CHS Community Health Systems, Inc.

Oppenheimer
28th Annual Healthcare Conference

March 21st, 2018

Forward-Looking Statements

This presentation contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, Section 21E of the Securities Exchange Act of 1934, as amended, and the Private Securities Litigation Reform Act of 1995 that involve risk and uncertainties. All statements in this presentation other than statements of historical fact, including statements regarding projections, expected operating results, and other events that depend upon or refer to future events or conditions or that include words such as "expects," "anticipates," "intends," "plans," "believes," "estimates," "thinks," and similar expressions, are forward-looking statements. Although the Company believes that these forward-looking statements are based on reasonable assumptions, these assumptions are inherently subject to significant economic and competitive uncertainties and contingencies, which are difficult or impossible to predict accurately and may be beyond the control of the Company. Accordingly, the Company cannot give any assurance that its expectations will in fact occur and cautions that actual results may differ materially from those in the forward-looking statements. A number of factors could affect the future results of the Company or the healthcare industry generally and could cause the Company's expected results to differ materially from those expressed in this presentation. These factors include, among other things: general economic and business conditions, both nationally and in the regions in which we operate; the impact of changes made to the Affordable Care Act, the potential for repeal or additional changes to the Affordable Care Act, its implementation or its interpretation (including through executive orders), as well as changes in other federal, state or local laws or regulations affecting our business; the extent to which states support increases, decreases or changes in Medicaid programs, implement health insurance exchanges or alter the provision of healthcare to state residents through regulation or otherwise; the future and long-term viability of health insurance exchanges and potential changes to the beneficiary enrollment process; risks associated with our substantial indebtedness, leverage and debt service obligations, and the fact that a substantial portion of our indebtedness will mature and become due in the near future, including our ability to refinance such indebtedness on acceptable terms or to incur additional indebtedness; demographic changes; changes in, or the failure to comply with, governmental regulations; potential adverse impact of known and unknown government investigations, audits, and federal and state false claims act litigation and other legal proceedings; our ability, where appropriate, to enter into and maintain provider arrangements with payors and the terms of these arrangements, which may be further affected by the increasing consolidation of health insurers and managed care companies and vertical integration efforts involving payors and healthcare providers; changes in, or the failure to comply with, contract terms with payors and changes in reimbursement rates paid by federal or state healthcare programs or commercial payors; any potential additional impairments in the carrying value of goodwill, other intangible assets, or other long-lived assets, or changes in the useful lives of other intangible assets; changes in inpatient or outpatient Medicare and Medicaid payment levels and methodologies; the effects related to the continued implementation of the sequestration spending reductions and the potential for future deficit reduction legislation; increases in the amount and risk of collectability of patient accounts receivable, including decreases in collectability which may result from, among other things, self-pay growth and difficulties in recovering payments for which patients are responsible, including co-pays and deductibles; the efforts of insurers, healthcare providers, large employer groups and others to contain healthcare costs, including the trend toward value-based purchasing; our ongoing ability to demonstrate meaningful use of certified electronic health record technology and recognize income for the related Medicare or Medicaid incentive payments, to the extent such payments have not expired; increases in wages as a result of inflation or competition for highly technical positions and rising supply and drug costs due to market pressure from pharmaceutical companies and new product releases; liabilities and other claims asserted against us, including self-insured malpractice claims; competition; our ability to attract and retain, at reasonable employment costs, qualified personnel, key management, physicians, nurses and other healthcare workers; trends toward treatment of patients in less acute or specialty healthcare settings, including ambulatory surgery centers or specialty hospitals; changes in medical or other technology; changes in U.S. generally accepted accounting principles; the availability and terms of capital to fund any additional acquisitions or replacement facilities or other capital expenditures; our ability to successfully make acquisitions or complete divestitures, including the disposition of hospitals and non-hospital businesses pursuant to our portfolio rationalization and deleveraging strategy, our ability to complete any such acquisitions or divestitures on desired terms or at all (including to realize the anticipated amount of proceeds from contemplated dispositions), the timing of the completion of any such acquisitions or divestitures, and our ability to realize the intended benefits from any such acquisitions or divestitures; the impact that changes in our relationships with joint venture or syndication partners could have on effectively operating our hospitals or ancillary services or in advancing strategic opportunities; our ability to successfully integrate any acquired hospitals, or to recognize expected synergies from acquisitions; the impact of seasonal severe weather conditions, including the timing and amount of insurance recoveries in relation to severe weather events such as Hurricanes Harvey and Irma; our ability to obtain adequate levels of general and professional liability insurance; timeliness of reimbursement payments received under government programs; effects related to outbreaks of infectious diseases; the impact of prior or potential future cyber-attacks or security breaches; any failure to comply with the terms of the Corporate Integrity Agreement; the concentration of our revenue in a small number of states; our ability to realize anticipated cost savings and other benefits from our current strategic and operational cost savings initiatives; changes in interpretations, assumptions and expectations regarding the Tax Act; and the other risk factors set forth in our other public filings with the Securities and Exchange Commission.

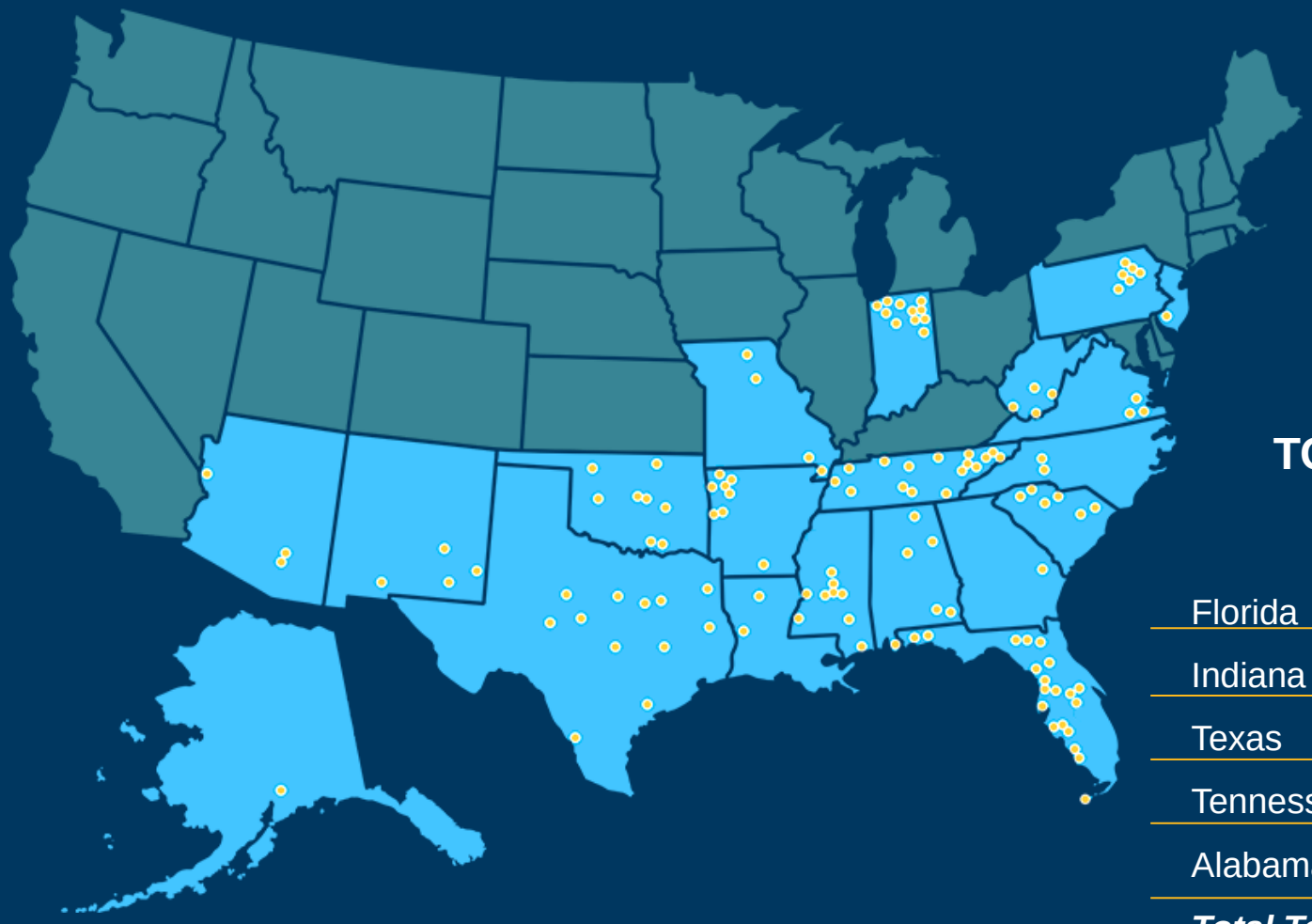
The consolidated operating results for the three months and year ended December 31, 2017, are not necessarily indicative of the results that may be experienced for any future periods. The Company cautions that the projections for calendar year 2018 set forth in this presentation are given as of the date hereof based on currently available information. The Company undertakes no obligation to revise or update any forward-looking statements, or to make any other forward-looking statements, whether as a result of new information, future events or otherwise.

Community Health Systems

- Founded in 1985
- NYSE Listed Company since 2000 Symbol: CYH
- 125 Hospitals in 19 States
- Over 700,000 Annual Admissions
- Over 3.9 Million Annual ED Visits
- 95,000 Employees
- 16,400 Physicians on Medical Staffs, including approximately 2,200 employed physicians

CHS Operating Imperatives

Serving Non-Urban and Select Urban Markets



125
Hospitals

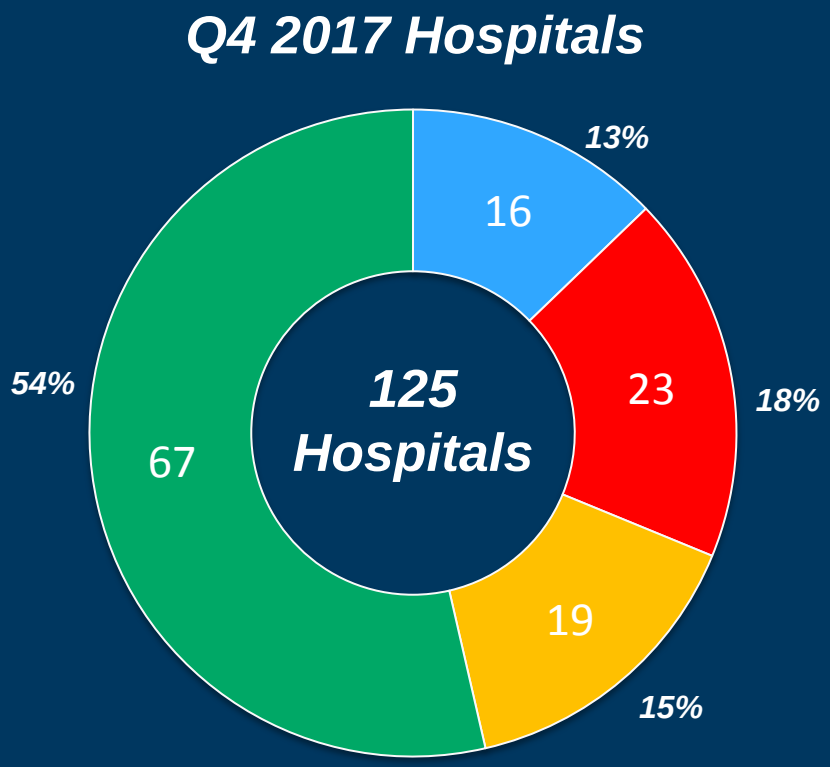
19
States

TOP FIVE STATES

	Hospitals	YE 2017 % of Revenue[(1)]
Florida	20	12.9%
Indiana	11	10.9%
Texas	12	10.0%
Tennessee	16	7.9%
Alabama	6	7.6%
Total Top 5		***49.3%***

(1) The revenue used in this calculation excludes the $591 million change in estimate for contractual allowances and provision for bad debts recorded during the three months ended December 31, 2017.

Breakdown of Hospitals by Type



Individual Hospitals with In-Market Competition

CHS hospitals not in close geographic proximity to other CHS hospitals; have in-market competitors

Individual Hospitals with Out-of-Market Competition

CHS hospitals not in close geographic proximity to another CHS hospital; have out-of-market competitors

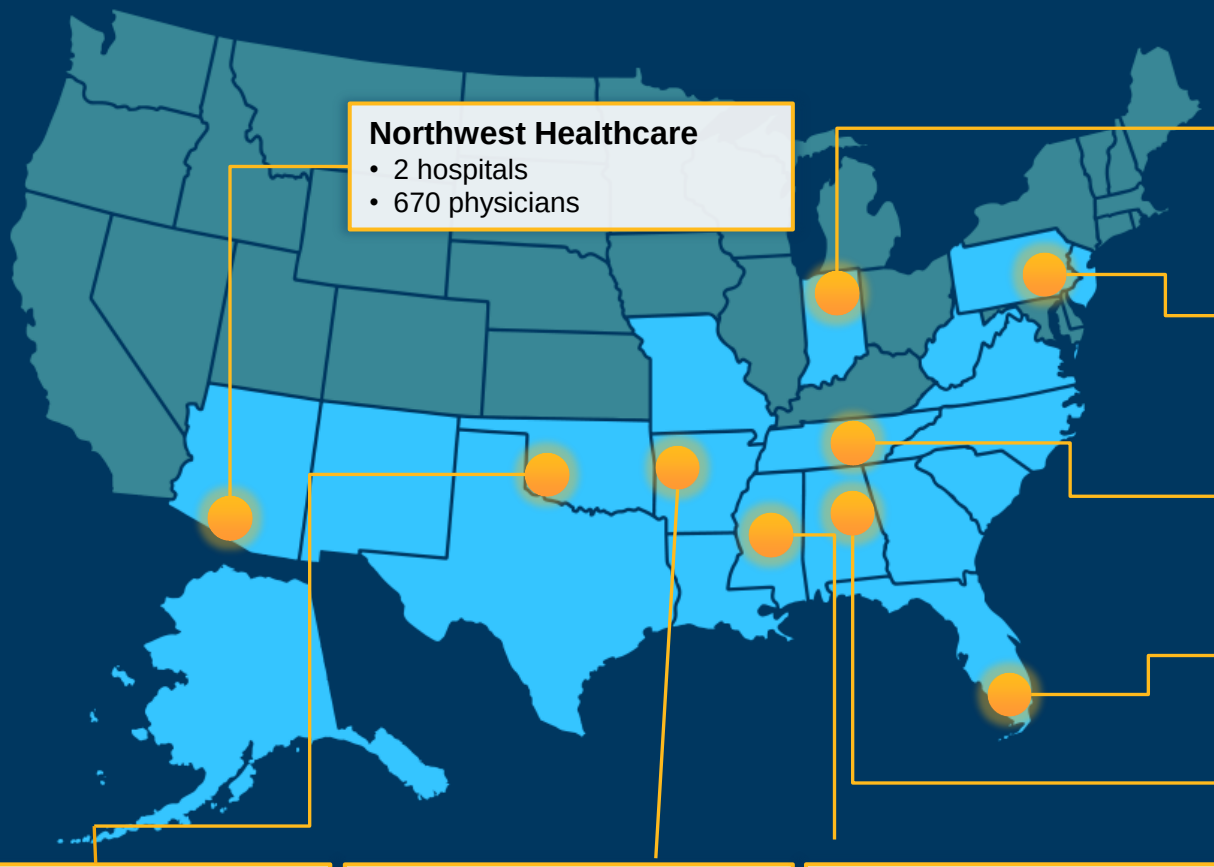
8 Local Hospital Markets

CHS hospitals in close geographic proximity to another CHS hospital

9 Statewide / Regional Hospital Networks

Common brand identity among CHS hospitals within a geographic area larger than a local hospital market

CHS Regional Networks



Northwest Healthcare
- 2 hospitals
- 670 physicians

Lutheran Health Network
- 8 hospitals
- 1,130 physicians

Commonwealth Health
- 6 hospitals
- 810 physicians

Tennova Healthcare
- 16 Hospitals
- 1,860 physicians

Bayfront Health
- 7 hospitals
- 1,510 physicians

Alabama Network
- 6 hospitals
- 1,500 physicians

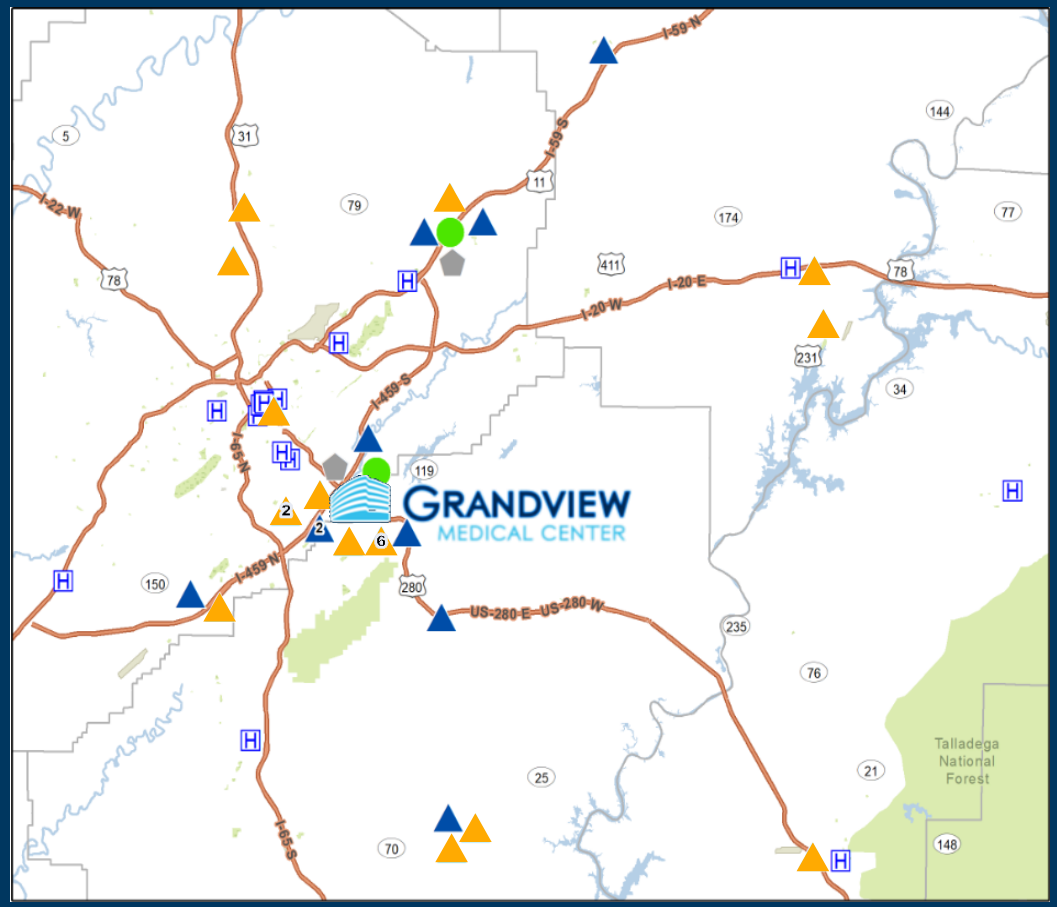
AllianceHealth Oklahoma
- 8 hospitals
- 400 physicians

Northwest Health Arkansas
- 5 hospitals
- 420 physicians

Merit Health
- 9 hospitals
- 1,290 physicians

** Active Medical Staff Physicians*

CHS Regional Networks – Grandview Health Market Access – Birmingham, AL



GRANDVIEW MEDICAL CENTER — 1 Hospital

9 — PCP Office Locations

14 — Specialist Office Locations

2 — Imaging Centers

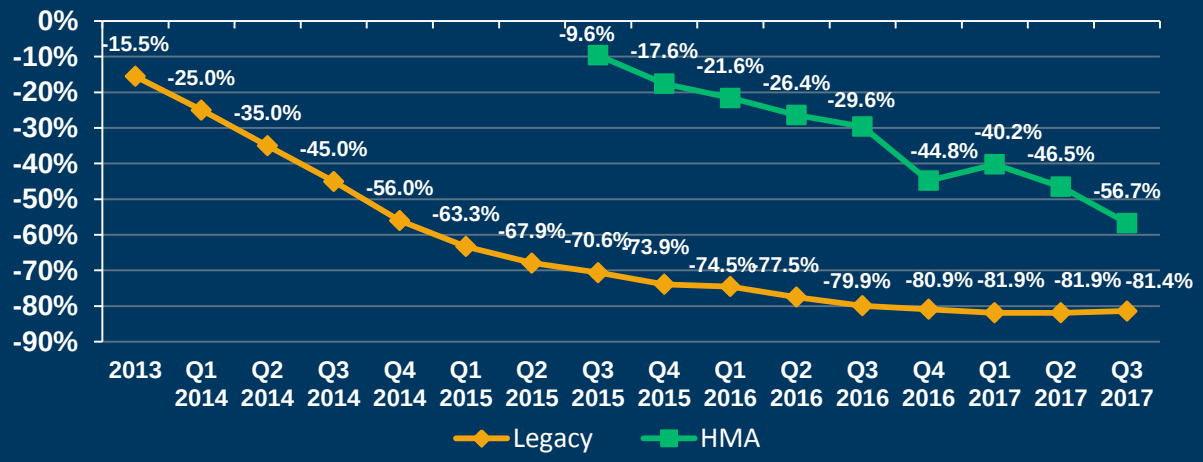
2 — Outpatient Centers

Demonstrate Quality

Consistent Reduction of the Serious Safety Event Rate

High Reliability

Using techniques from high-risk industries like nuclear power and aviation to create inherently safe hospital environments

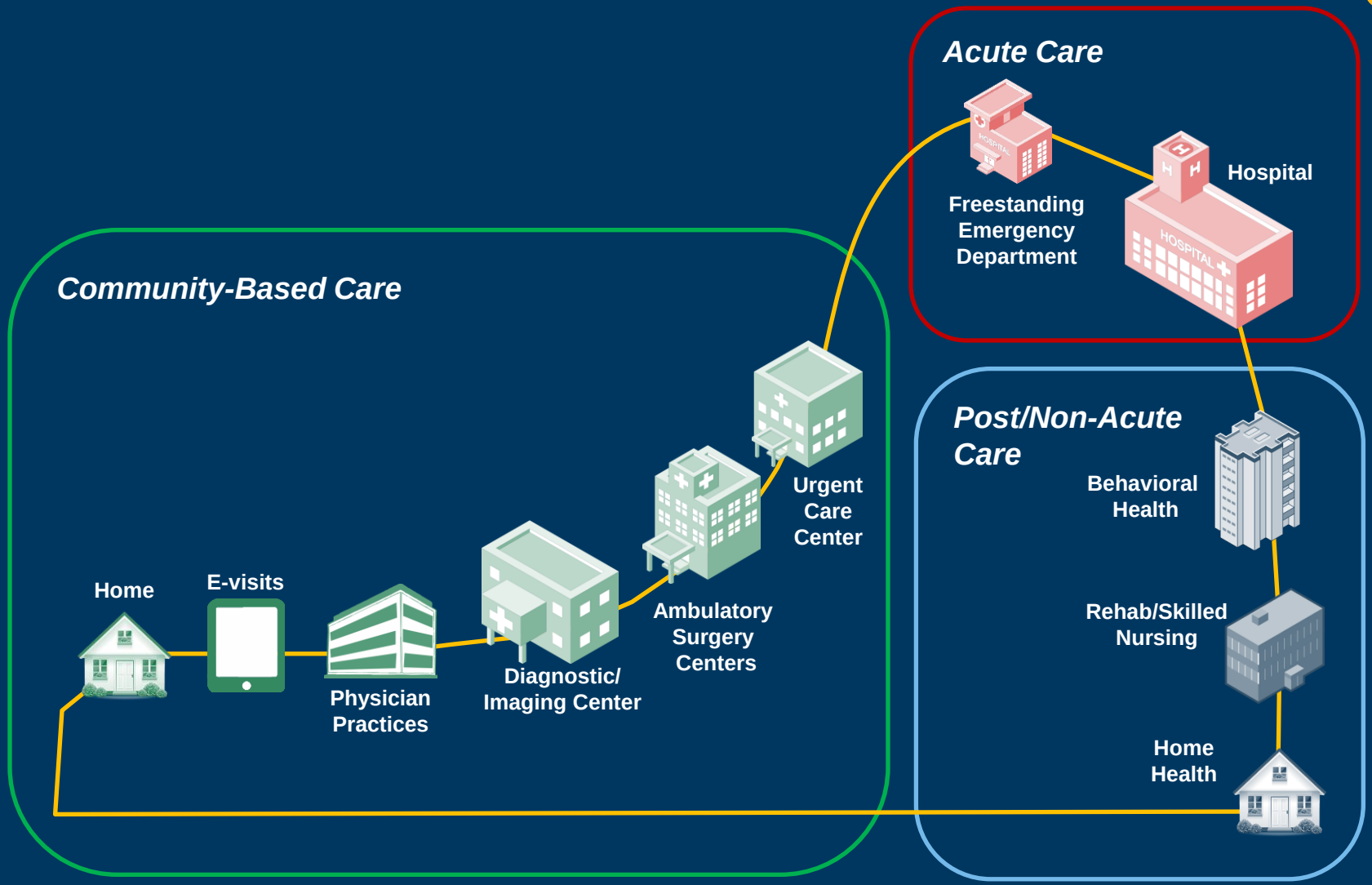


Note: CHS Legacy hospitals are compared to an April 2013 baseline, while HMA are compared to a June 2015 baseline; Data trails by one quarter and is not yet available for Q4 2017.

Ongoing Research Collaboration with Harvard

Collaborating with Harvard T.H. Chan School of Public Health on their continuing research related to the Safe Surgery Checklist - the World Health Organization (WHO) demonstrated significant reduction in surgical mortality and complications with the use of this tool.

Growth - Focused on the Continuum of Care



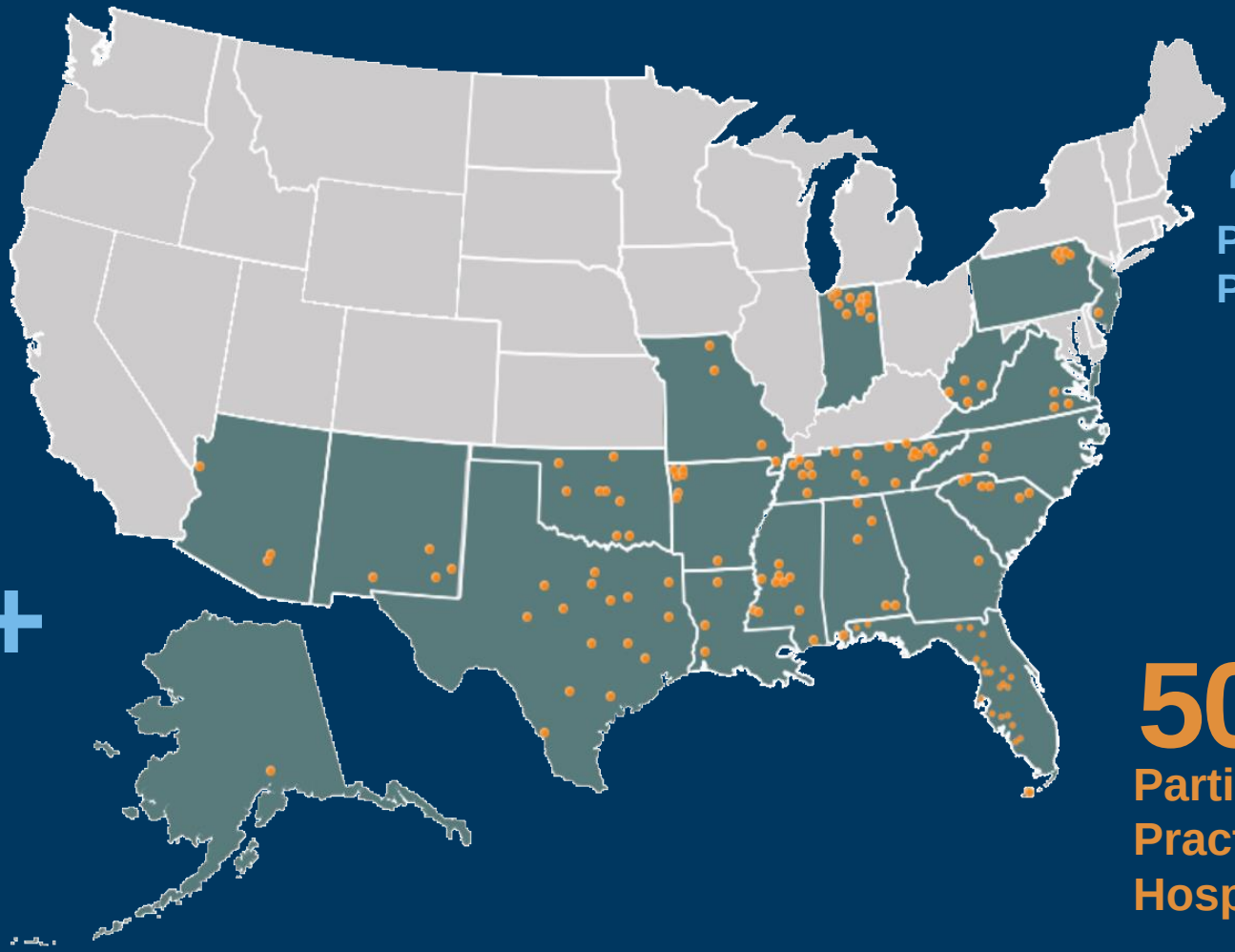
Growth - Through More Access Points

- **55 Surgery Centers**
- **45 Urgent Care Centers**
- **48 Walk-In or Retail Clinics**
- **9 Freestanding EDs**
- **62 Home Health Agencies** (20% JV partner)
- **115 Diagnostic Centers**
- **950 Physician Clinics**

Growth – Strategic and Consumer-Driven

Growth – Accountable Care Organizations (ACOs)

15
MSSP ACOs



4K+
Participating Providers

260K+
Attributed MFFS Lives

500+
Participating Practices & Hospitals

Growth – Transfer Center Strategy

Patient goes to ER | **Transferred for Higher Level of Care** | **Post Acute Placement**

Providers
Employed & Affiliated

Acute Care
Non-CHS, Urgent Care, FSER

Transport
EMS & Private

Community
Behavioral Health, SNFs, LTAC, IRF

CHS

CHS

Non-CHS


CHS & Non-CHS
IRF, SNF, LTAC

- Centralized access point to transfer patients into and out of CHS
- Staffed 24/7 with Nursing and Behavioral Health professionals
- Acute care and post acute care placement
- Behavioral Health telemedicine assessment and placement
- Compliance safety net for hospitals: recorded calls and standardized processes
- Data provides operational transparency and market insight
- Leverage size and scale of CHS markets and service line alignment

Medical Staff Collaboration and Clinical Integration

Medical Staff Alignment

- Value Based Care Initiatives
  - Accountable Care Organizations (ACOs)
  - Clinically Integrated Networks (CINs)
  - CMS Bundled Payment Programs (Total Joints)
- Service Line Development: Physician Leadership & Involvement
- ASC, Outpatient Partnerships
- Physician Outreach, Liaison Programs

Employed Provider Alignment

- Corporate Physician-led practice management support
- Improved On-Boarding & Ramp Up
- Centralized Scheduling, Online Scheduling: Consumerism focus yields growth

Strategic Physician Recruitment

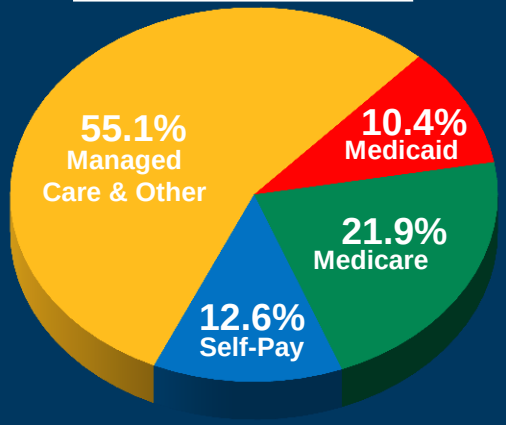
- Prioritized Recruitment Focus
- Key Driver for Strategic Service Line Development

Operational Efficiency

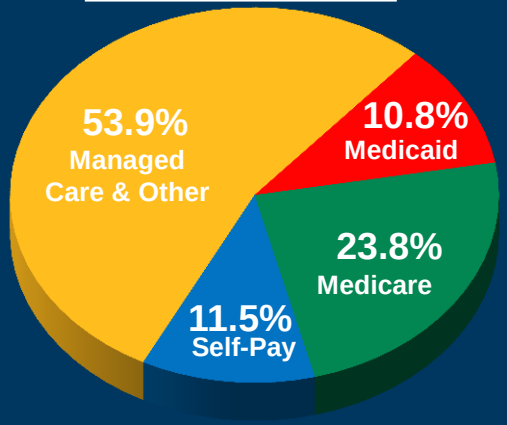
- SWB Management
- Supply Chain Optimization
- Shared Service Centers
- Vendor Efficiencies
- High Opportunity Hospitals
- Peak Performance Teams

Payor Mix (Consolidated)[1]

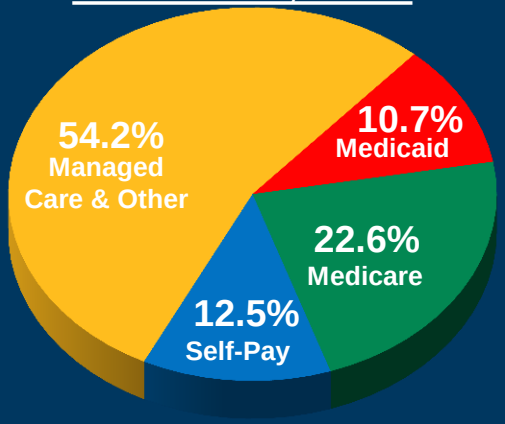
Three Months Ended December 31, 2017[2]



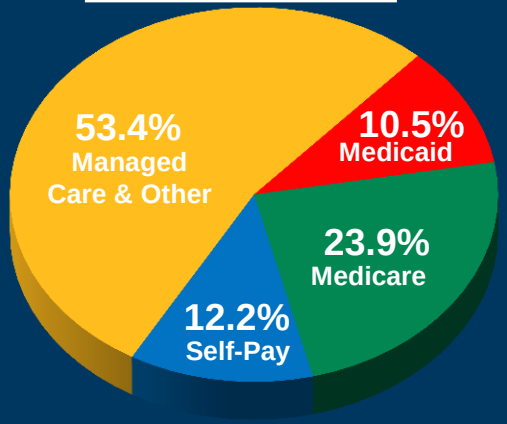
Three Months Ended December 31, 2016



Year Ended December 31, 2017[2]



Year Ended December 31, 2016



(1) Payor mix as a percent of net revenue before bad debt.

(2) The revenue used in this calculation excludes the $591 million change in estimate for contractual allowances and provision for bad debts recorded during the three months ended December 31, 2017.

Q4 2017 Highlights

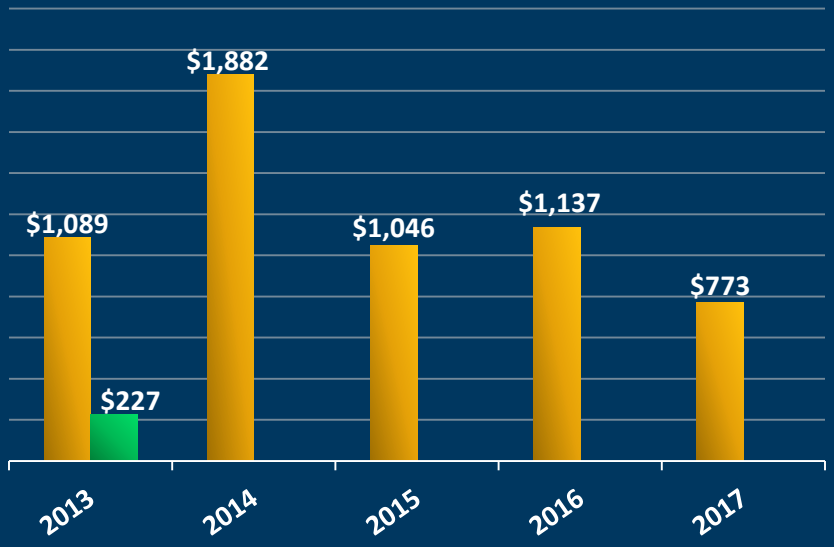
	Q4 2017 Compared to Q4 2016		YE 2017 Compared to YE 2016	
	Consolidated	**Same Store**	**Consolidated**	**Same Store**
Net Operating Revenues[(1)]	-18.3%	1.8%	-13.5%	0.2%
Admissions	-19.2%	-1.7%	-13.9%	-1.9%
Adjusted Admissions	-19.3%	-0.9%	-14.5%	-1.7%
Surgeries	-19.1%	-0.9%	-13.9%	-2.1%
ER Visits	-18.2%	1.4%	-15.0%	-0.8%

(1) The 2017 Non-GAAP Net Operating Revenues above exclude the $591 million change in estimate for contractual allowances and provision for bad debts recorded during the three months ended December 31, 2017. The information in this presentation should be reviewed together with the press release dated February 27, 2018, which contains GAAP reporting related to this change in estimate.

Cash Flow and Capital Expenditures

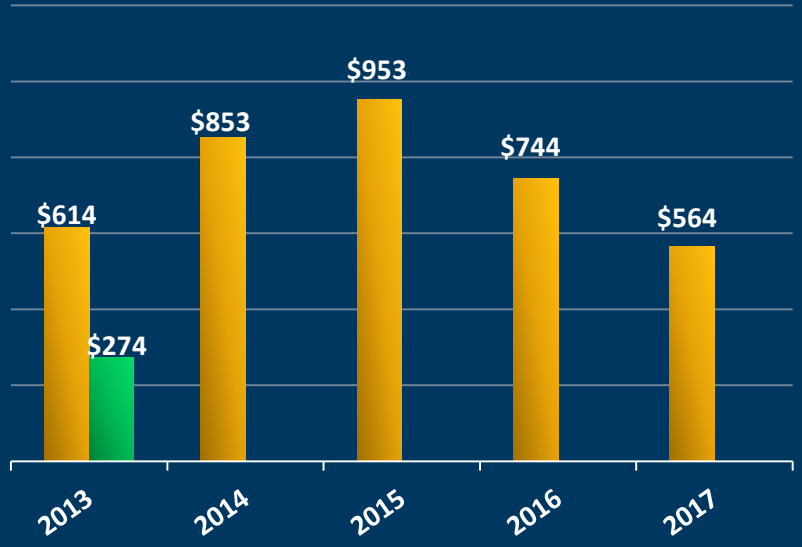
Cash Flows from Operations

($ in millions)



Capital Expenditures

($ in millions)



(1) Approximately $120 million was spent during the year ended December 31, 2015 for the replacement hospital, Grandview Medical Center in Birmingham, AL.

(2) The revenue used in this calculation excludes the $169 million change in estimate of the provision for bad debts recorded during the three months ended December 31, 2015.

(3) The revenue used in this calculation excludes the $591 million change in estimate for contractual allowances and provision for bad debts recorded during the three months ended December 31, 2017.

CapEx % of revenue (includes replacement hospitals)					
CHS	4.8%	4.6%	4.9%(1)(2)	4.0%	3.5%(3)
HMA	4.9%				

Replacement hospitals % of revenue					
CHS	0.5%	0.6%	0.6%(1)(2)	0.1%	0.0%(3)

Rationalizing Our Portfolio

QHC Spin-off – Completed April 29th, 2016

- 38 hospitals in 16 states
  - *Net proceeds: $1.2 billion*

Sale of Joint Venture – Completed May 4th, 2016

- Located in Las Vegas, NV with Universal Health Services, Inc.
  - *$445 million in cash to CHS, including return of capital for a replacement hospital*

Divestitures Complete – Completed in 4th Quarter 2016

- Completed sale and leaseback of ten medical office buildings, announced December 22nd
  - *Gross proceeds: $163 million*
- Completed sale of 80% interest in our Home Care Division, announced January 3rd
  - *Annualized revenue: ~$200 million, gross proceeds: $128 million*

Hospital Divestitures (30 Hospitals) – Transactions Closed in 2017

- Completed the sale of 30 hospitals between April 28th and November 1st
- Hospital divestitures included: 11 in PA, 4 in WA, 4 in FL, 3 in OH, 3 in MS, 3 in TX, 1 in AL, and 1 in LA
  - *Annualized revenue: ~$3.4 billion, with mid-single digit EBITDA margins, gross proceeds, excluding working capital: ~$1.7 billion*

Divestitures Underway in 2018

- 3 definitive agreements announced (1 in FL, 1 in TN, and 1 in LA)
- The total contemplated divestitures accounted for ~$2.0 billion of 2017 annual net revenue, with mid-single digit EBITDA margins
- Total estimated gross proceeds, excluding working capital of ~$1.3 billion
- Expect closing of these divestitures to occur during 2018
- Based on the anticipated timing of divestiture closings, we expect these divestitures to contribute ~$1.0 billion of net revenue in 2018

Additional Divestitures Expected

- Continue to optimize and further strengthen our portfolio

Refining our overall portfolio by eliminating these assets, future investments can be committed to our most attractive locations.

2017 Pro-forma Annual Results Adjusted for Current Hospital Divestiture Plan

Same Store

YE 2017 Compared to YE 2016			
	Current	**Pro-forma**	**Change**
Admissions	-1.9%	-1.6%	+30BPS
Adjusted Admissions	-1.7%	-1.4%	+30BPS
Surgeries	-2.1%	-1.9%	+20BPS

Consolidated

EBITDA Margin(1)	10.7%	11.4%	+70BPS

(1) The revenue and EBITDA used in this calculation excludes the $591 million change in estimate for contractual allowances and provision for bad debts recorded during the three months ended December 31, 2017.

Q4 2017 Pro-forma Quarterly Results Adjusted for Current Hospital Divestiture Plan

Same Store

Q4 2017 Compared to Q4 2016			
	Current	**Pro-forma**	**Change**
Admissions	-1.7%	-1.7%	Flat
Adjusted Admissions	-0.9%	-0.6%	+30BPS
Surgeries	-0.9%	-0.7%	+20BPS

Consolidated

EBITDA Margin(1)	11.2%	11.8%	+60BPS

(1) The revenue and EBITDA used in this calculation excludes the $591 million change in estimate for contractual allowances and provision for bad debts recorded during the three months ended December 31, 2017.

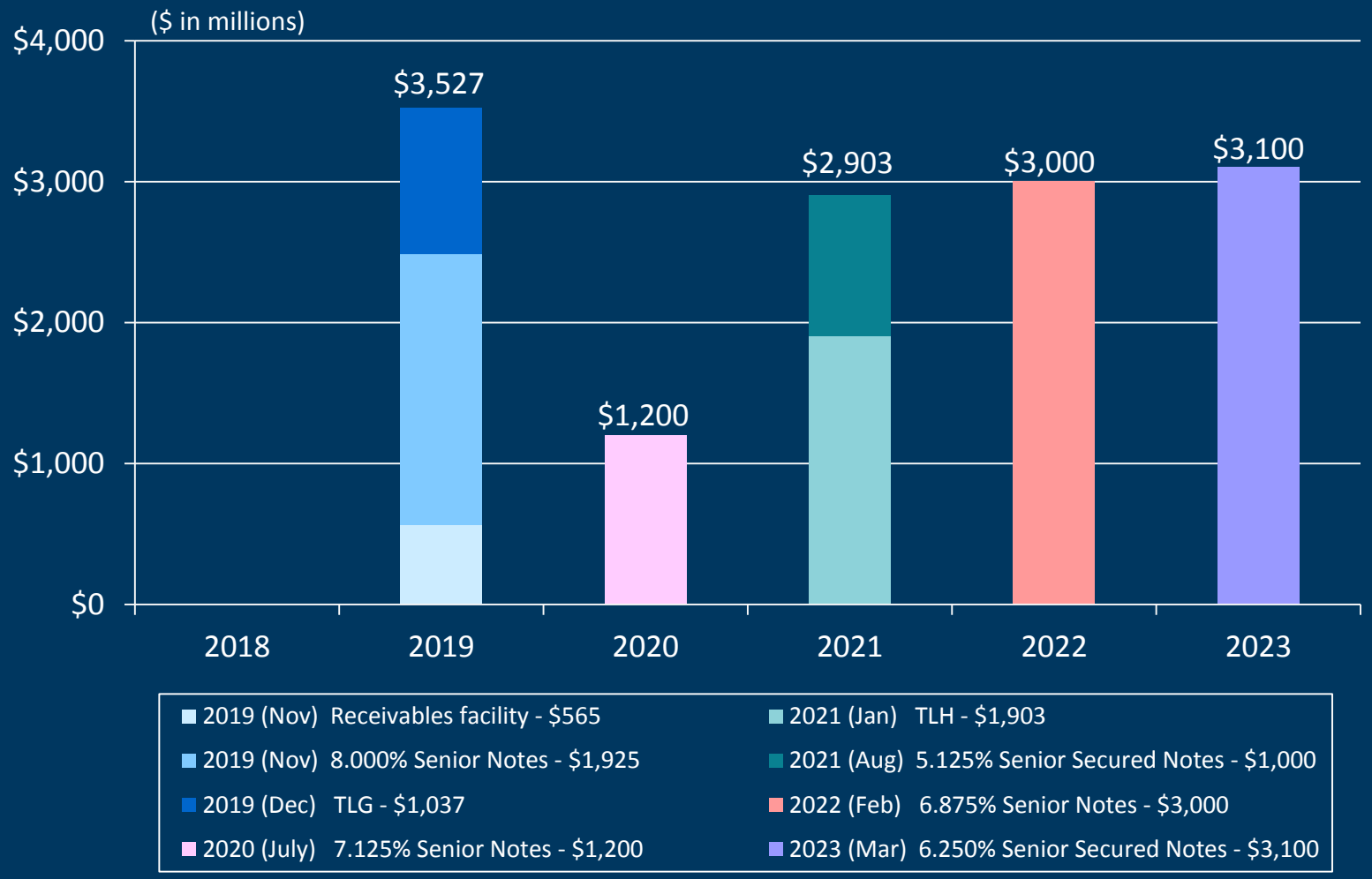
2018 Guidance Overview as of February 27, 2018

	2018 Projection Range
Net operating revenues (in millions)	$13,600 to $13,900
Adjusted EBITDA (in millions)	$1,550 to $1,650
Depreciation and amortization as a percentage of net operating revenues	5.0% to 5.1%
Interest expense as a percentage of net operating revenues	6.5% to 6.6%
Loss from continuing operations per share – diluted	$(1.50) to $(1.10)
Weighted-average diluted share (in millions)	113 to 114
Net cash provided by operating activities (in millions)	$700 to $800
Capital expenditures (in millions)	$475 to $575
Same-store adjusted admissions growth	(0.5)% to 0.5%
HITECH Incentives (in millions)	$0

2018 guidance reflects the impact of the anticipated timing of divestiture closings, which accounted for ~$2.0 billion of 2017 annual net revenue. Based on the anticipated timing of divestiture closings, we expect these divestitures to contribute ~$1.0 billion of net revenue in 2018.

Our comprehensive 2018 guidance has been provided on pages 19 and 20 on Form 8-K dated February 27th, 2018 and includes important assumptions and exclusions.

Debt Maturity as of December 31, 2017



Focused Strategy

CHS Community Health Systems, Inc.

Other Financial Information

Unaudited Supplemental Information

EBITDA is a non-GAAP financial measure which consists of net loss attributable to Community Health Systems, Inc. before interest, income taxes, and depreciation and amortization. Adjusted EBITDA, also a non-GAAP financial measure, is EBITDA adjusted to add back net income attributable to noncontrolling interests and to exclude the effect of discontinued operations, loss from early extinguishment of debt, impairment and (gain) loss on sale of businesses, gain on sale of investments in unconsolidated affiliates, expense incurred related to the spin-off of QHC, expense incurred related to the sale of a majority ownership interest in the Company's home care division, expense (income) related to government and other legal settlements and related costs, expense related to employee termination benefits and other restructuring charges, (income) expense from fair value adjustments on the CVR agreement liability accounted for at fair value related to the HMA legal proceedings, and related legal expenses, and the overall impact of the change in estimate related to net patient revenue recorded in the fourth quarter of 2017 resulting from the increase in contractual allowances and the provision for bad debts. During the three months ended December 31, 2017, the Company increased contractual allowances and the provision for bad debts after completing an extensive analysis of the Company's patient revenues and patient accounts receivable that was initiated as part of the development of new accounting processes and methodologies to adopt the new accounting standard on revenue recognition as required by generally accepted accounting principles on January 1, 2018. This analysis included an evaluation during the fourth quarter of 2017 of the Company's patient accounts receivable retained after the divestiture of 30 hospitals during 2017 and additional allowances recorded on such accounts receivable based on updated estimates of future collections, and certain other revenues. The full impact of this change in estimate is included in the reported results of operations for the three months and year ended December 31, 2017. These changes in estimate are not expected to have a material impact on the recognition of revenue on a prospective basis. The Company has included this adjustment in the calculation of Adjusted EBITDA based on its belief that these changes in estimate are consistent with the intended purpose of Adjusted EBITDA in assessing the Company's operational performance and compare the Company's performance between periods. The Company has from time to time sold noncontrolling interests in certain of its subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. The Company believes that it is useful to present Adjusted EBITDA because it adds back the portion of EBITDA attributable to these third-party interests and clarifies for investors the Company's portion of EBITDA generated by continuing operations. The Company reports Adjusted EBITDA as a measure of financial performance. Adjusted EBITDA is a key measure used by management to assess the operating performance of the Company's hospital operations and to make decisions on the allocation of resources. Adjusted EBITDA is also used to evaluate the performance of the Company's executive management team and is one of the primary targets used to determine short-term cash incentive compensation. In addition, management utilizes Adjusted EBITDA in assessing the Company's consolidated results of operations and operational performance and in comparing the Company's results of operations between periods. The Company believes it is useful to provide investors and other users of the Company's financial statements this performance measure to align with how management assesses the Company's results of operations. Adjusted EBITDA also is comparable to a similar metric called Consolidated EBITDA, as defined in the Company's senior secured credit facility, which is a key component in the determination of the Company's compliance with some of the covenants under the Company's senior secured credit facility (including the Company's ability to service debt and incur capital expenditures), and is used to determine the interest rate and commitment fee payable under the senior secured credit facility (although Adjusted EBITDA does not include all of the adjustments described in the senior secured credit facility).

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

Unaudited Supplemental Information

The following table reflects the reconciliation of Adjusted EBITDA, as defined, to net loss attributable to Community Health Systems, Inc. stockholders as derived directly from the condensed consolidated financial statements (in millions):

	Three Months Ended December 31,		Year Ended December 31,	
	2017	2016	2017	2016
Net loss attributable to Community Health Systems, Inc. stockholders	$ (2,013)	$ (220)	$ (2,459)	$ (1,721)
Adjustments:				
(Benefit from) provision for income taxes	(375)	37	(449)	(104)
Depreciation and amortization	196	261	861	1,100
Net income attributable to noncontrolling interests	6	22	63	95
Loss from discontinued operations	3	9	12	15
Interest expense, net	225	232	931	962
Loss from early extinguishment of debt	5	-	40	30
Impairment and (gain) loss on sale of businesses, net	1,760	224	2,123	1,919
Change in estimate for contractual allowances and provision for bad debts	591	-	591	-
Gain on sale of investments in unconsolidated affiliates	-	-	-	(94)
Expense (income) from government and other legal settlements and related costs	1	5	(31)	16
(Income) expense from fair value adjustments and legal expenses related to cases covered by the CVR	-	(6)	6	(6)
Expense related to the sale of a majority interest in home care division	-	-	1	1
Expense related to the spin-off of QHC	-	-	-	12
Expense related to employee termination benefits and other restructuring charges	10	-	14	-
Adjusted EBITDA	$ 409	$ 564	$ 1,703	$ 2,225

Income Summary

Note: The results below, including Non-GAAP Net Operating Revenues, Adjusted EBITDA, Adjusted EBITDA Margin and EPS from Continuing Operations Excluding Adjustments per Share, each exclude the $591 million change in estimate for contractual allowances and provision for bad debts recorded during the three months ended December 31, 2017. The information in this presentation should be reviewed together with the press release dated February 27, 2018, which contains GAAP reporting related to this change in estimate.

(Amounts in millions, except margin and EPS)

	Three Months Ended December 31,			Year Ended December 31,		
	2017	2016	Change	2017	2016	Change
Net Operating Revenues	$ 3,650	$ 4,469	-18.3%	$ 15,945	$ 18,438	-13.5%
Adjusted EBITDA[(1)]	$ 409	$ 564	-27.5%	$ 1,703	$ 2,225	-23.5%
Adjusted EBITDA Margin[(1)]	11.2%	12.6%	-140 BPS	10.7%	12.1%	-140 BPS
EPS from Continuing Operations Excluding Adjustments[(2)(3)]	$ (0.25)	$ 0.46	-154.3%	$ (1.20)	$ 0.46	-360.9%
Shares Outstanding (Weighted and Fully Diluted)	112	111		112	111	

(1) See the Unaudited Supplemental Information contained in this presentation for a definition of Adjusted EBITDA and a reconciliation of Adjusted EBITDA, as defined, to net loss attributable to Community Health Systems, Inc. stockholders as derived directly from our consolidated financial statements for the three months and year ended December 31, 2017 and 2016 (Slides 27 and 28).

(2) Diluted loss from continuing operations per share for the year ended December 31, 2017, was negatively impacted by $0.14, due to the change in the accounting treatment of tax deductions for stock compensation (ASU 2016-09) for the restricted stock vesting that occurs each year in the first quarter.

(3) See reconciliation of diluted EPS on slide 30.

Diluted EPS – Excluding Adjustments

	Three Months Ended December 31,		Year Ended December 31,	
	2017	2016	2017	2016
Net loss, as reported	$ (17.98)	$ (1.99)	$ (22.00)	$ (15.54)
Adjustments:				
Discontinued operations	0.03	0.09	0.11	0.13
Loss from early extinguishment of debt	0.03	-	0.23	0.17
Impairment and (gain) loss on sale of businesses, net	13.94	2.35	16.84	16.07
Expense (income) from government and other legal settlements and related costs	-	0.03	(0.18)	0.09
(Income) expense from fair value adjustments and legal expenses related to cases covered by the CVR	-	(0.04)	0.04	(0.04)
Gain on sale of investments in unconsolidated affiliates	-	-	-	(0.54)
Expense related to the spin-off of QHC	-	0.02	-	0.10
Expense related to the sale of a majority interest in home care division	-	-	-	0.01
Expense related to employee termination benefits and other restructuring charges	0.06	-	0.08	-
Change in estimate for contractual allowances and provision for bad debts	3.38	-	3.38	-
Expense related to change in Corporate income tax rate	0.29	-	0.29	-
(Loss) income from continuing operations, excluding adjustments	$ (0.25)	$ 0.46	$ (1.20)	$ 0.46

(Total per share amounts may not add due to rounding)

Balance Sheet Data

($ in millions)	December 31, 2017	December 31, 2016
Working Capital	$ 1,712	$ 1,779
Total Assets	$ 17,450	$ 21,944
Long Term Debt	$ 13,880[(1)(2)]	$ 14,789
Stockholders' (Deficit) Equity	$ (767)	$ 1,615

(1) At December 31, 2017, approximately 91% of our debt was fixed, including swaps.

(2) Net debt (long-term debt, plus current maturities of long-term debt, less cash and cash equivalents) has been reduced by $1.66 billion since December 31, 2016.