37th Annual J.P. Morgan Healthcare Conference

January 9, 2019

CHS Community Health Systems

Disclaimer Statement

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. 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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.

COMPANY BACKGROUND

CHS Community Health Systems

CHS Background

1985
Company Founded

2000
NYSE Listed Company
Symbol: CYH

2018

- **118** Hospitals in **20** States*
- Over **700,000** Annual Admissions
- Nearly **4 Million** Annual ED Visits
- **88,200** Employees
- **15,520** Physicians on Staffs
- **2,070** Employed Physicians

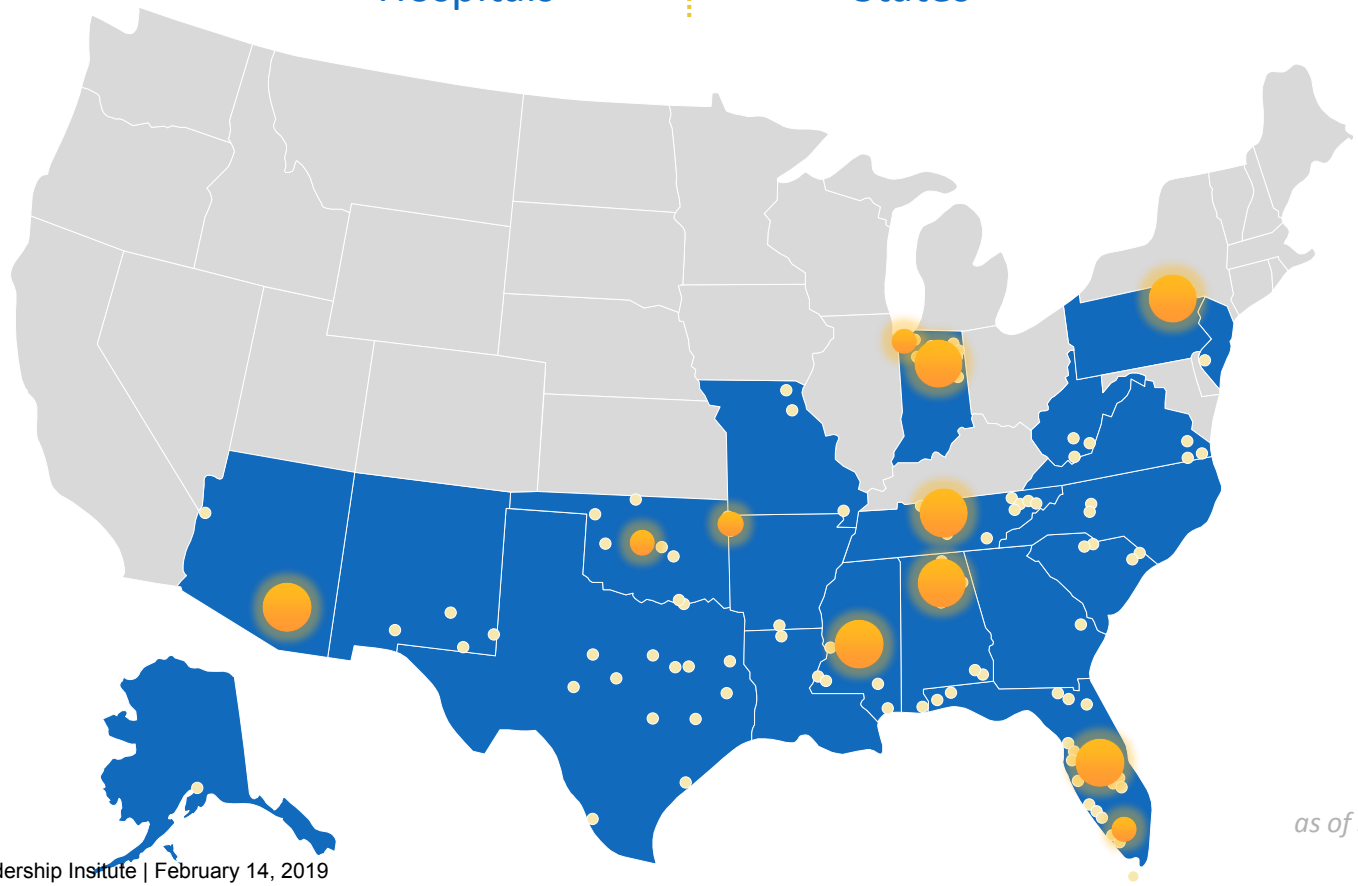
**as of September 30, 2018*

Strengthening Our Portfolio

By intentionally shifting the portfolio toward select suburban / urban markets, CHS is positioned for growth across the care continuum.

118
Hospitals

20
States



as of September 30, 2018

Executing Across the Portfolio

Investments provide platform for strong performance.

Leveraging recent strategic investments

Strategies are aligned with each market's opportunities

Portfolio is well-positioned

- Over 80% of our hospitals are in CSAs above 50,000 residents
- Attractive larger markets with growth potential

CHS Strategic Imperatives

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

Committed to Quality and Safety

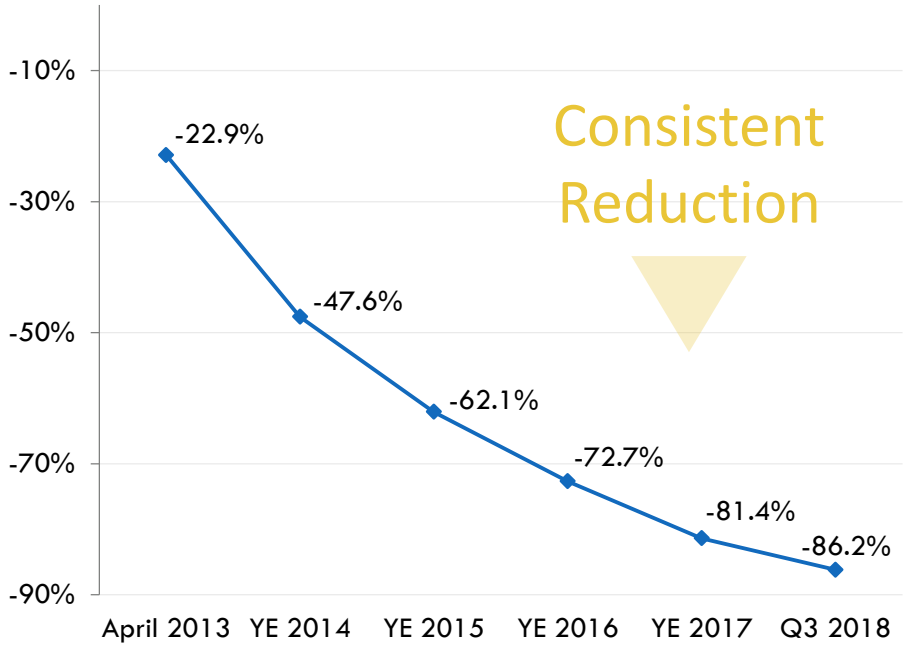
By leveraging techniques from high-risk industries such as nuclear power and aviation, CHS is creating inherently safe hospital environments for patients and staff.

DRIVERS OF HIGH RELIABILITY & SAFETY

- SAFETY IS A CORE VALUE
- STANDARDIZED PROGRAM ELEMENTS
- PEOPLE, PROCESS, & TECHNOLOGY

SERIOUS SAFETY EVENT RATE

(SSER)



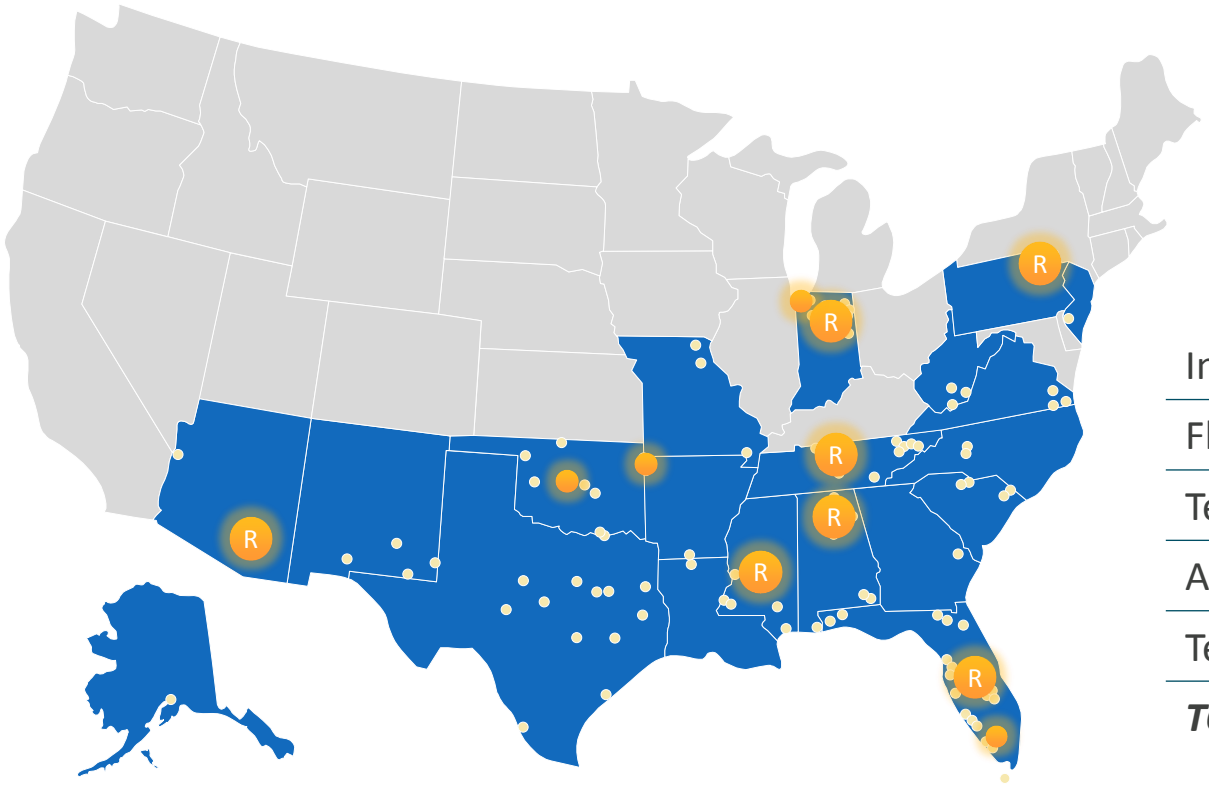
NOTE: Hospitals are compared to an April 2013 baseline.

DEVELOPING STRONGER MARKETS

CHS Community Health Systems

CHS Regional Network Model

The regional network model provides a direct connection to CHS resources while promoting agility and quicker execution of strategic opportunities.



TOP 5 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%**

4 of our top 5 states include the regional leadership model.

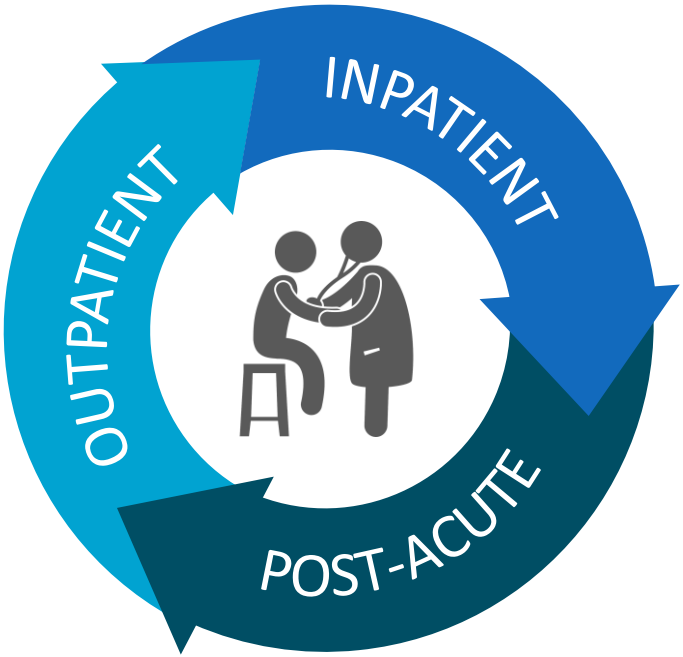
DRIVING GROWTH

CHS Community Health Systems

Building Healthcare Systems

CHS Community Health Systems

CHS is focused on providing high quality services throughout the care continuum.



ASSET	# YE 2018
Freestanding Emergency Departments	11
Urgent Care Centers / Walk-In / Retail Clinics	97
Physician Practices	765
Ambulatory Surgery Centers	51
Diagnostic / Imaging Centers	107
Hospitals	111
Behavioral Health	37
Rehab / SNF	33
Home Health *(20% JV Partner)*	81

Outpatient Developments

Outpatient strategies are driving growth.

53%

of net revenue comes from outpatient services

Access Point Expansion

Primary Care Development

Accountable Care Organization

Consumer Friendly Scheduling

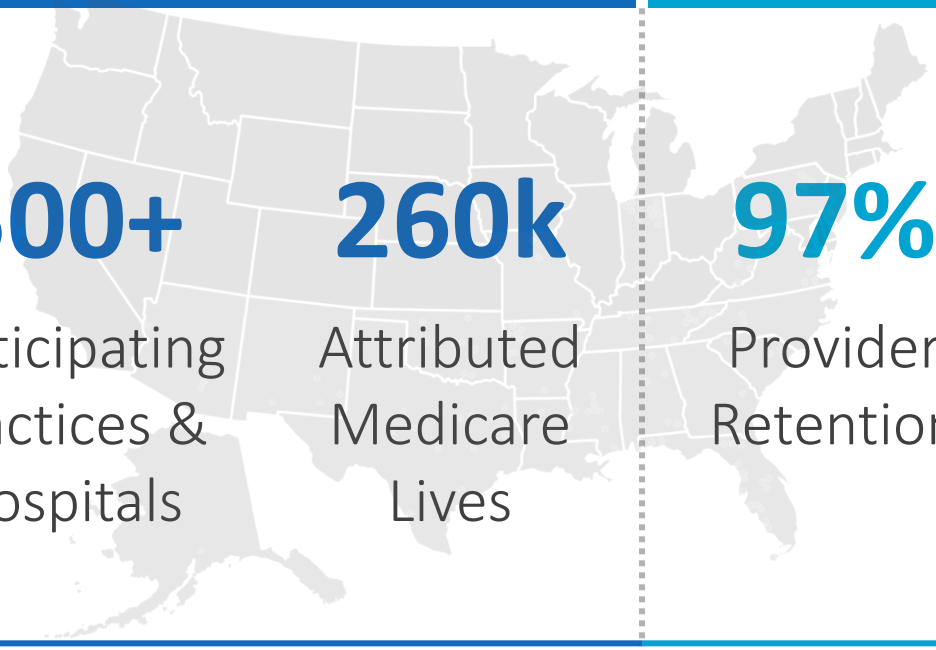
Digital / Online Marketing

Accountable Care Organizations

CHS Community Health Systems

CHS is focused on strategic physician alignment to further advance value-based care.

15 Medicare ACOs



2018 RESULTS			2019	
4K+	**500+**	**260k**	**97%**	**+150**
Participating Providers	Participating Practices & Hospitals	Attributed Medicare Lives	Provider Retention	New Independent Physicians

Digital Patient Engagement

Expanding reach, simplifying access, and focusing on the patient experience.

Search Engine & Website Optimization

Connecting with consumers the moment they are looking for health information

Digital Marketing

Reaching the most likely potential patients via highly targeted digital advertising

Centralized & Online Scheduling

Providing convenient 24/7 online access to physician and urgent care scheduling

Patient Engagement Technology

Engaging with patients via mobile before, during and after each healthcare encounter

Inpatient Service Line Investments

Larger market profile provides opportunities to expand service lines, case complexity, and acuity.

Medical Staff Development & Recruitment

Capital & Technology Prioritization

CHS Transfer Center

Emergency Department Operational Excellence

Provider & Clinical Outreach Services

CHS Transfer Center

The implementation of Transfer Center services facilitates admissions to CHS hospitals.

CHS TRANSFER CENTER OVERVIEW

Staffed

24/7

with Nursing and Behavioral Health professionals

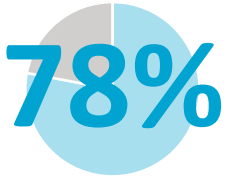
Facilitates

ACUTE & POST-ACUTE

care placement

PROGRESS TO DATE

Implementation Plan



complete as of YE 2018

Established in

13 markets

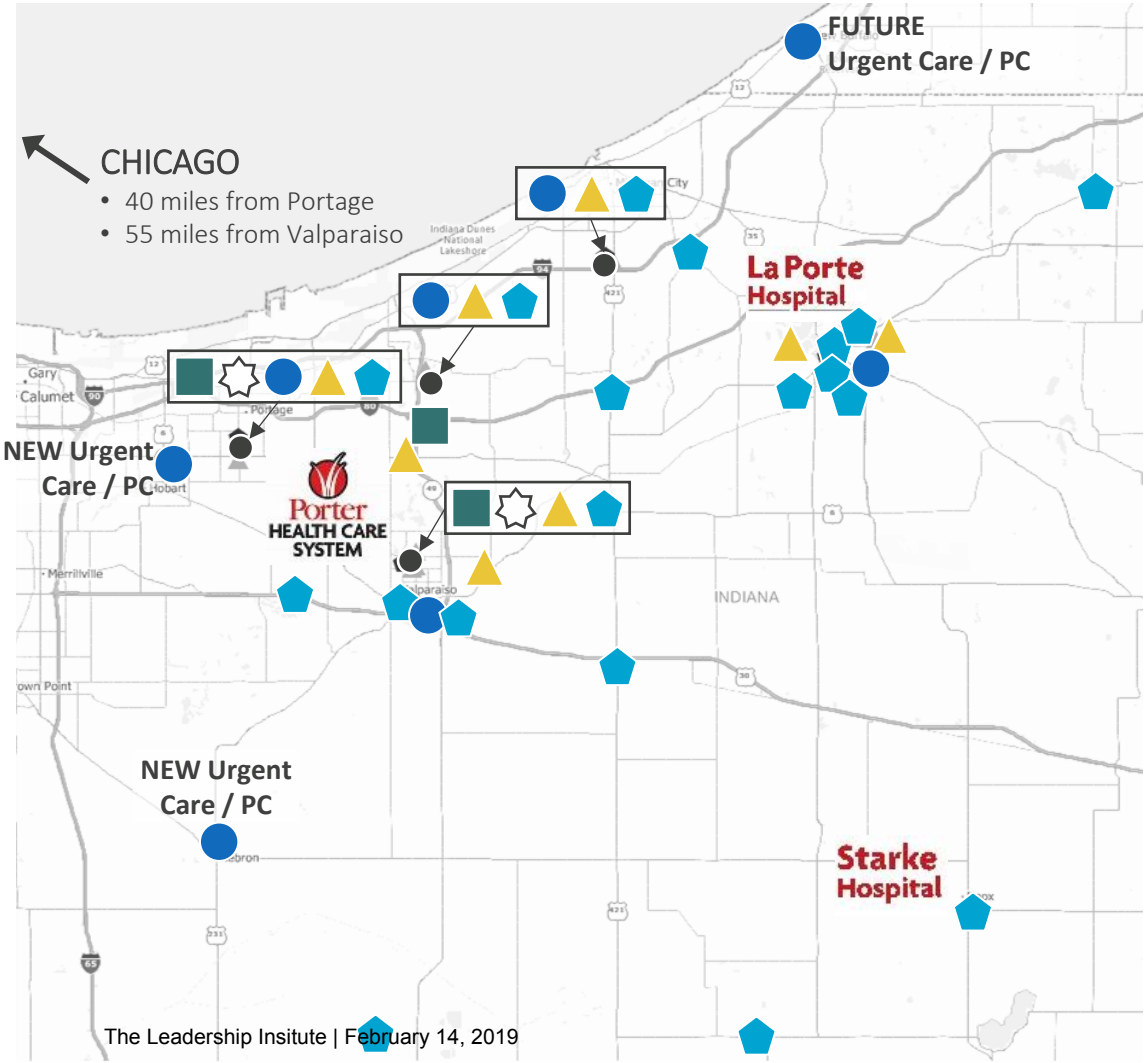
46 hospitals

RESULTS

- ✓ Sequential quarterly improvement in received transfers
- ✓ Data provides operational transparency and market insights

Care Continuum - NW Indiana Market

Northwest Indiana is a prime example of a market intentionally designed to capture patients across the care continuum.



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
- ✓ Digital Patient Engagement
- ✓ ACO
- ✓ Provider Outreach

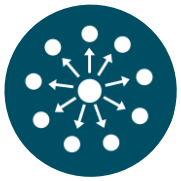
ADVANCING OPERATIONAL INITIATIVES

CHS Community Health Systems

Operational Efficiency

CHS is leveraging technology and scale to deliver operational excellence.

SWB Management



Shared Service Centers

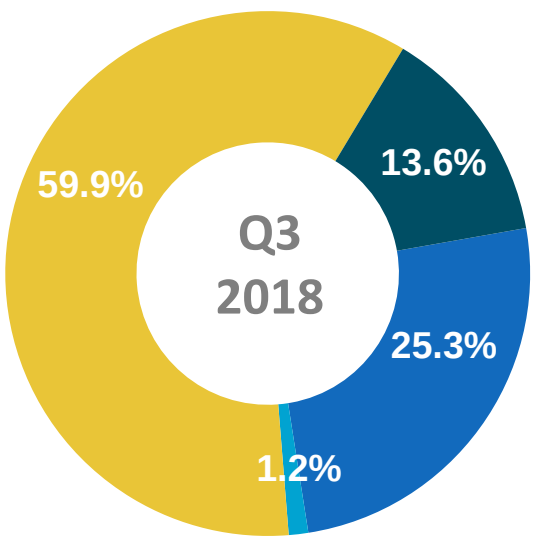
Supply Chain Optimization

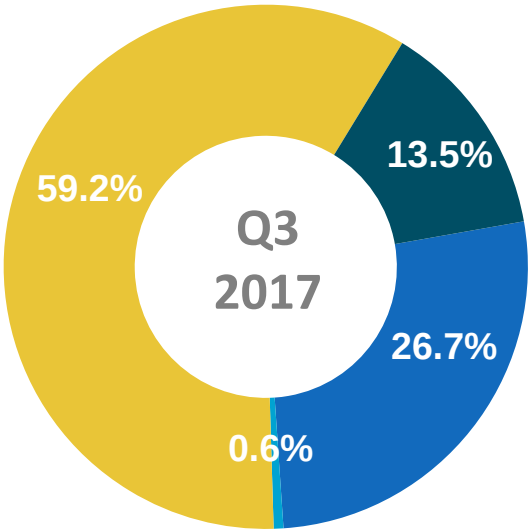
Vendor Efficiencies

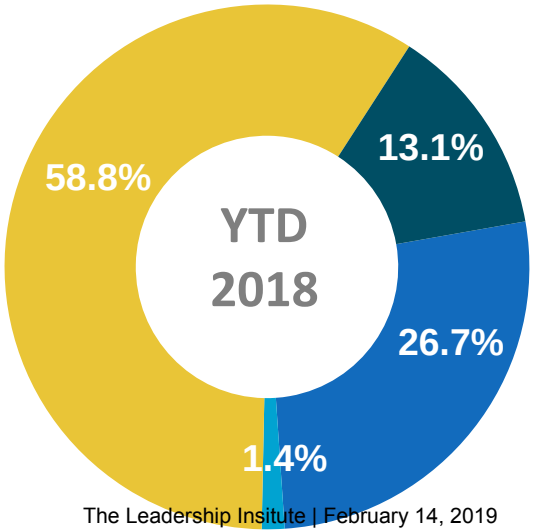
FINANCIAL PERFORMANCE

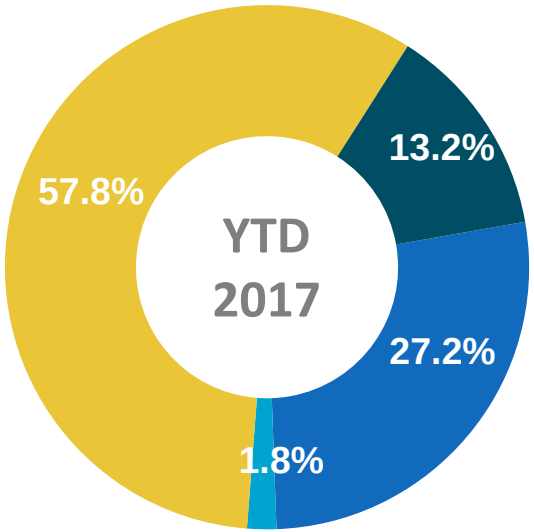
CHS Community Health Systems

Payor Mix (Consolidated)









- Payor mix is presented as a percent of net revenue after the provision for uncollectible revenue (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.

Key
- Managed Care & Other
- Medicaid
- Medicare
- Self-Pay

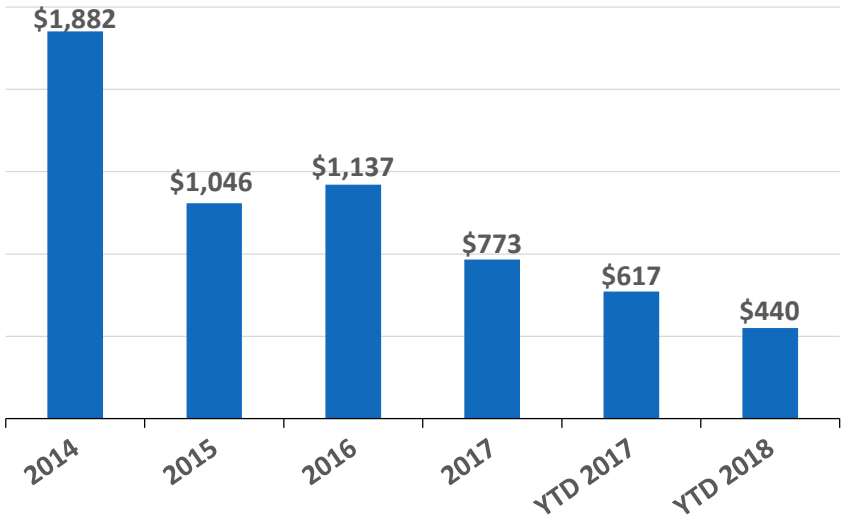
Q3 2018 Highlights

	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%
Net Revenue per AA		4.0%		3.5%

Cash Flow & Capital Expenditures

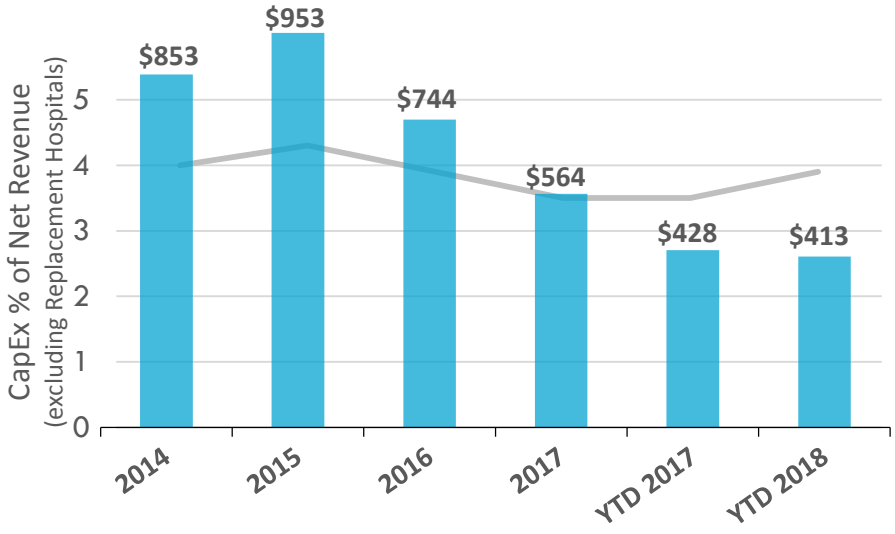
Cash Flows from Operations

($ in millions)



Capital Expenditures

($ in millions)



	2014	2015	2016	2017	YTD 2017	YTD 2018
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

Allowing for greater investments in stronger markets as well as debt reduction.

Transactions Completed in 2017

- Completed the sale of 30 hospitals
  - Annualized revenue: ~$3.4 billion, with mid-single digit EBITDA margins
  - Gross proceeds, excluding working capital: ~$1.7 billion

Transactions Completed in 2018

- Completed the sale of 13 hospitals
  - 2017 annual revenue: ~$1.1 billion, with low-single digit EBITDA margins
  - Gross proceeds, excluding working capital: ~$400 million

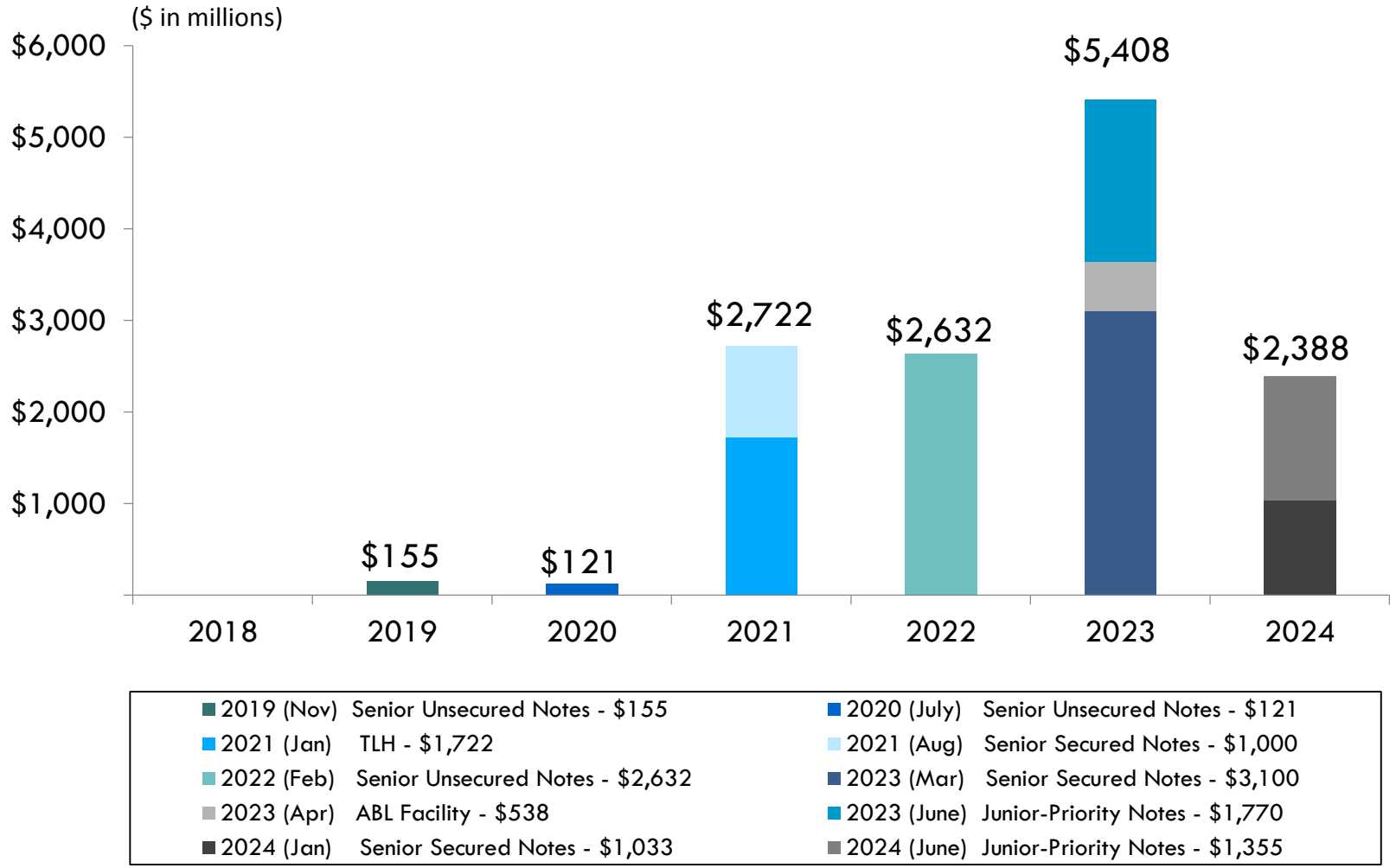
Transactions Underway in 2019 & Completed 2018 Divestitures

- 5 hospitals under definitive agreements (4 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 2019

Hospital Closures in 2018

- Closed 3 hospitals

Debt Maturity as of September 30, 2018



Positioned for Growth

Strategic execution and targeted capital investments provides a platform for 2019 and beyond.

1. Developing Stronger Markets

2. Driving Growth

3. Advancing Operational Initiatives

IMPROVED REVENUE & EBITDA

APPENDIX: Other Financial Information

CHS Community Health Systems

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 29 and 30).

(2) See reconciliation of diluted EPS excluding adjustments on slide 32.

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.