual adjustments and doubtful accounts) summarized by aging categories is as follows:

	Balance as of			
	As of December 31, 2006		As of December 31, 2005	
	0-150 Days	Over 150 Days	0-150 Days	Over 150 Days
Total gross accounts receivable	$ 1,840,045	$ 433,149	$ 1,526,620	$ 362,465

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,	
	2006	2005
Insured receivables	66.0%	65.0%
Self-pay receivables	34.0%	35.0%
Total	100.0%	100.0%

The total allowance for doubtful accounts, as reported in the condensed consolidated financial statements, as a percentage of self-pay receivables, net of other contractual allowance discounts, was approximately 64% at

December 31, 2006, and 54% at December 31, 2005.

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

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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. 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 in subsequent periods and result in a write-off of a portion or all of our goodwill.

Professional Liability Insurance Claims

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 4.6% and 4.1% in 2006 and 2005, respectively. To the extent that subsequent claims information varies from management s estimates, the liability is adjusted currently. Our insurance is underwritten on a claims-made basis. Prior to June 1, 2002 , substantially all of our professional and general liability risks were subject to a $0.5 million per occurrence deductible; for claims reported from June 1, 2002 through June 1, 2003, these deductibles were $2.0 million per occurrence. Additional coverage above these deductibles was purchased through captive insurance companies in which we had a 7.5% minority ownership interest in each and to which the premiums paid by us represented less than 8% of the total premium revenues of each captive insurance company. With the formation of our own wholly-owned captive insurance company in June 2003, we terminated our minority interest relationships in those entities. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 are self-insured up to $5 million per claim. Management on occasion has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals was purchased through commercial insurance companies and generally covers us for liabilities in excess of the self-insured amount and up to $100 million per occurrence for claims reported on or after June 1, 2003.

The following table represents the balance of our liability for the self-insured component of professional liability insurance claims and activity for each of the respective years listed (excludes premiums for insured coverage) (in thousands):

	Beginning of Year	Claims and Expenses Paid	Expense(1)	End of Year
2004	$ 40,912	$ 17,624	$ 40,561	$ 63,849
2005	63,849	15,544	40,066	88,371
2006	88,371	34,464	50,254	104,161

(1) Total expense, including premiums for insured coverage, was $49.7 million in 2004, $53.6 million in 2005 and $65.7 million in 2006.

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.

We operate in multiple states with varying tax laws. We are subject to both federal and state audits of tax returns. Our federal income tax returns have been examined by the Internal Revenue Service through fiscal year 2003. We agreed to a settlement at the Internal Revenue Service Appeals Office with respect to the 2003

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consolidated income tax return year. We have since received closing letters with respect to the examinations for the tax year 2003. The settlement was not material to our consolidated results of operations or financial position.

Recent Accounting Pronouncements

We adopted the provisions of SFAS No. 158, Employers Accounting for Defined Benefit Pension and Other Postretirement Plans, an amendment of SFAS No. 87, 88,106, and 132(R) (SFAS No. 158), for the year ended December 31, 2006. SFAS No. 158 requires an employer to recognize the overfunded or underfunded status of defined benefit pension and postretirement plans as an asset or liability in its consolidated statement of financial position and to recognize changes in that funded status in the year in which the changes occur through comprehensive income. It also requires disclosure in the notes to the consolidated financial statements additional information about certain effects on net periodic benefit cost for the next fiscal year that arise from delayed recognition of the gains or losses, prior service costs or credits, and transition asset or obligation. The adoption of SFAS No. 158 resulted in an increase to the pension liability of $13.8 million, deferred taxes of $5.5 million, and accumulated other comprehensive income of $8.3 million in the consolidated balance sheet for the year ending December 31, 2006.

In June 2006, the Financial Accounting Standards Board 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. We adopted FIN 48 as of January 1, 2007. The adoption of this interpretation will not have a material effect on our consolidated results of operations or 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 senior secured 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 2007. 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 would have resulted in interest expense fluctuating approximately $4 million for 2006, $7 million for 2005, and $5 million for 2004.

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

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Community Health Systems, Inc.
Franklin, Tennessee

We have audited the accompanying consolidated balance sheets of Community Health Systems, Inc. and subsidiaries (the Company) as of December 31, 2006 and 2005, and the related consolidated statements of income, stockholders equity, and cash flows for each of the three years in the period ended December 31, 2006. 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, 2006 and 2005, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2006, 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 Payments 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 effectiveness of the Company s internal control over financial reporting as of December 31, 2006, 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 20, 2007 expressed an unqualified opinion on management s assessment of the effectiveness of the Company s internal control over financial reporting and an unqualified opinion on the effectiveness of the Company s internal control over financial reporting.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 20, 2007

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2006	2005	2004
	(In thousands, except share and per share data)		
Net operating revenues	$ 4,365,576	$ 3,738,320	$ 3,203,507
Operating costs and expenses:			
Salaries and benefits	1,741,223	1,486,407	1,279,136
Provision for bad debts	547,781	377,596	324,643
Supplies	510,351	448,210	389,584
Rent	97,104	87,210	76,986
Other operating expenses	897,091	765,697	639,037
Minority interest in earnings	2,795	3,104	2,494
Depreciation and amortization	188,771	164,563	149,155
Total operating costs and expenses	3,985,116	3,332,787	2,861,035
Income from operations	380,460	405,533	342,472
Interest expense, net of interest income of $1,779, $5,742 and $526 in 2006, 2005 and 2004, respectively	102,299	94,613	75,256
Loss from early extinguishment of debt			788
Income from continuing operations before income taxes	278,161	310,920	266,428
Provision for income taxes	106,682	120,782	104,071
Income from continuing operations	171,479	190,138	162,357
Discontinued operations, net of taxes:			
Loss from operations of hospitals sold or held for sale	(657)	(10,505)	(7,279)
Net loss on sale of hospitals	(2,559)	(7,618)	(2,020)
Impairment of long-lived assets of hospital held for sale		(4,471)	(1,625)
Loss on discontinued operations	(3,216)	(22,594)	(10,924)
Net income	$ 168,263	$ 167,544	$ 151,433
Earnings per common share basic:			
Income from continuing operations	$ 1.81	$ 2.15	$ 1.70
Loss on discontinued operations	$ (0.04)	$ (0.26)	$ (0.12)
Net income	$ 1.77	$ 1.89	$ 1.58
Earnings per common share diluted:			

Income from continuing operations	$ 1.78	$ 2.02	$ 1.62
Loss on discontinued operations	$ (0.03)	$ (0.23)	$ (0.11)
Net income	$ 1.75	$ 1.79	$ 1.51
Weighted average number of shares outstanding:			
Basic	94,983,646	88,601,168	95,643,733
Diluted	96,232,910	98,579,977	105,863,790

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2006	2005
	(In thousands, except share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 40,566	$ 104,108
Patient accounts receivable, net of allowance for doubtful accounts of $478,565 and $346,024 in 2006 and 2005, respectively	773,984	656,029
Supplies	113,320	95,200
Deferred income taxes	13,249	4,128
Prepaid expenses and taxes	32,385	33,377
Other current assets	47,880	21,367
Total current assets	1,021,384	914,209
Property and equipment:		
Land and improvements	163,988	121,637
Buildings and improvements	1,634,893	1,307,978
Equipment and fixtures	831,485	699,024
	2,630,366	2,128,639
Less accumulated depreciation and amortization	(643,789)	(517,648)
Property and equipment, net	1,986,577	1,610,991
Goodwill	1,336,525	1,259,816
Other assets, net of accumulated amortization of $92,921 and $78,599 in 2006 and 2005, respectively	162,093	149,202
Total assets	$ 4,506,579	$ 3,934,218
LIABILITIES AND STOCKHOLDERS EQUITY		
Current liabilities:		
Current maturities of long-term debt	$ 35,396	$ 19,124
Accounts payable	247,747	189,940
Current income taxes payable	7,626	19,811
Accrued liabilities:		
Employee compensation	162,188	121,775

Interest	7,122	8,591
Other	115,204	78,162
Total current liabilities	575,283	437,403
Long-term debt	1,905,781	1,648,500
Deferred income taxes	141,472	157,579
Other long-term liabilities	160,370	126,159
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; 95,026,494 shares issued and 94,050,945 shares outstanding at December 31, 2006 and 94,539,837 shares issued and 93,564,288 shares outstanding at December 31, 2005	950	945
Additional paid-in capital	1,195,947	1,208,930
Treasury stock, at cost, 975,549 shares at December 31, 2006 and 2005	(6,678)	(6,678)
Unearned stock compensation		(13,204)
Accumulated other comprehensive income	5,798	15,191
Retained earnings	527,656	359,393
Total stockholders equity	1,723,673	1,564,577
Total liabilities and stockholders equity	$ 4,506,579	$ 3,934,218

See notes to consolidated financial statements.

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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	Stock Compensation	Income (Loss)	Deficit)	T
				(In thousands, except share data)					
CE, r 31, 2003	99,657,532	$ 997	$ 1,315,959	$ (975,549)	$ (6,678)	$ (2)	$ (103)	$ 40,416	$ 1,
ensive Income:									
ne								151,433	
ge in fair value t rate swaps, net pense of $3,459							6,149		
prehensive							6,149	151,433	
se of common	(12,000,000)	(120)	(290,400)						(
of common onnection with se of options	701,641	7	9,893						
of common mployee benefit	232,560	2	6,151						
fit from exercise s and offering			6,285						
ock ation						2			
CE, r 31, 2004	88,591,733	$ 886	$ 1,047,888	(975,549)	$ (6,678)	$	$ 6,046	$ 191,849	$ 1,
ensive Income:									
ne								167,544	
ge in fair value t rate swaps, net pense of $5,019							8,923		
ge in fair value le for sale							222		

prehensive										
								9,145	167,544	
ses of common										
	(2,239,700)	(22)	(79,830)							
of common										
onnection with										
se of options	3,134,721	31	49,543							
of common										
onnection with										
rsion of										
le debt	4,495,083	44	148,576							
l stock grant	558,000	6	18,160			(18,160)				
fit from exercise										
			24,453							
ock										
tion						4,956				
eous			140							
CE,										
r 31, 2005	94,539,837	$ 945	$ 1,208,930	(975,549)	$ (6,678)	$ (13,204)	$ 15,191	$ 359,393	$ 1,	
ensive Income:										
ne								168,263		
ge in fair value										
t rate swaps, net										
efit of $931							(1,654)			
ge in fair value										
le for sale										
							562			
nt to adopt										
tement No. 158,										
benefit of										
							(8,301)			
prehensive										
							(9,393)	168,263		
ses of common										
	(5,000,000)	(50)	(176,265)							(
of common										
onnection with										
se of options	867,833	9	14,564							
of common										
onnection with										
rsion of										
le debt	4,074,510	41	137,157							
l stock grant										
fit from exercise										
			4,750							
ock										
tion	544,314	5	20,068							

cation of									
pensation			(13,257)			13,204			
CE,									
r 31, 2006	95,026,494	$ 950	$ 1,195,947	(975,549)	$ (6,678)	$	$ 5,798	$ 527,656	$ 1,

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2006	2005	2004
	(In thousands)		
Cash flows from operating activities:			
Net income	$ 168,263	$ 167,544	$ 151,433
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	188,771	166,162	158,380
Deferred income taxes	(25,228)	9,889	41,902
Stock compensation expense	20,073	4,957	2
Excess tax benefits relating to stock-based compensation	(6,819)		
Loss on early extinguishment of debt			788
Minority interest in earnings	2,795	3,104	1,578
Impairment on hospital held for sale		6,718	2,539
Loss on sale of hospitals	3,937	6,295	2,186
Other non-cash expenses, net	500	740	669
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	(71,141)	(47,455)	(31,814)
Supplies, prepaid expenses and other current assets	(4,544)	(16,838)	(13,549)
Accounts payable, accrued liabilities and income taxes	52,151	84,956	(24,371)
Other	21,497	24,977	36,007
Net cash provided by operating activities	350,255	411,049	325,750
Cash flows from investing activities:			
Acquisitions of facilities and other related equipment	(384,618)	(158,379)	(133,033)
Purchases of property and equipment	(224,519)	(188,365)	(164,286)
Disposition of hospitals	750	51,998	7,850
Proceeds from sale of equipment	4,480	2,325	790
Increase in other assets	(36,350)	(34,851)	(29,800)
Net cash used in investing activities	(640,257)	(327,272)	(318,479)
Cash flows from financing activities:			
Proceeds from exercise of stock options	14,573	49,580	9,900
Proceeds from issuance of senior subordinated notes			300,000
Stock buy-back	(176,316)	(79,853)	(290,520)
Deferred financing costs	(2,153)	(1,259)	(12,783)
Excess tax benefits relating to stock-based compensation	6,819		
Redemption of convertible notes	(128)	(298)	

Proceeds from minority investors in joint ventures	6,890	1,383	
Redemption of minority investments in joint ventures	(915)	(3,242)	(3,522)
Distribution to minority investors in joint ventures	(3,220)	(1,939)	(1,238)
Borrowings under Credit Agreement	1,031,000		1,725,768
Repayments of long-term indebtedness	(650,090)	(26,539)	(1,668,709)
Net cash (used in) provided by financing activities	226,460	(62,167)	58,896
Net change in cash and cash equivalents	(63,542)	21,610	66,167
Cash and cash equivalents at beginning of period	104,108	82,498	16,331
Cash and cash equivalents at end of period	$ 40,566	$ 104,108	$ 82,498

See notes to consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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 that are the principal providers of primary healthcare services in non-urban communities. As of December 31, 2006, the Company owned, leased or operated 77 hospitals, licensed for 9,117 beds in 22 states. Pennsylvania represents the only area of geographic concentration; net operating revenues generated by the Company s hospitals in that state, as a percentage of consolidated net operating revenues, were 21.0% in 2006, 22.1% in 2005 and 19.0% in 2004.

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 and its subsidiaries, all of which are controlled by the Company through majority voting control. All significant intercompany accounts and transactions have been eliminated. Certain of the subsidiaries have minority stockholders. The amount of minority interest in equity is not material and is included in other long-term liabilities on the consolidated balance sheets and minority interest in income or loss 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, which were $88.9 million, $67.5 million and $47.9 million for the years ended December 31, 2006, 2005 and 2004, 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 No. 115, Accounting for Certain Investments in Debt and Equity Securities (SFAS 115). Currently, all of the Company s marketable securities are classified as 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. Interest and dividends on securities classified as available-for-sale are included in net revenue. Accumulated other comprehensive income included an unrealized gain of $0.6 million and $0.2 million at December 31, 2006 and December 31, 2005, respectively, related to these available-for-sale securities. The gross realized gains and losses from the sale of available-for-sale securities were not

material in all periods presented.

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 $61.2 million and $54.0 million at December 31, 2006 and 2005, 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 Statement of Financial Accounting Standards (SFAS) No. 34, Capitalization of Interest Cost, was $3.0 million for the year ended December 31, 2006, and $2.1 million for each of the years ended December 31, 2005 and 2004.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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, 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. The Company 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.

Third-Party Reimbursement. 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 42% of net operating revenues for the year ended December 31, 2006, 43% of net operating revenues for the year ended December 31, 2005 and 42% of net operating revenues for the year ended December 31, 2004, are related to services rendered to patients covered by the Medicare and Medicaid programs. Included in the amounts received from Medicare are approximately 0.44% of net operating revenues for 2006, 0.47% for 2005 and 0.45% for 2004 related to Medicare outlier payments. 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. 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, 2006, 2005 and 2004. Amounts due to third-party payors were $55 million as of December 31, 2006 and $43 million as of December 31, 2005 and are included in accrued liabilities-other in the accompanying consolidated balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 2004.

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 reflects 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 believes 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.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

In conjunction with recording a $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 will reserve 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 will reserve 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 provides a better approach to reflect changes in payor mix and historical collection patterns and to respond to changes in trends. The revised accounting methodology and the adequacy of resulting estimates will continue to be reviewed by monitoring historical cash collections as a percentage of trailing net revenues less provision for bad debts, 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.

The effect of this change in estimate was to increase the allowance for doubtful accounts by $65.0 million which resulted in an after tax decrease of income from continuing operations of $40.0 million, or $0.42 per share (diluted) for the year ended December 31, 2006.

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. The following table presents accounts receivable, net of the related contractual allowance (in thousands):

	As of December 31,			
	2006		2005	
	Medicare	Medicaid, Managed Care, Self-pay and Other	Medicare	Medicaid, Managed Care, Self-pay and Other
Gross accounts receivable	$ 499,419	$ 1,773,775	$ 433,369	$ 1,455,716
Contractual allowance	(382,614)	(638,031)	(349,807)	(537,225)
Accounts receivable, net of contractual allowance	$ 116,805	$ 1,135,744	$ 83,562	$ 918,491

Net Operating Revenues. Net operating revenues are recorded net of provisions for contractual allowance of approximately $10,569 million, $8,893 million and $7,214 million in 2006, 2005 and 2004, respectively. Net operating revenues are recognized when services are provided. 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 $222.9 million, $182.3 million and $133.4 million for the years ended December 31, 2006, 2005 and 2004, respectively. Also included in the provision for contractual allowance shown above is the value of administrative discounts provided to self-pay patients eliminated from net operating revenues which was $107.7 million, $82.5 million and $59.7 million for the years ended December 31, 2006, 2005 and 2004, 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.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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, 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.

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, 2004	$ 6,046	$	$	$ 6,046
2005 Activity, net of tax	8,923	222		9,145
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

Segment Reporting. SFAS No. 131, Disclosures About Segments of an Enterprise and Related Information, 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 operating segment if the businesses have similar economic characteristics and are considered similar under the criteria established by SFAS No. 131. The Company s operating segments have similar services, have similar types of patients, operate in a consistent manner and have similar economic and regulatory characteristics. Therefore, the Company has aggregated its operating segments into one reportable segment.

Derivative Instruments and Hedging Activities. In accordance with SFAS No. 133, Accounting for Derivative Instruments and Hedging Activities , 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

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

hedged item. Any portion of the fair value of a derivative instrument determined to be ineffective under the standard is recognized in current earnings.

The Company has entered into several interest rate swap agreements subject to the scope of this pronouncement. See Note 6 for further discussion about the swap transactions.

New Accounting Pronouncements. In June 2006, the Financial Accounting Standards Board 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 will not have a material effect on the Company s consolidated results of operations or consolidated financial position.

Reclassifications. Certain prior year amounts have been reclassified to conform to current year presentation. The Company disposed of four hospitals in March 2005, one lease expired pursuant to its terms during the quarter ended March 31, 2005, designated one hospital as being held for sale in the second quarter of 2005 which was sold during the first quarter 2006 and disposed of two hospitals in August 2004. The operating results of those hospitals have been classified as discontinued operations on the consolidated statements of income for all periods presented. There is no effect on net income for all periods presented related to the reclassifications made for the discontinued operations.

2. Accounting for Stock-Based Compensation

The Company adopted the provisions of SFAS No. 123(R), Share-Based Payments (SFAS No. 123(R)) on January 1, 2006, electing to use the modified prospective method for transition purposes. The modified prospective method requires that compensation expense be recorded for all unvested stock options and share awards that subsequently vest or are modified, without restatement of prior periods. Prior to January 1, 2006, the Company accounted for stock-based compensation using the recognition and measurement principles of APB Opinion 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. Under APB Opinion 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.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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 each of the two years ended prior to the adoption of SFAS No. 123(R) (in thousands, expect per share data):

	Year Ended	
	2005	2004
Net Income:	$ 167,544	$ 151,433
Add: Stock-Based compensation expense recognized under APB 25, net of tax	3,493	
Deduct: Total stock-based compensation under fair value based method for all awards, net of tax	$ 14,232	$ 6,601
Pro-forma net income	$ 156,805	$ 144,832
Net income per share:		
Basic as reported	$ 1.89	$ 1.58
Basic proforma	$ 1.77	$ 1.51
Diluted as reported	$ 1.79	$ 1.51
Diluted proforma	$ 1.68	$ 1.45

For purposes of the above table the fair value of each option grant was estimated on the date of grant using the Black-Scholes option pricing model with the following weighted-average assumptions used for grants during each of the years ended December 31:

	Year Ended	
	2005	2004
Expected volatility	36%	33%
Expected dividends	0	0
Expected term	4 years	4 years
Risk-free interest rate	3.88%	3.16%

On September 22, 2005 the Compensation Committee of the Board of Directors of Community Health Systems, Inc. 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 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 Plan). No performance shares or units or incentive stock options have been granted under the 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 Statement of Financial Accounting Standards (SFAS) No. 123 (revised 2004) Share-Based Payment would be avoided.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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, Accounting for Stock-Based Compensation Transition and Disclosure an Amendment of FASB Statement No. 123 , 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 Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan (the 2000 Plan). The 2000 Plan allows for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code as well as stock options which do not so qualify, stock appreciation rights, restricted stock, performance units and performance shares, phantom stock awards and share awards. Persons eligible to receive grants under the 2000 Plan include the Company s directors, officers, employees and consultants. To date, the options granted under the 2000 Plan are nonqualified stock options for tax purposes. Vesting of these granted options occurs in one third increments on each of the first three anniversaries of the award date. Options granted prior to 2005 have a 10 year contractual term and options granted in 2005 and 2006 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, 2006, 5,954,865 shares of 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 25 for periods prior to January 1, 2006, on the reported operating results for the respective periods (in thousands, except per share data):

	Year Ended December 31		
	2006	2005	2004
Effect on income from continuing operations before income taxes	$ (19,851)	$ (4,960)	$
Effect on net income	$ (12,549)	$ (3,493)	$
Effect on net income per share-diluted	$ (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 25 and related interpretations. This requirement reduced the Company s net operating cash flows and increased the Company s financing cash flows by $6.8 million for the year ended December 31, 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 25, was reclassified into additional paid-in capital upon the adoption of SFAS No. 123(R).

At December 31, 2006, $36.8 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 20 months. There were no modifications to awards during 2006.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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 year ended December 31, 2006, as follows:

	Year Ended December 31, 2006
Expected volatility	24.2%
Expected dividends	0
Expected term	4 years
Risk-free interest rate	4.67%

As part of adopting SFAS No. 123(R), 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. As part of adopting SFAS No. 123(R), 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. As required under SFAS No. 123(R), the Company will adjust the estimated forfeiture rate to its actual experience.

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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, 2006, and changes during each of the three years then ended 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, 2006
Outstanding at December 31, 2003	8,029,370	$ 17.59		
Granted	387,000	26.41		
Exercised	(614,444)	15.19		
Forfeited and cancelled	(345,647)	22.25		
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		$ 18,200
Forfeited and cancelled	(172,913)	34.02		
Outstanding at December 31, 2006	5,482,528	$ 26.48	6.8 years	$ 56,941
Exercisable at December 31, 2006	3,562,002	$ 21.55	6.3 years	$ 53,391

The weighted-average grant date fair value of stock options granted during the year ended December 31, 2006, was $10.38. 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, 2006. This amount changes based on the market value of the Company s common stock.

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. Certain of the restricted stock awards granted to the Company s senior executives also contain a performance objective that must be met in addition to the vesting requirements. If the performance objective is not attained the

awards will be forfeited in their entirety. Once the performance objective has been attained, restrictions will lapse in one-third increments on each of the first three anniversaries of the award date. Notwithstanding the above mentioned performance objectives and vesting requirements, the restrictions will lapse earlier in the event of death, disability, termination of employment by employer for reason other than for cause of the holder of the restricted stock or in the event of change in control of the Company. Restricted stock awards subject to performance standards are not considered outstanding for purposes of determining earnings per share until the performance objectives have been satisfied.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Restricted stock outstanding under the 2000 Plan as of December 31, 2006, and changes during each of the two years then ended are 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

As of December 31, 2006, there was $23.4 million of unrecognized stock-based compensation expense related to unvested restricted stock expected to be recognized over a weighted-average period of 21 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, 2006	2005
Directors fees earned and deferred into plan	$ 177,500	$ 184,500
Equivalent units	4,843.449	4,942.552

At December 31, 2006, there are a total of 9,786.001 units deferred in the plan with an aggregate fair value of $357,385, based on the closing market price of the Company s common stock at December 31, 2006 of $36.52.

3. Long-Term Leases, Acquisitions and Divestitures of Hospitals

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

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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.

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.

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 $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.

In connection with the above actions and in accordance with SFAS No. 144, the Company has classified the results of operations of Randolph County Medical Center, Sabine Medical Center, Scott County Hospital, The King s Daughters Hospital, Troy Regional Medical Center, Lakeview Community Hospital, Northeast Medical Center and Highland Medical Center as discontinued operations in the accompanying consolidated statements of income. The consolidated statements of income for each period presented have been restated to reflect the classification of these eight hospitals as discontinued operations.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Net operating revenues and loss reported for the eight hospitals in discontinued operations are as follows:

	Year Ended December 31,		
	2006	2005	2004
	(In thousands)		
Net operating revenues:	$ 4,294	$ 50,520	$ 156,711
Loss from operations of hospitals sold or held for sale before income taxes	(1,008)	(16,141)	(11,039)
Loss on sale of hospitals	(3,938)	(6,295)	(2,186)
Impairment of long-lived assets of hospital held for sale		(6,718)	(2,539)
Loss from discontinued operations, before taxes	(4,946)	(29,154)	(15,764)
Income tax benefit	1,730	6,560	4,840
Loss from discontinued operations, net of tax	$ (3,216)	$ (22,594)	$ (10,924)

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.

The computation of loss from discounted 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.

Included in the computation of the loss from discontinued operations, before taxes for the year ended December 31, 2004, is a write-off of $7.0 million of tangible assets and $2.7 million of goodwill at the two hospitals sold (see Note 3 Goodwill and Other Intangible Assets) and a write-down of $3.0 million of assets at the hospital held for sale.

Assets and liabilities of the hospitals classified as discontinued operations included in the accompanying consolidated balance sheets are as follows. There are no material assets or liabilities related to these hospitals remaining at December 31, 2006.

	December 31, 2005
	(In thousands)
Current assets	$ 4,133
Property and equipment	

Other assets		3,000
Current liabilities		(6,601)
Net assets	$	532

During 2004, the Company acquired, through two separate purchase transactions, most of the assets and working capital of two hospitals. On July 1, 2004, the Company acquired Galesburg Cottage Hospital, a 170 bed facility located in Galesburg, Illinois. On August 1, 2004, the Company acquired Phoenixville Hospital, a 143 bed facility located in Phoenixville, Pennsylvania. This acquisition also included a 95,000 square foot medical complex in nearby Limerick, Pennsylvania which houses an ambulatory surgical facility, an imaging center and medical office space. The aggregate consideration for the two hospitals totaled approximately $135 million, consisting of approximately $123 million in cash and approximately $12 million in assumed liabilities and acquisition costs. Goodwill recorded during 2004 is expected to be fully deductible for tax purposes.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Effective August 1, 2004, the Company sold Randolph County Medical Center, a 50 bed facility located in Pocahontas, Arkansas and Sabine Medical Center, a 48 bed facility located in Many, Louisiana, two of the Company s underperforming hospitals, to Associated Healthcare Systems in Brentwood, Tennessee. The aggregate sales price for these two hospitals was approximately $9 million of which $7.8 million was received in cash and $1.2 million was received in the form of a note, which was paid in full in 2005.

The aforementioned acquisitions 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, for certain acquisition transactions closed in 2006, is subject to settling amounts related to purchased working capital and in some instances final appraisals. Independent asset valuations are generally completed within 120 days of the date of acquisition; working capital settlements are generally made within 180 days of the date of acquisition. Adjustments to the purchase price allocation are not expected to be material.

The table below summarizes the allocations of the purchase price (including assumed liabilities) for these acquisitions (in thousands):

	2006	2005	2004
Current assets	$ 56,896	$ 19,144	$ 10,104
Property and equipment	262,335	110,854	76,917
Goodwill and other intangibles	66,490	43,619	49,048

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 2006 and 2005 as if the acquisitions had occurred as of January 1, 2005 (in thousands except per share data):

	Year Ended December 31,	
	2006	2005
Pro forma net operating revenues	$ 4,569,861	$ 4,307,657
Pro forma net income	159,940	138,940
Pro forma net income per share:		
Basic	1.68	1.57
Diluted	1.66	1.50

4. Goodwill and Other Intangible Assets

The changes in the carrying amount of goodwill are as follows (in thousands):

	Year Ended December 31, 2006	2005
Balance, beginning of year	$ 1,259,816	$ 1,213,783
Goodwill acquired as part of acquisitions during the year	67,550	51,773
Consideration adjustments and finalization of purchase price allocations for prior year s acquisitions	9,159	11,353
Goodwill written off as part of disposals		(17,093)
Balance, end of year	$ 1,336,525	$ 1,259,816

The Company performed its initial goodwill evaluation, as required by SFAS No. 142, during the first quarter of 2002 and the annual evaluation as of each succeeding September 30th. No impairment was indicated by these evaluations.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

The gross carrying amount of the Company s other intangible assets was $13.7 million as of December 31, 2006 and $11.9 million as of December 31, 2005, and the net carrying amount was $7.4 million and $7.6 million as of December 31, 2006 and 2005, respectively. 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 5 years. There are no expected residual values related to these intangible assets. Amortization expense for these intangible assets was $1.9 million, $1.3 million and $1.1 million during the years ended December 31, 2006, 2005 and 2004, respectively. Amortization expense on intangible assets is estimated to be $1.8 million in 2007, $1.2 million in 2008, $0.9 million in 2009, $0.8 million in 2010 and $0.5 million in 2011.

5. Income Taxes

The provision for income taxes for income from continuing operations consists of the following (in thousands):

	Year Ended December 31,		
	2006	2005	2004
Current			
Federal	$ 113,823	$ 100,588	$ 55,184
State	13,555	12,746	9,003
	127,378	113,334	64,187
Deferred			
Federal	(18,586)	5,737	33,994
State	(2,110)	1,711	5,890
	(20,696)	7,448	39,884
Total provision for income taxes for income from continuing operations	$ 106,682	$ 120,782	$ 104,071

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,					
	2006		2005		2004	
	Amount	%	Amount	%	Amount	%
Provision for income taxes at statutory federal rate	$ 97,356	35.0%	$ 108,822	35.0%	$ 93,250	35.0%

State income taxes, net of federal income tax benefit	7,439	2.7	9,570	3.0	9,608	3.6
Other	1,887	0.7	2,390	0.8	1,213	0.5
Provision for income taxes and effective tax rate for income from continuing operations	$ 106,682	38.4%	$ 120,782	38.8%	$ 104,071	39.1%

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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):

	2006		2005	
	Assets	Liabilities	Assets	Liabilities
Net operating loss and credit carryforwards	$ 26,709	$	$ 27,798	$
Property and equipment		136,249		124,439
Self-insurance liabilities	35,607		28,639	
Intangibles		101,569		85,745
Other liabilities		2,879		3,472
Long-term debt and interest	989			56
Accounts receivable	33,535		8,767	
Accrued expenses	20,362		17,861	
Other comprehensive income		1,952		8,391
Stock-Based compensation	6,353			
Other	12,078		6,733	
	135,633	242,649	89,798	222,103
Valuation allowance	(21,207)		(21,146)	
Total deferred income taxes	$ 114,426	$ 242,649	$ 68,652	$ 222,103

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 $458 million, which expire from 2007 to 2026. 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 $0.1 million and $1.5 million during the years ended December 31, 2006 and 2005, respectively. In addition to amounts previously discussed, the change in valuation allowance relates to a redetermination of the amount of, and realizability of, net operating losses in certain state income tax jurisdictions.

The Company paid income taxes, net of refunds received, of $128.1 million, $68.1 million and $60.9 million during 2006, 2005, and 2004, respectively.

Federal Income Tax Examination. The Company agreed to a settlement at the Internal Revenue Service Appeals Office with respect to the 2003 consolidated income tax return year. The Company has since received closing letters with respect to the examinations for the tax year 2003. This settlement was not material to the Company s consolidated

statement of income or financial position.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

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6. Long-Term Debt

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

	As of December 31, 2006	2005
Credit Facilities:		
Revolving Credit Loans	$	$
Term Loans	1,572,000	1,185,000
Convertible Notes		136,624
Tax-exempt bonds	8,000	8,000
Senior Subordinated Notes	300,000	300,000
Capital lease obligations (see Note 8)	44,670	21,792
Term loans from acquisitions		
Other	16,507	16,208
Total debt	1,941,177	1,667,624
Less current maturities	(35,396)	(19,124)
Total long-term debt	$ 1,905,781	$ 1,648,500

Credit Facilities. 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. This facility replaced the Company s previous credit facility and consists of a $1.2 billion term loan that matures in 2011 and a $425 million revolving credit facility that matures in 2009. The First Incremental Facility Amendment, dated as of December 13, 2006, provides for an additional tranche of term loans to the Credit Agreement in an aggregate principal amount of $400 million (the Incremental Term Loan Facility). 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 is available to be used for general corporate purposes. The Company may 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 will be equal to the greatest of (i) the Prime Rate in effect and (ii) the Federal Funds effective Rate, plus 50 basis points, plus (1) 75 basis points for the term loan and (2) the Applicable Margin for revolving credit loans or (b) the Eurodollar Rate plus (1) 175 basis points for the term loan and (2) the Applicable Margin for Eurodollar revolving credit loans. The Company also pays a commitment fee for the daily average unused commitments under the revolving credit facility. The commitment fee is based on a pricing grid depending on the Applicable Margin for Eurodollar revolving credit loans and ranges from 0.250% to 0.500%. The commitment fee is payable quarterly in arrears and on the revolving credit termination date with respect to the available revolving credit commitments. In addition, the Company will pay fees for each letter of credit issued under the credit facility. The purpose of the facility was to refinance 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. In connection with this refinancing, the Company recorded a pre-tax write-off of approximately $0.8 million in deferred loan costs relative to the early extinguishment of a portion of the previous credit facility.

As of December 31, 2006, the Company s availability for additional borrowings under its revolving tranche was $425 million, of which $21 million was set aside for outstanding letters of credit. The Company also has the ability to add up to $200 million of borrowing capacity from receivable transactions (including securitizations) under its senior secured credit facility which has not yet been accessed. The Company also has

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

the ability to amend the senior secured credit facility to provide for one or more tranches of term loans in an aggregate principal amount up to $400 million, which the Company has not yet accessed. As of December 31, 2006, the Company s weighted average interest rate under its credit agreement was 7.3%.

The terms of the credit agreement include various restrictive covenants. These covenants include restrictions on additional indebtedness, liens, investments, asset sales, capital expenditures, sale and leasebacks, contingent obligations, transactions with affiliates, dividends and stock repurchases and fundamental changes. The Company would be required to amend the existing credit agreement in order to pay dividends in excess of $300 million to the Company s shareholders. The covenants also require maintenance of various ratios regarding consolidated total indebtedness, consolidated interest, and fixed charges.

The Term Loans are scheduled to be paid with principal payments for future years as follows (in thousands):

	Term Loans
2007	$ 16,000
2008	16,000
2009	16,000
2010	295,000
2011	850,000
Thereafter	379,000
Total	$ 1,572,000

As of December 31, 2006 and 2005, the Company had letters of credit issued, primarily in support of potential insurance related claims and certain bonds of approximately $21 million and $23 million, respectively.

Convertible Notes. On October 15, 2001, the Company sold $287.5 million aggregate principal amount (including the underwriter s over-allotment option) of 4.25% convertible notes for face value. The notes were scheduled to mature on October 15, 2008 unless converted or redeemed earlier. Interest on the notes was payable semi-annually on April 15 and October 15 of each year. The interest payments commenced April 15, 2002. The notes were convertible, at the option of the holder, into shares of the Company s common stock at any time before the maturity date, unless the Company has previously redeemed or repurchased the notes, at a conversion rate of 29.8507 shares of common stock per $1,000 principal amount of notes representing a conversion price of $33.50. The conversion rate was subject to anti-dilution adjustment in some events.

On November 14, 2005 the Company elected to call for redemption $150.0 million in principal amount of the convertible notes. At the conclusion of the first call for redemption, $0.3 million in principal amount of the convertible notes were redeemed for cash, and $149.7 million of the convertible notes called for redemption, plus an additional $0.9 million of the convertible notes, were converted by the holders into 4,495,083 shares of the Company s common stock, $.01 par value per share. On December 16, 2005 the Company elected to call for redemption the remaining

convertible notes. In January 2006, at the conclusion of this second call for redemption $0.1 million in principal amount of the convertible notes were redeemed for cash and the remaining balance of $136.5 million were converted into 4,074,510 shares of the Company s common stock.

Tax-Exempt Bonds. Tax-Exempt Bonds bore interest at floating rates, which averaged 3.51% and 2.51% during 2006 and 2005, 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

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

subordinated notes were sold in an offering pursuant to Rule 144A and Regulation S under the Securities Act of 1933. The senior subordinated notes have not been registered under the Securities Act of 1933 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 Securities Act of 1933 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.

Other Debt. As of December 31, 2006, other debt consisted primarily of an industrial revenue bond and other obligations maturing in various installments through 2014.

The Company is currently a party to twelve separate interest swap agreements with an aggregate notional amount of $1,250 million, 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 175 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, 2006, 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):

2007	$ 35,396
2008	21,062
2009	18,523
2010	304,941
2011	851,714
Thereafter	709,541
	$ 1,941,177

The Company paid interest of $96 million, $90 million and $74 million on borrowings during the years ended December 31, 2006, 2005 and 2004, respectively.

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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, 2006 and 2005, 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,			
	2006		2005	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Assets:				
Cash and cash equivalents	$ 40,566	$ 40,566	$ 104,108	$ 104,108
Available-for-sale securities	25,334	25,334	19,778	19,778
Liabilities:				
Credit facilities	1,572,000	1,573,540	1,185,000	1,199,072
Convertible Notes			136,624	156,434
Tax-exempt Bonds	8,000	8,000	8,000	8,000
Senior Subordinated Notes	300,000	295,500	300,000	294,750
Other debt	4,344	4,344	5,536	5,536

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.

Credit facilities, term loans from acquisitions and other debt. Estimated fair value is based on information from the Company s bankers regarding relevant pricing for trading activity among the Company s lending institutions.

Convertible Notes. Estimated fair value is based on the average bid and ask price as quoted in public markets for these instruments.

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 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, 2006 and 2005, 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

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Company does not hold or issue derivative financial instruments for trading purposes. Interest rate swaps consisted of the following at December 31, 2006:

Swap #	Notional Amount (In 000 s)	Fixed Interest Rate	Termination Date	Fair Value (000 s)
1	100,000	2.04%	June 13, 2007	$ 1,466
2	150,000	3.30%	November 4, 2007	2,451
3	100,000	2.40%	June 13, 2008	3,848
4	100,000	3.586%	August 29, 2008	2,429
5	100,000	4.06%	May 30, 2008	1,486
6	100,000	3.9350%	June 6, 2009	2,497
7	100,000	4.3375%	November 30, 2009	1,810
8	100,000	4.9360%	October 4, 2010	186
9	100,000	4.7090%	January 24, 2011	1,043
10	100,000	4.7185%	August 19, 2011	1,155
11	100,000	4.7040%	August 19, 2011	1,249
12	100,000	4.6250%	August 19, 2011	1,224

(1) This swap agreement becomes effective June 13, 2007, concurrent with the termination of agreement No. 1 listed above.

Assuming no change in December 31, 2006 interest rates, approximately $15.7 million will be recognized in earnings through interest income during the year ending December 31, 2007 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.

8. Leases

The Company leases hospitals, medical office buildings, and certain equipment under capital and operating lease agreements. During 2006, the Company entered into $29.8 million of capital leases. 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	Capital
2007	$ 62,415	$ 7,285
2008	47,087	6,734
2009	37,239	4,381
2010	28,553	3,694

2011	24,292	3,382
Thereafter	98,807	37,924
Total minimum future payments	$ 298,393	$ 63,400
Less imputed interest		(18,730)
		44,670
Less current portion		(5,182)
Long-term capital lease obligations		$ 39,488

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Assets capitalized under capital leases as reflected in the accompanying consolidated balance sheets were $20.4 million of land and improvements, $179.3 million of buildings and improvements, and $49.5 million of equipment and fixtures as of December 31, 2006 and $12.1 million of land and improvements, $96.3 million of buildings and improvements and $43.9 million of equipment and fixtures as of December 31, 2005. The accumulated depreciation related to assets under capital leases was $71.8 million and $56.2 million as of December 31, 2006 and 2005, 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 a defined contribution plan, defined benefit plans, and deferred compensation plans. The Company s defined contribution plan is qualified under Section 401(k) of the Internal Revenue Code, and covers substantially all employees at its hospitals, clinics, and the corporate offices. Participants may contribute a portion of their compensation not exceeding a limit set annually by the Internal Revenue Service. This plan includes a provision for the Company to match a portion of employee contributions. Total expense under the 401(k) plan was $10.7 million, $8.8 million and $8.3 million for the years ended December 31, 2006, 2005 and 2004, respectively. The Company has three defined benefit, non-contributory pension plans (Pension plans) that covers certain employees at three of its hospitals. One of the pension plans was established in 2006. The Pension plans provide benefits to covered individuals satisfying certain age and service requirements. Employer contributions to the Pension plans are in accordance with the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as amended. The Company expects to contribute $0.2 million to the Pension plans in fiscal 2007. The Company also provides an unfunded supplemental executive retirement plan (SERP) for certain members of its executive management. The Company uses a December 31 measurement date for the benefit obligations and a January 1 measurement date for its net periodic costs. Variances from actuarially assumed rates will result in increases or decreases in benefit obligations, net periodic cost and funding requirements in future periods. The Company s deferred compensation plans allow participants to defer receipt of a portion of their compensation. The liability under the deferred compensation plans was $17.7 million at December 31, 2006 and $13.0 million at December 31, 2005. The Company has available-for-sale securities either restricted or generally designated to pay benefits of the deferred compensation plans and the SERP in the amounts of $25.3 million and $19.8 million at December 31, 2006 and 2005, respectively.

The Company adopted the provisions of SFAS No. 158, Employers Accounting for Defined Benefit Pension and Other Postretirement Plans, an amendment of SFAS No. 87, 88, 106, and 132(R) (SFAS No. 158), for the year ending December 31, 2006. SFAS No. 158 requires an employer to recognize the overfunded or underfunded status of defined benefit pension and postretirement plans as an asset or liability in its consolidated statement of financial position and to recognize changes in that funded status in the year in which the changes occur through comprehensive income. It also requires disclosure in the notes to the consolidated financial statements additional information about certain effects on net periodic benefit cost for the next fiscal year that arise from delayed recognition of the gains or losses, prior service costs or credits, and transition asset or obligation. The adoption of SFAS No. 158 resulted in an increase to the pension liability of $13.8 million, deferred taxes of $5.5 million, and an increase in the loss of accumulated other comprehensive income of $8.3 million in the consolidated balance sheet for the year ending December 31, 2006.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

A summary of the benefit obligations and funded status for the Company s pension and SERP plans follows (in thousands):

	Pension Plans		SERP	
	2006	2005	2006	2005
Change in benefit obligation:				
Benefit obligation, beginning of year	$ 27,467	$ 22,747	$ 22,280	$ 14,722
Service cost	3,757	3,043	3,023	2,113
Interest cost	1,601	1,364	1,225	846
Plan amendment	(5,769)			
Actuarial loss	(792)	323	(3,235)	4,599
Benefits paid	(44)	(10)		
Benefit obligation, end of year	26,220	27,467	23,293	22,280
Change in plan assets:				
Fair value of assets, beginning of year	12,452	5,336		
Actual return on plan assets	1,262	507		
Employer contributions		6,619		
Benefits paid	(44)	(10)		
Fair value of assets, end of year	13,670	12,452		
Unfunded status	$ (12,550)	$ (15,015)	$ (23,293)	$ (22,280)

A summary of the amounts recognized in the accompanying consolidated balance sheets follows (in thousands):

	Pension Plans		SERP	
	2006	2005	2006	2005
Noncurrent Asset	$	$	$	$
Current Liability				
Noncurrent Liability	(12,550)	(3,186)	(23,293)	(7,290)
Net amount recognized in the consolidated balance sheets	$ (12,550)	$ (3,186)	$ (23,293)	$ (7,290)

A summary of the plans benefit obligation in excess of the fair value of plan assets as of the end of the year follows (in thousands):

	Pension Plans		SERP	
	2006	2005	2006	2005

Projected benefit obligation	$ 26,220	$ 27,467	$ 23,293	$ 22,280
Accumulated benefit obligation	17,127	12,113	18,214	8,231
Fair value of plan assets	13,670	12,452		

As of December 31, 2005, the fair value of plan assets of $9.8 million exceeds the accumulated benefit obligation of $9.2 million by $0.6 million for one of the Pension plans. The other Pension plan s accumulated benefit obligation of $2.9 million exceeds the fair value of its plan assets of $2.6 million by $0.3 million.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

A summary of the weighted-average assumptions used by the Company to determine benefit obligations as of December 31 follows:

	Pension Plans		SERP	
	2006	2005	2006	2005
Discount Rate	5.73% - 5.95%	5.80%	5.75%	5.25%
Annual Salary Increases	4.00% - 5.00%	4.00%	5.00%	5.00%

A summary of the amounts recognized in Accumulated Other Comprehensive Income (AOCI) due to the adoption of SFAS No. 158 as of the end of the year follows (in thousands):

	Pension Plans		SERP	
	2006	2005	2006	2005
Amount recognized in AOCI prior to SFAS 158	$	$	$	$
Amount recognized in AOCI due to adoption of SFAS 158				
Prior service cost (credit)	3,583	N/A	6,586	N/A
Net actuarial (gain) loss	141	N/A	2,937	N/A
Total amount recognized in AOCI	3,724	N/A	9,523	N/A

A summary of the expected amortization amounts to be included in net periodic cost for 2007 are as follows (in thousands):

	Pension Plans	SERP
Prior service cost	$ 878	$ 884
Actuarial (gain)/loss	(22)	60

A summary of the weighted-average assumptions used by the Company to determine net periodic cost follows:

	Pension Plans			SERP		
	2006	2005	2004	2006	2005	2004
Discount rate	5.40% - 5.80%	6.00%	6.50%	5.50%	5.75%	6.00%
Rate of compensation increase	4.00% - 5.00%	4.00%	4.00%	5.00%	5.00%	5.00%

Expected long term rate of return on assets	8.50%	8.50%	8.50%	N/A	N/A	N/A

The Company s weighted-average asset allocations by asset category for its pension plans as of the end of the year follows:

	Pension Plans		SERP	
	2006	2005	2006	2005
Equity securities	100%	100%	N/A	N/A
Debt securities	0%	0%	N/A	N/A
Total	100%	100%	N/A	N/A

The Company s pension plan assets are invested in mutual funds with an underlying investment allocation of 60% equity securities and 40% debt securities. The expected long-term rate of return for the Company s pension plan assets is based on current expected long-term inflation and historical rates of return on equities and fixed income securities, taking into account the investment policy under the plan. The expected long-term rate of return is weighted based on the target allocation for each asset category. Equity securities are expected to return between 8% and 12% and debt securities are expected to return between 4% and 7%. The Company

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

expects its pension plan asset managers will provide a premium of approximately 0.5% to 1.5% per annum to the respective market benchmark indices.

The Company s investment policy related to its pension plans is to provide for growth of capital with a moderate level of volatility by investing in accordance with the target asset allocations stated above. The Company reviews its investment policy, including its target asset allocations, on a semi-annual basis to determine whether any changes in market conditions or amendments to its pension plans requires a revision to its investment policy.

The estimated future benefit payments reflecting future service as of the end of 2006 for the Company s pension and SERP plans follows (in thousands):

Years Ending	Pension Plans	SERP
2007	182	
2008	299	66
2009	468	66
2010	620	66
2011	717	1,486
2012 - 2016	8,499	12,062

10. Stockholders Equity

On June 14, 2000, the Company closed its initial public offering of 18,750,000 shares of common stock; and on July 3, 2000, the underwriters exercised their overallotment option and purchased 1,675,717 shares of common stock. These shares were offered at $13.00 per share. On November 3, 2000, the Company completed an offering of 18,000,000 shares of its common stock at an offering price of $28.1875. Of these shares, 8,000,000 shares were sold by affiliates of FL & Co. and other shareholders. On October 15, 2001, the Company completed an offering of 12,000,000 shares of its common stock at an offering price of $26.80 concurrent with its notes offering. The net proceeds to the Company from the 2001 and the two 2000 common stock offerings in the aggregate were $306.1 million and $514.5 million, respectively, and were used to repay long-term debt.

Authorized capital shares of the Company include 400,000,000 shares of capital stock consisting of 300,000,000 shares of common stock and 100,000,000 shares of Preferred Stock. Each of the aforementioned classes of capital stock has a par value of $.01 per share. Shares of Preferred Stock, none of which are outstanding as of December 31, 2006, may be issued in one or more series having such rights, preferences and other provisions as determined by the Board of Directors without approval by the holders of common stock.

On January 14, 2006, the Company commenced an open market repurchase program for up to 5,000,000 shares of the Company s common stock, not to exceed $200 million in repurchases. Under this program, the Company repurchased the entire 5,000,000 shares at a weighted average price of $35.23. This program concluded on November 8, 2006 when the maximum number of shares had been repurchased. This repurchase plan followed a prior repurchase plan for up to 5,000,000 shares which concluded on January 13, 2006. The Company repurchased 3,029,700 shares at a weighted average price of $31.20 per share under this program. On December 13, 2006, the Company commenced

another open market repurchase program for up to 5,000,000 shares of the Company s common stock not to exceed $200 million in repurchases. This program will conclude at the earlier of three years or when the maximum number of shares have been repurchased. As of December 31, 2006, the Company has not repurchased any shares under this program.

On September 21, 2004, the Company entered into an underwriting agreement (the Underwriting Agreement) among the Company, CHS/Community Health Systems, Inc., Citigroup Global Markets Inc. (the Underwriter), Forstmann Little & Co. Equity Partnership-V, L.P. and Forstmann Little & Co. Subordinated

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Debt and Equity Management Buyout Partnership-VI, L.P. (collectively, the Selling Stockholders). Pursuant to the Underwriting Agreement, the Underwriters purchased 23,134,738 shares of common stock from the Selling Stockholders for $24.21 per share. The Company did not receive any proceeds from any sales of shares by the Selling Stockholders. On September 27, 2004, the Company purchased from the Underwriters 12,000,000 of these shares for $24.21 per share. For corporate law purposes, the Company retired these shares upon repurchase. Accordingly, these 12,000,000 shares are treated as authorized and unissued shares.

11. Earnings Per Share

The following table sets forth the components of the numerator and denominator for the computation of basic and diluted income from continuing operations per share (in thousands, except share data):

	Year Ended December 31,		
	2006	2005	2004
Numerator:			
Numerator for basic earnings per share			
Income from continuing operations available to common stockholders basic	$ 171,479	$ 190,138	$ 162,357
Numerator for diluted earnings per share			
Income from continuing operations	$ 171,479	$ 190,138	$ 162,357
Interest, net of tax, on 4.25% convertible notes	135	8,565	8,757
Income from continuing operations available to common stockholders diluted	$ 171,614	$ 198,703	$ 171,114
Denominator:			
Weighted-average number of shares outstanding basic	94,983,646	88,601,168	95,643,733
Effect of dilutive securities:			
Non-employee director options	11,825	11,715	32,336
Unvested common shares			23,499
Restricted Stock awards	140,959	115,411	
Employee options	951,360	1,582,063	1,582,146
4.25% Convertible notes	145,120	8,385,031	8,582,076
Weighted-average number of shares outstanding diluted	96,232,910	98,695,388	105,863,790
Dilutive securities outstanding not included in the computation of earning per share because their effect is antidilutive:			
Employee options	1,261,367	31,100	262,025

12. Commitments and Contingencies

Construction Commitments. The Company has agreed, as part of the acquisition in 2003 of Southside Regional Medical Center in Petersburg, Virginia, to build a replacement facility with an aggregate estimated construction cost, including equipment, of approximately $135 million. Of this amount, approximately $18 million has been expended through December 31, 2006. The Company expects to spend $55 million in replacement hospital construction and equipment costs related to this project in 2007. This project is required to be completed in 2008. In addition, the Company has agreed, as part of the acquisition in 2004 of Phoenixville Hospital in Phoenixville, Pennsylvania, to spend $90 million in capital expenditures over eight years to develop and improve the hospital; of this amount approximately $19 million has been expended through December 2006. The Company expects to spend $19 million of this commitment in 2007. The

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Company has agreed as part of the acquisition in 2005 of Chestnut Hill Hospital, in Philadelphia, Pennsylvania to spend $41 million in capital expenditures over four years to develop and improve the hospital; of this amount approximately $7 million has been expended through December 2006. The Company expects to spend approximately $5 million of this commitment in 2007. As part of the acquisition in 2005 of Bedford County Medical Center in Shelbyville, Tennessee, the Company agreed to build a replacement facility with an aggregate estimated construction cost of approximately $35 million. Of this amount, approximately, $0.8 million has been expended through December 31, 2006. The Company expects to spend $12 million in replacement hospital construction costs related to this project in 2007. The project is required to be completed by June 30, 2009. Also as required by an amendment to a lease agreement entered into in 2005, the Company agreed to build a replacement facility at its Barstow, California location. Construction costs for this replacement facility are estimated to be approximately $60 million. Also in 2005, the Company entered into an agreement with a developer to build and lease to the Company new corporate headquarters. The Company accounts for this project as if it owns the assets. Construction of the new headquarters was completed in December 2006. In January 2007, the Company exercised a purchase option under that lease agreement and acquired the new headquarters by purchasing the equity interests of the previous owner for a purchase price of $34.9 million.

Physician Recruiting Commitments. As part of its physician recruitment strategy, the Company provides income guarantee agreements to certain physicians who agree to relocate to its communities and commit to remain in practice there. Under such agreements, the Company is required to make payments to the physicians in excess of the amounts they earned in their practice up to the amount of the income guarantee. These income guarantee periods are typically for 12 months. Such payments are recoverable by the Company from physicians who do not fulfill their commitment period, which is typically three years, to the respective community. At December 31, 2006, the maximum potential amount of future payments under these guarantees in excess of the liability recorded is $20.8 million.

Other. Under specified acquisition agreements, the Company has deposited funds into escrow accounts to be used solely for the purpose of recruiting physicians to that specified hospital. At December 31, 2006, the Company had $4.4 million deposited in escrow accounts, which is included in other long-term assets.

Professional Liability Risks. Substantially all of the Company s professional and general liability risks are subject to a per occurrence deductible. Prior to June 1, 2002, substantially all of the Company s professional and general liability risks were subject to a $0.5 million per occurrence deductible, and for claims reported from June 1, 2002 through June 1, 2003, these deductibles were $2.0 million per occurrence. Additional coverage above these deductibles was purchased through captive insurance companies in which the Company had a 7.5% minority ownership interest and to which the premiums paid by the Company represented less than 8% of the total premium revenues of the captive insurance companies. Concurrently, with the formation of the Company s own wholly-owned captive insurance company in June 2003, the Company terminated its minority interest relationships in those entities. Substantially all claims reported on or after June 1, 2003 and before June 1, 2005 are self-insured up to $4.0 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 changed 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 is purchased through commercial insurance companies and generally after the self-insured amount covers up to $100 million per occurrence for all claims reported on or after June 1, 2003. The Company s insurance is underwritten on a claims- made basis. The Company accrues an estimated liability for its uninsured exposure and self-insured retention based on historical loss patterns and actuarial projections. The Company s estimated liability for the self-insured portion of professional and general liability claims was $104.2 million and $88.4 million as of December 31, 2006 and 2005, respectively. These estimated liabilities

represent the present value of estimated future professional liability claims payments based on expected loss patterns using a weighted-average discount rate of 4.6% and 4.1% in 2006 and 2005, respectively. The weighted-average discount rate is based on an estimate of the risk-

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

free interest rate for the duration of the expected claim payments. The estimated undiscounted claims liability was $119.8 million and $107.7 million as of December 31, 2006 and 2005, respectively.

Legal Matters. The Company is a party to other legal proceedings incidental to its business. In the opinion of management, any ultimate liability with respect to these actions will not have a material adverse effect on the Company s consolidated financial position, cash flows or results of operations.

13. Subsequent Events

On January 31, 2007, the Company exercised, its purchase option with the developer of its newly constructed corporate headquarters and acquired the building by purchasing the equity interests of the previous owner for a purchase price of $34.9 million.

On February 1, 2007 the Company executed a definitive agreement to acquire 159-bed Lincoln General Hospital, located in Ruston, Louisiana. Ruston is located approximately 70 miles east of Shreveport, Louisiana. The seller, Lincoln Health System, Inc., is a non-profit organization owned jointly by a local non-profit and three other regional non-profit hospitals. The transaction is subject to regulatory approvals and is expected to close near the end of the first quarter of 2007.

14. Quarterly Financial Data (Unaudited)

	Quarter				
	1st	2nd	3rd	4th	Total
	(In thousands, except share and per share data)				
Year ended December 31, 2006:					
Net operating revenues	$ 1,026,562	$ 1,061,054	$ 1,123,483	$ 1,154,477	$ 4,365,576
Income from continuing operations before taxes	93,552	85,236	13,314	86,059	278,161
Income from continuing operations	57,254	52,369	8,241	53,615	171,479
Loss on discontinued operations	(3,216)				(3,216)
Net income	54,038	52,369	8,241	53,615	168,263
Income from continuing operations per share:					
Basic	0.59	0.55	0.09	0.57	1.80
Diluted	0.58	0.54	0.09	0.57	1.78
Net income per share:					
Basic	0.56	0.55	0.09	0.57	1.77
Diluted	0.55	0.54	0.09	0.57	1.75

Weighted-average number of shares:					
Basic	96,552,448	95,769,030	94,119,020	93,538,958	94,983,646
Diluted	98,209,271	96,870,315	95,258,771	94,644,589	96,232,910

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

	Quarter				
	1st	2nd	3rd	4th	Total
	(In thousands, except share and per share data)				
Year ended December 31, 2005:					
Net operating revenues	$ 908,263	$ 918,718	$ 929,269	$ 982,070	$ 3,738,320
Income from continuing operations before taxes	80,317	75,540	72,122	82,941	310,920
Income from continuing operations	49,079	46,150	44,066	50,843	190,138
Loss on discontinued operations	(13,091)	(5,622)	(1,180)	(2,701)	(22,594)
Net income	35,988	40,528	42,886	48,142	167,544
Income from continuing operations per share:					
Basic	0.56	0.52	0.50	0.57	2.15
Diluted	0.52	0.49	0.47	0.54	2.02
Net income per share:					
Basic	0.41	0.45	0.49	0.54	1.89
Diluted	0.39	0.43	0.46	0.51	1.79
Weighted-average number of shares:					
Basic	87,926,338	89,149,815	88,325,411	89,011,180	88,601,168
Diluted	98,087,086	99,328,929	98,528,968	98,389,422	98,579,977

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Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosure***

None

Item 9A. ***Controls and Procedures***

Our Chief Executive Officer and Chief Financial Officer, with the participation of other members of management, have evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a 15(e) and 15d 15(e)) under the Securities and Exchange Act of 1934, as amended, as of December 31, 2006. Based on such evaluations, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective (at the reasonable assurance level) to ensure that the information required to be included in this report has been recorded, processed, summarized and reported within the time periods specified in the Commission s rules and forms and to ensure that the information required to be included in this report was accumulated and communicated to management, including our Chief Executive Officer and Chief Financial Officer, to allow timely decisions regarding required disclosure. There have been no changes in our internal control over financial reporting during our fourth quarter ended December 31, 2006, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. ***Other Information***

None

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Management s Report on Internal Control over Financial Reporting

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States of America and include amounts based on management s estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the consolidated financial statements.

We are also responsible for establishing and maintaining adequate internal controls over financial reporting (as defined in Rule 13a 15(f) under the Securities and Exchange Act of 1934, as amended). We maintain a system of internal controls that is designed to provide reasonable assurance as to the fair and reliable preparation and presentation of the consolidated financial statements, as well as to safeguard assets from unauthorized use or disposition.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Conduct. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit and Compliance Committee of the Board of Directors, which is composed solely of outside directors, meets periodically with members of management, the internal auditors and the independent registered public accounting firm to review and discuss internal control over financial reporting and accounting and financial reporting matters. The independent registered public accounting firm and internal auditors report to the Audit and Compliance Committee and accordingly have full and free access to the Audit and Compliance Committee at any time.

We conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. This evaluation included review of the documentation of controls, evaluation of the design effectiveness of controls, testing of the operating effectiveness of controls and a conclusion on this evaluation. We have concluded that our internal control over financial reporting was effective as of December 31, 2006, based on these criteria.

Deloitte & Touche LLP, an independent registered public accounting firm, has issued an attestation report on management s assessment of internal control over financial reporting, which is included herein.

We do not expect that our disclosure controls and procedures or our internal controls will prevent all error and all fraud. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact there are resource constraints and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, within the Company have been detected.

/s/ Wayne T. Smith	/s/ W. Larry Cash
Wayne T. Smith Chairman, President and Chief Executive Officer	W. Larry Cash Executive Vice President and Chief Financial Officer

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Community Health Systems, Inc.
Franklin, Tennessee

We have audited management s assessment, included in the accompanying Management s Report on Internal Control over Financial Reporting, that Community Health Systems, Inc. and subsidiaries (the Company) maintained effective internal control over financial reporting as of December 31, 2006, based on criteria established in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting. Our responsibility is to express an opinion on management s assessment and an opinion on the effectiveness of the Company s internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, evaluating management s assessment, testing and evaluating the design and operating effectiveness of internal control, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinions.

A company s internal control over financial reporting is a process designed by, or under the supervision of, the company s principal executive and principal financial officers, or persons performing similar functions, and effected by the company s board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company s internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company s assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, management s assessment that the Company maintained effective internal control over financial reporting as of December 31, 2006, is fairly stated, in all material respects, based on the criteria established in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2006, based on the criteria established in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

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We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States of America), the consolidated financial statements as of and for the year ended December 31, 2006, of the Company and our report dated February 20, 2007, expressed an unqualified opinion on those consolidated financial statements and included an explanatory paragraph referring to the Company adopting the fair value recognition provisions of Statement of Financial Accounting Standards No. 123 (Revised 2004), Share Based Payments effective January 1, 2006.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 20, 2007

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PART III

Item 10. ***Directors and Executive Officers of the Company***

The information required by this Item is incorporated herein by reference from the Company s definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 22, 2007, under Members of the Board of Directors, Information About our Executive Officers, Compliance with Exchange Act Section 16(A) Beneficial Ownership Reporting and Corporate Governance Principles and Board Matters.

Item 11. ***Executive Compensation***

The information required by this Item is incorporated herein by reference from the Company s definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 22, 2007 under Executive Compensation.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

The information required by this Item is incorporated herein by reference from the Company s definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 22, 2007 under Security Ownership of Certain Beneficial Owners and Management.

Item 13. ***Certain Relationships and Related Transactions***

The information required by this Item is incorporated herein by reference from the Company s definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 22, 2007 under Certain Transactions.

Item 14. ***Principal Accountant Fees and Services***

The information required by this Item is incorporated herein by reference from the Company s definitive proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 22, 2007 under Ratification of the Appointment of Independent Registered Public Accounting Firm.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

Item 15(a) 1. *Financial Statements*

Reference is made to the index of financial statements and supplementary data under Item 8 in Part II.

Item 15(a) 2. *Financial Statement Schedules*

The following financial statement schedule is filed as part of this Report at page 94 hereof:

Schedule II *Valuation and Qualifying Accounts*

All other schedules are omitted since the required information is not present or is not present in amounts sufficient to require submission of the schedule, or because the information required is included in the consolidated financial statements and notes thereto.

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Item 15(a)(3) and 15(c):

The following exhibits are either filed with this Report or incorporated herein by reference.

	Description
2.1	Agreement and Plan of Merger between the Registrant, FLCH Acquisition Corp. and Community Health Systems, Inc., dated on June 9, 1996 (incorporated by reference to Exhibit 2.1 to the Company s Registration Statement on Form S-1 (No. 333-31790))
3.1	Form of Restated Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1 to the Company s Registration Statement on Form S-1 (No. 333-31790))
3.2	Form of Restated By laws of the Registrant (incorporated by reference to Exhibit 3.2 to the Registrant s Annual Report on Form 10-K for the year ended December 31, 2000)
4.1	Form of Common Stock Certificate (incorporated by reference to Exhibit 4.1 to the Company s Registration Statement on Form S-1 (No. 333-31790))
4.2	The Indenture, dated as of December 16, 2004, among the Company and SunTrust Bank, as trustee relating to the 6.5% Senior Subordinated Notes due December 15, 2012 (incorporated by reference to Exhibit 4.1 to the Registrants current report on Form 8-K on December 13, 2004 (No. 001-15925))
10.1	Amended and Restated Credit Agreement dated as of August 19, 2004, among, CHS/Community Health Systems, Inc., Community Health Systems, Inc., JPMorgan Chase Bank, as Administrative Agent, Wachovia Bank, National Association, as Syndication Agent, Bank of America, N.A., as Documentation Agent and JP Morgan Securities Inc. and Banc of America Securities LLC as Joint Lead Arrangers and Joint Bookrunners and the other lender party thereto (incorporated by reference to Exhibit 10.1 to the Registrant s Quarterly Report on Form 10-Q for the quarter ended June 30, 2002)
10.2	First Amendment and Waiver, dated as of December 16, 2004 representing an amendment to the Amended and Restated Wachovia Credit Agreement dated as of August 19, 2004, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., JPMorgan Chase Bank, as Administrative Agent, Wachovia Bank, National Association, as Syndication Agent Bank of America, N.A., as Documentation Agent and JP Morgan Securities Inc. and Banc of America Securities LLC as Joint Lead Arrangers and Joint Bookrunners and the other lenders party thereto (incorporated by reference to Exhibit 10.10 to the Company s Annual Report on Form 10-K for the year ended December 31, 2004)
10.3	Second Amendment dated as of July 8, 2005, to the Amended and Restated Credit Agreement dated as of August 19, 2004, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., the several lenders thereto, JP Morgan Chase Bank, as Administrative Agent, Wachovia Bank, National Association, as Syndication Agent, and Bank of America, N.A., as Documentation Agent (incorporated by reference to Exhibit 10.1 to the Company s Current Report on Form 8-K filed July 13, 2005 (No. 001-15925))
10.4	Third Amendment, dated December 13, 2006, among CHS/CHS Community Health Systems, Inc., Community Health Systems, Inc., the several banks and other financial institutions lenders parties thereto, JP Morgan Chase Bank, as Administrative Agent, Wachovia Bank, National Association, as Syndication Agent, and Bank of America, National Association, as Documentation Agent (incorporated by reference to Exhibit 10.2 to the Company s Current Report on Form 8-K filed December 13, 2006 (No. 001-15925))
10.5	First Incremental Facility Amendment, dated as of December 13, 2006, among CHS/CHS Community Health Systems, Inc., Community Health Systems, Inc., the several banks and other financial institutions lenders parties thereto, JP Morgan Chase Bank, as Administrative Agent, Wachovia Bank, National Association, as Syndication Agent, and Bank of America, National Association, as Documentation Agent (incorporated by reference to Exhibit 10.1 to the Company s Current Report on Form 8-K filed

December 13, 2006 (No. 001-15925))

10.6 Form of outside director Stock Option Agreement (incorporated by reference to Exhibit 10.1 to the Company s Registration Statement on Form S-1 (No. 333-31790))

10.7 Form of Amendment No. 1 to the Director Stock Option Agreement (incorporated by reference to the Company s Registration Statement on Form S-8 (No. 333-10034977))

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	Description
10.8	Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan, as amended and restated on February 23, 2005 (incorporated by reference to Exhibit 10.1 to the Company s Current Report on Form 8-K filed February 28, 2005 (No. 001-15925))
10.9	Form of Amendment No. 1 to the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan (incorporated by reference to Exhibit 99.1 to the Company s Current Report on Form 8-K dated December 20, 2005)
10.10	Form of Restricted Stock Award Agreement (Directors) (incorporated by reference to Exhibit 99.2 to the Company s Current Report on Form 8-K dated December 20, 2005)
10.11	Community Health Systems Deferred Compensation Plan Trust, Amended and Restated Effective February 26, 1999 (incorporated by reference to Exhibit 10.18 to the Company s Annual Report on Form 10-K for the year ended December 31, 2002)
10.12	Community Health Systems Deferred Compensation Plan, as amended effective October 1, 1993; January 1, 1994; January 1, 1998; April 1, 1999; July 1, 2000; and June 1, 2001 (incorporated by reference to Exhibit 10.19 to the Company s Annual Report on Form 10-K for the year ended December 31, 2002)
10.13	Community Health Systems, Inc. Director s Fees Deferral Plan (incorporated by reference to Exhibit 10.18 to the Company s Annual Report on Form 10-K for the year ended December 31, 2004)
10.14	Form of Restricted Stock Award Agreement (incorporated by reference to Exhibit 10.2 to the Company s Current Report on Form 8-K filed February 28, 2005 (No. 001-15925))
10.15	Form of Indemnification Agreement between the Registrant and its directors and executive officers (incorporated by reference to Exhibit 10.8 to the Company s Current Report on Form 8-K filed February 28, 2005 (No. 001-15925))
10.16	Community Health Systems, Inc. Supplemental Executive Retirement Plan (incorporated by reference to Exhibit 10.17 to the Company s Annual Report on Form 10-K for the year ended December 31, 2002)
10.17	Amendment No. 2 to the Community Health Systems, Inc. Supplemental Executive Retirement Plan dated December 10, 2002 (incorporated by reference to Exhibit 10.2 to the Company s Current Report on Form 8-K filed June 1, 2005 (No. 001-15925))
10.18	Supplemental Executive Retirement Plan Trust, dated June 1, 2005, by and between CHS/Community Health Systems, Inc., as grantor, and Wachovia Bank, N.A., as trustee (incorporated by reference to Exhibit 10.3 to the Company s Current Report on Form 8-K filed June 1, 2005 (No. 001-15925))
10.19	Participation Agreement entered into as of January 1, 2005, by and between Community Health Systems Professional Services Corporation and HealthTrust Purchasing Group, L.P. (incorporated by reference to Exhibit 10.19 to the Company s Annual Report on Form 10-K for the year ended December 31, 2004)
10.20	Form of Performance Based Restricted Stock Award Agreement between Registrant and its executive officers (incorporated by reference to Exhibit 10.1 to the Company s Current Report on Form 8-K filed March 3, 2006 (No. 001-15925))
21	List of subsidiaries*
23.1	Consent of Deloitte & Touche LLP*
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*

* Filed herewith.

Item 15(b):

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SIGNATURES

Pursuant to the requirements of section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Community Health Systems, Inc.

By: /s/ Wayne T. Smith
Wayne T. Smith
Chairman of the Board,
President and Chief Executive Officer

February 20, 2007

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Name	Title	Date
/s/ WAYNE T. SMITH Wayne T. Smith	President and Chief Executive Officer and Director (principal executive officer)	02/20/2007
/s/ W. LARRY CASH W. Larry Cash	Executive Vice President, Chief Financial Officer and Director (principal financial officer)	02/20/2007
/s/ T. MARK BUFORD T. Mark Buford	Vice President and Corporate Controller (principal accounting officer)	02/20/2007
/s/ JOHN A. CLERICO John A. Clerico	Director	02/20/2007
/s/ DALE F. FREY Dale F. Frey	Director	02/20/2007
/s/ HARVEY KLEIN, M.D. Harvey Klein, M.D.	Director	02/20/2007
/s/ JOHN A. FRY John A. Fry	Director	02/20/2007
/s/ JULIA B. NORTH	Director	02/20/2007

Julia B. North

/s/ H. MITCHELL WATSON, JR.	Director	02/20/2007

H. Mitchell Watson, Jr.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Community Health Systems, Inc.
Franklin, Tennessee

We have audited the consolidated financial statements of Community Health Systems, Inc. and subsidiaries (the Company) as of December 31, 2006 and 2005, and for each of the three years in the period ended December 31, 2006, and have issued our report thereon dated February 20, 2007 (included elsewhere in this Annual Report, such report expresses an unqualified opinion and includes an explanatory paragraph referring to the Company adopting the fair value recognition provisions of Statement of Financial Accounting Standards No. 123 (Revised 2004), Share Based Payments effective January 1, 2006). Our audits also included the financial statement schedule listed in Item 15 of this Annual Report. This consolidated financial statement schedule is the responsibility of the Company s management. Our responsibility is to express an opinion based on our audits. In our opinion, such consolidated financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 20, 2007

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Community Health Systems, Inc. and Subsidiaries

Schedule II Valuation and Qualifying Accounts

Description	Balance at Beginning of Year	Acquisitions and Dispositions	Charged to Costs and Expenses	Write-offs	Balance at End of Year
			(In thousands)		
Year ended December 31, 2006 allowance for doubtful accounts	$ 346,024	$ 31,241	$ 547,781	$ (446,481)	$ 478,565
Year ended December 31, 2005 allowance for doubtful accounts	$ 286,094	$	$ 377,596	$ (317,666)	$ 346,024
Year ended December 31, 2004 allowance for doubtful accounts	103,677	2,233	343,793	(163,609)	286,094

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Exhibit Index

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4.2	The Indenture, dated as of December 16, 2004, among the Company and SunTrust Bank, as trustee relating to the 6.5% Senior Subordinated Notes due December 15, 2012 (incorporated by reference to Exhibit 4.1 to the Registrants current report on Form 8-K on December 13, 2004 (No. 001-15925))
10.1	Amended and Restated Credit Agreement dated as of August 19, 2004, among, CHS/Community Health Systems, Inc., Community Health Systems, Inc., JPMorgan Chase Bank, as Administrative Agent, Wachovia Bank, National Association, as Syndication Agent, Bank of America, N.A., as Documentation Agent and JP Morgan Securities Inc. and Banc of America Securities LLC as Joint Lead Arrangers and Joint Bookrunners and the other lender party thereto (incorporated by reference to Exhibit 10.1 to the Registrant s Quarterly Report on Form 10-Q for the quarter ended June 30, 2002)
10.2	First Amendment and Waiver, dated as of December 16, 2004 representing an amendment to the Amended and Restated Wachovia Credit Agreement dated as of August 19, 2004, among CHS/Community Health Systems, Inc., Community Health Systems, Inc., JPMorgan Chase Bank, as Administrative Agent, Wachovia Bank, National Association, as Syndication Agent Bank of America, N.A., as Documentation Agent and JP Morgan Securities Inc. and Banc of America Securities LLC as Joint Lead Arrangers and Joint Bookrunners and the other lenders party thereto (incorporated by reference to Exhibit 10.10 to the Company s Annual Report on Form 10-K for the year ended December 31, 2004)
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* Filed herewith.