- ---
- ---

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

(MARK ONE)

/X/ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES AND EXCHANGE ACT OF 1934

FOR THE YEAR ENDED DECEMBER 31, 2000
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	13-3893191
(State of incorporation)	(IRS Employer Identification No.)
155 FRANKLIN ROAD, SUITE 400 Brentwood, Tennessee (Address of principal executive offices)	37027 (zip code)

Registrant's telephone number, including area code: (615) 373-9600

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

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

Securities registered pursuant to Section 12(g) of the Act: None

---

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 /X/ No / /

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

As of March 16, 2001 there were 86,141,941 shares of Common Stock, par value $.01 per share outstanding. The aggregate market value of the voting stock held by non-affiliates of the Registrant is $1,041,749,979. Market value is determined by reference to the closing price on March 16, 2001 of the Registrant's Common Stock as reported by the New York Stock Exchange.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive Proxy Statement to be filed under Regulation 14A in connection with the Annual Meeting of Stockholders of the Registrant scheduled to be held on May 22, 2001 have been incorporated by reference into Part I and Part III of this Report.

- ---
- ---

TABLE OF CONTENTS
FORM 10-K ANNUAL REPORT
COMMUNITY HEALTH SYSTEMS, INC.
YEAR ENDED DECEMBER 31, 2000

- ------------------------

Note: Portions of the Registrant's definitive Proxy Statement to be filed under Regulation 14A in connection with the Annual Meeting of Stockholders of the Registrant scheduled to be held on May 22, 2001 have been incorporated by reference into Part I, Item 4 and Part III, Items 10, 11, 12, and 13 of this Report.

PART I

ITEM 1.

BUSINESS OF COMMUNITY HEALTH SYSTEMS

OVERVIEW OF OUR COMPANY

We are the largest non-urban provider of general hospital healthcare services in the United States in terms of number of facilities and the second largest in terms of revenues and EBITDA. As of December 31, 2000, we owned, leased or operated 52 hospitals, geographically diversified across 20 states, with an aggregate of 4,688 licensed beds. In over 85% of our markets, we are the sole provider of these services. In most of our other markets, we are one of two providers of these services. For the fiscal year ended December 31, 2000, we generated $1.34 billion in revenues and $252.7 million in adjusted EBITDA (as such item is defined in footnote 10 of the table under the caption "Selected Operating Data").

In July 1996, affiliates of Forstmann Little & Co. acquired our predecessor company from its public stockholders. The predecessor company was formed in 1985. The aggregate purchase price for the acquisition was $1,100.2 million. Wayne T. Smith, who has over 30 years of experience in the healthcare industry, joined our company as President in January 1997. We named him Chief Executive Officer in April 1997 and Chairman of the Board in February 2001. Under this new ownership and leadership, we have:

- strengthened the senior management team in all key business areas;

- standardized and centralized our operations across key business areas;

- implemented a disciplined acquisition program;

- expanded and improved the services and facilities at our hospitals;

- recruited additional physicians to our hospitals;

- instituted a company-wide regulatory compliance program; and

- divested certain non-core assets.

As a result of these initiatives, we achieved revenue growth of 23.8% in 2000, 26.4% in 1999 and 15.1% in 1998. We also achieved growth in adjusted EBITDA of 23.8% in 2000, 22.7% in 1999 and 36.1% in 1998. Our adjusted EBITDA margins improved from 16.5% for 1997 to 18.9% for 2000.

Our hospitals typically have 50 to 200 beds and annual revenues ranging from $12 million to $70 million. They generally are located in non-urban markets with populations of 20,000 to 80,000 people and economically diverse employment bases. These facilities, together with their medical staffs, provide a wide range of inpatient and outpatient general hospital services and a variety of specialty services.

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

OUR BUSINESS STRATEGY

The key elements of our business strategy are to:

- increase revenue at our facilities;

- grow through selective acquisitions;

- reduce costs; and

- improve quality.

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 physicians 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, cardiology, OB/GYN, and occupational medicine; and

- providing the capital to invest in technology and the physical plant at the facilities, particularly in our emergency rooms.

By taking these actions, we believe that we can increase our share of the healthcare dollars spent by local residents and limit inpatient and outpatient migration to larger urban facilities. Total revenue for hospitals operated by us for a full year increased by 10.3% from 1999 to 2000. Total inpatient admissions for those same hospitals increased by 6.3% over the same period.

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, cardiology, and orthopedics completes the full range of medical and surgical services required to meet a community's core healthcare needs. When we acquire a hospital, we identify the healthcare needs of the community by analyzing demographic data and patient referral trends. We are then 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. During the past three years, we have increased the number of physicians affiliated with us by 405, including 84 in 1998, 156 in 1999 and 165 in 2000. The percentage of recruited or other physicians commencing practice that were surgeons or specialists grew from 45% in 1997 to 65% in 2000. We do not employ most of our physicians, but rather they are in private practice in their communities. We have been successful in recruiting physicians because of the practice opportunities afforded physicians in our markets, as well as the lower managed care penetration as compared to urban areas. These physicians are able to earn incomes comparable to incomes earned by physicians in urban centers. As of December 31, 2000, approximately 2,000 physicians were on active staff with our hospitals.

EMERGENCY ROOM INITIATIVES. Given that over 50% 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 room since often 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 16 of our emergency room facilities since 1997. Since 1997, we have entered into approximately 30 new contracts with emergency room operating groups to improve performance in our emergency rooms. We have 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.

Our upgrades include the implementation of specialized 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. 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. To capture a greater portion of the healthcare spending in our markets and to more efficiently utilize our hospital facilities, we have added a broad range of emergency, outpatient, and specialty services to our hospitals. Depending on the needs of the community, we identify opportunities to expand into various specialties, including orthopedics, cardiology, OB/GYN, and occupational medicine. In addition to expanding services, we have completed major capital projects at selected facilities to offer these types of services. For example, in 1999 we invested $1 million in a new cardiac catheterization laboratory at our Crestview, Florida hospital. As a result, this laboratory increased the number of procedures it performed by 84%, from 122 in 1998 to 224 in 1999. In 1999, major capital projects included renovations to nine emergency rooms, two operating rooms, two OB/ GYN facilities, and three intensive care units at various hospitals. In 2000, major capital projects included expansion of five emergency rooms, upgrades to three critical care units and two OB/GYN facilities and the purchase of an MRI and cath lab at various hospitals. We believe that through these efforts we will reduce patient migration to competing providers of healthcare services and increase volume.

MANAGED CARE STRATEGY. Managed care has seen growth across the U.S. as health plans expand service areas and membership. As we service primarily non-urban markets, we have limited relationships with managed care organizations. We have responded with a proactive and carefully considered strategy developed specifically for each of our facilities. Our experienced business development department reviews and approves all managed care contracts, which are managed through a central database. The primary mission of this department is to select and evaluate appropriate managed care opportunities, manage existing reimbursement arrangements, negotiate contracts, and educate our physicians. We have terminated our only risk sharing capitated contract, which we acquired through our acquisition of a California hospital.

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. We pursue acquisition candidates that:

- have a general service area population between 20,000 and 80,000 with a stable or growing population base;

- are the sole or primary provider of acute care services in the community;

- are located more than 25 miles from a competing hospital;

- 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.

Most hospitals we have acquired are located in service areas having populations within the lower to middle range of our criteria. However, we have also acquired hospitals having service area populations in the upper range of our criteria. For example, in 1998, we acquired a 162-bed facility in Roswell, New Mexico which has a service area population of over 70,000 and is located 200 miles from the nearest urban centers in Albuquerque, New Mexico and Lubbock, Texas; in 2000 we acquired a 164-bed facility in Kirksville, Missouri which has a service area population of over 100,000. Facilities similar to the ones located in Roswell and Kirksville offer even greater opportunities to expand services given their larger service area populations.

Most of our acquisition targets are municipal and other not-for-profit hospitals. We believe that our access to capital and ability to recruit physicians 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 facilities within the state.

Pursuant to hospital purchase agreements in effect as of December 31, 2000, we are required to construct four replacement hospitals through 2005 with an aggregate estimated construction cost, including equipment, of approximately $120 million. Of this amount, approximately $9 million has been expended as of December 31, 2000.

REDUCE COSTS

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

- standardizing and centralizing our operations;

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

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

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

- managing staffing levels according to patient volumes and the appropriate level of care.

In addition, each of our hospital management teams is supported by our centralized operational, reimbursement, regulatory, and compliance expertise as well as by our senior management team, which has an average of 20 years of experience in the healthcare industry. Adjusted EBITDA margins on a same hospitals basis improved from 18.8% in 1999 to 19.9% in 2000.

IMPROVE QUALITY

We have implemented various programs to ensure 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. Corporate support is provided to each facility to assist with accreditation reviews. Several of our facilities have received accreditation "with commendation" from the Joint Commission on Accreditation of Healthcare Organizations. 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.

SELECTED OPERATING DATA

The following table sets forth operating statistics for our hospitals for each of the years presented. Statistics for 2000 include a full year of operations for 45 hospitals, and partial periods for one hospital disposed of and seven hospitals acquired during the year. Statistics for 1999 include a full year of operations for 41 hospitals and partial periods for four hospitals acquired, and one hospital constructed and opened, during the year. Statistics for 1998 include a full year of operations for 37 hospitals and partial periods for four hospitals acquired during the year.

	YEARS ENDED DECEMBER 31,		
	2000	1999	1998
	(DOLLARS IN THOUSANDS)		
Number of hospitals (1)	52	46	41
Licensed beds (1)(2)	4,688	4,115	3,644
Beds in service (1)(3)	3,587	3,123	2,776
Admissions (4)	143,310	120,414	100,114
Adjusted admissions (5)	262,419	217,006	177,075
Patient days (6)	548,827	478,658	416,845
Average length of stay (days) (7)	3.8	4.0	4.2
Occupancy rate (beds in service) (8)	44.6%	44.1%	43.3%
Net operating revenues	$1,337,501	$1,079,953	$854,580
Net inpatient revenues as a % of total net operating revenues	51.0%	52.7%	55.7%
Net outpatient revenues as a % of total net operating revenues	47.3%	45.5%	42.6%
Adjusted EBITDA as a % of total net operating revenues	18.9%	18.9%	19.5%
Net cash flows provided by (used in) operating activities	$ 22,985	$ (11,746)	$ 15,719
Net cash flows used in investing activities	(244,441)	(155,541)	(236,553)
Net cash flows provided by financing activities	230,914	164,850	219,890

	YEAR ENDED DECEMBER 31,		PERCENTAGE INCREASE
	2000	1999	(DECREASE)
Same Hospitals Data (9)			
Admissions (4)	125,207	117,768	6.3%
Adjusted admissions (5)	227,780	212,246	7.3%
Patient days (6)	481,620	467,884	2.9%
Average length of stay (days) (7)	3.8	4.0	
Occupancy rate (beds in service) (8)	45.1%	44.8%	
Net operating revenues	$1,155,850	$1,047,950	
Adjusted EBITDA (10)	229,637	196,843	10.3%
Adjusted EBITDA, as a % of net operating revenues	19.9%	18.8%	16.7%

- ----------

(1) At end of period.

(2) 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.

(3) Beds in service are the number of beds that are readily available for patient use.

(4) Admissions represent the number of patients admitted for inpatient treatment.

(5) 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.

(6) Patient days represent the total number of days of care provided to inpatients.

(7) Average length of stay (days) represents the average number of days inpatients stay in our hospitals.

(8) We calculated percentages by dividing the average daily number of inpatients by the weighted average of beds in service.

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

(10) We define adjusted EBITDA as EBITDA adjusted to exclude cumulative effect of a change in accounting principle, impairment of long-lived assets and compliance settlement and Year 2000 remediation costs. EBITDA consists of income (loss) before interest, income taxes, depreciation and amortization, and amortization of goodwill. EBITDA and adjusted EBITDA should not be considered as measures of financial performance under generally accepted accounting principles. Items excluded from EBITDA and adjusted EBITDA are significant components in understanding and assessing financial performance. EBITDA and adjusted EBITDA are key measures used by management to evaluate our operations and provide useful information to investors. EBITDA and adjusted EBITDA should not be considered in isolation or as alternatives to net income, cash flows generated by operations, investing or financing activities, or other financial statement data presented in the consolidated financial statements as indicators of financial performance or liquidity. Because EBITDA and adjusted EBITDA are not measurements determined in accordance with generally accepted accounting principles and are thus susceptible to varying calculations, EBITDA and adjusted EBITDA as presented may not be comparable to other similarly titled measures of other companies.

SOURCES OF REVENUE

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

- the federal Medicare program;

- state Medicaid programs;

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

- patients directly.

The following table presents the approximate percentages of net revenue received from private, Medicare, Medicaid 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 and dispositions have had on these statistics.

NET OPERATING REVENUES BY PAYOR SOURCE	2000	1999	1998
Medicare	34.2%	36.2%	39.0%
Medicaid	11.8%	11.9%	10.2%
Managed Care (HMO/PPO)	15.9%	14.3%	14.0%
Private and Other	38.1%	37.6%	36.8%
Total	100.0%	100.0%	100.0%

As shown above, we receive a substantial portion of our revenue from the Medicare and Medicaid programs.

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 the hospital's customary charges for the services provided. In recent years, changes made to the Medicare and Medicaid programs have further reduced payment to hospitals. We expect this trend to continue. Since an important portion of our revenues 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, and employers, as well as by patients directly. 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."

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.

SUPPLY CONTRACTS

During fiscal 1997, we entered into an affiliation agreement with BuyPower, a group purchasing organization owned by Tenet Healthcare Corporation. Our affiliation with BuyPower combines the purchasing power of our hospitals with the purchasing power of more than 600 other healthcare providers affiliated with the program. This increased purchasing power has resulted in reductions in the prices paid by our hospitals for medical supplies and equipment and pharmaceuticals. In March 2000, we entered into an agreement with Broadlane Inc., an affiliate of Tenet Healthcare Corporation, to use their e-commerce marketplace as our exclusive internet purchasing portal.

INDUSTRY OVERVIEW

The U.S. Healthcare Financing Administration estimated that in 2000, total U.S. healthcare expenditures grew by 8.3% to $1.3 trillion. It projects total U.S. healthcare spending to grow by 8.6% in 2001 and by 6.5% annually from 2002 through 2010. By these estimates, healthcare expenditures will account for approximately $2.6 trillion, or 15.9% of the total U.S. gross domestic product, by 2010.

Hospital services, the market in which we operate, is the largest single category of healthcare at 32.1% of total healthcare spending in 2000, or $415.8 billion. The U.S. Healthcare Financing Administration projects the hospital services category to grow by 5.7% per year through 2010. It expects growth in hospital healthcare spending to continue due to the aging of the U.S. population and consumer demand for expanded medical services. As hospitals remain the primary setting for healthcare delivery, it expects hospital services to remain the largest category of healthcare spending.

U.S. HOSPITAL INDUSTRY. The U.S. hospital industry is broadly defined to include acute care, rehabilitation, and psychiatric facilities that are either public (government owned and operated), not-for-profit private (religious or secular), or for-profit institutions (investor owned). According to the American Hospital Association, there are approximately 5,015 inpatient hospitals in the U.S. which are not-for-profit owned, investor owned, or state or local government owned. Of these hospitals, 44% are located in non-urban communities. These facilities offer a broad range of healthcare services, including internal medicine, general surgery, cardiology, oncology, neurosurgery, 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, 25% 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 and, in many cases, a single hospital is the only provider of general healthcare services. According to the American Hospital Association, in 1998, there were 2,200 non-urban hospitals in the U.S. We believe that a majority of these hospitals are owned by not-for-profit or governmental entities.

FACTORS AFFECTING PERFORMANCE. Among the many factors that can influence a hospital's financial and operating performance are:

- facility size and location;

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

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

- facility payor mix.

We believe that non-urban hospitals are generally able to obtain higher operating margins than urban hospitals. Factors contributing to a non-urban hospital's margin advantage include fewer patients with complex medical problems, a lower cost structure, limited competition, and favorable Medicare

payment provisions. Patients needing the most complex care are more often served by the larger and/or more specialized urban hospitals. A non-urban hospital's lower cost structure results from its geographic location as well as the lower number of patients treated who need the most highly advanced services. Additionally, because non-urban hospitals are generally sole providers or one of a small group of providers in their markets, there is limited competition. This generally results in more favorable pricing with commercial payors. Medicare has special payment provisions for "sole community hospitals." Under present law, hospitals that qualify for this designation receive higher reimbursement rates and are guaranteed capital reimbursement equal to 90% of capital costs. As of December 31, 2000, 15 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 margins. These providers have increasingly exerted pressure on healthcare service providers to reduce the cost of care. The most active providers in this regard have been HMOs, PPOs, and other managed care organizations. The characteristics of non-urban markets make them less attractive to these managed care organizations. This is partly because the limited size of non-urban markets and their diverse, non-national employer bases minimize the ability of managed care organizations to achieve economies of scale. In 2000, approximately 16% of our revenues were paid by managed care organizations.

HOSPITAL INDUSTRY TRENDS

DEMOGRAPHIC TRENDS. According to the U.S. Census Bureau, there are approximately 35 million Americans aged 65 or older in the U.S. today, who comprise approximately 13% of the total U.S. population. By the year 2030 the number of elderly is expected to climb to 69 million, or 20% of the total population. Due to the increasing life expectancy of Americans, the number of people aged 85 years and older is also expected to increase from 4.3 million to 8.5 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 6.9% from 1990 to 1997 and are projected to grow by 4.6% from 1998 to 2002. The number of people aged 65 or older in these service areas grew by 16.4% from 1990 to 1997 and is projected to grow by 5.7% from 1998 to 2002.

CONSOLIDATION. During the late 1980s and early 1990s, there was significant industry consolidation involving large, investor owned hospital companies seeking to achieve economies of scale. While consolidation activity in the hospital industry is continuing, the consolidations are primarily taking place through mergers and acquisitions involving not-for-profit hospital systems.

Reasons for this activity include:

- limited access to capital;

- financial performance issues, including challenges associated with changes in reimbursement;

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

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

- the need to achieve general economies of scale and to gain access to standardized and centralized functions, including favorable supply agreements.

SHIFTING UTILIZATION TRENDS. Over the past decade, many procedures that had previously required hospital visits with overnight stays have been performed on an outpatient basis. This shift has been driven by cost containment efforts led by private and government payors. The focus on cost containment has coincided with advancements in medical technology that have allowed patients to be treated with less invasive procedures that do not require overnight stays. According to the American Hospital Association, the number of surgeries performed on an inpatient basis declined from 1994 to 1998 at an average annual rate of 0.3%, from 9.8 million in 1994 to 9.7 million in 1998. During the same period, the number of outpatient surgeries increased at an average annual rate of 4.3%, from 13.2 million in 1994 to 15.6 million in 1998. The mix of inpatient as compared to outpatient surgeries shifted from a ratio of 42.8% inpatient to 57.2% outpatient in 1994 to a ratio of 38.4% inpatient to 61.6% outpatient in 1998.

These trends have led to a reduction in the average length of stay and, as a result, inpatient utilization rates. According to the American Hospital Association, the average length of stay in general hospitals has declined from 6.7 days in 1994 to 6.0 days in 1998.

GOVERNMENT REGULATION

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

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

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

- failing to provide treatment to any individual who comes to a hospital's emergency room with an "emergency medical condition" or otherwise failing to properly treat and transfer emergency patients.

The Health Insurance Portability and Accountability Act of 1996 broadened the scope of the fraud and abuse laws by adding several criminal statutes that are not related to receipt of payments from a federal healthcare program. The Accountability Act created civil penalties for conduct, including upcoding and billing for medically unnecessary goods or services. It established new enforcement mechanisms to combat fraud and abuse. These include a bounty system, where a portion of the payments recovered is returned to the government agencies, as well as a whistleblower program. This law also expanded the categories of persons that may be excluded from participation in federal healthcare programs.

Another law regulating the healthcare industry is a section of the Social Security Act, known as the "anti-kickback" or "fraud and abuse" 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 money in connection with the referral of patients covered by a 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 is authorized to publish 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 mean that the activity violates the anti-kickback statute.

The Office of Inspector General is responsible for identifying fraud and abuse activities in government programs. In order to fulfill its duties, the Office of Inspector General performs audits, investigations, and inspections. In addition, it provides guidance to healthcare providers by identifying types of activities that could violate the anti-kickback statute. The Office of the Inspector General has identified the following incentive arrangements as potential violations:

- payment of any incentive by the hospital each time 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;

- 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 few 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 revenue 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 would 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 and Medicaid patients to healthcare entities in which they or any of their immediate family members have ownership or other financial interests. These types of referrals are commonly known as "self referrals." Sanctions for violating the Stark law include civil money penalties, assessments equal to twice the dollar value of each service, and exclusion from Medicare and Medicaid 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 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. The federal government has not finalized its regulations which will interpret several of the provisions included in the Stark law. We have structured our financial arrangements with physicians to comply with the statutory exceptions included in the Stark law. However, when the government finalizes these regulations, it may interpret certain provisions of this law in a manner different from the manner with which we have interpreted them. We cannot predict the final form that such regulations will take or the effect those regulations will have on us.

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

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 charged with responsibility 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. Regulations have recently been adopted, but not yet implemented, that expand the areas within a facility that must provide emergency treatment. 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.

FALSE CLAIMS ACT. Another trend in healthcare litigation is the use of the False Claims Act. This law 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. When a private party brings a qui tam action under the False Claims Act, 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 False Claims Act can be up to three times the actual damages sustained by the government plus civil penalties for each separate false claim. There are many potential bases for liability under the False Claims Act. Although liability under the False Claims Act arises when an entity knowingly submits a false claim for reimbursement to the federal government, the False Claims Act defines the term "knowingly" broadly. Thus, although simple negligence generally will not give rise to liability under the False Claims Act, submitting a claim with reckless disregard to its truth or falsity can constitute "knowingly" submitting a claim. See "Item 3--Legal Proceedings" for a description of pending, False Claims Act litigation.

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 effect 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 would 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 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 any of our recent hospital acquisitions. 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 have a negative impact on our ability to acquire additional hospitals. See "--Our Business Strategy."

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 hospitals in 11 states that have adopted certificate of need laws. 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.

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 a PPS, our hospitals are paid a prospectively determined 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. Each DRG is assigned a payment rate that is prospectively set using national average costs per case for treating a patient for a particular diagnosis. DRG payments do not consider the actual costs incurred by a hospital in providing a particular inpatient service. 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 threshold.

The DRG rates are adjusted by an update factor each federal fiscal year, which begins on October 1. The update factor is determined, in part, by the projected increase in the cost of goods and services that are purchased by hospitals. For several years the annual update factor has been lower than the projected increases in the costs of goods and services purchased by hospitals. DRG rate increases were 1.1% for federal fiscal year 1995, 1.5% for federal fiscal year 1996, and 2.0% for federal fiscal year 1997. For federal fiscal year 1998, there was no increase. The DRG rate was increased by the projected increase in the cost of goods and services minus 1.9% for federal fiscal year 1999; 1.8% for federal fiscal year 2000; and by the full increase in the cost of goods and services for federal fiscal year 2001. For both federal fiscal years 2002 and 2003, the DRG rate will be increased by the projected increase in the cost of goods and services minus 1.1%. Future legislation may decrease the rate of increase for DRG payments, but we are not able to predict the amount of the reduction or the effect that the reduction will have on us.

Outpatient services have traditionally been paid at the lower of customary charges or on a reasonable cost basis. The Balanced Budget Act established a PPS for outpatient hospital services that commenced on August 1, 2000. All services paid under the new PPS for hospital outpatient services are classified into groups called ambulatory payment classifications or "APCs". Services in each APC are similar clinically and in terms of the resources they require. Depending on the services provided, each outpatient encounter could result in the assignment of multiple APC payments. The Balanced Budget Refinement Act of 1999 eliminated the anticipated average reduction of 5.7% for various Medicare outpatient business under the Balanced Budget Act of 1997. Under the Balanced Budget Refinement Act of 1999, non-urban hospitals with 100 beds or less are held harmless under Medicare outpatient PPS through December 31, 2003. Thirty-four of our hospitals qualify for this relief. Losses under Medicare outpatient PPS for non-urban hospitals with greater than 100 beds and urban hospitals will be mitigated through a corridor reimbursement approach, where a percentage of losses will be reimbursed through December 31, 2003. All of our remaining hospitals qualify for relief under this provision.

Skilled nursing facilities have historically been paid by Medicare on the basis of actual costs, subject to limitations. The Balanced Budget Act established a PPS for Medicare skilled nursing facilities. The new PPS commenced in July 1998, and is being implemented progressively over a three year term. We have experienced reductions in payments for our skilled nursing services. However, the

Balanced Budget Refinement Act of 1999, effective as of October 1, 2000 and the Benefit and Improvement Act of 2000 established adjustments to the PPS payments made to skilled nursing facilities.

The Balanced Budget Act also required the Department of Health and Human Services to establish a PPS for home health services. The Balanced Budget Act of 1997 put in place the interim payment system, commonly known as "IPS," until the home health PPS could be implemented. As of October 1, 2000, the home health PPS replaced IPS. We have experienced reductions in payments for our home health services and a decline in home health visits due to a reduction in benefits by reason of the Balanced Budget Act. Home health PPS has increased payments for our home health services.

MEDICAID. Most state Medicaid payments are made under a PPS, reasonable cost, per diem, or established fee schedules. Medicaid is currently funded jointly by state and federal governments. The federal government and many states are currently considering significantly reducing Medicaid funding, while at the same time expanding Medicaid benefits. This could adversely affect future levels of Medicaid payments received by our hospitals.

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 certain 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.

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.

COMPETITION

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

In addition to the competition we face for acquisitions 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. Most of our hospitals face no direct competition because there are no other hospitals in their primary service areas. However, these hospitals do face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. These facilities are generally located in excess of 25 miles from our facilities. Patients in our primary service areas may travel to these other hospitals for a variety of reasons, including the need for services we do not offer or physician referrals. Patients who are required to seek services from these other hospitals may subsequently shift their preferences to those hospitals for services we do provide.

Some of our hospitals operate in primary service areas where they compete with 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 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

OUR COMPLIANCE PROGRAM. In early 1997, under our new management and leadership, we voluntarily adopted a company-wide compliance program. The program included the appointment of a compliance officer and committee, adoption of an ethics and business conduct code, employee education and training, implementation of an internal system for reporting concerns, auditing and monitoring programs, and a means for enforcing the program's policies.

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 function. This approach is intended to reinforce our company-wide commitment to operate strictly in accordance with the laws and regulations that govern our business.

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 anti-kickback and Stark laws, emergency department treatment and transfer requirements, and other patient disposition issues are also the focus of policy and training, standardized documentation requirements, and review and audit.

INPATIENT CODING COMPLIANCE ISSUE. In August 1997, during a routine internal audit at one of our facilities, we discovered inaccuracies in the DRG coding for some of our inpatient medical records. At that time, this was the primary auditing activity for our compliance program. These inaccuracies involved inpatient coding practices that had been put in place prior to the time we acquired our operating company in 1996.

Because of the concerns raised by the internal audit, we performed an internal review of historical inpatient coding practices. At the completion of this review in December 1997, we voluntarily disclosed the coding problems to the Office of Inspector General of the U.S. Department of Health and Human

Services. After discussions with the Inspector General, we agreed to have an independent consultant audit the coding for eight specific DRGs. This audit ultimately involved a review by the consultant of approximately 1,500 patient files. The audit procedures we followed generated a statistically valid estimate of the dollar amounts related to coding errors for these DRGs at 36 of our hospitals for the period 1993 to 1997.

The results of this audit were reviewed by the Inspector General and the Department of Justice, who also conducted their own investigation. We cooperated fully with their investigation. The government agencies advised us of potential liability under various legal theories, including the False Claims Act. Under the False Claims Act, we could be liable for as much as treble damages and penalties of between $5,000 and $10,000 per false claim submitted to Medicare and Medicaid.

We entered into a settlement agreement in May 2000 with these federal government agencies and the applicable state Medicaid programs. Pursuant to the settlement agreement, we paid approximately $31.8 million in May 2000 and were released from all civil claims relating to the coding of the eight specific DRGs for the hospitals and time periods covered in the audit. We funded this payment from our acquisition loan facility. During 1998 and 1999, we established a liability in our financial statements for this amount. We have also agreed with the Inspector General to continue our existing voluntary compliance program under a corporate compliance agreement and to adopt various additional compliance measures for a period of three years. These additional compliance measures include making various reports to the federal government and having our actions pursuant to the compliance agreement reviewed annually by a third party.

The compliance measures and reporting and auditing requirements contained in the compliance agreement include:

- continuing the duties and activities of our corporate compliance officer, corporate compliance work group, and facility compliance chairs and committees;

- maintaining our written ethics and conduct policy, which sets out our commitment to full compliance with all statutes, regulations, and guidelines applicable to federal healthcare programs;

- maintaining our written policies and procedures addressing the operation of our compliance program, including proper coding for inpatient hospital stays;

- continuing our general training on the ethics and conduct policy and adding training about our compliance program and the compliance agreement;

- continuing our specific training for the appropriate personnel on billing and coding issues;

- continuing independent third party periodic audits of our facilities' inpatient DRG coding;

- having an independent third party perform an annual review of our compliance with the compliance agreement;

- continuing our confidential disclosure program and "ethics hotline" to enable employees or others to disclose issues or questions regarding possible inappropriate policies or behavior;

- enhancing our screening program to ensure that we do not hire or engage employees or contractors who are ineligible persons for federal healthcare programs;

- reporting any material deficiency which resulted in an overpayment to us by a federal healthcare program; and

- submitting annual reports to the Inspector General which describe in detail the operations of our corporate compliance program for the past year.

Our substantial adherence to the terms and conditions of the compliance agreement will constitute an element of our eligibility to participate in the federal healthcare programs. Consequently, material, uncorrected violations of the compliance agreement could lead to suspension or disbarment from these federal programs. In addition, we will be subject to possible civil penalties for a failure to substantially comply with the terms of the compliance agreement, including stipulated penalties ranging between $1,000 to $2,500 per day. We will also be subject to a stipulated penalty of $25,000 per day, following notice and cure periods, for any deliberate and/or flagrant breach of the material provisions of the compliance agreement.

EMPLOYEES

At December 31, 2000, we employed approximately 14,073 full time employees and 3,616 part-time employees. Of these employees, approximately 973 are represented by labor organizations. We 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 generally maintain professional malpractice liability insurance and general liability insurance on a claims made basis in amounts and with deductibles that we believe to be sufficient for our operations. We also maintain umbrella liability coverage covering claims which, due to their nature or amount, are not covered by our insurance policies. We cannot assure you that professional liability insurance will cover all claims against us or continue to be available at reasonable costs for us to maintain adequate levels of insurance.

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.

ITEM 2.

PROPERTIES

Our hospitals are general care hospitals offering a wide range of inpatient and outpatient medical services. These services generally include internal medicine, general surgery, cardiology, oncology, orthopedics, OB/GYN, diagnostic and emergency room services, outpatient surgery, laboratory, radiology, respiratory therapy, physical therapy, and rehabilitation services. In addition, some of our hospitals provide skilled nursing and home health services based on individual community needs.

For each of our hospitals, the following table shows its location, the date of its acquisition or lease inception and the number of licensed beds as of December 31, 2000:

HOSPITAL	CITY	LICENSE BEDS(1)	DATE OF ACQUISITION/LEASE INCEPTION	OWNERSHIP TYPE
ALABAMA				
Woodland Community Hospital.....	Cullman	100	October, 1994	Owned
Parkway Medical Center Hospital.....	Decatur	120	October, 1994	Owned
L.V. Stabler Memorial Hospital.....	Greenville	72	October, 1994	Owned
Hartselle Medical Center.....	Hartselle	150	October, 1994	Owned
Edge Regional Hospital.....	Troy	97	December, 1994	Owned
Lakeview Community Hospital.....	Eufaula	74	April, 2000	Owned
South Baldwin Regional.....	Foley	82	June, 2000	Leased
ARIZONA				
Payson Regional Medical Center.....	Payson	66	August, 1997	Leased
Western Arizona Regional.....	Bullhead City	90	July, 2000	Owned
ARKANSAS				
Harris Hospital.....	Newport	132	October, 1994	Owned
Randolph County Medical Center.....	Pocahontas	50	October, 1994	Leased
CALIFORNIA				
Barstow Community Hospital.....	Barstow	56	January, 1993	Leased
Fallbrook Hospital.....	Fallbrook	47	November, 1998	Operated (2)
Watsonville Community Hospital.....	Watsonville	102	September, 1998	Owned
FLORIDA				
North Okaloosa Medical Center.....	Crestview	110	March, 1996	Owned
GEORGIA				
Berrien County Hospital.....	Nashville	71	October, 1994	Leased
Fannin Regional Hospital.....	Blue Ridge	34	January, 1986	Owned
ILLINOIS				
Crossroads Community Hospital.....	Mt. Vernon	55	October, 1994	Owned
Marion Memorial Hospital.....	Marion	99	October, 1996	Leased
KENTUCKY				
Parkway Regional Hospital.....	Fulton	70	May, 1992	Owned
Three Rivers Medical Center.....	Louisa	90	May, 1993	Owned
Kentucky River Medical Center.....	Jackson	55	August, 1995	Leased

HOSPITAL	CITY	LICENSE BEDS(1)	DATE OF ACQUISITION/LEASE INCEPTION	OWNERSHIP TYPE
LOUISIANA				
Byrd Regional Hospital.....	Leesville	70	October, 1994	Owned
Sabine Medical Center.....	Many	52	October, 1994	Owned
River West Medical Center.....	Plaquemine	80	August, 1996	Leased
MISSISSIPPI				
The King's Daughters Hospital.....	Greenville	137	September, 1999	Owned
MISSOURI				
Moberly Regional Medical Center.....	Moberly	114	November, 1993	Owned
Northeastern Regional Medical Center.....	Kirksville	164	December, 2000	Owned
NEW MEXICO				
Mimbres Memorial Hospital.....	Deming	49	March, 1996	Owned
Eastern New Mexico Medical Center.....	Roswell	162	April, 1998	Owned
Northeastern Regional Hospital.....	Las Vegas	54	April, 2000	Leased
NORTH CAROLINA				
Martin General Hospital.....	Williamston	49	November, 1998	Leased
PENNSYLVANIA				
Berwick Hospital.....	Berwick	144	March, 1999	Owned
SOUTH CAROLINA				
Marlboro Park Hospital.....	Bennettsville	109	August, 1996	Leased
Chesterfield General Hospital.....	Cheraw	66	August, 1996	Leased
Springs Memorial Hospital.....	Lancaster	194	November, 1994	Owned
TENNESSEE				
Lakeway Regional Hospital.....	Morristown	135	May, 1993	Owned
Scott County Hospital.....	Oneida	99	November, 1989	Leased
Cleveland Community Hospital.....	Cleveland	100	October, 1994	Owned
White County Community Hospital.....	Sparta	60	October, 1994	Owned
TEXAS				
Big Bend Regional Medical Center.....	Alpine	40	October, 1999	Owned
Northeast Medical Center.....	Bonham	75	August, 1996	Owned
Cleveland Regional Medical Center.....	Cleveland	115	August, 1996	Leased
Highland Medical Center.....	Lubbock	123	September, 1986	Owned
Scenic Mountain Medical Center.....	Big Spring	150	October, 1994	Owned

HOSPITAL	CITY	LICENSE BEDS(1)	DATE OF ACQUISITION/LEASE INCEPTION	OWNERSHIP TYPE
Hill Regional Hospital.....	Hillsboro	92	October, 1994	Owned
Lake Granbury Medical Center.....	Granbury	56	January, 1997	Leased
UTAH				
Tooele Valley Regional Medical Center.....	Tooele	38	October, 2000	Owned (3)
VIRGINIA				
Greensville Memorial Hospital.....	Emporia	114	March, 1999	Leased
Russell County Medical Center.....	Lebanon	78	September, 1986	Owned
Southampton Memorial Hospital.....	Franklin	105	March, 2000	Leased
WYOMING				
Evanston Regional Hospital.....	Evanston	42	November, 1999	Owned

- ------------------------

(1) Licensed beds are the number of beds for which the appropriate state agency licenses a facility regardless of whether the beds are actually available for patient use.

(2) We operate this hospital under a lease-leaseback and operating agreement. We recognize all operating statistics, revenue and expenses associated with this hospital in our consolidated financial statements.

(3) We acquired this hospital as of October 1, 2000. Prior to the acquisition, we operated this hospital under a management agreement and did not include the operating statistics of this hospital in our consolidated statistics. During the term of the management agreement, our fee was equal to the hospital's EBITDA.

ITEM 3.

LEGAL PROCEEDINGS

We entered into a settlement agreement in May 2000 with the Inspector General, the Department of Justice, and the applicable state Medicaid programs pursuant to which we paid approximately $31.8 million in exchange for a release of civil claims associated with possible inaccurate inpatient coding for the period 1993 to 1997. For a description of the terms of the settlement agreement as well as the events giving rise to the settlement agreement, see "Item 1--Compliance Program."

In May 1999, we were served with a complaint in U.S. EX REL. BLEDSOE V. COMMUNITY HEALTH SYSTEMS, INC., Case # 1-98-CV-0435-MHS (N.D. Ga.). This qui tam action seeks treble damages and penalties under the False Claims Act against us. The Department of Justice did not intervene in this action. The allegations in the amended complaint are extremely general, but involve Medicare billing at our White County Community Hospital in Sparta, Tennessee. In September 2000, the court granted our motion to transfer this case to federal court in Tennessee and our motion to dismiss the case is before the court. Based on our review of the allegations of the relator, we do not believe that this lawsuit is meritorious and we intend to vigorously defend ourselves against this action.

The Department of Justice also has notified us of the existence of U.S. EX REL. SMITH V. COMMUNITY HEALTH SYSTEMS, INC., filed in September 1999 in the federal court in Nashville, Tennessee. This qui tam lawsuit was brought against us by a former employee of our Lakeway Regional Hospital. The complaint alleges violations of the False Claims Act in connection with alleged inflated costs caused by incorrect allocation of employee salaries to Lakeway Regional Hospital's rehabilitation unit, as well as improper

Medicare reimbursement for patients readmitted to that hospital from the rehabilitation unit. Our review indicates that the allegations relating to the reimbursement for the readmitted patients lack factual support. In addition, our review indicates that any inaccuracies in salary allocations to the rehabilitation unit's cost reports were relatively minimal in amount. The Department of Justice has advised us informally that it has decided not to intervene, but we have not been formally served with the complaint. We intend to assert a number of factual and legal defenses to these allegations.

The Department of Justice also has notified us of the existence of U.S. EX REL. KOWATLI V. RUSSELL COUNTY MEDICAL CENTER, ET AL., filed in January 1999 in the federal court in Abingdon, Virginia. This lawsuit was brought by a physician who formerly had privileges at Russell County Medical Center. The complaint is filed under the False Claims Act against various individual doctors as well as Russell County Medical Center and us. The complaint alleges that the defendants engaged in unnecessary and unsafe medical procedures, tests and hospitalizations. The physician had previously filed two antitrust actions against the doctors and hospital which were both found to be without merit and dismissed by the courts. Based upon our investigation into the allegations at the request and direction of the Department of Justice, we do not believe this lawsuit has any merit. We have not been served with the complaint, and the Department of Justice has not made a decision to intervene.

In 1999, we received federal grand jury subpoenas from the U.S. Attorney's Office for the Eastern District of Arkansas seeking documents from our Harris Hospital facility relating to its mammography department. Investigators from the Food and Drug Administration and the State of Arkansas also sought documents and interviewed employees relating to the activities of the Harris Hospital mammography department. We have cooperated with the government's investigation and made documents and individuals available. In January 2001, we received a contact letter in connection with this matter from the Civil Division of the United States Attorney's Office. The letter alleges violations of the False Claims Act and the Mammography Quality Standards Act. We have reopened our investigation into this matter to determine whether the allegations have merits and will defend them accordingly.

Because of the uncertain nature of litigation, we cannot predict the outcome of these matters.

We also receive various inquiries or subpoenas from state regulators, fiscal intermediaries, and the Department of Justice regarding various Medicare and Medicaid issues. In addition, we are subject to other claims and lawsuits arising in the ordinary course of our business or arising out of transactions. Plaintiffs in these lawsuits generally request punitive or other damages that by state law may not be able to be covered by insurance. We are not aware of any pending or threatened litigation which we believe would have a material adverse impact on us.

ITEM 4.

SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

No matters were submitted to a vote of security holders during the fourth quarter of the year ended December 31, 2000.

PART II

ITEM 5.

MARKET FOR REGISTRANT'S COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

We completed an initial public offering of our Common Stock which began trading on June 9, 2000 and was closed on June 14, 2000. Our Common Stock is listed on the New York Stock Exchange under the symbol CYH. At March 16, 2001, there were approximately 48 record holders and 4,150 beneficial holders of our Common Stock. The following table sets forth, for the periods indicated, the high and low sale prices per share of our Common Stock as reported by the New York Stock Exchange. Our Common Stock did not trade below the June 9, 2000 initial public offering price of $13.00.

	HIGH	LOW
Year Ended December 31, 2000		
Second Quarter (beginning June 9, 2000)	$16.3125	$ 13.00
Third Quarter	32.50	15.625
Fourth Quarter	37.20	24.25

We have not paid any cash dividends since its inception, and do not anticipate the payment of cash dividends in the foreseeable future.

The shares of our Common Stock sold in our initial public offering were registered under the Securities Act of 1933, as amended, on a Registration Statement on Form S-1 (the "Registration Statement") (Registration No. 333-31790). In total, we sold 20,425,717 shares in the offering at $13.00 per share, including 1,675,717 shares sold on July 3, 2000 in connection with the exercise by the underwriters of their overallotment option. After deducting the underwriting discounts and commissions and the offering expenses described above, the Company received net proceeds from the offering of $245.7 million which was used to repay long-term debt.

On November 3, 2000, we closed a second public offering of Common Stock. The shares of our Common Stock sold in the offering were registered under the Securities Act of 1933, as amended, on a Registration Statement on Form S-1 (the "Registration Statement") (Registration No. 333-47354). The 10,000,000 shares offered by the Company and 8,000,000 shares offered by the selling shareholders under the Registration Statement were sold at a price of $28.1875 per share. After deducting the underwriting discounts and commissions and the offering expenses described above, the Company received net proceeds from the offering of $268.9 million which was used to repay long-term debt.

ITEM 6.

SELECTED FINANCIAL DATA

	YEAR ENDED DECEMBER 31,				PERIOD FROM JULY 1 THROUGH DECEMBER 31,	PREDECESSOR(1) PERIOD FROM JANUARY 1 THROUGH JUNE 30,
	2000	1999	1998	1997	1996(3)	1996(2)
	(IN THOUSANDS, EXCEPT SHARE AND PER SHARE DATA)					
CONSOLIDATED STATEMENT OF OPERATIONS DATA						
Net operating revenues	$1,337,501	$1,079,953	$ 854,580	$ 742,350	$ 327,922	$294,166
Income (loss) from operations	155,112	105,255	(95,152)	53,081	27,118	(34,069)
Net income (loss)	9,569	(16,789)	(183,290)	(32,171)	(13,102)	(27,252)
Net income (loss) per share -- Diluted	0.14	(0.31)	(3.38)	(0.60)	(0.24)	--
Weighted-average number of shares outstanding -- Diluted (4)	69,187,191	54,545,030	54,249,895	53,989,089	53,786,432	--
CONSOLIDATED BALANCE SHEET DATA (AS OF END OF PERIOD OR YEAR)						
Cash and cash equivalents	$ 13,740	$ 4,282	$ 6,719	$ 7,663	$ 26,588	$ 10,410
Total assets	2,213,837	1,895,084	1,747,016	1,643,521	1,630,630	506,323
Long-term obligations	1,216,790	1,430,099	1,273,502	1,053,450	1,009,698	246,216
Stockholders' equity	756,174	229,708	246,826	433,625	465,673	165,879

- --------------------------

(1) Effective in July 1996, we acquired all of the outstanding common stock of our principal subsidiary, CHS/Community Health Systems, Inc. The predecessor company had a substantially different capital structure compared to ours. Because of the limited usefulness of the earnings per share information for the predecessor company, these amounts have been excluded.

(2) Includes two acquisitions.

(3) Includes six acquisitions.

(4) See note 10 to the consolidated financial statements, included later in this Form 10-K.

ITEM 7.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

You should read this discussion together with our consolidated financial statements and the accompanying notes and Selected Financial Data included elsewhere in this Form 10-K.

OVERVIEW

We are the largest non-urban provider of general hospital healthcare services in the United States in terms of number of facilities and the second largest in terms of revenues and EBITDA. As of December 31, 2000, we owned, leased or operated 52 hospitals, geographically diversified across 20 states, with an aggregate of 4,688 licensed beds. In over 85% of our markets, we are the sole provider of general hospital healthcare services. In most of our other markets, we are one of two providers of general hospital healthcare services. For the fiscal year ended December 31, 2000, we generated $1.34 billion in net operating revenues and $252.7 million in adjusted EBITDA. We achieved revenue growth of 23.8% in 2000 and 26.4% in 1999. We also achieved growth in adjusted EBITDA of 23.8% in 2000 and 22.7% in 1999.

ACQUISITIONS

During 2000, we acquired, through five purchases and two capital lease transactions, most of the assets, including working capital, of seven hospitals. These acquisitions include the purchase of assets of a hospital which we were managing under an operating agreement. We had purchased the working capital accounts of that hospital in 1998. The consideration for the seven hospitals totaled approximately $247 million. This consideration consisted of $148 million in cash, which we borrowed under our acquisition loan facilities, and assumed liabilities of $99 million. We prepaid the lease obligation relating to each lease transaction. We included the prepayment as part of the cash consideration.

During 1999, we acquired, through three purchases and one capital lease transaction, most of the assets, including working capital, of four hospitals. The consideration for the four hospitals totaled approximately $78 million. This consideration consisted of $59.7 million in cash, which we borrowed under our acquisition loan facility, and assumed liabilities of $18.1 million. We prepaid the entire lease obligation relating to the lease transaction. We included the prepayment as part of the cash consideration. We also opened one additional hospital, after completion of construction, at a cost of $15.3 million. This owned hospital replaced a hospital that we managed.

During 1998, we acquired, through two purchase and two capital lease transactions, most of the assets, including working capital, of four hospitals. The consideration for the four hospitals totaled approximately $219 million. This consideration consisted of $169.8 million in cash, which we borrowed under our acquisition loan facility, and assumed liabilities of $48.8 million. We prepaid the entire lease obligation relating to each lease transaction. We included the prepayment as part of the cash consideration. Also, effective December 1, 1998, we entered into an operating agreement relating to a 38 licensed bed hospital. We also purchased the working capital accounts of that hospital. The cash payment made for this hospital was $2.8 million. Pursuant to this operating agreement, upon specified conditions being met, we will be obligated to construct a replacement hospital and to purchase for $0.9 million the remaining assets of the hospital. Upon completion, all rights of ownership and operation will transfer to us.

Goodwill from the acquisition of our predecessor company in 1996 was $662.1 million and from subsequent hospital acquisitions was $323.5 million as of December 31, 2000. Based on management's

assessment of the goodwill's estimated useful life, we generally amortize our goodwill over 40 years. Goodwill represented 130.3% of our shareholders' equity as of December 31, 2000; the amount of goodwill amortized equaled 16.6% of our income from operations for the year ended December 31, 2000. Significant adverse changes in facts regarding our industry, markets and operations could cause our management to shorten the estimated useful life used to amortize our goodwill. This could result in material increases in amortization of goodwill, or cause impairments to the carrying amount of such goodwill, resulting in a non-cash charge which would reduce operating income.

In the future, we intend to acquire, on a selective basis, two to four hospitals in our target markets annually. Because of the financial impact of acquisitions, it is difficult to make meaningful comparisons between our financial statements for the periods presented. Because EBITDA margins at hospitals we acquire are, at the time of acquisition, lower than those of our existing hospitals, acquisitions can negatively affect our EBITDA margins on a consolidated basis.

On May 1, 2000, we terminated the lease of a hospital previously held for disposition. At December 31, 2000, the carrying amounts of one of our hospitals, which is being held for disposition, were segregated from our remaining assets and classified in other assets, net in our consolidated balance sheet as of December 31, 2000. We do not expect the impact of any gain or loss on our financial results to be material.

SOURCES OF REVENUE

Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-reimbursement and other payment methods. Approximately 46% of net operating revenues for the year ended December 31, 2000, 48% for the year ended December 31, 1999, and 49% for the year ended December 31, 1998, are related to services rendered to patients covered by the Medicare and Medicaid programs. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than the standard billing rates. We account for the differences between the estimated program reimbursement rates and the standard billing rates as contractual adjustments, which we deduct from gross revenues to arrive at net operating revenues. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We record adjustments to the estimated billings in the periods that such adjustments become known. We account for adjustments to previous program reimbursement estimates as contractual adjustments and report them in future periods as final settlements are determined. Adjustments related to final settlements or appeals that increased revenue were insignificant in each of the years ended December 31, 2000, 1999 and 1998. Net amounts due to third-party payors as of December 31, 2000 were $2.3 million and as of December 31, 1999 were $9.1 million. We included these amounts in "Accrued Liabilities--Other" in our balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 1997.

We expect the percentage of revenues received from the Medicare program to increase due to the general aging of the population and the restoration of some payments under the Balanced Budget Refinement Act of 1999 and Benefit and Improvement Protection Act of 2000. The payment rates under the Medicare program for inpatients are based on a prospective payment system, based upon the diagnosis of a patient. While these rates are indexed for inflation annually, the increases have historically been less than actual inflation. Reductions in the rate of increase in Medicare reimbursement may have an adverse impact on our net operating revenue growth.

The implementation of Medicare's new prospective payment system for outpatient hospital care, effective August 1, 2000, had a favorable impact, however, not material to our overall operating results. The Health Care Financing Administration estimated that this new prospective payment system will result in an overall 9.7% increase in projected outpatient payments which began August 1, 2000.

In December 2000, the Benefit Improvement and Protection Act of 2000 became law. It is estimated that the changes to be implemented to many facets of the Medicare reimbursement system will increase reimbursement. We do not believe these increases will be material to our overall operating results.

In addition, Medicaid programs, insurance companies, and employers are actively negotiating the amounts paid to hospitals as opposed to their standard rates. The trend toward increased enrollment in managed care may adversely affect our net operating revenue growth.

RESULTS OF OPERATIONS

Our hospitals offer a variety of services involving a broad range of inpatient and outpatient medical and surgical services. These include orthopedics, cardiology, OB/GYN, occupational medicine, rehabilitation treatment, home health, and skilled nursing. The strongest demand for hospital services generally occurs during January through April and the weakest demand for these services occurs during the summer months. Accordingly, eliminating the effect of new acquisitions, our net operating revenues and earnings are generally highest during the first quarter and lowest during the third quarter.

The following tables summarize, for the periods indicated, selected operating data.

	YEARS ENDED DECEMBER 31,		
	2000	1999	1998
	(EXPRESSED AS A PERCENTAGE OF NET OPERATING REVENUES)		
Net operating revenues	100.0	100.0	100.0
Operating expenses (1)	(81.1)	(81.1)	(80.5)
Adjusted EBITDA (2)	18.9	18.9	19.5
Depreciation and amortization	(5.4)	(5.3)	(5.8)
Amortization of goodwill	(1.9)	(2.3)	(3.1)
Impairment of long-lived assets	--	--	(19.3)
Compliance settlement and Year 2000 remediation costs (3)	--	(1.6)	(2.4)
Income (loss) from operations	11.6	9.7	(11.1)
Interest, net	(9.5)	(10.8)	(11.8)
Income (loss) before cumulative effect of a change in accounting principle and income taxes	2.1	(1.1)	(22.9)
Provision for (benefit from) income taxes	1.4	0.5	(1.5)
Income (loss) before cumulative effect of a change in accounting principle	0.7	(1.6)	(21.4)

	YEARS ENDED DECEMBER 31,	
	2000	1999
Percentage change from prior period:		
Net operating revenues	23.8	26.4
Admissions	19.0	20.3
Adjusted admissions (4)	20.9	22.6
Average length of stay	(5.0)	(4.8)
Adjusted EBITDA (2)	23.8	22.7
Same hospitals percentage change from prior period (5):		
Net operating revenues	10.3	7.6
Admissions	6.3	4.9
Adjusted admissions	7.3	7.7
Adjusted EBITDA (2)	16.7	12.6

- ------------------------

(1) Operating expenses include salaries and benefits, provision for bad debts, supplies, rent, and other operating expenses, and exclude the items that are excluded for purposes of determining adjusted EBITDA as discussed in footnote (2) below.

(2) We define adjusted EBITDA as EBITDA adjusted to exclude cumulative effect of a change in accounting principle, impairment of long-lived assets and compliance settlement and Year 2000 remediation costs. EBITDA consists of income (loss) before interest, income taxes, depreciation and amortization, and amortization of goodwill. EBITDA and adjusted EBITDA should not be considered as measures of financial performance under generally accepted accounting principles. Items excluded from EBITDA and adjusted EBITDA are significant components in understanding and assessing financial performance. EBITDA and adjusted EBITDA are key measures used by management to evaluate our operations and provide useful information to investors. EBITDA and adjusted EBITDA should not be considered in isolation or as alternatives to net income, cash flows generated by operations, investing or financing activities, or other financial statement data presented in the consolidated financial statements as indicators of financial performance or liquidity. Because EBITDA and adjusted EBITDA are not measurements determined in accordance with generally accepted accounting principles and are thus susceptible to varying calculations, EBITDA and adjusted EBITDA as presented may not be comparable to other similarly titled measures of other companies.

(3) Includes Year 2000 remediation costs representing 0.0% in 1998, 0.3% in 1999 and 0.0% in 2000.

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

YEAR ENDED DECEMBER 31, 2000 COMPARED TO YEAR ENDED DECEMBER 31, 1999

Net operating revenues increased by 23.8% to $1,337.5 million in 2000 from $1,080.0 million in 1999. Of the $257.5 million increase in net operating revenues, the hospitals we acquired, including one constructed, in 2000 and 1999, contributed $149.6 million and hospitals we owned throughout both periods contributed $107.9 million. The $107.9 million, or 10.3%, increase in same hospitals net operating revenues was attributable primarily to inpatient and outpatient volume increases. In 2000, we experienced an estimated $25 million of reductions from the Balanced Budget Act of 1997. We have experienced lower payments from a number of payors, resulting primarily from:

- reductions mandated by the Balanced Budget Act of 1997, particularly in the areas of reimbursement for Medicare outpatient, capital, bad debts, home health, and skilled nursing;

- reductions in various states' Medicaid programs; and

- reductions in length of stay for patients not reimbursed on an admission basis.

We expect the Balanced Budget Refinement Act of 1999 and the Benefit Improvement and Protection Act of 2000 to lessen the impact of these reductions in future periods.

Inpatient admissions increased by 19.0%. Adjusted admissions increased by 20.9%. Average length of stay decreased by 5.0%. On a same hospitals basis, inpatient admissions increased by 6.3% and adjusted admissions increased by 7.3%. The increase in same hospitals inpatient admissions and adjusted admissions was due primarily to an increase in services offered, physician relationship development efforts, and the addition of physicians through our focused recruitment program. On a same hospitals basis, net outpatient operating revenues increased 13.7%. Outpatient growth reflects the continued trend toward a preference for outpatient procedures, where appropriate, by patients, physicians, and payors.

Operating expenses, as a percentage of net operating revenues, remained unchanged at 81.1% from 1999 to 2000. Adjusted EBITDA margin remained unchanged at 18.9% from 1999 to 2000. Salaries and benefits, as a percentage of net operating revenues, decreased from 38.8% in 1999 to 38.7% in 2000. Provision for bad debts, as a percentage of net operating revenues, increased to 9.1% in 2000 from 8.8% in 1999 due to an increase in self-pay revenues and payor remittance slowdowns in part caused by an increase in the number of acquisition conversions. The conversion is the process by which the Company must apply for new Medicare and Medicaid provider numbers on acquired hospitals. This process results in billing delays and payor remittance slowdowns and subsequently an increase in the allowance for uncollectible receivables during the conversion period. Supplies, as a percentage of net operating revenues, decreased to 11.5% in 2000 from 11.7% in 1999. Rent and other operating expenses, as a percentage of net operating revenues, remained unchanged at 21.7% from 1999 to 2000.

On a same hospitals basis, operating expenses as a percentage of net operating revenues decreased from 81.2% in 1999 to 80.1% in 2000 and adjusted EBITDA margin increased from 18.8% in 1999 to 19.9% in 2000. These efficiency and productivity gains resulted from the achievement of target staffing ratios, physician recruiting efforts, and improved compliance with national purchasing contracts. Operating expenses improved as a percentage of net operating revenues in every major category except provision for bad debts which increased slightly and other operating expenses which were flat compared to 1999.

Depreciation and amortization increased by $15.0 million from $56.9 million in 1999 to $71.9 million in 2000. The twelve hospitals acquired in 1999 and 2000 accounted for $5.9 million of the increase and facility renovations and purchases of equipment primarily accounted for the remaining $9.1 million.

Amortization of goodwill increased by $1.0 million from $24.7 million in 1999 to $25.7 million in 2000. This increase primarily related to the twelve hospitals acquired, including one constructed, in 1999 and 2000.

Interest, net increased by $10.9 million from $116.5 million in 1999 to $127.4 million in 2000. The twelve hospitals acquired, including one constructed, in 1999 and 2000 accounted for approximately $8.5 million of the increase, borrowings under our credit agreement to finance capital expenditures and physician recruiting accounted for $10.0 million of the increase, borrowings to fund our compliance settlement accounted for $1.9 million of the increase and changes in interest rates accounted for $8.2 million of the increase. These increases were offset by savings of approximately $16.0 million from the repayment of long-term debt with the proceeds from our initial public and secondary offerings in 2000 and a savings of $1.7 million from an increase in cash flow from operations.

Income before income taxes for 2000 was $27.7 million compared to a loss of $11.2 million in 1999. This improvement is primarily the result of revenue growth from both acquisitions and same store hospitals, management's ability to control expenses and a reduction in the growth rate of interest expense.

The provision for income taxes in 2000 was $18.2 million compared to $5.6 million in 1999. Due to the non-deductible nature of certain goodwill amortization, the resulting effective tax rate is in excess of the statutory rate.

Net income for 2000 was $9.6 million as compared to $16.8 million net loss in 1999.

YEAR ENDED DECEMBER 31, 1999 COMPARED TO YEAR ENDED DECEMBER 31, 1998

Net operating revenues increased by 26.4% to $1,080.0 million in 1999 from $854.6 million in 1998. Of the $225.4 million increase in net operating revenues, the nine hospitals we acquired, including one constructed, in 1998 and 1999, contributed $160.6 million and hospitals we owned throughout both periods contributed $64.8 million. The $64.8 million, or 7.6%, increase in same hospitals net operating revenues was attributable primarily to inpatient and outpatient volume increases, partially offset by a decrease in reimbursement. In 1999, we experienced an estimated $23 million of revenue reductions from the Balanced Budget Act of 1997. We have experienced lower payments from a number of payors, resulting primarily from:

- reductions mandated by the Balanced Budget Act of 1997, particularly in the areas of reimbursement for Medicare outpatient, capital, bad debts, home health, and skilled nursing;

- reductions in various states' Medicaid programs; and

- reductions in length of stay for patients not reimbursed on an admission basis.

Inpatient admissions increased by 20.3%. Adjusted admissions increased by 22.6%. Average length of stay decreased by 4.8%. On a same hospitals basis, inpatient admissions increased by 4.9% and adjusted admissions increased by 7.7%. The increase in same hospitals inpatient admissions and adjusted admissions was due primarily to an increase in services offered, physician relationship development efforts, and the addition of physicians through our focused recruitment program. On a same hospitals basis, net outpatient operating revenues increased 14.8%. Outpatient growth reflects the continued trend toward a preference for outpatient procedures, where appropriate, by patients, physicians, and payors.

Operating expenses, as a percentage of net operating revenues, increased from 80.5% in 1998 to 81.1% in 1999 due to higher operating expenses and lower initial adjusted EBITDA margins associated with acquired hospitals and one recently constructed hospital. Adjusted EBITDA margin decreased from 19.5% in 1998 to 18.9% in 1999. Salaries and benefits, as a percentage of net operating revenues, increased to 38.8% in 1999 from 38.4% in 1998, due to acquisitions of hospitals in 1998 and 1999

having higher salaries and benefits as a percentage of net operating revenues than our 1998 results. Provision for bad debts, as a percentage of net operating revenues, increased to 8.8% in 1999 from 8.1% in 1998 due to an increase in self-pay revenues and payor remittance slowdowns in part caused by payors converting their information systems to become year 2000 compliant. Supplies, as a percentage of net operating revenues, decreased to 11.7% in 1999 from 11.8% in 1998. Rent and other operating expenses, as a percentage of net operating revenues, decreased to 21.7% in 1999 from 22.3% in 1998.

On a same hospitals basis, operating expenses as a percentage of net operating revenues decreased from 81.1% in 1998 to 80.3% in 1999 and adjusted EBITDA margin increased from 18.9% in 1998 to 19.7% in 1999. These efficiency and productivity gains resulted from the achievement of target staffing ratios and improved compliance with national purchasing contracts. Operating expenses improved as a percentage of net operating revenues in every major category except provision for bad debts.

Depreciation and amortization increased by $7.0 million from $49.9 million in 1998 to $56.9 million in 1999. The nine hospitals acquired in 1998 and 1999 accounted for $7.1 million of the increase, and facility renovations and purchases of equipment accounted for the remaining $3.3 million. These increases were offset by a $3.4 million reduction in depreciation and amortization related to the 1998 impairment write-off of certain assets.

Amortization of goodwill decreased by $1.9 million from $26.6 million in 1998 to $24.7 million in 1999. The 1998 impairment charge resulted in a $3.6 million reduction in amortization of goodwill, offset by an increase of $1.7 million primarily related to the nine hospitals acquired in 1998 and 1999.

Interest, net increased by $15.3 million from $101.2 million in 1998 to $116.5 million in 1999. The nine hospitals acquired in 1998 and 1999 accounted for $10.2 million of the increase, and borrowings under our credit agreement to finance capital expenditures accounted for the remaining $5.1 million.

Loss before cumulative effect of a change in accounting principle and income taxes for 1999 was $11.2 million compared to a loss of $196.3 million in 1998. A majority of this variance was due to a $164.8 million charge for impairment of long-lived assets recorded in 1998. In December 1998, in connection with our periodic review process, we determined that as a result of adverse changes in physician relationships, undiscounted cash flows from seven of our hospitals were below the carrying value of long-lived assets associated with those hospitals. Therefore, in accordance with Statement of Financial Accounting Standards No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of," we adjusted the carrying value of the related long-lived assets, primarily goodwill, to their estimated fair value. We based the estimated fair values of these hospitals on specific market appraisals.

The provision for income taxes in 1999 was $5.6 million compared to a benefit of $13.4 million in 1998. Due to the non-deductible nature of certain goodwill amortization and the goodwill portion of the 1998 impairment charge, the effective tax rate is in excess of the statutory rate.

Including the impairment of long-lived assets, compliance settlement costs, Year 2000 remediation costs, and cumulative effect of a change in accounting principle charges, net loss for 1999 was $16.8 million as compared to $183.3 million net loss in 1998. In 1997, we initiated a voluntary review of inpatient medical records to determine whether documentation supported the inpatient codes billed to certain governmental payors for the years 1993 through 1997. We executed a settlement agreement with the appropriate state and federal governmental agencies for a negotiated settlement amount of approximately $31.8 million, which we paid in May 2000. We recorded as a charge to income, under the caption "Compliance settlement and Year 2000 remediation costs," $20 million in 1998 and $14 million in 1999.

LIQUIDITY AND CAPITAL RESOURCES

2000 COMPARED TO 1999

Net cash provided by operating activities increased by $34.7 million, from a use of $11.7 million during 1999 to cash provided of $23.0 million during 2000 due primarily to an increase in net income of $26.4 million, use of deferred tax assets of $17.2 million during 2000 as compared to creating deferred tax assets of $3.8 million in 1999, and an increase in accounts payable and accrued liabilities, offset by an increase in accounts receivable and the $31.8 million compliance settlement payment made during 2000. The use of cash in investing activities increased $88.9 million from $155.5 million in 1999 to $244.4 million in 2000. The increase is due primarily to an increase in cash used to finance hospital acquisitions of $88.5 million during 2000 and an increase in cash used to finance all other capital expenditures of $0.4 million. Net cash provided by financing activities increased $66.0 million from $164.9 million in 1999 to $230.9 million in 2000. We raised $514.5 million in proceeds, net of expenses from our initial public and secondary offerings completed in 2000, which were used to repay long term debt. Our borrowings during 2000 were $241.3 million and, excluding the offering proceeds, repayments would have been $11.0 million. Excluding the 2000 offering proceeds and the refinancing of our credit facility in 1999, this represents a $64.8 million increase compared to borrowings of $186.3 million and repayments of $20.9 million in 1999. The $64.8 million increase in borrowings is related to the increase in the amount spent on acquisitions of facilities partially offset by an increase in operating cash flows.

1999 COMPARED TO 1998

Net cash provided by operating activities decreased by $27.4 million, from $15.7 million during 1998 to a use of $11.7 million during 1999 due primarily to an increase in accounts receivable at both same hospitals and newly-acquired hospitals. The use of cash in investing activities decreased from $236.6 million in 1998 to $155.5 million in 1999. The $81.1 million decrease was due primarily to a decrease in cash used to finance hospital acquisitions of $112.9 million during 1999. This decrease was offset by a $31.8 million increase in cash used primarily to finance capital expenditures during 1999, including approximately $15.0 million of Year 2000 expenditures. The 1998 use of cash to acquire facilities included four hospitals, two of which were larger facilities. Net cash provided by financing activities decreased from $219.9 million in 1998 to $164.9 million in 1999. Excluding the refinancing of our credit facility, borrowings in 1999 would have been $186.3 million and repayments would have been $20.9 million. This represents a $56.2 million decrease compared to $242.5 million borrowed in 1998 and repayments of long-term indebtedness of $20.9 million in 1999 compared to repayments of $18.8 million in 1998. The $56.2 million decrease in borrowings related to a lesser amount spent on acquisition of facilities, partially offset by increased capital expenditures and an increase in the accounts receivable balance.

CAPITAL EXPENDITURES

Our capital expenditures for 2000 totaled $63.0 million compared to $65.0 million in 1999 and $51.3 million in 1998. Our capital expenditures for 1999 excludes $15.3 million of costs associated with the opening and construction of one additional hospital. The decrease in capital expenditures in 2000 was due primarily to the increase in purchases of medical equipment and information system upgrades in 1999 related to year 2000 compliance. These same expenditures account for the increase in capital expenditures during 1999 as compared to 1998.

Pursuant to hospital purchase agreements in effect as of December 31, 2000, we are required to construct four replacement hospitals through 2005 with an aggregate estimated construction cost, including equipment, of approximately $120 million. We expect total capital expenditures of approximately $90 million in 2001, including approximately $60 million for renovation and equipment purchases and approximately $30 million for construction of replacement hospitals.

CAPITAL RESOURCES

Net working capital was $167.7 million at December 31, 2000 compared to $65.2 million at December 31, 1999. The $102.5 million increase was attributable primarily to an increase in accounts receivable due to a combination of growth in same hospitals revenues during 2000 and the addition of seven hospitals in 2000 as well as the payment of approximately $31.8 million related to the compliance settlement, which was borrowed against the acquisition loan facility, offset by an increase in accounts payable.

During March 1999, we amended our credit agreement. The amended credit agreement provides for $644 million in term debt with quarterly amortization and staggered maturities in 2000, 2001, 2002, 2003, 2004 and 2005. This agreement also provides for revolving facility debt for working capital of up to $200 million and for acquisitions of up to $263.2 million. This revolving facility matures on December 31, 2002. Borrowings under the facility bear interest at either LIBOR or the higher of the prime rate, the three month certificate of deposit rate plus 1% of the federal funds rate plus 1/2 of 1%, plus in all cases various applicable margins. Some of these margins are fixed and others are based upon financial covenant ratio tests. As of December 31, 2000, under our credit agreement, our weighted average interest rate was 10.03%. As of December 31, 2000, we had availability to borrow an additional $159.9 million under the working capital revolving facility and an additional $193.2 million under the acquisition loan revolving facility.

We are required to pay a quarterly commitment fee at a rate which ranges from .375% to .500% based on specified financial performance criteria. This fee applies to unused commitments under the revolving credit facility and the acquisition loan facility.

The terms of the credit agreement include various restrictive covenants. These covenants include restrictions on additional indebtedness, investments, asset sales, capital expenditures, dividends, sale and leasebacks, contingent obligations, transactions with affiliates, and fundamental changes. The covenants also require maintenance of various ratios regarding senior indebtedness, senior interest, and fixed charges.

We believe that internally generated cash flows and borrowings under our revolving credit facility and acquisition facility will be sufficient to finance acquisitions, capital expenditures and working capital requirements through the next 12 months. If funds required for future acquisitions exceed existing sources of capital, we will need to increase our credit facilities or obtain additional capital by other means.

REIMBURSEMENT, LEGISLATIVE AND REGULATORY CHANGES

Legislative and regulatory action has resulted in continuing change in the Medicare and Medicaid reimbursement programs which will continue to limit payment increases under these programs. Within the statutory framework of the Medicare and Medicaid programs, there are substantial areas subject to administrative rulings, interpretations, and discretion which may further affect payments made under those programs, and the federal and state governments might, in the future, reduce the funds available under those programs or require more stringent utilization and quality reviews of hospital facilities. Additionally, there may be a continued rise in managed care programs and future restructuring of the financing and delivery of healthcare in the United States. These events could have an adverse effect on our future financial results.

INFLATION

The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. In addition, suppliers pass along rising costs to us in the form of higher prices. We have implemented cost control measures, including our

case and resource management program, to curb increases in operating costs and expenses. We have, to date, offset increases in operating costs by increasing reimbursement for services and expanding services. However, we cannot predict our ability to cover or offset future cost increases.

RECENT ACCOUNTING PRONOUNCEMENT NOT YET ADOPTED

SFAS No. 133, "Accounting for Derivative Instruments and Hedging Activities", is effective for all fiscal years beginning after June 15, 2000. SFAS No. 133, as amended, establishes accounting and reporting standards for derivative instruments, including certain derivative instruments embedded in other contracts and for hedging activities. Under SFAS No. 133, certain contracts that were not formerly considered derivatives may now meet the definition of a derivative. The Company will adopt SFAS No. 133 effective January 1, 2001. Management does not expect the adoption of SFAS No. 133 to have a significant impact on the financial position, results of operations, or cash flows of the Company.

FEDERAL INCOME TAX EXAMINATIONS

The Internal Revenue Service is examining our filed federal income tax returns for the tax periods ended between December 31, 1993 and December 31, 1996. The Internal Revenue Service has indicated that it is considering a number of adjustments, primarily involving temporary or timing differences. To date, a revenue agent's report has not been issued in connection with the examination of these tax periods. While we anticipate a resolution of the current examinations within the next six months, we do not expect that the ultimate outcome of the Internal Revenue Service examinations will have a material effect on us.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We are exposed to interest rate changes, primarily as a result of our credit agreement which bears interest based on floating rates. We have not taken any action to cover interest rate market risk, and are not a party to any interest rate market risk management activities.

A 1% change in interest rates on variable rate debt would have resulted in interest expense fluctuating approximately $9 million for 2000, $8 million for 1999, and $6 million for 1998.

SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

THIS ANNUAL REPORT INCLUDES FORWARD-LOOKING STATEMENTS WHICH COULD DIFFER FROM ACTUAL FUTURE RESULTS.

Some of the matters discussed in this Annual Report include forward-looking statements. Statements that are predictive in nature, that depend upon or refer to future events or conditions or that include words such as "expects," "anticipates," "intends," "plans," "believes," "estimates," "thinks," and similar expressions are forward-looking statements. These statements involve known and unknown risks, uncertainties, and other factors that may cause our actual results and performance to be materially different from any future results or performance expressed or implied by these forward-looking statements. These factors include the following:

- general economic and business conditions, both nationally and in the regions in which we operate;
- demographic changes;
- existing governmental regulations and changes in, or the failure to comply with, governmental regulations or our corporate compliance agreement;
- legislative proposals for healthcare reform;
- our ability, where appropriate, to enter into managed care provider arrangements and the terms of these arrangements;
- changes in Medicare and Medicaid payment levels;
- liability and other claims asserted against us;
- competition;
- our ability to attract and retain qualified personnel, including physicians;
- trends toward treatment of patients in lower acuity healthcare settings;
- changes in medical or other technology;
- changes in generally accepted accounting principles;
- the availability and terms of capital to fund additional acquisitions or replacement facilities; and
- our ability to successfully acquire and integrate additional hospitals.

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

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.

INDEX TO FINANCIAL STATEMENTS

INDEPENDENT AUDITORS' REPORT

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

We have audited the accompanying consolidated balance sheets of Community Health Systems, Inc. and subsidiaries as of December 31, 2000 and 1999, and the related consolidated statements of operations, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2000. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the consolidated financial position of Community Health Systems, Inc. and subsidiaries as of December 31, 2000 and 1999, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2000, in conformity with accounting principles generally accepted in the United States of America.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 20, 2001

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(IN THOUSANDS, EXCEPT SHARE AND PER SHARE DATA)

	YEAR ENDED DECEMBER 31,		
	2000	1999	1998
Net operating revenues	$ 1,337,501	$ 1,079,953	$ 854,580
Operating costs and expenses:			
Salaries and benefits	517,392	419,320	328,264
Provision for bad debts	122,303	95,149	69,005
Supplies	154,211	126,693	100,633
Rent	31,385	25,522	22,344
Other operating expenses	259,474	209,084	167,944
Depreciation and amortization	71,931	56,943	49,861
Amortization of goodwill	25,693	24,708	26,639
Impairment of long-lived assets	--	--	164,833
Compliance settlement and Year 2000 remediation costs	--	17,279	20,209
Total operating costs and expenses	1,182,389	974,698	949,732
Income (loss) from operations	155,112	105,255	(95,152)
Interest expense, net of interest income of $600, $288 and $261 in 2000, 1999 and 1998, respectively	127,370	116,491	101,191
Income (loss) before cumulative effect of a change in accounting principle and income taxes	27,742	(11,236)	(196,343)
Provision for (benefit from) income taxes	18,173	5,553	(13,405)
Income (loss) before cumulative effect of a change in accounting principle	9,569	(16,789)	(182,938)
Cumulative effect of a change in accounting principle, net of taxes of $189	--	--	(352)
Net income (loss)	$ 9,569	$ (16,789)	$ (183,290)
Basic and diluted earnings (loss) per common share:			
Income (loss) before cumulative effect of a change in accounting principle	$ 0.14	$ (0.31)	$ (3.37)
Cumulative effect of a change in accounting principle	--	--	(0.01)
Net income (loss)	$ 0.14	$ (0.31)	$ (3.38)
Weighted average number of shares outstanding:			
Basic	67,610,399	54,545,030	54,249,895
Diluted	69,187,191	54,545,030	54,249,895

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(IN THOUSANDS, EXCEPT SHARE DATA)

	DECEMBER 31,	
	2000	1999
ASSETS		
Current assets:		
Cash and cash equivalents	$ 13,740	$ 4,282
Patient accounts receivable, net of allowance for doubtful accounts of $52,935 and $34,499 in 2000 and 1999, respectively	309,826	226,350
Supplies	39,679	32,134
Prepaid expenses and taxes	19,989	9,846
Deferred income taxes	2,233	5,862
Other current assets	23,110	22,022
Total current assets	408,577	300,496
Property and equipment:		
Land and improvements	46,268	41,327
Buildings and improvements	536,428	470,856
Equipment and fixtures	267,505	219,659
	850,201	731,842
Less accumulated depreciation and amortization	(142,120)	(108,499)
Property and equipment, net	708,081	623,343
Goodwill, net of accumulated amortization of $123,459 and $97,766 in 2000 and 1999, respectively	985,568	877,890
Other assets, net of accumulated amortization of $37,142 and $34,265 in 2000 and 1999, respectively	111,611	93,355
Total assets	$2,213,837	$1,895,084
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Current maturities of long-term debt	$ 17,433	$ 27,029
Accounts payable	83,191	57,392
Compliance settlement payable	--	30,900
Accrued liabilities:		
Employee compensation	56,840	49,346
Interest	27,389	19,451
Other	56,020	51,159
Total current liabilities	240,873	235,277
Long-term debt	1,201,590	1,407,604
Other long-term liabilities	15,200	22,495
Commitments and contingencies:		
Stockholders' equity:		
Preferred stock, $.01 par value per share, 100,000,000 shares authorized; none issued	--	--
Common stock, $.01 par value per share, 300,000,000 shares authorized; 87,105,562 shares issued and 86,137,582 shares outstanding at December 31, 2000 and 56,588,787 shares issued and 55,620,807 shares outstanding at December 31, 1999	871	566
Additional paid-in capital	998,092	483,237
Accumulated deficit	(235,783)	(245,352)
Treasury stock, at cost, 967,980 shares at December 31, 2000 and 1999	(6,587)	(6,587)
Notes receivable for common stock	(334)	(1,997)
Unearned stock compensation	(85)	(159)
Total stockholders' equity	756,174	229,708
Total liabilities and stockholders' equity	$2,213,837	$1,895,084

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(IN THOUSANDS, EXCEPT SHARE DATA)

	COMMON STOCK		ADDITIONAL PAID-IN CAPITAL	ACCUMULATED DEFICIT	TREASURY STOCK		NOTES RECEIVABLE FOR COMMON STOCK	UNEARNED STOCK COMPENSATION	TOTAL
	SHARES	AMOUNT			SHARES	AMOUNT			
BALANCE, January 1, 1998	56,376,695	$564	$480,435	$ (45,273)	(135,868)	$(1,041)	$(1,050)	$ --	$433,635
Issuance of common stock	212,092	2	1,653	--	150,067	1,120	(900)	--	1,875
Common stock purchased for treasury, at cost	--	--	--	--	(970,269)	(5,634)	204	--	(5,430)
Payments on notes receivable	--	--	--	--	--	--	36	--	36
Net loss	--	--	--	(183,290)	--	--	--	--	(183,290)
BALANCE, December 31, 1998	56,588,787	566	482,088	(228,563)	(956,070)	(5,555)	(1,710)	--	246,826
Issuance of common stock	--	--	907	--	314,425	1,748	(440)	--	2,215
Common stock purchased for treasury, at cost	--	--	--	--	(326,335)	(2,780)	--	--	(2,780)
Payments on notes receivable	--	--	--	--	--	--	153	--	153
Unearned stock compensation	--	--	242	--	--	--	--	(242)	--
Earned stock compensation	--	--	--	--	--	--	--	83	83
Net loss	--	--	--	(16,789)	--	--	--	--	(16,789)
BALANCE, December 31, 1999	56,588,787	566	483,237	(245,352)	(967,980)	(6,587)	(1,997)	(159)	229,466
Issuance of common stock in connection with initial public offering, net of issuance costs	20,425,717	204	245,498	--	--	--	--	--	245,702
Issuance of common stock in connection with secondary public offering, net of issuance costs	10,000,000	100	268,722	--	--	--	--	--	268,822
Issuance of common stock in connection with the exercise of options	91,058	1	635	--	--	--	--	--	636
Payments on notes receivable	--	--	--	--	--	--	1,663	--	1,663
Earned stock compensation	--	--	--	--	--	--	--	74	74
Net income	--	--	--	9,569	--	--	--	--	9,569
BALANCE, December 31, 2000	87,105,562	$871	$998,092	$(235,783)	(967,980)	$(6,587)	$ (334)	$ (85)	$756,934

receivable.....	153
Unearned stock compensation.....	--
Earned stock compensation.....	83
Net loss.....	(16,789)
BALANCE, December 31, 1999.....	229,708
Issuance of common stock in connection with initial public offering, net of issuance costs.....	245,702
Issuance of common stock in connection with secondary public offering, net of issuance costs...	268,822
Issuance of common stock in connection with the exercise of options.....	636
Payments on notes receivable.....	1,663
Earned stock compensation.....	74
Net income.....	9,569
BALANCE, December 31, 2000.....	$756,174

See notes to consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS

	YEAR ENDED DECEMBER 31,		
	2000	1999	1998
	(DOLLARS IN THOUSANDS)		
Cash flows from operating activities:			
Net income (loss)	$ 9,569	$(16,789)	$(183,290)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:			
Depreciation and amortization	97,624	81,651	76,500
Deferred income taxes	17,210	(3,799)	(14,797)
Impairment charge	--	--	164,833
Compliance settlement costs	--	14,000	20,000
Stock compensation expense	74	83	--
Other non-cash (income) expenses, net	(5,030)	(570)	(528)
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	(52,989)	(42,973)	(33,908)
Supplies, prepaid expenses and other current assets	(15,604)	(17,598)	(7,724)
Accounts payable, accrued liabilities and income taxes	17,931	(28,071)	4,461
Compliance settlement payable	(30,900)	--	--
Other	(14,900)	2,320	(9,828)
Net cash provided by (used in) operating activities	22,985	(11,746)	15,719
Cash flows from investing activities:			
Acquisitions of facilities, pursuant to purchase agreements	(148,216)	(59,699)	(172,597)
Purchases of property and equipment	(63,005)	(80,255)	(52,880)
Proceeds from sale of equipment	107	121	1,531
Increase in other assets	(33,327)	(15,708)	(12,607)
Net cash used in investing activities	(244,441)	(155,541)	(236,553)
Cash flows from financing activities:			
Proceeds from issuance of common stock	514,524	2,215	1,875
Proceeds from exercise of stock options	636	--	--
Common stock purchased for treasury	--	(2,780)	(5,634)
Borrowings under Credit Agreement	241,310	436,300	242,491
Repayments of long-term indebtedness	(525,556)	(270,885)	(18,842)
Net cash provided by financing activities	230,914	164,850	219,890
Net change in cash and cash equivalents	9,458	(2,437)	(944)
Cash and cash equivalents at beginning of period	4,282	6,719	7,663
Cash and cash equivalents at end of period	$ 13,740	$ 4,282	$ 6,719

See notes to consolidated financial statements.

1. BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

BUSINESS. Community Health Systems Inc. (the "Company") owns, leases and operates acute care hospitals that are the principal providers of primary healthcare services in non-urban communities. As of December 31, 2000, the Company owned, leased or operated 52 hospitals, licensed for 4,688 beds in 20 states.

USE OF ESTIMATES. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

PRINCIPLES OF CONSOLIDATION. The consolidated financial statements include the accounts of the Company and its subsidiaries. All significant intercompany accounts and transactions have been eliminated. Certain of the subsidiaries have minority stockholders. The amount of minority interest in equity and minority interest in income or loss is not material and is included in other long-term liabilities and other operating expenses.

CASH EQUIVALENTS. The Company considers highly liquid investments with original maturities of three months or less to be cash equivalents.

SUPPLIES. Supplies, principally medical supplies, are stated at the lower of cost (first-in, first-out basis) or market.

PROPERTY AND EQUIPMENT. Property and equipment are recorded at cost. Depreciation is recognized using the straight-line method over the estimated useful lives of the land improvements (2 to 15 years; weighted average useful life is 11 years), buildings and improvements (5 to 40 years; weighted average useful life is 33 years) and equipment and fixtures (5 to 20 years; weighted average useful life is 7 years). Costs capitalized as construction in progress were $30.3 million and $27.2 million at December 31, 2000 and 1999, respectively, and are included in buildings and improvements. Expenditures for renovations and other significant improvements are capitalized; however, maintenance and repairs which do not improve or extend the useful lives of the respective assets are charged to operations as incurred. Interest capitalized in accordance with Statement of Financial Accounting Standards ("SFAS") No. 34, "Capitalization of Interest Cost," was $2.5 million, $1.4 million and $0.7 million for the years ended December 31, 2000, 1999, and 1998, respectively.

The Company also leases certain facilities and equipment under capital leases (see Notes 2 and 7). Such assets are amortized on a straight-line basis over the lesser of the terms of the respective leases, or the remaining useful lives of the assets.

GOODWILL. Goodwill represents the excess of cost over the fair value of net assets acquired and is amortized on a straight-line basis ranging from 18 to 40 years. Annually, as required by Accounting Principles Board ("APB") Opinion No. 17, the Company reviews its total enterprise goodwill for possible impairment, by comparing total projected undiscounted cash flows to the total carrying amount of goodwill.

OTHER ASSETS. Other assets consist primarily of the noncurrent portion of deferred income taxes and costs associated with the issuance of debt which are amortized over the life of the related debt using the effective interest method. Amortization of deferred financing costs is included in interest expense.

1. BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

THIRD-PARTY REIMBURSEMENT. Net operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems, provisions of cost-reimbursement and other payment methods. Approximately 46% of net operating revenues for the year ended December 31, 2000, 48% for the year ended December 31, 1999, and 49% for the year ended December 31, 1998, are related to services rendered to patients covered by the Medicare and Medicaid programs. In addition, the Company is reimbursed by non-governmental payors using a variety of payment methodologies. Amounts received by the Company for treatment of patients covered by such programs are generally less than the standard billing rates. The differences between the estimated program reimbursement rates and the standard billing rates are accounted for as contractual adjustments, which are deducted from gross revenues to arrive at net operating revenues. Final settlements under certain of these programs are subject to adjustment based on administrative review and audit by third parties. Adjustments to the estimated billings are recorded in the periods that such adjustments become known. Adjustments to previous program reimbursement estimates are accounted for as contractual adjustments and reported in future periods as final settlements are determined. Adjustments related to final settlements or appeals increased revenue by an insignificant amount in each of the years ended December 31, 2000, 1999 and 1998. Net amounts due to third-party payors as of December 31, 2000 were $2.3 million and as of December 31, 1999 were $9.1 million and are included in accrued liabilities-other in the accompanying balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 1997.

CONCENTRATIONS OF CREDIT RISK. The Company grants unsecured credit to its patients, most of whom reside in the service area of the Company's facilities and are insured under third-party payor agreements. Because of the geographic diversity of the Company's facilities and non-governmental third-party payors, Medicare and Medicaid represent the Company's only significant concentrations of credit risk.

NET OPERATING REVENUES. Net operating revenues are recorded net of provisions for contractual adjustments of approximately $1,649 million, $1,157 million and $829 million in 2000, 1999 and 1998, respectively. Net operating revenues are recognized when services are provided. In the ordinary course of business the Company renders services to patients who are financially unable to pay for hospital care. The value of these services to patients who are unable to pay is not material to the Company's consolidated results of operations.

PROFESSIONAL LIABILITY INSURANCE CLAIMS. The Company accrues, on a quarterly basis, for estimated losses resulting from professional liability claims to the extent they are not covered by insurance. The accrual, which includes an estimate for incurred but not reported claims, is based on historical loss patterns and annual actual projections. To the extent that subsequent claims information varies from management's estimates, the liability is adjusted currently.

ACCOUNTING FOR THE IMPAIRMENT OF LONG-LIVED ASSETS. In accordance with SFAS No. 121, "Accounting for Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed Of," whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets and related intangible assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

1. BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

INCOME TAXES. The Company accounts for income taxes under the asset and liability method, in which deferred income tax assets and liabilities are recognized for the tax consequences of "temporary differences" by applying enacted statutory tax rates applicable to future years to differences between the financial statement carrying amounts and the tax bases of existing assets and liabilities. The effect on deferred taxes of a change in tax rates is recognized in the statement of operations during the period in which the tax rate change becomes law.

COMPREHENSIVE INCOME. SFAS No. 130, "Reporting Comprehensive Income," defines comprehensive income as the change in equity of a business enterprise during a period from transactions and other events and circumstances from non-owner sources. Comprehensive income (loss) for 2000, 1999 and 1998 is equal to the net income (loss) reported.

STOCK-BASED COMPENSATION. The Company accounts for stock-based compensation using the intrinsic value method prescribed in APB Opinion No. 25, "Accounting for Stock Issued to Employees" and related interpretations. Compensation cost, if any, is measured as the excess of the fair value of the Company's stock at the date of grant over the amount an employee must pay to acquire the stock. SFAS No. 123, "Accounting for Stock-Based Compensation," established accounting and disclosure requirements using a fair value based method of accounting for stock-based employee compensation plans; however, it allows an entity to continue to measure compensation for those plans using the intrinsic value method of accounting prescribed by APB Opinion No. 25. The Company has elected to continue to measure compensation under the method of accounting as described above, and has adopted the disclosure requirements of SFAS No. 123.

SEGMENT REPORTING. SFAS No. 131, "Disclosures About Segments of an Enterprise and Related Information," requires that a public company report annual and interim financial and descriptive information about its reportable operating segments. Operating segments, as defined, are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker in deciding how to allocate resources and in assessing performance. SFAS No. 131 allows aggregation of similar operating segments into a single operating segment if the businesses have similar economic characteristics and are considered similar under the criteria established by SFAS No. 131. The Company owns, leases and operates 52 acute care hospitals in 52 different non-urban communities. All of these hospitals have similar services, have similar types of patients, operate in a consistent manner and have similar economic and regulatory characteristics. Therefore, the Company has one reportable segment.

RECENT ACCOUNTING PRONOUNCEMENT NOT YET ADOPTED. SFAS No. 133, "Accounting for Derivative Instruments and Hedging Activities", is effective for all fiscal years beginning after June 15, 2000. SFAS No. 133, as amended, establishes accounting and reporting standards for derivative instruments, including certain derivative instruments embedded in other contracts and for hedging activities. Under SFAS No. 133, certain contracts that were not formerly considered derivatives may now meet the definition of a derivative. The Company will adopt SFAS No. 133 effective January 1, 2001. Management does not expect the adoption of SFAS No. 133 to have a significant impact on the financial position, results of operations, or cash flows of the Company.

2. LONG-TERM LEASES AND PURCHASES OF HOSPITALS

During 2000, the Company acquired five hospitals through purchase transactions, effective in March, April, July, October and December and acquired two hospitals through capital lease transactions, effective in April and June, respectively. The consideration for the seven hospitals totaled

2. LONG-TERM LEASES AND PURCHASES OF HOSPITALS (CONTINUED)

$246.9 million. The consideration consisted of $147.6 million in cash, which was borrowed under the acquisition loan facilities and assumed liabilities of $99.3 million. The entire lease obligation relating to each lease transaction was prepaid. The repayment was included as part of the cash consideration. Licensed beds at these seven hospitals totaled 607 beds.

During 1999, the Company acquired, through three purchase transactions, effective in March, September, and November, respectively, and one capital lease transaction, effective in March, most of the assets, including working capital, of four hospitals. The consideration for the four hospitals totaled $77.8 million. The consideration consisted of $59.7 million in cash, which was borrowed under the acquisition loan facilities, and assumed liabilities of $18.1 million. The entire lease obligation relating to the lease transaction was prepaid. The prepayment was included as part of the cash consideration. The Company also constructed and opened an additional hospital at a cost of $15.3 million, which replaced a hospital we managed. Licensed beds at the four hospitals acquired totaled 477.

During 1998, the Company acquired, through two purchase transactions, effective in April and September, respectively, and two capital lease transactions, effective in November, most of the assets, including working capital, of four hospitals. The consideration for the four hospitals totaled $218.6 million. The consideration consisted of $169.8 million in cash, which was borrowed under the acquisition loan facilities, and assumed liabilities of $48.8 million. The entire lease obligation relating to each lease transaction was prepaid. The prepayment was included as part of the cash consideration. Licensed beds at these four hospitals totaled 360.

Also, effective December 1, 1998, the Company entered into an operating agreement relating to, and purchased certain working capital accounts, primarily accounts receivable, supplies and accounts payable, of a 38 licensed bed hospital, for a cash payment of $2.8 million. Pursuant to this agreement, the hospital was acquired on October 1, 2000, with the remaining assets being purchased for $0.9 million and is included in the acquisitions described above.

The foregoing acquisitions were accounted for using the purchase method of accounting. The allocation of the purchase price for acquisition transactions closed in 2000 has been determined by the Company based upon available information and is subject to obtaining final asset valuations prepared by independent appraisers, and settling amounts related to purchased working capital. Independent asset valuations are generally completed within 120 days of the date of acquisition; working capital settlements are generally made within 180 days of the date of acquisition. Adjustments to the purchase price allocation are not expected to be material.

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

	2000	1999	1998
Current assets	$39,844	$15,514	$40,680
Property and equipment	84,512	53,746	116,443
Goodwill	122,585	24,840	61,441

The operating results of the foregoing hospitals have been included in the consolidated statements of operations from their respective dates of acquisition. The following pro forma combined summary of operations of the Company gives effect to using historical information of the operations of the hospitals

2. LONG-TERM LEASES AND PURCHASES OF HOSPITALS (CONTINUED)
purchased in 2000 and 1999 as if the acquisitions had occurred as of January 1, 1999 (in thousands except per share data):

	YEAR ENDED DECEMBER 31,	
	2000	1999
Pro forma net operating revenues	$1,456,867	$1,347,785
Pro forma net income (loss)	6,008	(24,904)
Pro forma net income (loss) per share:		
Basic	$ 0.09	$ (0.46)
Diluted	$ 0.09	$ (0.46)

3. IMPAIRMENT OF LONG-LIVED ASSETS

In December 1998, in connection with the Company's periodic review process, it was determined that primarily as a result of adverse changes in physician relationships, undiscounted cash flows from seven of the Company's hospitals were below the carrying value of long-lived assets associated with those hospitals. Therefore, in accordance with SFAS No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed Of", the Company adjusted the carrying value of the related long-lived assets to their estimated fair value. The estimated fair values of these hospitals were based on independently prepared specific market appraisals. The impairment charge of $164.8 million was comprised of reductions to goodwill of $134.3 million, tangible property of $27.1 million and identifiable intangibles of $3.4 million.

Of the seven impaired hospitals, two are located in Georgia; two are located in Texas; one is located in Florida; one is located in Louisiana; and one is located in Kentucky. The events and circumstances leading to the impairment charge were unique to each of the hospitals.

One of our Kentucky hospitals lost its only anesthesiologist due to unexpected death and a leading surgeon due to illness. We had not been able to successfully recruit a replacement surgeon. One of our Georgia hospitals lost a key surgeon due to unexpected death and a leading specialist due to relocation to another market. We had not been able to successfully recruit replacement physicians. One of our Louisiana hospitals relies heavily on foreign physicians and, following the departure of four foreign physicians from its market over a short period of time, had difficulties replacing these physicians because of regulatory changes in recruiting foreign physicians. The skilled nursing and home health reimbursement for one of our Texas hospitals was disproportionately and adversely affected by the Balanced Budget Act of 1997. In addition, the market in which this hospital operates relies on foreign physicians that have been difficult to recruit because of regulatory changes. Our other Georgia hospitals terminated an employed specialty surgeon who was responsible for over 5% of the hospital's revenue. We had not been able to replace the surgeon. In addition, this hospital's skilled nursing reimbursement was disproportionately and adversely affected by the Balanced Budget Act of 1997. Our other Texas hospital lost market share and was excluded from several key managed care contracts caused by the combination in 1998 of two larger competing hospitals. This is our only hospital which competes with more than one hospital in its primary service area. A Florida hospital we then owned terminated discussions in 1998 with an unrelated hospital, located in a contiguous county, to build a combined replacement facility. The short and long-term success of this hospital was in our view dependent upon the combination being effected.

Generally, we have not experienced difficulty in recruiting physicians and specialists for our hospitals. However, for the four hospitals referred to above we have experienced difficulty in recruiting

3. IMPAIRMENT OF LONG-LIVED ASSETS (CONTINUED)

physicians and specialists where the number of physicians on staff is low. These four hospitals averaged 13 physicians per hospital as of December 31, 1998. The average number of physicians on the medical staff of our other hospitals was 39 physicians at that time. We continually monitor the relationships of our hospitals with their physicians and any physician recruiting requirements. We have frequent discussions with board members, chief executive officers and chief financial officers of our hospitals. We are not aware of any significant adverse relationships with physicians or any recurring physician recruitment needs that, if not resolved in a timely manner, would have a material adverse effect on our results of operations and financial position, either currently or in future periods.

4. INCOME TAXES

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

	YEAR ENDED DECEMBER 31,		
	2000	1999	1998
Current			
Federal	$ 195	$ --	$ --
State	1,328	2,815	1,204
	1,523	2,815	1,204
Deferred			
Federal	16,519	3,163	(11,036)
State	131	(425)	(3,573)
	16,650	2,738	(14,609)
Total provision for (benefit from) income taxes	$18,173	$5,553	$(13,405)

The following table reconciles the differences between the statutory federal income tax rate and the effective tax rate (dollars in thousands):

	YEAR ENDED DECEMBER 31,					
	2000		1999		1998	
	AMOUNT	%	AMOUNT	%	AMOUNT	%
Provision for (benefit from) income taxes at statutory federal rate	$ 9,710	35.0%	$(3,933)	35.0%	$(68,843)	35.0%
State income taxes, net of federal income tax benefit	1,459	5.3	2,389	(21.3)	(1,379)	0.7
Non-deductible goodwill amortization	6,675	24.0	6,751	(60.1)	7,859	(4.0)
Impairment charge - goodwill	--	--	--	--	41,652	(21.2)
Other	329	1.2	346	(3.0)	7,306	(3.7)
Provision for (benefit from) income taxes and effective tax rate	$18,173	65.5%	$ 5,553	(49.4)%	$(13,405)	6.8%

4. INCOME TAXES (CONTINUED)

Deferred income taxes are based on the estimated future tax effects of differences between the financial statement and tax bases of assets and liabilities under the provisions of the enacted tax laws. Deferred income taxes as of December 31, consist of (in thousands):

	2000		1999	
	ASSETS	LIABILITIES	ASSETS	LIABILITIES
Net operating loss and credit carryforwards	$77,316	$ --	$76,798	$ --
Property and equipment	--	54,420	--	40,020
Self-insurance liabilities	6,421	--	6,212	--
Intangibles	--	14,204	--	9,385
Other liabilities	--	736	--	1,828
Long-term debt and interest	--	4,409	--	4,373
Accounts receivable	12,956	--	5,362	--
Accrued expenses	4,140	--	15,975	--
Other	3,259	308	2,538	1,578
	104,092	74,077	106,885	57,184
Valuation allowance	(15,999)	--	(18,474)	--
Total deferred income taxes	$88,093	$74,077	$88,411	$57,184

Management believes that the net deferred tax assets will ultimately be realized, except as noted below. Management's conclusion is based on its estimate of future taxable income and the expected timing of temporary difference reversals. The Company has federal net operating loss carryforwards of $153.4 million which expire from 2001 to 2020 and state net operating loss carryforwards of $284.8 million which expire from 2001 to 2020.

The valuation allowance, which was recognized at the date of the acquisition by affiliates of Forstmann Little & Co. ("FL & Co.") of the operating company of the Company in June 1996 (the "Acquisition") of $13.2 million, relates primarily to state net operating losses and other tax attributes. Any future decrease in this valuation allowance will be recorded as a reduction in goodwill recorded in connection with the Acquisition.

The valuation allowance decreased by $2.5 million and increased by $0.2 million during the years ended December 31, 2000 and 1999, respectively. The decrease relates to a redetermination of the amount, and realizability of net operating losses in certain state income tax jurisdictions for which a valuation allowance was previously provided. The increase is primarily related to net operating losses in certain state income tax jurisdictions not expected to be realized.

The Company paid income taxes, net of refunds received, of $1.5 million, and $1.4 million during 2000 and 1999, respectively.

FEDERAL INCOME TAX EXAMINATIONS. The Internal Revenue Service ("IRS") is examining the Company's federal income tax returns for the tax periods between December 31, 1993 and December 31, 1996. The IRS has indicated that it is considering certain adjustments primarily involving "temporary" or timing differences. To date, a Revenue Agent's Report has not been issued in connection with the examination of these tax periods. In management's opinion, the ultimate outcome of the IRS examination will not have a material effect on the Company's results of operations or financial condition.

5. LONG-TERM DEBT

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

	AS OF DECEMBER 31,	
	2000	1999
Credit Facilities:		
Revolving Credit Loans	$ --	$ 109,750
Acquisition Loans	70,000	138,551
Term Loans	568,679	624,345
Subordinated debentures	500,000	500,000
Taxable bonds	26,100	29,700
Tax-exempt bonds	8,000	8,000
Capital lease obligations (see Note 7)	21,100	20,828
Term loan from acquisition in 2000	21,700	--
Other	3,444	3,459
Total debt	1,219,023	1,434,633
Less current maturities	(17,433)	(27,029)
Total long-term debt	$1,201,590	$1,407,604

CREDIT FACILITIES. In connection with the Acquisition, a $900 million credit agreement was entered into with a consortium of creditors (the "Credit Agreement"). The financing under the Credit Agreement consists of (i) a 6 1/2 year term loan facility (the "Tranche A Loan") in an aggregate principal amount equal to $50 million, (ii) a 7 1/2 year term loan facility (the "Tranche B Loan") in an aggregate principal amount equal to $132.5 million, (iii) an 8 1/2 year term loan facility (the "Tranche C Loan") in an aggregate principal amount equal to $132.5 million, (iv) a 9 1/2 year term loan facility (the "Tranche D Loan") in an original aggregate principal amount equal to $100 million and amended to an aggregate principal amount of $350 million in March 1999 (collectively, the "Term Loans"), (v) a revolving credit facility (the "Revolving Credit Loans") in an aggregate principal amount equal to $200 million, of which up to $90 million may be used, to the extent available, for standby and commercial letters of credit and up to $25 million is available to the Company pursuant to a swingline facility and (vi) a reducing acquisition loan facility (the "Acquisition Loans") in an aggregate principal amount of $285 million, reduced to $263.2 million in July 2000.

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

2001	$ 10,094
2002	47,216
2003	125,360
2004	162,970
2005	223,039
2006	--
Total	$568,679

Revolving Credit Loans may be made, and letters of credit may be issued, at any time during the period between July 22, 1996, the loan origination date (the "Origination Date"), and December 31,

5. LONG-TERM DEBT (CONTINUED)
2002 (the "Termination Date"). No letter of credit is permitted to have an expiration date after the Termination Date. The Acquisition Loans may be made at any time during the period preceding the Termination Date.

The Acquisition Loans facility will automatically be reduced and the Acquisition Loans will be repaid to the following levels on each of the following anniversaries of the Origination Date: July 22, 2001, $215.3 million; July 22, 2002, $139.0 million; with payment of any remaining balance on the Termination Date.

The Company may elect that all or a portion of the borrowings under the Credit Agreement bear interest at a rate per annum equal to (a) an annual benchmark rate, which will be equal to the greatest of (i) "Prime Rate," (ii) the "Base" CD Rate plus 1% or (iii) the Federal Funds effective rate plus 50 basis points (the "ABR") or (b) the Eurodollar Rate, in each case increased by the applicable margin (the "Applicable Margin") which will vary between 1.50% and 3.75% per annum. The applicable margin on the Revolving Credit Loans, Acquisition Loans and Tranche A Loan is subject to a reduction based on achievement of certain levels of total senior indebtedness to annualized consolidated EBITDA, as defined in the Credit Agreement. To date, the Company has not achieved a reduction of the Applicable Margin.

Interest based on the ABR is payable on the last day of each calendar quarter and interest based on the Eurodollar Rate is payable on set maturity dates. The borrowings under the Credit Agreement bore interest at rates ranging from 9.13% to 10.38% as of December 31, 2000.

The Company is also required to pay a quarterly commitment fee at a rate which ranges from .375% to .500% based on the Eurodollar Applicable Margin for Revolving Credit Loans. This rate is applied to unused commitments under the Revolving Credit Loans and the Acquisition Loans.

The Company is also required to pay letters of credit fees at rates which vary from 1.625% to 2.625%.

All or a portion of the outstanding borrowings under the Credit Agreement may be prepaid at any time and the unutilized portion of the facility for the Revolving Credit Loans or the Acquisition Loans may be terminated, in whole or in part, at the Company's option. Repaid Term Loans and permanent reductions to the Acquisition Loans and Revolving Credit Loans may not be reborrowed.

Credit Facilities generally are required to be prepaid with the net proceeds (in excess of $20 million) of certain permitted asset sales and the issuances of debt obligations (other than certain permitted indebtedness) of the Company or any of its subsidiaries.

Generally, prepayments of Term Loans will be applied to principal payments due during the next twelve months with any excess being applied pro rata to scheduled principal payments thereafter.

The terms of the Credit Agreement include certain restrictive covenants. These covenants include restrictions on indebtedness, investments, asset sales, capital expenditures, dividends, sale and leasebacks, contingent obligations, transactions with affiliates, and fundamental change. The covenants also require maintenance of certain ratios regarding senior indebtedness, senior interest, and fixed charges. The Company was in compliance with all debt covenants at December 31, 2000.

As of December 31, 2000 and 1999, the Company had letters of credit issued, primarily in support of its Taxable Bonds and Tax-Exempt Bonds, of approximately $40 million and $43 million, respectively.

5. LONG-TERM DEBT (CONTINUED)

Availability at December 31, 2000 and 1999 under the Revolving Credit Loans facility was approximately $160 million and $47 million, respectively and under the Acquisition Loans facility was approximately $193 million and $144 million, respectively.

SUBORDINATED DEBENTURES. In connection with the Acquisition, the Company issued its subordinated debentures to an affiliate of FL & Co. for $500 million in cash. The debentures are a general senior subordinated obligation of the Company, are not subject to mandatory redemption and mature in three equal annual installments beginning June 30, 2007, with the final payment due on June 30, 2009. The debentures bear interest at a fixed rate of 7.50% which is payable semi-annually in January and July. Total interest expense for the debentures was $37.5 million for each of the years ended December 31, 2000, 1999 and 1998.

TAXABLE BONDS AND TAX-EXEMPT BONDS. Taxable Bonds bear interest at a floating rate which averaged 6.40% and 5.29% during 2000 and 1999, respectively. These bonds are subject to mandatory annual redemptions with the final payment of $17.4 million due on October 1, 2003. Tax-Exempt Bonds bear interest at floating rates which averaged 4.21% and 3.36% during 2000 and 1999, respectively. These bonds are not subject to mandatory annual redemptions under the bond provisions and are due in 2010. Taxable Bonds and Tax-Exempt Bonds are both guaranteed by letters of credit.

TERM LOAN FROM ACQUISITION IN 2000. The Company acquired a hospital in December 2000, in which we assumed debt upon acquisition, through an amended and restated credit agreement dated December 1, 2000. The loan bears interest at a rate of 9.18% as of December 31, 2000 and has the same terms as the Tranche A Term Loan in the "Credit Agreement", previously described. Required principal payments are as follows: $1,350,000 in 2001, $1,875,000 in 2002 and $18,475,000 in 2003.

OTHER DEBT. As of December 31, 2000, other debt consisted primarily of an industrial revenue bond and other obligations maturing in various installments through 2014.

As of December 31, 2000, the scheduled maturities of long-term debt outstanding, including capital leases, for each of the next five years and thereafter are as follows (in thousands):

2001	$ 17,433
2002	126,166
2003	165,549
2004	164,090
2005	224,118
Thereafter	521,667
	$1,219,023

The Company paid interest of $115 million, $118 million and $101 million on borrowings during the years ended December 31, 2000, 1999 and 1998, respectively.

6. FAIR VALUES OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Company using available market information as of December 31, 2000 and 1999, and valuation methodologies considered appropriate.

6. FAIR VALUES OF FINANCIAL INSTRUMENTS (CONTINUED)
The estimates presented are not necessarily indicative of amounts the Company could realize in a current market exchange (in thousands):

	AS OF DECEMBER 31,			
	2000		1999	
	CARRYING AMOUNT	ESTIMATED FAIR VALUE	CARRYING VALUE	ESTIMATED FAIR VALUE
Assets:				
Cash and cash equivalents	$13,740	$13,740	$ 4,282	$ 4,282
Liabilities:				
Credit facilities	638,679	633,506	872,646	862,174
Taxable Bonds	26,100	26,100	29,700	29,700
Tax-exempt Bonds	8,000	8,000	8,000	8,000
Other term loans	21,700	21,483	--	--

Cash and cash equivalents: The carrying amount approximates fair value due to the short term maturity of these instruments (less than three months).

Credit facilities and other term loans: Estimated fair value is based on communications with the Company's bankers regarding relevant pricing for trading activity among the Company's lending institutions.

Taxable and Tax-exempt Bonds: The carrying amount approximates fair value as a result of the weekly interest rate reset feature of these publicly traded instruments.

The Company believes that it is not practicable to estimate the fair value of the subordinated debentures because of (i) the fact that the subordinated debentures were issued in connection with the issuance of the original equity of the Company at the date of Acquisition as an investment unit, (ii) the related party nature of the subordinated debentures, (iii) the lack of comparable securities, and (iv) the lack of a credit rating of the Company by an established rating agency.

7. LEASES

The Company leases hospitals, medical office buildings, and certain equipment under capital and operating lease agreements. All lease agreements generally require the Company to pay maintenance, repairs, property taxes and insurance costs. Commitments relating to noncancellable operating and capital leases for each of the next five years and thereafter are as follows (in thousands):

YEAR ENDED DECEMBER 31,	OPERATING	CAPITAL
2001	$ 24,141	$ 5,715
2002	21,073	4,738
2003	19,379	3,706
2004	17,160	2,773
2005	11,943	2,311
Thereafter	72,376	23,999
Total minimum future payments	$166,072	43,242
Less debt discounts		(22,142)
		21,100
Less current portion		(2,290)
Long-term capital lease obligations		$18,810

7. LEASES (CONTINUED)

Assets capitalized under capital leases as reflected in the accompanying consolidated balance sheets were $9.9 million of land and improvements, $73.3 million of buildings and improvements, and $35.5 million of equipment and fixtures as of December 31, 2000 and $5.8 million of land and improvements, $55.7 million of buildings and improvements and $19.2 million of equipment and fixtures as of December 31, 1999. The accumulated depreciation related to assets under capital leases was $26.4 million and $15.1 million as of December 31, 2000 and 1999, respectively. Depreciation of assets under capital leases is included in depreciation and amortization and amortization of debt discounts on capital lease obligations is included in interest expense in the consolidated statements of operations.

8. EMPLOYEE BENEFIT PLANS

The Company has a defined contribution plan that is qualified under Section 401(k) of the Internal Revenue Code, which covers all eligible employees at its hospitals, clinics, and the corporate offices. Participants may contribute a portion of their compensation not exceeding a limit set annually by the Internal Revenue Service. This plan includes a provision for the Company to match a portion of employee contributions. The Company also provides a defined contribution welfare benefit plan for post-termination benefits to executive and middle management employees. Total expense under the 401(k) plan was $2.8 million, $2.9 million and $2.2 million for the years ended December 31, 2000, 1999 and 1998, respectively. Total expense under the welfare benefit plan was $0.7 million, $0.8 million and $0.9 million for the years ended December 31, 2000, 1999 and 1998, respectively.

9. STOCKHOLDERS' EQUITY

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

Authorized capital shares of the Company include 400,000,000 shares of capital stock consisting of 300,000,000 shares of common stock and 100,000,000 shares of Preferred Stock. Each of the aforementioned classes of capital stock has a par value of $.01 per share. Shares of Preferred Stock, none of which are outstanding as of December 31, 2000, may be issued in one or more series having such rights, preferences and other provisions as determined by the Board of Directors without approval by the holders of common stock.

Common shares held by employees that were acquired directly from the Company are the subject of a stockholder's agreement under which each share, until vested, is subject to repurchase, upon termination of employment. Shares vest, on a cumulative basis, each year at a rate of 20% of the total shares issued beginning after the first anniversary date of the purchase. Further, under the stockholder's agreement shares of common stock held by stockholders other than FL&Co. will only be transferable together with shares transferred by FL&Co. until FL&Co.'s ownership falls below 25%.

During 1997, the Company granted options to purchase 191,614 shares of common stock to non-employee directors at an exercise price of $8.96 per share. One-third of such options are

9. STOCKHOLDERS' EQUITY (CONTINUED)
exercisable each year on a cumulative basis beginning on the first anniversary of the date of grant and expiring ten years from the date of grant. As of December 31, 2000, 178,839 non-employee director options to purchase common stock were exercisable with a weighted average remaining contractual life of 6.5 years.

In November 1996, the Board of Directors approved an Employee Stock Option Plan (the "1996 Plan") to provide incentives to key employees of the Company. Options to purchase up to 756,636 shares of common stock are authorized under the 1996 Plan. All options granted pursuant to the 1996 Plan are generally exercisable each year on a cumulative basis at a rate of 20% of the total number of common shares covered by the option beginning one year from the date of grant and expiring ten years from the date of grant. There will be no additional grants of options under the 1996 Plan.

In April 2000, the Board of Directors approved the 2000 Stock Option and Award Plan (the "2000 Plan"). The 2000 Plan provides for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code as well as stock options which do not so qualify, stock appreciation rights, restricted stock, performance units and performance shares, phantom stock awards and share awards. Persons eligible to receive grants under the 2000 Plan include the Company's directors, officers, employees and consultants. Options to purchase 4,562,791 shares of common stock are authorized under the 2000 Plan. All options granted pursuant to the 2000 Plan are generally exercisable each year on a cumulative basis at a rate of 33 1/3% of the total number of common shares covered by the option beginning on the first anniversary of the date of grant and expiring ten years from the date of grant. As of December 31, 2000, there were 3,917,500 options granted and 645,291 shares of unissued common stock reserved for future grants under the 2000 Plan.

The options granted are "nonqualified" for tax purposes. For financial reporting purposes, the exercise price of certain option grants under the 1996 plan were considered to be below the fair value of the stock at the time of grant. The fair value of those grants was determined based on an appraisal conducted by an independent appraisal firm as of the relevant date. Options granted under the 2000 Plan were granted to employees at the fair value of the related stock. The aggregate differences between fair value and the exercise price is being charged to compensation expense over the relevant vesting periods. Such expense aggregated $74,000 and $83,000 in 2000 and 1999, respectively.

9. STOCKHOLDERS' EQUITY (CONTINUED)

A summary of the number of shares of common stock issuable upon the exercise of options under the Company's 1996 Plan and 2000 Plan for fiscal 2000, 1999 and 1998 and changes during those years is presented below:

	SHARES	PRICE RANGE	WEIGHTED AVERAGE PRICE
Balance at December 31, 1997	431,282	$ 6.99	$ 6.99
Granted	299,292	6.99	6.99
Exercised	--	--	--
Forfeited or canceled	(119,801)	6.99	6.99
Balance at December 31, 1998	610,773	$ 6.99	$ 6.99
Granted	90,376	6.99	6.99
Exercised	--	--	--
Forfeited or canceled	(150,907)	6.99	6.99
Balance at December 31, 1999	550,242	$ 6.99	$ 6.99
Granted	3,943,000	13.00-31.70	13.69
Exercised	(78,284)	6.99	6.99
Forfeited or canceled	(83,927)	6.99-20.06	9.40
Balance at December 31, 2000	4,331,031	$ 6.99-31.70	$13.05

The following table summarizes information concerning currently outstanding and exercisable options:

OPTIONS OUTSTANDING				OPTIONS EXERCISABLE	
RANGE OF EXERCISE PRICES	NUMBER OUTSTANDING	WEIGHTED AVERAGE REMAINING CONTRACTUAL LIFE	WEIGHTED AVERAGE EXERCISE PRICE	NUMBER EXERCISABLE	WEIGHTED AVERAGE EXERCISE PRICE
$ 6.99	413,531	6.8 years	$ 6.99	153,668	$6.99
$13.00-31.70	3,917,500	9.5 years	$13.69	--	--

Under SFAS No. 123, the fair value of each option grant is estimated on the date of grant using the Black-Scholes option-pricing model. The weighted-average fair value of each option granted during 2000, 1999 and 1998 were $6.11, $5.10 and $2.05, respectively. In 2000 and 1998, the exercise price of options granted was the same as the fair value of the related stock. In 1999, the exercise price of options granted was less than the fair value of the related stock. The following weighted-average assumptions were used for grants in fiscal 2000, 1999 and 1998: risk-free interest rate of 6.46%, 5.49% and 5.14%; expected volatility of the Company's common stock based on peer companies in the healthcare industry of 58%, 45% and 34%, respectively; no dividend yields; and weighted-average expected life of the options of 3 years for all years.

Had the fair value of the options granted been recognized as compensation expense on a straight-line basis over the vesting period of the grant, the Company's net income (loss) and income

9. STOCKHOLDERS' EQUITY (CONTINUED)
(loss) per share would have been reduced to the pro forma amounts indicated below (in thousands except per share data):

	2000	1999	1998
Pro forma net income (loss)	$6,907	$(17,010)	$(183,513)
Pro forma net income (loss) per share:			
Basic	$ 0.10	$ (0.31)	$ (3.38)
Diluted	$ 0.10	$ (0.31)	$ (3.38)

10. EARNINGS PER SHARE

The following table sets forth the computation of basic and diluted net income (loss) per share (in thousands, except share data):

	YEAR ENDED DECEMBER 31,		
	2000	1999	1998
NUMERATOR:			
Income (loss) before cumulative effect of a change in accounting principle	$ 9,569	$ (16,789)	$ (182,938)
Cumulative effect of a change in accounting principle	--	--	(352)
Net income (loss) available to common -- basic and diluted	$ 9,569	$ (16,789)	$ (183,290)
DENOMINATOR:			
Weighted-average number of shares outstanding -- basic	67,610,399	54,545,030	54,249,895
Effect of dilutive securities:			
Non-employee director options	54,885	--	--
Unvested common shares	802,471	--	--
Employee options	719,436	--	--
Weighted-average number of shares outstanding -- diluted	69,187,191	54,545,030	54,249,895
Dilutive securities outstanding not included in the computation of earnings (loss) per share because their effect is antidilutive:			
Non-employee director options	--	191,614	191,614
Unvested common shares	--	1,031,734	1,239,902
Employee options	--	550,242	610,773

11. ACCOUNTING CHANGE

In 1998, the Company adopted The American Institute of Certified Public Accountants Statement of Position 98-5, "Reporting on the Costs of Start-Up Activities," which affects the accounting for start-up costs. The change involved expensing these costs as incurred, rather than capitalizing and subsequently amortizing such costs. The cumulative effect of the change on the accumulated deficit as of the beginning of 1998 is reflected as a charge of $0.5 million ($0.4 million net of taxes) to 1998 earnings.

12. COMMITMENTS AND CONTINGENCIES

CONSTRUCTION COMMITMENTS. As of December 31, 2000, the Company has obligations under certain hospital purchase agreements to construct four hospitals through 2005 with an aggregate estimated construction cost, including equipment, of approximately $120 million.

PROFESSIONAL LIABILITY RISKS. Substantially all of the Company's professional and general liability risks are subject to a $0.5 million per occurrence deductible (with an annual deductible cap of $5 million). The Company's insurance is underwritten on a "claims-made basis." The Company accrues an estimated liability for its uninsured exposure and self-insured retention based on historical loss patterns and actuarial projections. The Company's estimated liability for the self-insured portion of professional and general liability claims was $16.6 million and $16.4 million as of December 31, 2000 and 1999, respectively. These estimated liabilities represent the present value of estimated future professional liability claims payments based on expected loss patterns using a discount rate of 5.77% and 5.72% in 2000 and 1999, respectively. The discount rate is based on an estimate of the risk-free interest rate for the duration of the expected claim payments. The estimated undiscounted claims liability was $19.5 million and $18.9 million as of December 31, 2000 and 1999, respectively. The effect of discounting professional and general liability claims was a $0.3 million increase to expense in 2000 and $0.1 million decrease in 1999 and 1998.

COMPLIANCE SETTLEMENT AND YEAR 2000 REMEDIATION COSTS. In 1997, the Company initiated a voluntary review of its inpatient medical records in order to determine the extent it may have had coding inaccuracies under certain government programs. At December 31, 1998, an estimate of the costs of these coding inaccuracies settlement was accrued based on information available and additional costs were accrued at December 31, 1999. In March 2000, the Company reached a settlement with appropriate governmental agencies pursuant to which the Company paid approximately $31.8 million to settle potential liabilities related to coding inaccuracies occurring from October 1993 through September 1997. Year 2000 remediation costs totaled $3.3 million and $0.2 million for 1999 and 1998, respectively.

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

13. RELATED PARTY TRANSACTIONS

Notes receivable for common shares held by employees, as disclosed on the consolidated balance sheets, represent the outstanding balance of notes accepted by the Company as partial payment for the purchase of the common shares from senior management employees. These notes bear interest at 6.84%, are full recourse promissory notes and are secured by the shares to which they relate. Each of the full recourse promissory notes mature on the fifth anniversary date of the note, with accelerated maturities in case of employee termination, Company stock repurchases, or stockholder's sale of common stock. Employees have fully paid for purchases of common stock by cash or by a combination of cash and full recourse promissory notes.

The Company purchased marketing services and materials at a cost of $239,400 and $268,000 in 2000 and 1999, respectively, from a company owned by the spouse of one of the Company's officers.

13. RELATED PARTY TRANSACTIONS (CONTINUED)

In 1996, in connection with the Company's relocation from Houston to Nashville, the Company provided a $100,000 non-interest bearing loan to one of its executives. This loan was repaid on December 13, 2000.

14. QUARTERLY FINANCIAL DATA (UNAUDITED)

	QUARTER				
	1ST	2ND	3RD	4TH	TOTAL
	(IN THOUSANDS, EXCEPT SHARE AND PER SHARE DATA)				
2000					
Net operating revenues	$ 308,651	$ 317,136	$ 342,447	$ 369,267	$1,337,501
Income before taxes	4,850	3,413	5,163	14,316	27,742
Net income	921	178	1,258	7,212	9,569
Net income per share:					
Basic	0.02	--	0.02	0.09	0.14
Diluted	0.02	--	0.02	0.09	0.14
Weighted average number of shares:					
Basic	54,634,285	58,175,050	75,120,860	81,717,585	67,610,399
Diluted	55,838,214	59,310,601	77,193,350	84,067,319	69,187,191
1999					
Net operating revenues	$ 263,004	$ 261,821	$ 266,896	$ 288,232	$1,079,953
Income (loss) before taxes	6,498	254	(4,036)	(13,952)	(11,236)
Net income (loss)	1,918	(1,843)	(4,427)	(12,437)	(16,789)
Net income (loss) per share:					
Basic	0.04	(0.03)	(0.08)	(0.23)	(0.31)
Diluted	0.03	(0.03)	(0.08)	(0.23)	(0.31)
Weighted average number of shares:					
Basic	54,439,895	54,517,660	54,495,334	54,459,838	54,545,030
Diluted	55,632,718	54,517,660	54,495,334	54,459,838	54,545,030

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

PART III

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF THE REGISTRANT

The information required by this Item is incorporated herein by reference to the Company's proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of Stockholders of the Company scheduled to be held on May 22, 2001 under "Election of Directors", no later than 120 days after the end of the year of the Company's fiscal year.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this Item is incorporated herein by reference to the Company's proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of the Stockholders of the Company scheduled to be held on May 22, 2001 under "Executive Compensation", no later than 120 days after the end of the Company's fiscal year.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

The information required by this Item is incorporated herein by reference to the Company's proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of Stockholders of the Company scheduled to be held on May 22, 2001 under "Security Ownership of Certain Beneficial Owners and Management", no later than 120 days after the end of the Company's fiscal year.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

The information required by this Item is incorporated herein by reference to the Company's proxy statement to be filed under Regulation 14A in connection with the Annual Meeting of Stockholders of the Company to be held on May 22, 2001 under "Certain Transactions", scheduled no later than 120 days after the end of the Company's fiscal year.

PART IV

ITEM 14. EXHIBITS, FINANCIAL STATEMENT SCHEDULES, AND REPORTS ON FORM 8-K

Item 14(a)(1), 14(a)(2) and 14(d):

The following financial statement schedule is filed as part of this Report at page 64 hereof:

Schedule II--Valuation and Qualifying Accounts

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

Item 14(a)(3) and 14(c):

The following exhibits are filed with this Report.

NO.	DESCRIPTION
2.1	Agreement and Plan of Merger between the Registrant, FLCH Acquisition Corp. and Community Health Systems, Inc., dated on June 9, 1996 (incorporated by reference to Exhibit 2.1 to the Company's Registration Statement on Form S-1 (No. 333-7190))

NO.	DESCRIPTION
3.1	Form of Restated Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1 to the Company's Registration Statement on Form S-1 (No. 333-7190))
3.2	Form of Restated By-laws of the Registrant *
4.1	Form of Common Stock Certificate (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.1	Form of outside director Stock Option Agreement (incorporated by reference to Exhibit 10.1 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.2	Form of Stockholder's Agreement between the Registrant and outside directors (incorporated by reference to Exhibit 10.2 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.3	Form of Employee Stockholder's Agreement (incorporated by reference to Exhibit 10.3 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.4	The Registrant's Employee Stock Option Plan and form of Stock Option Agreement (incorporated by reference to Exhibit 10.4 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.5	The Registrant's 2000 Stock Option and Award Plan (incorporated by reference to Exhibit 10.5 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.6	Form of Stockholder's Agreement between the Registrant and employees (incorporated by reference to Exhibit 10.6 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.7	Registration Rights Agreement, dated July 9, 1996, among the Registrant, FLCH Acquisition Corp., Forstmann Little & Co. Equity Partnership -- V, L.P. and Forstmann Little & Co. Subordinated Debt and Equity Management Buyout Partnership -- VI, L.P. (incorporated by reference to Exhibit 10.7 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.8	Form of Indemnification Agreement between the Registrant and its directors and executive officers (incorporated by reference to Exhibit 10.8 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.9	Amended and Restated Credit Agreement, dated as of March 26, 1999, among Community Health Systems, Inc., the Registrant, certain lenders, The Chase Manhattan Bank, as Administrative Agent, and Nationsbank, N.A. and The Bank of Nova Scotia, as Co-Agents (incorporated by reference to Exhibit 10.9 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.10	First Amendment, dated February 24, 2000, to the Amended and Restated Credit Agreement, dated as of March 26, 1999, among Community Health Systems, Inc., the Registrant, certain lenders, The Chase Manhattan Bank, as Administrative Agent, and Nationsbank, N.A. and The Bank of Nova Scotia, as Co-Agents (incorporated by reference to Exhibit 10.10 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.11	Form of Management Rights Letter between Registrant and the partnerships affiliated with Forstmann Little & Co. (incorporated by reference to Exhibit 10.11 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.12	Form of Series A 7 1/2% Subordinated Debenture (incorporated by reference to Exhibit 10.12 to the Company's Registration Statement on Form S-1 (No. 333-7190))

NO.	DESCRIPTION
10.13	Form of Series B 7 1/2% Subordinated Debenture (incorporated by reference to Exhibit 10.13 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.14	Form of Series C 7 1/2% Subordinated Debenture (incorporated by reference to Exhibit 10.14 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.15	Corporate Compliance Agreement between the Office of Inspector General of the Department of Health and Human Services and the Registrant (incorporated by reference to Exhibit 10.15 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.16	Tenet BuyPower Purchasing Assistance Agreement, dated June 13, 1997, between Community Health Systems, Inc. and Tenet HealthSystem Inc., Addendum, dated September 19, 1997 and First Amendment, dated March 15, 2000 (incorporated by reference to Exhibit 10.16 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.17	The Registrant's 2000 Employee Stock Purchase Plan (incorporated by reference to Exhibit 10.17 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.18	Settlement Agreement between the United States of America, the states of Illinois, New Mexico, South Carolina, Tennessee, Texas, West Virginia and the Registrant (incorporated by reference to Exhibit 10.18 to the Company's Registration Statement on Form S-1 (No. 333-7190))
21	List of subsidiaries (incorporated by reference to Exhibit 21 to the Company's Registration Statement on Form S-1 (No. 333-47354))
23.1	Consent of Deloitte & Touche LLP*

- ------------------------

* Filed herewith.

Item 14(b):

During the last quarter of the year ended December 31, 2000, the Registrant did not file a Current Report on Form 8-K.

SIGNATURES

Pursuant to the requirements section 13 or 15(d) of the Securities Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, in the City of Brentwood, State of Tennessee, on the 29th day of March, 2001.

COMMUNITY HEALTH SYSTEMS, INC.

By: /s/ WAYNE T. SMITH
Wayne T. Smith
CHARIMAN OF THE BOARD
PRESIDENT AND CHIEF EXECUTIVE OFFICER

Pursuant to the requirements of the Securities Act of 1933, this Report has been signed below by the following persons in the capacities indicated.

NAME	TITLE	DATE
/s/ WAYNE T. SMITH Wayne T. Smith	President and Chief Executive Officer and Director (principal executive officer)	March 29, 2001
/s/ W. LARRY CASH W. Larry Cash	Executive Vice President and Chief Financial Officer (principal financial officer)	March 29, 2001
/s/ T. MARK BUFORD T. Mark Buford	Vice President and Corporate Controller (principal accounting officer)	March 29, 2001
/s/ SHEILA P. BURKE Sheila P. Burke	Director	March 29, 2001
/s/ ROBERT J. DOLE Robert J. Dole	Director	March 29, 2001
/s/ J. ANTHONY FORSTMANN J. Anthony Forstmann	Director	March 29, 2001
/s/ THEODORE J. FORSTMANN Theodore J. Forstmann	Director	March 29, 2001
/s/ DALE F. FREY Dale F. Frey	Director	March 29, 2001
/s/ SANDRA J. HORBACH Sandra J. Horbach	Director	March 29, 2001
/s/ THOMAS H. LISTER Thomas H. Lister	Director	March 29, 2001
/s/ MICHAEL A. MILES Michael A. Miles	Director	March 29, 2001

INDEPENDENT AUDITORS' REPORT

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

We have audited the consolidated financial statements of Community Health Systems, Inc. and subsidiaries as of December 31, 2000 and 1999, and for each of the three years in the period ended December 31, 2000, and have issued our report thereon dated February 20, 2001 (included elsewhere in this Annual Report). Our audits also included the consolidated financial statement schedule listed in Item 14 of this Annual Report on Form 10-K. This consolidated financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, such consolidated financial statement schedule, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 20, 2001

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
SCHEDULE II--VALUATION AND QUALIFYING ACCOUNTS

(IN THOUSANDS)

DESCRIPTION	BALANCE AT BEGINNING OF YEAR	CHARGED TO COSTS AND EXPENSES	WRITE-OFFS	BALANCE AT END OF YEAR
Year ended December 31, 2000 allowance for doubtful accounts	$34,499	$122,303	$(103,867)	$52,935
Year ended December 31, 1999 allowance for doubtful accounts	28,771	95,149	(89,421)	34,499
Year ended December 31, 1998 allowance for doubtful accounts	20,873	69,005	(61,107)	28,771

EXHIBIT INDEX

NO.	DESCRIPTION
2.1	Agreement and Plan of Merger between the Registrant, FLCH Acquisition Corp. and Community Health Systems, Inc., dated on June 9, 1996 (incorporated by reference to Exhibit 2.1 to the Company's Registration Statement on Form S-1 (No. 333-7190))
3.1	Form of Restated Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1 to the Company's Registration Statement on Form S-1 (No. 333-7190))
3.2	Form of Restated By-laws of the Registrant*
4.1	Form of Common Stock Certificate (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.1	Form of outside director Stock Option Agreement (incorporated by reference to Exhibit 10.1 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.2	Form of Stockholder's Agreement between the Registrant and outside directors (incorporated by reference to Exhibit 10.2 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.3	Form of Employee Stockholder's Agreement (incorporated by reference to Exhibit 10.3 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.4	The Registrant's Employee Stock Option Plan and form of Stock Option Agreement (incorporated by reference to Exhibit 10.4 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.5	The Registrant's 2000 Stock Option and Award Plan (incorporated by reference to Exhibit 10.5 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.6	Form of Stockholder's Agreement between the Registrant and employees (incorporated by reference to Exhibit 10.6 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.7	Registration Rights Agreement, dated July 9, 1996, among the Registrant, FLCH Acquisition Corp., Forstmann Little & Co. Equity Partnership -- V, L.P. and Forstmann Little & Co. Subordinated Debt and Equity Management Buyout Partnership -- VI, L.P. (incorporated by reference to Exhibit 10.7 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.8	Form of Indemnification Agreement between the Registrant and its directors and executive officers (incorporated by reference to Exhibit 10.8 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.9	Amended and Restated Credit Agreement, dated as of March 26, 1999, among Community Health Systems, Inc., the Registrant, certain lenders, The Chase Manhattan Bank, as Administrative Agent, and Nationsbank, N.A. and The Bank of Nova Scotia, as Co-Agents (incorporated by reference to Exhibit 10.9 to the Company's Registration Statement on Form S-1 (No. 333-7190))

NO.	DESCRIPTION
10.10	First Amendment, dated February 24, 2000, to the Amended and Restated Credit Agreement, dated as of March 26, 1999, among Community Health Systems, Inc., the Registrant, certain lenders, The Chase Manhattan Bank, as Administrative Agent, and Nationsbank, N.A. and The Bank of Nova Scotia, as Co-Agents (incorporated by reference to Exhibit 10.10 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.11	Form of Management Rights Letter between Registrant and the partnerships affiliated with Forstmann Little & Co. (incorporated by reference to Exhibit 10.11 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.12	Form of Series A 7 1/2% Subordinated Debenture (incorporated by reference to Exhibit 10.12 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.13	Form of Series B 7 1/2% Subordinated Debenture (incorporated by reference to Exhibit 10.13 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.14	Form of Series C 7 1/2% Subordinated Debenture (incorporated by reference to Exhibit 10.14 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.15	Corporate Compliance Agreement between the Office of Inspector General of the Department of Health and Human Services and the Registrant (incorporated by reference to Exhibit 10.15 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.16	Tenet BuyPower Purchasing Assistance Agreement, dated June 13, 1997, between Community Health Systems, Inc. and Tenet HealthSystem Inc., Addendum, dated September 19, 1997 and First Amendment, dated March 15, 2000 (incorporated by reference to Exhibit 10.16 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.17	The Registrant's 2000 Employee Stock Purchase Plan (incorporated by reference to Exhibit 10.17 to the Company's Registration Statement on Form S-1 (No. 333-7190))
10.18	Settlement Agreement between the United States of America, the states of Illinois, New Mexico, South Carolina, Tennessee, Texas, West Virginia and the Registrant (incorporated by reference to Exhibit 10.18 to the Company's Registration Statement on Form S-1 (No. 333-7190))
21	List of subsidiaries (incorporated by reference to Exhibit 21 to the Company's Registration Statement on Form S-1 (No. 333-47354))
23.1	Consent of Deloitte & Touche LLP*

- ------------------------

* Filed herewith.

EXHIBIT 3.2

AMENDED AND RESTATED BY-LAWS

OF

COMMUNITY HEALTH SYSTEMS, INC.

(hereinafter called the "Corporation")

(As of February 21, 2001)

ARTICLE I

OFFICES

SECTION 1. REGISTERED OFFICE. The registered office of the Corporation within the State of Delaware shall be in the City of Wilmington, County of New Castle.

SECTION 2. OTHER OFFICES. The Corporation may also have an office or offices other than said registered office at such place or places, either within or without the State of Delaware, as the Board of Directors shall from time to time determine or the business of the Corporation may require.

ARTICLE II

MEETINGS OF STOCKHOLDERS

SECTION 1. PLACE OF MEETINGS. All meetings of the stockholders for the election of directors or for any other purpose shall be held at any such time and place, either within or without the State of Delaware as shall be designated from time to time by the Board of Directors and stated in the notice of the meeting or in a duly executed waiver of notice thereof.

SECTION 2. ANNUAL MEETINGS. Annual meetings of stockholders shall be held on such date and at such time as shall be designated from time to time by the Board of Directors and stated in the notice of the meeting or in a duly executed waiver thereof. At such annual meetings, the stockholders shall elect by a plurality vote the directors standing for election and transact such other business as may properly be brought before the meeting in accordance with these Restated By-Laws.

SECTION 3. SPECIAL MEETINGS. Special meetings of stockholders, for any purpose or purposes, unless otherwise prescribed by statute may be called by the Board of Directors, the Chairman of the Board of Directors, if one shall have been elected, or the President.

SECTION 4. NOTICE OF MEETINGS. Except as otherwise expressly required by statute, notice of each annual and special meeting of stockholders stating the date, place and hour of the meeting, and, in the case of a special meeting, the purpose or purposes for which the meeting is called, shall be given to each stockholder of record entitled to vote thereat not less than ten nor more than sixty days before the date of the meeting. Business transacted at any special

meeting of stockholders shall be limited to the purposes stated in the notice. Notice of any meeting shall not be required to be given to any person who attends such meeting (except when such person attends the meeting in person or by proxy for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because the meeting is not lawfully called or convened) or who, either before or after the meeting, shall submit a signed written waiver of notice, in person or by proxy. Neither the business to be transacted at, nor the purpose of, an annual or special meeting of stockholders need be specified in any written waiver of notice.

SECTION 5. ORGANIZATION. At each meeting of stockholders, the Chairman of the Board, if one shall have been elected, or, in the event of such person's absence or if one shall not have been elected, the President, shall act as chairman of the meeting. The Secretary or, in the event of such person's absence or inability to act, the person whom the chairman of the meeting shall appoint secretary of the meeting, shall act as secretary of the meeting and keep the minutes thereof.

SECTION 6. CONDUCT OF BUSINESS. The chairman of any meeting of stockholders shall determine the order of business and the procedure at the meeting, including such regulation of the manner of voting and the conduct of discussion as seems to him or her in order. The date and time of the opening and closing of the polls for each matter upon which the stockholders will vote at a meeting shall be announced at the meeting.

SECTION 7. QUORUM, ADJOURNMENTS. The holders of a majority of the voting power of the issued and outstanding shares of capital stock of the Corporation entitled to vote thereat, present in person or represented by proxy, shall constitute a quorum for the transaction of business at all meetings of stockholders, except as otherwise provided by statute or by the Restated Certificate of Incorporation. If, however, such quorum shall not be present or represented by proxy at any meeting of stockholders, the stockholders entitled to vote thereat, present in person or represented by proxy, shall have the power to adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present or represented by proxy. At such adjourned meeting at which a quorum shall be present or represented by proxy, any business may be transacted which might have been transacted at the meeting as originally called. If the adjournment is for more than thirty days, or, if after adjournment a new record date is set, a notice of the adjourned meeting shall be given to each stockholder of record entitled to vote at the meeting.

SECTION 8. VOTING. Except as otherwise provided by statute or the Restated Certificate of Incorporation and these Restated By-Laws, each stockholder of the Corporation shall be entitled at each meeting of stockholders to one vote for each share of capital stock of the Corporation standing in such stockholder's name on the record of stockholders of the Corporation:

(a) on the date fixed pursuant to the provisions of Section 7 of Article V of these Restated By-Laws as the record date for the determination of the stockholders who shall be entitled to notice of and to vote at such meeting; or

(b) if no such record date shall have been so fixed, then at the close of business on the day next preceding the day on which notice thereof shall be given,

or, if notice is waived, at the close of business on the date next preceding the day on which the meeting is held.

Each stockholder entitled to vote at any meeting of stockholders may authorize another person or persons to act for such stockholder by a proxy signed by such stockholder or such stockholder's attorney-in-fact, or as otherwise authorized in accordance with the Delaware General Corporation Law, but no proxy shall be voted after three years from its date, unless the proxy provides for a longer period. Any such proxy shall be delivered to the secretary of the meeting at or prior to the time designated in the order of business for so delivering such proxies. When a quorum is present at any meeting, the affirmative vote of the holders of a majority of the voting power of the shares of the Corporation which are present in person or represented by proxy at the meeting and entitled to vote thereon, shall decide any question brought before such meeting, unless the question is one upon which by express provision of statute or of the Restated Certificate of Incorporation or of these Restated By-Laws, a different vote is required, in which case such express provision shall govern and control the decision of such question. Unless required by statute, or determined by the chairman of the meeting to be advisable, the vote on any question need not be by ballot. On a vote by ballot, each ballot shall be signed by the stockholder voting, or by such stockholder's proxy, if there be such proxy.

SECTION 9. LIST OF STOCKHOLDERS ENTITLED TO VOTE. At least ten days before each meeting of stockholders, a complete list of the stockholders entitled to vote at the meeting, arranged in alphabetical order, and showing the address of each stockholder and the number of shares registered in the name of each stockholder shall be prepared. Such list shall be open to the examination of any stockholder, for any purpose germane to the meeting, during ordinary business hours, for a period of at least ten days prior to the meeting, as required by the Delaware General Corporation Law. The list shall also be produced and kept at the time and place of the meeting during the whole time thereof, and may be inspected by any stockholder of the Corporation who is present.

SECTION 10. INSPECTORS. The Board of Directors shall, in advance of any meeting of stockholders, appoint one or more inspectors to act at such meeting or any adjournment thereof. If any of the inspectors so appointed shall fail to appear or act, the chairman of the meeting shall, or if inspectors shall not have been appointed, the chairman of the meeting may appoint one or more inspectors. Each inspector, before entering upon the discharge of such inspector's duties, shall take and sign an oath faithfully to execute the duties of inspector at such meeting with strict impartiality and according to the best of such inspector's ability. The inspectors shall determine the number of shares of capital stock of the Corporation outstanding and the voting power of each, the number of shares represented at the meeting, the existence of a quorum, the validity and effect of proxies, and shall receive votes, ballots or consents, hear and determine all challenges and questions arising in connection with the right to vote, count and tabulate all votes, ballots or consents, determine the results, and do such acts as are proper to conduct the election or vote with fairness to all stockholders. On request of the chairman of the meeting, the inspectors shall make a report in writing of any challenge, request or matter determined by them and shall execute a certificate of any fact found by them. No director or candidate for the office of director shall act as an inspector of an election of directors. Inspectors need not be stockholders.

SECTION 11. CONSENT OF STOCKHOLDERS IN LIEU OF MEETING. Unless otherwise provided by statute or in the Restated Certificate of Incorporation, any action required to be taken or which may be taken at any annual or special meeting of the stockholders of the Corporation may be taken without a meeting, without prior notice and without a vote, if a consent in writing, setting forth the action so taken, shall be signed by the holders of outstanding stock having not less than the minimum number of votes that would be necessary to authorize or take such action at a meeting at which all shares entitled to vote thereon were present and voted. Prompt notice of the taking of any such corporate action without a meeting by less than unanimous written consent shall be given to those stockholders who have not consented in writing.

SECTION 12. ADVANCE NOTICE PROVISIONS FOR ELECTION OF DIRECTORS. Only persons who are nominated in accordance with the following procedures shall be eligible for election as directors of the Corporation. Nominations of persons for election to the Board of Directors may be made at any annual meeting of stockholders, or at any special meeting of stockholders called for the purpose of electing directors, (a) by or at the direction of the Board of Directors (or any duly authorized committee thereof) or (b) by any stockholder of the Corporation (i) who is a stockholder of record on the date of the giving of the notice provided for in this Section 12 and on the record date for the determination of stockholders entitled to vote at such meeting and (ii) who complies with the notice procedures set forth in this Section 12.

In addition to any other applicable requirements, for a nomination to be made by a stockholder such stockholder must have given timely notice thereof in proper written form to the Secretary of the Corporation.

To be timely, a stockholder's notice to the Secretary must be delivered to or mailed and received at the principal executive offices of the Corporation (a) in the case of an annual meeting, not less than 45 or more than 75 days prior to the first anniversary of the date on which the Corporation first mailed its proxy materials for the preceding year's annual meeting of stockholders; provided, however, that if the date of the annual meeting is advanced more than 30 days prior to or delayed by more than 30 days after the anniversary of the preceding year's annual meeting, to be timely, notice by the stockholder must be so delivered not later than the close of business on the later of the 90th day prior to such annual meeting or the 10th day following the day on which public announcement of the date of such meeting is first made; and (b) in the case of a special meeting of stockholders called for the purpose of electing directors, not later than the close of business on the later of the 90th day prior to such special meeting or the 10th day following the day on which public announcement is first made of the date of the special meeting. For purposes of this Section 12 and Section 13, "public announcement" shall mean disclosure in a press release reported by the Dow Jones News Service, Associated Press or a comparable national news service or in a document publicly filed by the Corporation with the Securities and Exchange Commission pursuant to Section 13, 14 or 15(d) of the Securities Exchange Act of 1934, as amended (the "Exchange Act").

To be in proper written form, a stockholder's notice to the Secretary must set forth (a) as to each person whom the stockholder proposes to nominate for election as a director (i) the name, age, business address and residence address of the person, (ii) the principal occupation or employment of the person, (iii) the class or series and number of shares of capital stock of the Corporation which are owned beneficially or of record by the person and (iv) any other

information relating to the person that would be required to be disclosed in a proxy statement or other filings required to be made in connection with solicitations of proxies for election of directors pursuant to Section 14 of the Exchange Act, and the rules and regulations promulgated thereunder; and (b) as to the stockholder giving the notice (i) the name and record address of such stockholder, (ii) the class or series and number of shares of capital stock of the Corporation which are owned beneficially or of record by such stockholder, (iii) a description of all arrangements or understandings between such stockholder and each proposed nominee and any other person or persons (including their names) pursuant to which the nomination(s) are to be made by such stockholder, (iv) a representation that such stockholder intends to appear in person or by proxy at the meeting to nominate the persons named in its notice and (v) any other information relating to such stockholder that would be required to be disclosed in a proxy statement or other filings required to be made in connection with solicitations of proxies for election of directors pursuant to Section 14 of the Exchange Act and the rules and regulations promulgated thereunder. Such notice must be accompanied by a written consent of each proposed nominee to be named as a nominee and to serve as a director if elected.

No person shall be eligible for election as a director of the Corporation unless nominated in accordance with the procedures set forth in this Section 12. If the Chairman of the meeting determines that a nomination was not made in accordance with the foregoing procedures, the Chairman shall declare to the meeting that the nomination was defective and such defective nomination shall be disregarded.

SECTION 13. ADVANCE NOTICE PROVISIONS FOR BUSINESS TO BE TRANSACTED AT ANNUAL MEETING. No business may be transacted at an annual meeting of stockholders, other than business that is either (a) specified in the notice of meeting (or any supplement thereto) given by or at the direction of the Board of Directors (or any duly authorized committee thereof), (b) otherwise properly brought before the annual meeting by or at the direction of the Board of Directors (or any duly authorized committee thereof) or (c) otherwise properly brought before the annual meeting by any stockholder of the Corporation (i) who is a stockholder of record on the date of the giving of the notice provided for in this Section 13 and on the record date for the determination of stockholders entitled to vote at such annual meeting and (ii) who complies with the notice procedures set forth in this Section 13.

In addition to any other applicable requirements, for business to be properly brought before an annual meeting by a stockholder, such stockholder must have given timely notice thereof in proper written form to the Secretary of the Corporation.

To be timely, a stockholder's notice to the Secretary must be delivered to or mailed and received at the principal executive offices of the Corporation not less than 45 or more than 75 days prior to the first anniversary of the date on which the Corporation first mailed its proxy materials for the preceding year's annual meeting of stockholders; provided, however, that if the date of the annual meeting is advanced more than 30 days prior to or delayed by more than 30 days after the anniversary of the preceding year's annual meeting, to be timely notice by the stockholder must be so delivered not later than the close of business on the later of the 90th day prior to such annual meeting or the 10th day following the day on which public announcement of the date of such meeting is first made.

To be in proper written form, a stockholder's notice to the Secretary must set forth as to each matter such stockholder proposes to bring before the annual meeting (i) a brief description of the business desired to be brought before the annual meeting and the reasons for conducting such business at the annual meeting, (ii) the name and record address of such stockholder, (iii) the class or series and number of shares of capital stock of the Corporation which are owned beneficially or of record by such stockholder, (iv) a description of all arrangements or understandings between such stockholder and any other person or persons (including their names) in connection with the proposal of such business by such stockholder and any material interest of such stockholder in such business and (v) a representation that such stockholder intends to appear in person or by proxy at the annual meeting to bring such business before the meeting.

No business shall be conducted at the annual meeting of stockholders except business brought before the annual meeting in accordance with the procedures set forth in this Section 13. If the Chairman of an annual meeting determines that business was not properly brought before the annual meeting in accordance with the foregoing procedures, the Chairman shall declare to the meeting that the business was not properly brought before the meeting and such business shall not be transacted.

ARTICLE III

DIRECTORS

SECTION 1. PLACE OF MEETINGS. Meetings of the Board of Directors shall be held at such place or places, within or without the State of Delaware, as the Board of Directors may from time to time determine or as shall be specified in the notice of any such meeting.

SECTION 2. ANNUAL MEETING. The Board of Directors shall meet for the purpose of organization, the election of officers and the transaction of other business, as soon as practicable after each annual meeting of stockholders, on the same day and at the same place where such annual meeting shall be held. Notice of such meeting need not be given. In the event such annual meeting is not so held, the annual meeting of the Board of Directors may be held at such other time or place (within or without the State of Delaware) as shall be specified in a notice thereof given as hereinafter provided in Section 5 of this Article III.

SECTION 3. REGULAR MEETINGS. Regular meetings of the Board of Directors shall be held at such time and place as the Board of Directors may fix. If any day fixed for a regular meeting shall be a legal holiday at the place where the meeting is to be held, then the meeting which would otherwise be held on that day shall be held at the same hour on the next succeeding business day.

SECTION 4. SPECIAL MEETINGS. Special meetings of the Board of Directors may be called by the Chairman of the Board, if one shall have been elected, or by two or more directors of the Corporation or by the President.

SECTION 5. NOTICE OF MEETINGS. Notice of regular meetings of the Board of Directors need not be given except as otherwise required by law or these Restated By-Laws. Notice of each special meeting of the Board of Directors for which notice shall be required, shall

be given by the Secretary as hereinafter provided in this Section 5, in which notice shall be stated the time and place of the meeting. Except as otherwise required by these By-Laws, such notice need not state the purposes of such meeting. Notice of any special meeting, and of any regular or annual meeting for which notice is required, shall be given to each director at least (a) four hours before the meeting if by telephone or by being personally delivered or sent by telex, telecopy, or similar means or (b) two days before the meeting if delivered by mail to the director's residence or usual place of business. Such notice shall be deemed to be delivered when deposited in the United States mail so addressed, with postage prepaid, or when transmitted if sent by telex, telecopy, or similar means. Neither the business to be transacted at, nor the purpose of, any special meeting of the Board of Directors need be specified in the notice or waiver of notice of such meeting. Any director may waive notice of any meeting by a writing signed by the director entitled to the notice and filed with the minutes or corporate records. The attendance at or participation of the director at a meeting shall constitute waiver of notice of such meeting, unless the director at the beginning of the meeting or promptly upon such director's arrival objects to holding the meeting or transacting business at the meeting.

SECTION 6. ORGANIZATION. At each meeting of the Board of Directors, the Chairman of the Board, if one shall have been elected, or, in the absence of the Chairman of the Board or if one shall not have been elected, the President (or, in the President's absence, another director chosen by a majority of the directors present) shall act as chairman of the meeting and preside thereat. The Secretary or, in such person's absence, any person appointed by the chairman shall act as secretary of the meeting and keep the minutes thereof.

SECTION 7. QUORUM AND MANNER OF ACTING. A majority of the entire Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors, and, except as otherwise expressly required by statute or the Restated Certificate of Incorporation or these Restated By-Laws, the affirmative vote of a majority of the directors present at any meeting at which a quorum is present shall be the act of the Board of Directors. In the absence of a quorum at any meeting of the Board of Directors, a majority of the directors present thereat may adjourn such meeting to another time and place. Notice of the time and place of any such adjourned meeting shall be given to all of the directors unless such time and place were announced at the meeting at which the adjournment was taken, in which case such notice need only be given to the directors who were not present thereat. At any adjourned meeting at which a quorum is present, any business may be transacted which might have been transacted at the meeting as originally called. The directors shall act only as a Board and the individual directors shall have no power as such.

SECTION 8. ACTION BY CONSENT. Unless restricted by the Restated Certificate of Incorporation, any action required or permitted to be taken by the Board of Directors or any committee thereof may be taken without a meeting if all members of the Board of Directors or such committee, as the case may be, consent thereto in writing, and the writing or writings are filed with the minutes of the proceedings of the Board of Directors or such committee, as the case may be.

SECTION 9. TELEPHONIC MEETING. Unless restricted by the Restated Certificate of Incorporation, any one or more members of the Board of Directors or any committee thereof may participate in a meeting of the Board of Directors or such committee by means of a conference

telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other. Participation by such means shall constitute presence in person at a meeting.

SECTION 10. COMMITTEES. The Board of Directors may, by resolution passed by a majority of the entire Board of Directors, designate one or more committees, including an executive committee, each committee to consist of one or more of the directors of the Corporation. The Board of Directors may designate one or more directors as alternate members of any committee, who may replace any absent or disqualified member at any meeting of the committee. In the absence of disqualification of any member of a committee, the member or members present at any meeting and not disqualified from voting, whether or not such members constitute a quorum, may unanimously appoint another member of the Board of Directors to act at the meeting in the place of any such absent or disqualified member.

Each such committee, to the extent provided in the resolution creating it, shall have and may exercise all the powers and authority of the Board of Directors in the management of the business and affairs of the Corporation, and may authorize the seal of the Corporation to be affixed to all papers which require it; PROVIDED, HOWEVER, that no such committee shall have the power or authority in reference to the following matters: (a) approving or adopting, or recommending to the stockholders, any action or matter expressly required by the Delaware General Corporation Law to be submitted to stockholders for approval or (b) adopting, amending or repealing any by-law of the Corporation. Each such committee shall serve at the pleasure of the Board of Directors and have such name as may be determined from time to time by resolution adopted by the Board of Directors. Each committee shall keep regular minutes of its meetings and report the same to the Board of Directors.

SECTION 11. FEES AND COMPENSATION. Directors and members of committees may receive such compensation, if any, for their services, and such reimbursement for expenses, as may be fixed or determined by the Board of Directors. No such payment shall preclude any director from serving the Corporation in any other capacity and receiving compensation therefor.

SECTION 12. RESIGNATIONS. Any director of the Corporation may resign at any time by giving written notice of such director's resignation to the Corporation. Any such resignation shall take effect at the time specified therein or, if the time when it shall become effective shall not be specified therein, immediately upon its receipt. Unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

ARTICLE IV

OFFICERS

SECTION 1. GENERAL. The executive officers of the Corporation shall be chosen by the Board of Directors and shall include a President, one or more Vice Presidents (including Senior, Executive, Group or other classifications of Vice Presidents), a Treasurer and a Secretary. The Board of Directors, in its discretion, may also choose as an officer of the Corporation the Chairman of the Board and any Vice Chairman of the Board. The President shall appoint other

officers (including, one or more Vice Presidents, Assistant Secretaries and one or more Assistant Treasurers) as may be necessary or desirable. The officers of the Corporation shall perform such duties and have such powers as from time to time may be assigned to them by the Board of Directors or, to the extent appointed by the President, the President. The Board of Directors may also delegate to any officer of the Corporation the power to appoint such other officers and to proscribe their respective duties and powers. Any number of offices may be held by the same person, unless otherwise prohibited by law, the Restated Certificate of Incorporation or these Restated By-Laws. The officers of the Corporation need not be stockholders of the Corporation nor, except in the case of the Chairman of the Board and Vice Chairman of the Board of Directors, need such officers be directors of the Corporation.

SECTION 2. TERM. All officers of the Corporation shall hold office until their successors are chosen and qualified, or until their earlier resignation or removal. Any vacancy occurring in any office of the Corporation shall be filled by the Board of Directors, except that any vacancy in any office that have been appointed by the President or any other officer of the Corporation may be filled by the person who has the authority to fill that office.

SECTION 3. RESIGNATIONS. Any officer of the Corporation may resign at any time by giving written notice of such officer's resignation to the Corporation. Any such resignation shall take effect at the time specified therein or, if the time when it shall become effective shall not be specified therein, immediately upon receipt. Unless otherwise specified therein, the acceptance of any such resignation shall not be necessary to make it effective.

SECTION 4. REMOVAL. Any officer may be removed at any time by the Board of Directors with or without cause, except that any officer appointed by the President or any other officer of the Corporation may also be removed at any time by the President or any other officer who had appointed that officer with or without cause.

SECTION 5. COMPENSATION. The compensation for the five (5) most highly compensated executive officers of the Corporation for their services as such officers shall be fixed from time to time by the Board of Directors. The compensation for all other officers of the Corporation shall be fixed from time to time by the President; compensation for other executive officers shall be in consultation with the Board of Directors. An officer of the Corporation shall not be prevented from receiving compensation by reason of the fact that such officer is also a director of the Corporation.

SECTION 6. CHAIRMAN OF THE BOARD. The Chairman of the Board, if one shall have been elected, shall be a member of the Board, an officer of the Corporation (if the Board of Directors, in its discretion, chooses to make the Chairman of the Board an officer of the Corporation) and, if present, shall preside at each meeting of the Board of Directors or the stockholders. The Chairman of the Board shall advise and counsel with the President, and in the President's absence with other executives of the Corporation, and shall perform such other duties as may from time to time be assigned to the Chairman of the Board by the Board of Directors.

ARTICLE V

STOCK CERTIFICATES AND THEIR TRANSFER

SECTION 1. STOCK CERTIFICATES. Every holder of stock in the Corporation shall be entitled to have a certificate, signed by, or in the name of the Corporation by, the Chairman of the Board or a Vice Chairman of the Board or the President or a Vice President and by the Treasurer or an Assistant Treasurer or the Secretary or an Assistant Secretary of the Corporation, certifying the number of shares owned by such holder in the Corporation. If the Corporation shall be authorized to issue more than one class of stock or more than one series of any class, the designations, preferences and relative, participating, optional or other special rights of each class of stock or series thereof and the qualifications, limitations or restriction of such preferences and/or rights shall be set forth in full or summarized on the face or back of the certificate which the Corporation shall issue to represent such class or series of stock, provided that, except as otherwise provided in Section 202 of the Delaware General Corporation Law, in lieu of the foregoing requirements, there may be set forth on the face or back of the certificate which the Corporation shall issue to represent such class or series of stock, a statement that the Corporation will furnish without charge to each stockholder who so requests the designations, preferences and relative, participating, optional or other special rights of each class of stock or series thereof and the qualifications, limitations or restrictions of such preferences and/or rights.

SECTION 2. FACSIMILE SIGNATURES. Any or all of the signatures on a certificate may be a facsimile, engraved or printed. In case any officer, transfer agent or registrar who has signed or whose facsimile signature has been placed upon a certificate shall have ceased to be such officer, transfer agent or registrar before such certificate is issued, it may be issued by the Corporation with the same effect as if such person was such officer, transfer agent or registrar at the date of issue.

SECTION 3. LOST CERTIFICATES. The Board of Directors may direct a new certificate or certificates to be issued in place of any certificate or certificates theretofore issued by the Corporation alleged to have been lost, stolen, or destroyed. When authorizing such issue of a new certificate or certificates, the Board of Directors may, in its discretion and as a condition precedent to the issuance thereof, require the owner of such lost, stolen, or destroyed certificate or certificates, or the owner's legal representative, to give the Corporation a bond in such sum as it may direct sufficient to indemnify it against any claim that may be made against the Corporation on account of the alleged loss, theft or destruction of any such certificate or the issuance of such new certificate.

SECTION 4. TRANSFERS OF STOCK. Upon surrender to the Corporation or the transfer agent of the Corporation of a certificate for shares duly endorsed or accompanied by proper evidence of succession, assignment or authority to transfer, it shall be the duty of the Corporation to issue a new certificate to the person entitled thereto, cancel the old certificate and record the transaction upon its records; PROVIDED, HOWEVER, that the Corporation shall be entitled to recognize and enforce any lawful restriction on transfer. Whenever any transfer of stock shall be made for collateral security, and not absolutely, it shall be so expressed in the entry of transfer if, when the certificates are presented to the Corporation for transfer, both the transferor and the transferee request the Corporation to do so.

SECTION 5. TRANSFER AGENTS AND REGISTRARS. The Board of Directors may appoint, or authorize any officer or officers to appoint, one or more transfer agents and one or more registrars.

SECTION 6. REGULATIONS. The Board of Directors may make such additional rules and regulations, not inconsistent with these Restated By-Laws, as it may deem expedient concerning the issue, transfer and registration of certificates for shares of stock of the Corporation.

SECTION 7. FIXING THE RECORD DATE. In order that the Corporation may determine the stockholders entitled to notice of or to vote at any meeting of stockholders or any adjournment thereof, or entitled to receive payment of any dividend or other distribution or allotment of any rights, or entitled to exercise any rights in respect of any change, conversion or exchange of stock or for the purpose of any other lawful action, the Board of Directors may fix, in advance, a record date, which shall not be more than 60 nor less than 10 days before the date of such meeting, nor more than 60 days prior to any other action. A determination of stockholders of record entitled to notice of or to vote at a meeting of stockholders shall apply to any adjournment of the meeting; PROVIDED, however, that the Board of Directors may fix a new record date for the adjourned meeting.

In order that the Corporation may determine the stockholders entitled to consent to corporate action in writing without a meeting, the Board of Directors may fix a record date, which shall not precede the date upon which the resolution fixing the record date is adopted by the Board of Directors, and which record date shall be not more than 10 days after the date upon which the resolution fixing the record date is adopted. If no record date has been fixed by the Board of Directors and no prior action by the Board of Directors is required by the Delaware General Corporation Law, the record date shall be the first date on which a signed written consent setting forth the action taken or proposed to be taken is delivered to the Secretary of the Corporation at the Corporation's principal executive offices. If no record date has been fixed by the Board of Directors and prior action by the Board of Directors is required by the Delaware General Corporation Law with respect to the proposed action by written consent of the stockholders, the record date for determining stockholders entitled to consent to corporate action in writing shall be at the close of business on the day on which the Board of Directors adopts the resolution taking such prior action.

SECTION 8. REGISTERED STOCKHOLDERS. The Corporation shall be entitled to recognize the exclusive right of a person registered on its records as the owner of shares of stock to receive dividends and to vote as such owner, and shall not be bound to recognize any equitable or other claim to or interest in such share or shares of stock on the part of any other person, whether or not it shall have express or other notice thereof, except as otherwise provided by law.

ARTICLE VI

INDEMNIFICATION OF DIRECTORS AND OFFICERS

SECTION 1. GENERAL. Each person who was or is made a party or is threatened to be made a party to or is involved (including, without limitation, as a witness) in any threatened, pending or completed action, suit, arbitration, alternative dispute resolution mechanism,

investigation, administrative hearing or any other proceeding, whether civil, criminal, administrative or investigative ("Proceeding") brought by reason of the fact that such person (the "Indemnitee") is or was a director or officer of the Corporation or is or was serving at the request of the Corporation as a director or officer of another corporation or of a partnership, joint venture, trust or other enterprise, including service with respect to an employee benefit plan, whether the basis of such Proceeding is alleged action in an official capacity as a director or officer or in any other capacity while serving as such a director or officer, shall be indemnified and held harmless by the Corporation (unless such Proceeding was brought by or in the right of the Indemnitee without the prior written approval of the Board of Directors) to the fullest extent permitted by the laws of the State of Delaware in effect on the date hereof or as such laws may from time to time hereafter be amended to increase the scope of such permitted indemnification, against all expenses, liabilities, losses and claims (including attorneys' fees, judgments, fines, excise taxes under the Employee Retirement Income Security Act of 1974, as amended from time to time, penalties and amounts to be paid in settlement) actually incurred or suffered by such Indemnitee in connection with such Proceeding (collectively, "Losses"). Without diminishing the scope of the indemnification provided by this Section 1, the rights of indemnification of an Indemnitee provided hereunder shall include but not be limited to those rights set forth in this Article VI.

SECTION 2. DERIVATIVE ACTIONS. The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to or is involved (including, without limitation, as a witness) in any Proceeding brought by or in the right of the Corporation to procure a judgment in its favor by reason of the fact that such person (also an "Indemnitee") is or was a director or officer of the Corporation, or is or was serving at the request of the Corporation as a director or officer of another corporation or of a partnership, joint venture, trust or other enterprise, including service with respect to an employee benefit plan, against Losses actually incurred or suffered by the Indemnitee in connection with the defense or settlement of such action or suit if the Indemnitee acted in good faith and in a manner the Indemnitee reasonably believed to be in or not opposed to the best interests of the Corporation, provided that no indemnification shall be made in respect of any claim, issue or matter as to which Delaware law expressly prohibits such indemnification by reason of an adjudication of liability of the Indemnitee unless and only to the extent that the Court of Chancery of the State of Delaware or the court in which such action or suit was brought shall determine upon application that, despite the adjudication of liability but in view of all the circumstances of the case, the Indemnitee is fairly and reasonably entitled to indemnity for such expenses which the Court of Chancery or such other court shall deem proper.

SECTION 3. INDEMNIFICATION IN CERTAIN CASES. Notwithstanding any other provision of this Article VI, to the extent that an Indemnitee has been wholly successful on the merits or otherwise in any Proceeding referred to in Sections 1 or 2 of this Article VI on any claim, issue or matter therein, the Indemnitee shall be indemnified against Losses actually incurred or suffered by the Indemnitee in connection therewith. If the Indemnitee is not wholly successful in such Proceeding but is successful, on the merits or otherwise, as to one or more but less than all claims, issues or matters in such Proceeding, the Corporation shall indemnify the Indemnitee, against Losses actually incurred or suffered by the Indemnitee in connection with each successfully resolved claim, issue or matter. In any review or Proceeding to determine such extent of indemnification, the Corporation shall bear the burden of proving any lack of success and which amounts sought in indemnity are allocable to claims, issues or matters which were not successfully

resolved. For purposes of this Section 3 and without limitation, the termination of any such claim, issue or matter by dismissal with or without prejudice shall be deemed to be a successful resolution as to such claim, issue or matter.

SECTION 4. PROCEDURE. (a) Any indemnification under Sections 1 and 2 of this Article VI (unless ordered by a court) shall be made by the Corporation only as authorized in the specific case upon a determination that indemnification of the Indemnitee is proper (except that the right of the Indemnitee to receive payments pursuant to Section 5 of this Article VI shall not be subject to this Section 4) in the circumstances because the Indemnitee has met the applicable standard of conduct. Such determination shall be made promptly, but in no event later than 60 days after receipt by the Corporation of the Indemnitee's written request for indemnification. The Secretary of the Corporation shall, promptly upon receipt of the Indemnitee's request for indemnification, advise the Board of Directors that the Indemnitee has made such request for indemnification.

(b) The entitlement of the Indemnitee to indemnification shall be determined, with respect to a person who is a director or officer at the time of such determination, in the specific case (1) by the Board of Directors by a majority vote of the directors who are not parties to such Proceeding (the "Disinterested Directors"), even though less than a quorum, or (2) by a committee of the Disinterested Directors designated by majority vote of the Disinterested Directors, even though less than a quorum, or (3) if there are no Disinterested Directors, or if such Disinterested Directors so direct, by independent legal counsel, or (4) by the stockholders. The entitlement of the Indemnitee to indemnification shall be determined with respect to any person who is not a director or officer at the time of such determination by any means reasonably determined by the Corporation.

(c) In the event the determination of entitlement is to be made by independent legal counsel, such independent legal counsel shall be selected by the Board of Directors and approved by the Indemnitee. Upon failure of the Board of Directors to so select such independent legal counsel or upon failure of the Indemnitee to so approve, such independent legal counsel shall be selected by the American Arbitration Association in New York, New York or such other person as such Association shall designate to make such selection.

(d) If a determination is made pursuant to Section 4(b) of this Article VI that the Indemnitee is not entitled to indemnification to the full extent of the Indemnitee's request, the Indemnitee shall have the right to seek entitlement to indemnification in accordance with the procedures set forth in Section 6 of this Article VI.

(e) If a determination pursuant to Section 4(b) of this Article VI with respect to entitlement to indemnification shall not have been made within 60 days after receipt by the Corporation of such request, the requisite determination of entitlement to indemnification shall be deemed to have been made and the Indemnitee shall be absolutely entitled to such indemnification, absent (i) misrepresentation by the Indemnitee of a material fact in the request for indemnification or (ii) a final judicial determination that all or any part of such indemnification is expressly prohibited by law.

(f) The termination of any proceeding by judgment, order, settlement or conviction, or upon a plea of NOLO CONTENDERE or its equivalent, shall not, of itself, adversely affect the rights of the Indemnitee to indemnification hereunder except as may be specifically provided herein, or create a presumption that the Indemnitee did not act in good faith and in a manner which the Indemnitee reasonably believed to be in or not opposed to the best interests of the Corporation or create a presumption that (with respect to any criminal action or proceeding) the Indemnitee had reasonable cause to believe that the Indemnitee's conduct was unlawful.

(g) For purposes of any determination of good faith hereunder, the Indemnitee shall be deemed to have acted in good faith if the Indemnitee's action is based on the records or books of account of the Corporation or an affiliate, including financial statements, or on information supplied to the Indemnitee by the officers of the Corporation or an affiliate in the course of their duties, or on the advice of legal counsel for the Corporation or an affiliate or on information or records given or reports made to the Corporation or an affiliate by an independent certified public accountant or by an appraiser or other expert selected with reasonable care to the Corporation or an affiliate. The Corporation shall have the burden of establishing the absence of good faith. The provisions of this Section 4(g) of this Article VI shall not be deemed to be exclusive or to limit in any way the other circumstances in which the Indemnitee may be deemed to have met the applicable standard of conduct set forth in these Restated By-Laws.

(h) The knowledge and/or actions, or failure to act, of any other director, officer, agent or employee of the Corporation or an affiliate shall not be imputed to the Indemnitee for purposes of determining the right to indemnification under these Restated By-Laws.

SECTION 5. ADVANCES FOR EXPENSES AND COSTS. All expenses (including attorneys fees) incurred by or on behalf of the Indemnitee (or reasonably expected by the Indemnitee to be incurred by the Indemnitee within three months) in connection with any Proceeding shall be paid by the Corporation in advance of the final disposition of such Proceeding within twenty days after the receipt by the Corporation of a statement or statements from the Indemnitee requesting from time to time such advance or advances whether or not a determination to indemnify has been made under Section 4 of this Article VI. The Indemnitee's entitlement to such advancement of expenses shall include those incurred in connection with any Proceeding by the Indemnitee seeking an adjudication or award in arbitration pursuant to these By-Laws. The financial ability of an Indemnitee to repay an advance shall not be a prerequisite to the making of such advance. Such statement or statements shall reasonably evidence such expenses incurred (or reasonably expected to be incurred) by the Indemnitee in connection therewith and shall include or be accompanied by a written undertaking by or on behalf of the Indemnitee to repay such amount if it shall ultimately be determined that the Indemnitee is not entitled to be indemnified therefor pursuant to the terms of this Article VI.

SECTION 6. REMEDIES IN CASES OF DETERMINATION NOT TO INDEMNIFY OR TO ADVANCE EXPENSES. (a) In the event that (i) a determination is made that the Indemnitee is not entitled to indemnification hereunder, (ii) advances are not made pursuant to Section 5 of this Article VI or (iii) payment has not been timely made following a determination of entitlement to indemnification pursuant to Section 4 of this Article VI, the Indemnitee shall be entitled to seek a final adjudication either through an arbitration proceeding or in an appropriate court of the State of

Delaware or any other court of competent jurisdiction of the Indemnitee's entitlement to such indemnification or advance.

(b) In the event a determination has been made in accordance with the procedures set forth in Section 4 of this Article VI, in whole or in part, that the Indemnitee is not entitled to indemnification, any judicial proceeding or arbitration referred to in paragraph (a) of this Section 6 shall be DE NOVO and the Indemnitee shall not be prejudiced by reason of any such prior determination that the Indemnitee is not entitled to indemnification, and the Corporation shall bear the burdens of proof specified in Sections 3 and 4 of this Article VI in such proceeding.

(c) If a determination is made or deemed to have been made pursuant to the terms of Sections 4 or 6 of this Article VI that the Indemnitee is entitled to indemnification, the Corporation shall be bound by such determination in any judicial proceeding or arbitration in the absence of (i) a misrepresentation of a material fact by the Indemnitee or (ii) a final judicial determination that all or any part of such indemnification is expressly prohibited by law.

(d) To the extent deemed appropriate by the court, interest shall be paid by the Corporation to the Indemnitee at a reasonable interest rate for amounts which the Corporation indemnifies or is obliged to indemnify the Indemnitee for the period commencing with the date on which the Indemnitee requested indemnification (or reimbursement or advancement of expenses) and ending with the date on which such payment is made to the Indemnitee by the Corporation.

SECTION 7. RIGHTS NON-EXCLUSIVE. The indemnification and advancement of expenses provided by, or granted pursuant to, the other Sections of this Article VI shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any law, by-law, agreement, vote of stockholders or disinterested directors or otherwise, both as to action in such person's official capacity and as to action in another capacity while holding such office.

SECTION 8. INSURANCE. The Corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise, including service with respect to an employee benefit plan, against any liability asserted against such person and incurred by such person in any such capacity, or arising out of such person's status as such, whether or not the Corporation would have the power to indemnify such person against such liability under the provisions of this Article VI.

SECTION 9. DEFINITION OF CORPORATION. For purposes of this Article VI, references to "the Corporation" shall include, in addition to the resulting corporation, any constituent corporation (including any constituent of a constituent) absorbed in a consolidation or merger which, if its separate existence had continued, would have had power and authority to indemnify its directors, officers, and employees or agents, so that any person who is or was a director, officer, employee or agent of such constituent corporation, or is or was serving at the request of such constituent corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise, including service with respect to an employee benefit plan, shall stand in the same position under this Article VI with respect to the

resulting or surviving corporation as such person would have with respect to such constituent corporation if its separate existence had continued.

SECTION 10. OTHER DEFINITIONS. For purposes of this Article VI, references to "fines" shall include any excise taxes assessed on a person with respect to any employee benefit plan; and references to "serving at the request of the Corporation" shall include any service as a director, officer, employee or agent of the corporation which imposes duties on, or involves services by, such director, officer, employee, or agent with respect to an employee benefit plan, its participants or beneficiaries; and a person who acted in good faith and in a manner such person reasonably believed to be in the interest of the participants and beneficiaries of an employee benefit plan shall be deemed to have acted in a manner "not opposed to the best interests of the Corporation" as referred to in this Article VI.

SECTION 11. SURVIVAL OF RIGHTS. The indemnification and advancement of expenses provided by, or granted pursuant to this Article VI shall, unless otherwise provided when authorized or ratified, continue as to a person who has ceased to be a director, officer, employee or agent and shall inure to the benefit of the heirs, executors and administrators of such a person. No amendment, alteration, rescission or replacement of these By-Laws or any provision hereof shall be effective as to an Indemnitee with respect to any action taken or omitted by such Indemnitee in Indemnitee's position with the Corporation or any other entity which the Indemnitee is or was serving at the request of the Corporation prior to such amendment, alteration, rescission or replacement.

SECTION 12. INDEMNIFICATION OF EMPLOYEES AND AGENTS OF THE CORPORATION. The Corporation may, by action of the Board of Directors from time to time, grant rights to indemnification and advancement of expenses to employees and agents of the Corporation with the same scope and effect as the provisions of this Article VI with respect to the indemnification of directors and officers of the Corporation.

SECTION 13. SAVINGS CLAUSE. If this Article VI or any portion hereof shall be invalidated on any ground by any court of competent jurisdiction, then the Corporation shall nevertheless indemnify each person entitled to indemnification under the first paragraph of this Article VI as to all losses actually and reasonably incurred or suffered by such person and for which indemnification is available to such person pursuant to this Article VI to the full extent permitted by any applicable portion of this Article VI that shall not have been invalidated and to the full extent permitted by applicable law.

ARTICLE VII

GENERAL PROVISIONS

SECTION 1. DIVIDENDS. Subject to the provisions of statute and the Restated Certificate of Incorporation, dividends upon the shares of capital stock of the Corporation may be declared by the Board of Directors at any regular or special meeting. Dividends may be paid in cash, in property or in shares of stock of the Corporation, unless otherwise provided by statute or the Restated Certificate of Incorporation.

SECTION 2. RESERVES. Before payment of any dividend, there may be set aside out of any funds of the Corporation available for dividends such sum or sums as the Board of Directors may, from time to time, in its absolute discretion, think proper as a reserve or reserves to meet contingencies, or for equalizing dividends, or for repairing or maintaining any property of the Corporation or for such other purpose as the Board of Directors may think conducive to the interests of the Corporation. The Board of Directors may modify or abolish any such reserve in the manner in which it was created.

SECTION 3. SEAL. The seal of the Corporation shall be in such form as shall be approved by the Board of Directors.

SECTION 4. FISCAL YEAR. The fiscal year of the Corporation shall be December 31 and may be changed by resolution of the Board of Directors.

SECTION 5. CHECKS, NOTES, DRAFTS, ETC. All checks, notes, drafts or other orders for the payment of money of the Corporation shall be signed, endorsed or accepted in the name of the Corporation by such officer, officers, person or persons as from time to time may be designated by the Board of Directors or by an officer or officers authorized by the Board of Directors to make such designation.

SECTION 6. EXECUTION OF CONTRACTS, DEEDS, ETC. The Board of Directors may authorize any officer or officers, agent or agents, in the name and on behalf of the Corporation to enter into or execute and deliver any and all deeds, bonds, mortgages, contracts and other obligations or instruments, and such authority may be general or confined to specific instances.

SECTION 7. VOTING OF STOCK IN OTHER CORPORATIONS. Unless otherwise provided by resolution of the Board of Directors, the Chairman of the Board or the President, from time to time, may (or may appoint one or more attorneys or agents to) cast the votes which the Corporation may be entitled to cast as a shareholder or otherwise in any other corporation, any of whose shares or securities may be held by the Corporation, at meetings of the holders of the shares or other securities of such other corporation. In the event one or more attorneys or agents are appointed, the Chairman of the Board or the President may instruct the person or persons so appointed as to the manner of casting such votes or giving such consent. The Chairman of the Board or the President may, or may instruct the attorneys or agents appointed to, execute or cause to be executed in the name and on behalf of the Corporation and under its seal or otherwise, such written proxies, consents, waivers or other instruments as may be necessary or proper in the circumstances.

ARTICLE VIII

AMENDMENTS

These Restated By-Laws may be repealed, altered, amended or rescinded in whole or in part, or new By-Laws may be adopted by either the affirmative vote of the holders of at least a majority of the voting power of all of the issued and outstanding shares of capital stock of the Corporation entitled to vote thereon or by the Board of Directors.

Adopted by resolution of
the Board of Directors on
February 21, 2001

/s/ Rachel A. Seifert, Secretary

EXHIBIT 23.1

INDEPENDENT AUDITORS' CONSENT

We consent to the incorporation by reference in Registration Statement No. 333-44870 of Community Health Systems, Inc. on Form S-8 of our reports dated February 20, 2001, appearing in the Annual Report on Form 10-K of Community Health Systems, Inc. for the year ended December 31, 2000.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
March 29, 2001