

COMMUNITY HEALTH SYSTEMS INC

Form 10-K

February 29, 2008

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

Form 10-K

(Mark One)

- ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES
EXCHANGE ACT OF 1934**
For the year ended December 31, 2007
- OR**
- TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES
EXCHANGE ACT OF 1934**
For the transition period from to

Commission file number 001-15925

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

Delaware
(State of incorporation)

4000 Meridian Boulevard
Franklin, Tennessee
(Address of principal executive offices)

13-3893191
*(IRS Employer
Identification No.)*

37067
(Zip Code)

Registrant's telephone number, including area code:
(615) 465-7000

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

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, \$.01 par value	New York Stock Exchange

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

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

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

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

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

Large accelerated filer <input checked="" type="checkbox"/>	Accelerated filer <input type="checkbox"/>	Non-accelerated filer <input type="checkbox"/> (Do not check if a smaller reporting company)	Smaller reporting company <input type="checkbox"/>
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Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). YES NO

The aggregate market value of the voting stock held by non-affiliates of the Registrant was \$3,838,926,302. Market value is determined by reference to the closing price on June 30, 2007 of the Registrant's Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2007) have any non-voting common stock outstanding. As of February 1, 2008, there were 96,618,751 shares of common stock, par value \$.01 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required for Part III of this annual report is incorporated by reference from portions of the Registrant's definitive proxy statement for its 2008 annual meeting of stockholders to be filed with the Securities and Exchange Commission within 120 days after the end of the Registrant's fiscal year ended December 31, 2007.

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PART I

Item 1. *BUSINESS OF COMMUNITY HEALTH SYSTEMS*

Overview of Our Company

We are the largest publicly traded operator of hospitals in the United States in terms of number of facilities and net operating revenues. We provide healthcare services through these hospitals that we own and operate in non-urban and selected urban markets throughout the United States. As of December 31, 2007, included in our continuing operations, are 115 hospitals that we owned, leased or operated. These hospitals are geographically diversified across 27 states, with an aggregate of 16,971 licensed beds. We generate revenues by providing a broad range of general and specialized hospital healthcare services to patients in the communities in which we are located. Services provided by our hospitals include, but are not limited to, general acute care services, emergency room services, general and specialty surgery, critical care, internal medicine, obstetrics and diagnostic services. As part of providing these services we also own, outright or through partnerships with physicians, physician practices, imaging centers, and ambulatory surgery centers. In addition to our hospitals and related businesses, we also own and operate home health agencies, including four home health agencies located in markets where we do not operate a hospital. Through our corporate ownership and operation of these businesses we provide: standardization and centralization of operations across key business areas; a strategic direction to expand and improve services and facilities at our hospitals; implementation of quality of care improvement programs; and assistance in the recruitment of additional physicians to the markets in which our hospitals are located. In a number of our markets, we have partnered with local physicians or not-for-profit providers, or both, in the ownership of our facilities. Through our wholly-owned subsidiary, Quorum Health Resources, LLC (QHR), we also provide management and consulting services to non-affiliated general acute care hospitals located throughout the United States.

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

Effective July 25, 2007, we completed our acquisition of Triad Hospitals, Inc., or Triad. Of the 115 hospitals included in our continuing operations as of December 31, 2007, 43 of them were acquired as part of the acquisition of Triad. The acquisition of Triad also expanded our operations into five states where we previously did not own any facilities.

Available Information

Our Internet address is www.chs.net and the investor relations section of our website is located at www.chs.net/investor/index.html. We make available free of charge, through the investor relations section of our website, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K as well as amendments to those reports, as soon as reasonably practical after they are filed with the Securities and Exchange Commission. Our filings are also available to the public at the website maintained by the Securities and Exchange Commission, www.sec.gov.

We also make available free of charge, through the investor relations section of our website, our Governance Principles, our Code of Conduct and the charters of our Audit and Compliance Committee, the Compensation

Committee and the Governance and Nominating Committee.

We have included the Chief Executive Officer and the Chief Financial Officer certifications regarding the company's public disclosure required by Section 302 of the Sarbanes-Oxley Act of 2002 as Exhibits 31.1 and 31.2 of this report. We timely submitted to the New York Stock Exchange (the NYSE) the 2007 Annual

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CEO certification regarding our compliance with the NYSE's corporate governance listing standards as required by NYSE Rule 303A.

Our Business Strategy

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

- increase revenue at our facilities;
- improve profitability;
- improve quality; and
- grow through selective acquisitions.

Increase Revenue at Our Facilities

Overview. We seek to increase revenue at our facilities by providing a broader range of services in a more attractive care setting, as well as by supporting and recruiting physicians. We identify the healthcare needs of the community by analyzing demographic data and patient referral trends. We also work with local hospital boards, management teams, and medical staffs to determine the number and type of additional physician specialties needed. Our initiatives to increase revenue include:

- recruiting additional primary care physicians and specialists;
- expanding the breadth of services offered at our hospitals through targeted capital expenditures to support the addition of more complex services, including orthopedics, cardiovascular services, and urology; and
- providing the capital to invest in technology and the physical plant at the facilities, particularly in our emergency rooms, surgery departments, critical care departments, and diagnostic services.

Physician Recruiting. The primary method of adding or expanding medical services is the recruitment of new physicians into the community. A core group of primary care physicians is necessary as an initial contact point for all local healthcare. The addition of specialists who offer services, including general surgery, OB/GYN, cardiovascular services, orthopedics and urology, completes the full range of medical and surgical services required to meet a community's core healthcare needs. At the time we acquire a hospital and from time to time thereafter, we identify the healthcare needs of the community by analyzing demographic data and patient referral trends. As a result of this analysis, we are able to determine what we believe to be the optimum mix of primary care physicians and specialists. We employ recruiters at the corporate level to support the local hospital managers in their recruitment efforts. We have increased the number of physicians affiliated with us through our recruiting efforts, net of turnover, by approximately 440 in 2007, 300 in 2006 and 290 in 2005. The percentage of recruited or other physicians commencing practice with us that were specialists was over 50% in 2007. Although in recent years we have begun employing more physicians, most of our physicians are in private practice in their communities and are not our employees. We have been successful in recruiting physicians because of the practice opportunities afforded physicians in our markets, as well as lower managed care penetration as compared to larger urban areas.

Emergency Room Initiatives. Given that over approximately 55% of our hospital admissions originate in the emergency room, we systematically take steps to increase patient flow in our emergency rooms as a means of optimizing utilization rates for our hospitals. Furthermore, the impression of our overall operations by our customers

is substantially influenced by our emergency rooms since generally that is their first experience with our hospitals. The steps we take to increase patient flow in our emergency rooms include renovating and expanding our emergency room facilities, improving service and reducing waiting times, as well as publicizing our emergency room capabilities in the local community. We have expanded or renovated 13 of our emergency rooms during the past three years, including three in 2007. We have also implemented marketing campaigns that emphasize the speed, convenience, and quality of our emergency rooms to enhance each community's awareness of our emergency room services.

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

Expansion of Services. In an effort to better meet the healthcare needs of the communities we serve and to capture a greater portion of the healthcare spending in our markets, we have added a broad range of services to our facilities. These services range from various types of diagnostic equipment capabilities to additional and renovated emergency rooms, surgical and critical care suites and specialty services. For example, in 2007, we spent \$61 million as a part of 35 major construction projects. This includes \$15.1 million on 9 major construction projects which have been started at the hospitals acquired in the Triad acquisition. The 2007 projects included new emergency rooms, cardiac cathertization labs, intensive care units, hospital additions, and an ambulatory surgery center. These projects improved various diagnostic and other inpatient and outpatient service capabilities. We continue to believe that appropriate capital investments in our facilities combined with the development of our service capabilities will reduce the migration of patients to competing providers while providing an attractive return on investment. We also employ a small group of clinical consultants at our corporate headquarters to assist the hospitals in their development of surgery, emergency services, critical care and cardiovascular services. In conjunction with an interest in a joint venture that we acquired as part of the Triad acquisition, pursuant to the terms of the joint venture agreement, we built an acute care hospital in Cedar Park, Texas, which opened in December 2007. The joint venture partner is a not-for-profit entity. Since the Triad acquisition, we spent approximately \$38.6 million in construction costs, including equipment related to this hospital. We estimate approximately \$2 million will be spent in 2008 to complete this hospital.

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

Improve Profitability

Overview. To improve efficiencies and increase operating margins, we implement cost containment programs and adhere to operating philosophies that include:

standardizing and centralizing our operations;

optimizing resource allocation by utilizing our company-devised case and resource management program, which assists in improving clinical care and containing expenses;

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

installing a standardized management information system, resulting in more efficient billing and collection procedures; and

monitoring and enhancing productivity of our human resources.

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In addition, each of our hospital management teams is supported by our centralized operational, reimbursement, regulatory and compliance expertise, as well as by our senior management team, which has an average of over 25 years of experience in the healthcare industry.

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

Billing and Collections. We have adopted standard policies and procedures with respect to billing and collections. We have also automated and standardized various components of the collection cycle, including statement and collection letters and the movement of accounts through the collection cycle. Upon completion of an acquisition, our management information system team converts the hospital's existing information system to our standardized system. This enables us to quickly implement our business controls and cost containment initiatives.

Physician Support. We support our newly recruited physicians to enhance their transition into our communities. We have implemented physician practice management seminars and training. We host these seminars bi-monthly. All newly recruited physicians are required to attend a three-day introductory seminar that covers issues involved in starting up a practice.

Procurement and Materials Management. We have standardized and centralized our operations with respect to medical supplies, equipment and pharmaceuticals used in our hospitals. We have a participation agreement with HealthTrust Purchasing Group, L.P. (Health Trust), a group purchasing organization (GPO). HealthTrust is the source for a substantial portion of our medical supplies, equipment and pharmaceuticals. This agreement extends to March 2010, with automatic renewal terms of one year unless either party terminates by giving notice of non-renewal.

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

Other Initiatives. We have also improved margins by implementing standard programs with respect to ancillary services in areas including emergency rooms, pharmacy, laboratory, imaging, home health, skilled nursing, centralized outpatient scheduling and health information management. We have reduced costs associated with these services by improving contract terms and standardizing information systems. We work to identify and communicate best practices and monitor these improvements throughout the Company.

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

Case and Resource Management. Our case and resource management program is a company-devised program developed with the goal of improving clinical care and cost containment. The program focuses on:

appropriately treating patients along the care continuum;

reducing inefficiently applied processes, procedures and resources;

developing and implementing standards for operational best practices; and

using on-site clinical facilitators to train and educate care practitioners on identified best practices.

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Our case and resource management program integrates the functions of utilization review, discharge planning, overall clinical management, and resource management into a single effort to improve the quality and efficiency of care. Issues evaluated in this process include patient treatment, patient length of stay and utilization of resources.

Under our case and resource management program, patient care begins with a clinical assessment of the appropriate level of care, discharge planning, and medical necessity for planned services. Once a patient is admitted to the hospital, we conduct a review for ongoing medical necessity using appropriateness criteria. We reassess and adjust discharge plan options as the needs of the patient change. We closely monitor cases to prevent delayed service or inappropriate utilization of resources. Once the patient attains clinical improvement, we encourage the attending physician to consider alternatives to hospitalization through discussions with the facility's physician advisor. Finally, we refer the patient to the appropriate post-hospitalization resources.

Improve Quality

We have implemented various programs to ensure continuous improvement in the quality of care provided. We have developed training programs for all senior hospital management, chief nursing officers, quality directors, physicians and other clinical staff. We share information among our hospital management to implement best practices and assist in complying with regulatory requirements. We have standardized accreditation documentation and requirements. All hospitals conduct patient, physician, and staff satisfaction surveys to help identify methods of improving the quality of care.

Each of our hospitals is governed by a board of trustees, which includes members of the hospital's medical staff. The board of trustees establishes policies concerning the hospital's medical, professional, and ethical practices, monitors these practices, and is responsible for ensuring that these practices conform to legally required standards. We maintain quality assurance programs to support and monitor quality of care standards and to meet Medicare and Medicaid accreditation and regulatory requirements. Patient care evaluations and other quality of care assessment activities are reviewed and monitored continuously.

Grow Through Selective Acquisitions

Acquisition Criteria. Each year we intend to acquire, on a selective basis, two to four hospitals that fit our acquisition criteria. Generally, we pursue acquisition candidates that:

- have a service area population between 20,000 and 400,000 with a stable or growing population base;
- are the sole or primary provider of acute care services in the community;
- are located in an area with the potential for service expansion;
- are not located in an area that is dependent upon a single employer or industry; and
- have financial performance that we believe will benefit from our management's operating skills.

In each year since 1997, we have met or exceeded our acquisition goals. Occasionally, we have pursued acquisition opportunities outside of our specified criteria when such opportunities have had uniquely favorable characteristics. In addition to two hospitals acquired from local governmental entities in 2007, we also acquired Triad, which, at the time of our acquisition, owned and operated 50 hospitals in 17 states across the U.S., with 1 hospital in Ireland. Although we intend to meet our acquisition goal in 2008, by completing the previously announced acquisition of a two hospital

system in Spokane, Washington, we do not anticipate actively pursuing acquisitions for the remainder of 2008 as we continue to concentrate on the integration of Triad. Beyond 2008, we intend on returning to our strategy of growing through selective acquisitions. We currently estimate that there are approximately 400 hospitals that meet our acquisition criteria. These hospitals are primarily owned by governmental, not-for-profit, or faith based agencies.

Disciplined Acquisition Approach. We have been disciplined in our approach to acquisitions. We have a dedicated team of internal and external professionals who complete a thorough review of the hospital's financial and operating performance, the demographics and service needs of the market and the physical

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

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

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

At the time we acquire a hospital, we may commit to an amount of capital expenditures, such as a replacement facility, renovations, or equipment over a specified period of time. As an obligation under hospital purchase agreements in effect as of December 31, 2007, we are required to build replacement facilities in Petersburg, Virginia, by August 2008, Clarksville, Tennessee by June 2009, Shelbyville, Tennessee by June 2009 and Valparaiso, Indiana by April 2011. Also, as required by an amendment to a lease agreement entered into in 2005, we agreed to build a replacement hospital at our Barstow, California location. In conjunction with a joint venture agreement with a non-profit entity, we constructed an acute care hospital in Cedar Park, Texas, which opened in December 2007. Estimated construction costs, including equipment costs, are approximately \$761.4 million for these five replacement hospitals and one de novo hospital of which approximately \$362.1 million has been incurred to date (including costs incurred by Triad prior to our acquisition). In addition, other commitments under purchase agreements, which include amounts for costs such as capital improvements, equipment, selected leases and physician recruiting in effect as of December 31, 2007, obligate us to spend approximately \$265.6 million through 2011.

Integration of Triad

We believe we can improve and grow the operations of the hospitals we acquired in the acquisition of Triad through our standardization and centralization strategies related to billing and collections, physician recruiting, emergency room initiatives, managed care contracting and our various improvement strategies, as previously discussed. We believe our objective of increasing shareholder value through this acquisition can be achieved through a combination of standardization of the information systems, the implementation of controls designed to enhance discipline over capital spending and synergies in overhead costs obtained through economies of scale.

Industry Overview

The Centers for Medicare and Medicaid Services, or CMS, reported that in 2006 total U.S. healthcare expenditures grew by 6.7% to \$2.1 trillion. It projected total U.S. healthcare spending to grow by 6.6% in 2007, by an average of 7.0% annually from 2008 through 2010 and by 6.9% annually from 2011 through 2016. By these estimates, healthcare expenditures will account for approximately \$4.1 trillion, or 19.6% of the total U.S. gross domestic product, by 2016.

Hospital services, the market in which we operate, is the largest single category of healthcare at 31% of total healthcare spending in 2006, or \$648.2 billion, as reported by CMS. CMS projects the hospital services category to

grow by at least 6.8% per year through 2016. It expects growth in hospital healthcare spending to continue due to the aging of the U.S. population and consumer demand for expanded medical services. As

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hospitals remain the primary setting for healthcare delivery, it expects hospital services to remain the largest category of healthcare spending.

U.S. Hospital Industry. The U.S. hospital industry is broadly defined to include acute care, rehabilitation, and psychiatric facilities that are either public (government owned and operated), not-for-profit private (religious or secular), or for-profit institutions (investor owned). According to the American Hospital Association, there are approximately 4,900 inpatient hospitals in the U.S. which are not-for-profit owned, investor owned, or state or local government owned. Of these hospitals, approximately 41% are located in non-urban communities. We believe that a majority of these hospitals are owned by not-for-profit or governmental entities. These facilities offer a broad range of healthcare services, including internal medicine, general surgery, cardiology, oncology, orthopedics, OB/GYN, and emergency services. In addition, hospitals also offer other ancillary services including psychiatric, diagnostic, rehabilitation, home health, and outpatient surgery services.

Urban vs. Non-Urban Hospitals

According to the U.S. Census Bureau, 21% of the U.S. population lives in communities designated as non-urban. In these non-urban communities, hospitals are typically the primary source of healthcare. In many cases a single hospital is the only provider of general healthcare services in these communities.

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

facility size and location;

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

a facility's ability to participate in group purchasing organizations; and

facility payor mix.

We believe that non-urban hospitals are generally able to obtain higher operating margins than urban hospitals. Factors contributing to a non-urban hospital's margin advantage include fewer patients with complex medical problems, a lower cost structure, limited competition, and favorable Medicare payment provisions. Patients needing the most complex care are more often served by the larger and/or more specialized urban hospitals. A non-urban hospital's lower cost structure results from its geographic location, as well as the lower number of patients treated who need the most highly advanced services. Additionally, because non-urban hospitals are generally sole providers or one of a small group of providers in their markets, there is limited competition. This generally results in more favorable pricing with commercial payors. Medicare has special payment provisions for sole community hospitals. Under present law, hospitals that qualify for this designation can receive higher reimbursement rates. As of December 31, 2007, 26 of our hospitals were sole community hospitals. In addition, we believe that non-urban communities are generally characterized by a high level of patient and physician loyalty that fosters cooperative relationships among the local hospitals, physicians, employees and patients.

The type of third party responsible for the payment of services performed by healthcare service providers is also an important factor which affects hospital operating margins. These providers have increasingly exerted pressure on healthcare service providers to reduce the cost of care. The most active providers in this regard have been HMOs, PPOs, and other managed care organizations. The characteristics of non-urban markets make them less attractive to these managed care organizations. This is partly because the limited size of non-urban markets and their diverse, non-national employer bases minimize the ability of managed care organizations to achieve economies of scale as

compared to economics of scale that can be achieved in many urban markets.

Hospital Industry Trends

Demographic Trends. According to the U.S. Census Bureau, there are presently approximately 37.3 million Americans aged 65 or older in the U.S. who comprise approximately 12.4% of the total

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U.S. population. By the year 2030, the number of elderly is expected to climb to 71.5 million, or 20% of the total population. Due to the increasing life expectancy of Americans, the number of people aged 85 years and older is also expected to increase from 5.3 million to 9.6 million by the year 2030. This increase in life expectancy will increase demand for healthcare services and, as importantly, the demand for innovative, more sophisticated means of delivering those services. Hospitals, as the largest category of care in the healthcare market, will be among the main beneficiaries of this increase in demand. Based on data compiled for us, the populations of the service areas where our hospitals are located grew by 23.4% from 1990 to 2006 and are expected to grow by 6.1% from 2006 to 2010. The number of people aged 55 or older in these service areas grew by 34.4% from 1990 to 2006 and is expected to grow by 14.1% from 2006 to 2010.

Consolidation. During recent years a significant amount of private equity capital has been invested into the hospital industry. Also, in addition to our own acquisition of Triad in 2007, consolidation activity, primarily through mergers and acquisitions involving both for-profit and not-for-profit hospital systems is continuing. Reasons for this activity include:

excess capacity of available capital;

valuation levels;

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

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

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

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

regulatory changes.

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The following table sets forth operating statistics for our hospitals for each of the years presented, which are included in our continuing operations. Statistics for 2007 include a full year of operations for 70 hospitals and partial periods for 45 hospitals. Statistics for 2006 include a full year of operations for 63 hospitals and partial periods for 7 hospitals acquired during the year. Statistics for 2005 include a full year of operations for 59 hospitals and partial periods for 4 hospitals acquired during the year less one hospital that was consolidated with another hospital we own in the same community. Hospitals which have been sold and hospitals which are classified as held for sale are excluded from all periods presented.

	Year Ended December 31,		
	2007	2006	2005
	(Dollars in thousands)		
Consolidated Data			
Number of hospitals (at end of period)	115	70	63
Licensed beds(1)	16,971	8,406	7,398
Beds in service(2)	14,604	6,753	5,986
Admissions(3)	463,212	307,964	275,044
Adjusted admissions(4)	848,707	570,969	508,037
Patient days(5)	1,941,887	1,264,256	1,140,605
Average length of stay (days)(6)	4.2	4.1	4.1
Occupancy rate (beds in service)(7)	52.4%	54.3%	54.4%
Net operating revenues	\$ 7,127,494	\$ 4,180,136	\$ 3,576,117
Net inpatient revenues as a % of total net operating revenues	49.3%	50.0%	50.8%
Net outpatient revenues as a % of total net operating revenues	48.6%	48.8%	48.0%
Net Income	\$ 30,289	\$ 168,263	\$ 167,544
Net Income as a % of total net operating revenues	0.4%	4.0%	4.7%
Liquidity Data			
Adjusted EBITDA(8)	\$ 827,032	\$ 564,339	\$ 555,725
Adjusted EBITDA as a % of total net operating revenues(8)	11.6%	13.5%	15.5%
Net cash flows provided by operating activities	\$ 687,738	\$ 350,255	\$ 411,049
Net cash flows provided by operating activities as a % of total net operating revenues	9.6%	8.4%	11.5%
Net cash flows used in investing activities	\$ (7,498,858)	\$ (640,257)	\$ (327,272)
Net cash flows provided by (used in) financing activities	\$ 6,903,428	\$ 226,460	\$ (62,167)

See pages 9 through 11 for footnotes.

	Year Ended December 31,		(Decrease) Increase
	2007	2006	
	(Dollars in thousands)		
Same-Store Data(9)			
Admissions(3)	434,317	439,056	(1.1)%

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Adjusted admissions(4)	792,190	789,184	(0.4)%
Patient days(5)	1,824,399	1,872,581	
Average length of stay (days)(6)	4.2	4.3	
Occupancy rate (beds in service)(7)	52.6%	54.4%	
Net operating revenues	\$ 6,571,528	\$ 6,308,656	
Income from operations	\$ 460,110	\$ 550,519	
Income from operations as a% of net operating revenues	7.0%	8.7%	
Depreciation and amortization	\$ 293,972	\$ 279,485	
Equity in earnings of unconsolidated affiliates	\$ 23,627	\$ 20,105	

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- (1) Licensed beds are the number of beds for which the appropriate state agency licenses a facility regardless of whether the beds are actually available for patient use.
- (2) Beds in service are the number of beds that are readily available for patient use.
- (3) Admissions represent the number of patients admitted for inpatient treatment.
- (4) Adjusted admissions is a general measure of combined inpatient and outpatient volume. We computed adjusted admissions by multiplying admissions by gross patient revenues and then dividing that number by gross inpatient revenues.
- (5) Patient days represent the total number of days of care provided to inpatients.
- (6) Average length of stay (days) represents the average number of days inpatients stay in our hospitals.
- (7) We calculated percentages by dividing the average daily number of inpatients by the weighted average of beds in service.
- (8) EBITDA consists of net income (loss) before interest, income taxes, depreciation and amortization. Adjusted EBITDA is EBITDA adjusted to exclude discontinued operations, loss from early extinguishment of debt and minority interest in earnings. We have from time to time sold minority interests in certain of our subsidiaries or acquired subsidiaries with existing minority interest ownership positions. We believe that it is useful to present adjusted EBITDA because it excludes the portion of EBITDA attributable to these third party interests and clarifies for investors our portion of EBITDA generated by continuing operations. We use adjusted EBITDA as a measure of liquidity. We have included this measure because we believe it provides investors with additional information about our ability to incur and service debt and make capital expenditures. Adjusted EBITDA is the basis for a key component in the determination of our compliance with some of the covenants under our senior secured credit facility, as well as to determine the interest rate and commitment fee payable under the senior secured credit facility. (Although Adjusted EBITDA does not include all of the adjustments described in the senior secured credit facility).

Adjusted EBITDA is not a measurement of financial performance or liquidity under generally accepted accounting principles. It should not be considered in isolation or as a substitute for net income, operating income, cash flows from operating, investing or financing activities, or any other measure calculated in accordance with generally accepted accounting principles. The items excluded from adjusted EBITDA are significant components in understanding and evaluating financial performance and liquidity. Our calculation of adjusted EBITDA may not be comparable to similarly titled measures reported by other companies.

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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, 2007, 2006, and 2005 (in thousands):

	Year Ended December 31,		
	2007	2006	2005
Adjusted EBITDA	\$ 827,032	\$ 564,339	\$ 555,725
Interest expense, net	(364,533)	(94,411)	(87,185)
Provision for income taxes	(43,003)	(110,152)	(119,804)
Deferred income taxes	(39,894)	(25,228)	9,889
Loss from operations of hospitals sold or held for sale	(11,067)	(6,873)	(8,737)
Income tax benefit on the non-cash impairment and loss on sale of hospitals	4,457	1,378	924
Depreciation and amortization of discontinued operations	16,365	9,485	8,900
Stock compensation expense	38,771	20,073	4,957
Excess tax benefits relating to stock based compensation	(1,216)	(6,819)	
Other non-cash (income) expenses, net	19,017	500	740
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	131,300	(71,141)	(47,455)
Supplies, prepaid expenses and other current assets	(31,977)	(4,544)	(16,838)
Accounts payable, accrued liabilities and income taxes	125,959	52,151	84,956
Other	16,527	21,497	24,977
Net cash provided by operating activities	\$ 687,738	\$ 350,255	\$ 411,049

- (9) Includes former Triad hospital's data, as if they were owned August 1 through December 31, for both comparable periods and other acquired hospitals to the extent we operated them during comparable periods in both years.

Sources of Revenue

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

the federal Medicare program;

state Medicaid or similar programs;

healthcare insurance carriers, health maintenance organizations or HMOs, preferred provider organizations or PPOs, and other managed care programs; and

patient directly.

The following table presents the approximate percentages of net operating revenue received from Medicare, Medicaid, managed care, self-pay and other sources for the periods indicated. The data for the years presented are not strictly comparable due to the significant effect that hospital acquisitions have had on these statistics.

Net Operating Revenues by Payor Source	2007	2006	2005
Medicare	29.0%	30.4%	31.8%
Medicaid	10.3%	11.1%	11.2%
Managed Care and other third party payors	50.7%	46.7%	45.6%
Self-pay	10.0%	11.8%	11.4%
Total	100.0%	100.0%	100.0%

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

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

In addition to government programs, we are paid by private payors, which include insurance companies, HMOs, PPOs, other managed care companies, employers, and by patients directly. Blue Cross payors are included in Managed Care and other third party payors line in the above table. Patients are generally not responsible for any difference between customary hospital charges and amounts paid for hospital services by Medicare and Medicaid programs, insurance companies, HMOs, PPOs, and other managed care companies, but are responsible for services not covered by these programs or plans, as well as for deductibles and co-insurance obligations of their coverage. The amount of these deductibles and co-insurance obligations has increased in recent years. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government or business payors. To further reduce their healthcare costs, an increasing number of insurance companies, HMOs, PPOs, and other managed care companies are negotiating discounted fee structures or fixed amounts for hospital services performed, rather than paying healthcare providers the amounts billed. We negotiate discounts with managed care companies, which are typically smaller than discounts under governmental programs. If an increased number of insurance companies, HMOs, PPOs, and other managed care companies succeed in negotiating discounted fee structures or fixed amounts, our results of operations may be negatively affected. For more information on the payment programs on which our revenues depend, see *Payment* on page 16.

As of December 31, 2007, Pennsylvania and Texas represented the only areas of geographic concentration. Net operating revenues as a percentage of consolidated net operating revenues generated in Pennsylvania were 13.1% in 2007, 22.0% in 2006 and 23.1% in 2005. Net operating revenues as a percentage of consolidated net operating revenues generated in Texas were 13.0% in 2007, 10.4% in 2006 and 11.6% in 2005.

Hospital revenues depend upon inpatient occupancy levels, the volume of outpatient procedures, and the charges or negotiated payment rates for hospital services provided. Charges and payment rates for routine inpatient services vary significantly depending on the type of service performed and the geographic location of the hospital. In recent years, we have experienced a significant increase in revenue received from outpatient services. We attribute this increase to:

advances in technology, which have permitted us to provide more services on an outpatient basis; and

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

Government Regulation

Overview. The healthcare industry is required to comply with extensive government regulation at the federal, state, and local levels. Under these regulations, hospitals must meet requirements to be certified as hospitals and qualified to

participate in government programs, including the Medicare and Medicaid programs. These requirements relate to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, hospital use, rate-setting, compliance with building codes, and

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environmental protection laws. There are also extensive regulations governing a hospital's participation in these government programs. If we fail to comply with applicable laws and regulations, we can be subject to criminal penalties and civil sanctions, our hospitals can lose their licenses and we could lose our ability to participate in these government programs. In addition, government regulations may change. If that happens, we may have to make changes in our facilities, equipment, personnel, and services so that our hospitals remain certified as hospitals and qualified to participate in these programs. We believe that our hospitals are in substantial compliance with current federal, state, and local regulations and standards.

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

Recent Changes. In recent years, numerous changes have been made in the oversight of health care providers to provide an increased emphasis on the linkage between quality of care criteria and payment levels. For example, hospital Medicare payments are now impacted by the hospital's accurate reporting of the basic elements of care provided to patients with certain diagnoses. The federal government, numerous states, and several managed care organizations have begun to initiate payment prohibitions for care associated with events considered preventable by the provider, such as falls, incorrect blood transfusion matching, and wrong site surgeries. As another indication of this trend and focus, the Joint Commission no longer gives numerical scores at scheduled triennial surveys; they now score hospitals and other accredited providers on a pass-fail basis based on unannounced surveys. Because hospitals no longer are able to prepare for a survey at a time certain, it is possible that there will be an increase in negative survey findings, which could lead to a loss of accreditation. Other provider types are facing similar changes in payment and quality oversight.

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

making claims to Medicare for services not provided or misrepresenting actual services provided in order to obtain higher payments;

paying money to induce the referral of patients where services are reimbursable under a federal health program; or

paying money to limit or reduce the services provided to Medicare beneficiaries.

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of the fraud and abuse laws. Under HIPAA, any person or entity that knowingly and willfully defrauds or attempts to defraud a healthcare benefit program, including private healthcare plans, may be subject to fines, imprisonment or both. Additionally, any person or entity that knowingly and willfully falsifies or conceals a material fact or makes any material false or fraudulent statements in connection with the delivery or payment of healthcare services by a healthcare benefit plan is subject to a fine, imprisonment or both.

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

The Office of Inspector General of the Department of Health and Human Services, or OIG, is responsible for identifying and investigating fraud and abuse activities in federal healthcare programs. As part of its duties,

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the OIG provides guidance to healthcare providers by identifying types of activities that could violate the anti-kickback statute. The OIG also publishes regulations outlining activities and business relationships that would be deemed not to violate the anti-kickback statute. These regulations are known as safe harbor regulations. However, the failure of a particular activity to comply with the safe harbor regulations does not necessarily mean that the activity violates the anti-kickback statute.

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

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

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

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

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

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

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

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

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

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

We have a variety of financial relationships with physicians who refer patients to our hospitals. Physicians own interests in a number of our facilities. Physicians may also own our stock. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases, management agreements, and professional service agreements. We provide financial incentives to recruit physicians to relocate to communities served by our hospitals. These incentives include relocation, reimbursement for certain direct expenses, income guarantees and, in some cases, loans. Although we believe that we have structured our arrangements with physicians in light of the safe harbor rules, we cannot assure you that regulatory authorities will not determine otherwise. If that happens, we could be subject to criminal and civil penalties and/or exclusion from participating in Medicare, Medicaid, or other government healthcare programs.

The Social Security Act also includes a provision commonly known as the Stark law. This law prohibits physicians from referring Medicare patients to healthcare entities in which they or any of their immediate family members have ownership interests or other financial arrangements. These types of referrals are commonly known as self-referrals. Sanctions for violating the Stark law include denial of payment, civil money penalties, assessments equal to twice the dollar value of each service, and exclusion from government payor programs. There are ownership and compensation arrangement exceptions to the self-referral prohibition. One exception allows a physician to make a referral to a hospital if the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. Another exception allows a physician to refer patients to a healthcare entity in which the physician has an ownership interest if the entity is located in a rural area, as defined in the statute. There are also exceptions for many

of the customary financial arrangements between physicians and providers, including employment contracts, leases, and recruitment agreements. From time to time, the federal government has issued regulations which interpret the provisions included in the Stark law. We strive to comply with the Stark law and regulations; however, the government may interpret the law and regulations differently. If we are found to have violated the Stark law or regulations, we could be subject to significant sanctions, including damages, penalties, and exclusion from federal health care programs.

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Many states in which we operate also have adopted similar laws relating to financial relationships with physicians. Some of these state laws apply even if the payment for care does not come from the government. These statutes typically provide criminal and civil penalties as well as loss of licensure. While there is little precedent for the interpretation or enforcement of these state laws, we have attempted to structure our financial relationships with physicians and others in light of these laws. However, if we are found to have violated these state laws, it could result in the imposition of criminal and civil penalties as well as possible licensure revocation.

False Claims Act. Another trend in healthcare litigation is the increased use of the False Claims Act, or FCA. This law makes providers liable for, among other things, the knowing submission of a false claim for reimbursement by the federal government. The FCA has been used not only by the U.S. government, but also by individuals who bring an action on behalf of the government under the law's qui tam or whistleblower provisions and share in any recovery. When a private party brings a qui tam action under the FCA, it files the complaint with the court under seal, and the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation.

Civil liability under the FCA can be up to three times the actual damages sustained by the government plus civil penalties of up to \$11,000 for each separate false claim submitted to the government. There are many potential bases for liability under the FCA. Although liability under the FCA arises when an entity knowingly submits a false claim for reimbursement, the FCA defines the term knowingly to include reckless disregard of the truth or falsity of the claim being submitted.

A number of states in which we operate have enacted state false claims legislation. These state false claims laws are generally modeled on the federal FCA, with similar damages, penalties, and qui tam enforcement provisions. An increasing number of healthcare false claims cases seek recoveries under both federal and state law.

Provisions in the Deficit Reduction Act of 2005 (DRA) that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal FCA. Additionally, the DRA requires every entity that receives annual payments of at least \$5 million from a state Medicaid plan to establish written policies for its employees that provide detailed information about federal and state false claims statutes and the whistleblower protections that exist under those laws. Both provisions of the DRA are expected to result in increased false claims litigation against health care providers. We have substantially complied with the written policy requirements.

Corporate Practice of Medicine; Fee-Splitting. Some states have laws that prohibit unlicensed persons or business entities, including corporations, from employing physicians. Some states also have adopted laws that prohibit direct or indirect payments or fee-splitting arrangements between physicians and unlicensed persons or business entities. Possible sanctions for violations of these restrictions include loss of a physician's license, civil and criminal penalties and rescission of business arrangements. These laws vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. We structure our arrangements with healthcare providers to comply with the relevant state law. However, we cannot assure you that governmental officials responsible for enforcing these laws will not assert that we, or transactions in which we are involved, are in violation of these laws. These laws may also be interpreted by the courts in a manner inconsistent with our interpretations.

Emergency Medical Treatment and Active Labor Act. The Emergency Medical Treatment and Active Labor Act imposes requirements as to the care that must be provided to anyone who comes to facilities providing emergency medical services seeking care before they may be transferred to another facility or otherwise denied care. Sanctions for failing to fulfill these requirements include exclusion from participation in Medicare and Medicaid programs and civil money penalties. In addition, the law creates private civil remedies which enable an individual who suffers personal harm as a direct result of a violation of the law to sue the offending hospital for damages and equitable relief. A medical facility that suffers a financial loss as a direct result of another participating hospital's violation of the law

also has a similar right. Although we believe that our practices are in compliance with the law, we can give no assurance that governmental officials responsible for enforcing the law or others will not assert we are in violation of these laws.

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

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

Certificates of Need. The construction of new facilities, the acquisition of existing facilities and the addition of new services at our facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. We operate 59 hospitals in 15 states that have adopted certificate of need laws for acute care facilities. If we fail to obtain necessary state approval, we will not be able to expand our facilities, complete acquisitions or add new services in these states. Violation of these state laws may result in the imposition of civil sanctions or the revocation of a hospital's licenses.

Privacy and Security Requirements of HIPAA. The Administrative Simplification Provisions of HIPAA require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. We believe we are in compliance with these regulations.

The Administrative Simplification Provisions also require CMS to adopt standards to protect the security and privacy of health-related information. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. If we violate these regulations, we could be subject to monetary fines and penalties, criminal sanctions and civil causes of action. We have implemented and operate continuing employee education programs to reinforce operational compliance with policy and procedures which adhere to privacy regulations. The HIPAA security standards and privacy regulations serve similar purposes and overlap to a certain extent, but the security regulations relate more specifically to protecting the integrity, confidentiality and availability of electronic protected health information while it is in our custody or being transmitted to others. We believe we have established proper controls to safeguard access to protected health information.

Payment

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

Payments for inpatient acute services are generally made pursuant to a prospective payment system, commonly known as PPS. Under PPS, our hospitals are paid a predetermined amount for each hospital discharge based on the patient's diagnosis. Specifically, each discharge is assigned to a diagnosis-related group, commonly known as a (DRG), based upon the patient's condition and treatment during the relevant inpatient stay. For the federal fiscal year 2007 (i.e., the federal fiscal year beginning October 1, 2006), each

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DRG was assigned a payment rate using 67% of the national average charge per case and 33% of the national average cost per case. For the federal fiscal year 2008, each DRG is assigned a payment rate using 67% of the national average cost per case and 33% of the national average charge per case and 50% of the change to severity adjusted DRG weights. Severity adjusted DRG s more accurately reflect the costs a hospital incurs for caring for a patient and accounts more fully for the severity of each patient s condition. For the federal fiscal year 2009, each DRG is assigned a payment rate using 100% of the national average cost per case and 100% of the severity adjusted DRG weights. DRG payments are based on national averages and not on charges or costs specific to a hospital. However, DRG payments are adjusted by a predetermined geographic adjustment factor assigned to the geographic area in which the hospital is located. While a hospital generally does not receive payment in addition to a DRG payment, hospitals may qualify for an outlier payment when the relevant patient s treatment costs are extraordinarily high and exceed a specified regulatory threshold.

The DRG rates are adjusted by an update factor on October 1 of each year, the beginning of the federal fiscal year. The index used to adjust the DRG rates, known as the market basket index, gives consideration to the inflation experienced by hospitals in purchasing goods and services. Under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, DRG payment rates were increased by the full market basket index, for the federal fiscal years 2005, 2006, 2007 and 2008 or 3.3%, 3.7%, 3.4% and 3.3%, respectively. The Deficit Reduction Act of 2005 imposes a 2% reduction to the market basket index beginning in the federal fiscal year 2007, and thereafter, if patient quality data is not submitted. We intend to comply with this data submission requirement. Future legislation may decrease the rate of increase for DRG payments, but we are not able to predict the amount of any reduction or the effect that any reduction will have on us.

In addition, hospitals may qualify for Medicare disproportionate share payments when their percentage of low income patients exceeds specified regulatory thresholds. A majority of our hospitals qualify to receive Medicare disproportionate share payments. For the majority of our hospitals that qualify to receive Medicare disproportionate share payments, these payments were increased by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 effective April 1, 2004. These Medicare disproportionate share payments as a percentage of net operating revenues were 1.8% for the year ended December 31, 2007 and 2.1% for each of the two years ended December 31, 2006 and 2005.

Beginning August 1, 2000, we began receiving Medicare reimbursement for outpatient services through a PPS. Under the Balanced Budget Refinement Act of 1999, non-urban hospitals with 100 beds or less were held harmless through December 31, 2004 under this Medicare outpatient PPS. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 extended the hold harmless provision for non-urban hospitals with 100 beds or less and for non-urban sole community hospitals with more than 100 beds through December 31, 2005. The Deficit Reduction Act of 2005 extended the hold harmless provision for non-urban hospitals with 100 beds or less that are not sole community hospitals through December 31, 2008; however that Act reduced the amount these hospitals would receive in hold harmless payment by 5% in 2006, 10% in 2007 and 15% in 2008. Of our 115 hospitals in continuing operations at December 31, 2007, 31 qualified for this relief. The outpatient conversion factor was increased 3.3% effective January 1, 2005; however, coupled with adjustments to other variables within the outpatient PPS resulted in an approximate 4.8% to 5.2% net increase in outpatient PPS payments. The outpatient conversion factor was increased 3.7% effective January 1, 2006; however coupled with adjustments to other variables with the outpatient PPS, an approximate 2.2% to 2.6% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.4% effective January 1, 2007; however, coupled with adjustments to other variables with the outpatient PPS, an approximate 2.5% to 2.9% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.3% effective January 1, 2008; however, coupled with adjustments to other variables with outpatient PPS, an approximate 3.0% to 3.4% net increase in outpatient payments is expected to occur.

Skilled nursing facilities and swing bed facilities were historically paid by Medicare on the basis of actual costs, subject to limitations. The Balanced Budget Act of 1997 established a PPS for Medicare skilled nursing facilities and mandated that swing bed facilities must be incorporated into the skilled nursing facility PPS. For federal fiscal year 2005, skilled nursing facility PPS payment rates were increased by the full market basket of 2.8%. For federal fiscal year 2006, skilled nursing facility PPS payment rates were increased 3.1%; however coupled with adjustments to other variables within the skilled nursing facility PPS, an approximate 3.9% to

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4.3% net increase in skilled nursing facility PPS payments occurred. Skilled nursing facility PPS rates were increased by the full SNF market basket index of 3.1% and 3.3% for the federal fiscal years 2007 and 2008, respectively.

The Department of Health and Human Services established a PPS for home health services effective October 1, 2000. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 implemented an 0.8% reduction to the market basket increase to the home health agency PPS per episodic payment rate effective April 1, 2004 and for the federal fiscal years 2005 and 2006, and increased Medicare payments by 5.0% to home health services provided in rural areas from April 1, 2004 through March 31, 2005. The Deficit Reduction Act of 2005 extended the 5.0% increase to home health services provided in rural areas for an additional year effective January 1, 2006 and froze home health agency payments for 2006 at 2005 levels. The home health agency PPS per episodic payment rate increased by 2.3% on January 1, 2005, 0% on January 1, 2006, and 3.3% on January 1, 2007. The home health agency PPS per episodic payment rate increased by 3% on January 1, 2008; however, coupled with adjustments to other variables with home health agency PPS, an approximate 1.5% to 1.9% net increase in home health agency payments is expected to occur.

Medicaid. Most state Medicaid payments are made under a PPS or under programs which negotiate payment levels with individual hospitals. Medicaid is currently funded jointly by state and federal government. The federal government and many states are currently considering significantly reducing Medicaid funding, while at the same time expanding Medicaid benefits. We can provide no assurance that reductions to Medicaid fundings will not have a material adverse effect on our results of operations.

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

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

Commercial Insurance. Our hospitals provide services to individuals covered by private healthcare insurance. Private insurance carriers pay our hospitals or in some cases reimburse their policyholders based upon the hospital's established charges and the coverage provided in the insurance policy. Commercial insurers are trying to limit the costs of hospital services by negotiating discounts, including PPS, which would reduce payments by commercial insurers to our hospitals. Reductions in payments for services provided by our hospitals to individuals covered by commercial insurers could adversely affect us.

Supply Contracts

In March 2005, we began purchasing items, primarily medical supplies, medical equipment and pharmaceuticals, under an agreement with HealthTrust, a GPO in which we are a minority partner. Triad was also a minority partner in HealthTrust and we acquired their ownership interest and contractual rights in the acquisition. As of December 31, 2007, we have a 19.3% ownership in HealthTrust. By participating in this organization we are able to procure items at competitively priced rates for our hospitals. There can be no assurance that our arrangement with HealthTrust will continue to provide the discounts we expect to achieve.

Competition

The hospital industry is highly competitive. An important part of our business strategy is to continue to acquire hospitals in non-urban markets and select urban markets. However, other for-profit hospital companies and not-for-profit hospital systems generally attempt to acquire the same type of hospitals as we do. In

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addition, some hospitals are sold through an auction process, which may result in higher purchase prices than we believe are reasonable.

In addition to the competition we face for acquisitions, we must also compete with other hospitals and healthcare providers for patients. The competition among hospitals and other healthcare providers for patients has intensified in recent years. Our hospitals are located in non-urban and selected urban service areas. Those hospitals in non-urban service areas face no direct competition because there are no other hospitals in their primary service areas. However, these hospitals do face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in those service areas may travel to these other hospitals for a variety of reasons, including the need for services we do not offer or physician referrals. Patients who are required to seek services from these other hospitals may subsequently shift their preferences to those hospitals for services we do provide. Those hospitals in selected urban service areas may face competition from hospitals that are more established than our hospitals. Certain of these competing facilities offer services, including extensive medical research and medical education programs, which are not offered by our facilities. In addition, in certain markets where we operate, there are large teaching hospitals that provide highly specialized facilities, equipment and services that may not be available at our hospitals.

Some of our hospitals operate in primary service areas where they compete with another hospital. Some of these competing hospitals use equipment and services more specialized than those available at our hospitals and some of the hospitals that compete with us are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. These hospitals can make capital expenditures without paying sales, property and income taxes. We also face competition from other specialized care providers, including outpatient surgery, orthopedic, oncology, and diagnostic centers.

The number and quality of the physicians on a hospital's staff is an important factor in a hospital's competitive advantage. Physicians decide whether a patient is admitted to the hospital and the procedures to be performed. Admitting physicians may be on the medical staffs of other hospitals in addition to those of our hospitals. We attempt to attract our physicians' patients to our hospitals by offering quality services and facilities, convenient locations, and state-of-the-art equipment.

Compliance Program

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

Our company-wide compliance program has been in place since 1997. Currently, the program's elements include leadership, management and oversight at the highest levels, a Code of Conduct, risk area specific policies and procedures, employee education and training, an internal system for reporting concerns, auditing and monitoring programs, and a means for enforcing the program's policies.

Since its initial adoption, the compliance program continues to be expanded and developed to meet the industry's expectations and our needs. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring activities have been prepared and implemented to address the functional and operational aspects of our business. Included within these functional areas are materials and activities for business

sub-units, including laboratory, radiology, pharmacy, emergency, surgery, observation, home health, skilled nursing, and clinics. Specific areas identified through regulatory interpretation and enforcement activities have also been addressed in our program. Claims preparation and submission, including coding, billing, and cost reports, comprise the bulk of these areas. Financial arrangements with physicians and other referral sources, including compliance with anti-kickback and Stark laws, emergency department treatment and transfer requirements, and other patient disposition issues are also the focus of policy and

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training, standardized documentation requirements, and review and audit. Another focus of the program is the interpretation and implementation of the HIPAA standards for privacy and security.

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

Employees

At December 31, 2007, we employed approximately 59,000 full-time employees and 23,200 part-time employees. Of these employees, approximately 2,600 are union members. We currently believe that our labor relations are good.

Professional Liability

As part of our business of owning and operating hospitals, we are subject to legal actions alleging liability on our part. To cover claims arising out of the operations of hospitals, we maintain professional malpractice liability insurance and general liability insurance on a claims made basis in excess of those amounts for which we are self-insured, in amounts we believe to be sufficient for our operations. We also maintain umbrella liability coverage for claims which, due to their nature or amount, are not covered by our other insurance policies. However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. For a further discussion of our insurance coverage, see our discussion of professional liability insurance claims in Management's discussion and analysis of financial condition and results of operations.

Environmental Matters

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

Environmental Insurance for the Former Triad Hospitals

We are insured for both storage tank and pollution issues for the former Triad hospitals under one insurance policy. Our policy coverage is \$2 million per occurrence with a \$25,000 deductible and a \$10 million annual aggregate.

Environmental Insurance for All Other Community Health Systems Hospitals

We are insured for onsite and offsite third party bodily injury, property damage and clean up costs including business interruption coverage for actual losses or rental value resulting from pollution issues. Our policy coverage for pollution is \$3 million per occurrence with a \$100,000 deductible and a \$6 million annual aggregate.

We are insured for damages of personal property or environmental injury arising out of environmental impairment of both underground and above ground storage tanks for all of our hospitals (other than the former Triad hospitals). This policy also pays for the clean up resulting from storage tanks. Our policy coverage is \$2 million per occurrence with a \$25,000 deductible and a \$5 million annual aggregate.

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The following risk factors could materially and adversely affect our future operating results and could cause actual results to differ materially from those predicted in the forward-looking statements we make about our business.

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

We are significantly leveraged. The chart below shows our level of indebtedness and other information as of December 31, 2007. In connection with the consummation of our acquisition of Triad, a \$7.215 billion of senior secured financing under a new credit facility, or New Credit Facility, was obtained by our wholly-owned subsidiary, CHS/Community Health Systems, Inc. or CHS. CHS also issued the 8.875% senior notes, of the Notes, having an aggregate principal amount of \$3.021 billion. Both the indebtedness under the New Credit Facility and the Notes are senior obligations of CHS and are guaranteed on a senior basis by us and by certain of our domestic subsidiaries. We used the net proceeds from the Notes offering and the net proceeds of the \$6.065 billion term loans under the New Credit Facility to pay the consideration under the merger agreement with Triad, to refinance certain of our existing indebtedness and the indebtedness of Triad, to complete certain related transactions, to pay certain costs and expenses of the transactions and for general corporate uses. As of December 31, 2007, a \$750 million revolving credit facility and a \$300 million delayed draw term loan facility are available to us for working capital and general corporate purposes under the New Credit Facility, with \$36 million of the revolving credit facility being set aside for outstanding letters of credit.

Also, in connection with the consummation of the acquisition of Triad, we completed an early repayment of the \$300 million aggregate principal amount of 6.5% Senior Subordinated Notes due 2012 through a cash tender offer and consent solicitation.

	As of December 31, 2007 (\$ in millions)
Senior secured credit facility	
Term loans	\$ 5,965.0
Notes	3,021.3
Other	111.8
Total debt	9,098.1
Stockholder equity	1,710.8

As of December 31, 2007, our \$3.750 billion notional amount of interest rate swap agreements represented approximately 63% of our variable rate debt. On a prospective basis, a 1% change in interest rates on the remaining unhedged variable rate debt existing as of December 31, 2007, would result in interest expense fluctuating approximately \$22 million per year.

The New Credit Facility agreement and/or the Notes contain various covenants that limit our ability to take certain actions, including our ability to:

incur, assume or guarantee additional indebtedness;

issue redeemable stock and preferred stock;

repurchase capital stock;

make restricted payments, including paying dividends and making investments;

redeem debt that is junior in right of payment to the notes;

create liens;

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

enter into agreements that restrict dividends from subsidiaries;

merge, consolidate, sell or otherwise dispose of substantial portions of our assets;

enter into transactions with affiliates; and

guarantee certain obligations.

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

A breach of any of these covenants could result in a default under our New Credit Facility and/or the Notes. Upon the occurrence of an event of default under our New Credit Facility or the Notes, all amounts outstanding under our New Credit Facility and the Notes may become due and payable and all commitments under the New Credit Facility to extend further credit may be terminated.

Our leverage could have important consequences for you, including the following:

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

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

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

some of our borrowings, including borrowings under our New Credit Facility, are at variable rates of interest, exposing us to the risk of increased interest rates;

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

we may be vulnerable in a downturn in general economic conditions or in our business, or we may be unable to carry out capital spending that is important to our growth.

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

We may be able to incur substantial additional indebtedness in the future. The terms of the indenture governing the notes do not fully prohibit us from doing so. For example, under the indenture for the Notes, we may incur up to \$7.815 billion pursuant to a credit facility or a qualified receivables transaction, less certain amounts repaid with the proceeds of asset dispositions. Our New Credit Facility provides for commitments of up to \$7.115 billion in the aggregate. Our New Credit Facility also gives us the ability to provide for one or more additional tranches of term

loans in aggregate principal amount of up to \$600 million without the consent of the existing lenders if specified criteria are satisfied. If new debt is added to our current debt levels, the related risks that we now face could intensify.

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

An important part of our business strategy is to acquire two to four hospitals each year. However, not-for-profit hospital systems and other for-profit hospital companies generally attempt to acquire the same type of hospitals as we do. Some of these other purchasers have greater financial resources than we do. Our principal competitors for acquisitions have included Health Management Associates, Inc. and LifePoint

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Hospitals, Inc. On some occasions, we also compete with Universal Health Services, Inc. In addition, some hospitals are sold through an auction process, which may result in higher purchase prices than we believe are reasonable. Therefore, we may not be able to acquire additional hospitals on terms favorable to us.

If we fail to improve the operations of acquired hospitals, we may be unable to achieve our growth strategy.

Many of the hospitals we have acquired, had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced temporary delays in improving the operating margins or effectively integrating the operations of these acquired hospitals. In the future, if we are unable to improve the operating margins of acquired hospitals, operate them profitably, or effectively integrate their operations, we may be unable to achieve our growth strategy. We acquired 50 hospitals in the Triad acquisition. In the past, we have not acquired this many hospitals at one time. We may experience delays or difficulties in improving the operating margins or effectively integrating the operations of these acquired hospitals.

Given the number of hospitals acquired, senior management may need to devote a significant amount of time to integration of the acquired hospitals, which may detract from the ability of senior management to execute our past acquisition strategy of attempting to acquire two to four hospitals each year. Except for a two hospital system, for which we currently have a definitive agreement to acquire, we do not anticipate acquiring more hospitals during 2008.

We may not be able to successfully integrate our acquisition of Triad or realize the potential benefits of the acquisition, which could cause our business to suffer.

We may not be able to combine successfully the operations of former Triad hospitals with our operations and, even if such integration is accomplished, we may never realize the potential benefits of the acquisition. The integration of former Triad hospitals with our operations requires significant attention from management and may impose substantial demands on our operations or other projects. In addition, Triad's corporate officers did not continue their employment with us. The integration of Triad also involves a significant capital commitment, and the return that we achieve on any capital invested may be less than the return that we would achieve on our other projects or investments. Any of these factors could cause delays or increased costs of combining former Triad hospitals with us; and could adversely affect our operations, financial results and liquidity.

Certain of Triad's joint venture partners have put or call rights, the exercise of which could affect our available cash and/or operating results. Triad entered into a number of joint venture transactions that entitle its joint venture partners to require Triad to purchase the partner's interest or to require Triad to sell its interest to the partner. The consideration provided for in these contracts may not be at an advantageous amount vis-à-vis the consideration paid for the Triad acquisition. If these rights are exercised, we may be required to make unanticipated payments, our operations at certain facilities may be adversely affected, or we may be required to divest certain facilities.

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

Hospitals that we acquire may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. Although we generally seek indemnification from prospective sellers covering these matters, we may nevertheless have material liabilities for past activities of acquired hospitals. In the case of the Triad acquisition, there was no indemnification provided given the fact that Triad was a public company and the acquisition was effective through a merger.

As a result of the Triad acquisition, on a consolidated basis, we are subject to all of the potential liabilities relating to the hospitals held by Triad, including liabilities relating to pending or threatened litigation matters, which, if adversely

decided, could have a material adverse effect on our future results and operations.

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State efforts to regulate the construction, acquisition or expansion of hospitals could prevent us from acquiring additional hospitals, renovating our facilities or expanding the breadth of services we offer.

Some states require prior approval for the construction or acquisition of healthcare facilities and for the expansion of healthcare facilities and services. In giving approval, these states consider the need for additional or expanded healthcare facilities or services. In some states in which we operate, we are required to obtain certificates of need, known as CONs, for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and some other matters. Other states may adopt similar legislation. We may not be able to obtain the required CONs or other prior approvals for additional or expanded facilities in the future. In addition, at the time we acquire a hospital, we may agree to replace or expand the facility we are acquiring. If we are not able to obtain required prior approvals, we would not be able to acquire additional hospitals and expand the breadth of services we offer.

State efforts to regulate the sale of hospitals operated by not-for-profit entities could prevent us from acquiring additional hospitals and executing our business strategy.

Many states, including some where we have hospitals and others where we may in the future acquire hospitals, have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In other states that do not have specific legislation, the attorneys general have demonstrated an interest in these transactions under their general obligations to protect charitable assets from waste. These legislative and administrative efforts focus primarily on the appropriate valuation of the assets divested and the use of the proceeds of the sale by the non-profit seller. While these review and, in some instances, approval processes can add additional time to the closing of a hospital acquisition, we have not had any significant difficulties or delays in completing acquisitions. However, future actions on the state level could seriously delay or even prevent our ability to acquire hospitals.

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

The hospital industry is highly competitive. In addition to the competition we face for acquisitions and physicians, we must also compete with other hospitals and healthcare providers for patients. The competition among hospitals and other healthcare providers for patients has intensified in recent years. Our hospitals are located in non-urban service areas. In approximately 65% of our markets, we are the sole provider of general healthcare services. In most of our other markets, the primary competitor is a not-for-profit hospital. These not-for-profit hospitals generally differ in each jurisdiction. However, our hospitals face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. Patients in our primary service areas may travel to these other hospitals for a variety of reasons. These reasons include physician referrals or the need for services we do not offer. Patients who seek services from these other hospitals may subsequently shift their preferences to those hospitals for the services we provide.

Some of our hospitals operate in primary service areas where they compete with one other hospital. One of our hospitals competes with more than one other hospital in its primary service area. Some of these competing hospitals use equipment and services more specialized than those available at our hospitals. In addition, some competing hospitals are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. These hospitals can make capital expenditures without paying sales, pr