CHS Community Health Systems, Inc.

Credit Suisse 27th Annual Healthcare Conference

November 14, 2018

Forward-Looking Statements

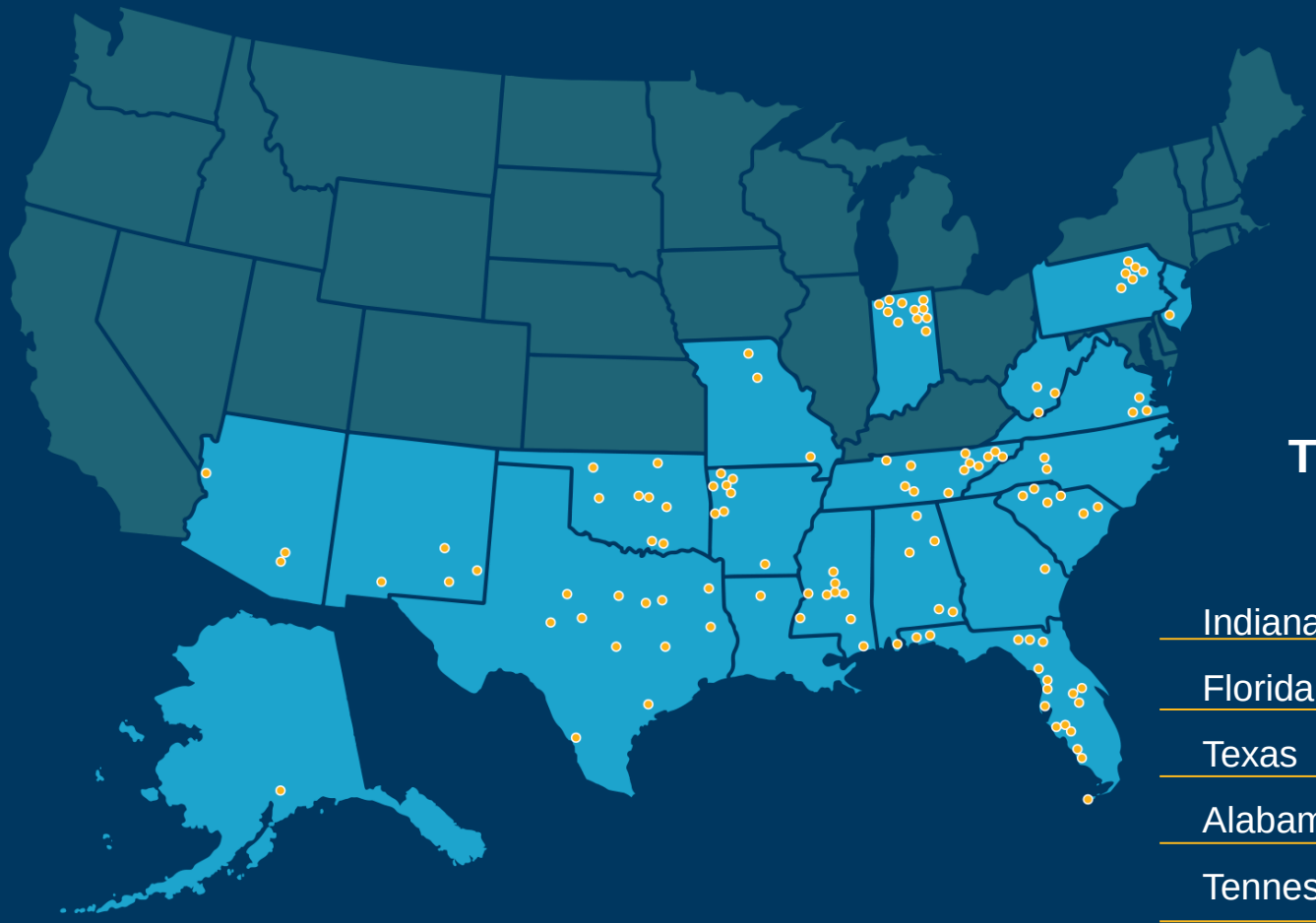
This presentation contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, Section 21E of the Securities Exchange Act of 1934, as amended, and the Private Securities Litigation Reform Act of 1995 that involve risk and uncertainties. All statements in this presentation other than statements of historical fact, including statements regarding projections, expected operating results, and other events that depend upon or refer to future events or conditions or that include words such as "expects," "anticipates," "intends," "plans," "believes," "estimates," "thinks," and similar expressions, are forward-looking statements. Although the Company believes that these forward-looking statements are based on reasonable assumptions, these assumptions are inherently subject to significant economic and competitive uncertainties and contingencies, which are difficult or impossible to predict accurately and may be beyond the control of the Company. Accordingly, the Company cannot give any assurance that its expectations will in fact occur and cautions that actual results may differ materially from those in the forward-looking statements. A number of factors could affect the future results of the Company or the healthcare industry generally and could cause the Company's expected results to differ materially from those expressed in this presentation. These factors include, among other things: general economic and business conditions, both nationally and in the regions in which we operate; the impact of changes made to the Affordable Care Act, the potential for repeal or additional changes to the Affordable Care Act, its implementation or its interpretation (including through executive orders), as well as changes in other federal, state or local laws or regulations affecting our business; the extent to which states support increases, decreases or changes in Medicaid programs, implement health insurance exchanges or alter the provision of healthcare to state residents through regulation or otherwise; the future and long-term viability of health insurance exchanges and potential changes to the beneficiary enrollment process; risks associated with our substantial indebtedness, leverage and debt service obligations, and the fact that a substantial portion of our indebtedness will mature and become due in the near future, including our ability to refinance such indebtedness on acceptable terms or to incur additional indebtedness; demographic changes; changes in, or the failure to comply with, governmental regulations; potential adverse impact of known and unknown government investigations, audits, and federal and state false claims act litigation and other legal proceedings; our ability, where appropriate, to enter into and maintain provider arrangements with payors and the terms of these arrangements, which may be further affected by the increasing consolidation of health insurers and managed care companies and vertical integration efforts involving payors and healthcare providers; changes in, or the failure to comply with, contract terms with payors and changes in reimbursement rates paid by federal or state healthcare programs or commercial payors; any potential additional impairments in the carrying value of goodwill, other intangible assets, or other long-lived assets, or changes in the useful lives of other intangible assets; changes in inpatient or outpatient Medicare and Medicaid payment levels and methodologies; the effects related to the continued implementation of the sequestration spending reductions and the potential for future deficit reduction legislation; increases in the amount and risk of collectability of patient accounts receivable, including decreases in collectability which may result from, among other things, self-pay growth and difficulties in recovering payments for which patients are responsible, including co-pays and deductibles; the efforts of insurers, healthcare providers, large employer groups and others to contain healthcare costs, including the trend toward value-based purchasing; our ongoing ability to demonstrate meaningful use of certified electronic health record technology and recognize income for the related Medicare or Medicaid incentive payments, to the extent such payments have not expired; increases in wages as a result of inflation or competition for highly technical positions and rising supply and drug costs due to market pressure from pharmaceutical companies and new product releases; liabilities and other claims asserted against us, including self-insured malpractice claims; competition; our ability to attract and retain, at reasonable employment costs, qualified personnel, key management, physicians, nurses and other healthcare workers; trends toward treatment of patients in less acute or specialty healthcare settings, including ambulatory surgery centers or specialty hospitals; changes in medical or other technology; changes in U.S. generally accepted accounting principles; the availability and terms of capital to fund any additional acquisitions or replacement facilities or other capital expenditures; our ability to successfully make acquisitions or complete divestitures, including the disposition of hospitals and non-hospital businesses pursuant to our portfolio rationalization and deleveraging strategy, our ability to complete any such acquisitions or divestitures on desired terms or at all (including to realize the anticipated amount of proceeds from contemplated dispositions), the timing of the completion of any such acquisitions or divestitures, and our ability to realize the intended benefits from any such acquisitions or divestitures; the impact that changes in our relationships with joint venture or syndication partners could have on effectively operating our hospitals or ancillary services or in advancing strategic opportunities; our ability to successfully integrate any acquired hospitals, or to recognize expected synergies from acquisitions; the impact of seasonal severe weather events, including the timing and amount of insurance recoveries in relation to severe weather events, which impacted several of our affiliated hospitals in 2017; our ability to obtain adequate levels of general and professional liability insurance; timeliness of reimbursement payments received under government programs; effects related to outbreaks of infectious diseases; the impact of prior or potential future cyber-attacks or security breaches; any failure to comply with the terms of the Corporate Integrity Agreement; the concentration of our revenue in a small number of states; our ability to realize anticipated cost savings and other benefits from our current strategic and operational cost savings initiatives; changes in interpretations, assumptions and expectations regarding the Tax Act; and the other risk factors set forth in our Annual Report on Form 10-K for the year ended December 31, 2017, filed with the Securities and Exchange Commission on February 28, 2018, and our other public filings with the Securities and Exchange Commission.

The consolidated operating results for the three and nine months ended September 30, 2018, are not necessarily indicative of the results that may be experienced for any future periods. The Company cautions that the projections for calendar year 2018 set forth in this presentation are given as of the date hereof based on currently available information. The Company undertakes no obligation to revise or update any forward-looking statements, or to make any other forward-looking statements, whether as a result of new information, future events or otherwise.

Community Health Systems

- Founded in 1985
- NYSE Listed Company since 2000 Symbol: CYH
- 118 Hospitals in 20 States*
- Over 700,000 Annual Admissions
- Over 3.9 Million Annual ED Visits
- 88,200 Employees
- 15,520 Physicians on Medical Staffs, including approximately 2,070 employed physicians

Serving Select Markets



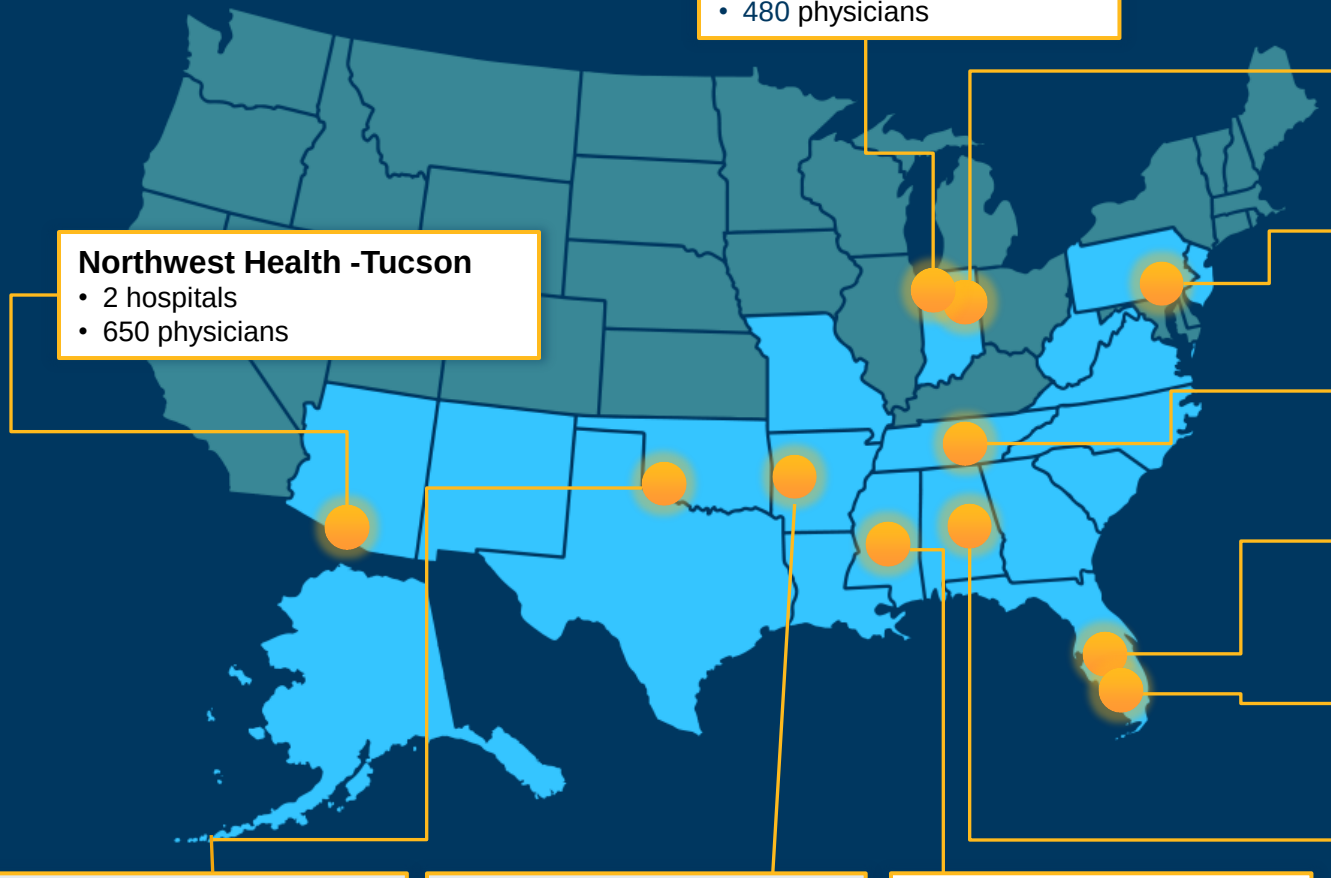
118
Hospitals

20
States

TOP FIVE STATES

	Hospitals	Q3 2018 % of Net Revenue
Indiana	11	12.9%
Florida	18	12.4%
Texas	12	12.1%
Alabama	6	9.3%
Tennessee	12	7.4%
Total Top 5		***54.1%***

CHS Regional Networks



Northwest Indiana
- 3 hospitals
- 480 physicians

Lutheran Health Network
- 8 hospitals
- 1,080 physicians

Commonwealth Health
- 6 hospitals
- 820 physicians

Northwest Health -Tucson
- 2 hospitals
- 650 physicians

Tennova Healthcare
- 12 Hospitals
- 1,730 physicians

Bayfront Health
- 7 hospitals
- 1,620 physicians

Physicians Regional - Naples
- 2 hospitals
- 320 physicians

Alabama Network
- 6 hospitals
- 1,440 physicians

AllianceHealth Oklahoma
- 8 hospitals
- 390 physicians

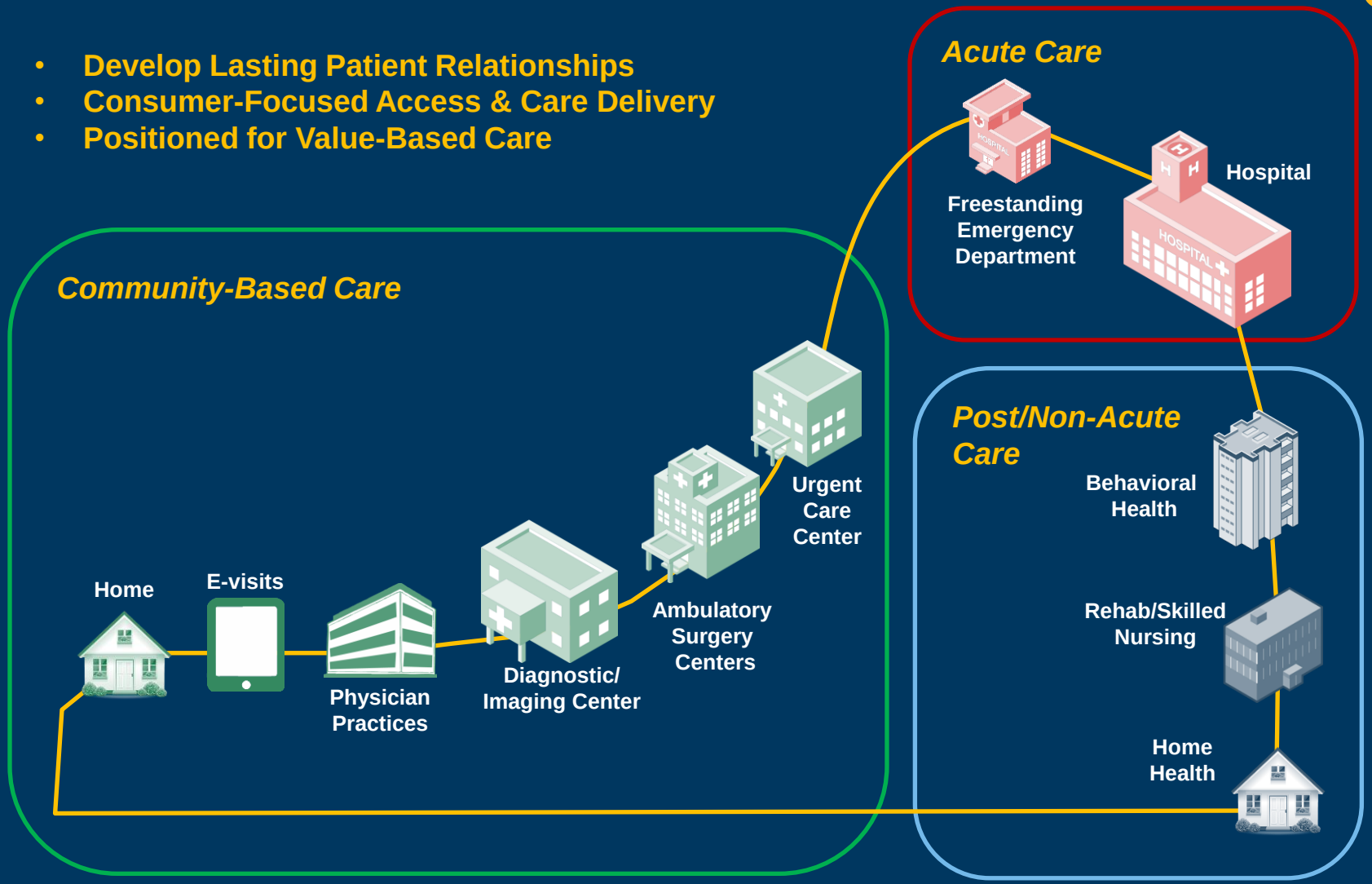
Northwest Health Arkansas
- 5 hospitals
- 420 physicians

Merit Health
- 9 hospitals
- 1,200 physicians

** Active Medical Staff Physicians as of September 30, 2018*

Growth Across the Continuum of Care

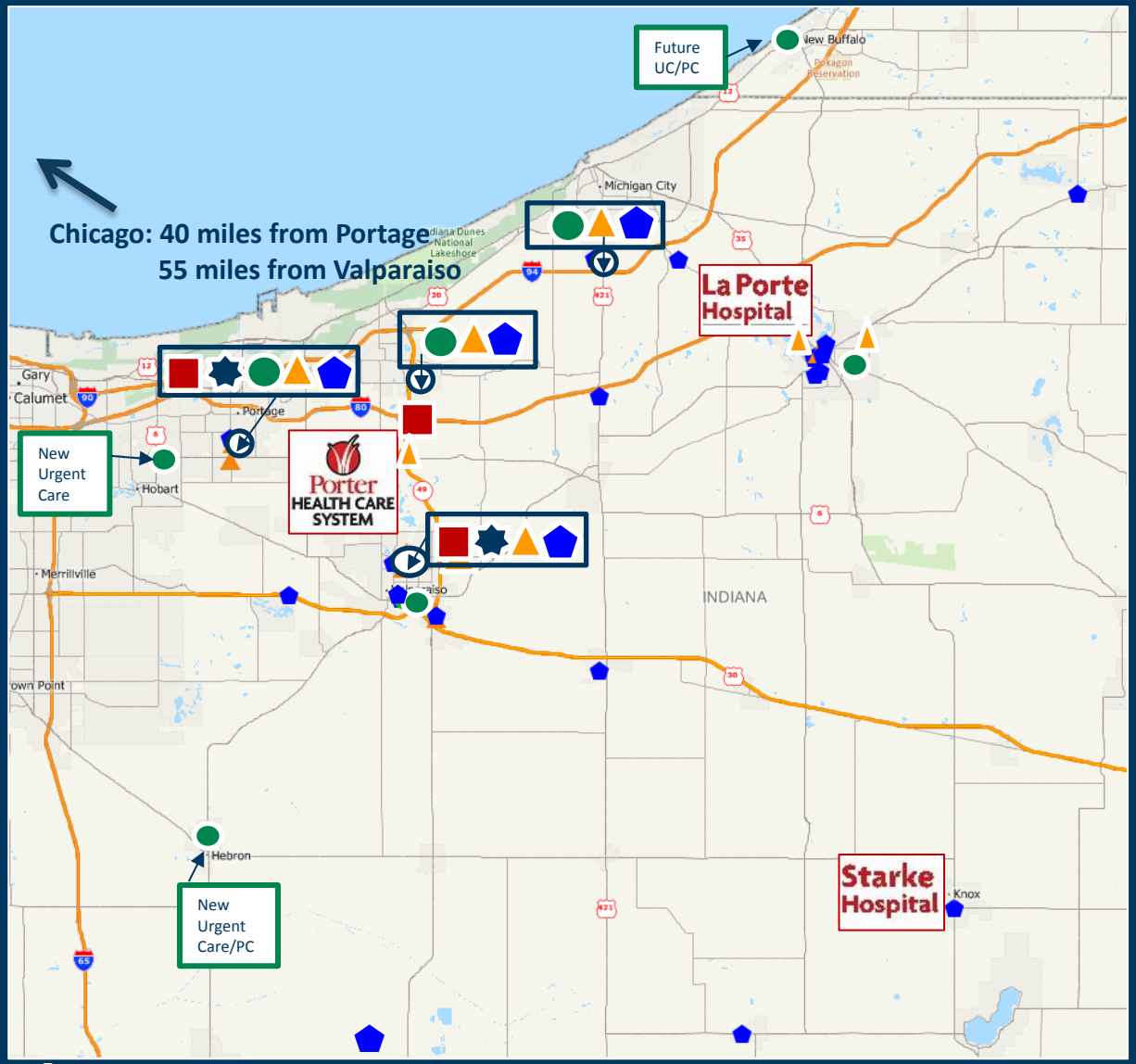
- Develop Lasting Patient Relationships
- Consumer-Focused Access & Care Delivery
- Positioned for Value-Based Care



Growth – Access Point Expansion

- **50 Surgery Centers**
- **42 Urgent Care Centers**
- **49 Walk-In or Retail Clinics**
- **10 Freestanding EDs**
- **86 Home Health Agencies** (20% JV partner)
- **106 Diagnostic Centers**
- **765 Physician Clinics**

CHS Market Growth Focus: Northwest Indiana



3 Hospitals

Porter HEALTH CARE SYSTEM

La Porte Hospital

Starke Hospital

- 3 ASCs
- 2 FSEDs
- 5 Urgent Care Clinics
- 13 Outpatient Centers
- 19 Physician Offices

- ✓ Transfer Center
- ✓ Provider Outreach
- ✓ ACO

CHS Strategic Imperatives

Our Strategic Imperatives are the most highly-prioritized, high-impact areas of focus for our organization.

Key Initiatives Drive Market Strategy

- High Reliability Focus
- Patient Experience
- CMS Star Ratings

- Engaged Employee Teams
- Efficient Throughput
- Expense Management

- Consumer-Friendly Access
- Transfer Center
- Digital Engagement

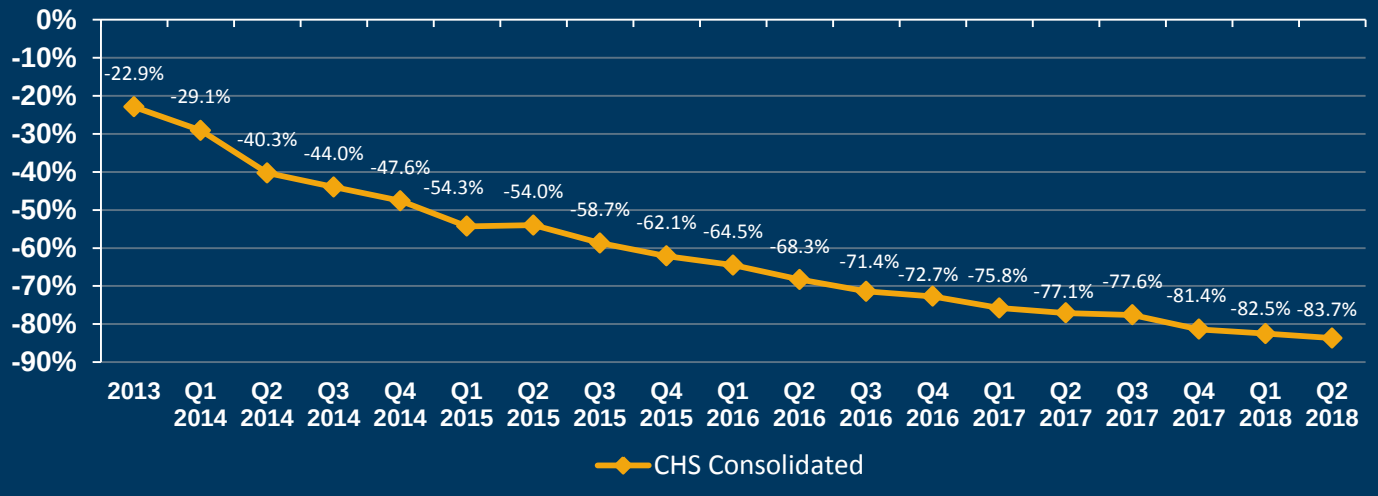
- Provider Relations & Outreach
- ACO Alignment
- Service Line Development

Demonstrate Quality

Consistent Reduction of the Serious Safety Event Rate

High Reliability

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

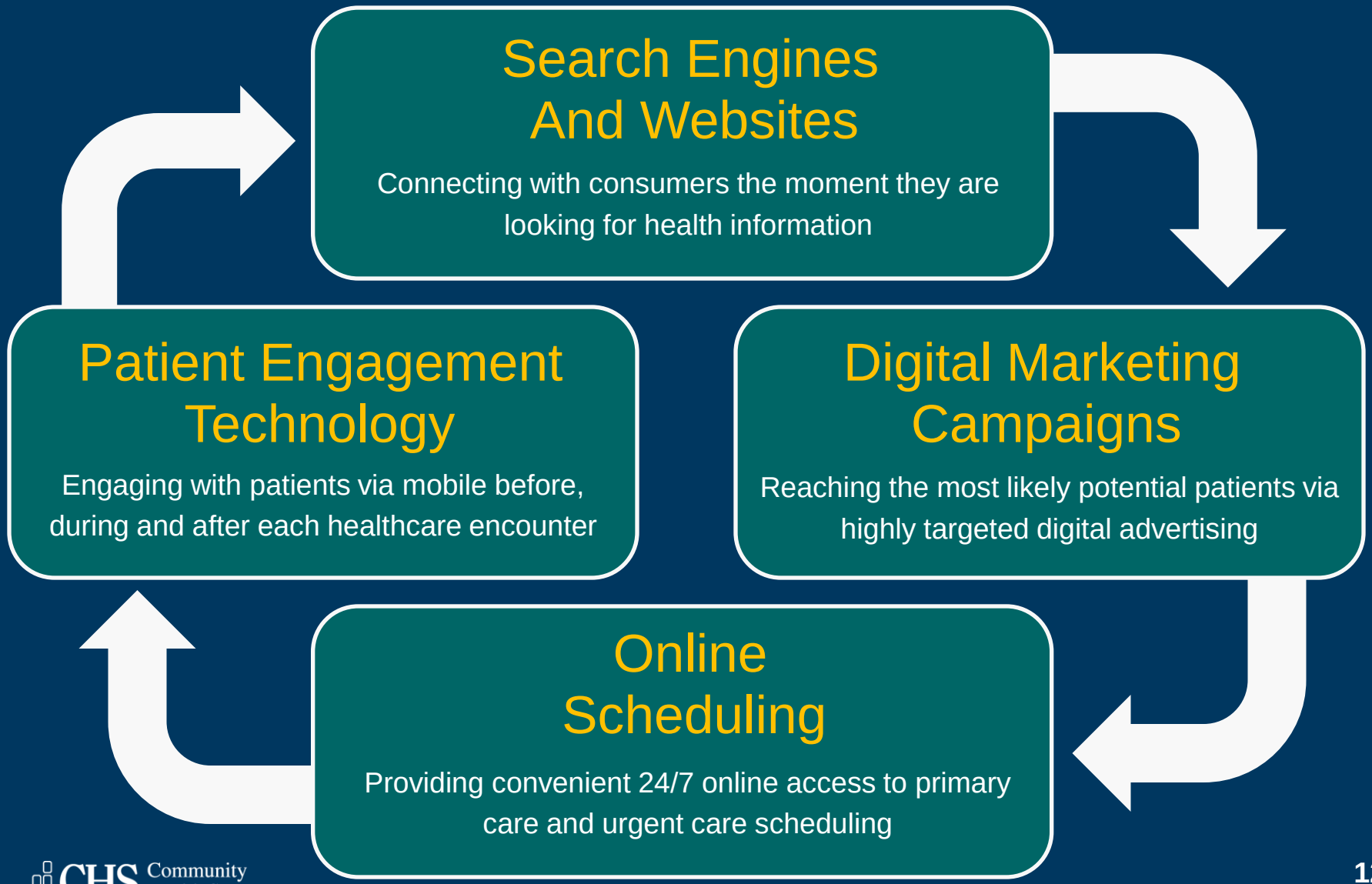


Note: Hospitals are compared to an April 2013 baseline; Data trails by one quarter and is not yet available for Q3 2018.

Ongoing Research Collaboration with Harvard

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

Connecting Digitally



Connecting Patients – Transfer Center

Call to CHS Transfer Center

Transferred to Appropriate Level of Care

Post Acute Placement Options

Patient Entry Points

- **Physician Practices**
- **Acute Care, Urgent Care and FSEDs**
- **EMS Transport**
- **Community-based Behavioral Health (BH), SNF, IRF**

CHS Transfer Center

CHS

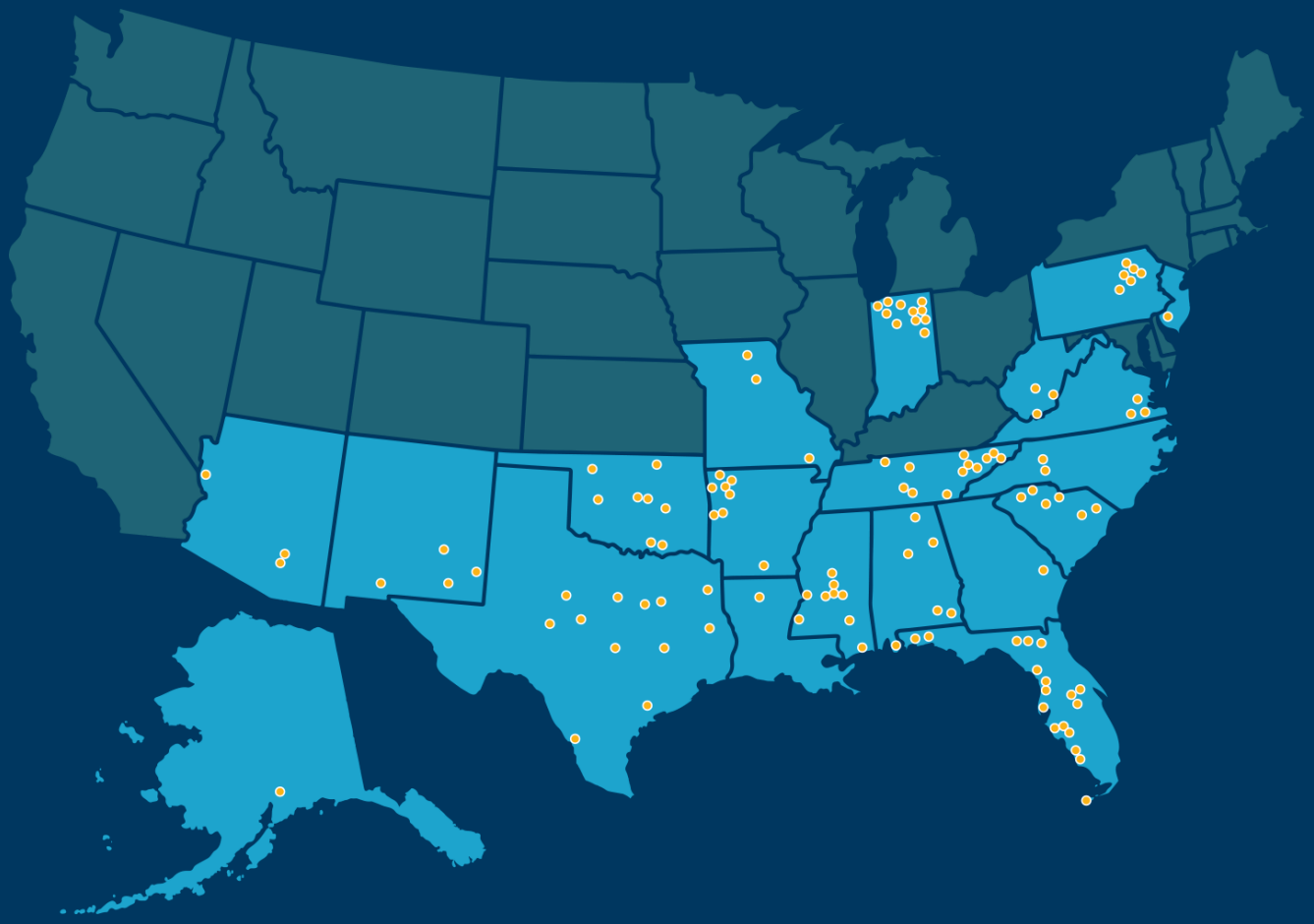
Non-CHS

CHS/Non-CHS BH & Post Acute

- Transfer patients into and out of CHS-affiliated hospitals
- Staffed 24/7 with Nursing and Behavioral Health professionals
- Acute care and post acute care placement
- Behavioral Health telemedicine assessment and placement
- Data provides operational transparency and market insights

Physician Alignment – Accountable Care Organizations (ACOs)

15 MSSP ACOs



4K+
Participating Providers

500+
Participating Practices & Hospitals

260K+
Attributed MFFS Lives

Medical Staff Collaboration and Clinical Integration

Medical Staff Alignment

- Value Based Care Initiatives (e.g. ACOs)
- Service Line Leadership
- ASC, Outpatient Partnerships
- Physician Outreach, Liaison Programs

Employed Provider Alignment

- Corporate Physician-led Practice Support
- Centralized Scheduling, Online Scheduling

Strategic Physician Recruitment

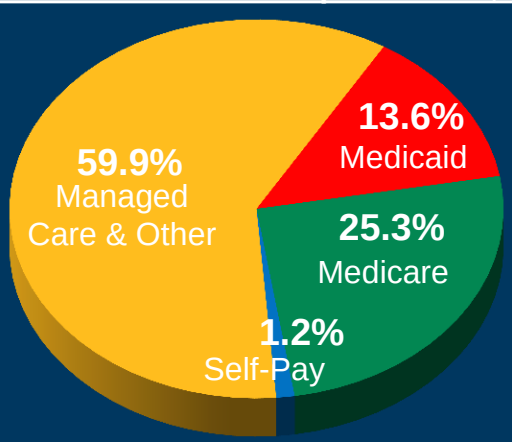
- Prioritized Recruitment Focus
- Service Line Development

Operational Efficiency

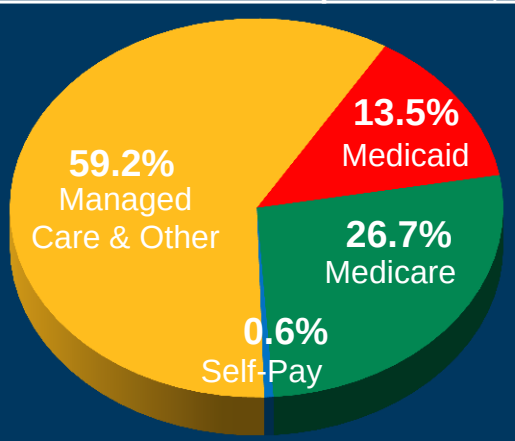
- SWB Management
- Supply Chain Optimization
- Vendor Efficiencies
- Shared Service Centers
- High Opportunity Hospitals
- Peak Performance Teams

Payor Mix (Consolidated)

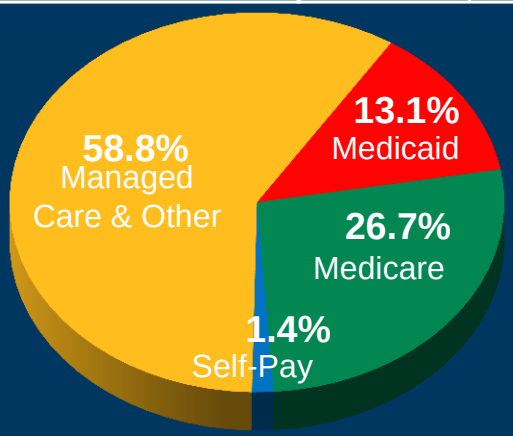
Three Months Ended September 30, 2018



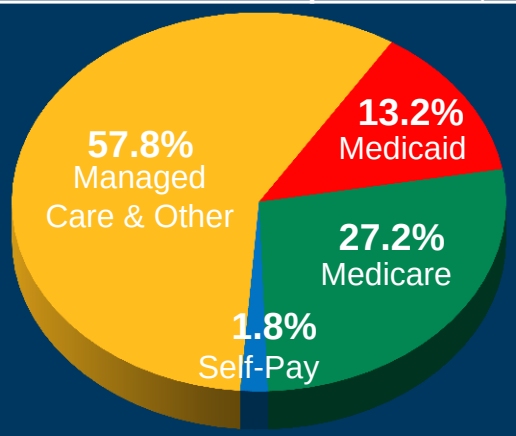
Three Months Ended September 30, 2017



Nine Months Ended September 30, 2018



Nine Months Ended September 30, 2017



- **Payor mix is presented as a percent of net revenue after the provision for uncollectible revenue (or, for 2017, provision for bad debt).**
- **Total consolidated uncompensated care as a percentage of adjusted net revenue (net revenue before the provision for uncollectible revenue + charity care + administrative self pay discount) for the three months ended September 30, 2018 was 32.3% compared to 30.9% for the same period in 2017.**

Q3 2018 Highlights

	Q3 2018 compared to Q3 2017		YTD 2018 compared to YTD 2017	
	Consolidated	**Same Store**	**Consolidated**	**Same Store**
Net Operating Revenues	-5.9%	3.2%	-13.0%	2.6%
Admissions	-12.4%	-2.3%	-16.5%	-2.4%
Adjusted Admissions	-12.2%	-0.8%	-16.9%	-0.9%
Surgeries	-8.8%	0.3%	-15.2%	-0.7%
ER Visits	-13.1%	-1.7%	-17.0%	-1.1%

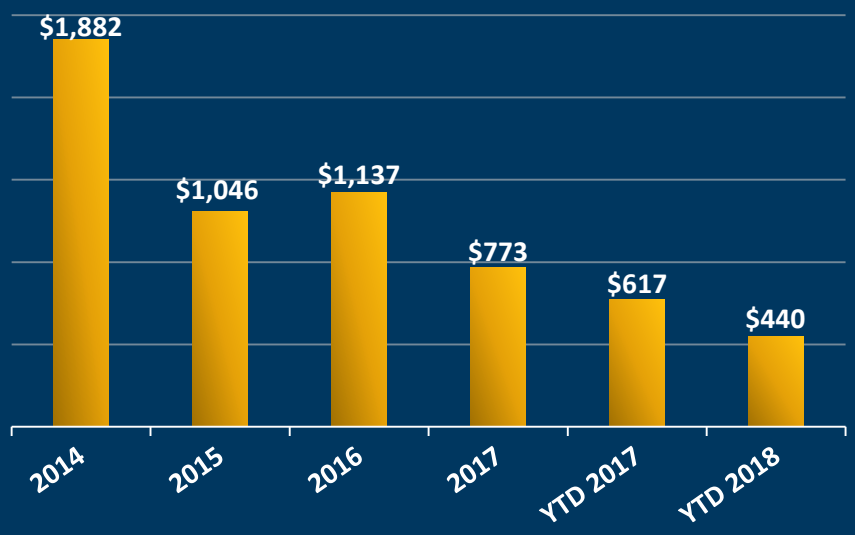
Q3 2018 Same-Store Operations Highlights

	Same-Store
Net Revenue	+3.2%
Net Revenue per Adjusted Admission	+4.0%
Year-over-Year Results:	
Adjusted Admissions	-0.8%
Surgeries	+0.3%
Year-over-Year Results:	
Salaries and Benefits	-50BPS
Supplies	-30BPS
Other Operating Expenses	+70BPS

Cash Flow and Capital Expenditures

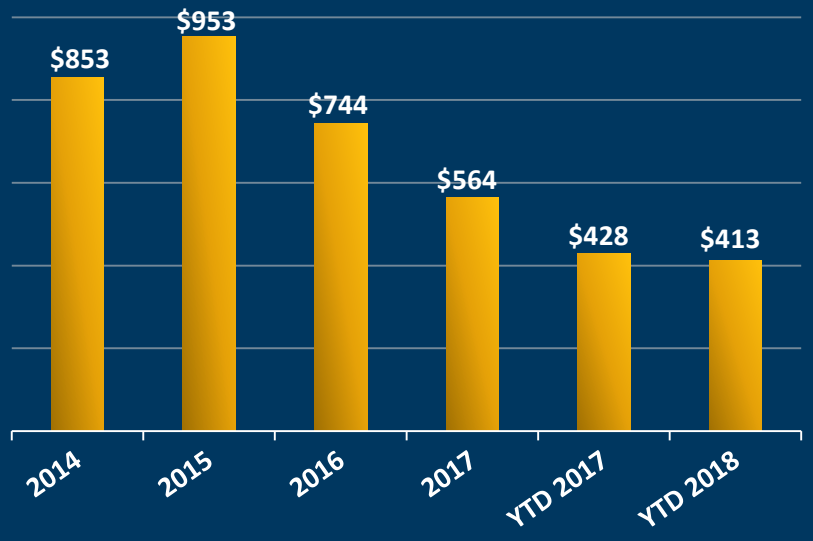
Cash Flows from Operations

($ in millions)



Capital Expenditures

($ in millions)



CapEx % of net revenue (includes replacement hospitals)					
4.6%	4.9%	4.0%	3.5%	3.5%	3.9%
Replacement hospitals % of net revenue					
0.6%	0.6%	0.1%	0.0%	0.0%	0.0%

Rationalizing Our Portfolio

Hospital Divestitures (30 Hospitals) – Transactions Closed in 2017

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

Hospital Divestitures – Transactions Closed in 2018

- Completed sale of one hospital (in FL), announced April 2nd
- Completed sale of three hospitals (in TN), announced June 1st
- Completed sale of one hospital (in TN), announced June 1st
- Completed sale of one hospital (in LA), announced June 1st
- Completed sale of one hospital (in WV)
- Completed sale of one hospital (in FL), announced August 1st
- Completed sale of one hospital (in OK), announced October 1st
- Completed sale of two hospitals (in AR), announced November 1st

Divestitures Underway in 2018

- 3 hospitals under definitive agreements (2 in SC and 1 in NJ)
- Total contemplated divestitures accounted for at least $2.0 billion of 2017 annual net revenue, with mid-single digit EBITDA margins
- Total estimated gross proceeds, excluding working capital of ~$1.3 billion
- Expect the remainder of these divestitures to close during 2018 and 2019

Closures in 2018

- Completed one in Missouri
- Closing two in Tennessee

Continue to Optimize and Further Strengthen Our Portfolio

By rationalizing our portfolio, future investments can be committed to our most attractive locations.

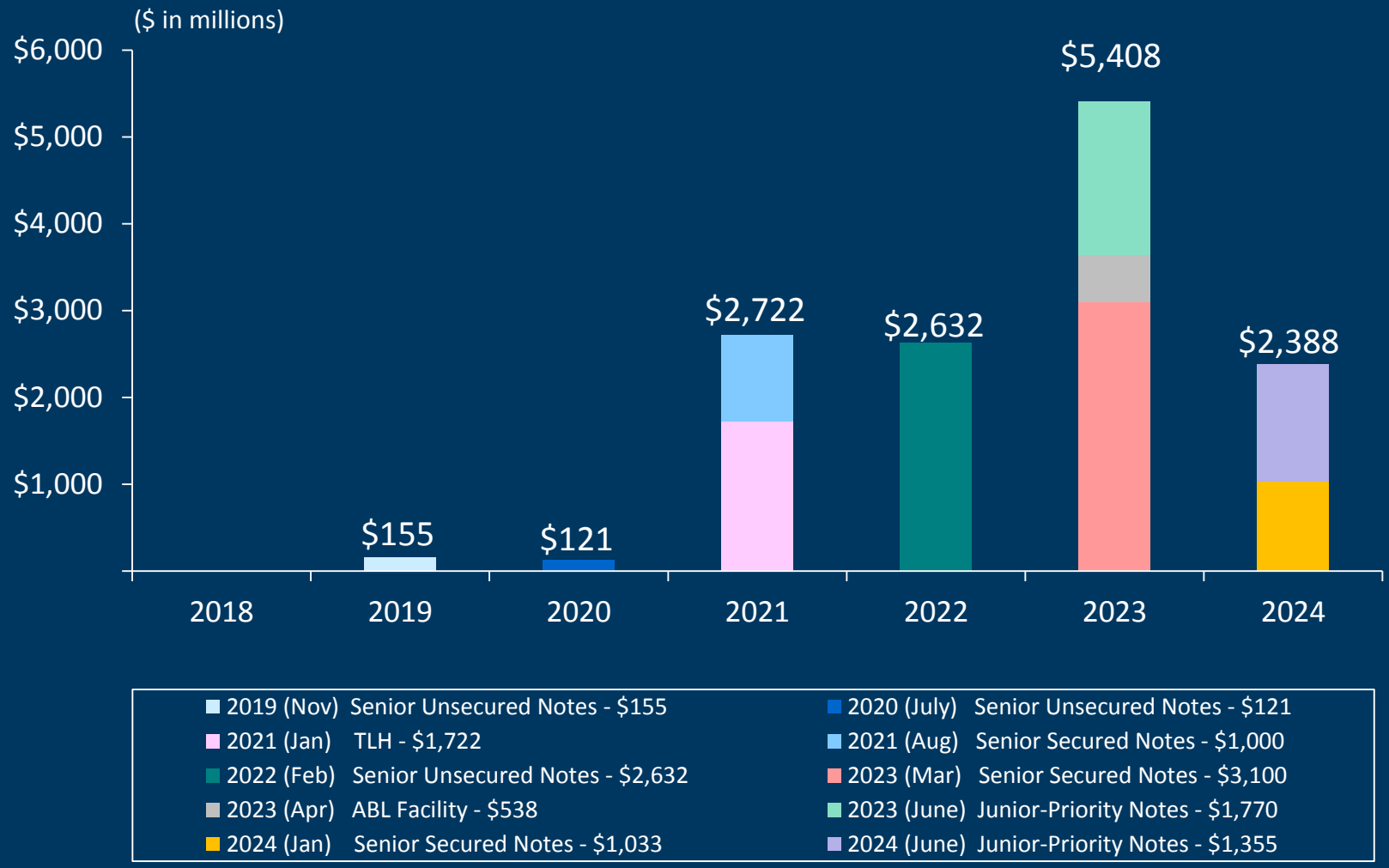
2018 Guidance Overview as of October 29, 2018

	2018 Projection Range
Net operating revenues (in millions)	$14,000 to $14,200
Adjusted EBITDA (in millions)	$1,600 to $1,650
Depreciation and amortization as a percentage of net operating revenues	5.0%
Interest expense as a percentage of net operating revenues	7.0%
Loss from continuing operations per share – diluted	$(2.25) to $(2.10)
Weighted-average diluted share (in millions)	113
Net cash provided by operating activities (in millions)	$550 to $650
Capital expenditures (in millions)	$500 to $575
Same-store adjusted admissions	(1.0)% to 0.0%
HITECH Incentives (in millions)	$0

The 2018 projections include the impact of completed and announced divestitures expected to close in 2018.

Our comprehensive 2018 guidance has been provided on pages 17 and 18 on Form 8-K dated October 29, 2018 and includes important assumptions and exclusions.

Debt Maturity as of September 30, 2018



Focused Strategy

CHS Community Health Systems, Inc.

Other Financial Information

Unaudited Supplemental Information

EBITDA is a non-GAAP financial measure which consists of net loss attributable to Community Health Systems, Inc. before interest, income taxes, and depreciation and amortization. Adjusted EBITDA, also a non-GAAP financial measure, is EBITDA adjusted to add back net income attributable to noncontrolling interests and to exclude the effect of discontinued operations, loss (gain) from early extinguishment of debt, impairment and (gain) loss on sale of businesses, gain on sale of investments in unconsolidated affiliates, expense incurred related to the spin-off of QHC, expense incurred related to the sale of a majority ownership interest in the Company's home care division, expense (income) related to government and other legal settlements and related costs, expense related to employee termination benefits and other restructuring charges, expense (income) from settlement and fair value adjustments on the CVR agreement liability related to the HMA legal proceedings and related legal expenses, and the overall impact of the change in estimate related to net patient revenue recorded in the fourth quarter of 2017 resulting from the increase in contractual allowances and the provision for bad debts. The Company has from time to time sold noncontrolling interests in certain of its subsidiaries or acquired subsidiaries with existing noncontrolling interest ownership positions. The Company believes that it is useful to present Adjusted EBITDA because it adds back the portion of EBITDA attributable to these third-party interests and clarifies for investors the Company's portion of EBITDA generated by continuing operations. The Company reports Adjusted EBITDA as a measure of financial performance. Adjusted EBITDA is a key measure used by management to assess the operating performance of the Company's hospital operations and to make decisions on the allocation of resources. Adjusted EBITDA is also used to evaluate the performance of the Company's executive management team and is one of the primary targets used to determine short-term cash incentive compensation. In addition, management utilizes Adjusted EBITDA in assessing the Company's consolidated results of operations and operational performance and in comparing the Company's results of operations between periods. The Company believes it is useful to provide investors and other users of the Company's financial statements this performance measure to align with how management assesses the Company's results of operations. Adjusted EBITDA also is comparable to a similar metric called Consolidated EBITDA, as defined in the Company's senior secured credit facility, which is a key component in the determination of the Company's compliance with some of the covenants under the Company's senior secured credit facility (including the Company's ability to service debt and incur capital expenditures), and is used to determine the interest rate and commitment fee payable under the senior secured credit facility (although Adjusted EBITDA does not include all of the adjustments described in the senior secured credit facility).

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

Unaudited Supplemental Information

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
Net loss attributable to Community Health Systems, Inc. stockholders	$ (325)	$ (110)	$ (460)	$ (446)
Adjustments:				
Provision for (benefit from) income taxes	104	(59)	58	(74)
Depreciation and amortization	173	206	531	665
Net income attributable to noncontrolling interests	17	20	55	56
Loss from discontinued operations	-	2	-	10
Interest expense, net	256	238	720	706
Loss (gain) from early extinguishment of debt	27	4	(32)	35
Impairment and (gain) loss on sale of businesses, net	112	33	314	363
Expense (income) from government and other legal settlements and related costs	2	1	9	(32)
Expense (income) from settlement and fair value adjustments and legal expenses related to cases covered by the CVR	4	(6)	13	6
Expense related to the sale of a majority interest in home care division	-	-	-	1
Expense related to employee termination benefits and other restructuring charges	2	2	15	4
Adjusted EBITDA	$ 372	$ 331	$ 1,223	$ 1,294

Income Summary

(Amounts in millions, except margin and EPS)

	Three Months Ended September 30,			Nine Months Ended September 30,		
	2018	2017	Change	2018	2017	Change
Net Operating Revenues	$ 3,451	$ 3,666	-5.9%	$ 10,702	$ 12,295	-13.0%
Adjusted EBITDA[(1)]	$ 372	$ 331	12.4%	$ 1,223	$ 1,294	-5.5%
Adjusted EBITDA Margin[(1)]	10.8%	9.0%	180 BPS	11.4%	10.5%	90 BPS
EPS from Continuing Operations, Excluding Adjustments[(2)]	$ (1.64)	$ (0.77)	-113.0%	$ (1.52)	$ (0.95)	-60.0%
Shares Outstanding (Weighted and Fully Diluted)	113	112		113	112	

(1) See the Unaudited Supplemental Information contained in this presentation for a definition of Adjusted EBITDA and a reconciliation of Adjusted EBITDA, as defined, to net loss attributable to Community Health Systems, Inc. stockholders as derived directly from our consolidated financial statements for the three and nine months ended September 30, 2018 and 2017 (slides 26 and 27).

(2) See reconciliation of diluted EPS excluding adjustments on slide 29.

Diluted EPS – Excluding Adjustments

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
Net loss, as reported	$ (2.88)	$ (0.98)	$ (4.08)	$ (3.99)
Adjustments:				
Discontinued operations	-	0.02	-	0.08
Loss (gain) from early extinguishment of debt	0.19	0.02	(0.22)	0.20
Impairment and (gain) loss on sale of businesses, net	0.79	0.19	2.32	2.87
Expense (income) from government and other legal settlements and related costs	0.01	0.01	0.06	(0.19)
Expense (income) from settlement and fair value adjustments and legal expenses related to cases covered by the CVR	0.03	(0.04)	0.09	0.05
Expense related to employee termination benefits and other restructuring charges	0.02	0.01	0.11	0.03
Tax effect of non-deductible portion of HMA legal settlement	0.21	-	0.21	-
Loss from continuing operations, excluding adjustments	$ (1.64)	$ (0.77)	$ (1.52)	$ (0.95)

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

Balance Sheet Data

($ in millions)	September 30, 2018	December 31, 2017
Working Capital	$ 1,245	$ 1,712
Total Assets	$ 16,469	$ 17,450
Long Term Debt	$ 13,535	$ 13,880
Stockholders' Deficit	$ (1,205)	$ (767)

- At September 30, 2018, approximately 94% of our debt was fixed, including swaps.
- Net debt (long-term debt, plus current maturities of long-term debt, less cash and cash equivalents) has been reduced by $1.8 billion since December 31, 2016.
- Days revenue outstanding, adjusted for the impact of receivables for state Medicaid supplemental payment programs, was 58 days at September 30, 2018 and 56 days at December 31, 2017.