

Jackson Hospital CORP
Form S-4
September 25, 2007

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**Subject to completion, as filed with the Securities and Exchange Commission on September 24, 2007
Registration No. 333-**

**UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549**

**Form S-4
REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933**

CHS/Community Health Systems, Inc.
(Exact Name of Registrant as Specified in Its Charter)

Delaware
(State of Incorporation)

8062
*(Primary Standard Industrial
Classification Code Number)*

76-0137985
*(I.R.S. employer
identification number)*

**4000 Meridian Boulevard
Franklin, Tennessee 37067
(615) 465-7000**

*(Address, Including Zip Code, and Telephone Number, Including Area Code, of Registrant's Principal Executive
Offices)*

**Rachel A. Seifert
CHS/Community Health Systems, Inc.
Senior Vice President, Secretary and General Counsel
4000 Meridian Boulevard
Franklin, Tennessee 37067
(615) 465-7000**

(Name, Address, Including Zip Code, and Telephone Number, Including Area Code, of Agent for Service)

Copy to:

**Joshua N. Korff, Esq.
Kirkland & Ellis LLP
Citicorp Center
153 East 53rd Street**

New York, New York 10022
(212) 446-4800

Approximate date of commencement of proposed sale to the public: The exchange will occur as soon as reasonably practicable after the effectiveness of this registration statement.

If the securities being registered on this form are being offered in connection with the formation of a holding company and there is compliance with General Instruction G, check the following box.

If this form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, please check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering.

If this form is a post-effective amendment filed pursuant to Rule 462(d) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering.

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered(1)	Proposed Maximum Aggregate Offering Price(1)	Amount of Registration Fee
87/8% Senior Notes due 2015	\$3,021,331,000	\$92,755
Guarantees(2)	N/A	N/A

(1) Estimated solely for the purpose of calculating the registration fee in accordance with Rule 457(o) promulgated under the Securities Act of 1933, as amended (the Securities Act).

(2) No separate consideration will be received for the guarantees, and no separate fee is payable, pursuant to Rule 457(n) under the Securities Act.

The Registrants hereby amend this Registration Statement on such date or dates as may be necessary to delay its effective date until the Registrants shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities act of 1933, as amended, or until this Registration Statement shall become effective on such date as the commission, acting pursuant to said Section 8(a), may determine.

Table of Contents**ADDITIONAL REGISTRANTS**

Exact Name of Registrant as Specified in its Charter	Incorporation or Organization	Primary State or Other Jurisdiction of Standard Industrial Classification	Code Number	I.R.S. Employer Identification No.	Address, Including Zip Code, and Telephone Number, Including Area Code, of Registrant's Principal Executive Offices
Centre Hospital Corporation	AL		8062	20-4370931	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Cullman Hospital Corporation	AL		8062	63-1157234	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Foley Hospital Corporation	AL		8062	62-1811413	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Fort Payne Hospital Corporation	AL		8062	20-4370870	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Greenville Hospital Corporation	AL		8062	63-1134649	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Forrest City Arkansas Hospital Company, LLC	AR		8062	20-4217095	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Forrest City Clinic Company, LLC	AR		8062	20-5624608	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Forrest City Hospital Corporation	AR		8062	20-4216978	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Phillips Hospital Corporation	AR		8062	75-2976342	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Payson Hospital Corporation	AZ		8062	86-0874009	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Chesterfield/Marlboro, L.P.	DE		8062	59-3303026	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
CHHS Holdings, LLC	DE		8062	20-2189938	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Cleveland Regional Medical Center, L.P.	DE		8062	59-3215798	4000 Meridian Blvd. Franklin, TN 37067

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Community GP Corp.	DE	8062	62-1648466	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067
Community Health Investment Corporation	DE	8062	76-0152801	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067
Community Health Systems, Inc.	DE	8062	13-3893191	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067
Community LP Corp.	DE	8062	62-1648206	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067 615-465-7000

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Fallbrook Hospital Corporation	DE	8062	91-1918215	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Hallmark Healthcare Corporation	DE	8062	63-0817574	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Hospital of Barstow, Inc.	DE	8062	76-0385534	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Lancaster Hospital Corporation	DE	8062	57-1010381	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
National Healthcare of Cleveland, Inc.	DE	8062	62-1281627	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
National Healthcare of Cullman, Inc.	DE	8062	63-0928788	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
National Healthcare of Decatur, Inc.	DE	8062	63-0928790	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
National Healthcare of Hartselle, Inc.	DE	8062	63-0928787	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
National Healthcare of Leesville, Inc.	DE	8062	95-4066162	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
National Healthcare of Mt. Vernon, Inc.	DE	8062	58-1622971	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
National Healthcare of Newport, Inc.	DE	8062	71-0616802	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
NWI Hospital Holdings, LLC	DE	8062	20-8398145	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Pennsylvania Hospital Company, LLC	DE	8062	06-1694707	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Phoenixville Hospital Company, LLC	DE	8062	20-1055060	4000 Meridian Blvd. Franklin, TN 37067

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Pottstown Hospital Company, LLC	DE	8062	06-1694708	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067
Ruston Hospital Corporation	DE	8062	20-8066937	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067
Ruston Louisiana Hospital Company, LLC	DE	8062	20-8066999	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067 615-465-7000

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Watsonville Hospital Corporation	DE	8062	91-1894113	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Webb Hospital Corporation	DE	8062	20-0167530	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Webb Hospital Holdings, LLC	DE	8062	20-0167590	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Fannin Regional Hospital, Inc.	GA	8062	76-0350464	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Anna Hospital Corporation	IL	8062	36-4431843	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Galesburg Hospital Corporation	IL	8062	37-1485782	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Granite City Hospital Corporation	IL	8062	36-4460625	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Granite City Illinois Hospital Company, LLC	IL	8062	36-4460628	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Marion Hospital Corporation	IL	8062	37-1359605	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Red Bud Hospital Corporation	IL	8062	36-4444121	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Red Bud Illinois Hospital Company, LLC	IL	8062	36-4443919	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Waukegan Hospital Corporation	IL	8062	20-3978400	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Waukegan Illinois Hospital Company, LLC	IL	8062	20-3978521	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Hospital of Fulton, Inc.	KY	8062	61-1218106	4000 Meridian Blvd. Franklin, TN 37067

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Hospital of Louisa, Inc.	KY	8062	61-1238190	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067
Jackson Hospital Corporation	KY	8062	61-1285331	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067
Farmington Hospital Corporation	MO	8062	20-4795037	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067 615-465-7000

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Farmington Missouri Hospital Company, LLC	MO	8062	20-4795132	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Kirksville Hospital Corporation	MO	8062	36-4373298	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Moberly Hospital, Inc.	MO	8062	43-1651906	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Williamston Hospital Corporation	NC	8062	62-1749107	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Salem Hospital Corporation	NJ	8062	22-3838322	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Deming Hospital Corporation	NM	8062	85-0438008	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Roswell Hospital Corporation	NM	8062	74-2870118	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
San Miguel Hospital Corporation	NM	8062	74-2930034	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
CHS Holdings Corp.	NY	8062	13-3936167	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Hallmark Holdings Corp.	NY	8062	13-3936166	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Kay County Hospital Corporation	OK	8062	20-4052833	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Kay County Oklahoma Hospital Company, LLC	OK	8062	20-4052936	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
CHS Berwick Hospital Corporation	PA	8062	23-2975836	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Clinton Hospital Corporation	PA	8062	90-0003715	4000 Meridian Blvd. Franklin, TN 37067

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Coatesville Hospital Corporation	PA	8062	23-3069798	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067
Northampton Hospital Corporation	PA	8062	52-2325498	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067
Sunbury Hospital Corporation	PA	8062	20-3346421	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067 615-465-7000

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West Grove Hospital Corporation	PA	8062	25-1892279	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Brownsville Hospital Corporation	TN	8062	42-1557534	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Cleveland Hospital Corporation	TN	8062	62-1587878	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Dyersburg Hospital Corporation	TN	8062	42-1557536	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Hospital of Morristown, Inc.	TN	8062	62-1528689	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Jackson Hospital Corporation	TN	8062	42-1557525	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Jackson, Tennessee Hospital Company, LLC	TN	8062	42-1557540	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Lakeway Hospital Corporation	TN	8062	62-1564360	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Lexington Hospital Corporation	TN	8062	42-1557533	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Martin Hospital Corporation	TN	8062	42-1557527	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
McKenzie Hospital Corporation	TN	8062	42-1557531	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
McNairy Hospital Corporation	TN	8062	42-1557530	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Shelbyville Hospital Corporation	TN	8062	20-2909388	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Sparta Hospital Corporation	TN	8062	62-1587742	4000 Meridian Blvd. Franklin, TN 37067

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Big Bend Hospital Corporation	TX	8062	75-2717545	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067
Big Spring Hospital Corporation	TX	8062	75-2574581	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067
Granbury Hospital Corporation	TX	8062	75-2682017	615-465-7000 4000 Meridian Blvd. Franklin, TN 37067 615-465-7000

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Jourdanton Hospital Corporation	TX	8062	74-3011840	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
NHCI of Hillsboro, Inc.	TX	8062	74-2425482	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Weatherford Hospital Corporation	TX	8062	20-5694260	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Weatherford Texas Hospital Company, LLC	TX	8062	20-5694301	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Tooele Hospital Corporation	UT	8062	87-0619248	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Emporia Hospital Corporation	VA	8062	54-1924866	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Franklin Hospital Corporation	VA	8062	52-2200240	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Petersburg Hospital Company, LLC	VA	8062	02-0691413	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Russell County Medical Center, Inc.	VA	8062	54-1594711	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Virginia Hospital Company, LLC	VA	8062	02-0691406	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Oak Hill Hospital Corporation	WV	8062	27-0003893	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
Evanston Hospital Corporation	WY	8062	83-0327475	4000 Meridian Blvd. Franklin, TN 37067 615-465-7000
QHG of Enterprise, Inc.	AL	8062	63-1159023	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
QHG of Jacksonville, Inc.	AL	8062	62-1637909	5800 Tennyson Parkway Plano, TX 75024

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QHG of Springdale, Inc.	AR	8062	62-1755664	214-473-7000 5800 Tennyson Parkway Plano, TX 75024
Triad-El Dorado, Inc.	AR	8062	62-1628508	214-473-7000 5800 Tennyson Parkway Plano, TX 75024
Abilene Hospital, LLC	DE	8062	46-0496920	214-473-7000 5800 Tennyson Parkway Plano, TX 75024

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Abilene Merger, LLC	DE	8062	46-0496918	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
Arizona DH, LLC	DE	8062	91-2065656	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
ARMC, LP	DE	8062	46-0496933	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
Birmingham Holdings, LLC	DE	8062	20-3320362	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
Bluffton Health System, LLC	DE	8062	62-1792272	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
Brownwood Hospital, L.P.	DE	8062	62-1762521	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
Brownwood Medical Center, LLC	DE	8062	62-1762523	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
Carlsbad Medical Center, LLC	DE	8062	62-1762526	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
Claremore Regional Hospital, LLC	DE	8062	62-1757649	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
Clarksville Holdings, LLC	DE	8062	20-3320418	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
College Station Hospital, L.P.	DE	8062	62-1762360	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
College Station Medical Center, LLC	DE	8062	62-1762359	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
College Station Merger, LLC	DE	8062	62-1771861	5800 Tennyson Parkway Plano, TX 75024 214-473-7000	
CP Hospital GP, LLC	DE	8062	20-3904557	5800 Tennyson Parkway Plano, TX 75024	

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CPLP, LLC	DE	8062	20-3904614	214-473-7000 5800 Tennyson Parkway Plano, TX 75024
Crestwood Hospital LP, LLC	DE	8062	62-1762369	214-473-7000 5800 Tennyson Parkway Plano, TX 75024
Crestwood Hospital, LLC	DE	8062	62-1769644	214-473-7000 5800 Tennyson Parkway Plano, TX 75024 214-473-7000

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CSMC, LLC	DE	8062	62-1762362	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
CSRA Holdings, LLC	DE	8062	20-5111915	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Deaconess Holdings, LLC	DE	8062	47-0890490	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Deaconess Hospital Holdings, LLC	DE	8062	20-2401268	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Desert Hospital Holdings, LLC	DE	8062	20-8111921	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Detar Hospital, LLC	DE	8062	62-1764943	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Dukes Health System, LLC	DE	8062	52-2379885	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Gadsden Regional Medical Center, LLC	DE	8062	63-1102773	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Greenbrier VMC, LLC	DE	8062	75-2887493	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
GRMC Holdings, LLC	DE	8062	20-8112090	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Hobbs Medco, LLC	DE	8062	62-1769641	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Las Cruces Medical Center, LLC	DE	8062	75-2905434	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Lea Regional Hospital, LLC	DE	8062	62-1760149	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Longview Merger, LLC	DE	8062	62-1769639	5800 Tennyson Parkway Plano, TX 75024

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LRH, LLC	DE	8062	62-1762421	214-473-7000 5800 Tennyson Parkway Plano, TX 75024
Lutheran Health Network of Indiana, LLC	DE	8062	62-1762363	214-473-7000 5800 Tennyson Parkway Plano, TX 75024
Massillon Health System, LLC	DE	8062	34-1840860	214-473-7000 5800 Tennyson Parkway Plano, TX 75024

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Medical Center of Brownwood, LLC	DE	8062	62-1762425	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
MMC of Nevada, LLC	DE	8062	42-1543617	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Navarro Hospital, L.P.	DE	8062	62-1762428	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Navarro Regional, LLC	DE	8062	62-1762429	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
NRH, LLC	DE	8062	62-1762431	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Oregon Healthcorp, LLC	DE	8062	62-1769632	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Palmer-Wasilla Health System, LLC	DE	8062	62-1762371	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Quorum Health Resources, LLC	DE	8062	62-1742954	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Regional Hospital of Longview, LLC	DE	8062	62-1762464	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Russellville Holdings, LLC	DE	8062	62-1771866	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
SACMC, LLC	DE	8062	62-1762472	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
San Angelo Community Medical Center, LLC	DE	8062	62-1762473	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
San Angelo Hospital, L.P.	DE	8062	62-1762476	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
San Angelo Medical, LLC	DE	8062	62-1769697	5800 Tennyson Parkway Plano, TX 75024

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Southern Texas Medical Center, LLC	DE	8062	62-1769737	214-473-7000 5800 Tennyson Parkway Plano, TX 75024
St. Joseph Health System, LLC	DE	8062	51-0382045	214-473-7000 5800 Tennyson Parkway Plano, TX 75024
Tennyson Holdings, Inc.	DE	8062	20-3943816	214-473-7000 5800 Tennyson Parkway Plano, TX 75024

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Triad Holdings III, LLC	DE	8062	75-2821745	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Triad Holdings IV, LLC	DE	8062	62-1766957	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Triad Holdings V, LLC	DE	8062	51-0327978	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Triad Healthcare Corporation	DE	8062	75-2816101	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Triad of Alabama, LLC	DE	8062	62-1762412	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Triad of Oregon, LLC	DE	8062	62-1761990	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Triad-ARMC, LLC	DE	8062	46-0496926	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Triad-Denton Hospital GP, LLC	DE	8062	75-2887764	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Triad-Denton Hospital, L.P.	DE	8062	75-2887765	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Triad-Navarro Regional Hospital Subsidiary, LLC	DE	8062	62-1681610	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
VHC Medical, LLC	DE	8062	62-1769671	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Vicksburg Healthcare, LLC	DE	8062	62-1752111	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Victoria Hospital, LLC	DE	8062	62-1760818	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Victoria of Texas, L.P.	DE	8062	62-1754940	5800 Tennyson Parkway Plano, TX 75024

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WHMC, LLC	DE	8062	62-1762551	214-473-7000 5800 Tennyson Parkway Plano, TX 75024
Willamette Valley Medical Center, LLC	DE	8062	62-1762552	214-473-7000 5800 Tennyson Parkway Plano, TX 75024
Women & Children s Hospital, LLC	DE	8062	62-1762556	214-473-7000 5800 Tennyson Parkway Plano, TX 75024

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Exact Name of Registrant as Specified in its Charter	State or Other Jurisdiction of Incorporation or Organization	Primary Standard Industrial Classification Code Number	I.R.S. Employer Identification No.	Address, Including Zip Code, and Telephone Number, Including Area Code, of Registrant's Principal Executive Offices
Woodland Heights Medical Center, LLC	DE	8062	62-1762558	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Woodward Health System, LLC	DE	8062	62-1762418	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
QHG Georgia Holdings, Inc.	GA	8062	58-2386459	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
QHG Georgia, L.P.	GA	8062	58-2387537	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
Frankfort Health Partner, Inc.	IN	8062	35-2009540	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
IOM Health System, L.P.	IN	8062	35-1963748	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
QHG of Bluffton, Inc.	IN	8062	62-1792274	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
QHG of Clinton County, Inc.	IN	8062	35-2006952	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
QHG of Fort Wayne, Inc.	IN	8062	35-1946949	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
QHG of Warsaw, Inc.	IN	8062	62-1764509	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
QHG of Forrest County, Inc.	MS	8062	62-1704095	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
QHG of Hattiesburg, Inc.	MS	8062	62-1704097	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
River Region Medical Corporation	MS	8062	62-1576702	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
NC-DSH, Inc.	NV	8062	88-0305790	5800 Tennyson Parkway Plano, TX 75024

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QHG of Barberton, Inc.	OH	8062	31-1472381	214-473-7000 5800 Tennyson Parkway Plano, TX 75024
QHG of Massillon, Inc.	OH	8062	31-1472380	214-473-7000 5800 Tennyson Parkway Plano, TX 75024
SouthCrest, L.L.C.	OK	8062	62-1723864	214-473-7000 5800 Tennyson Parkway Plano, TX 75024 214-473-7000

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Exact Name of Registrant as Specified in its Charter	State or Other Jurisdiction of Incorporation or Organization	Primary Standard Industrial Classification Code Number	I.R.S. Employer Identification No.	Address, Including Zip Code, and Telephone Number, Including Area Code, of Registrant's Principal Executive Offices
Triad-South Tulsa Hospital Company, Inc.	OK	8062	62-1678883	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
QHG of South Carolina, Inc.	SC	8062	62-1587267	5800 Tennyson Parkway Plano, TX 75024 214-473-7000
QHG of Spartanburg, Inc.	SC	8062	57-1040117	5800 Tennyson Parkway Plano, TX 75024 214-473-7000

Name, address, including zip code, and telephone number, including area code, of agent for service

Rachel A. Seifert
CHS/Community Health Systems, Inc.
Senior Vice President, Secretary and General Counsel
4000 Meridian Boulevard
Franklin, Tennessee 37067
(615) 465-7000

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The information in this prospectus is not complete and may be changed. We may not sell these securities until the registration statement filed with the Securities and Exchange Commission is effective. The prospectus is not an offer to sell these securities and is not soliciting an offer to buy these securities in any state where the offer or sale is not permitted.

SUBJECT TO COMPLETION, DATED SEPTEMBER 24, 2007

PROSPECTUS

\$3,021,331,000
CHS/Community Health Systems, Inc.
Exchange Offer for
87/8% Senior Notes due 2015

Offer for outstanding 87/8% Senior Notes due 2015, in the aggregate principal amount of \$3,021,331,000 (which we refer to as the Old Notes) in exchange for up to \$3,021,331,000 in aggregate principal amount of 87/8% Senior Notes due 2015 which have been registered under the Securities Act of 1933, as amended (which we refer to as the Exchange Notes and, together with the Old Notes, the notes).

Terms of the Exchange Offer:

Expires 5:00 p.m., New York City time, , 2007, unless extended.

Not subject to any condition other than that the exchange offer does not violate applicable law or any interpretation of the staff of the Securities and Exchange Commission.

We can amend or terminate the exchange offer.

We will exchange all 87/8% Senior Notes due 2015 that are validly tendered and not validly withdrawn.

We will not receive any proceeds from the exchange offer.

The exchange of notes will not be a taxable exchange for U.S. federal income tax purposes.

You may withdraw tendered outstanding Old Notes any time before the expiration of the exchange offer.

Terms of the Exchange Notes:

The Exchange Notes will be general unsecured obligations and will rank equally in right of payment with all existing and future unsecured senior debt, senior in right of payment to all existing and future senior subordinated debt and effectively subordinated in right of payment to secured indebtedness to the extent of the value of the assets securing such indebtedness, including all borrowings under senior secured credit facilities.

The Exchange Notes mature on July 15, 2015. The Exchange Notes will bear interest semi-annually in cash in arrears on January 15 and July 15 of each year, commencing on January 15, 2008.

We may redeem the Exchange Notes in whole or in part from time to time. See Description of Exchange Notes.

We may also redeem up to 35% of the aggregate principal amount of the Exchange Notes using the proceeds of certain equity offerings completed before July 15, 2010. See Description of Exchange Notes.

The terms of the Exchange Notes are identical to our outstanding Old Notes except for transfer restrictions and registration rights.

For a discussion of specific risks that you should consider before tendering your outstanding 87/8% Senior Notes due 2015 in the exchange offer, see Risk Factors beginning on page 14.

There is no public market for the Old Notes or the Exchange Notes, However, you may trade the Old Notes in the Private Offering Resale and Trading through Automatic Linkages, or PORTALtm, market.

Each broker-dealer that receives Exchange Notes pursuant to the exchange offer must acknowledge that it will deliver a prospectus in connection with any resale of the Exchange Notes. A broker dealer who acquired Old Notes as a result of market making or other trading activities may use this exchange offer prospectus, as supplemented or amended, in connection with any resales of the Exchange Notes.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of the Exchange Notes or determined if this prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

The date of this prospectus is , 2007

You should rely only on the information contained in this prospectus. We have not authorized anyone to provide you with information different from that contained in this prospectus. The selling noteholders are offering to sell, and seeking offers to buy, 87/8% Senior Notes due 2015 only in jurisdictions where offers and sales are permitted. The information contained in this prospectus is accurate only as of the date of this prospectus, regardless of the time of delivery of this prospectus or of any sale of our 87/8% Senior Notes due 2015.

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PROSPECTUS SUMMARY

The following summary should be read in conjunction with, and is qualified in its entirety by, the more detailed information and financial statements (including the accompanying notes) appearing elsewhere in this prospectus or incorporated by reference herein. You should carefully read this prospectus and the information incorporated by reference herein, including the section entitled Risk Factors and the pro forma financial data, which gives effect to our acquisition of Triad, the offering of the Old Notes, the additional debt financings to fund the purchase price for the acquisition of Triad and certain other transactions.

Unless otherwise indicated or the context requires otherwise, references in this prospectus to CHS, we, our, us and the Company refer to Community Health Systems, Inc. and its consolidated subsidiaries, including CHS/Community Health Systems, Inc., the issuer of the Notes, both before and after the consummation of the Merger, as defined below. References to the Issuer refer to CHS/Community Health Systems, Inc. alone, and references to Holdings refer to Community Health Systems, Inc. alone. Triad refers to Triad Hospitals, Inc. and its consolidated subsidiaries unless the context otherwise requires. Financial information identified in this prospectus as pro forma gives effect to the closing of the Transactions. See Unaudited Pro Forma Condensed Financial Statements.

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 net operating revenues. As of July 25, 2007, prior to the acquisition of Triad, we owned, leased or operated 79 hospitals, geographically diversified across 23 states, with an aggregate of 9,550 licensed beds. We generate revenues by providing a broad range of general hospital healthcare services to patients in the communities in which we are located. Services provided by our hospitals include emergency room services, general surgery, critical care, internal medicine, obstetrics and diagnostic services. As part of providing these services, we also own physician practices, imaging centers, home health agencies and ambulatory surgery centers. Our net operating revenues for the year ended December 31, 2006 and for the six months ended June 30, 2007 were \$4,366 million and \$2,453 million, respectively.

Historically, we have grown by acquiring hospitals and by improving the operations of our facilities. We targeted hospitals in growing, non-urban healthcare markets for acquisition 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 and a lower level of managed care presence in these markets. We believe that smaller populations support less direct competition for hospital-based services. Over the past several years, we also have expanded our focus beyond these non-urban markets, acquiring larger facilities in more urban markets. Based on our experience and our observations about our industry, we have recognized that more rapid growth opportunities exist for a skillful and disciplined operator in selected larger markets.

On July 25, 2007, we acquired Triad, a publicly-owned hospital company. Triad provides a broad range of general hospital healthcare services to patients in non-urban and mid-size markets located primarily in the southern, midwestern and western United States. As of July 25, 2007, Triad owned, leased or operated 50 hospitals in 17 states, with an aggregate of approximately 9,600 licensed beds. Upon closing of the acquisition, we became the largest publicly-owned provider of hospital services, operating 129 hospitals in 28 states with an aggregate of approximately 19,200 licensed beds. Pro forma for the Triad acquisition, our net operating revenues for the year ended December 31, 2006 and for the six months ended June 30, 2007 would have been \$9,903 million and \$5,429 million, respectively. In connection with the consummation of the merger the Company obtained \$7,215 million of senior secured financing under a new credit facility (the New Credit Facility) and its wholly-owned subsidiary, CHS/Community Health Systems, Inc. issued the Old Notes at the closing of the merger. We also refer to the acquisition of Triad as the

Merger. See Unaudited Pro Forma Condensed Financial Statements.

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We believe the Triad acquisition will:

complement our non-urban market presence with mid-size markets having greater population growth than non-urban markets and less competition than major metropolitan markets;

increase the scale of our operations, enabling us to realize corporate overhead efficiencies and purchasing savings;

increase our operating growth and profitability as we centralize certain functions and standardize best practices across these facilities; and

increase our presence in 12 states and expand into five new states.

Our Strengths

We believe the following strengths will allow us to continue to improve our operations and profitability:

Leading local market provider. We are a leading provider of acute care services in the markets we serve. As of June 30, 2007, we are one of three or fewer providers in approximately 98% of our markets, and we are the sole provider in approximately 85% of our markets. We have focused on non-urban markets with strong demographic growth and underserved medical populations. In general, reimbursement is more favorable in these markets than in markets with more direct competition for hospital-based services. In some of our markets, we receive higher reimbursement rates from Medicare for designated sole community hospitals. Additionally, our leading market position enables us to achieve a strong return on investments in facility expansion and physician recruitment. As of June 30, 2007, pro forma for the Triad acquisition, we are one of three or fewer providers in approximately 86% of our markets and the sole provider in approximately 65% of our markets.

Geographic diversity and operating scale. We operated 79 hospitals in 23 states as of July 25, 2007, prior to the acquisition of Triad. With our acquisition of Triad, we have expanded into five new states and operate 129 hospitals across 28 states. Pro forma for the Triad acquisition, our 2006 revenue exposure to any one state is less than 13% (as compared to less than 21% for us prior to the acquisition). Our geographic diversity helps to mitigate risk associated with fluctuating state regulations related to Medicaid reimbursement and state-specific economic conditions. Furthermore, we believe our current operations, together with those we acquired from Triad, will enable us to realize the benefits of economies of scale, purchasing power and increased operating efficiencies.

Strong presence in attractive markets. The underserved non-urban markets, on which we have historically focused, provide an attractive environment for our operations. With fewer hospitals and healthcare providers and generally a lower level of managed care penetration, these markets allow us to profitably provide much needed acute care services. We believe the Triad acquisition expands our presence in non-urban markets and complements our non-urban focus, as Triad's mid-size markets have greater population growth than non-urban markets. Triad's facilities also enjoy strong patient and physician loyalty and have less direct competition than hospitals in major metropolitan markets.

Emphasis on quality of care. We have developed significant expertise in implementing a variety of programs to ensure continuous improvement in the quality of care provided at our hospitals. This is an evolving aspect of our business, as payors and accrediting agencies expand their views of quality to include measurement, reporting and continual improvement of the timeliness, safety, effectiveness, efficiency and patient-centeredness of clinical care. We understand that high levels of clinical care are only achieved when quality is a company-wide leadership focus that embraces patient, physician and employee satisfaction and continual, systematic improvements. Seeking the highest

levels of improvement typically yields the best results for patients, reduces risk and improves our financial performance. We have developed and implemented programs to support and monitor quality of care improvement that include:

standardized data and benchmarks to assist and monitor hospital quality improvement efforts;

recommended policies and procedures based on the best medical and scientific evidence;

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hospital-based training and coaching to achieve success with respect to expectations of accrediting agencies;

training programs for hospital management and clinical staff regarding regulatory and reporting requirements, as well as skills in leadership, communications and service;

sharing of best practices for regulatory compliance and performance improvement; and

evidence-based tools for improving patient, physician and staff satisfaction.

Strong history of generating revenue growth and improving profitability. Since 2001, we have grown from 57 to 79 hospitals and have increased revenue from \$1,657 million to \$4,366 million, and income from continuing operations from \$44.7 million to \$171.5 million for the year ended December 31, 2006 (2001 numbers are not restated for insignificant discontinued operations). We have improved profitability by recruiting primary care physicians and specialists, expanding our service offerings to include more complex care, optimizing our emergency room strategy across our portfolio of hospitals and selectively making capital investments in projects that generate a high return on investment. Upon closing of the Triad acquisition, we believe that a significant opportunity exists to continue to improve profitability, as approximately 30% of the combined company's facilities have been acquired within the past four years.

Experienced management team with a proven track record. We have a strong and committed management team that has substantial industry knowledge and a proven track record of operations success in the hospital industry. Our chief executive officer and chief financial officer each have over 30 years of experience in the healthcare industry and have worked together since 1973. Our management team has successfully acquired and integrated 55 hospitals, and we believe this experience positions us well to integrate and improve the operations of the Triad facilities in addition to successfully executing our business strategy.

Our Strategy

We intend to continue to grow our business and improve our financial performance by implementing our business strategy, the key elements of which are to:

Increase revenues at our facilities. We intend to increase revenues at our facilities by providing a broader range of services in a more attractive care setting. Our primary method of expanding medical services is recruiting additional primary care physicians and specialists. We intend to continue to expand the breadth of services offered at our hospitals through targeted capital expenditures to support the addition of more complex services, including orthopedics, cardiovascular services and urology. We also provide the capital to invest in technology and the physical plant at our facilities, particularly in our emergency rooms, surgery/critical care departments and diagnostic services. For example, as part of our successful and ongoing emergency room enhancement strategy, we have implemented a standardized management system across all of our facilities. Emergency rooms represent approximately 60% of our hospital admissions, and we believe the Triad acquisition presents an additional growth opportunity as Triad has not pursued a similar emergency room enhancement strategy. Additionally, we believe a number of our standardized practices, including centralized physician recruiting, managed care contracting, facilities management and resource and case management programs, can be successfully applied to Triad's facilities.

Increase operating efficiencies to improve profitability. We continually focus on improving operating efficiency to increase our operating margins. We seek to reduce costs and enhance efficiency through various methods and across the broad spectrum of our operations, including:

standardizing and centralizing our methods of operation and management;

improving quality of care and patient, physician and staff satisfaction;

implementing management and healthcare industry best practices, which drive efficiencies in areas as diverse and wide-ranging as adjusting staffing levels to patient volume and acuity, and adopting drug formularies;

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utilizing our proven case and resource management program, which guides our hospitals in the allocation and application of resources, which assists in optimizing clinical care and, in turn, containing expenses;

capitalizing on our participation in a wide range of group purchasing arrangements by monitoring and ensuring compliance by our hospitals with the terms of those purchasing arrangements; and

utilizing standardized management information systems appropriate for the size and complexity of a particular hospital.

Complete successful integration of Triad. We have successfully acquired and integrated 55 hospitals since 1996 and our focus over the next two years will be to successfully integrate the acquisition of Triad. We have an established, experienced and dedicated team to manage the integration of Triad. We believe that, in the first year following the acquisition of Triad, we will realize approximately \$28 million of annual cost savings related to cash expenses from the elimination of certain head count reductions and the elimination of certain duplicate overhead costs. We anticipate that we will realize additional savings from improved pricing opportunities under our purchasing contracts, the elimination of certain other duplicate corporate overhead costs and the implementation of other cost saving initiatives that management has identified. Additionally, we intend to continue to pursue a disciplined approach in making capital investments that generate a high return on investment, and will apply this focus to our acquired hospitals. Over the last four years, Triad has invested approximately \$1,573 million (or approximately 9% of revenues) into its facilities. We believe we can leverage these already well-capitalized facilities and increase operating efficiencies and profitability.

Deleverage balance sheet. Historically, we have generated relatively strong and stable cash flow which has allowed us to fund our growth-related investments while maintaining reasonable leverage levels. From March 31, 2000 (prior to the June, 2000 initial public offering of our common stock) to June 30, 2007, our debt as a percentage of total capitalization decreased from 86.6% to 51.8%. We intend to continue our strategy of utilizing cash flows from our combined operations to service debt and to fund our future growth initiatives. We will also consider issuing equity or equity-related securities or divesting selected hospital facilities to deleverage our balance sheet.

Our Industry

The U.S. healthcare industry is large and growing. The Centers for Medicare and Medicaid Services, or CMS, reported that in 2005, total U.S. healthcare expenditures grew by 6.9% to \$2.0 trillion. It also projected total U.S. healthcare spending to grow by 6.8% in 2006 and by an average of 6.9% per year through 2015. By these estimates, healthcare expenditures will account for approximately \$3.9 trillion, or 19.2% of the total U.S. gross domestic product, by 2015.

Hospital services, the market in which we operate, is the largest single category of healthcare at 31% of total healthcare spending in 2005, or \$611.6 billion, as reported by CMS. CMS projects the hospital services market to grow by an average of 7.0% per year through 2015. 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, CMS expects hospital services to remain the largest category of healthcare spending.

We believe that we are well-positioned to benefit from the expected growth in hospital spending as well as shifts in demographics in the United States. According to the U.S. Census Bureau, there are approximately 36.9 million Americans age 65 or older in the United States, who comprise approximately 13% of the total U.S. population. By the year 2030, the number of elderly is expected to climb to 71.5 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 9.6 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 current hospitals are located grew 19.6% from 1990 to 2005, and

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are expected to grow 4.9% from 2005 to 2010. The number of people aged 55 or older in these service areas grew 25.8% from 1990 to 2005, and is expected to grow 12.7% from 2005 to 2010. We believe that the aging of the population will benefit both non-urban and mid-size markets, particularly in the southern regions in which we operate.

The acute care hospital sector is characterized by a stable Medicare reimbursement and commercial pricing environment. In the United States, general acute care hospitals are instrumental to the delivery of quality healthcare and represent a critical element of the overall healthcare infrastructure. Approximately 82% of these hospitals are owned and managed by not-for-profit or government entities that, according to the American Hospital Association, or the AHA, tend to have lower operating margins than investor-owned hospitals. We believe that Medicare, which accounts for approximately 30% of total hospital spending, will continue to provide appropriate pricing increases that will enable hospitals to provide high quality clinical care. For fiscal 2007, Medicare has budgeted a total payment increase of \$3,400 million for acute care inpatient services, which we believe is consistent with recent historical experience. CMS forecasts Medicare hospital spending to nearly double over the next 10 years.

Commercial pricing has also been stable for hospital providers, and we believe that commercial payors typically offer rate increases that exceed those offered by Medicare. With respect to commercial reimbursement, based on our experience, well-positioned hospital companies generally have been successful at receiving mid- to high single-digit private pay increases over the past few years, and we expect this trend to continue.

Our Corporate Information

Community Health Systems, Inc. was incorporated in Delaware on June 6, 1996. CHS/Community Health Systems, Inc. was incorporated in Delaware on March 25, 1985. Our principal executive offices are located at 4000 Meridian Boulevard, Franklin, Tennessee 37067, and our telephone number is (615) 465-7000. Our website is www.chs.net. **Information on our website shall not be deemed part of this prospectus.**

The Transactions

On July 25, 2007, we acquired Triad, a publicly-owned hospital company. Triad provides a broad range of general hospital healthcare services to patients in non-urban and mid-size markets located primarily in the southern, midwestern and western United States. As of July 25, 2007, prior to the acquisition, Triad owned, leased or operated 50 hospitals in 17 states, with an aggregate of approximately 9,600 licensed beds. Upon closing of the acquisition, we have become the largest publicly-owned provider of hospital services, operating 129 hospitals in 28 states with an aggregate of approximately 19,200 licensed beds. Pro forma for the Triad acquisition, our net operating revenues for the year ended December 31, 2006 and for the six months ended June 30, 2007 would have been \$9,903 million and \$5,429 million, respectively. See Unaudited Pro Forma Condensed Financial Information.

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Purpose of the Exchange Offer

On July 25, 2007, we sold, through a private placement exempt from the registration requirements of the Securities Act, \$3,021,331,000 of our 87/8% Senior Notes due 2015, all of which are eligible to be exchanged for Exchange Notes. We refer to these notes as Old Notes in this prospectus.

Simultaneously with the private placement, we entered into a registration rights agreement with the initial purchasers of the Old Notes. Under the registration rights agreement, we are required to use our reasonable best efforts to cause a registration statement for substantially identical Notes, which will be issued in exchange for the Old Notes, to be filed within 90 days and to become effective on or within 210 days of issuance of the Old Notes. We refer to the Notes to be registered under this exchange offer registration statement as Exchange Notes and collectively with the Old Notes, we refer to them as the Notes in this prospectus. You may exchange your Old Notes for Exchange Notes in this exchange offer. You should read the discussion under the headings Summary of the Exchange Offer, The Exchange Offer and Description of Exchange Notes for further information regarding the Exchange Notes.

We did not register the Old Notes under the Securities Act or any state securities law, nor do we intend to after the exchange offer. As a result, the Old Notes may only be transferred in limited circumstances under the securities laws. If the holders of the Old Notes do not exchange their Old Notes in the exchange offer, they lose their right to have the Old Notes registered under the Securities Act, subject to certain limitations. Anyone who still holds Old Notes after the exchange offer may be unable to resell their Old Notes.

Summary of the Exchange Offer

The Exchange Offer

Securities Offered \$3,021,331,000 aggregate principal amount of 87/8% Senior Notes due 2015.

The Exchange Offer We are offering to exchange the Old Notes for a like principal amount at maturity of the Exchange Notes. Old Notes may be exchanged only in integral principal multiples of \$1,000. This exchange offer is being made pursuant to a registration rights agreement dated as of July 25, 2007 which granted the initial purchasers and any subsequent holders of the Old Notes certain exchange and registration rights. This exchange offer is intended to satisfy those exchange and registration rights with respect to the Old Notes. After the exchange offer is complete, you will no longer be entitled to any exchange or registration rights with respect to your Old Notes.

Expiration Date; Withdrawal of Tender The exchange offer will expire 5:00 p.m., New York City time, on _____, 2007, or a later time if we choose to extend this exchange offer. You may withdraw your tender of Old Notes at any time prior to the expiration date. All outstanding Old Notes that are validly tendered and not validly withdrawn will be exchanged. Any Old Notes not accepted by us for exchange for any reason will be returned to you at our expense as promptly as possible after the expiration or termination of the exchange offer.

Resales

We believe that you can offer for resale, resell and otherwise transfer the Exchange Notes without complying with the registration and prospectus delivery requirements of the Securities Act if:

you acquire the Exchange Notes in the ordinary course of business;

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you are not participating, do not intend to participate, and have no arrangement or understanding with any person to participate, in the distribution of the Exchange Notes;

you are not an affiliate of ours, as defined in Rule 405 of the Securities Act; and

you are not a broker-dealer.

If any of these conditions is not satisfied and you transfer any Exchange Notes without delivering a proper prospectus or without qualifying for a registration exemption, you may incur liability under the Securities Act. We do not assume, or indemnify you against, this liability.

Each broker-dealer acquiring Exchange Notes issued for its own account in exchange for Old Notes, which it acquired through market-making activities or other trading activities, must acknowledge that it will deliver a proper prospectus when any Exchange Notes issued in the exchange offer are transferred. A broker-dealer may use this prospectus for an offer to resell, a resale or other retransfer of the Exchange Notes issued in the exchange offer.

Conditions to the Exchange Offer

Our obligation to accept for exchange, or to issue the Exchange Notes in exchange for, any Old Notes is subject to certain customary conditions relating to compliance with any applicable law, or any applicable interpretation by any staff of the Securities and Exchange Commission, or any order of any governmental agency or court of law. We currently expect that each of the conditions will be satisfied and that no waivers will be necessary. See The Exchange Offer Conditions to the Exchange Offer.

Procedures for Tendering Notes Held in the Form of Book-Entry Interests

The Old Notes were issued as global securities and were deposited upon issuance with U.S. Bank National Association which issued uncertificated depositary interests in those outstanding Old Notes, which represent a 100% interest in those Old Notes, to The Depository Trust Company.

Beneficial interests in the outstanding Old Notes, which are held by direct or indirect participants in the Depository Trust Company, are shown on, and transfers of the Old Notes can only be made through, records maintained in book-entry form by The Depository Trust Company.

You may tender your outstanding Old Notes by instructing your broker or bank where you keep the Old Notes to tender them for you. In some cases you may be asked to submit the BLUE-colored Letter of Transmittal that may accompany this prospectus. By tendering your Old Notes you will be deemed to have acknowledged and agreed to be bound by the terms set forth under The Exchange Offer. Your outstanding Old Notes will be tendered in multiples of \$1,000.

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A timely confirmation of book-entry transfer of your outstanding Old Notes into the exchange agent's account at The Depository Trust Company, under the procedure described in this prospectus under the heading "The Exchange Offer" must be received by the exchange agent on or before 5:00 p.m., New York City time, on the expiration date.

United States Federal Income Tax Considerations

The exchange offer should not result in any income, gain or loss to the holders of old notes or to us for United States Federal Income Tax Purposes. See "Certain U.S. Federal Income Tax Considerations."

Use of Proceeds

We will not receive any proceeds from the issuance of the Exchange Notes in the exchange offer. We used the net proceeds from the sale of the Old Notes, together with borrowings under our New Credit Facility, to fund the Transactions, to pay fees and expenses and for general corporate purposes. See "Use of Proceeds."

Exchange Agent

U.S. Bank National Association is serving as the exchange agent for the exchange offer.

Shelf Registration Statement

In limited circumstances, holders of Old Notes may require us to register their Old Notes under a shelf registration statement.

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Description of the Exchange Notes

Issuer	CHS/Community Health Systems, Inc.
Notes Offered	\$3,021,331,000 aggregate principal amount of 87/8% Exchange Notes due 2015.
Maturity Date	July 15, 2015.
Interest Payment Dates	January 15 and July 15 of each year, commencing on January 15, 2008.
Guarantees	<p>The Exchange Notes will be unconditionally guaranteed on a senior basis by Holdings and certain of our current and future domestic subsidiaries.</p> <p>On a pro forma basis, our non-guarantor subsidiaries would have accounted for approximately \$2,006 million, or 37%, of our total revenue for the six months ended June 30, 2007, and approximately \$4,370 million, or 33%, of our total assets, and approximately \$1,397 million, or 12%, of our total liabilities, in each case as of June 30, 2007. To the extent that the purchase price allocation changes the valuation of guarantor and non-guarantor assets and liabilities, the ratio of non-guarantor assets and liabilities to total assets and liabilities could change.</p>
Ranking	<p>The Exchange Notes and guarantees thereof will:</p> <ul style="list-style-type: none"> be effectively subordinated to all of our and the guarantors obligations under all secured indebtedness, including any borrowings under our New Credit Facility to the extent of the value of the assets securing such obligations, and be effectively subordinated to all obligations of each of our subsidiaries that is not a guarantor of the Exchange Notes; rank <i>pari passu</i> in right of payment with all of our and the guarantors existing and future unsecured senior indebtedness; and rank senior in right of payment to all of our and the guarantors future subordinated indebtedness. <p>As of June 30, 2007, on a pro forma basis after giving effect to the Transactions, we would have had approximately \$6,133 million aggregate principal amount of senior secured indebtedness outstanding, and an additional \$1,150 million that we would have been able to borrow under our New Credit Facility, to which the Exchange Notes would have been effectively subordinated to the extent of the value of the collateral.</p>
Optional Redemption	Prior to July 15, 2011, we may redeem some or all of the Exchange Notes at a redemption price equal to 100% of the principal amount of the Exchange Notes plus accrued and unpaid interest and additional interest, if

any, to the applicable redemption date plus the applicable make-whole premium set forth in this prospectus.

We may redeem some or all of the Exchange Notes at any time and from time to time on or after July 15, 2011, at the redemption

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price set forth in this prospectus. In addition, at any time prior to July 15, 2010, we may redeem up to 35% of the aggregate principal amount of the Exchange Notes with the proceeds of certain equity offerings. See Description of the Exchange Notes Optional Redemption.

Change of Control

If a change of control occurs, each holder of Exchange Notes will have the right to require us to purchase all or a portion of its Exchange Notes at 101% of the principal amount of the Exchange Notes on the date of purchase, plus any accrued and unpaid interest to the date of repurchase. See Description of the Exchange Notes Change of Control.

Certain Covenants

The indenture governing the Exchange Notes contains covenants that, among other things, limit our ability and the ability of our restricted subsidiaries to:

incur or guarantee additional indebtedness;

pay dividends or make other restricted payments;

make certain investments;

create or incur certain liens;

sell assets and subsidiary stock;

transfer all or substantially all of our assets or enter into merger or consolidation transactions; and

enter into transactions with our affiliates.

However, these limitations are subject to a number of important qualifications and exceptions. See Description of the Exchange Notes Certain Covenants.

Use of Proceeds

We will not receive any proceeds from the issue of the Exchange Notes. We used the net proceeds from the sale of the Old Notes, together with borrowings under our New Credit Facility, to fund the Transactions to pay fees and expenses and for general corporate uses. See Use of Proceeds.

Risk Factors

Investing in the Exchange Notes involves substantial risk. See Risk Factors for a discussion of certain factors that you should consider before investing in the Exchange Notes.

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SUMMARY HISTORICAL AND PRO FORMA FINANCIAL AND OTHER DATA

COMMUNITY HEALTH SYSTEMS, INC.

The following table sets forth a summary of our selected consolidated historical financial data as of and for the periods presented. The summary historical financial information, except for Other Financial Data and Operating Data, as of December 31, 2005 and 2006, and for each of the fiscal years ended December 31, 2004, 2005 and 2006, have been derived from our audited consolidated financial statements incorporated by reference in this prospectus. The consolidated balance sheet and statement of operations data as of and for the years ended December 31, 2002 and 2003 were derived from our audited consolidated financial statements, not included herein, giving effect to adjustments for discontinued operations. The summary historical financial information, except for Other Financial Data and Operating Data, for the six month periods ended June 30, 2006 and June 30, 2007, have been derived from our unaudited interim condensed consolidated financial statements incorporated by reference in this prospectus. In the opinion of management, the unaudited interim financial data includes all adjustments, consisting of only normal non-recurring adjustments, considered necessary for a fair presentation of this information. The results of operations for interim periods are not necessarily indicative of the results that may be expected for the entire year. The following data should be read in conjunction with our consolidated financial statements and related Exchange Notes,

Management's Discussion and Analysis of Financial Condition and Results of Operations and other financial information included or incorporated by reference in this prospectus.

The summary unaudited pro forma financial data as of and for the six months ended June 30, 2007 have been prepared to give effect to the Transactions in the manner described under Unaudited Pro Forma Condensed Financial Information and the Exchange Notes thereto as if they had occurred on January 1, 2006, in the case of the summary unaudited pro forma condensed income statement, and on June 30, 2007, in the case of the summary unaudited pro forma condensed balance sheet. The pro forma adjustments are based upon available information and certain assumptions that we believe are reasonable. The summary unaudited pro forma financial and other data are for informational purposes only and do not purport to represent what our results of operations, balance sheet data or other financial information actually would have been if the Transactions had occurred at any other date, and such data do not purport to project the results of operations for any future period or our financial condition as of any future date.

The summary historical and unaudited pro forma financial and other data should be read in conjunction with

Unaudited Pro Forma Condensed Financial Information, Selected Historical Financial Data, Management's Discussion and Analysis of Financial Condition and Results of Operations and our audited and unaudited consolidated financial statements and related Exchange Notes appearing elsewhere or incorporated by reference in this prospectus.

Table of Contents**SUMMARY HISTORICAL AND PRO FORMA FINANCIAL AND OTHER DATA****COMMUNITY HEALTH SYSTEMS, INC.**

	Year Ended December 31,			Six Months Ended June 30,		Pro Forma Six Months Ended June 30,		P Y De
	2004	2005	2006	2006	2007	2006	2007(1)	
	(Dollars in thousands)							
Statement								
Operating revenues	\$ 3,203,507	\$ 3,738,320	\$ 4,365,576	\$ 2,087,616	\$ 2,453,125	\$ 4,834,881	\$ 5,429,035	\$
Operating expenses:								
Benefits	1,279,136	1,486,407	1,741,223	827,815	981,421	1,959,312	2,230,381	
Provision for doubtful	324,643	377,596	547,781	223,295	284,360	472,169	587,924	
Depreciation	389,584	448,210	510,351	248,520	286,541	720,270	792,303	
Amortization	76,986	87,210	97,104	46,628	54,240	101,400	116,888	
Interest	639,037	765,697	897,091	426,156	503,815	893,983	1,049,240	
Interest in	2,494	3,104	2,795	1,068	818	11,052	13,649	
Earnings of								
Other						(19,824)	(23,608)	
Income and	149,155	164,563	188,771	89,689	104,619	210,067	235,858	
Operating costs	2,861,035	3,332,787	3,985,116	1,863,171	2,215,814	4,348,429	5,002,635	
Operating income	342,472	405,533	380,460	224,445	237,311	486,452	426,400	
Interest expense, net	75,256	94,613	102,299	45,657	61,559	350,169	363,042	
Amortization of debt	788							
Income from continuing operations before	266,428	310,920	278,161	178,788	175,752	136,283	63,358	
Income tax expense	104,071	120,782	106,682	69,165	67,665	53,104	34,072	
Income from continuing operations	162,357	190,138	171,479	109,623	108,087	\$ 83,179	\$ 29,286	\$
Income tax expense	(10,924)	(22,594)	(3,216)	(3,216)				

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	\$ 151,433	\$ 167,544	\$ 168,263	\$ 106,407	\$ 108,087
of Cash					
provided by					
activities	\$ 325,750	\$ 411,049	\$ 350,255	\$ 207,046	\$ 215,988
used in					
activities	(318,479)	(327,272)	(640,257)	(295,767)	(309,270)
used in)					
financing					
	58,896	(62,167)	226,460	8,770	74,073
Financial Data:					
Expenditures	164,286	188,365	224,519	94,194	108,849
Operational Data:					
Hospitals at					
end	66	69	77	74	79
Licensed beds					
Period(2)	7,358	7,974	9,117	8,546	9,550
Capacity(3)	5,960	6,476	7,341	6,871	7,777
(4)	267,390	291,633	326,235	157,214	175,763
Admissions(5)	493,776	538,445	605,511	290,305	326,960
(6)	1,091,889	1,204,001	1,334,728	654,822	717,654
Length of stay					
	4.1	4.1	4.1	4.2	4.1
Occupancy rate (beds in					
	51.2%	52.9%	53.0%	54.5%	52.8%
Net revenues					
Percentage of total					
Operating revenues	50.5%	50.9%	50.0%	50.3%	49.2%
Net revenues					
Percentage of total					
Operating revenues	48.1%	47.8%	48.7%	48.4%	49.6%
Balance Sheet Data					
(End):					
Capital	\$ 453,090	\$ 476,806	\$ 446,101	\$ 405,857	\$ 521,289
Fixed equipment	1,484,548	1,610,991	1,986,577	1,757,218	2,089,142
Accumulated depreciation	82,498	104,108	40,566	24,157	21,357
Net fixed equipment	3,632,608	3,934,218	4,506,579	4,178,660	4,793,111
Other assets	1,831,735	1,667,624	1,941,177	1,677,604	1,999,997
Term					
	225,390	283,738	301,842	289,592	346,880
Shareholders' equity	\$ 1,239,991	\$ 1,564,577	\$ 1,723,673	\$ 1,698,299	\$ 1,860,967

(1) The pro forma results include the historical results for Holdings adjusted to include the historical results of Triad and other pro forma adjustments to give effect to the Transactions as previously described.

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- (2) Licensed beds are the number of beds for which the appropriate state agency licenses a facility which may vary in some instances from beds 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 (in days) represents the average number of days inpatients stay in our hospitals.
- (8) We calculated occupancy rate percentages by dividing the average daily number of inpatients by the weighted-average of beds in service.

	2002	Year Ended December 31,			2006	Six Months Ended June 30,		Pro Forma Six Months Ended June 30,	Pro Forma Year Ended December 31,
		2003	2004	2005		2006	2007	2007	2006
Ratio of Earnings to Fixed Charges	3.21x	3.58x	3.74x	3.61x	3.13x	4.03x	3.25x	1.14x	1.14x

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RISK FACTORS

You should carefully consider the risk factors set forth below, as well as the other information contained in this prospectus. This prospectus contains forward-looking statements that involve risk and uncertainties. Any of the following risks could materially and adversely affect our business, financial condition or results of operations. Additional risks and uncertainties not currently known to us, or those we currently view to be immaterial, may also materially and adversely affect our business, financial condition or results of operations. In such a case, you may lose all or part of your original investment.

Risks Related to the Exchange Notes

We may not be able to generate sufficient cash to service all of our indebtedness, including the notes, and we may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments or to refinance our debt obligations depends on our financial and operating performance, which is subject to prevailing economic and competitive conditions and to financial, business and other factors beyond our control. We cannot assure you that we will maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness. See [Forward-Looking Statements](#) and [Management's Discussion and Analysis of Financial Condition and Results of Operations](#) [Liquidity and Capital Resources](#).

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay capital expenditures, including those required for operating our existing hospitals, for integrating our historical acquisitions, including the Triad acquisition, or for future acquisitions. We also may be forced to sell assets or operations, seek additional capital or restructure or refinance our indebtedness, including the notes. We cannot assure you that we would be able to take any of these actions, that these actions would be successful and permit us to meet our scheduled debt service obligations, or that these actions would be permitted under the terms of our existing or future debt agreements, including our New Credit Facility and the indenture governing the notes. For example, our New Credit Facility and the indenture governing the notes restrict our ability to dispose of assets and use the proceeds from any dispositions. We may not be able to consummate those dispositions, and any proceeds we receive may not be adequate to meet any debt service obligations then due. See [Description of Certain Indebtedness](#) and [Description of the Exchange Notes](#).

We are a holding company and may not have access to sufficient cash to make payments on the notes.

We are a holding company with no direct operations. Our principal assets are the equity interests we hold in our operating subsidiaries. As a result, we are dependent upon dividends and other payments from our subsidiaries to generate the funds necessary to meet our outstanding debt service and other obligations. Our subsidiaries may not generate sufficient cash from operations to enable us to make principal and interest payments on our indebtedness, including the notes. In addition, any payments of dividends, distributions, loans or advances to us by our subsidiaries could be subject to legal and contractual restrictions. Our subsidiaries are permitted under the terms of our indebtedness, including the indenture governing the notes, to incur additional indebtedness that may restrict payments from those subsidiaries to us. The agreements governing the current and future indebtedness of our subsidiaries may not permit those subsidiaries to provide us with sufficient cash to fund payments on the notes when due.

Our subsidiaries are separate and distinct legal entities, and they may have (except to the extent of the guarantees) no obligation, contingent or otherwise, to pay amounts due under the notes or to make any funds available to pay those amounts, whether by dividend, distribution, loan or other payment.

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Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.

Our borrowings under the New Credit Facility are expected to be, at variable rates of interest, and expose us to interest rate risk. If interest rates increase, our debt service obligations on the variable rate indebtedness would increase even though the amount borrowed remained the same, and our net income would decrease.

Our pro forma cash interest expense, net, for the six months ended June 30, 2007, would have been \$365.8 million. At June 30, 2007, pro forma for the Triad acquisition, a fluctuation in interest rates of 0.125% on the New Credit Facility would have resulted in a fluctuation in our cash interest expense of approximately \$3.9 million for the six months ended June 30, 2007.

If we default on our obligations to pay our indebtedness, we may not be able to make payments on the notes.

Any default under the agreements governing our indebtedness, including a default under our New Credit Facility that is not waived by the required lenders, and the remedies sought by the holders of indebtedness as a result of a default, could render us unable to pay principal, premium, if any, and interest on the notes and substantially decrease the market value of the notes. If we are unable to generate sufficient cash flow and are otherwise unable to obtain funds necessary to meet required payments of principal, premium, if any, and interest on our indebtedness, or if we otherwise fail to comply with the various covenants, including financial and operating covenants, in the instruments governing our indebtedness, including covenants in the indenture governing the notes and our New Credit Facility, we could be in default under the terms of the agreements governing this indebtedness, including our New Credit Facility and the indenture governing the notes. In the event of any default, the holders of this indebtedness could elect to declare all the funds borrowed to be due and payable, together with accrued and unpaid interest, the lenders under our New Credit Facility could elect to terminate their commitments under this facility, cease making further loans and institute foreclosure proceedings against our assets, and we could be forced into bankruptcy or liquidation. If our operating performance declines, we may in the future need to obtain waivers from the required lenders under our New Credit Facility to avoid being in default. If we breach our covenants under our New Credit Facility and seek a waiver, we may not be able to obtain a waiver from the required lenders. If this occurs, we would be in default under our New Credit Facility, the lenders could exercise their rights, as described above, and we could be forced into bankruptcy or liquidation. See Description of Certain Indebtedness and Description of the Exchange Notes.

Your ability to receive payments on these notes is junior to those lenders who have a security interest in our assets to the extent of the value of those assets.

Our obligations under the notes are unsecured, but our obligations under the New Credit Facility are secured by an interest in substantially all of our assets. CHS is a borrower under the New Credit Facility and Holdings and certain of its existing and future domestic and foreign subsidiaries have guaranteed obligations under the New Credit Facility on a senior secured basis. If we are declared bankrupt or insolvent, or if we default under the New Credit Facility, the lenders could declare all of the funds borrowed thereunder, together with accrued interest, immediately due and payable. If we are unable to repay such indebtedness, the lenders could foreclose on the pledged assets to the exclusion of holders of the notes, even if an event of default exists under the indenture at such time. In such event, because the notes will not be secured by any of our assets, it is possible that there would be no assets remaining from which claims of the holders of notes could be satisfied or, if any assets remained, they might be insufficient to satisfy such claims fully. See Description of Certain Indebtedness.

Claims of holders of the notes will be structurally subordinated to claims of creditors of our subsidiaries that do not guarantee the notes.

As of the issue date, the notes will be guaranteed by certain of our subsidiaries. Claims of holders of the notes will be structurally subordinated to the claims of creditors of our subsidiaries that do not guarantee the

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notes, including trade creditors. All obligations of these subsidiaries will have to be satisfied before any of the assets of such subsidiaries would be available for distribution, upon a liquidation or otherwise, to us or creditors of us, including the holders of the notes.

We estimate, on a pro forma basis, our non-guarantor subsidiaries would have accounted for approximately \$2,006 million, or 37%, of our total revenue for the 6 months ended June 30, 2007, and approximately \$4,370 million, or 33%, of our total assets, and approximately \$1,397 million, or 12%, of our total liabilities, in each case as of June 30, 2007. To the extent that the purchase price allocation changes the valuation of guarantor and non-guarantor assets and liabilities, the ratio of non-guarantor assets and liabilities to total assets and liabilities could change.

We may not be able to satisfy our obligations to holders of the notes upon a change of control.

Upon the occurrence of a change of control, as defined in the indenture governing the notes, the holders of the notes will be entitled to require us to repurchase the outstanding notes at a purchase price equal to 101% of the principal amount of the notes plus accrued and unpaid interest, if any, to the date of repurchase. Failure to make this repurchase would result in a default under the indenture. Also, our New Credit Facility may effectively prevent the purchase of the notes by us if a change of control occurs and these lenders do not consent to our purchase of the notes, unless all amounts outstanding under the New Credit Facility are repaid in full. Our failure to purchase or give a notice of purchase of the notes would be a default under the indenture, which would in turn be a default under the New Credit Facility. In addition, a change of control may constitute an event of default under the New Credit Facility. A default under the New Credit Facility would result in a default under the indenture if the lenders accelerate the debt under the New Credit Facility. Any future credit agreements or other agreements to which we become a party may contain similar restrictions and provisions. The exercise by holders of the notes of their right to require us to repurchase the notes could cause a default under our other debt agreements due to the financial effect of these repurchases on us, even if the change of control itself does not cause a default under the indenture.

In the event of a change of control, we may not have sufficient funds to repurchase the notes and to satisfy our other obligations under the notes and any other indebtedness. The source of funds for any purchase of notes would be available cash or cash generated from other sources, which may not be available. Upon the occurrence of a change of control, we could seek to refinance our indebtedness or obtain a waiver from our lenders, but it is possible that we would not be able to obtain a waiver or refinance our indebtedness on commercially reasonable terms, if at all. On the other hand, the provisions in the indenture governing the notes regarding a change of control could make it more difficult for a potential acquiror to obtain control of us. See [Description of the Exchange Notes](#) [Change of Control](#).

The change of control provisions in the indenture governing the notes may not protect you in the event we consummate a highly leveraged transaction, reorganization, restructuring, merger or other similar transaction, unless such transaction constitutes a change of control under the indenture. Some of these transactions may not involve a change in voting power or beneficial ownership or, even if they do, may not involve a change of the magnitude required under the definition of change of control in the indenture to trigger our obligation to repurchase the notes. Except as described above, the indenture does not contain provisions that permit the holders of the notes to require us to repurchase or redeem the notes in the event of a takeover, recapitalization or similar transaction. Therefore, if an event occurs that does not constitute a change of control as defined under the indenture governing the notes, we will not be required to make an offer to repurchase the notes, and you may be required to hold your notes despite the event. See [Description of Certain Indebtedness](#) and [Description of the Exchange Notes](#) [Change of Control](#).

Subsidiary guarantors will be automatically released from their obligations under the New Credit Facility in a variety of circumstances, which may cause those subsidiary guarantors to be released from their guarantees of the notes.

While any obligations under the New Credit Facility remain outstanding, any subsidiary guarantee of the notes may be released without action by, or consent of, any holder of the notes or the trustee under the

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indenture governing the notes, if such subsidiary guarantor is no longer a guarantor of obligations under the New Credit Facility or any other indebtedness. See Description of Certain Indebtedness and Description of the Exchange Notes. Upon the closing of any asset sale permitted under the New Credit Facility consisting of the sale of all of the equity interests of any subsidiary guarantor, the obligations of such subsidiary guarantor under the New Credit Facility will be automatically discharged and released. In addition, if any shares of a subsidiary guarantor are subject to certain permitted interest transfers under the New Credit Facility, including transfers of such shares in connection with permitted joint ventures or permitted syndication transactions under the New Credit Facility, the obligations of such subsidiary guarantor under the New Credit Facility will be automatically discharged and released. You will not have a claim as a creditor against any subsidiary that is no longer a guarantor of the notes, and the indebtedness and other liabilities, including trade payables, whether secured or unsecured, of those subsidiaries will effectively be senior to claims of noteholders.

Holdings and some of our subsidiaries will guarantee the notes. Federal and state statutes allow courts, under specific circumstances, to void guarantees and require note holders to return payments received from guarantors.

Under the terms of the indenture governing the notes, the notes will be guaranteed by Holdings and certain of our subsidiaries at the time of issuance. If Holdings or one of the subsidiaries that is a guarantor of the notes becomes the subject of a bankruptcy case or a lawsuit filed by unpaid creditors of any such guarantor, the guarantees entered into by these guarantors may be reviewed under the federal bankruptcy law and comparable provisions of state fraudulent transfer laws. Under these laws, a guarantee could be voided, or claims in respect of a guarantee could be subordinated to other obligations of a guarantor, if, among other things, the guarantor, at the time it incurred the indebtedness evidenced by its guarantee:

received less than reasonably equivalent value or fair consideration for entering into the guarantee; and

either:

was insolvent or rendered insolvent by reason of entering into the guarantee; or

was engaged in a business or transaction for which the guarantor's remaining assets constituted unreasonably small capital; or

intended to incur, or believed that it would incur, debts or contingent liabilities beyond its ability to pay such debts or contingent liabilities as they become due.

In such event, any payment by a guarantor pursuant to its guarantee could be voided and required to be returned to the guarantor, or to a fund for the benefit of the guarantor's creditors, under those circumstances.

If a guarantee of a guarantor were voided as a fraudulent conveyance or held unenforceable for any other reason, in all likelihood holders of the notes would be creditors solely of CHS/Community Health Systems, Inc. and those guarantors whose guarantees had not been voided. The notes then would in effect be structurally subordinated to all liabilities of the guarantor whose guarantee was voided.

The measures of insolvency for purposes of these fraudulent transfer laws will vary depending upon the law applied in any proceeding to determine whether a fraudulent transfer has occurred. Generally, however, a guarantor would be considered insolvent if:

the sum of its debts, including contingent liabilities, was greater than the fair saleable value of all of its assets; or

the present fair saleable value of its assets was less than the amount that would be required to pay its probable liability on its existing debts, including contingent liabilities, as they become absolute and mature; or

it could not pay its debts or contingent liabilities as they become due.

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We cannot assure you as to what standard a court would use to determine whether or not a guarantor would be solvent at the relevant time, or regardless of the standard used, that the guarantees would not be subordinated to any guarantor's other debt.

If a court held that the guarantees should be voided as fraudulent conveyances, the court could void, or hold unenforceable, the guarantees, which could mean that you may not receive any payments under the guarantees, and the court may direct you to return any amounts that you have already received from any guarantor. Furthermore, the holders of the notes would cease to have any direct claim against the applicable guarantor. Consequently, the applicable guarantor's assets would be applied first to satisfy the applicable guarantor's other liabilities, before any portion of its assets could be applied to the payment of the notes. Sufficient funds to repay the notes may not be available from other sources, including the remaining guarantors, if any. Moreover, the avoidance of a guarantee could result in acceleration of such debt (if not otherwise accelerated due to our or our guarantors' insolvency or other proceeding).

Each guarantee contains a provision intended to limit the guarantor's liability to the maximum amount that it could incur without causing the incurrence of obligations under its guarantee to be a fraudulent transfer. This provision may not be effective to protect the guarantees from being voided under fraudulent transfer law, or may reduce or eliminate the guarantor's obligation to an amount that effectively makes the guarantee worthless.

Risks Related to Our Indebtedness

Our level of indebtedness could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, and prevent us from meeting our obligations under the agreements relating to our indebtedness.

We are significantly leveraged. After the Merger was completed, we had total debt of approximately \$9,154 million. The New Credit Facility and the indenture governing the notes contains, and our future debt agreements will contain, covenants and events of default that may limit our ability to raise additional capital, react to changes or meet our obligations under our financing agreements. See [Use of Proceeds](#), [Description of the Exchange Notes](#) and [Description of Certain Indebtedness](#).

Our leverage could have important consequences for you, including the following:

it may limit our ability to obtain additional debt or equity financing for working capital, capital expenditures, debt service requirements, debt service prepayments and general corporate or other purposes;

a substantial portion of our cash flows from operations will be dedicated to the payment of principal and interest on our indebtedness and will not be available for other purposes, including our operations, capital expenditures and future business opportunities;

the debt service requirements of our indebtedness could make it more difficult for us to satisfy our financial obligations;

some of our borrowings, including borrowings under our New Credit Facility, will be at variable rates of interest, exposing us to the risk of increased interest rates;

it may limit our ability to adjust to changing market conditions and place us at a competitive disadvantage compared to our competitors that have less debt; and

we may be vulnerable in a downturn in general economic conditions or in our business, or we may be unable to carry out capital spending that is important to our growth.

Despite current indebtedness levels, we may still be able to incur substantially more debt. This could further exacerbate the risks described above.

We, our subsidiaries and any of our future subsidiaries may be able to incur substantial additional indebtedness in the future. The terms of the indenture governing the notes do not fully prohibit us from doing

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so, and all of this additional debt may be senior to the notes. For example, under the indenture for the notes, we or our subsidiaries may incur up to \$7,815 million pursuant to a credit facility or a qualified receivables transaction, less certain amounts repaid with the proceeds of asset dispositions. If we incur any additional indebtedness, including trade payables, that ranks equally with the notes, the holders of that debt will be entitled to share ratably with you in any proceeds distributed in connection with any insolvency, liquidation, reorganization, dissolution or other winding-up of us. This may have the effect of reducing the amount of proceeds paid to you. Additionally, upon consummation of the Transactions, our New Credit Facility will provide for commitments of up to \$7,215 million in the aggregate. We also have the ability to amend our New Credit Facility to provide for one or more additional tranches of term loans in aggregate principal amount of up to \$600.0 million. All borrowings under our New Credit Facility would be secured senior indebtedness. If new debt is added to our current debt levels, the related risks that we and our subsidiaries now face could intensify. See [Description of the Exchange Notes](#) and [Description of Certain Indebtedness](#).

Restrictive covenants in our debt agreement will limit our flexibility in operating our business.

The indenture governing the notes contains various covenants that limit our ability and/or our restricted subsidiaries ability to:

- incur, assume or guarantee additional indebtedness;
- issue redeemable stock and preferred stock;
- repurchase capital stock;
- make restricted payments, including paying dividends and making investments;
- redeem debt that is junior in right of payment to the notes;
- create liens without securing the notes;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- enter into agreements that restrict dividends from subsidiaries;
- merge, consolidate, sell or otherwise dispose of substantially all our assets;
- enter into transactions with affiliates; and
- guarantee indebtedness.

In addition, our New Credit Facility also contains restrictive covenants and requires us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet those financial ratios and tests can be affected by events beyond our control, and we cannot assure you that we will meet those tests. A breach of any of these covenants could result in a default under our New Credit Facility and/or the notes. Upon the occurrence of an event of default under our New Credit Facility, the lenders could elect to declare all amounts outstanding under our New Credit Facility to be immediately due and payable and terminate all commitments to extend further credit. If we were unable to repay those amounts, the lenders under our New Credit Facility could proceed against the collateral granted to them to secure that indebtedness. We have pledged a significant portion of our assets as collateral under our New Credit Facility. If the lenders under our New Credit Facility accelerate the repayment of borrowings, we cannot assure you that we will have sufficient assets to repay our New Credit Facility and our other indebtedness, including the notes.

See Description of Certain Indebtedness.

Risks Related to Our Business

We may not be able to successfully integrate our acquisition of Triad or realize the potential benefits of the acquisition, which could cause our business to suffer.

We may not be able to combine successfully the operations of Triad with our operations and, even if such integration is accomplished, we may never realize the potential benefits of the acquisition. The integration of

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Triad with our operations requires significant attention from management and may impose substantial demands on our operations or other projects. In addition, a significant number of Triad's corporate officers, who are covered by change of control arrangements, did not continue their employment with us beyond the date of the Merger. The integration of Triad also involves a significant capital commitment, and the return that we achieve on any capital invested may be less than the return that we would achieve on our other projects or investments. Any of these factors could cause delays or increased costs of combining the companies could adversely affect our operations, financial results and liquidity.

Certain of Triad's joint venture partners have put or call rights, the exercise of which could affect our available cash and/or operating results. Triad entered into a number of joint venture transactions that entitle its joint venture partners to require Triad to purchase the partner's interest or to require Triad to sell its interest to the partner. Some of these rights are triggered by Triad's change in control as a result of the Merger and others by the passage of time. The consideration provided for in these contracts may not be at an advantageous amount vis-à-vis the Merger consideration. If these rights are exercised, we may be required to make unanticipated payments, our operations at these facilities may be adversely affected, or we may be required to divest the facility.

If we fail to improve the operations of future acquired hospitals, we may be unable to successfully execute our growth strategy.

Most of the hospitals we have acquired or will acquire had or may have significantly lower operating margins than we do and/or operating losses prior to the time we acquired them. In the past, we have occasionally experienced temporary delays in improving the operating margins or effectively integrating the operations of these acquired hospitals. In the future, if we are unable to improve the operating margins of acquired hospitals, operate them profitably, or effectively integrate their operations, we may be unable to successfully execute our growth strategy. We acquired 50 hospitals in the Merger. In the past we have not acquired this many hospitals at one time. We may experience delays or difficulties in improving the operating margins or effectively integrating the operations of these acquired hospitals. In addition, we have and will incur other significant transaction-related costs.

Given the number of hospitals being acquired, senior management may need to devote a significant amount of time to integration of the acquired hospitals, which may detract from the ability of senior management to execute our business strategy.

If the hospitals we acquire have unknown or contingent liabilities, we could be liable for material obligations.

Hospitals that we acquire may have unknown or contingent liabilities, including liabilities for environmental matters and failure to comply with healthcare laws and regulations. Although we seek indemnification from sellers covering these matters, we may nevertheless have material liabilities for past activities of acquired hospitals.

In addition, we have assumed all of Triad's potential liabilities, including liabilities relating to pending or threatened litigation matters and government investigations, which, if adversely decided, could have a material adverse effect on our future results and/or operations. We do not have any rights of indemnification with respect to the Merger.

State efforts to regulate the construction, acquisition or expansion of hospitals could prevent us from constructing or acquiring new hospitals, renovating our facilities or expanding the breadth of services we offer.

Some states require prior approval for the construction or acquisition of healthcare facilities and for the expansion of healthcare facilities and services. In giving approval, these states consider the need for new or expanded healthcare facilities or services. In some states in which we operate, we are required to obtain certificates of need, or CONs, for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and some other matters.

Other states may adopt similar legislation. We may not be able to obtain

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the required CONs or other prior approvals for new or expanded facilities in the future. In addition, at the time we acquire a hospital, we may agree to replace or expand the facility we are acquiring. If we are not able to obtain required prior approvals, we would not be able to acquire or construct new hospitals and expand the breadth of services we offer.

If we are unable to effectively compete for patients, local residents could use other hospitals.

The hospital industry is highly competitive. 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. In approximately 85% of our current markets, we are the sole provider of general healthcare services. After the Merger was consummated, this percentage decreased to approximately 65%. In our other markets, the competitors are typically not-for-profit hospitals. These not-for-profit hospitals generally differ in each jurisdiction. In addition, some competing hospitals 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. However, our hospitals also face competition from hospitals outside of their primary service area, including hospitals in major metropolitan areas that provide more complex services. These facilities generally are located some distance from our facilities, but patients in our primary service areas may travel to these other hospitals for a variety of reasons. These reasons include physician referrals or the need for services we do not offer. Patients who seek services from these other hospitals may subsequently shift their preferences to those hospitals for the services we provide.

We expect that these competitive trends will continue. Our inability to compete effectively with other hospitals and other healthcare providers could result in local residents using other hospitals.

The failure to obtain our medical supplies at favorable prices could cause our operating results to decline.

In March 2005, we entered into a five-year participation agreement with automatic renewal terms of one year each with HealthTrust Purchasing Group, L.P., or HealthTrust, a Group Purchasing Organization, or GPO, which replaced a similar arrangement with another GPO. Triad has a similar relationship with this GPO. GPOs attempt to obtain favorable pricing on medical supplies with manufacturers and vendors who sometimes negotiate exclusive supply arrangements in exchange for the discounts they give. In the past, exclusive relationships have been the subject of challenge by excluded vendors and inquiry by regulators. To the extent these exclusive supply arrangements are challenged or deemed unenforceable, we could incur higher costs for our medical supplies currently obtained through HealthTrust. These higher costs could cause our operating results to decline. There can be no assurance that our arrangement with HealthTrust will provide the discounts we expect to achieve.

If the fair value of our reporting units declines, a material non-cash charge to earnings from impairment of our goodwill could result.

At June 30, 2007, we had approximately \$1,345 million of goodwill recorded on our books, and on a pro forma basis at June 30, 2007, we would have had \$4,279 million of goodwill. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. If a test of our goodwill for impairment indicates that impairment has occurred, we are required to record an impairment charge for the difference between the carrying value of the goodwill and the implied fair value of the goodwill in the period in which the determination is made. If we make changes in our business strategy or if market or other conditions adversely affect our business, we may be forced to record an impairment charge, which would lead to a decrease in our assets and a reduction in our net income or an increase in our net losses.

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Risks Related to Our Industry

If federal or state healthcare programs or managed care companies reduce the payments we receive as reimbursement for services we provide, our net operating revenues may decline.

On a pro forma basis, assuming the completion of the Transactions on January 1, 2006, 41.7% of our net operating revenues would have come from the Medicare and Medicaid programs. In recent years, federal and state governments made significant changes in the Medicare and Medicaid programs, including the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Some of these changes have decreased the amount of money we receive for our services relating to these programs.

In recent years, Congress and some state legislatures have introduced an increasing number of other proposals to make major changes in the healthcare system, including an increased emphasis on the linkage between quality of care criteria and payment levels, such as the submission of patient quality data to the Secretary of Health and Human Services. Future federal and state legislation may further reduce the payments we receive for our services. For example, the Governor of the State of Tennessee implemented cuts in the third quarter of 2005 in TennCare by restricting eligibility and capping specified services.

In addition, insurance and managed care companies and other third parties from whom we receive payment for our services increasingly are attempting to control healthcare costs by requiring that hospitals discount payments for their services in exchange for exclusive or preferred participation in their benefit plans. We believe that this trend may continue and may reduce the payments we receive for our services.

If we fail to comply with extensive laws and government regulations, including fraud and abuse laws, we could suffer penalties or be required to make significant changes to our operations.

The healthcare industry is required to comply with many laws and regulations at the federal, state and local government levels. These laws and regulations require that hospitals meet various requirements, including those relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, compliance with building codes, environmental protection, health and safety, and privacy. These laws include the Health Insurance Portability and Accountability Act of 1996, or HIPAA, and a section of the Social Security Act known as the anti-kickback statute. If we fail to comply with applicable laws and regulations, including fraud and abuse laws, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in the Medicare, Medicaid and other federal and state healthcare programs, and we may be subject to claims for damages brought by governmental or private parties.

In addition, there are heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment. The ongoing investigations relate to various referral, cost reporting and billing practices, laboratory and home healthcare services, and physician ownership and joint ventures involving hospitals.

In the future, different interpretations or enforcement of these laws and regulations could subject our current practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses.

We continue to be affected by an industry-wide shortage of qualified healthcare professionals and by increasing labor costs.

We and other healthcare providers have had and continue to have difficulties in retaining qualified personnel to staff our healthcare facilities, particularly nurses and pharmacists, and in such situations we may be required to use temporary employment agencies to provide additional personnel. The labor costs are generally higher for temporary employees than for full-time employees. In addition, some states in which we operate have increased minimum staffing standards. As minimum staffing standards are increased, we may be required to retain additional staffing. In addition, in recent years we have experienced increases in our labor costs primarily due to higher wages and greater benefits required to attract and retain qualified personnel and to increase staffing levels in our healthcare facilities. Although we have undertaken strategic and structural

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initiatives to address these issues, if these initiatives are unsuccessful, our financial condition, results of operations and cash flows could be adversely affected.

If we become subject to significant legal actions, we could be subject to substantial uninsured liabilities or increased insurance costs.

In recent years, physicians, hospitals and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability, negligent credentialing, over-charging or related legal theories. Many of these actions involve large claims and significant defense costs. To protect us from the cost of these claims, we maintain professional malpractice liability insurance and general liability insurance coverage in excess of those amounts for which we are self-insured, in amounts that we believe to be sufficient for our operations. However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. If the costs of malpractice and other liability insurance rise rapidly or uninsured claims are incurred, our profitability could decline. For a further discussion of our insurance coverage, see our discussion of professional liability insurance claims in the section entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations" in our Annual Report on Form 10-K for the year ended December 31, 2006, incorporated by reference in this prospectus.

If we experience growth in self-pay volume and revenue, our financial condition or results of operations could be adversely affected.

Like others in the hospital industry, we have experienced an increase in our provision for bad debts as a percentage of net operating revenue due to a growth in self-pay volume and revenue. If we experience growth in self-pay volume and revenue, our results of operations could be adversely affected. Further, our ability to improve collections for self-pay patients may be limited by statutory, regulatory and investigatory initiatives, including private lawsuits directed at hospital charges, and collection practices for uninsured and underinsured patients.

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FORWARD-LOOKING STATEMENTS

This prospectus contains forward-looking statements within the meaning of the federal securities laws, which involve risks and uncertainties. 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 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, but are not limited to, the following:

general economic and business conditions, both nationally and in the regions in which we operate;

our ability to successfully integrate any acquisitions or to recognize expected synergies from such acquisitions;

risks associated with our substantial indebtedness, leverage and debt service obligations;

demographic changes;

existing governmental regulations and changes in, or the failure to comply with, governmental regulations;

legislative proposals for healthcare reform;

the impact of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which includes specific reimbursement changes for small urban and non-urban hospitals;

our ability, where appropriate, to enter into managed care provider arrangements, and the terms of these arrangements;

changes in inpatient or outpatient Medicare and Medicaid payment levels;

increases in the amount and risk of collectibility of patient accounts receivable;

increases in wages as a result of inflation or competition for highly technical positions, and rising supply cost due to market pressure from pharmaceutical companies and new product releases;

liability and other claims asserted against us, including self-insured malpractice claims;

competition;

our ability to attract and retain 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 generally accepted accounting principles;

the availability and terms of capital to fund any acquisitions or replacement facilities;

our ability to successfully acquire and integrate additional hospitals (including the hospitals acquired from Triad);

our ability to obtain adequate levels of general and professional liability insurance;

potential adverse impact of known and unknown government investigations; and

timeliness of reimbursement payments received under government programs.

Some of the other important factors that could cause actual results to differ materially from our expectations are disclosed under Risk Factors and elsewhere in this prospectus, including, without limitation, in conjunction with the forward-looking statements included in this prospectus. Although we believe that these

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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 filing. All subsequent written and oral forward-looking statements attributable to us, or to persons acting on our behalf, are expressly qualified in their entirety by these cautionary statements. We do not undertake any obligation to publicly update or revise any forward-looking statement as a result of new information, future events or otherwise, except as otherwise required by law.

INDUSTRY AND MARKET DATA

The data included in this prospectus regarding markets and ranking, including the size of certain markets and our position and the position of our competitors within these markets, are based on reports of government agencies, published industry sources and other sources we believe to be reliable. While we believe that these studies and reports and our own research and estimates are reliable and appropriate, neither we nor the initial purchasers have independently verified such data and neither we nor the initial purchasers make any representations as to the accuracy of such information.

THE TRANSACTIONS

On July 25, 2007, we acquired Triad, a publicly-owned hospital company. Triad provides a broad range of general hospital healthcare services to patients in non-urban and mid-size markets located primarily in the southern, midwestern and western United States. As of July 25, 2007, prior to the acquisition, Triad owned, leased or operated 50 hospitals in 17 states, with an aggregate of approximately 9,600 licensed beds. Upon closing of the acquisition, we became the largest publicly-owned provider of hospital services, operating 129 hospitals in 28 states with an aggregate of approximately 19,200 licensed beds. On a pro forma basis, our net operating revenues for the year ended December 31, 2006 and for the six months ended June 30, 2007 would have been \$9,903 million and \$5,429 million, respectively.

Table of Contents**USE OF PROCEEDS**

The registration rights agreement requires that we register the Exchange Notes with the SEC and offer to exchange the registered Exchange Notes for the outstanding Old Notes. This exchange offer is intended to satisfy our obligations under the registration rights agreement. We will not receive any cash proceeds from the issuance of the Exchange Notes. In consideration for issuing the Exchange Notes contemplated in this prospectus, you will receive outstanding securities in like principal amount, the form and terms of which are the same as the form and terms of the Exchange Notes except as otherwise described in this prospectus. The Old Notes surrendered in exchange for Exchange Notes will be retired and canceled. Accordingly, no additional debt will result from the exchange. We have agreed to bear the expense of the exchange offer.

We used the net proceeds from the issuance of the Old Notes, in addition to our cash on hand and cash at Triad, and borrowings under our New Credit Facility described under Description of Certain Indebtedness New Senior Secured Credit Facilities, to complete the acquisition of Triad and certain related transactions and repay certain of our debt and the debt of Triad. See our unaudited pro forma financial information included elsewhere in this prospectus. The sources and uses of funds in connection with such transactions are as follows:

Sources of Funds

	(Dollars in millions)
New Senior Secured Revolving Credit Facility(1)	\$
New Senior Secured Delayed Draw Term Loan Facility(1)	
New Senior Secured Term Loan Facility	6,065
The Notes(2)	3,000
Total Sources	\$ 9,065

Uses of Funds

Equity Purchase Price	\$ 4,973
Refinance Existing Triad Debt	1,688
Refinance Existing CHS Debt	1,942
Redemption Tendering Fees	59
Severance and Termination Costs	90
Breakup Fees and Expenses	39
Working Capital(3)	15
Other Fees and Expenses	259
Total Uses	\$ 9,065

(1) We do not have any outstanding borrowings under our new \$750.0 million senior secured revolving credit facility, or our \$400.0 million New Senior Secured delayed draw term loan facility, immediately following the

consummation of the Transactions.

- (2) Notes are net of discount of \$21.3 million.
- (3) Working capital will be used for general corporate uses.

Table of Contents**CAPITALIZATION**

The following table sets forth our capitalization as of June 30, 2007:

on an actual basis; and

after giving pro forma effect to the issuance of the notes, our acquisition of Triad and the financing thereof and the other pro forma transactions. See Unaudited Pro Forma Condensed Financial Statements for a description of the pro forma transactions and the financing of our acquisition of Triad.

	As of June 30, 2007	
	Actual	Pro Forma
	(Dollars in millions)	
Cash and Cash Equivalents	\$ 21	\$ 99
Debt:		
New Senior Secured Revolving Credit Facility(1)	\$	\$
New Senior Secured Term Loan Facility(1)		6,065
New Senior Secured Delayed Draw Term Loan Facility(1)		
Capital Leases and Other	58	68
Existing Secured Debt	1,642	
Total Secured Debt	1,700	6,133
The Notes(2)		3,000
Total Senior Debt	1,700	9,133
Senior Subordinated Notes	300	
Total Debt	2,000	9,133
Shareholders' Equity(3)	1,861	1,829
Total Capitalization	\$ 3,861	\$ 10,962

(1) We do not have any outstanding borrowings under our \$750.0 million new senior secured revolving credit facility or our \$400.0 million new senior secured delayed draw term loan facility.

(2) Notes are net of discount of \$21.3 million.

(3) Pro forma shareholders' equity reflects the non-cash write-off of deferred loan costs associated with the refinancing of existing indebtedness of both us and Triad. See the notes to our unaudited pro forma condensed financial information for additional discussion.

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UNAUDITED PRO FORMA CONDENSED FINANCIAL STATEMENTS

On March 19, 2007, Holdings and a wholly-owned subsidiary of CHS/Community Health Systems, Inc., which subsidiary we refer to as Merger Sub, entered into a definitive Agreement and Plan of Merger, or the Merger Agreement, with Triad. On July 25, 2007, pursuant to the Merger Agreement, Merger Sub merged with and into Triad, with Triad continuing as the surviving corporation and a wholly-owned subsidiary of the Issuer. We refer to this business combination as the Merger. In connection with entry into the Merger Agreement, Holdings entered into a debt financing for up to \$7,215 million of senior secured financing and issued \$3,021 million of the Old Notes, which financing we collectively refer to herein as the Debt Financing. The Merger Agreement and related documents effectuated the occurrence of the following events, which we collectively refer to as the Transactions:

the Merger;

the entering into by CHS of the New Credit Facility, consisting of a \$6,065 million senior secured term loan, a \$750 million senior secured revolving credit facility and a \$400 million delayed draw senior secured term loan, of which \$6,065 million was drawn on the closing date;

the issuance by CHS of up to \$3,021 million (\$3,000 million, net of discount) of Old Notes;

the refinancing of certain of our existing indebtedness and that of Triad, which together totaled approximately \$3,630 million as of June 30, 2007;

the merger of Merger Sub with and into Triad, with Triad as the surviving corporation, and the payment of approximately \$6,915 million as merger consideration, including the refinancing or assumption of Triad's then outstanding debt; and

the payment of approximately \$448 million of fees and expenses, including severance costs, related to the foregoing transactions.

The following unaudited pro forma condensed financial statements are based on our historical financial statements and those of Triad after giving effect to the Transactions. The effects of the Merger have been prepared using the purchase method of accounting and applying the assumptions and adjustments described in the accompanying notes.

We derived the following unaudited pro forma condensed financial statements by applying pro forma adjustments to our historical consolidated financial statements incorporated by reference in this prospectus, and Triad historical consolidated financial statements incorporated by reference in this prospectus.

The unaudited pro forma condensed statements of operations data for the periods presented give effect to the Transactions as if they had been consummated on January 1, 2006. The unaudited pro forma condensed balance sheet data give effect to the Transactions as if they had occurred on June 30, 2007. We describe the assumptions underlying the pro forma adjustments in the accompanying notes, which should also be read in conjunction with these unaudited pro forma condensed financial statements. You should also read this information in conjunction with the:

Separate unaudited historical financial statements of CHS as of and for the six month period ended June 30, 2007, incorporated by reference in this prospectus;

Separate historical financial statements of CHS as of and for the fiscal year ended December 31, 2006, incorporated by reference in this prospectus;

Separate unaudited historical financial statements of Triad as of and for the six month period ended June 30, 2007, incorporated by reference in this prospectus; and

Separate historical financial statements of Triad as of and for the fiscal year ended December 31, 2006, incorporated by reference in this prospectus.

The pro forma adjustments related to the purchase price allocation and financing of the Transactions are preliminary and based on information obtained to date by management, and are subject to revision as

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additional information becomes available as to, among other things, the fair value of acquired assets and liabilities as well as any pre-acquisition contingencies and finalization of acquisition-related costs. The actual adjustments described in the accompanying notes may differ from those reflected in these unaudited pro forma condensed financial statements. Revisions to the preliminary purchase price allocation and financing of the Transactions may have a significant impact on the pro forma amounts of total assets, total liabilities and stockholders' equity, operating expense and costs, depreciation and amortization and interest expense.

The unaudited pro forma condensed financial statements do not reflect non-recurring charges that will be incurred in connection with the (i) write-off of certain deferred financing costs, (ii) tender premiums on our previously outstanding Senior Subordinated Notes and (iii) certain other non-recurring Merger costs, such as cash expenditures for restructuring and integration activities and retention bonuses, which cannot be reasonably estimated at this time.

The unaudited pro forma condensed financial statements should not be considered indicative of actual results that would have been achieved had the Transactions been consummated on the date or for the periods indicated, and do not purport to indicate consolidated balance sheet data or results of operations as of any future date or any future period.

The unaudited pro forma condensed financial statements should be read in conjunction with the information contained in Selected Historical Financial Data, Management's Discussion and Analysis of Financial Condition and Results of Operations and the consolidated financial statements and accompanying notes incorporated by reference in this prospectus.

Table of Contents**COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES****UNAUDITED PRO FORMA CONDENSED BALANCE SHEET**

	As of June 30, 2007			
	CHS as Reported	Triad	Adjustments (Dollars in thousands)	Pro Forma
ASSETS				
Current assets:				
Cash and cash equivalents	\$ 21,357	\$ 63,200	\$ (5,217,358)(a) (3,833,043)(b) 9,065,000(b)	\$ 99,156
Patient accounts receivable	876,523	979,400		1,855,923
Supplies	121,964	152,700		274,664
Deferred income taxes	13,249	41,600		54,849
Prepaid expenses and taxes	36,287	48,900		85,187
Other current assets	62,933	100,900		163,833
Total current assets	1,132,313	1,386,700	14,599	2,533,612
Property and equipment:	2,809,988	4,510,100	500,000(a)	7,820,088
Less accumulated depreciation and amortization	(720,846)	(1,341,100)		(2,061,946)
Property and equipment, net	2,089,142	3,169,000	500,000	5,758,142
Goodwill	1,344,956	1,365,800	(1,365,800)(a) 2,934,358(a)	4,279,314
Investment in and advances to unconsolidated affiliates		260,200		260,200
Other assets	226,700	197,500	5,000(a) 183,956(b) (31,611)(c)	581,545
Total assets	\$ 4,793,111	\$ 6,379,200	\$ 2,240,502	\$ 13,412,813
LIABILITIES AND STOCKHOLDERS EQUITY				
Current liabilities:				
Current maturities of long-term debt	\$ 25,757	\$ 26,900	\$ (16,900)(b)	\$ 35,757
Accounts payable	257,730	245,100		502,830
Current income taxes payable	49,010	39,500		88,510
Accrued liabilities	278,527	347,700	(19,587)(b)	606,640

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Total current liabilities	611,024	659,200	(36,487)(b)	1,233,737
Long-term debt	1,974,240	1,670,600	5,452,400(b)	9,097,240
Deferred income taxes	141,472	172,200	192,500(a)	506,172
Other long-term liabilities	205,408	201,800		407,208
Minority interests in equity of consolidated entities		339,100		339,100
Stockholders' equity:				
Preferred stock				
Common stock	959	900	(900)(a)	959
Additional paid-in capital	1,215,321	2,450,800	(2,450,800)(a)	1,215,321
Treasury stock, at cost	(6,678)	(3,200)	3,200(a)	(6,678)
Unearned stock compensation		(5,200)	5,200(a)	
Accumulated other comprehensive income	15,622	(7,100)	7,100(a)	15,622
Retained Earnings	635,743	900,100	(900,100)(a)	604,132
			(31,611)(c)	
Total stockholders' equity	1,860,967	3,336,300	(3,367,911)	1,829,356
Total liabilities and stockholders' equity	\$ 4,793,111	\$ 6,379,200	\$ 2,240,502	\$ 13,412,813

The accompanying notes are an integral part of these unaudited pro forma condensed financial statements.

Table of Contents**COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES****UNAUDITED PRO FORMA CONDENSED STATEMENTS OF INCOME**

	Year Ended December 31, 2006			
	CHS	Triad	Adjustments	Pro Forma
	as Reported	as Reported		
		(Dollars in thousands)		
Net operating revenues	\$ 4,365,576	\$ 5,537,900		\$ 9,903,476
Operating costs and expenses:				
Salaries and benefits	1,741,223	2,233,100	49,700(f) (11,821)(j)	4,012,202
Provision for bad debts	547,781	576,900		1,124,681
Supplies	510,351	957,900		1,468,251
Rent	97,104		116,814(g)	213,918
Other operating expenses	897,091	1,069,800	(116,814)(g) (6,000)(h) (3,802)(k)	1,840,275
Reimbursable expenses		49,700	(49,700)(f)	
Minority interest in earnings	2,795	22,000		24,795
Equity in earnings of unconsolidated affiliates		(43,500)		(43,500)
Depreciation and amortization	188,771	229,800	15,000(e) 1,000(i)	434,571
Total operating costs and expenses	3,985,116	5,095,700	(5,623)	9,075,193
Income from operations	380,460	442,200	5,623	828,283
Interest expense, net	102,299	95,300	513,002(d)	710,601
ESOP expense		12,500	(12,500)(l)	
Gain on sales of assets		(6,000)	6,000(h)	
Income from continuing operations before income taxes	278,161	340,400	(500,879)	117,682
Provision for income taxes	106,682	132,500	(192,838)(m)	46,344
Income from continuing operations	\$ 171,479	\$ 207,900	\$ (308,041)	\$ 71,338
Income from continuing operations per common share:				
Basic	\$ 1.81	\$ 2.41		\$ 0.75
Diluted	\$ 1.78	\$ 2.38		\$ 0.74
Weighted-average number of shares outstanding:				

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Basic	94,983,646	86,306,434	94,983,646
Diluted	96,232,910	87,153,019	96,232,910

The accompanying notes are an integral part of these unaudited pro forma condensed financial statements.

Table of Contents**COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES****UNAUDITED PRO FORMA CONDENSED STATEMENTS OF INCOME**

	Six Months Ended June 30, 2006			
	CHS as Reported	Triad	Adjustments	Pro Forma
	(Dollars in thousands)			
Net operating revenues	\$ 2,087,616	\$ 2,747,265		\$ 4,834,881
Operating costs and expenses:				
Salaries and benefits	827,815	1,111,382	25,954(f) (5,839)(j)	1,959,312
Provision for bad debts	223,295	248,874		472,169
Supplies	248,520	471,750		720,270
Rent	46,628		54,772(g)	101,400
Other operating expenses	426,156	525,430	(54,772)(g) (614)(h) (2,217)(k)	893,983
Reimbursable expenses		25,954	(25,954)(f)	
Minority interest in earnings	1,068	9,984		11,052
Equity in earnings of unconsolidated affiliates		(19,824)		(19,824)
Depreciation and amortization	89,689	112,378	7,500(e) 500(i)	210,067
Total operating costs and expenses	1,863,171	2,485,928	(670)	4,348,429
Income from operations	224,445	261,337	670	486,452
Interest expense, net	45,657	47,414	257,098(d)	350,169
ESOP expense		6,099	(6,099)(l)	
Gain on sales of assets		(614)	614(h)	
Income from continuing operations before income taxes	178,788	208,438	(250,943)	136,283
Provision for income taxes	69,165	80,552	(96,613)(m)	53,104
Income from continuing operations	\$ 109,623	\$ 127,886	\$ (154,330)	\$ 83,179
Income from continuing operations per common share:				
Basic	\$ 1.14	\$ 1.49		\$ 0.87
Diluted	\$ 1.13	\$ 1.48		\$ 0.85
Weighted-average number of shares outstanding:				

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Basic	96,158,575	85,958,229	96,158,575
Diluted	97,536,815	86,665,173	97,536,815

The accompanying notes are an integral part of these unaudited pro forma condensed financial statements.

Table of Contents**COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES****UNAUDITED PRO FORMA CONDENSED STATEMENTS OF OPERATIONS**

	Six Months Ended June 30, 2007			
	CHS as Reported	Triad	Adjustments	Pro Forma
	(Dollars in thousands)			
Net operating revenues	\$ 2,453,125	\$ 2,975,910		\$ 5,429,035
Operating costs and expenses:				
Salaries and benefits	981,421	1,230,591	24,582(f) (6,213)(j)	2,230,381
Provision for bad debts	284,360	303,564		587,924
Supplies	286,541	505,762		792,303
Rent	54,240		62,648(g)	116,888
Other operating expenses	503,815	610,284	(62,648)(g) 388(h) (2,599)(k)	1,049,240
Reimbursable expenses		24,582	(24,582)(f)	
Minority interest in earnings	818	12,831		13,649
Equity in earnings of unconsolidated affiliates		(23,608)		(23,608)
Depreciation and amortization	104,619	123,239	7,500(e) 500(i)	235,858
Total operating costs and expenses	2,215,814	2,787,245	(424)	5,002,635
Income from operations	237,311	188,665	424	426,400
Interest expense, net	61,559	48,225	253,258(d)	363,042
ESOP expense		7,504	(7,504)(l)	
Loss on sales of assets		388	(388)(h)	
Income from continuing operations before income taxes	175,752	132,548	(244,942)	63,358
Provision for income taxes	67,665	60,710	(94,303)(m)	34,072
Income from continuing operations	\$ 108,087	\$ 71,838	\$ (150,639)	\$ 29,286
Income from continuing operations per common shares:				
Basic	\$ 1.16	\$ 0.82		\$ 0.31
Diluted	\$ 1.14	\$ 0.80		\$ 0.31
Weighted-average number of shares outstanding:				

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Basic	93,373,357	87,379,366	93,373,357
Diluted	94,422,000	89,340,770	94,422,000

The accompanying notes are an integral part of these unaudited pro forma condensed financial statements.

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**NOTES TO UNAUDITED PRO FORMA
CONDENSED FINANCIAL STATEMENTS
(Dollars in thousands)**

1. Purchase Price

The total purchase price of the acquisition of Triad is as follows:

Cash paid for shares outstanding or issuable	\$ 4,972,812
Repayment or assumption of Triad's debt obligations	1,697,500
Estimated direct transaction costs	244,546
Total	\$ 6,914,858

Under the purchase method of accounting, the total purchase price as shown in the table above will be allocated to Triad's tangible and intangible assets based upon their estimated fair value as of July 25, 2007, the date of completion of the transaction. Any excess of the purchase price over the estimated fair value of the tangible and intangible assets will be recorded as goodwill. Based upon the purchase price and assumptions regarding valuations of acquired assets and liabilities, the purchase price allocation is as follows (in thousands):

Current assets	\$ 1,386,700
Property and equipment	3,669,000
Goodwill	2,934,358
Other long-term assets	457,700
Amortizable intangible assets	5,000
Current liabilities	(632,300)
Other long-term liabilities	(566,500)
Minority interest	(339,100)
	\$ 6,914,858

Goodwill will not be amortized but will be tested for impairment on an annual basis and whenever events or circumstances occur indicating that the goodwill may be impaired. The preliminary purchase price allocation for Triad is subject to revision as more detailed analysis is completed and additional information on, among other things, the fair values of Triad's assets and liabilities, any preacquisition contingencies and finalization of acquisition-related costs, becomes available. Any change in the fair value of the assets and liabilities of Triad will change the amount of the purchase price allocable to goodwill. The final purchase price allocation may differ materially from the allocation presented here.

2. Pro Forma Adjustments

Pro forma adjustments are necessary to reflect the purchase price, to adjust amounts related to Triad's assets and liabilities to an estimate of their fair values, to reflect financing transactions associated with the transaction, to reflect changes in depreciation and amortization expense resulting from the fair value adjustments to tangible and intangible

assets, to reflect other transactions directly related to the transaction, and to reflect the income tax effects related to the pro forma adjustments. There were no intercompany transactions between us and Triad. Certain pro forma adjustments were made to conform Triad's accounting policies and presentation to our accounting policies and presentation.

Table of Contents**NOTES TO UNAUDITED PRO FORMA****CONDENSED FINANCIAL STATEMENTS (Continued)**

The accompanying unaudited pro forma condensed financial statements have been prepared as if the transaction was completed on June 30, 2007 for balance sheet purposes and on January 1, 2006 for income statement purposes, and reflect the following adjustments:

(a) To record the transaction:

Cash payments for:

Purchase of Triad outstanding shares	\$ 4,835,908
Triad stock option costs and other equity-based instruments	136,904
Transaction costs	244,546
	\$ 5,217,358

Included in transaction costs are severance costs of \$90 million, primarily resulting from change in control provisions, direct transaction costs of \$116 million, which primarily include estimated investment banker fees, attorneys' fees and accounting fees, break-up fees and expenses of \$39 million.

Elimination of existing Triad stockholders' equity:

Common stock	\$ 900
Capital in excess of par value	2,450,800
Treasury stock, at cost	(3,200)
Unearned stock compensation	(5,200)
Retained earnings	900,100
Accumulated other comprehensive income	(7,100)
	\$ 3,336,300

The difference between the preliminary estimated fair value of assets acquired based on management's estimates of fair value and Triad's historical net book value of property and equipment:

	Historical Net Book Value	Estimated Fair Value	Estimated Increase
Land	\$ 214,000	\$ 414,000	\$ 200,000
Buildings and improvements	1,624,791	1,924,791	300,000
Equipment	872,809	872,809	

Construction in progress	457,400	457,400	
	\$ 3,169,000	\$ 3,669,000	\$ 500,000

The final fair value amounts will be determined based upon management's final best estimate of fair value. Deferred income tax liabilities will increase by an estimated \$192,500 to reflect the impact of the pro forma purchase price adjustments related to the increase in fair value of Triad's property and equipment. Estimate of additional goodwill and identifiable intangibles as a result of the purchase price allocation are detailed in footnote 1 to these unaudited pro forma condensed financial statements.

Table of Contents**NOTES TO UNAUDITED PRO FORMA****CONDENSED FINANCIAL STATEMENTS (Continued)**

(b) To record the payments made from the proceeds of the new indebtedness:

Sources

New Senior Secured Term Loan Facility	\$ 6,065,000
The Notes	3,021,331
Notes discount	(21,331)
Subtotal	9,065,000

Uses

Cash payments for Triad stock and transaction costs:	
Purchase Triad outstanding shares	(4,835,908)
Triad stock option costs and other equity-based compensation	(136,904)
Transaction costs	(244,546)
Subtotal	(5,217,358)

Cash payments related to refinancing and debt repayment:

Triad Term Loan A	(487,500)
Triad 7% Senior Notes	(600,000)
Triad 7% Senior Subordinated Notes	(600,000)
CHS Term Loans	(1,642,000)
CHS Senior Subordinated Notes	(300,000)
Accrued Interest	(19,587)
Financing fees(1)	(183,956)
Subtotal	(3,833,043)

Working Capital(2)	(14,599)
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Total uses	\$ (9,065,000)
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(1) Financing fees will be capitalized as deferred loan costs and amortized into interest expense.

(2) Working capital will be used for general corporate uses.

(c) To reflect the non-cash write-off of deferred loan costs associated with the refinancing of existing indebtedness of both us and Triad:

Deferred

	Loan Costs
CHS \$1,200 million Term Loan	\$ 6,897
CHS \$400 million Term Loan	1,962
CHS 6 1/2% Senior Subordinated Notes	5,370
Triad Term Loan A	4,066
Triad 7% Senior Notes	3,245
Triad 7% Senior Subordinated Notes	10,071
	\$ 31,611

Such amounts for CHS debt will be reflected in the results of operations as a loss on extinguishment of debt upon completion of the refinancing.

Table of Contents**NOTES TO UNAUDITED PRO FORMA****CONDENSED FINANCIAL STATEMENTS (Continued)**

(d) To record additional interest expense based upon the assumed debt structure as follows:

	Year Ended December 31, 2006	Six Months Ended June 30, 2006	Six Months Ended June 30, 2007
Senior Secured Term Loan Facility	\$ 453,698	\$ 219,979	\$ 235,107
The Notes	268,143	134,072	134,072
Capital leases and other debt	2,826	1,366	2,155
Deferred loan costs	22,950	11,475	11,475
Commitment fees	5,750	2,875	2,875
Amortization of note discount	1,935	946	1,035
Interest rate swaps	(15,342)	(6,418)	(8,686)
Standby letters of credit	642	321	312
Total interest costs	740,602	364,616	378,345
Less: Capitalized interest	(8,190)	(3,084)	(8,860)
Interest income	(21,811)	(11,363)	(6,443)
Interest expense, net	710,601	350,169	363,042
Less: Interest expense, net, as reported			
CHS	(102,299)	(45,657)	(61,559)
Triad	(95,300)	(47,414)	(48,225)
Net interest expense adjustment	\$ 513,002	\$ 257,098	\$ 253,258

For purposes of these unaudited pro forma condensed financial statements, management has assumed a weighted-average interest rate of 7.48% for the year ended December 31, 2006, 7.31% for the six months ended June 30, 2006 and 7.61% for the six months ended June 30, 2007 on its Senior Secured Term Loan Facility, and the actual interest rate of 87/8% on the notes. A fluctuation in interest rates of 0.125% on the Senior Secured Term Loan Facility would result in an annual fluctuation in interest expense of approximately \$7.6 million.

(e) To adjust depreciation expense related to the write-up of Triad's property and equipment to fair market value. Management believes the write-up will be primarily to land and buildings, of which it estimates the buildings to have a weighted-average useful life remaining of 20 years. A change in building value of \$10.0 million will affect depreciation expense by approximately \$0.5 million annually and a change in equipment value of \$10.0 million will affect depreciation by approximately \$1.3 million.

(f) Triad's costs classified as reimbursable expenses, which relate to salaries and benefits of its subsidiary, Quorum Health Resources, LLC, or QHR, are reclassified to salaries and benefits to conform with our presentation in the

income statement.

(g) Triad's rent expense is reclassified from other operating expense to rent to conform with our presentation in the income statement.

(h) Triad's (gain) loss on sale of assets is reclassified to other operating expenses to conform with our presentation in the income statement.

(i) To record amortization expense related to the write-up of identifiable intangible assets. Management believes such intangible assets will principally relate to certificates of need, licenses and permits, and will have a useful life of approximately five years.

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NOTES TO UNAUDITED PRO FORMA

CONDENSED FINANCIAL STATEMENTS (Continued)

(j) To record the elimination of salaries and benefits for actual costs incurred related to (1) 25 Triad corporate officers who were covered by change of control arrangements, and whose employment did not continue beyond the date of the Merger and whose positions are not being replaced, and (2) 19 other Triad corporate employees who terminated their employment with Triad prior to the Merger and whose positions are not being replaced. Management believes that the positions being eliminated will have no impact on revenue-generating activities subsequent to the Merger.

(k) To record the elimination of duplicate board of directors fees and directors and officers insurance expense less the incremental increase in the post-Merger directors and officers insurance expense.

(l) To record the elimination of Triad's Employee Stock Ownership Plan, or ESOP, which terminated upon the completion of the Merger and for which we do not have a similar plan, nor the intent to create such a plan in its place.

(m) To record the income tax effects of the pro forma statement of operations adjustments using a statutory tax rate of 38.5%.

3. Other Historical Costs

Included in Triad's other operating expenses for the six months ended June 30, 2007 are \$20.9 million of legal, investment banking and other fees related to the Merger. Such costs are not included in the pro forma adjustments, however, the Company's management believes that since these costs are transaction specific, the resulting reduction to earnings is such that Triad's earnings for the six months ended June 30, 2007 are not indicative of future operating results.

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THE EXCHANGE OFFER

Terms of the Exchange Offer; Period for Tendering Outstanding Old Notes

We issued the Old Notes on July 25, 2007 and entered into a registration rights agreement with the initial purchasers. The registration rights agreement requires that we register the Exchange Notes with the SEC and offer to exchange the registered Exchange Notes for the outstanding Old Notes.

Upon the terms and subject to the conditions set forth in this prospectus, we will accept any and all Old Notes that were acquired pursuant to Rule 144A or Regulation S validly tendered and not withdrawn prior to 5:00 p.m., New York City time, on the expiration date of the exchange offer. We will issue \$1,000 principal amount of Exchange Notes in exchange for each \$1,000 principal amount of Old Notes accepted in the exchange offer. Holders may tender some or all of their Old Notes pursuant to the exchange offer. However, Old Notes may be tendered only in integral multiples of \$1,000.

The form and terms of the Exchange Notes are the same as the form and terms of the outstanding Old Notes except that:

- (1) the Exchange Notes being issued in the exchange offer will be registered under the Securities Act and will not have legends restricting their transfer;
- (2) the Exchange Notes being issued in the exchange offer will not contain the registration rights and liquidated damages provisions contained in the outstanding Old Notes; and
- (3) interest on the Exchange Notes will accrue from the last interest date on which interest was paid on your Old Notes.

The Exchange Notes will evidence the same debt as the outstanding securities and will be entitled to the benefits of the indenture.

We intend to conduct the exchange offer in accordance with the applicable requirements of the Securities Exchange Act of 1934, as amended, referred to herein as the Exchange Act, and the rules and regulations of the SEC.

We will be deemed to have accepted validly tendered Old Notes when, as and if we have given oral or written notice of our acceptance to the exchange agent. The exchange agent will act as agent for the tendering holders for the purpose of receiving the Exchange Notes from us.

If any tendered Old Notes are not accepted for exchange because of an invalid tender or the occurrence of specified other events set forth in this prospectus, the certificates for any unaccepted Old Notes will be promptly returned, without expense, to the tendering holder.

Holders who tender Old Notes in the exchange offer will not be required to pay brokerage commissions or fees or transfer taxes with respect to the exchange of Old Notes pursuant to the exchange offer. We will pay all charges and expenses, other than transfer taxes in certain circumstances, in connection with the exchange offer. See Fees and Expenses and Transfer Taxes below.

The exchange offer will remain open for at least 20 full business days. The term expiration date will mean 5:00 p.m., New York City time, on _____, 2007, unless we, in our sole discretion, extend the exchange offer, in which case the

term expiration date will mean the latest date and time to which the exchange offer is extended.

To extend the exchange offer, prior to 9:00 a.m., New York City time, on the next business day after the previously scheduled expiration date, we will:

- (1) notify the exchange agent of any extension by oral notice (promptly confirmed in writing) or written notice,
- (2) mail to the registered holders an announcement of any extension, and issue a notice by press release or other public announcement before such expiration date.

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We reserve the right, in our sole discretion:

- (1) if any of the conditions below under the heading "Conditions to the Exchange Offer" shall have not been satisfied,
 - (a) to delay accepting any Old Notes,
 - (b) to extend the exchange offer, or
 - (c) to terminate the exchange offer, and
- (2) to amend the terms of the exchange offer in any manner, provided however, that if we amend the exchange offer to make a material change, including the waiver of a material condition, we will extend the exchange offer, if necessary, to keep the exchange offer open for at least five business days after such amendment or waiver; provided further, that if we amend the exchange offer to change the percentage of notes being exchanged or the consideration being offered, we will extend the exchange offer, if necessary, to keep the exchange offer open for at least ten business days after such amendment or waiver.

Any delay in acceptance, extension, termination or amendment will be followed as promptly as practicable by oral or written notice to the registered holders.

Procedures for Tendering Old Notes Through Brokers and Banks

Since the Old Notes are represented by global book-entry notes, The Depository Trust Company or DTC, as depository, or its nominee is treated as the registered holder of the Old Notes and will be the only entity that can tender your Old Notes for Exchange Notes. Therefore, to tender Old Notes subject to this exchange offer and to obtain Exchange Notes, you must instruct the institution where you keep your Old Notes to tender your Old Notes on your behalf so that they are received on or prior to the expiration of this exchange offer.

The BLUE-colored "Letter of Transmittal" shall be used by you to give such instructions.

IF YOU WISH TO ACCEPT THIS EXCHANGE OFFER, PLEASE INSTRUCT YOUR BROKER OR ACCOUNT REPRESENTATIVE IN TIME FOR YOUR OLD NOTES TO BE TENDERED BEFORE THE 5:00 PM (NEW YORK CITY TIME) DEADLINE ON _____, 2007.

To tender your Old Notes in the exchange offer you must represent for our benefit that:

- (1) You are acquiring the Exchange Notes for your outstanding Old Notes in the ordinary course of business;
- (2) You do not have an arrangement or understanding with any person to participate in the distribution of Exchange Notes;
- (3) You are not an "affiliate" as defined under Rule 405 of the Securities Act;
- (4) You will also have to acknowledge that if you are not a broker-dealer, you are not engaged in and do not intend to engage in a distribution of the Exchange Notes; and
- (5) You will also have to acknowledge that if you are a broker-dealer, and acquired the Old Notes as a result of market making activities or other trading activities, you will deliver a prospectus meeting the requirements of the Securities Act in connection with any for sale of such Exchange Notes.

You must make such representations by executing the Blue colored Letter of Transmittal and delivering it to the institution through which you hold your Old Notes.

Such institution will have to acknowledge that such representations were made by you.

You may tender some or all of your Old Notes in this exchange offer. However, your Old Notes may be tendered only in integral multiples of \$1,000.

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When you tender your outstanding Old Notes and we accept them, the tender will be a binding agreement between you and us as described in this prospectus.

The method of delivery of outstanding Old Notes and all other required documents to the exchange agent is at your election and risk.

We will decide all questions about the validity, form, eligibility, acceptance and withdrawal of tendered Old Notes, and our reasonable determination will be final and binding on you. We reserve the absolute right to:

- (1) reject any and all tenders of any particular Old Note not properly tendered;
- (2) refuse to accept any Old Note if, in our reasonable judgment or the judgment of our counsel, the acceptance would be unlawful; and
- (3) waive any defects or irregularities or conditions of the exchange offer as to any particular Old Notes before the expiration of the offer.

Our interpretation of the terms and conditions of the exchange offer will be final and binding on all parties. You must cure any defects or irregularities in connection with tenders of Old Notes as we will reasonably determine. Neither us, the exchange agent nor any other person will incur any liability for failure to notify you or any defect or irregularity with respect to your tender of Old Notes. If we waive any terms or conditions pursuant to (3) above with respect to a noteholder, we will extend the same waiver to all noteholders with respect to that term or condition being waived.

Procedures for Brokers and Custodian Banks; DTC ATOP Account

In order to accept this exchange offer on behalf of a holder of Old Notes you must submit or cause your DTC participant to submit an Agent's Message as described below.

The exchange agent, on our behalf will seek to establish an Automated Tender Offer Program (ATOP) account with respect to the outstanding Old Notes at DTC promptly after the delivery of this prospectus. Any financial institution that is a DTC participant, including your broker or bank, may make book-entry tender of outstanding Old Notes by causing the book-entry transfer of such Old Notes into our ATOP account in accordance with DTC's procedures for such transfers. Concurrently with the delivery of Old Notes, an Agent's Message in connection with such book-entry transfer must be transmitted by DTC to, and received by, the exchange agent on or prior to 5:00 pm, New York City Time on the expiration date. The confirmation of a book entry transfer into the ATOP account as described above is referred to herein as a Book-Entry Confirmation.

The term Agent's Message means a message transmitted by the DTC participants to DTC, and thereafter transmitted by DTC to the exchange agent, forming a part of the Book-Entry Confirmation which states that DTC has received an express acknowledgment from the participant in DTC described in such Agent's Message stating that such participant and beneficial holder agree to be bound by the terms of this exchange offer.

Each Agent's Message must include the following information:

- (1) Account number of the beneficial owner tendering such Old Notes;
- (2) Principal amount of Old Notes tendered by such beneficial owner; and

(3) A confirmation that the beneficial holder of the Old Notes tendered has made the representations for the benefit of the Company set forth under Procedures for Tendering Old Notes Held Through Brokers or Banks above.

BY SENDING AN AGENT'S MESSAGE THE DTC PARTICIPANT IS DEEMED TO HAVE CERTIFIED THAT THE BENEFICIAL HOLDER FOR WHOM NOTES ARE BEING TENDERED HAS BEEN PROVIDED WITH A COPY OF THIS PROSPECTUS.

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The delivery of Old Notes through DTC, and any transmission of an Agent's Message through ATOP, is at the election and risk of the person tendering Old Notes. We will ask the exchange agent to instruct DTC to promptly return those Old Notes, if any, that were tendered through ATOP but were not accepted by us, to the DTC participant that tendered such Old Notes on behalf of holders of the Old Notes.

Acceptance of Outstanding Old Notes for Exchange; Delivery of Exchange Notes Issued in the Exchange Offer upon Expiration of the Exchange Offer

We will accept validly tendered Old Notes when the conditions to the exchange offer have been satisfied or we have waived them. We will have accepted our validly tendered Old Notes when we have given oral or written notice to the exchange agent. The exchange agent will act as agent for the tendering holders for the purpose of receiving the Exchange Notes from us. If we do not accept any tendered Old Notes for exchange because of an invalid tender or other valid reason, the exchange agent will promptly return the certificates, without expense, to the tendering holder after the exchange offer terminates or expires. If a holder has tendered Old Notes by book-entry transfer, we will promptly credit the Notes to an account maintained with The Depository Trust Company after the exchange offer terminates or expires.

THE AGENT'S MESSAGE MUST BE TRANSMITTED TO EXCHANGE AGENT ON OR BEFORE 5:00 PM, NEW YORK CITY TIME, ON THE EXPIRATION DATE.

Withdrawal Rights

You may withdraw your tender of outstanding Notes at any time before 5:00 p.m., New York City time, on the expiration date.

For a withdrawal to be effective, you should contact your bank or broker where your Old Notes are held and have them send an ATOP notice of withdrawal so that it is received by the exchange agent before 5:00 p.m., New York City time, on the expiration date. Such notice of withdrawal must:

- (1) specify the name of the person that tendered the Old Notes to be withdrawn;
- (2) identify the Old Notes to be withdrawn, including the CUSIP number and principal amount at maturity of the Old Notes; specify the name and number of an account at the DTC to which your withdrawn Old Notes can be credited.

We will decide all questions as to the validity, form and eligibility of the notices and our determination will be final and binding on all parties. Any tendered Old Notes that you withdraw will not be considered to have been validly tendered. We will promptly return any outstanding Old Notes that have been tendered but not exchanged, or credit them to the DTC account. You may re-tender properly withdrawn Old Notes by following one of the procedures described above before the expiration date.

Conditions To The Exchange Offer

Notwithstanding any other provision herein, we are not required to accept for exchange, or to issue Exchange Notes in exchange for, any outstanding Old Notes. We may terminate or amend the exchange offer, before the expiration of the exchange offer:

- (1) if any federal law, statute, rule or regulation has been adopted or enacted which, in our judgment, would reasonably be expected to impair our ability to proceed with the exchange offer;

(2) if any stop order is threatened or in effect with respect to the registration statement which this prospectus is a part of or the qualification of the indenture under the Trust Indenture Act of 1939; or

(3) if there is a change in the current interpretation by the staff of the SEC which permits holders who have made the required representations to us to resell, offer for resale, or otherwise transfer Exchange Notes issued in the exchange offer without registration of the Exchange Notes and delivery of a prospectus, as discussed above.

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These conditions are for our sole benefit and we may assert them at any time before the expiration of the exchange offer. Our failure to exercise any of the foregoing rights will not be a waiver of our rights.

Exchange Agent

You should direct questions, requests for assistance, and requests for additional copies of this prospectus and the BLUE-colored Letter of Transmittal to the exchange agent at:

U.S. BANK NATIONAL ASSOCIATION

By Registered or Certified Mail, Hand Delivery or Overnight Courier:

U.S. Bank National Association
Specialized Finance Unit
60 Livingston Avenue
St. Paul, MN 55107
Attention: Rachel Muehlbauer

By Facsimile:
(651) 495-8158

(For Eligible Institutions Only)

By Telephone:
(800) 934-6802

Delivery to an address other than set forth above will not constitute a valid delivery.

Fees And Expenses

We will not make any payment to brokers, dealers, or others soliciting acceptances of the exchange offer except for reimbursement of mailing expenses.

We will pay the estimated cash expenses connected with the exchange offer.

Accounting Treatment

The Exchange Notes will be recorded at the same carrying value as the existing Old Notes, as reflected in our accounting records on the date of exchange. Accordingly, we will recognize no gain or loss for accounting purposes. The expenses of the exchange offer will be expensed over the term of the Exchange Notes.

Transfer Taxes

If you tender outstanding Old Notes for exchange you will not be obligated to pay any transfer taxes. However, if you instruct us to register Exchange Notes in the name of, or request that your Old Notes not tendered or not accepted in the exchange offer be returned to, a person other than you, you will be responsible for paying any transfer tax owed.

YOU MAY SUFFER ADVERSE CONSEQUENCES IF YOU FAIL TO EXCHANGE OUTSTANDING OLD NOTES.

If you do not tender your outstanding Old Notes, you will not have any further registration rights, except for the rights described in the registration rights agreement and described above, and your Old Notes will continue to be subject to

restrictions on transfer when we complete the exchange offer. Accordingly, if you do not tender your Old Notes in the exchange offer, your ability to sell your Old Notes could be adversely affected. Once we have completed the exchange offer, holders who have not tendered Notes will not continue to be entitled to any increase in interest rate that the indenture provides for if we do not complete the exchange offer.

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Consequences Of Failure to Exchange

The Old Notes that are not exchanged for Exchange Notes pursuant to the exchange offer will remain restricted securities. Accordingly, the Old Notes may be resold only:

- (1) to us upon redemption thereof or otherwise;
- (2) so long as the outstanding securities are eligible for resale pursuant to Rule 144A, to a person inside the United States who is a qualified institutional buyer within the meaning of Rule 144A under the Securities Act in a transaction meeting the requirements of Rule 144A, in accordance with Rule 144 under the Securities Act, or pursuant to another exemption from the registration requirements of the Securities Act, which other exemption is based upon an opinion of counsel reasonably acceptable to us;
- (3) outside the United States to a foreign person in a transaction meeting the requirements of Rule 904 under the Securities Act; or
- (4) pursuant to an effective registration statement under the Securities Act, in each case in accordance with any applicable securities laws of any state of the United States.

Resale of the Exchange Notes

With respect to resales of Exchange Notes, based on interpretations by the staff of the SEC set forth in no-action letters issued to third parties, we believe that a holder or other person who receives Exchange Notes (other than a person that is our affiliate within the meaning of Rule 405 under the Securities Act) in exchange for Old Notes in the ordinary course of business and who is not participating, does not intend to participate, and has no arrangement or understanding with any person to participate, in the distribution of the Exchange Notes, will be allowed to resell the Exchange Notes to the public without further registration under the Securities Act and without delivering to the purchasers of the Exchange Notes a prospectus that satisfies the requirements of Section 10 of the Securities Act. However, if any holder acquires Exchange Notes in the exchange offer for the purpose of distributing or participating in a distribution of the Exchange Notes, the holder cannot rely on the position of the staff of the SEC expressed in the no-action letters or any similar interpretive letters, and must comply with the registration and prospectus delivery requirements of the Securities Act in connection with any resale transaction, unless an exemption from registration is otherwise available. Further, each broker-dealer that receives Exchange Notes for its own account in exchange for Old Notes, where the Old Notes were acquired by the broker-dealer as a result of market-making activities or other trading activities, must acknowledge that it will deliver a prospectus in connection with any resale of the Exchange Notes.

Shelf Registration

The registration rights agreement also requires that we file a shelf registration statement if:

- (1) we cannot file a registration statement for the exchange offer because the exchange offer is not permitted by law or SEC policy;
- (2) a law or SEC policy prohibits a holder from participating in the exchange offer;
- (3) a holder cannot resell the Exchange Notes it acquires in the exchange offer without delivering a prospectus and this prospectus is not appropriate or available for resales by the holder; or
- (4) a holder is a broker-dealer and holds Notes acquired directly from us or one of our affiliates.

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We will also register the Exchange Notes under the securities laws of jurisdictions that holders may request before offering or selling Notes in a public offering. We do not intend to register Exchange Notes in any jurisdiction unless a holder requests that we do so.

Old Notes may be subject to restrictions on transfer until:

- (1) a person other than a broker-dealer has exchanged the Old Notes in the exchange offer;
- (2) a broker-dealer has exchanged the Old Notes in the exchange offer and sells them to a purchaser that receives a prospectus from the broker, dealer on or before the sale;
- (3) the Old Notes are sold under an effective shelf registration statement that we have filed; or
- (4) the Old Notes are sold to the public under Rule 144 of the Securities Act.

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COMMUNITY HEALTH SYSTEMS, INC.**

The following table of our selected consolidated historical financial data should be read in conjunction with Management's Discussion and Analysis of Financial Conditions and Results of Operations and the consolidated financial statements and notes thereto incorporated by reference in this prospectus. The consolidated statement of operations data for each of the fiscal years ended December 31, 2004, 2005 and 2006, and the consolidated balance sheet data at December 31, 2005 and 2006 have been derived from our audited consolidated financial statements incorporated by reference in this prospectus. The consolidated balance sheet and statement of operations data as of and for the years ended December 31, 2002 and 2003 were derived from our audited consolidated financial statements, not included herein, giving effect to adjustments for discontinued operations. The consolidated statement of operations data for the six-month periods ended June 30, 2006 and June 30, 2007 have been derived from our unaudited interim condensed consolidated financial statements incorporated by reference in this prospectus. In the opinion of management, the unaudited interim financial data includes all adjustments, consisting of only normal non-recurring adjustments, considered necessary for a fair presentation of this information. The results of operations for interim periods are not necessarily indicative of the results that may be expected for the entire year. The following data should be read in conjunction with our consolidated financial statements and related notes, Management's Discussion and Analysis of Financial Condition and Results of Operations and other financial information included or incorporated by reference in this prospectus.

	Year Ended December 31,					Six Months Ended	
	2002	2003	2004	2005	2006	June 30,	2007
	(Dollars in thousands)						
Consolidated Statement of Operations Data:							
Net operating revenues	\$ 2,039,250	\$ 2,676,520	\$ 3,203,507	\$ 3,738,320	\$ 4,365,576	\$ 2,087,616	\$ 2,453,125
Salaries and benefits	820,765	1,070,283	1,279,136	1,486,407	1,741,223	827,815	981,421
Provision for doubtful accounts	177,761	255,808	324,643	377,596	547,781	223,295	284,360
Supplies	238,243	314,818	389,584	448,210	510,351	248,520	286,541
Rent	50,156	65,080	76,986	87,210	97,104	46,628	54,240
Other operating expenses	403,656	541,464	639,037	765,697	897,091	426,156	503,815
Minority interest in earnings	2,070	2,329	2,494	3,104	2,795	1,068	818
Depreciation and amortization	106,505	132,930	149,155	164,563	188,771	89,689	104,619
Total operating costs and expenses	1,799,156	2,382,712	2,861,035	3,332,787	3,985,116	1,863,171	2,215,814
	240,094	293,808	342,472	405,533	380,460	224,445	237,311

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Income from operations								
Interest expense, net	59,960	68,192	75,256	94,613	102,299	45,657	61,559	
Loss from early extinguishment of debt	8,646		788					
Income from continuing operations before income taxes	171,488	225,616	266,428	310,920	278,161	178,788	175,752	
Provision for income taxes	70,433	90,197	104,071	120,782	106,682	69,165	67,665	
Income from continuing operations	101,055	135,419	162,357	190,138	171,479	109,623	108,087	
Loss on discontinued operations, net of taxes	(1,071)	(3,947)	(10,924)	(22,594)	(3,216)	(3,216)		
Net income	\$ 99,984	\$ 131,472	\$ 151,433	\$ 167,544	\$ 168,263	\$ 106,407	\$ 108,087	
Balance Sheet Data:								
Working capital	\$ 329,296	\$ 298,016	\$ 453,090	\$ 476,806	\$ 446,101	\$ 405,857	\$ 521,289	
Property and equipment, net	1,029,337	1,395,345	1,484,548	1,610,991	1,986,577	1,757,218	2,089,142	
Cash and cash equivalents	132,844	16,331	82,498	104,108	40,566	24,157	21,357	
Total assets	2,809,496	3,350,211	3,632,608	3,934,218	4,506,579	4,178,660	4,793,111	
Total debt	1,192,458	1,474,658	1,831,735	1,667,624	1,941,177	1,677,604	1,999,997	
Other long-term obligations	102,832	156,577	225,390	283,738	301,842	289,592	346,880	
Stockholders equity	\$ 1,214,305	\$ 1,350,589	\$ 1,239,991	\$ 1,564,577	\$ 1,723,673	\$ 1,698,299	\$ 1,860,967	

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	Year Ended December 31,			Six Months Ended June 30,	
	2004	2005	2006	2006	2007
	(Dollars in thousands)				
Consolidated Data:					
Number of hospitals (at end of period)	66	69	77	74	79
Licensed beds(1)	7,358	7,974	9,117	8,546	9,550
Beds in service(2)	5,960	6,476	7,341	6,871	7,777
Admissions(3)	267,390	291,633	326,235	157,214	175,763
Adjusted admissions(4)	493,776	538,445	605,511	290,305	326,960
Patient days(5)	1,091,889	1,204,001	1,334,728	654,822	717,654
Average length of stay (days)(6)	4.1	4.1	4.1	4.2	4.1
Occupancy rate (beds in service)(7)	51.2%	52.9%	53.0%	54.5%	52.8%
Net operating revenues	\$ 3,203,507	\$ 3,738,320	\$ 4,365,576	2,087,616	2,453,125
Net inpatient revenues as a percentage of total net operating revenues	50.5%	50.9%	50.0%	50.3%	49.2%
Net outpatient revenues as a percentage of total net operating revenues	48.1%	47.8%	48.7%	48.4%	49.6%
Other Financial Data:					
Capital expenditures	\$ 164,286	\$ 188,365	\$ 224,519	\$ 94,194	\$ 108,849
Liquidity Data:					
Net cash flows provided by operating activities	\$ 325,750	\$ 411,049	\$ 350,255	\$ 207,046	\$ 215,988
Net cash flows used in investing activities	\$ (318,479)	\$ (327,272)	\$ (640,257)	\$ (295,767)	\$ (309,270)
Net cash flows provided by (used in) financing activities	\$ 58,896	\$ (62,167)	\$ 226,460	\$ 8,770	\$ 74,073

	Year Ended December 31,		Six Months Ended June 30,	
	2005	2006	2006	2007
	(Dollars in thousands)			
Same-Store Data:(8)				
Admissions(3)	291,633	294,820	155,696	156,330
Adjusted admissions(4)	538,445	543,074	288,022	289,197
Patient days(5)	1,204,001	1,213,429	649,396	641,224
Average length of stay (days)(6)	4.1	4.1	4.2	4.1
Occupancy rate (beds in service)(7)	52.9%	53.3%	54.7%	53.5%
Net operating revenues	\$ 3,737,607	\$ 4,000,828	\$ 2,072,549	\$ 2,182,151
Income from operations	\$ 406,774	\$ 365,173	\$ 225,266	\$ 225,635

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Depreciation and amortization	\$ 163,455	\$ 173,443	\$ 88,961	\$ 93,686
Minority interest in earnings	\$ 3,104	\$ 3,140	\$ 1,068	\$ 818

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

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- (3) Admissions represent the number of patients admitted for inpatient treatment.
- (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) Patient days represent the total number of days of care provided to inpatients.
- (6) Average length of stay (days) represents the average number of days inpatients stay in our hospitals.
- (7) We calculated percentages by dividing the average daily number of inpatients by the weighted average of beds in service.
- (8) Includes acquired hospitals to the extent we operated them during comparable periods in each year.

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OUR BUSINESS

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 net operating revenues. As of July 25, 2007, prior to the acquisition of Triad, we owned, leased or operated 79 hospitals, geographically diversified across 23 states, with an aggregate of 9,550 licensed beds. We generate revenues by providing a broad range of general hospital healthcare services to patients in the communities in which we are located. Services provided by our hospitals include emergency room services, general surgery, critical care, internal medicine, obstetrics and diagnostic services. As part of providing these services, we also own physician practices, imaging centers, home health agencies and ambulatory surgery centers. For the six months ended June 30, 2007, our net operating revenues were \$2,453 million.

Historically, we have grown by acquiring hospitals and by improving the operations of our facilities. We targeted hospitals in growing, non-urban healthcare markets for acquisition 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 and a lower level of managed care presence in these markets. We believe that smaller populations support less direct competition for hospital-based services. Over the past several years, we also have expanded our focus beyond these non-urban markets, acquiring larger facilities in more urban markets. Based on our experience and our observations about our industry, we have recognized that more rapid growth opportunities exist for a skillful and disciplined operator in selected larger markets.

On July 25, 2007, we acquired Triad, a publicly-owned hospital company. Triad provides a broad range of general hospital healthcare services to patients in non-urban and mid-size markets located primarily in the southern, midwestern and western United States. As of July 25, 2007, Triad owned, leased or operated 50 hospitals in 17 states, with an aggregate of approximately 9,600 licensed beds. Upon closing of the acquisition, we became the largest publicly-owned provider of hospital services, operating 129 hospitals in 28 states with an aggregate of approximately 19,200 licensed beds. Pro forma for the Triad acquisition, our net operating revenues for the year ended December 31, 2006 and the six months ended June 30, 2007 would have been \$9,903 million and \$5,429 million, respectively. In connection with the Merger, the Company obtained \$7,215 million of senior secured financing under the New Credit Facility and its wholly-owned subsidiary, CHS/Community Health Systems, Inc. issued the Old Notes at the Closing of the Merger. We also refer to the acquisition of Triad as the Merger. See Unaudited Pro Forma Condensed Financial Statements.

We believe the Triad acquisition will:

complement our non-urban market presence with mid-size markets having greater population growth than non-urban markets and less competition than major metropolitan markets;

increase the scale of our operations, enabling us to realize corporate overhead efficiencies and purchasing savings;

increase our operating growth and profitability as we centralize certain functions and standardize best practices across these facilities; and

increase our presence in 12 states and expand into five new states.

Our Industry

The U.S. healthcare industry is large and growing. CMS reported that in 2005, total U.S. healthcare expenditures grew by 6.9% to \$2.0 trillion. It also projected total U.S. healthcare spending to grow by 6.8% in 2006 and by an average of 6.9% per year through 2015. By these estimates, healthcare expenditures will account for approximately \$3.9 trillion, or 19.2% of the total U.S. gross domestic product, by 2015.

Hospital services, the market in which we operate, is the largest single category of healthcare at 31% of total healthcare spending in 2005, or \$611.6 billion, as reported by CMS. CMS projects the hospital services

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market to grow by an average of 7.0% per year through 2015. 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, CMS expects hospital services to remain the largest category of healthcare spending.

We believe that we are well-positioned to benefit from the expected growth in hospital spending as well as shifts in demographics in the United States. According to the U.S. Census Bureau, there are approximately 36.9 million Americans age 65 or older in the United States, who comprise approximately 13% of the total U.S. population. By the year 2030 the number of elderly is expected to climb to 71.5 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 9.6 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 current hospitals are located grew 19.6% from 1990 to 2005 and are expected to grow 4.9% from 2005 to 2010. The number of people aged 55 or older in these service areas grew 25.8% from 1990 to 2005, and is expected to grow 12.7% from 2005 to 2010. We believe the aging of the population will benefit both non-urban and mid-size markets, particularly in the southern regions in which we operate.

The acute care hospital sector is characterized by a stable Medicare reimbursement and commercial pricing environment. In the United States, general acute care hospitals are instrumental to the delivery of quality healthcare and represent a critical element of the overall healthcare infrastructure. Approximately 82% of these hospitals are owned and managed by not-for-profit or government entities that, according to the AHA, tend to have lower operating margins than investor-owned hospitals. We believe that Medicare, which accounts for approximately 30% of total hospital spending, will continue to provide appropriate pricing increases that will enable hospitals to provide high quality clinical care. For fiscal 2007, Medicare has budgeted a total payment increase of \$3,400 million for acute care inpatient services, which we believe is consistent with recent historical experience. CMS forecasts Medicare hospital spending to nearly double over the next 10 years.

Commercial pricing has also been stable for hospital providers, and we believe commercial payors typically offer rate increases that exceed those offered by Medicare. With respect to commercial reimbursement, based on our experience, well-positioned hospital companies generally have been successful at receiving mid- to high single-digit private pay increases over the past few years, and we expect this trend to continue.

Urban vs. Non-Urban Hospitals

According to the United States Census Bureau, 21% of the United States population lives in communities designated as non-urban. In these non-urban communities, hospitals are typically the primary source of healthcare. In many cases, a single hospital is the only provider of general healthcare services in these communities. According to the AHA, in 2006, there were approximately 2,000 non-urban hospitals in the United States. 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.

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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 can receive higher reimbursement rates. As of December 31, 2006, 19 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 operating margins. These payors have increasingly exerted pressure on healthcare service providers to reduce the cost of care. The most active payors in this regard have been health maintenance organizations, or HMOs, preferred provider organizations, or 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 2006, approximately 23.9% of our net operating revenues were paid by managed care organizations as compared to 23.7% in 2005 and 22.2% in 2004.

Our Strengths

We believe the following strengths will allow us to continue to improve our operations and profitability:

Leading local market provider. We are a leading provider of acute care services in the markets we serve. As of June 30, 2007, we are one of three or fewer providers in approximately 98% of our markets, and we are the sole provider in approximately 85% of our markets. We have focused on non-urban markets with strong demographic growth and underserved medical populations. In general, reimbursement is more favorable in these markets than in markets with more direct competition for hospital-based services. In some of our markets, we receive higher reimbursement rates from Medicare for designated sole community hospitals. Additionally, our leading market position enables us to achieve a strong return on investments in facility expansion and physician recruitment. As of June 30, 2007, pro forma for the Triad acquisition, we are one of three or fewer providers in approximately 86% of our markets and the sole provider in approximately 65% of our markets.

Geographic diversity and operating scale. We operated 79 hospitals in 23 states as of July 25, 2007, prior to the acquisition of Triad. With our acquisition of Triad, we have expanded into five new states and operate 129 hospitals across 28 states. Pro forma for the Triad acquisition, our 2006 revenue exposure to any one state is less than 13% (as compared to less than 21% for us prior to the acquisition). Our geographic diversity helps to mitigate risk associated with fluctuating state regulations related to Medicaid reimbursement and state-specific economic conditions. Furthermore, we believe our current operations, together with those we acquired from Triad, will enable us to realize the benefits of economies of scale, purchasing power and increased operating efficiencies.

Strong presence in attractive markets. The underserved non-urban markets, on which we have historically focused, provide an attractive environment for our operations. With fewer hospitals and healthcare providers and generally a lower level of managed care penetration, these markets allow us to profitably provide much needed acute care

services. We believe the Triad acquisition expands our presence in non-urban markets and complements our non-urban focus, as Triad's mid-size markets have greater population growth than non-urban markets. Triad's facilities also enjoy strong patient and physician loyalty and have less direct competition than hospitals in major metropolitan markets.

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Emphasis on quality of care. We have developed significant expertise in implementing a variety of programs to ensure continuous improvement in the quality of care provided at our hospitals. This is an evolving aspect of our business, as payors and accrediting agencies expand their views of quality to include measurement, reporting and continual improvement of the timeliness, safety, effectiveness, efficiency and patient-centeredness of clinical care. We understand that high levels of clinical care are only achieved when quality is a company-wide leadership focus that embraces patient, physician and employee satisfaction and continual, systematic improvements. Seeking the highest levels of improvement typically yields the best results for patients, reduces risk and improves our financial performance. We have developed and implemented programs to support and monitor quality of care improvement that include:

- standardized data and benchmarks to assist and monitor hospital quality improvement efforts;
- recommended policies and procedures based on the best medical and scientific evidence;
- hospital-based training and coaching to achieve success with respect to expectations of accrediting agencies;
- training programs for hospital management and clinical staff regarding regulatory and reporting requirements, as well as skills in leadership, communications and service;
- sharing of best practices for regulatory compliance and performance improvement; and
- evidence-based tools for improving patient, physician and staff satisfaction.

Strong history of generating revenue growth and improving profitability. Since 2001, we have grown from 57 to 79 hospitals and have increased revenue from \$1,657 million to \$4,366 million, and income from continuing operations from \$44.7 million to \$171.5 million for the year ended December 31, 2006 (2001 numbers are not restated for insignificant discontinued operations). We have improved profitability by recruiting primary care physicians and specialists, expanding our service offerings to include more complex care, optimizing our emergency room strategy across our portfolio of hospitals and selectively making capital investments in projects that generate a high return on investment. Upon closing of the Triad acquisition, we believe that a significant opportunity exists to continue to improve profitability, as approximately 30% of the combined company's facilities have been acquired within the past four years.

Experienced management team with a proven track record. We have a strong and committed management team that has substantial industry knowledge and a proven track record of operations success in the hospital industry. Our chief executive officer and chief financial officer each have over 30 years of experience in the healthcare industry and have worked together since 1973. Our management team has successfully acquired and integrated 55 hospitals, and we believe this experience positions us well to integrate and improve the operations of the Triad facilities in addition to successfully executing our business strategy.

Our Strategy

We intend to continue to grow our business and improve our financial performance by implementing our business strategy, the key elements of which are to:

- increase revenues at our facilities;
- increase operating efficiencies to improve profitability;

complete the successful integration of Triad; and

deleverage our balance sheet.

Increase Revenues at Our Facilities

Overview. We intend to increase revenues at our facilities by providing a broader range of services in a more attractive care setting. Our primary method of expanding medical services is recruiting additional primary care physicians and specialists. We intend to continue to expand the breadth of services offered at our hospitals through targeted capital expenditures to support the addition of more complex services, including

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orthopedics, cardiovascular services and urology. We also provide the capital to invest in technology and the physical plant at our facilities, particularly in our emergency rooms, surgery/critical care departments and diagnostic services.

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, obstetrics, gynecology, cardiovascular services, orthopedics and urology, completes the full range of medical and surgical services required to meet a community's core healthcare needs. We analyze demographic data and patient referral trends to identify the healthcare needs of the communities in which each of our hospitals is located. As a result of this analysis, we are able to determine what we believe to be the optimal mix of primary care physicians and specialists. We employ recruiters at the corporate level to support the local hospital managers in their recruitment efforts. We have increased the number of physicians affiliated with us through our recruiting efforts, net of turnover, by approximately 300 in 2006, 290 in 2005 and 270 in 2004. Over 60% of the physicians commencing practice with us in 2006 were specialists. Although in recent years we have begun employing more physicians, most of our physicians are in private practice in their communities and thus are not our employees. We have been successful in recruiting physicians because of the practice opportunities and income potential afforded physicians in our markets, as well as lower managed care penetration as compared to major metropolitan areas. We believe our analysis of community demographics and patient referral trends, our approach to determining the optimal mix of primary care physicians and specialists, and our centralized physician recruiting program can be successfully applied to Triad's facilities.

Emergency Room Initiatives. Approximately 60% of our hospital admissions originate in the emergency room. We systematically take steps to upgrade our emergency rooms and increase patient flow in our emergency rooms as a means of optimizing utilization rates for our hospitals. The impression of our overall operations by our customers is substantially influenced by our emergency rooms, since generally that is their first experience with our hospitals. One component of upgrading our emergency rooms is the implementation of specialized computer 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 and tracking patient flow. 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. 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 also implemented marketing campaigns that emphasize the quality and convenience of our emergency rooms to enhance community awareness. We believe the Triad acquisition presents an opportunity for growth, as Triad has not pursued a similar emergency room enhancement strategy.

Expansion of Services. In an effort to better meet the healthcare needs of the communities we serve and to capture a greater portion of the healthcare spending in our markets, we have added a broad range of services to our facilities. These services range from various types of diagnostic equipment capabilities to additional and renovated emergency rooms, surgical and critical care suites and specialty services. We continue to believe that appropriate capital investments in our facilities, combined with the development of our service capabilities, will reduce the migration of patients to competing providers while providing an attractive return on investment. Over the last four years, Triad has invested approximately \$1,573 million (or approximately 9% of revenues) into its facilities, and we believe we can leverage these already well-capitalized facilities and increase operating efficiencies and profitability.

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Increase Operating Efficiencies to Improve Profitability

Overview. We continually focus on improving operating efficiency to increase our operating margins. We seek to reduce costs and enhance efficiency through various methods and across the broad spectrum of our operations, including:

standardizing and centralizing our methods of operation and management;

improving quality of care and patient, physician and staff satisfaction;

implementing management and healthcare industry best practices, which drive efficiencies in areas as diverse and wide-ranging as adjusting staffing levels to patient volume and acuity, and adopting drug formularies;

utilizing our proven case and resource management program, which guides our hospitals in the allocation and application of resources, which assists in optimizing clinical care and, in turn, containing expenses;

capitalizing on our participation in a wide range of group purchasing arrangements by monitoring and ensuring compliance by our hospitals with the terms of those purchasing arrangements; and

utilizing standardized management information systems appropriate for the size and complexity of a particular hospital.

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 over 25 years of experience in the healthcare industry.

Standardization and Centralization. Our standardization and centralization initiatives encompass nearly every aspect of our business, from developing standard policies and procedures with respect to patient accounting and physician practice management to implementing standard processes to initiate, evaluate and complete construction projects. Our standardization and centralization initiatives are a key element in improving our operating results.

Physician Support. We support our newly recruited physicians to enhance their transition into our communities. We have implemented physician practice management seminars and training. We host these seminars bi-monthly.

Procurement and Materials Management. We have standardized and centralized our operations with respect to medical supplies, equipment and pharmaceuticals used in our hospitals. We are in the second year of a five-year participating agreement with automatic renewal terms of one year with HealthTrust, a GPO. HealthTrust is the source for a substantial portion of our medical supplies, equipment and pharmaceuticals.

Billing and Collections. We have adopted standard policies and procedures with respect to billing and collections. We have also automated and standardized various components of the collection cycle, including statement and collection letters and the movement of accounts through the collection cycle.

Internal Controls Over Financial Reporting. We have centralized many of our significant internal controls over financial reporting and standardized those other controls that are performed at our hospital locations. We continuously monitor compliance with and evaluate the effectiveness of our internal controls over financial reporting.

Case and Resource Management. Our case and resource management program guides our hospitals in the allocation and application of resources, assists in optimizing clinical care and, in turn, assists in containing expenses.

Facilities Management. We have standardized interiors, lighting and furniture programs. We have also implemented a standard process to initiate, evaluate and complete construction projects. Our corporate staff monitors all construction projects, and reviews and pays all construction project invoices. Our

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initiatives in this area have reduced our construction costs while maintaining the same level of quality, and have shortened the time it takes us to complete these projects.

Other Initiatives. We have also improved margins by implementing standard programs with respect to ancillary services in areas including emergency rooms, pharmacy, laboratory, imaging, home health, skilled nursing, centralized outpatient scheduling and health information management. We have reduced costs associated with these services by improving contract terms and standardizing information systems. We work to identify and communicate best practices and monitor these improvements throughout the Company.

Complete Successful Integration of Triad

We have successfully acquired and integrated 55 hospitals since 1996, and our focus over the next two years will be to successfully integrate the acquisition of Triad. We have an established, experienced and dedicated team to manage the integration of Triad. We believe that, in the first year following the acquisition of Triad, we will realize approximately \$28 million of annual cost savings related to cash expenses from the elimination of certain head count reductions and the elimination of certain duplicate overhead costs. We anticipate that we will realize additional savings from improved pricing opportunities under our purchasing contracts, the elimination of certain other duplicate corporate overhead costs and the implementation of other cost saving initiatives that management has identified. Additionally, we intend to continue to pursue a disciplined approach in making capital investments that generate a high return on investment, and will apply this focus to our acquired hospitals. Over the last four years, Triad has invested approximately \$1,573 million (or approximately 9% of revenues) into its facilities. We believe we can leverage these already well-capitalized facilities and increase operating efficiencies and profitability.

Deleverage Balance Sheet

Historically, we have generated relatively strong and stable cash flow which has allowed us to fund our growth-related investments while maintaining reasonable leverage levels. From March 31, 2000 (prior to the June, 2000 initial public offering of our common stock) to June 30, 2007, our debt as a percentage of total capitalization decreased from 86.6% to 51.8%. We intend to continue our strategy of utilizing cash flows from our combined operations to service debt and to fund our future growth initiatives. We will also consider issuing equity or equity-related securities or divesting selected hospital facilities to deleverage our balance sheet.

Sources of Revenue

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

the federal Medicare program;

state Medicaid or similar programs;

healthcare insurance carriers, HMOs, PPOs and other managed care programs; and

patients directly.

The following table presents the approximate percentages of net operating revenue received from Medicare, Medicaid, managed care, self-pay and other sources for the periods indicated. The data for the years

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presented are not strictly comparable due to the significant effect that hospital acquisitions have had on these statistics.

	2004	2005	2006
Net Operating Revenues by Payor Source			
Medicare	31.9%	32.0%	30.7%
Medicaid	10.3%	11.2%	11.0%
Managed Care	22.2%	23.7%	23.9%
Self-pay	12.9%	11.5%	11.9%
Other Third-Party Payors	22.7%	21.6%	22.5%
Total	100.0%	100.0%	100.0%

As shown above, we receive a substantial portion of our revenue from the Medicare and Medicaid programs. Other Third-Party Payors includes insurance companies for which we do not have insurance provider contracts, workers compensation carriers, and non-patient service revenue, such as rental income and cafeteria sales.

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 a hospital's customary charges for the services provided. Since a substantial portion of our revenue 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, employers, and by patients directly. The Blue Cross HMO payors are included in the above-captioned Managed Care line item. All other Blue Cross payors are included in the above-captioned Other Third-Party Payors line item. 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 Our Business 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.

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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 the Medicare and Medicaid programs. In addition, most of our hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations, or the Joint Commission. This accreditation indicates that a hospital satisfies the applicable health and administrative standards to participate in the Medicare and Medicaid programs.

Recent Changes. In recent years, numerous changes have been made in the oversight of healthcare providers to provide an increased emphasis on the linkage between quality of care criteria and payment levels. For example, hospital Medicare payments are now impacted by the hospital's accurate reporting of the basic elements of care provided to patients with certain diagnoses. As another indication of this trend and focus, the Joint Commission no longer gives numerical scores at scheduled triennial surveys; it now scores hospitals and other accredited providers on a pass-fail basis at unannounced surveys. Because hospitals no longer are able to prepare for a survey at a time certain, it is possible that there will be an increase in negative survey findings, which could lead to a loss of accreditation. Other provider types are facing similar changes in payment and quality oversight.

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 does any of the following:

- makes claims to Medicare for services not provided or misrepresents actual services provided in order to obtain higher payments;

- pays money to induce the referral of patients where services are reimbursable under a federal health program; or

- pays money to limit or reduce the services provided to Medicare beneficiaries.

HIPAA broadened the scope of the fraud and abuse laws. Under HIPAA, any person or entity that knowingly and willfully defrauds or attempts to defraud a healthcare benefit program, including private healthcare plans, may be subject to fines, imprisonment or both. Additionally, any person or entity that knowingly and willfully falsifies or conceals a material fact or makes any material false or fraudulent statements in connection with the delivery or payment of healthcare services by a healthcare benefit plan is subject to a fine, imprisonment or both.

Another law regulating the healthcare industry is a section of the Social Security Act, known as the anti-kickback 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

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remuneration of any kind in exchange for items or services that are reimbursed under most federal or state healthcare programs. 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, or OIG, is responsible for identifying and investigating fraud and abuse activities in federal healthcare programs. As part of its duties, the OIG provides guidance to healthcare providers by identifying types of activities that could violate the anti-kickback statute. The OIG also publishes 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 necessarily mean that the activity violates the anti-kickback statute.

The OIG has identified the following incentive arrangements as potential violations of the anti-kickback statute:

payment of any incentive by the hospital when 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 (but excluding compliance training);

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 number 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 relocation, reimbursement for certain direct expenses, income 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 could 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 patients to healthcare entities in which they or any of their immediate family members have ownership interests or other financial arrangements. These types of referrals are commonly known as self-referrals.

Sanctions for violating the Stark law include denial of payment, civil money penalties, assessments equal to twice the dollar value of each service and exclusion from government payor 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 an interest in 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

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customary financial arrangements between physicians and providers, including employment contracts, leases and recruitment agreements. In January 2002 and March 2004, the federal government issued regulations that interpret some of the provisions included in the Stark law. We strive to comply with the Stark law and regulations; however, the government may interpret the law and regulations differently. If we are found to have violated the Stark law or regulations, we could be subject to significant sanctions, including damages, penalties and exclusion from federal healthcare programs.

Many states in which we operate also have adopted, or are considering adopting, similar laws relating to financial relationships with physicians. 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.

False Claims Act. Another trend in healthcare litigation is the increased use of the False Claims Act, or FCA. This law makes providers liable for, among other things, the knowing submission of a false claim for reimbursement by the federal government. The FCA 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 and share in any recovery. When a private party brings a *qui tam* action under the FCA, it files the complaint with the court under seal, and 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 FCA can be up to three times the actual damages sustained by the government plus civil penalties of up to \$11,000 for each separate false claim submitted to the government. There are many potential bases for liability under the FCA. Although liability under the FCA arises when an entity knowingly submits a false claim for reimbursement, the FCA defines the term *knowingly* to include reckless disregard of the truth or falsity of the claim being submitted.

A number of states in which we operate have enacted or are considering enacting state false claims legislation. These state false claims laws are generally modeled on the federal FCA, with similar damages, penalties and *qui tam* enforcement provisions. An increasing number of healthcare false claims cases seek recoveries under both federal and state law.

Provisions in the Deficit Reduction Act of 2005, or the DRA, that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal FCA. Additionally, the DRA requires every entity that receives annual payments of at least \$5.0 million from a state Medicaid plan to establish written policies for its employees that provide detailed information about federal and state false claims statutes and the whistleblower protections that exist under those laws. Both provisions of the DRA are expected to result in increased false claims litigation against healthcare providers. We have complied with the written policy requirements.

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. Sanctions for failing to fulfill these requirements include exclusion from participation in the 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 seek to comply with the law, we can give no assurance that government officials responsible for enforcing the law or others will not assert that we are in violation of these laws.

Privacy and Security Requirements of HIPAA. The Administrative Simplification Provisions of HIPAA require the use of uniform electronic data transmission standards for healthcare claims and payment

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transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. We believe we are in compliance with these regulations.

The Administrative Simplification Provisions also require CMS to adopt standards to protect the security and privacy of health-related information. These privacy regulations became effective April 14, 2001, but compliance with these regulations was not required until April 2003. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. If we violate these regulations, we could be subject to monetary fines and penalties, criminal sanctions and civil causes of action. We have implemented and operate continuing employee education programs to reinforce operational compliance with policy and procedures which adhere to privacy regulations. Regulations relating to the security of electronic protected health information went into effect on April 21, 2003, and compliance was required as of April 21, 2005. The HIPAA security standards and privacy regulations serve similar purposes and overlap to a certain extent, but the security regulations relate more specifically to protecting the integrity, confidentiality and availability of electronic protected health information while it is in our custody or being transmitted to others. We believe we have established proper controls to safeguard access to protected health information.

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 government officials responsible 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.

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 44 hospitals in 12 states that have adopted certificate of need laws for acute care facilities. 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.

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 reviews 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 the process. 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 limit our ability to acquire additional hospitals.

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 could be financed, in part, by reductions in payments to healthcare providers under Medicare, Medicaid and other government programs. We cannot

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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.

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 PPS, our hospitals are paid a predetermined amount for each hospital discharge based on the patient's diagnosis. Specifically, each discharge is assigned to a DRG based upon the patient's condition and treatment during the relevant inpatient stay. For the federal fiscal year 2007, each DRG is assigned a payment rate using 67% of the national average charge per case and 33% of the national average cost per case. For the federal fiscal year 2008, each DRG is assigned a payment rate using 67% of the national average cost per case and 33% of the national average charge per case. For the federal fiscal year 2009, each DRG is assigned a payment rate using 100% of the national average cost per case. DRG payments are based on national averages and not on charges or costs specific to a hospital. 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 regulatory threshold.

The DRG rates are adjusted by an update factor on October 1 of each year, the beginning of the federal fiscal year (*i.e.*, the federal fiscal year beginning October 1, 2006 is referred to as the 2007 federal fiscal year). The index used to adjust the DRG rates, known as the market basket index, gives consideration to the inflation experienced by hospitals in purchasing goods and services. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, DRG payment rates were increased by the full market basket index, for the federal fiscal years 2004, 2005, 2006 and 2007 or 3.4%, 3.3%, 3.7% and 3.4%, respectively. The Deficit Reduction Act of 2005 imposes a 2% reduction to the market basket index beginning in the federal fiscal year 2007 if patient quality data is not submitted. We intend to comply with this data submission requirement. Future legislation may decrease the rate of increase for DRG payments, but we are not able to predict the amount of any reduction or the effect that any reduction will have on us.

In addition, hospitals may qualify for Medicare disproportionate share payments when their percentage of low income patients exceeds specified regulatory thresholds. A majority of our hospitals qualify to receive Medicare disproportionate share payments. For the majority of our hospitals that qualify to receive Medicare disproportionate share payments, these payments were increased by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 effective April 1, 2004. These Medicare disproportionate share payments as a percentage of net operating revenues were 2.1% for each of the three years ended December 31, 2006, 2005 and 2004, respectively.

Beginning August 1, 2000, we began receiving Medicare reimbursement for outpatient services through a PPS. Under the Balanced Budget Refinement Act of 1999, non-urban hospitals with 100 beds or fewer were held harmless through December 31, 2004 under this Medicare outpatient PPS. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 extended the hold harmless provision for non-urban hospitals with 100 beds or fewer and for non-urban sole community hospitals with more than 100 beds through December 31, 2005. The Deficit Reduction Act of 2005 extended the hold harmless provision for non-urban hospitals with 100 beds or fewer that are not sole community hospitals through December 31, 2008; however the Act reduces the amount these hospitals would receive in hold harmless payment by 5% in 2006, 10% in 2007 and 15% in 2008. Of our 77 hospitals at December 31, 2006, 31 qualified for this relief. The outpatient conversion factor rate was increased by 3.4% effective January 1, 2004; however, adjustments to other variables within the outpatient PPS resulted in an approximate 4.3% to 4.7% net increase in outpatient PPS payments. The outpatient conversion factor was increased 3.3% effective January 1, 2005; however, coupled with adjustments to other variables within the outpatient PPS resulted in an approximate 4.8% to

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5.2% net increase in outpatient PPS payments. The outpatient conversion factor was increased 3.7% effective January 1, 2006; however, coupled with adjustments to other variables with the outpatient PPS, an approximate 2.2% to 2.6% net increase in outpatient payments occurred. The outpatient conversion factor was increased 3.4% effective January 1, 2007; however, coupled with adjustments to other variables with the outpatient PPS, an approximate 2.5% to 2.9% net increase in outpatient payments is expected to occur.

Skilled nursing facilities and swing bed facilities were historically paid by Medicare on the basis of actual costs, subject to limitations. The Balanced Budget Act of 1997 established a PPS for Medicare skilled nursing facilities and mandated that swing bed facilities must be incorporated into the skilled nursing facility PPS. For federal fiscal year 2004, skilled nursing facility PPS payment rates are increased by the full market basket of 3.0% coupled with a 3.26% increase to reflect the difference between the market basket forecast and the actual market basket increase from the start of the skilled nursing facility PPS in July 1998. For federal fiscal year 2005, skilled nursing facility PPS payment rates were increased by the full market basket of 2.8%. For federal fiscal year 2006, skilled nursing facility PPS payment rates were increased 3.1%; however, coupled with adjustments to other variables within the skilled nursing facility PPS, an approximate 3.9% to 4.3% net increase in skilled nursing facility PPS payments occurred. For federal fiscal year 2007, skilled nursing facility PPS rates were increased by the full SNF market basket index of 3.1%.

The Department of Health and Human Services established a PPS for home health services effective October 1, 2000. The home health agency PPS per episodic payment rate increased by 3.3% on October 11, 2003. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 implemented an 0.8% reduction to the market basket increase to the home health agency PPS per episodic payment rate effective April 1, 2004 and for the federal fiscal years 2005 and 2006, and increased Medicare payments by 5.0% to home health services provided in rural areas from April 1, 2004 through March 31, 2005. The Deficit Reduction Act of 2005 extended the 5.0% increase to home health services provided in rural areas for an additional year effective January 1, 2006 and froze home health agency payments for 2006 at 2005 levels. The home health agency PPS per episodic payment rate increased by 2.3% on January 1, 2005, 0% on January 1, 2006, and 3.3% on January 1, 2007.

Medicaid. Most state Medicaid payments are made under a PPS or under programs which negotiate payment levels with individual hospitals. Medicaid is currently funded jointly by state and federal government. The federal government and many states are currently considering significantly reducing Medicaid funding, while at the same time expanding Medicaid benefits. We can provide no assurance that reductions to Medicaid funding will not have a material adverse effect on our results of operations.

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 specified 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. DRG outlier payments have been and continue to be the subject of CMS audit and adjustment. The OIG is also actively engaged in audits and investigations into alleged abuses of the DRG outlier payment system.

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.

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Supply Contracts

In March 2005, we began purchasing items, primarily medical supplies, medical equipment and pharmaceuticals, under an agreement with HealthTrust, a GPO in which we are a minority partner. By participating in this organization we are able to procure items at competitively priced rates for our hospitals. There can be no assurance that our arrangement with HealthTrust will provide the discounts we expect to achieve. Prior to March 2005, we had an agreement with and purchased supplies using Broadlane Inc., another GPO.

Competition

The hospital industry is highly competitive, including competition 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 and mid-size service areas. In approximately 85% of our markets, we are the sole provider of general healthcare services. After the Merger, this percentage decreased to 65%. In many of our other markets, the primary competitor is a not-for-profit hospital. These not-for-profit hospitals generally differ in each jurisdiction. In addition, our hospitals face competition from hospitals outside of their primary service area, including hospitals in urban areas that provide more complex services. These facilities generally are located some distance from our facilities. Patients in our primary service areas may travel to these other hospitals for a variety of reasons. These reasons include physician referrals or the need for services we do not offer. Patients who seek services from these other hospitals may subsequently shift their preferences to those hospitals for the services we provide.

Some of our hospitals operate in primary service areas where they compete with one or more other hospitals. Some of these competing hospitals use equipment and services more specialized than those available at our hospitals. In addition, some competing hospitals 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

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 where our utilization of standardization and centralization techniques and initiatives 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 functions. This approach is intended to reinforce our company-wide commitment to operate strictly in accordance with the laws and regulations that govern our business.

Our company-wide compliance program has been in place since 1997. Currently, the program's elements include leadership, management and oversight at the highest levels, a Code of Conduct, risk area specific policies and procedures, employee education and training, an internal system for reporting concerns, auditing and monitoring programs, and a means for enforcing the program's policies.

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,

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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 compliance with 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. Another focus of the program is the interpretation and implementation of HIPAA standards for privacy and security.

We have a Code of Conduct which applies to all directors, officers, employees and consultants, and a confidential disclosure program to enhance the statement of ethical responsibility expected of our employees and business associates who work in the accounting, financial reporting and asset management areas of our Company. Our Code of Conduct is posted on our website, www.chs.net.

Employees

At June 30, 2007, we employed approximately 26,000 full-time employees and 12,000 part-time employees. Of these employees, approximately 2,000 are union members. We currently 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 maintain professional malpractice liability insurance and general liability insurance on a claims made basis in excess of those amounts for which we are self-insured, in amounts we believe to be sufficient for our operations. We also maintain umbrella liability coverage for claims which, due to their nature or amount, are not covered by our other insurance policies. However, our insurance coverage does not cover all claims against us or may not continue to be available at a reasonable cost for us to maintain adequate levels of insurance. For a further discussion of our insurance coverage, see our discussion of professional liability insurance claims in Management's Discussion and Analysis of Financial Condition and Results of Operations Professional Liability Insurance Claims.

Environmental Matters

We are subject to various federal, state, and local laws and regulations governing the use, discharge and disposal of hazardous materials, including petroleum products and medical and/or low-level radioactive wastes. Compliance with these laws and regulations has not had, and is not in the future expected to have, a material adverse effect on our business, competitive position, or results of operations.

Environmental laws also can impose liability for the investigation and cleanup of environmental contamination on any current or former owners or tenants of property, or on those parties who sent wastes off-site for disposal. Although we are not currently aware of any such material obligations at any of our current or former properties or at third-party disposal sites, we may be required to conduct or participate in remedial activities in the future and may be subject to claims for personal injury or property or natural resources damages in the future as a result of such matters. The costs associated with such matters can be significant. We have insurance coverage for certain damages to personal property or personal injury arising out of contamination associated with some of our underground and above-ground storage tanks. This policy also pays for environmental clean up resulting from storage tank leaks. Our policy coverage is \$2.0 million per occurrence with a \$25,000 deductible and a \$5.0 million annual aggregate.

Legal Proceedings

From time to time, we receive various inquiries or subpoenas from state regulators, fiscal intermediaries, CMS 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. We are not aware of any pending or threatened litigation that is not covered by insurance policies or reserved for in our financial

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statements or which we believe would have a material adverse impact on us. It is also possible that claims may be filed against us that are under seal, which we may or may not be aware of or of which we may or may not be able to publicly disclose. With respect to any such items, we may not be able to assess the potential impact until the matter is unsealed and a full inquiry can be made.

In May 1999, we were served with a complaint in *U.S. ex rel. Bledsoe v. Community Health Systems, Inc.*, subsequently moved to the Middle District of Tennessee, Case No. 2-00-0083. This *qui tam* action sought 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 were extremely general, but involved Medicare billing at our White County Community Hospital in Sparta, Tennessee. By order entered on September 19, 2001, the U.S. District Court granted our motion for judgment on the pleadings and dismissed the case, with prejudice.

The *qui tam* whistleblower (also referred to as a relator) appealed the district court's ruling to the U.S. Court of Appeals for the Sixth Circuit. On September 10, 2003, the Sixth Circuit Court of Appeals rendered its decision in this case, affirming in part and reversing in part the District Court's decision to dismiss the case with prejudice. The court affirmed the lower court's dismissal of certain of plaintiff's claims on the grounds that his allegations had been previously publicly disclosed. In addition, the appeals court agreed that, as to all other allegations, the relator had failed to include enough information to meet the special pleading requirements for fraud under the False Claims Act and the Federal Rules of Civil Procedure. However, the case was returned to the district court to allow the relator another opportunity to amend his complaint in an attempt to plead his fraud allegations with particularity.

In May 2004, the relator in *U.S. ex rel. Bledsoe* filed an amended complaint alleging fraud involving Medicare billing at White County Community Hospital. We then filed a renewed motion to dismiss the amended complaint. On January 6, 2005, the District Court dismissed with prejudice the bulk of the relator's allegations. The only remaining allegations involve a handful of 1997-98 charges at White County. After further motion practice between the relator and the United States Government regarding the relator's right to participate in a previous settlement with the Company, the District Court again dismissed all claims in the case on December 13, 2005. On January 9, 2006, the relator filed a notice of appeal to the U.S. Court of Appeals for the Sixth Circuit and on September 6, 2007, the Court of Appeals issued its 25 page opinion affirming in part, reversing in part, and remanding the case to the District Court for further proceedings. We are in the process of evaluating our next steps with respect to this case.

In August 2004, we were served with a complaint in *Arleana Lawrence and Robert Hollins v. Lakeview Community Hospital and Community Health Systems, Inc. (now styled Arleana Lawrence and Lisa Nichols v. Eufaula Community Hospital, Community Health Systems, Inc., South Baldwin Regional Medical Center and Community Health Systems Professional Services Corporation)* in the Circuit Court of Barbour County, Alabama (Eufaula Division). This alleged class action was brought by the plaintiffs on behalf of themselves and as the representatives of similarly situated uninsured individuals who were treated at our Lakeview Hospital or any of our other Alabama hospitals. The plaintiffs allege that uninsured patients who do not qualify for Medicaid, Medicare or charity care are charged unreasonably high rates for services and materials and that we use unconscionable methods to collect bills. The plaintiffs seek restitution of overpayment, compensatory and other allowable damages and injunctive relief. In October 2005, the complaint was amended to eliminate one of the named plaintiffs and to add our management company subsidiary as a defendant. In November 2005, the complaint was again amended to add another plaintiff, Lisa Nichols, and another defendant, our hospital in Foley, Alabama, South Baldwin Regional Medical Center. Discovery has been concluded on the class determination issues. A class certification hearing was held on June 13, 2007 and we await the ruling of the court. We are vigorously defending this case.

On March 3, 2005, we were served with a complaint in *Sheri Rix v. Heartland Regional Medical Center and Health Care Systems, Inc.* in the Circuit Court of Williamson County, Illinois. This alleged class action was brought by the plaintiff on behalf of herself and as the representative of similarly situated uninsured individuals who were treated at

our Heartland Regional Medical Center. The plaintiff alleges that uninsured patients who do not qualify for Medicaid, Medicare or charity care are charged unreasonably high rates for

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services and materials and that we use unconscionable methods to collect bills. The plaintiff seeks recovery for breach of contract and the covenant of good faith and fair dealing, violation of the Illinois Consumer Fraud and Deceptive Practices Act, restitution of overpayment, and for unjust enrichment. The plaintiff class seeks compensatory and other damages and equitable relief. The Circuit Court Judge recently granted our motion to dismiss this case, but allowed the plaintiff to re-plead her case. The plaintiff elected to appeal the Circuit Court's decision in lieu of amending her case. The parties are briefing their positions. We are vigorously defending this case.

On April 8, 2005, we were served with a first amended complaint, styled *Chronister, et al. v. Granite City Illinois Hospital Company, LLC d/b/a Gateway Regional Medical Center*, in the Circuit Court of Madison County, Illinois. The complaint seeks class action status on behalf of the uninsured patients treated at Gateway Regional Medical Center and alleges statutory, common law, and consumer fraud in the manner in which the hospital bills and collects for the services rendered to uninsured patients. The plaintiff seeks compensatory and punitive damages and declaratory and injunctive relief. Our motion to dismiss has been granted in part and denied in part and discovery has commenced. *Gateway Regional Medical Center v. Holman* is a companion case to the *Chronister* action, seeking counterclaim recovery on a collections case. *Holman* has been stayed pending the outcome of the *Chronister* action. We are vigorously defending these cases.

On February 10, 2006, we received a letter from the Civil Division of the Department of Justice requesting documents in an investigation they are conducting involving the Company. The inquiry relates to the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients. These programs are referred to by different names, including intergovernmental payments, upper payment limit programs, and Medicaid disproportionate share hospital payments. The February 10th letter focused on our hospitals in three states: Arkansas, New Mexico and South Carolina. On August 31, 2006, we received a follow-up letter from the Department of Justice requesting additional documents relating to the programs in New Mexico and the payments to the Company's three hospitals there. For hospitals in New Mexico, the payments for this program approximate 0.3% of annual net operating revenue for 2006. We have provided the Department of Justice with the requested documents and continue to cooperate with the government's inquiry. We are unable at this time to evaluate the existence or extent of any potential financial exposure.

In August 2006, our facility in Petersburg, Virginia (Southside Regional Medical Center) was notified of the pendency of a federal False Claims Act case styled *U.S. ex rel. Vuyyuru v. Jadhav et al.* filed in the Eastern District of Virginia. In addition to naming the hospital, Community Health Systems Professional Services Corporation, our management subsidiary, has also been named. The suit alleges that Dr. Jadhav, Southside Regional Medical Center, and other healthcare providers performed medically unnecessary procedures and billed federal healthcare programs and also alleges that the defendants defamed Dr. Vuyyuru in the process of terminating his medical staff privileges. Almost all of the allegations pre-date our acquisition of this facility and the seller's successor-in-interest has agreed to indemnify the Company and its affiliates. We believe that the allegations in this case are without merit and are vigorously defending the case. A motion to dismiss the case has been granted and the relator has appealed the ruling to the U.S. Court of Appeals for the Fourth Circuit.

Triad Hospitals, Inc. Litigation

Triad is the subject of litigation entitled *In re: Triad Hospitals, Inc. Shareholders Litigation*, pending in the 296th District Court of Collin County, Texas. The consolidated amended petition alleges, among other things, that (i) the \$54 per share in cash purchase price to be paid to the stockholders in connection with the Triad merger with the Company is inadequate; (ii) the go shop auction process that led to the higher offer from the Company was flawed; (iii) the directors violated their fiduciary duties to shareholders by administering a sale process that failed to maximize shareholder value; (iv) the terms of the merger agreement with CHS, which included a so-called non-solicitation

clause and a \$130 million termination fee, would artificially deter higher bids for the Company; (v) the directors breached their fiduciary duties by approving, in mid December 2006, amended Change in Control Severance Agreements with several Triad executives; and

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(vi) the Company failed to disclose certain purportedly material information relating to the valuation of the Company and the process leading to the approval of the merger. The consolidated amended petition seeks declaratory rulings regarding the breaches of fiduciary duties, sought to enjoin the closing of the merger transaction, and an award plaintiffs attorneys fees and costs. The Company believes that this consolidated lawsuit is without merit. Shortly after filing their amended petition and initiating discovery, the plaintiffs abandoned their efforts to seek pre-merger relief. On September 19, 2007, the plaintiffs advised us that they were seeking to nonsuit the case, which will dispose of the case.

Triad, and its subsidiary, Quorum Health Resources, Inc. are defendants in a *qui tam* case styled *U.S. ex rel. Whitten vs. Quorum Health Resources, Inc. et al.*, which is pending in the Southern District of Georgia, Brunswick Division. Whitten, a long-term employee of a two hospital system in Brunswick and Camden, Georgia sued both his employer and Quorum Health Resources, Inc. and its predecessors, which had managed the facility from 1989 through September 2000; upon his termination of employment, Whitten signed a release and was paid \$124,000. Whitten's original *qui tam* complaint was filed under seal in November 2002 and the case was unsealed in 2004. Whitten alleges various charging and billing infractions, including charging for routine equipment supplies and services not separately billable, billing for observation services that were not medically necessary or for which there was no physician order, billing labor and delivery patients for durable medical equipment that was not separately billable, inappropriate preparation of patients' histories and physicals, billing for cardiac rehabilitation services without physician supervision, performing outpatient dialysis without Medicare certification, and performing mental health services without the proper staff assignments. In October 2005, the district court granted Quorum's motion for summary judgment on the grounds that his claims were precluded under his severance agreement with the hospital, without reaching two other arguments made by Quorum, which included that a prior settlement agreement between the hospital and the federal government precluded the claims brought by Whitten as well as the doctrine of prior public disclosure. On appeal to the 11th Circuit Court of Appeals, the court reversed the findings of the district court regarding the severance agreement, but remanded the case to the district court for findings on Quorum's other two arguments. Limited discovery has been conducted and renewed motions to resolve the case in Quorum's favor and to stay further discovery have recently been filed. The Company continues to believe that the relator's claims are without merit and will continue to vigorously defend this case.

In a case styled *U.S. ex rel. Bartlett vs. Quorum Health Resources, Inc., et al.*, pending in the Western District of Pennsylvania, Johnstown Division, the relator alleges in his second amended complaint, filed in January 2006 (the first amended complaint having been dismissed), alleges that Quorum conspired with the hospital to pay a illegal remuneration in violation of the anti-kickback statute and the Stark laws, thus causing false claims to be filed. A renewed motion to dismiss that was filed in March 2006 asserting that the second amended complaint did not cure the defects contained in the first amended complaint. In September 2006, the hospital and one of the other hospital affiliate defendants filed for protection under Chapter 11 of the federal bankruptcy code, which imposes an automatic stay on proceedings in the case. The Company believes that this case is without merit and should the stay be lifted, will continue to vigorously defend it.

Quorum is a defendant in a *qui tam* case styled *U.S. ex rel. Mosby vs. Quorum Health Resources, Inc., et al.*, pending in the Western District of Mississippi, Western Division. Mosby was a long time medical records employee at a Quorum managed facility. She alleges wrongful termination for being a whistleblower and because of her race. Mosby's first amended complaint was filed in May 2003 and contains allegations of false claims related to non-allowable costs and cost reports. In October 2003, Quorum filed a motion to dismiss, asserting that Mosby's substantive allegations were lifted from the 1997 Alderson case filed in Tampa against Quorum, which was resolved in a settlement with the government in 2001; without any predicate false claims cases, the Company believes that Mosby's retaliatory discharge allegations are unsupported. We await the court's ruling on this motion.

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TRIAD'S BUSINESS

Prior to our acquisition of Triad, Triad was one of the largest publicly owned hospital companies in the United States. Triad provides a broad range of general hospital healthcare services to patients in non-urban and mid-sized markets located primarily in the southern, midwestern and western United States. As of July 25, 2007, prior to the acquisition, Triad owned, leased or operated 50 hospitals in 17 states with an aggregate of approximately 9,600 beds. Triad also operates one general acute care hospital located in Dublin, Ireland. Included among Triad's U.S. hospital facilities is one hospital operated through a 50/50 joint venture that is not consolidated for financial reporting purposes and one hospital that is under construction. Triad is also a minority investor in three joint ventures that own seven general acute care hospitals in Georgia and Nevada. Through Triad's wholly-owned subsidiary, QHR, Triad also provides management and consulting services to independent general acute care hospitals located throughout the United States.

Triad's general acute care hospitals typically provide a full range of services commonly available in hospitals, such as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics, obstetrics, diagnostic and emergency services. These hospitals also generally provide outpatient and ancillary healthcare services such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology and physical therapy. Outpatient services also are provided by ambulatory surgery centers that Triad operates. In addition, some of Triad's general acute care hospitals have a limited number of licensed psychiatric beds and provide psychiatric skilled nursing services.

Triad's Formation

Triad's healthcare service business previously comprised the Pacific Group business of HCA, Inc., or HCA. On May 11, 1999, HCA divested its Pacific Group business to Triad through a spin-off to its stockholders. The spin-off was accomplished by a pro rata distribution of all outstanding shares of Triad's common stock to the stockholders of HCA. Triad was incorporated under the laws of the State of Delaware in 1999. Information about certain indemnification and other arrangements entered into by HCA and Triad in connection with the distribution is included in the consolidated financial statements.

On April 27, 2001, Triad completed its merger with Quorum Health Group, Inc., or Quorum, for approximately \$2,400 million in cash, stock and assumption of debt. Pursuant to the terms of the Quorum merger agreement, each former Quorum shareholder was entitled to receive \$3.50 in cash and 0.4107 shares of Triad's common stock for each outstanding share of Quorum stock, plus cash in lieu of fractional shares of Triad's common stock.

Triad's Markets

Triad provides a broad range of general hospital healthcare services to patients in non-urban and mid-size markets located primarily in the southern, midwestern and western United States. As of July 25, 2007, Triad owned, leased or operated 50 hospitals in 17 states. In approximately 70% of its markets, Triad is one of three or fewer providers and in approximately 38% of its markets, Triad is the sole provider.

Through QHR, Triad's separate contract management services and consulting subsidiary, Triad also provides consulting, education, intensive resource and management services to independent hospitals and hospital systems located primarily in non-urban areas throughout the United States.

Table of Contents**Triad's Selected Financial Data**

The following selected consolidated financial data of Triad as of and for the years ended December 31, 2004, 2005 and 2006 should be read in conjunction with and is qualified by reference to Management's Discussion and Analysis of Financial Condition and Results of Operations contained in Triad's Annual Reports on Form 10-K for the years ended December 31, 2004, 2005 and 2006, which are incorporated by reference in this prospectus, and Triad's audited consolidated financial statements and related notes to the consolidated financial statements for the years ended December 31, 2004, 2005 and 2006, which are incorporated by reference in this prospectus. The consolidated statement of operations data for the six month periods ended June 30, 2006 and June 30, 2007 have been derived from Triad's unaudited interim condensed consolidated financial statements incorporated by reference in this prospectus. The consolidated balance sheet and statement of operations data as of and for the years ended December 31, 2002 and 2003 were derived from Triad's audited consolidated financial statements, not included herein.

	Year Ended December 31,					Six Months Ended	
	2002	2003	2004	2005	2006	June 30,	2007
	(Dollars in millions)						
Income Statement Data:							
Revenues	\$ 3,145.3	\$ 3,550.6	\$ 4,218.0	\$ 4,747.3	\$ 5,537.9	\$ 2,747.3	\$ 2,975.9
Salaries and benefits	1,319.2	1,446.0	1,695.4	1,940.2	2,233.1	1,111.4	1,230.6
Reimbursable expenses	54.7	51.6	51.1	51.1	49.7	26.0	24.6
Supplies	491.9	556.4	692.4	801.3	957.9	471.7	505.7
Other operating expenses	567.1	663.2	781.2	874.0	1,069.8	525.4	610.3
Provision for doubtful accounts	237.8	360.6	427.2	403.3	576.9	248.9	303.5
Depreciation	140.0	153.0	172.3	199.6	223.2	108.8	119.4
Amortization	6.0	5.8	6.3	6.3	6.6	3.6	3.9
Interest expense	135.6	133.7	113.7	110.6	115.3	57.6	53.9
Interest income	(1.7)	(2.7)	(2.6)	(9.0)	(20.0)	(10.2)	(5.7)
Refinancing transaction costs		39.9	76.0	8.4			
ESOP expense	10.8	8.5	10.3	14.1	12.5	6.1	7.5
Litigation settlement	(10.4)						
(Gain) Loss on sales of assets	(4.5)	(1.4)		(0.4)	(6.0)	(0.6)	0.4
Total operating costs and expenses	2,946.5	3,414.6	4,023.3	4,399.5	5,219.0	2,548.7	2,854.1
Income from continuing operations before minority interests, equity in earnings and income tax provision	198.8	136.0	194.7	347.8	318.9	198.6	121.8

Minority interests in earnings of consolidated entities	(6.0)	(0.3)	(1.4)	(11.5)	(22.0)	(10.0)	(12.8)
Equity in earnings of affiliates	21.7	25.4	20.5	35.0	43.5	19.8	23.6
Income from continuing operations before income tax provision	214.5	161.1	213.8	371.3	340.4	208.4	132.6
Income tax provision	(86.0)	(64.1)	(81.8)	(141.9)	(132.5)	(80.5)	(60.7)
Income from continuing operations	128.5	97.0	132.0	229.4	207.9	127.9	71.9
Income (loss) from discontinued operations, net of tax	13.0	(1.8)	59.0	(3.4)	14.4	15.3	(0.4)
Net income(a)	\$ 141.5	\$ 95.2	\$ 191.0	\$ 226.0	\$ 222.3	\$ 143.2	\$ 71.5
Balance Sheet Data:							
Working capital	\$ 618.6	\$ 593.3	\$ 593.6	\$ 958.6	\$ 892.9	\$ 940.5	\$ 727.5
Property and equipment, net	1,767.1	2,023.0	2,264.0	2,584.2	2,940.2	2,769.6	3,169.0
Cash and cash equivalents	67.4	14.2	56.6	310.2	208.6	276.0	63.2
Total assets	4,381.6	4,735.4	4,981.4	5,736.9	6,233.8	5,997.5	6,379.2
Total debt	1,689.1	1,758.0	1,667.0	1,703.5	1,705.4	1,707.5	1,697.5
Other long-term obligations	314.7	419.2	501.0	598.1	721.8	645.5	713.1
Total stockholders equity	\$ 1,954.5	\$ 2,076.3	\$ 2,343.3	\$ 2,927.7	\$ 3,226.4	\$ 3,115.9	\$ 3,336.3

(a) Includes charges related to impairment of long-lived assets of discontinued operations of \$7.5 million (\$4.7 million after tax benefit) and \$18.5 million (\$12.4 million after tax benefit) for the years ended December 31, 2005 and 2003, respectively.

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	Year Ended December 31,			Six Months Ended	
	2004	2005	2006	June 30, 2006	2007
	(Dollars in millions)				
Consolidated Data:					
Number of hospitals (at end of period)(a)	45	48	52	50	50
Licensed beds(b)	7,475	8,674	9,614	9,250	9,618
Beds in service(c)	6,766	7,773	8,314	8,183	8,356
Admissions(d)	296,542	316,963	349,491	174,344	179,717
Adjusted admissions(e)	506,334	538,635	596,061	295,935	310,098
Patient days(f)	1,380,089	1,484,104	1,643,495	826,582	843,709
Average length of stay (days)(g)	4.7	4.7	4.7	4.7	4.7
Occupancy rate (beds in service)(h)	56.3%	52.0%	54.0%	55.8%	55.8%
Revenues	\$ 4,218.0	\$ 4,747.3	\$ 5,537.9	\$ 2,747.3	\$ 2,975.9
Net inpatient revenues as a percentage of total revenues	52.7%	54.6%	54.5%	54.6%	53.1%
Net outpatient revenues as a percentage of total revenues	47.3%	45.4%	45.5%	45.4%	46.9%
Other Financial Data:					
Capital expenditures	\$ 436.0	\$ 393.7	\$ 461.8	\$ 233.4	\$ 350.1
Liquidity Data:					
Net cash flows provided by operating activities	\$ 358.1	\$ 419.6	\$ 303.4	\$ 132.9	\$ 215.8
Net cash flows used in investing activities	\$ (209.9)	\$ (584.5)	\$ (467.9)	\$ (189.7)	\$ (375.0)
Net cash flows provided by (used in) financing activities	\$ (105.8)	\$ 418.5	\$ 62.9	\$ 22.6	\$ 13.8

	Year Ended December 31,		Six Months Ended	
	2005	2006	2006	2007
	(Dollars in millions)			
Same-Store Data(i)				
Admissions(d)	303,783	309,251	168,749	171,112
Adjusted admissions(e)	517,695	530,541	285,523	292,337
Patient days(f)	1,412,379	1,436,712	801,992	808,088
Average length of stay (days)(g)	4.7	4.7	4.8	4.7
Occupancy rate (beds in service)(h)	54.9%	55.2%	56.4%	56.5%
Net operating revenues	\$ 4,575,600	\$ 4,996,500	\$ 2,680,300	\$ 2,824,000
Income from operations	\$ 475,000	\$ 436,000	\$ 257,100	\$ 189,800
Depreciation and amortization	\$ 200,600	\$ 209,900	\$ 108,300	\$ 115,500
Minority interest in earnings	\$ 10,400	\$ 16,300	\$ 10,200	\$ 12,800

- (a) Number of hospitals excludes facilities designated as discontinued operations and facilities under construction. This table does not include any operating statistics for facilities designated as discontinued operations and non-consolidating joint ventures.
- (b) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

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- (c) Beds in service are the number of beds that are readily available for patient use.
- (d) Admissions represent the total number of patients admitted (in the facility for a period in excess of 23 hours) to our hospitals and are used by management and certain investors as a general measure of inpatient volume.
- (e) Adjusted admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Adjusted admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The adjusted admissions computation adjusts outpatient revenue to the volume measure (admissions) used to measure inpatient volume resulting in a general measure of combined inpatient and outpatient volume.
- (f) Patient days represent the total number of days of care provided to inpatients.
- (g) Average length of stay represents the average number of days admitted patients stay in our hospitals.
- (h) Occupancy rate represents the percentage of hospital available beds occupied by patients. Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.
- (i) Includes acquired hospitals to the extent Triad operated them during comparable periods in both years.

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

	Year Ended December 31,			Six Months Ended June 30,	
	2004	2005	2006	2006	2007
	(Expressed as a percentage of revenues)				
Consolidated(a):					
Revenues	100.0%	100.0%	100.0%	100.0%	100.0%
Operating expenses(b)	(88.0)	(85.5)	(87.6)	(86.2)	(89.4)
Depreciation and amortization	(4.3)	(4.3)	(4.2)	(4.1)	(4.1)
Minority interest in earnings	(0.0)	(0.2)	(0.4)	(0.4)	(0.4)
Income from operations	7.7	10.0	7.8	9.3	6.1
Interest expense, net	(2.6)	(2.2)	(1.7)	(1.7)	(1.6)
Income from continuing operations before income taxes	5.1	7.8	6.1	7.6	4.5
Provision for income taxes	(2.0)	(3.0)	(2.4)	(2.9)	(2.1)
Income from continuing operations	3.1	4.8	3.7	4.7	2.4
Income (Loss) on discontinued operations	1.4	(0.0)	0.3	0.5	0.0
Net income	4.5	4.8	4.0	5.2	2.4

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	Year Ended		Six Months
	December 31,		Ended
	2005	2006	June 30,
	2007		
	(Expressed in percentages)		
Percentage increase from prior year(s):			
Revenues	12.5	16.6	8.3
Admissions	6.9	10.3	3.1
Adjusted admissions(c)	6.4	10.7	4.8
Average length of stay			(1.0)
Same-store percentage increase from prior year(d):			
Revenues	6.5	9.2	5.4
Admissions	0.7	1.8	1.4
Adjusted admissions(c):	0.2	2.5	2.4

- (a) Pursuant to Statement of Financial Accounting Standards, or SFAS No. 144, Accounting for the Impairment or Disposal of Long-Lived Assets, Triad has restated its prior period financial statements and statistical results to reflect the reclassification of discontinued operations.
- (b) Operating expenses include salaries and benefits, reimbursable expenses, supplies, other operating expenses, provision for doubtful accounts, refinancing transaction costs, ESOP expense, litigation settlement, gain on sales of assets, and equity in earning of affiliates.
- (c) Adjusted admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Adjusted admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The adjusted admissions computation adjusts outpatient revenue to the volume measure (admissions) used to measure inpatient volume resulting in a general measure of combined inpatient and outpatient volume.
- (d) Includes acquired hospitals to the extent Triad operated them during comparable periods in both years.

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The following sets forth information regarding our executive officers (ages as of June 30, 2007). Each of our executive officers holds an identical position with CHS/Community Health Systems, Inc. and Community Health Systems Professional Services Corporation, two of our wholly owned subsidiaries:

Name	Age	Position
Wayne T. Smith	61	Chairman of the Board, President and Chief Executive Officer and Director (Class III)
W. Larry Cash	58	Executive Vice President, Chief Financial Officer and Director (Class I)
David L. Miller	58	Division President Operations
Gary D. Newsome	49	Division President Operations
Michael T. Portacci	49	Division President Operations
William S. Hussey	58	Division President Operations
Thomas D. Miller	49	Division President Operations
Rachel A. Seifert	48	Senior Vice President, Secretary and General Counsel
T. Mark Buford	54	Vice President and Corporate Controller
Harvey Klein, M.D.	70	Director (Class I)
H. Mitchell Watson, Jr.	70	Director (Class I)
Dale F. Frey	74	Director (Class II)
John A. Fry	47	Director (Class II)
John A. Clerico	66	Director (Class III)
Julia B. North	60	Director (Class III)

Wayne T. Smith serves as Chairman, President and Chief Executive Officer. Mr. Smith joined us in January 1997 as President. In April 1997, we also named him our Chief Executive Officer and a member of the Board of Directors. In February 2001, he was elected Chairman of our Board of Directors. Prior to joining us, Mr. Smith spent 23 years at Humana, Inc., most recently as President and Chief Operating Officer, and as a director, from 1993 to mid-1996. He is currently a member of the Board of Directors of (i) Citadel Broadcasting Corporation, and serves on its audit committee, and (ii) Praxair, Inc., and serves on its compensation and governance and nominating committees. Mr. Smith is a member of the board of directors and a past chairman of the Federation of American Hospitals.

W. Larry Cash serves as Executive Vice President and Chief Financial Officer. Prior to joining Community Health Systems, he served as Vice President and Group Chief Financial Officer of Columbia/HCA Healthcare Corporation from September 1996 to August 1997. Prior to Columbia/HCA, Mr. Cash spent 23 years at Humana, Inc., most recently as Senior Vice President of Finance and Operations from 1993 to 1996. He is also a director of Cross Country Healthcare, Inc. and serves on its audit (chair) and compensation committees.

David L. Miller serves as Division President Operations. Mr. D. Miller joined us in November 1997 as a Group Vice President, and presently manages hospitals in Alabama, Florida, Louisiana, North Carolina, South Carolina, Virginia and West Virginia. Prior to joining us, he served as a Divisional Vice President for Health Management Associates, Inc. from January 1996 to October 1997. From July 1994 to December 1995, Mr. D. Miller was the Chief Executive Officer of a facility owned by Health Management Associates, Inc.

Gary D. Newsome serves as Division President Operations. Mr. Newsome joined us in February 1998 as Group Vice President, and presently manages hospitals in Illinois, Kentucky, New Jersey and Pennsylvania. Prior to joining us, he was a Divisional Vice President of Health Management Associates, Inc. From January 1995 to January 1996, Mr. Newsome served as Assistant Vice President/Operations and Group Operations Vice President responsible for certain facilities operated by Health Management Associates, Inc.

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Michael T. Portacci serves as Division President – Operations. Mr. Portacci joined us in 1987 as a hospital administrator and became a Group Director in 1991. In 1994, he became Group Vice President, and presently manages hospitals in Arizona, California, Missouri, New Mexico, Texas, Utah and Wyoming.

William S. Hussey serves as Division President – Operations. Mr. Hussey joined us in June 2001 as a Group Assistant Vice President. In January 2003, he was promoted to Group Vice President to manage our acquisition of seven hospitals in West Tennessee, and in January 2004, he was promoted to Group Senior Vice President and assumed responsibility for additional hospitals. Mr. Hussey presently manages hospitals in Arkansas, Georgia, Kentucky and Tennessee. Prior to joining us, he served as President and CEO for a hospital facility in Ft. Myers, Florida (1998 to 2001). From 1992 to 1997, Mr. Hussey served as President – Tampa Bay Division, for Columbia/HCA Healthcare Corporation.

Thomas D. Miller serves as Division President – Operations. Mr. T. Miller joined the Company at the time of the Triad Merger and is assigned oversight responsibility for the Company’s facilities in Indiana, Kentucky, and Ohio. From 1998 until his promotion to his current position, Mr. T. Miller served as the president and chief executive officer of Lutheran Health Network in northeast Indiana, a system that includes five hospital facilities. For the ten years prior to 1998, he was with Hospital Corporation of America, in various, increasingly responsible positions of hospital and market leadership.

Rachel A. Seifert serves as Senior Vice President, Secretary and General Counsel. She joined us in January 1998 as Vice President, Secretary and General Counsel. From 1992 to 1997, she was Associate General Counsel of Columbia/HCA Healthcare Corporation and became Vice President – Legal Operations in 1994. Prior to joining Columbia/HCA in 1992, she was in private practice in Dallas, Texas.

T. Mark Buford, C.P.A., serves as Vice President and Corporate Controller. Mr. Buford has served as our Corporate Controller since 1986 and as Vice President since 1988.

Harvey Klein, M.D., has served as Attending Physician at the New York Hospital since 1992. Dr. Klein serves as the William S. Paley Professor of Clinical Medicine at Cornell University Medical College, a position he has held since 1992. He also has been a Member of the Board of Overseers of Weill Medical College of Cornell University since 1997. Dr. Klein is a member of the American Board of Internal Medicine and American Board of Internal Medicine, Gastroenterology.

H. Mitchell Watson, Jr., currently retired. From 1982 to 1989, Mr. Watson was a Vice President of IBM, serving from 1982 to 1986 as President, Systems Product Division, and from 1986 to 1989 as Vice President, Marketing. From 1989 to 1992, Mr. Watson was President and Chief Executive Officer of ROLM Company. Mr. Watson is a member of the Board of Directors of Praxair, Inc., and serves on its audit and compensation committee. Mr. Watson is chairman emeritus of Helen Keller International and the Chairman of the Brevard Music Center.

Dale F. Frey, was elected as our Lead Director in February 2004. Mr. Frey is currently retired. From 1984 until 1997, Mr. Frey was the Chairman of the Board and President of General Electric Investment Corp. From 1980 to 1997, he was also Vice President of General Electric Company. Mr. Frey is also a director of Ambassadors Group, Inc., and K&F Industries Holdings, Inc.

John A. Fry, presently serves as President of Franklin & Marshall College. From 1995 to 2002, he was Executive Vice President of the University of Pennsylvania and served as the Chief Operating Officer of the University and as a member of the executive committee of the University of Pennsylvania Health System. Mr. Fry is a member of (i) the Board of Directors of Allied Security Holdings, LLC, and (ii) the Board of Trustees of Delaware Investments, with oversight responsibility for all of the portfolios in that mutual fund family.

John A. Clerico, has served as chairman and as a registered financial advisor of ChartMark Investments, Inc. since 2000. From 1992 to 2000, he served as an Executive Vice President and the Chief Financial Officer and a Director of Praxair, Inc. From 1983 until its spin-off of Praxair, Inc. in 1992, he served as an executive officer in various financial and accounting areas of Union Carbide Corporation. Mr. Clerico currently serves

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on the Board of Directors of (i) Educational Development Corporation, and on its audit and executive committees, and (ii) Global Industries, Ltd., and on its audit and finance (chair) committees.

Julia B. North, was appointed to our Board of Directors in December 2004. She is presently retired. Over the course of her career, Ms. North has served in many senior executive positions, including as President of Consumer Services for BellSouth Telecommunications from 1994 to 1997. After leaving BellSouth Telecommunications in 1997, she served as the President and CEO of VSI Enterprises, Inc. She currently serves on the Board of Directors of (i) Acuity Brands, Inc., and on its compensation and governance and nominating committees, and (ii) Simtrol Inc., and on its audit committee.

The executive officers named above were appointed by the Board of Directors to serve in such capacities until their respective successors have been duly appointed and qualified, or until their earlier death, resignation or removal from office.

Table of Contents**SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT**

Holdings owns 100% of the Issuer's capital stock. The following table sets forth certain information with respect to the beneficial ownership of Holdings' common stock at September 17, 2007, by: (1) each person or entity who owns of record or beneficially 5% or more of any class of Holdings' voting securities; (2) each of our named executive officers and directors; and (3) all of our directors and named executive officers as a group. Except as noted below, the address for each of the directors and named executive officers is c/o CHS/Community Health Systems, Inc., 4000 Meridian Boulevard, Franklin, Tennessee 37067.

Name	Shares of Common Stock Beneficially Owned(1)	
	Number of Shares	Percentage of Class
5% Shareholders:		
FMR Corp.	9,222,049(2)	9.6%
TPG-Axon Management	6,234,000(3)	6.5%
T. Rowe Price Associates, Inc.	4,962,422(4)	5.1%
Directors:		
John A. Clerico	57,000(5)	*
Dale F. Frey	44,837(6)	*
John A. Fry	32,000(7)	*
Harvey Klein	42,000(8)	*
Julia B. North	28,000(9)	*
H. Mitchell Watson, Jr.	34,000(10)	*
Wayne T. Smith	2,092,541(11)	2.1%
W. Larry Cash	893,355(12)	0.9%
Other Named Executive Officers:		
David L. Miller	410,373(13)	*
Gary D. Newsome	348,845(14)	*
Michael T. Portacci	372,535(15)	*
All Directors and Executive Officers as Group (15 persons)	4,998,669(16)	5.0%

* Represents less than 1%.

(1) For purposes of this table, a person or group of persons is deemed to have beneficial ownership of any shares of common stock when such person or persons has the right to acquire them within 60 days after September 17, 2007. For purposes of computing the percentage of outstanding shares of common stock held by each person or group of persons named above, any shares which such person or persons have the right to acquire within 60 days after September 17, 2007 is deemed to be outstanding but is not deemed to be outstanding for the purpose of computing the percentage ownership of any other person.

(2) Shares beneficially owned are based on a Schedule 13G filed on February 14, 2007, by FMR Corp. The address of FMR Corp. is 82 Devonshire St., Boston, MA 02109.

(3)

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Shares beneficially owned are based on a Schedule 13G filed on June 21, 2007, by TPG-Axon Management. The address of TPG-Axon Management is 888 Seventh Avenue 38th Floor, New York, NY 10019. These securities are owned by GPLLC, PartnersGP, TPG-Axon Domestic, TPG-Axon Offshore, Dinakar Singh and Singh LLC. For purposes of reporting requirements of the Exchange Act, TPG-Axon Management, as investment manager to TPG-Axon Domestic and TPG-Axon Offshore, has the power to direct the disposition and voting of the shares held by TPG-Axon Domestic and TPG-Axon Offshore. PartnersGP is the general partner of TPG-Axon Domestic. GPLLC is the general partner of PartnersGP and TPG-Axon Management. Singh LLC is a Managing Member of GPLLC. Mr. Singh, an individual, is the Managing Member of Singh LLC and in such capacity may be deemed to control Singh LLC, GPLLC and TPG-Axon Management, and therefore may be deemed the beneficial owner of the

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securities held by TPG-Axon Domestic and TPG-Axon Offshore. Mr. Singh and Eric Mandelblatt are Co-Chief Executive Officers of TPG-Axon Management.

- (4) Shares beneficially owned are based upon a Schedule 13G filed on February 13, 2007, by T. Rowe Price Associates, Inc. The address of T. Rowe Price Associates, Inc., is 100 East Pratt St., Baltimore, MD 21202. These securities are owned by various individual and institutional investors, which T. Rowe Price Associates, Inc. (Price Associates) serves as investment advisor with power to direct investments and/or sole power to vote the securities. For purposes of the reporting requirements of the Exchange Act, Price Associates is deemed to be a beneficial owner of such securities; however, Price Associates expressly disclaims that it is, in fact, the beneficial owner of such securities.
- (5) Includes 20,000 shares subject to options which are currently exercisable or exercisable within 60 days of September 17, 2007.
- (6) Includes 15,000 shares subject to options which are currently exercisable or exercisable within 60 days of September 17, 2007.
- (7) Includes 15,000 shares subject to options which are currently exercisable or exercisable within 60 days of September 17, 2007.
- (8) Includes 25,000 shares subject to options which are currently exercisable or exercisable within 60 days of September 17, 2007.
- (9) Includes 10,000 shares subject to options which are currently exercisable or exercisable within 60 days of September 17, 2007.
- (10) Includes 15,000 shares subject to options which are currently exercisable or exercisable within 60 days of September 17, 2007.
- (11) Includes 1,099,999 shares subject to options which are currently exercisable or exercisable within 60 days of September 17, 2007.
- (12) Includes 559,999 shares subject to options which are currently exercisable or exercisable within 60 days of September 17, 2007.
- (13) Includes 226,666 shares subject to options which are currently exercisable or exercisable within 60 days of September 17, 2007.
- (14) Includes 226,666 shares subject to options which are currently exercisable or exercisable within 60 days of September 17, 2007.
- (15) Includes 226,666 shares subject to options which are currently exercisable or exercisable within 60 days of September 17, 2007.
- (16) Includes 2,826,662 shares subject to options which are currently exercisable or exercisable within 60 days of September 17, 2007.

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CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

We employ Brad Cash, son of W. Larry Cash. In 2006, Brad Cash received compensation of \$219,822, including relocation expense of \$29,941, while sequentially serving as a Chief Financial Officer of two of our hospitals.

In 2005, CHS established Community Health Systems Foundation, a tax-exempt charitable foundation. One of the purposes of the Foundation is to match charitable contributions made by the Company's directors and officers up to an aggregate maximum per year of \$25,000 per individual. In 2006, the Company contributed \$1.5 million to this foundation.

We believe each of the transactions or financial relationships were on terms as favorable as could have been obtained from unrelated third parties.

We had no loans outstanding during 2006 from us to any of our directors, nominees for director, executive officers, or any beneficial owners of 10% or more of our equity securities, or any family member of any of the foregoing.

We apply the following policy and procedure with respect to related person transactions. All such transactions are first referred to the General Counsel to determine if they are exempted or included under our written policy. If they are included, the transaction must be reviewed by the Audit and Compliance Committee to consider and determine whether the benefits of the relationship outweigh the potential conflicts inherent in such relationships and whether the transaction is otherwise in compliance with our Code of Conduct and other policies, including for example, the independence standards of the Governance Principles of the Board of Directors. Related person transactions are reviewed not less frequently than annually if they are to continue beyond the year in which the transaction is initiated.

Related person transaction means those financial relationships involving us and any of our subsidiaries, on the one hand, and any person who is a director (or nominee) or an executive officer, any immediate family member of any of the foregoing persons, any person who is a direct or beneficial owner of 5% or more of our common stock (our only class of voting securities), or is employed by or in a principal position with such an owner, on the other hand.

Exempted from related person transactions are those transactions in which the consideration in the transaction during a fiscal year is expected to be less than \$120,000 (aggregating any transactions conducted as a series of transactions).

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DESCRIPTION OF CERTAIN INDEBTEDNESS

New Credit Facility

In connection with the acquisition of Triad, we entered into the New Credit Facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The New Credit Facility provides for financing consisting of a \$6,065 million funded term loan facility with a maturity of seven years, a \$400 million delayed draw term loan facility with a maturity of seven years and a \$750 million revolving credit facility with a maturity of six years. The revolving credit facility also includes a subfacility for letters of credit and a swingline subfacility. In addition, we are entitled, subject to obtaining lender commitments and meeting certain other conditions, to incur up to an additional \$600 million term loans under the New Credit Facility.

The credit agreement requires us to make quarterly amortization payments of each term loan facility in quarterly amounts equal to 0.25% of the outstanding amount of the term loans, if any, with the outstanding principal balance payable on the anniversary of the credit agreement in 2014.

The term loan facility must be prepaid in an amount equal to (1) 100% of the net cash proceeds of certain asset sales and dispositions by Holdings and its subsidiaries, subject to certain exceptions and reinvestment rights, (2) 100% of the net cash proceeds of issuances of certain debt obligations by Holdings and its subsidiaries, subject to certain exceptions, and (3) 50%, subject to reduction to a lower percentage based on our leverage ratio, of excess cash flow for any year, commencing in 2008, subject to certain exceptions.

Voluntary prepayments and commitment r