CHS Community Health Systems, Inc.

36th Annual J.P. Morgan Healthcare Conference

January 10th, 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 press release 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 the potential repeal of or significant changes to the Affordable Care Act, its implementation or its interpretation, 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, which may be affected by whether a sufficient number of payors participate as well as the impact of the 2016 federal elections on the Affordable Care Act; risks associated with our substantial indebtedness, leverage and debt service obligations, 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; 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; 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 in states that have not expanded Medicaid and difficulties in recovering payments for which patients are responsible, including co-pays and deductibles; the efforts of insurers, healthcare providers 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, including those of HMA, 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 the external, criminal cyber-attack suffered by us in the second quarter of 2014, including potential reputational damage, the outcome of our investigation and any potential governmental inquiries, the outcome of litigation filed against us in connection with this cyber-attack, the extent of remediation costs and additional operating or other expenses that we may continue to incur, and the impact of 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; 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 and nine months ended September 30, 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 2017 set forth in this press release 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

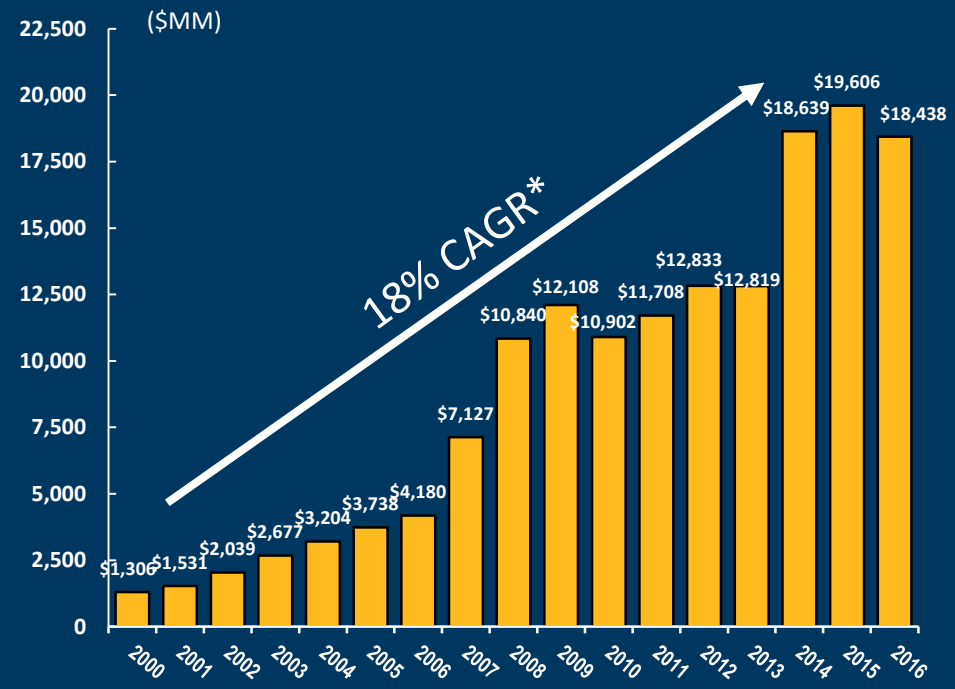
- Founded in 1985
- NYSE Listed Company since 2000 Symbol: CYH
- 133* Hospitals in 20 States
- Over 700,000 Annual Admissions
- Over 4 Million Annual ED Visits
- 100,000 Employees
- 17,300 Physicians on Medical Staffs, including approximately 2,300 employed physicians

CHS Community Health Systems, Inc.

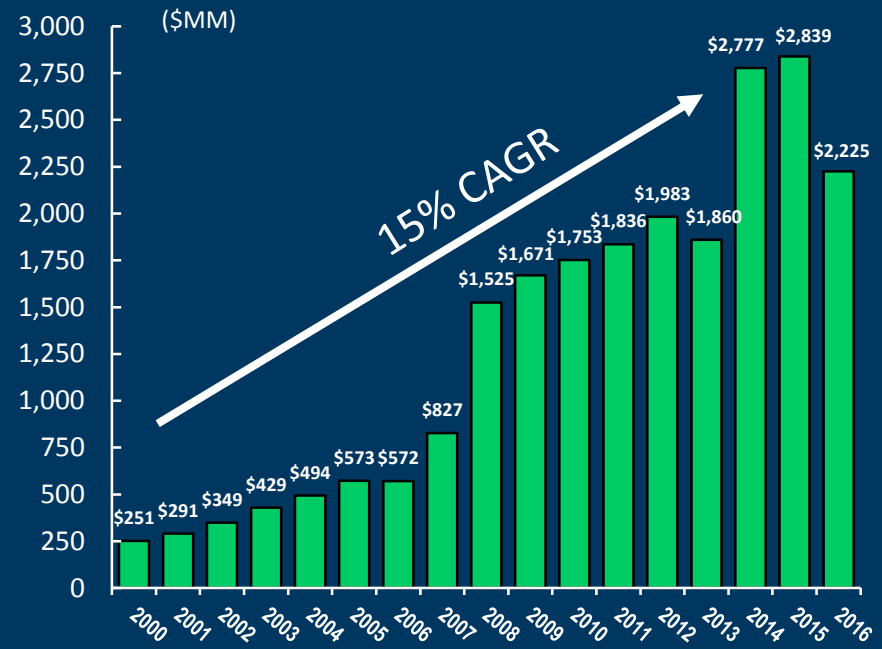
*as of September 30, 2017

CHS – An Experienced Operator

Revenues



Adjusted EBITDA **

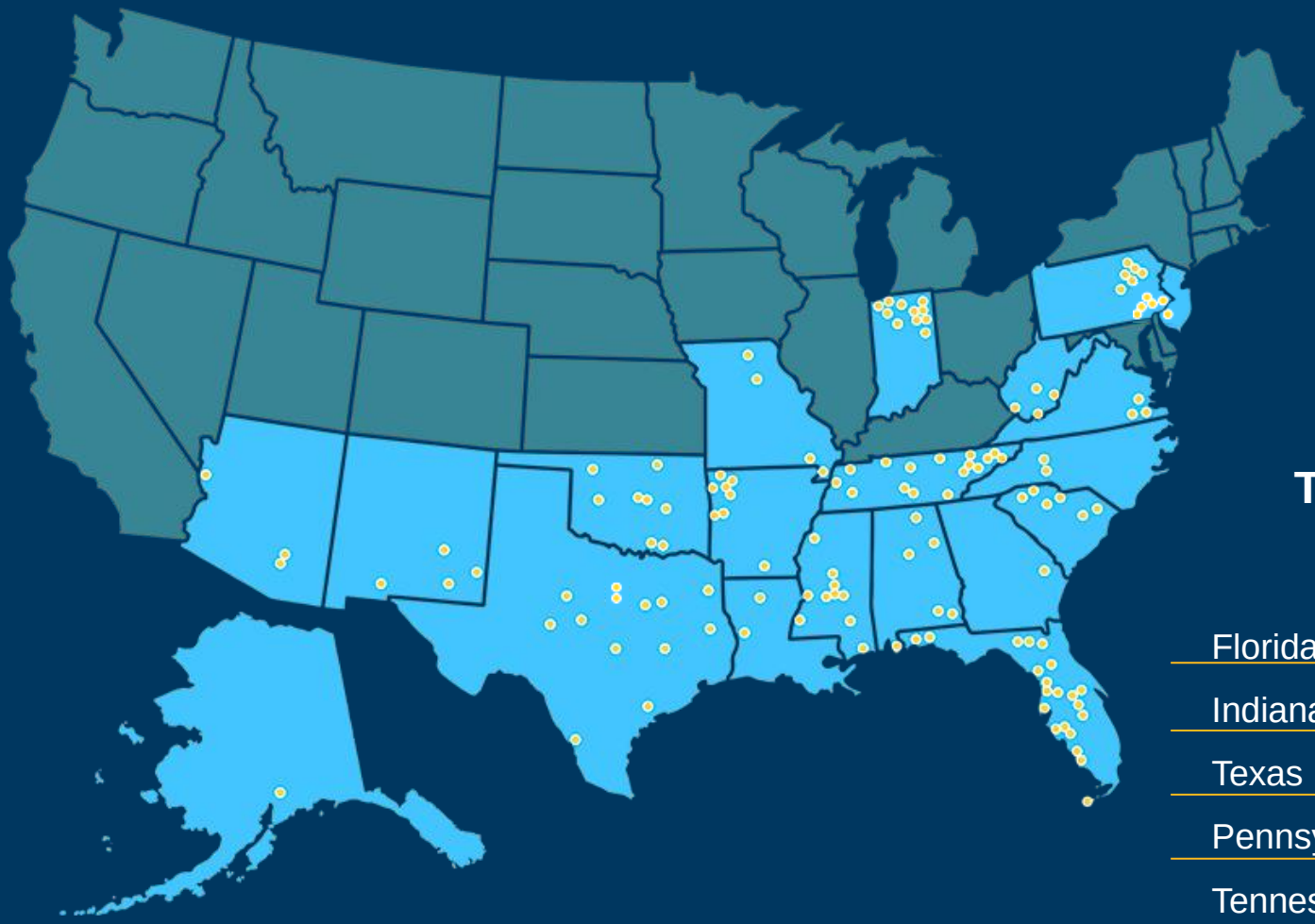


* CAGR is calculated prior to the change in presentation of bad debt.
Revenue and EBITDA for 2009 and prior years have not been adjusted for discontinued operations.
2015 amounts exclude $169 million bad debt adjustment recorded in Q415.
2007 amounts include adjustments for change in estimate taken in Q407.
2006 EBITDA excludes increase in allowance for doubtful accounts of $65 million taken in Q306.

** 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 income attributable to Community Health Systems, Inc. stockholders as derived directly from our consolidated financial statements for the three and nine months ended September 30, 2017 and 2016 (slides 29 and 30). For purposes of this presentation, EBITDA means Adjusted EBITDA.

CHS Operating Imperatives

Serving Non-Urban and Select Urban Markets



133*
Hospitals

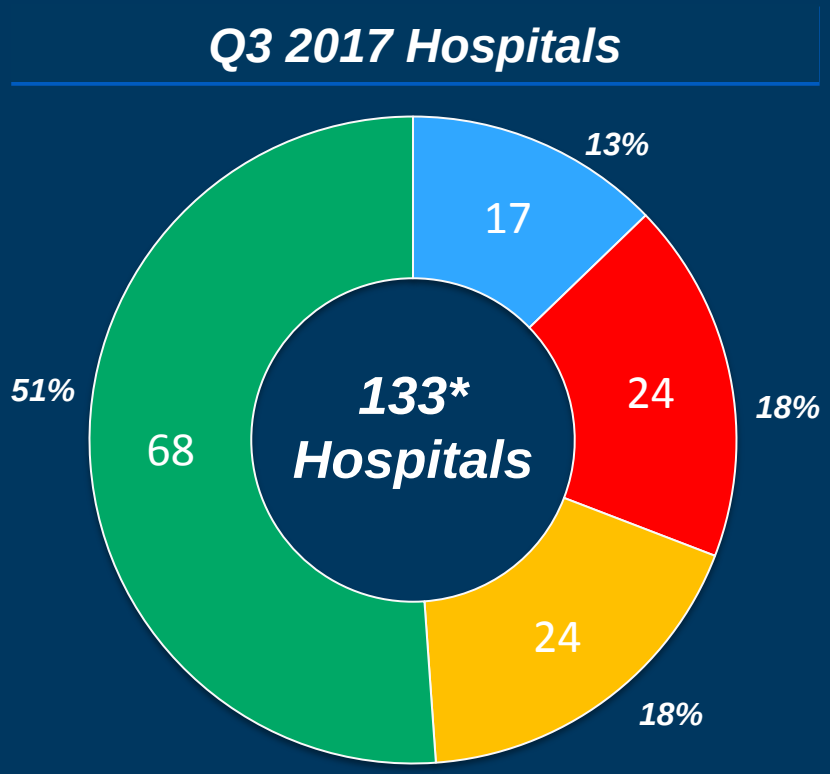
20
States

TOP FIVE STATES

	Hospitals	Q3 2017 % of Revenue
Florida	21	13.0%
Indiana	11	11.7%
Texas	13	11.5%
Pennsylvania	11	9.8%
Tennessee	16	8.5%
Total Top 5		***52.8%***

*as of September 30, 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

9 Local Hospital Markets

CHS hospitals in close geographic proximity to another CHS hospital

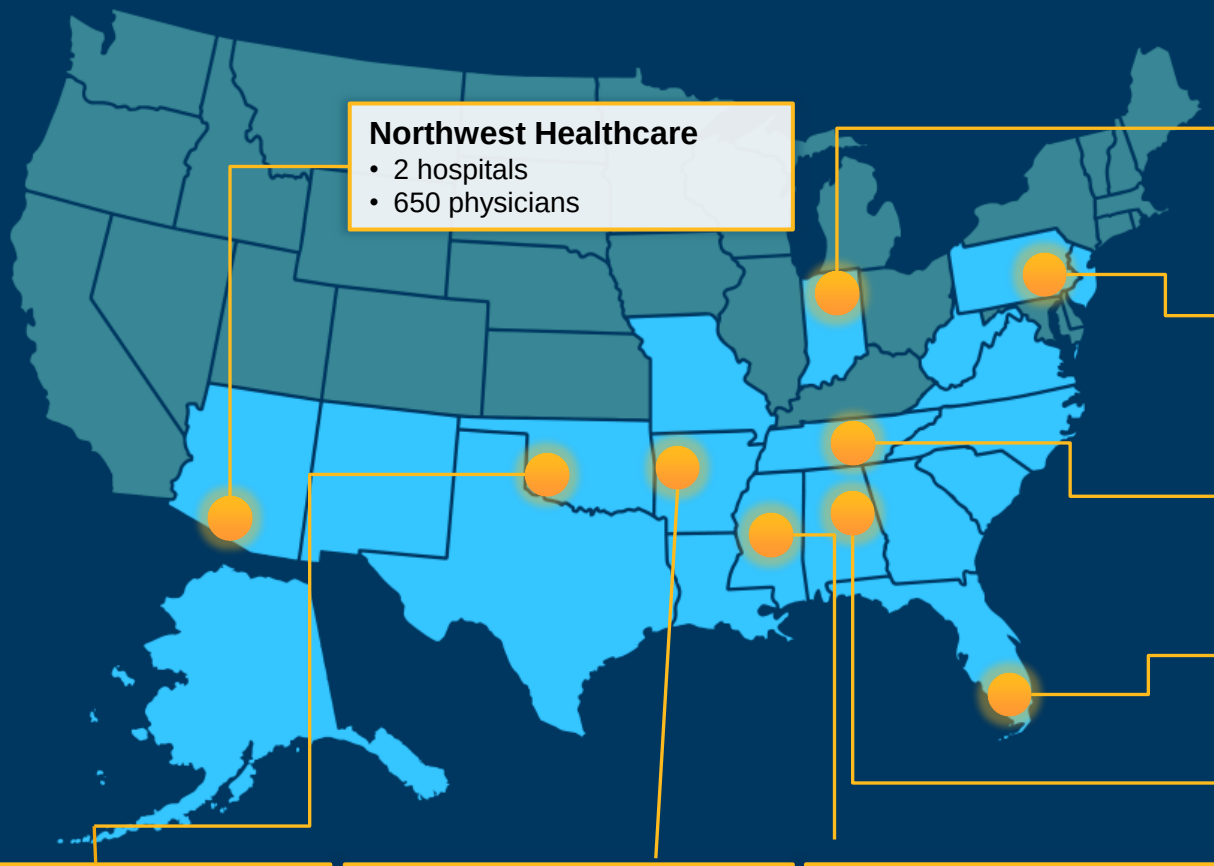
9 Statewide / Regional Hospital Networks

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

CHS Community Health Systems, Inc.

*as of September 30, 2017

CHS Regional Networks



Northwest Healthcare
- 2 hospitals
- 650 physicians

Lutheran Health Network
- 8 hospitals
- 1,140 physicians

Commonwealth Health
- 6 hospitals
- 810 physicians

Tennova Healthcare
- 16 Hospitals
- 1,860 physicians

Bayfront Health
- 7 hospitals
- 1,540 physicians

Alabama Network
- 6 hospitals
- 1,500 physicians

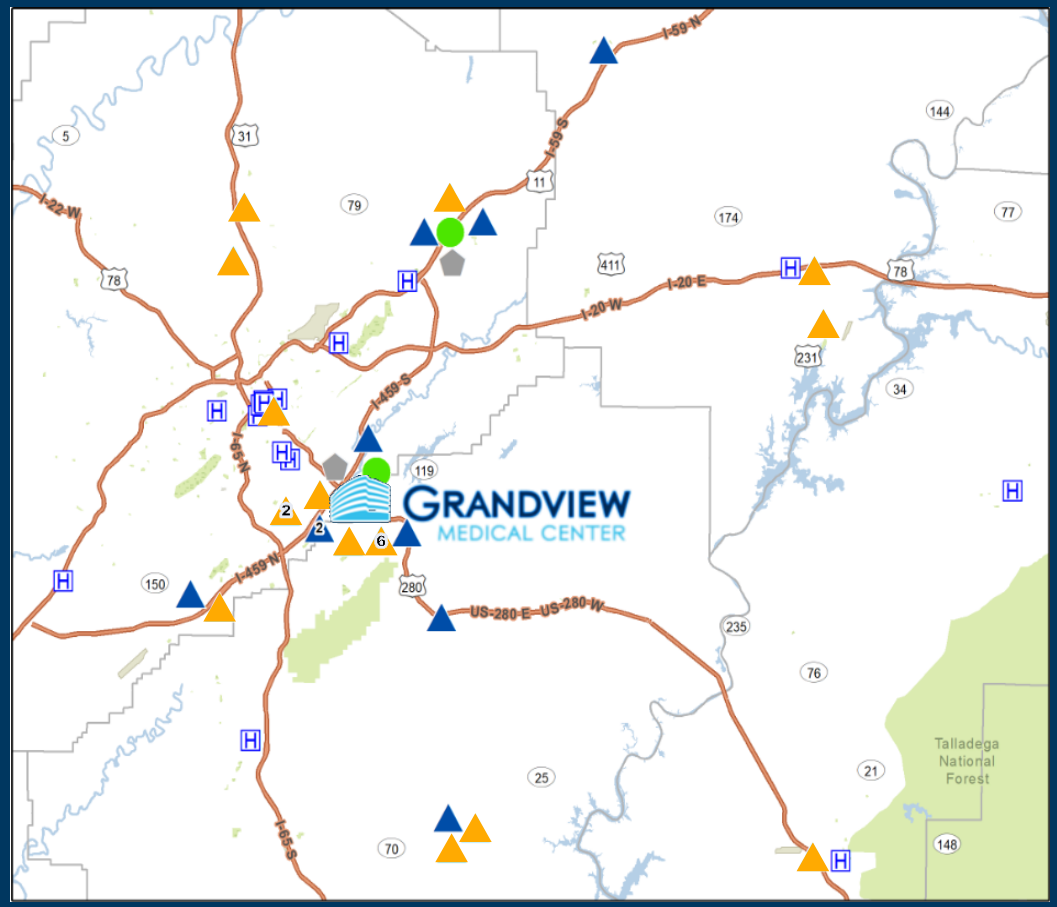
AllianceHealth Oklahoma
- 8 hospitals
- 390 physicians

Northwest Health Arkansas
- 5 hospitals
- 420 physicians

Merit Health
- 10 hospitals
- 1,330 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

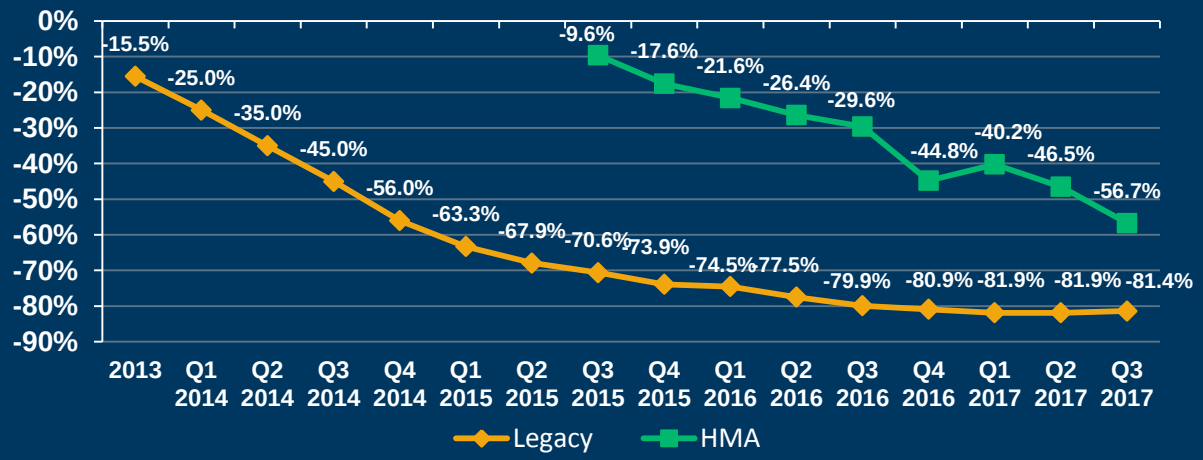
2 — Outpatient Centers

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

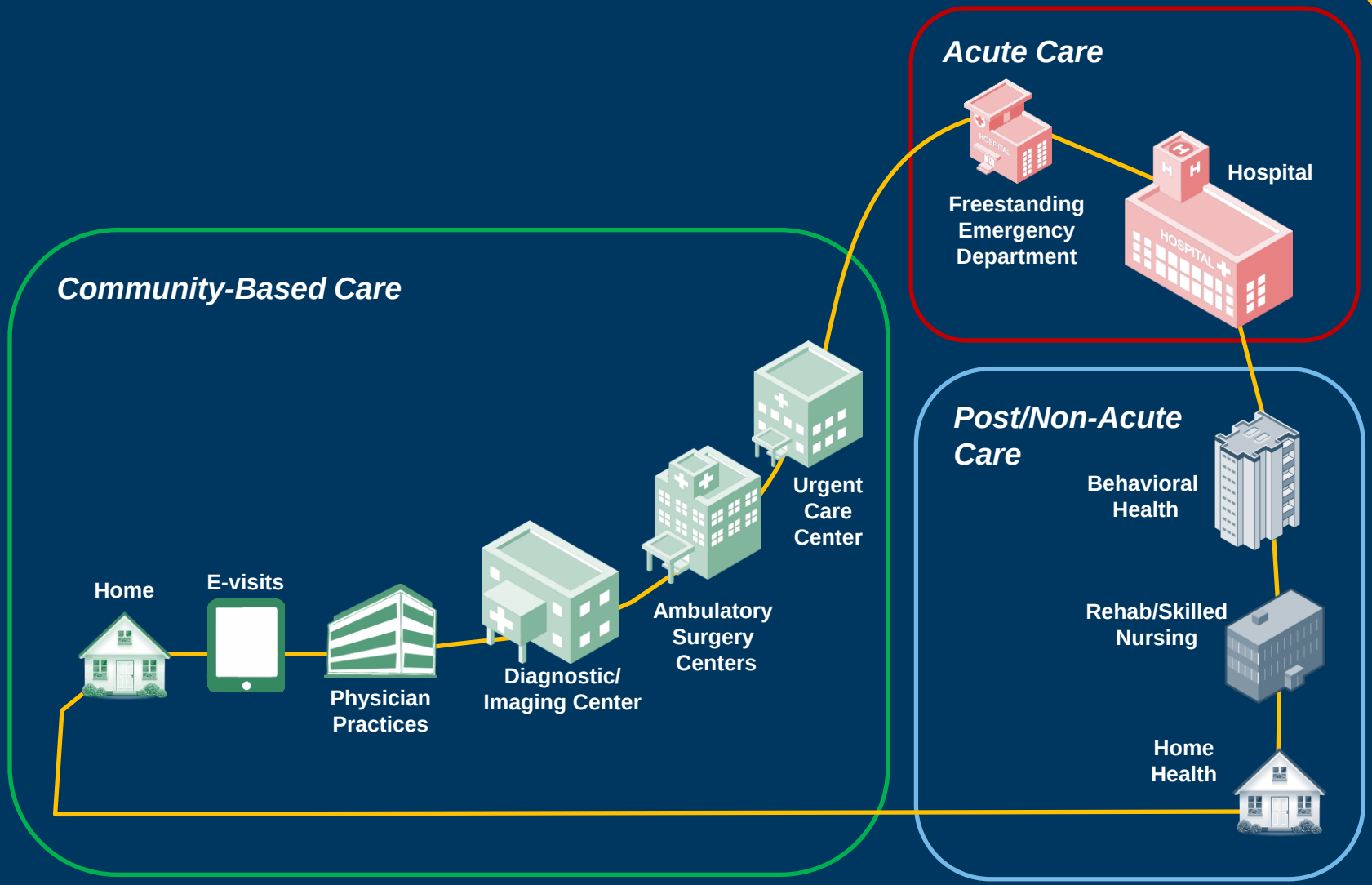


Note: CHS Legacy hospitals are compared to an April 2013 baseline, while HMA are compared to a June 2015 baseline.

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

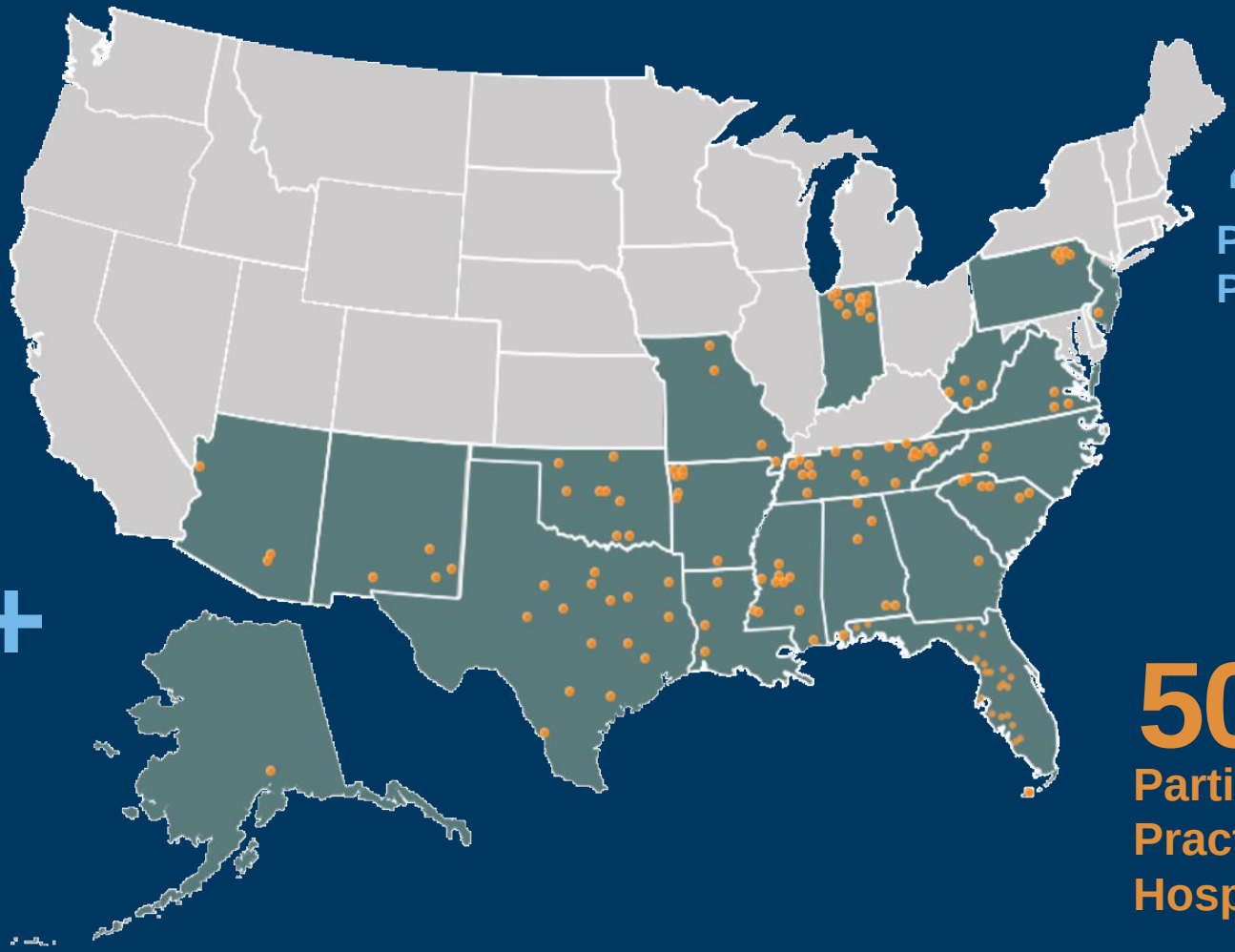
- **50 Surgery Centers**
- **43 Urgent Care Centers**
- **45 Walk-In or Retail Clinics**
- **7 Freestanding EDs**
- **75 Home Health Agencies** (20% JV partner)
- **117 Diagnostic Centers**
- **1,000 Physician Clinics**

*as of September 30, 2017

Growth – Strategic and Consumer-Driven

Growth – Accountable Care Organizations (ACOs)

15
MSSP ACOs



4K+
Participating Providers

260K+
Attributed MFFS Lives

500+
Participating Practices & Hospitals

*as of January 2018

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

Delivering Care More Efficiently

Shared Resources for Productivity Improvement, Cost Controls, and Quality Improvement

- Acquisitions/Divestitures
- Ancillary Services
- Billing and Collections
- Compliance
- ER Management
- Executive Recruitment
- Facilities Management
- Financial Reporting
- Group Purchasing
- Health Information Management
- Home Care
- Human Resources/ Recruiting
- Information Systems
- Legal Services
- Managed Care
- Patient Engagement and Experience
- Physician Practice Management
- Physician Recruitment
- Quality and Clinical Support
- Revenue Strategies
- Strategy and Marketing

Continue to Improve Efficiency to Lower Costs

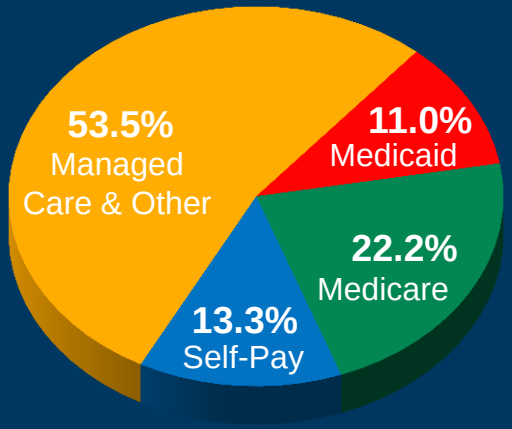
- Centralized payroll center
- Consolidating business office and other support functions to Shared Services Centers
- Standardized procurement processes
- Leveraging technology to manage operating effectiveness

Operational Efficiency

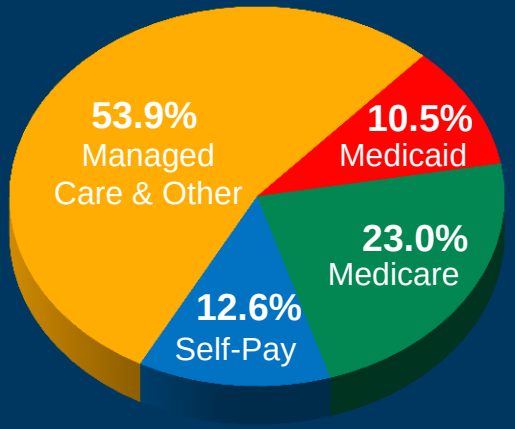
- SWB Management
- Supply Chain Optimization
- Shared Service Centers
- Vendor Efficiencies
- High Opportunity Hospitals
- Peak Performance Teams

Payor Mix (Consolidated)

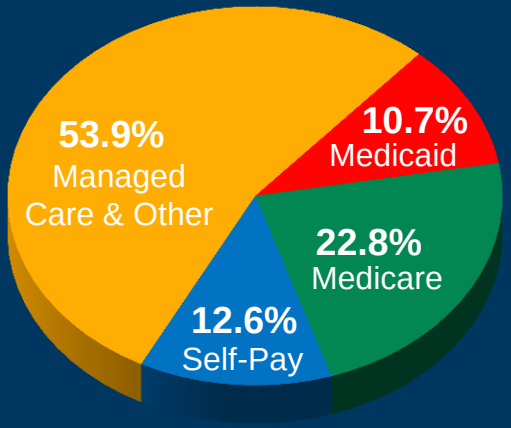
Three Months Ended
September 30, 2017



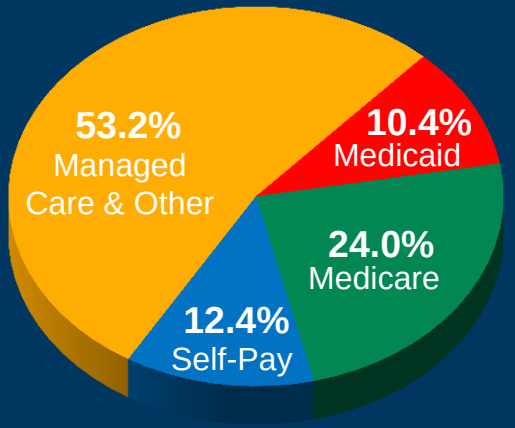
Three Months Ended
September 30, 2016



Nine Months Ended
September 30, 2017



Nine Months Ended
September 30, 2016



*Payor mix as a percent of net revenue before bad debt.

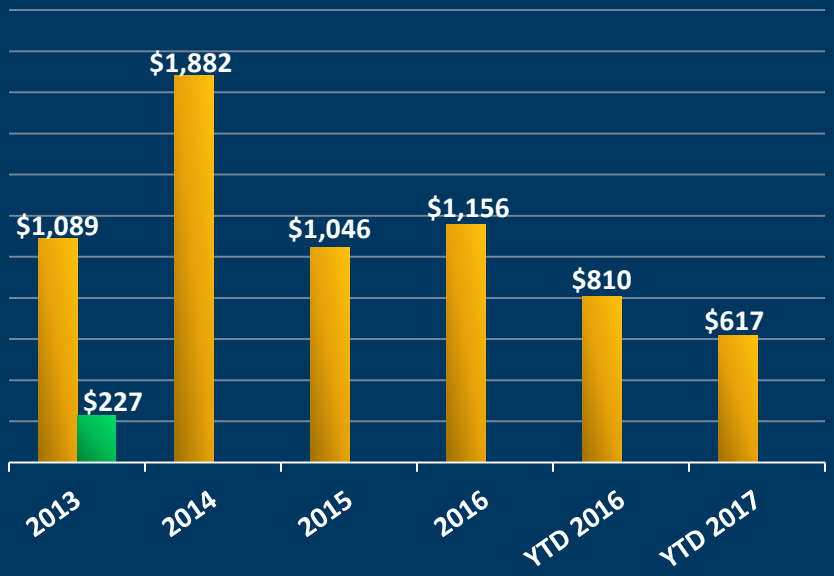
Q3 2017 Highlights

	Q3 2017 compared to Q3 2016		YTD 2017 compared to YTD 2016	
	Consolidated	**Same Store**	**Consolidated**	**Same Store**
Net Operating Revenues	-16.3%	-1.5%	-12.0%	-0.3%
Admissions	-14.8%	-2.3%	-12.3%	-1.9%
Adjusted Admissions	-15.5%	-2.3%	-13.0%	-1.9%
Surgeries	-16.3%	-3.7%	-12.2%	-2.6%
ER Visits	-16.3%	-2.7%	-14.0%	-1.5%

Cash Flow and Capital Expenditures

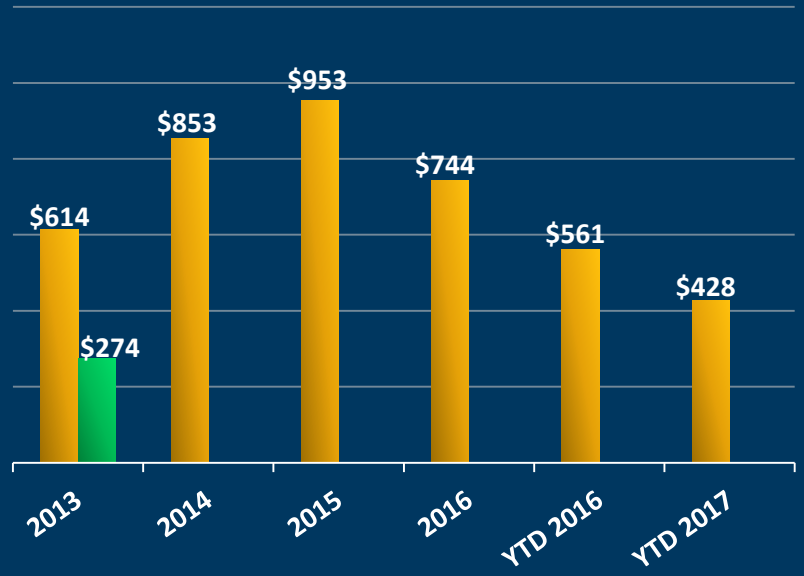
Cash Flows from Operations

($ 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.

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

Replacement hospitals % of revenue						
CHS	0.5%	0.6%	0.6%(1)(2)	0.2%	0.1%	0.1%

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

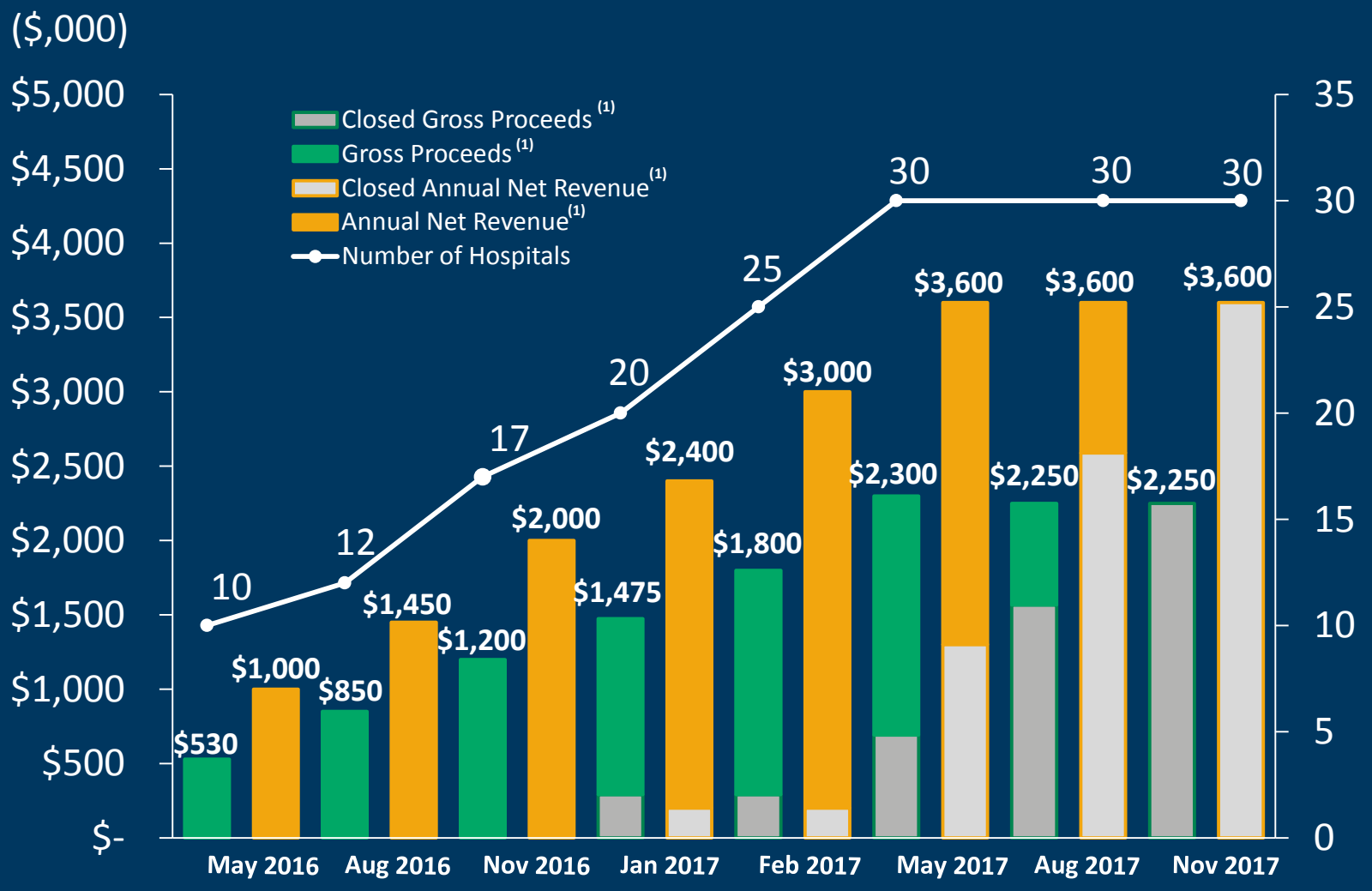
- Completed the sale of one hospital (in AL), announced April 28th
- Completed the sale of eight hospitals (3 in OH, 3 in FL, 2 in PA), announced May 1st
- Completed the sale of two hospitals (both in MS), announced May 1st
- Completed the sale of two hospitals (Rockwood Health System in WA), announced June 30th
- Completed the sale of four hospitals (in PA), announced June 30th
- Completed the sale of one hospital (in LA), announced June 30th
- Completed the sale of two hospitals (in TX), announced June 30th
- Completed the sale of two hospitals (both in WA), announced August 31st
- Completed the sale of five hospitals (in PA), announced September 29th
- Completed the sale of one hospital (in TX), announced October 2nd
- Completed the sale of one hospital (in FL), announced October 31st
- Completed the sale of one hospital (in MS), announced November 1st
  - *Annualized revenue: ~$3.4 billion, with mid-single digit EBITDA margins, Gross proceeds, including working capital: ~$1.95 billion*

Additional Divestitures Expected

- Expect other hospital divestitures of at least $2.0 billion of net revenue, with mid-single digit EBITDA margins
- Signed several letters of intent for hospitals, accounting for more than $1.2 billion of annual net revenue

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

DIVESTITURE GROWTH



(1) Includes Home Care division, 1 sale and leaseback transaction and recently closed hospitals divestitures.

2017 Guidance Overview as of November 1, 2017

	2017 Projection Range
▪ Net operating revenues less provision for bad debt (in millions) –	$15,800 to $15,900
▪ Adjusted EBITDA (in millions)	$1,675 to $1,725
▪ Depreciation and amortization as a percentage of net operating revenues	5.5% to 5.6%
▪ Interest expense as a percentage of net operating revenues	5.8% to 5.9%
▪ Loss from continuing operations per share – diluted	$(1.30) to $(1.20)
▪ Weighted-average diluted share (in millions)	112 to 112.5
▪ Net cash provided by operating activities (in millions)	$900 to $1,000
▪ Capital expenditures (in millions) –	$575 to $725
▪ Same-store hospital adjusted admissions decline	(2.0)% to (1.5)%
▪ HITECH Incentives (in millions)	$25 to $30

Our comprehensive 2017 guidance has been provided on pages 18 and 19 on Form 8-K dated November 1, 2017 and includes important assumptions and exclusions.

Recent Capital Structure Highlights

- On March 16, 2017, completed offering of $2.2 billion of 6.250% Senior Secured Notes due in 2023, in which proceeds fully extinguished our 2018 notes and 2018 term loans.

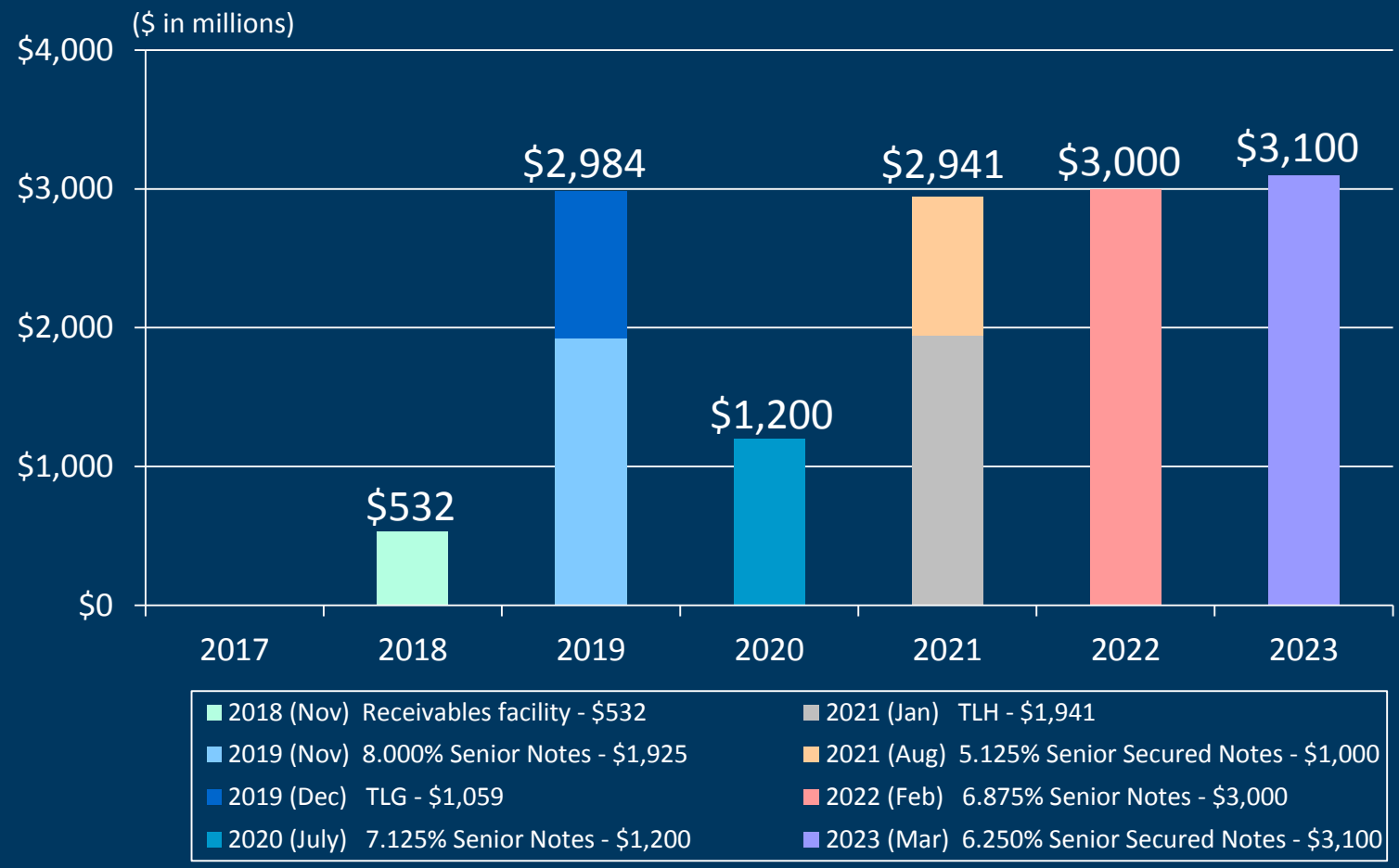
- On May 12, 2017, completed a $900 million tack-on (upsized from $700 million) to 6.250% Senior Secured Notes due 2023 at an issue price of 101.75%, to yield 5.83%. Net proceeds of the tack-on offering were used to prepay and fully extinguish Term Loan A Facility (due January 2019).

- On May 30, 2017, extended revolving credit facility from January 2019 to January 2021.

- From May 4, 2017, through September 30, 2017, paid-down approximately $1.38 billion of term loan debt using net proceeds from asset sales.

- On November 13, 2017, amended and extended receivables facility. The $600 million receivables facility is now due in November 2019.

Debt Maturity as of September 30, 2017



BANK COVENANT TESTS AS OF SEPTEMBER 30, 2017			
Secured Net Leverage Ratio	3.80	Interest Coverage Ratio	2.45
Benchmark	4.50	Benchmark	1.75
EBITDA Cushion	15%	EBITDA Cushion	29%

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, and (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. During the three months ended June 30, 2017, the Company incurred a significant amount of and included an adjustment for employee termination benefits and other restructuring charges in Adjusted EBITDA. The Company has included this adjustment (and intends to continue including this adjustment on a prospective basis) based on its belief that such expense, which may differ significantly between periods in a manner not correlated with the Company's ongoing operational performance, is consistent with management's intended use of Adjusted EBITDA to assess the Company's results of operations and compare operating results 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 September 30,		Nine Months Ended September 30,	
	2017	2016	2017	2016
Net loss attributable to Community Health Systems, Inc. stockholders	$ (110)	$ (79)	$ (446)	$ (1,500)
Adjustments:				
Benefit from income taxes	(59)	(29)	(74)	(141)
Depreciation and amortization	206	265	665	839
Net income attributable to noncontrolling interests	20	23	56	73
Loss from discontinued operations	2	2	10	5
Interest expense, net	238	233	706	730
Loss from early extinguishment of debt	4	-	35	30
Impairment and (gain) loss on sale of businesses, net	33	39	363	1,695
Gain on sale of investments in unconsolidated affiliates	-	-	-	(94)
Expense (income) from government and other legal settlements and related costs	1	10	(32)	10
(Income) expense from fair value adjustments and legal expenses related to cases covered by the CVR	(6)	-	6	1
Expense related to the sale of a majority interest in home care division	-	1	1	1
Expense related to the spin-off of QHC	-	-	-	12
Expense related to employee termination benefits and other restructuring charges	2	-	4	-
Adjusted EBITDA	$ 331	$ 465	$ 1,294	$ 1,661

Income Summary

(Amounts in millions, except margin and EPS)

	Three Months Ended September 30,			Nine Months Ended September 30,		
	2017	2016	Change	2017	2016	Change
Net Operating Revenues	$ 3,666	$ 4,380	-16.3%	$ 12,295	$ 13,969	-12.0%
Adjusted EBITDA[(1)]	$ 331	$ 465	-28.8%	$ 1,294	$ 1,661	-22.1%
Adjusted EBITDA Margin[(1)]	9.0%	10.6%	-160 BPS	10.5%	11.9%	-140 BPS
EPS from Continuing Operations, Excluding Adjustments[(2)(3)]	$ (0.77)	$ (0.35)	-120%	$ (0.95)	$ 0.00	-
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 and nine months ended September 30, 2017 and 2016 (slides 29 and 30).

(2) Diluted loss from continuing operations per share for the nine months ended September 30, 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 32.

Diluted EPS – Excluding Adjustments

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2017	2016	2017	2016
Net loss, as reported	$ (0.98)	$ (0.71)	$ (3.99)	$ (13.55)
Adjustments:				
Discontinued operations	0.02	0.02	0.08	0.05
Loss from early extinguishment of debt	0.02	-	0.20	0.18
Impairment and (gain) loss on sale of businesses, net	0.19	0.28	2.87	13.72
Expense (income) from government and other legal settlements and related costs	0.01	0.06	(0.19)	0.06
(Income) expense from fair value adjustments and legal expenses related to cases covered by the CVR	(0.04)	-	0.05	-
Gain on sale of investments in unconsolidated affiliates	-	-	-	(0.54)
Expense related to the spin-off of QHC	-	-	-	0.08
Expense related to employee termination benefits and other restructuring charges	0.01	-	0.03	-
(Loss) income from continuing operations, excluding adjustments	$ (0.77)	$ (0.35)	$ (0.95)	$ 0.00

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

Balance Sheet Data

($ in millions)	September 30, 2017	December 31, 2016
Working Capital	$ 2,401	$ 1,779
Total Assets	$ 19,735	$ 21,944
Long Term Debt	$ 13,901[(1)]	$ 14,789
Stockholders' Equity	$ 1,213	$ 1,615

(1) At September 30, 2017, approximately 90% of our debt was fixed, including swaps.